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

[redacted]

APPEAL NO. 17F-00680
APPEAL NO. 17F-00755

PETITIONER,

Vs.

CASE [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Duval
UNIT: 88778

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned reconvened a telephonic administrative hearing in the above-referenced matter on January 23, 2018 at 2:00 p.m.

APPEARANCES

For the Petitioner: [redacted], Attorney for the petitioner.

For the Respondent: Roger Williams, Legal Counsel for the respondent.

ISSUE

At issue is the respondent's action on December 6, 2016 to deny the petitioner's request for Institutional Care Program (ICP) Medicaid for the retroactive months of August 2016 and September 2016.

The petitioner is also disputing the Department's inclusion as income, the healthcare premium amount during the period in question.

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

PRELIMINARY STATEMENT

Appeal Number 17F-00755 is closed as invalid as the issues under appeal involve granting a hardship on the funding of the QIT for the months of August 2016 and September 2016 and the inclusion of the health insurance premium as income, which are being addressed under Appeal Number 17F-00680.

The hearing was originally scheduled to convene on February 22, 2017 at 10:15 a.m.

On February 22, 2017, the undersigned received an email from the respondent to inform of the petitioner's attorney's request for a continuance to allow additional time to get the authorized representative form signed by the petitioner. The respondent did not object. The request for a continuance was granted. The hearing was rescheduled to April 13, 2017 at 10:15 a.m.

On April 13, 2017, the petitioner's attorney requested a continuance due to a break-in at his office.

On May 4, 2017, the respondent contacted the Office of Appeal Hearings by email and informed the undersigned that the petitioner's spouse and power-of-attorney stated that she did not authorize anyone to represent her husband and was not aware of a hearing request. The respondent also informed the undersigned that the petitioner's spouse did not want any more contact from the Department of Children and Families.

On May 23, 2017, the undersigned issued the Preliminary Order of Dismissal (POTD) to allow petitioner's spouse to submit in writing if there was a need for a hearing and to respond within 10 calendar days from the date of the order.

On May 27, 2017, the petitioner's spouse submitted written correspondence stating that there were inaccuracies in the POTD. The petitioner's spouse stated in the written correspondence that she requested a hearing and that she wished to proceed with the hearing. The petitioner's spouse stated in the letter that she wished for her attorney, [redacted] to represent the petitioner.

Based on the petitioner's spouse's written correspondence, the hearing was rescheduled to July 13, 2017 at 9:00 a.m.

On July 12, 2017, a joint motion for a continuance was filed due to a medical emergency on the part of the petitioner and due to the respondent's need to prepare for the hearing. The joint motion for a continuance was granted. The hearing was rescheduled to October 10, 2017 at 10:15 a.m.

On October 10, 2017, a joint motion for a continuance was requested. The joint request was granted. The hearing was scheduled to reconvene on October 18, 2017 at 3:30 p.m.

The hearing convened as scheduled on October 18, 2017 at 3:30 p.m.

Appearing as a witness for the petitioner was his daughter, [redacted].

Appearing as a witness for the respondent was Viola Dickinson, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

During the hearing, the petitioner's representative pointed out that there was a Notice of Case Action (NOCA) that was previously issued prior to the NOCA that was issued on December 9, 2016. The respondent submitted the NOCA, dated September 1, 2016, denying the application for ICP Medicaid, which was completed on August 1, 2016. The respondent contends that the petitioner did not request a hearing at the time. The respondent's records show that the hearing was requested on January 23, 2017.

The petitioner's representative contends that the requested verifications were provided and that a hearing was not requested at the time because he was under the impression that the respondent was going to reopen the case as information was provided.

The respondent contends that a review of the information was completed and that it was determined that the QIT was not properly funded for the month of August 2016; therefore, it could not reopen the case. The respondent requested for the appeal to be dismissed on its contention that the petitioner's representative failed to submit a timely request for a hearing.

Based on the evidence and testimony presented, the undersigned concludes that the issue under appeal for the NOCA dated September 1, 2016 is non-jurisdictional. The respondent issued a NOCA dated December 9, 2016 denying the petitioner's application for ICP Medicaid for the months of November 2016 through January 2017. The respondent explained that the Department can review any of the three retroactive months, which would include August 2016 and September 2016, from the date of the application that was submitted in November 2016. Since the petitioner's representative

requested a timely appeal for the NOCA dated December 9, 2016, the undersigned concludes that the Office of Appeal Hearings has jurisdiction over this matter. Therefore, the respondent's motion to dismiss the above-styled matter was denied

The hearing required rescheduling as the petitioner's representative requested a continuance to allow additional time to prepare for the hearing. The hearing was scheduled to reconvene on December 5, 2017 at 9:30 a.m.

On November 6, 2017, the petitioner's representative requested a continuance due to a conflict in his schedule. The respondent did not object. The request for a continuance was granted. The hearing was rescheduled to January 9, 2018 at 10:45 a.m.

The hearing convened as scheduled on January 9, 2018 at 10:45 a.m.

Appearing as a witness for the respondent was the petitioner's son-in-law, [redacted]

Appearing as an observer for the petitioner was the petitioner's spouse, [redacted]

The hearing exceeded the allotted time and required rescheduling. The hearing was rescheduled to January 23, 2018 at 2:00 p.m.

The hearing convened as scheduled on January 23, 2018 at 2:00 p.m.

Evidence was submitted and entered as the Petitioner's Exhibits 1 through 3 and the Respondent's Exhibits 1 through 2.

The record was held open until 5:00 p.m. on February 14, 2018 to allow the petitioner and 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 February 14, 2018.

FINDINGS OF FACT

1. The petitioner's representative applied for Institutional Care Program (ICP) Medicaid on August 1, 2016 (*Respondent's Exhibit 2, page 28*). The reported income was Social Security income in the amount of $582 and a civil service annuity from the Office of Personnel Management (OPM) in the amount of $2663, for a total of $3245.

2. The respondent contends that the income limit for ICP is $2205. The Department determined that the petitioner's income exceeded the income limit and required $1046 to be deposited into a Qualified Income Trust (QIT) in order to meet the income limit.

3. The petitioner's representative contends that the petitioner was residing in a nursing home and was later admitted into the hospital. The petitioner was eventually admitted into hospice, where he passed away at the age of 89 on [redacted] The petitioner's representative contends that the petitioner's family was confused as to the reason why the petitioner's case was approved and later denied.

4. The Department explained that the months of August 2016 and September 2016 were not approved because the QIT was not properly funded. The respondent contends that $1000 was deposited for the month of August 2016, when $1046 was

required. The respondent contends that $0 was deposited for the month of September 2016, when $1046 was required.

5. The Department explained that the petitioner's case was initially approved in October 2016 and later denied because it received notification that the petitioner passed away in [redacted].

6. The petitioner does not dispute that the QIT was not properly funded for the months of August 2016 and September 2016. The petitioner's representatives are seeking a hardship for not properly funding the account for those months. The petitioner's representative argues that the petitioner's spouse has limited means and that she is now having to live independently. The petitioner's representative argues that if the petitioner's spouse pays the facility the $10000 that is owed, it will drain her assets and create a financial hardship. The petitioner's representative argues that the petitioner's spouse, age 90, is in good physical health but will have a limited ability to survive if she has to pay the facility. The petitioner's representative contends that the petitioner's spouse has about $50000 in assets as of the date of the hearing. The petitioner's representative argues that the petitioner's spouse needs a hearing aid and that she needs sewage work on her home that costs $400. The petitioner's representative argues that the [redacted]) requires a conversion from a septic to a sewage system that will cost about $15000. The petitioner's representative argues that the petitioner's spouse's living expenses are an extra $1000. The petitioner's son in law contends that he assists the petitioner's spouse in her finances and that her income has been reduced. The petitioner's son in law

contends that the petitioner's spouse uses a portion of her savings to pay her monthly expenses and that her savings would be greatly reduced if she is to pay the facility what is owed.

7. The petitioner's representative also believes that the petitioner's health insurance premium that was deducted from his OPM annuity payment should be excluded as income, as he believes this was unavailable to him. The petitioner's representative argues that the OPM was not willing to change the distribution of income to the petitioner; therefore, he believes it was inaccessible. The petitioner's son in law argues that he contacted the OPM, who informed him that the premiums paid for insurance for the petitioner and his spouse was a requirement and could not be waived. The petitioner's representative was allowed the opportunity to provide any memorandum of law to support his position that the health insurance premium should not be included as income. No additional evidence was provided by the petitioner's representative.

8. The respondent contends that the petitioner provided bank statements to his bank accounts for the months of July 2016 and August 2016. The respondent contends that there was $40000 in a certificate of deposit (CD), $25000 in a credit union, $13000 in another credit union, and over $8000 in other credit union accounts available to the petitioner and the petitioner's spouse. The respondent contends that the petitioner's spouse was allowed to own assets that do not exceed the ICP resource limit in the amount of $120900.

9. The respondent explained that the individual's gross income is initially used to determine eligibility, and if determined eligible, the budgeting process is continued to

allow medical insurance premiums to be included as deductions. The respondent further explained that it expects the attorneys to explain to their clients what is needed to fund the QIT. The respondent explained that certain income may be considered to be unavailable if there is a divorced or separated couple and the court mandates for a certain amount of income, such as alimony, to be allocated to the spouse. The respondent contends that the petitioner's representative explained that the petitioner's spouse would not meet a hardship because she has proper representation, has sufficient income, and has access to a sufficient amount in assets. The Respondent's Exhibit 3 includes an email dated January 26, 2018 from Raymond Seigler, Senior Human Service Program Specialist with the Department of Children and Families, which states: "Under funding an income trust would not be grounds of a hardship case due to the clients receive medical care, food, shelter, and other necessities of life by the nursing facility. An undue hardship is defined by Fla. Admin. Code R. 65A-1.702(15)(e)…"

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. Federal Regulations at 20 CFR § 416.1121 Types of unearned income 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, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

13. The above authority explains that unearned income includes annuities and Social Security income. Therefore, the undersigned concludes that the respondent was correct to include the petitioner's annuity payments and Social Security income as income in its determination of eligibility for the ICP Medicaid program.

14. Federal Regulations at 20 CFR §416.1123 How we count unearned income states:

> (a) *When we count unearned income.* We count unearned income at the earliest of the following points: when you receive it or when it is credited to your account or set aside for your use. We determine your unearned income for each month. We describe exceptions to the rule on how we count unearned income in paragraphs (d), (e) and (f) of this section.
> (b) *Amount considered as income.* We may include more or less of your unearned income than you actually receive.
> (2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums.

15. The Department's Program Policy Manual, CFOP 165-22, passage 1840.0102 Deductions from Gross Income (MSSI, SFP) states:

> Some deductions withheld from gross income must be included as income. Examples of these deductions include:
> 1. premiums for Supplemental Medical Insurance (SMI/Medicare) from a Title II (Social Security) benefit,
> 2. premiums for health insurance or hospitalization,
> 3. premiums for life insurance,
> 4. federal and state income taxes,
> 5. Social Security taxes,
> 6. optional deductions,

7. a garnished or seized payment,
8. guardianship fees, and
9. child support if not redirected irrevocably from the source.

16. The above authorities explain that the Department is to include more unearned income than is received, such as the amount paid in Medicare premiums. The Department's policy further clarifies that premiums paid for health insurance must be included as income. The findings show that the healthcare premiums that were deducted from the petitioner's annuity payment were included as unearned income. The petitioner's representative was given the opportunity to provide evidence to support his position that the health insurance premium should not be counted as income but none was provided. The undersigned was not able to locate any governing authorities that would allow the respondent to exclude the health insurance premiums as income. Therefore, the undersigned concludes that the Department was correct to include the health insurance premiums paid by the petitioner as income.

17. The Fla. Admin. Code at R. 65A-1.713 sets forth the SSI-Related Medicaid income eligibility criteria and 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 Rule 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 Rule 65A-1.702(14)(a), F.A.C...
> (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., 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:

> (c) 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.
> (3) When Income Is Considered Available for Budgeting. The department counts income when it is received, when it is credited to the individual's account, or when it is set aside for their use, whichever is earlier...
> (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)...
> (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** (emphasis added).

18. The Department's Program Policy Manual, CFOP 165-22, passage 1840.0110 Income Trusts (MSSI), states:

> ……..
> 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…..
> The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested.** This may require the individual to begin funding an executed income trust account prior to its official approval by the Circuit Legal Counsel (emphasis added).

19. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, includes the Eligibility Standards for SSI-Related Programs, effective April 2016. The chart lists the income limit for an individual under the ICP Medicaid program as $2199 at the time of the Department's action.

20. The Department's Program Policy Manual, 165-22, at Appendix A-22.1, Guidelines For Reviewing Income Trusts, states in part:

> Step 2: If the monthly amount of income designated to go into the trust is subtracted from (excluded) the individual's gross income, is the individual's remaining income (outside the trust) below the institutional care income limit? (The eligibility specialist must verify how much income is designated to go into the trust account each month.)
> Cite: 42 CFR 435.236 and 435.1005; and subsection 409.904 (3), Florida Statutes.
> Background: The trust language does not have to indicate a specific amount of income will go into the trust account monthly; however, documentation must confirm that adequate funds are placed into the account each month to reduce the individual's available income outside the account to within the Institutional Care Program limits.
> Policy: Income cannot be excluded until it is placed into the trust. The individual is not eligible on the factor of income until his countable income (income outside the trust) is below the institutional care income limit. Trusts cannot be funded retroactively.

21. The above authorities explain that to be eligible for the ICP Medicaid program, an individual may not have gross income that exceeds 300% of the federal benefit rate after allowable deductions. Individuals whose income exceeds the income limit may qualify for ICP Medicaid by funding a QIT account that meets the criteria. For the ICP program, the Department determines if an individual's income qualifies him or her for the program by including his or her total gross income, excluding income placed in the QIT account, for the month in which the income is received. The total gross income must be less than the ICP income standard for the individual to be eligible for each month. If an individual's gross income exceeds the ICP income standard, the individual or the legal authorized representative must deposit sufficient income into the trust account in the month received to reduce the countable income to within the program income standard. The deposit must be made for each month ICP coverage is

requested. The income limit for an individual under the ICP program was $2199 at the time of the Department's action. The findings show that the petitioner's QIT was funded for the month of August 2016 in the amount of $1000 and $0 for the month of September 2016. The petitioner's representative does not dispute that the QIT was not properly funded for the months at issue.

22. According to the above controlling authorities, monthly income outside of the QIT is countable income and is compared to the limit of $2199. The petitioner's income outside of the QIT exceeded the ICP income limit for August 2016 and September 2016. In this case, the petitioner's gross monthly income totaled $3245. The applicable income limit for the ICP Program was $2199. The findings show that the petitioner's family deposited into the QIT an undisputed $1000 for the month of August 2016 and $0 for the month of September 2016. The petitioner's representative argues that the Department should allow a hardship to be granted in the petitioner's case, as paying the facility what is owed would create a financial hardship for the petitioner's spouse and his family. The undersigned could find no legal authority that would allow for a hardship to be granted in situations of an improperly funded QIT. The petitioner's representative was given the opportunity to supply memorandums of law to support his position that a hardship should be granted; none were provided. Based on the controlling authorities, the undersigned concludes that the petitioner did not meet his burden to show that the Department incorrectly denied his request for a hardship to be granted for the months of August 2016 and September 2016.

23. The undersigned concludes the Department's action to deny ICP eligibility for August 2016 and September 2016 was correct, as the petitioner's income exceeded the income limit.

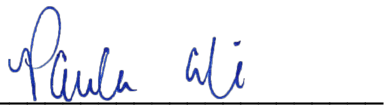
DECISION

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 __20__ day of __March_____, 2018, in Tallahassee, Florida.



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

[redacted]

APPEAL NO. 17F-06963

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 Indian River
UNIT: 88510

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on November 20, 2017, at 10:45 a.m. and reconvened on January 24, 2018, at 1:15 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Patricia Roy, DCF supervisor

STATEMENT OF ISSUE

At issue is whether Respondent's (or the Department) action to deny Petitioner's Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that she does not meet the disability criteria is proper. Petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

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 Department of Health's Division of Disability Determinations (DDD) conducts disability reviews regarding medical eligibility for individuals applying for disability benefits under the federal Social Security and Supplemental Security Income programs and the state Medically Needy program. Once a disability review is completed, the claim is returned to DCF for a final determination of non-medical eligibility and effectuation of any benefits due.

The appeal was continued from December 7, 2017, due to Petitioner's failure to appear for the reconvening of the hearing.

During the first hearing, no representative from the Division of Disability Determination (DDD) was present. Petitioner did not submit exhibits. Respondent submitted a 43-page evidence packet which was accepted and marked as Respondent's Composite Exhibit 1.

At the second hearing, Consevilla Martinez, Operations Service Manager with DDD, appeared as a witness for the Department. During the second hearing, Petitioner mentioned that she had not received any additional evidence related to the information DDD used to make its most recent determination, but agreed to go forward with the hearing. She did not submit any exhibits. Respondent submitted an additional evidence packet which was accepted and marked as Respondent's Composite Exhibit 2.

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. In March 2014, Petitioner underwent [redacted]. After the procedure, Petitioner experienced a [redacted] and developed [redacted]. She was diagnosed with [redacted] and [redacted]. She underwent [redacted] in September 2016.

2. After the surgery, Petitioner applied for Supplemental Security Income (SSI) with the Social Security Administration (SSA) alleging she is disabled. Petitioner is unsure of the exact date she applied or the reason she was denied. She filed an appeal challenging the SSA decision and has retained legal counsel to help with the process. As of the day of this hearing, the SSA appeal is still pending.

3. Prior to the issue under this appeal, Petitioner had been receiving Medicaid coverage under the Family-Related Medicaid Program, having an eligible minor in her household. She last received that coverage in [redacted] when her son turned 18.

4. Petitioner ([redacted] is 50-year old female with 12 years of educational experience. She does not meet the aged criteria for SSI-Related Medicaid benefits. She is not pregnant; does not have a minor child and no longer meets the technical requirement for the Family-Related Medicaid category. Petitioner did not allege blindness. Disability must be established to determine Medicaid eligibility.

5. Petitioner is not currently employed, but previously worked as a housekeeper for more than 10 years. Prior to that, she worked for a few years in a school cafeteria.

Petitioner has a history of medical issues going back 2014. After her [redacted], she worked briefly, then eventually stopped. She last worked in 2015.

6. On July 28, 2017, Petitioner applied for Medicaid benefits through the Department's SSI-Related Medicaid Program to continue her benefits. Information obtained from Petitioner was forwarded to DDD for review.

7. DDD reviewed Petitioner's medical records and determined that her conditions were not severe enough to prevent her from engaging in substantial gainful activity (SGA). DDD denied Petitioner Medicaid Disability on September 19, 2017. DDD denied Petitioner's application on the contention that she is capable of performing other work, no visual impairment (N 32).

8. On September 26, 2017, the Department mailed Petitioner a Notice of Case Action informing her that her July 28, 2017 Medicaid application was denied, "Reason: you or a member(s) of your household do not meet the disability requirement", see Respondent's Composite Exhibit 1. On October 12, 2017, Petitioner requested a hearing.

9. Initially, Respondent explained that DDD did not consider Petitioner's [redacted] a disabling condition. Petitioner disputed the [redacted] diagnosis and asserted as follows: That she has developed [redacted] and [redacted] after a gastric bypass. That she has [redacted] and [redacted] in her stomach and is constantly in pain. That she cannot remember things like she used to. That her SSA appeal will convene in March 2018. That she needs Medicaid to continue with her treatments until SSA makes a final decision.

10. After the first hearing, the Department contacted DDD regarding this case. On December 14, 2017, DDD requested additional medical records from [redacted], Inc. and [redacted], Inc. to perform a more thorough disability review.

11. An Interpretative Summary Assessment dated 6/10/2015 by [redacted], shows diagnoses of [redacted] and a score of 52 in Global Assessment of Functioning (GAF). A Mental Status Examination dated November 22, 2017 by [redacted] Master's Degree, indicates the petitioner's concentration was impaired; however, her abstractional capacity, insight and judgment were intact. A Psychiatric Evaluation Test dated December 19, 2017 by [redacted] indicates that Petitioner was diagnosed with [redacted] ([redacted] Her cognition, judgement, demeanor and thought process were within normal limits. Additionally, she had a full range of affect. No hospitalizations for a mental impairment have been reported within the past 12 months, *see* Respondent's Composite Exhibit 2, pages 29-35.

12. DDD utilizes a federally regulated five-step sequential evaluation in determining disability. Case Analysis Form dated September 22, 2017 indicates the steps that are followed and what is evaluated in each step:

– Is impairment severe? Yes.
– Is it expected to last more than a year? Yes
– Does the impairment meet or equal a disability listing in the federal regulation? No.
– Can claimant perform previous related work (PRW)? No.
– Can claimant perform other work? Yes.

> ADLs
> …Clmt is able to take care of her personal needs like bathing and dressing herself. Clmt does chores justa (sic) little bit at a time. Clmt does drive a little only to the store and back. Clmt does not do anykind (sic) of lifting, she does not have any trouble ambulating effectively. During the day she will lounge in the chair, and do some chores around the house. Clmt is taking medication. Clmt was diagnosed with [redacted], [redacted] back in 2014 after gastric bypass surgery…

13. DDD's Physical Residual Functional Capacity Assessment dated September 19, 2017, determined that all of Petitioner's recent physical exams are within normal limits with normal gait and no neurological deficits. Therefore, Petitioner is capable of:

> Occasionally lift and/or carry 20 pounds.
> Frequently lift and/or carry 10 pounds.
> Stand and/or walk (with normal breaks) about 6 hours in an 8-hour workday.
> Sit (with normal breaks) about 6 hours in an 8-hour workday.
> Push and/or pull (included operation of hand and/or foot controls) as unlimited, other than as shown for lift and/or carry.

14. Psychiatric Review Technique Form (PRTF) dated September 18, 2017 by [redacted] *see* Respondent's Composite Exhibit 1, pages 10- 36, addresses Petitioner's mental impairment and states in part.

> CONSULTANT'S NOTES
>
> …On going treatment records reveal minimal evidence of persisting psychopathology in spite of the reported complaints, with her mental complaints commanding no significant treatment attention. She is functionally independent within her physical tolerances. Mental illness is not severely limiting,

15. Psychiatric Review Technique Form (PRTF) dated January 18, 2018 by [redacted] [redacted] addresses Petitioner's mental impairment and states in part. The PRTF gives a diagnosis of [redacted]. Petitioner's mental impairment was rated as being "not severe." The categories upon which the PRTF is based are affective

disorders. Petitioner was given a mild rating as far as difficulties in maintaining concentration, persistence, and pace.

CONSULTANT'S NOTES

50yo with [redacted] in the contest of a [redacted] that had to be reversed. There has been recent worsening of her [redacted], such that her concentration is now impaired at times. She is able to relate effectively and appropriately in spite of some subjective distress. She is independent in ADLs within her physical tolerances.

16. A Mental Residual Functional Capacity (MRF) Assessment dated January 22, 2018 indicates the following conclusion:

A. Understanding and memory: Mild
B. Sustained concentration and Persistence: Moderate
C. Social: Mild
D. Adaptation: Mild

SUMMARY: Claimant can understand, retain and carry out complex instructions. Claimant can consistently and usefully perform familiar tasks on a sustained basis, with minimal (normal) supervision and can cooperate effectively with public and co-workers in completing simple tasks and transactions. Claimant can adjust to the mental demands of most new task settings. Functional restrictions beyond levels assessed above are not attributable to claimant's mental illness as reflected in the objective medical evidence on file.

17. DDD Medical Evaluation Form dated January 22, 2018 indicates the following:

Addendum:

The medical records show [redacted].

Mental was (sic) assessment was done and the PPCS provided a Psychiatric Review Technique and Mental Residual Functional Capacity Assessment. Clm with [redacted] in the contest of a failed [redacted] that had to be reversed. There has been recent worsening of her [redacted], such that her concentration is now impaired at times. She is able to relate effectively and appropriately inspite (sic) of some subjective distress. She is independent in ADLs within her physical tolerances.

> Based on clm's age, education and remaining profile clm can perform light work activity. Therefoer (sic), this case is denied N32. Voc Rule 201.13.

18. During the hearing, the witness explained the DDD's five-step evaluation process in details. The following are Petitioner's results (in bold).

> Step 1: Engaging in SGA. **N/A**
> Step 2: Is there a MDI? **Yes**
> Step 3: Does this impairment meet or equal a listing? **No**
> Step 4: Is the claimant able to perform PRW? **No**
> Step 5: Is the claimant able to perform other work? **Yes**

19. On January 22, 2018, DDD issued an updated decision denying Petitioner's Medicaid Disability with the same code N32-NON-PAY Capacity for SGA.

20. DDD asserts Petitioner's condition is not serious enough to meet eligibility in the SSI-Related Medicaid, in that she has enough physical and mental functional capacities to perform substantial gainful activity. The witness explained that the initial diagnosis of [redacted] was concluded based on smoking history information taken from the medical record. The witness testified that Petitioner's most recent medical records were reviewed and all relevant medical information was considered before issuing this most recent decision.

21. Respondent's witness further argued that Petitioner maintains the functional capacity to perform light physical exertion and a full range of light work consistent with vocational rule 202.13. Light physical exertion entails having the capacity to stand and walk for six hours in an eight-hour day, lift 20 lbs. occasionally, and 10 lbs. frequently. Respondent's witness argued Petitioner should be capable of performing the following light work jobs: cashier, ticket seller, and mail clerk.

22. Respondent explained that since DDD has determined that Petitioner does not meet its disability criteria, her Medicaid application was denied. Petitioner asserted that her current conditions are worsening by the day and that she has been avoiding appointments because she cannot afford to pay for doctors' visits. That she is constantly in pain and needs to rest on a regular basis. That she suffered from [redacted] and [redacted] and cannot concentrate or remember details. Petitioner maintains that she is physically and mentally unable to work. She is seeking Medicaid coverage to pay for much needed medical services while waiting on her disability appeal with SSA.

CONCLUSIONS OF LAW

23. 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.

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

25. 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, children, and pregnant women, and (2) Adult-Related (referred to as SSI-Related Medicaid) for disabled adults and adults 65 or older.

26. 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…
> (5) Medicaid for pregnant women…

27. Petitioner last received Family-Related Medicaid coverage in July 2017 when her child was a minor. The evidence submitted establishes that Petitioner no longer has a minor child in the home and is not pregnant. She is not age 65 or older and has not been considered disabled by the SSA. Therefore, the Department considered Petitioner for SSI-Related Medicaid.

28. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for Elderly and Disabled Individuals Who Have Income of Less Than the Federal Poverty Level. For an individual less than 65 years of age to receive 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.

29. Title 20 of the Code of Federal Regulations § 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.)

30. Federal Regulation 42 C.F.R. § 435.541 provides that a state Medicaid determination of disability must be in accordance with the requirements for evaluating evidence under the SSI program specified in 20 C.F.R. §§ 416.901 through 416.998.

31. Federal Regulation at 20.C.F.R. § 416.920, Evaluation of Disability of Adults, explains the five-step sequential evaluation process used in determining disability. The regulation states in part:

> (a) General—(1) Purpose of this section. This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 416.905.
> (2) Applicability of these rules. These rules apply to you if you are age 18 or older and you file an application for Supplemental Security Income disability benefits.
> (3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled.
> (4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. 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 at 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 § 416.909, 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 to subpart P of part 404 of this chapter 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 paragraph (f) and (h) of this section and § 416.960(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 paragraph (g) of this section and § 416.960(c).)
> (c) You must have a severe impairment. If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience.

32. The cited authority sets forth the five steps of a disability assessment. In evaluating Petitioner's claim of disability, the sequential evaluation as set forth in 20 C.F.R. §416.920 is used.

33. In evaluating the first step, it has been determined Petitioner is not presently engaging in SGA. Therefore, the first step is considered met.

34. In evaluating the second step, Petitioner's physical impairments are considered severe and meet requisite durational requirements. The second step is met.

35. The third step requires determining whether Petitioner's impairments meet or equal the "Listing of Impairments" indicated in Appendix 1 to subpart P of section 404 of the Social Security Act. Based on the cumulative evidence, Petitioner's impairments do not meet or equal the "Listing of impairments", which includes sections [redacted].

36. The evidence does not support meeting or equaling listing [redacted], which requires evidence of [redacted]

[redacted]. They may also lead to complications, such as [redacted], or be accompanied by manifestations in other body systems.

37. In terms of physical health, Petitioner remains quite functional. While she does have a history of [redacted] issues, her impairments do not rise to the level of severity required in listing 5.00. She has been gaining weight since the [redacted], from 99 lbs. in 2016 to 125lbs. in 2017.

38. Regarding section 12.00: Mental Disorders (specifically listings 12.03 [redacted] the objective medical evidence failed to showed any one extreme limitation or marked limitation of two of the following areas of mental functioning: 1) Understanding and Memory, 2) Sustained Concentration and Persistence, 3) Social (interaction with others), and 4) Adaption, which is a requirement of the listings. The evidence also failed to show a medically documented history of a chronic mental disorder of at least two year's duration that has caused more than a minimal limitation of ability to do basic work activities with symptoms or signs currently attenuated by medication or psychosocial support. Accordingly, Petitioner's impairments do not rise to the level of severity required for the above listings.

39. In terms of mental health, Petitioner is taking medication for [redacted]. The evidence indicates Petitioner is able to engage in activities of daily living, maintain social functioning. She reports no hospitalizations for a mental impairment within the past year. The evidence further shows she is capable of functioning independently outside of her home. In light of this, Petitioner's mental impairments do not rise to the level of severity required to meet or equal the above listings.

40. The fourth step requires determining whether Petitioner can still do past relevant work based on her residual functional capacity. Petitioner has past relevant work history working mostly as a housekeeper. Since petitioner has some mild restrictions in concentration, persistence & pace (CPP), it would be appropriate to move on to step five.

41. The fifth step requires considering Petitioner's residual functional capacity, age, education, and work experience to determine if she can adjust to other work. The evidence indicates Petitioner is a 50 year-old female with 12 years of educational experience with past relevant work history as a housekeeper. The DDD assessment shows Petitioner would be capable of performing light exertional activity based on her current physical and mental impairments; this is consistent with the cumulative evidence.

42. While the evidence shows Petitioner has some medically determinable impairments, these impairments (physical or mental) should not preclude her from adjusting to work in the national economy. Based on the totality of the evidence presented, Petitioner should be capable of performing light and even sedentary work. According to the Dictionary of Occupational Titles, some "light work" jobs include Cashier, code 211.362-010, Ticket Seller, code 211.467-030; and Mail Clerk, code 209.687-026. In light of this, Petitioner is found not disabled at step five, which is in accordance with medical-vocational guideline 202.13. *See* 20 C.F.R. §416.969.

DECISION

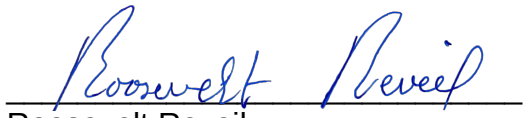
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department's action is affirmed.

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 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 01 day of March, 2017,

in Tallahassee, Florida.



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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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 08 Alachua
UNIT: 88264

RESPONDENT.
_____/

APPEAL NO. 17F-07017

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 30, 2018 at 1:11 p.m.

APPEARANCES

For the Petitioner: [redacted], pro se

For the Respondent: Stephanie Ross, economic self-sufficiency specialist II

STATEMENT OF ISSUE

At issue the petitioner's enrollment in the SSI-Relative Medicaid Program with a $732 monthly share of cost. The petitioner seeks a lower share of cost. The petitioner holds the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The Department of Children and Families (Department or respondent) determines eligibility for both the Family-Related and SSI-Related Medicaid Programs.

By notice dated October 6, 2017, the Department informed the petitioner that she was enrolled in the SSI-Related Medically Needy Program with a $732 share of cost.

On October 16, 2017, the petitioner requested a hearing to challenge the decision.

The hearing was scheduled to convene telephonically on November 27, 2017 at 3:00 p.m., but was continued at the petitioner's request for time to obtain legal advice and/or seek legal representation.

On January 3, 2018, the petitioner left a voicemail message which stated that she had obtained legal advice and was ready to proceed with the hearing pro se.

Pursuant to notice the hearing was rescheduled for January 30, 2018 at 1:00 p.m. and convened as scheduled.

There were no additional witnesses for the petitioner. The petitioner submitted documentary evidence which was admitted into the record as Petitioner's Exhibit 1.

There were no additional witnesses for the Department. The Department submitted documentary evidence which was admitted into the record as Respondent's Exhibit 1.

The hearing record was closed on January 30, 2018.

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) has been determined disabled by the Social Security Administration. She received Supplemental Security Income (SSI) from at least

January 2017 – June or July 2017. Individuals who receive SSI are also eligible to receive full coverage Medicaid benefits.

2. The petitioner was approved for $932 monthly Social Security spousal survivor benefits (from her late husband) in June or July 2017. Her SSI was terminated. 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 $732 monthly share of cost. (Respondent's Composite Exhibit 1)

3. The petitioner requested a hearing on October 16, 2017. She seeks a lower share of cost.

4. The petitioner explained that she has been diagnosed with multiple medical conditions which require numerous prescription medications. The medications were being paid for by Medicaid prior to termination of her full coverage benefits. The petitioner stated that the medications are medically necessary, but she cannot afford to pay the total expense out-of-pocket, nor can she afford to incur $732 in medical expenses each month in order to be eligible for Medicaid. The petitioner would like her share of cost lowered to approximately $46 monthly; this is the amount she can afford after paying all her other monthly expenses. (Petitioner testimony)

5. The petitioner estimated that she currently pays approximately $125 to $150 monthly out-of-pocket for the essential prescription medication only, but did not have documentation of her estimate. (Petitioner testimony)

6. The Department explained its 2017 budget calculation. The Department's Program Policy Manual at Appendix A-9 shows the October 2017 income limit for full

coverage SSI-Related Medicaid for an individual was $885. The petitioner's $932 monthly Social Security survivor income exceeded program limitations. Accordingly, the Department enrolled petitioner in the Medically Needy Program. The Department explained its calculations as follows: $932 gross income minus $20 standard disregard and $180 Medically Needy Income Level (MNIL) equals share of cost of $732. (Respondent Composite Exhibit 1)

7. The Department explained that its policies require documentation of recurring out-of-pocket medical expenses prior to budgeting and encouraged the petitioner to submit verification of her asserted monthly out-of-pocket prescription expenses. (Department testimony)

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 for October 2017 set the income limit for full Medicaid for an aged or disabled individual at $885. The petitioner's monthly income of $932 exceeded that limit. The Department's determination that the petitioner was no longer 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 $732 share of cost. The Department's determination in this matter was correct.

18. Fla. Admin. Code R. 65A-1.713(4)(c) addresses recurring out-of-pocket medical expenses:

> …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.

19. The cited authority allows a deduction for certain recurring out-of-pocket medical expenses. The petitioner may wish to file documentation of her asserted out-of-pocket monthly medical expenses with the Department to determine if the expenses impact her share of cost.

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 __March_____, 2018,

in Tallahassee, Florida.

Leslie Green

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]
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Flagler
UNIT: 88368

RESPONDENT.
_____/

APPEAL NO. 17F-07094

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 5, 2018 at 9:35 a.m.

APPEARANCES

For the Petitioner: The petitioner was not present and was represented by [redacted]

For the Respondent: Ernestine Bethune, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

ISSUE

At issue is the respondent's action on October 18, 2017 to deny the petitioner's application for Family-Related Medicaid due to the imposition of a Child Support Enforcement (CSE) sanction.

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

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on December 4, 2017 at 9:30 a.m.

On November 30, 2017, the petitioner's representative contacted the Office of Appeal Hearings by email to request a continuance. The petitioner's request was granted. The hearing was rescheduled to convene on February 5, 2018 at 9:30 a.m.

Appearing as a witness for the respondent was Mari Coyle, Revenue Administrator III with CSE for the Department of Revenue (DOR).

Evidence was received and entered as the Respondent's Exhibits 1 through 2. The record was held open until 5:00 p.m. on February 9, 2018 to allow the respondent to provide additional evidence, which was received and entered as the Respondent's Exhibit 3.

The record was closed at 5:00 p.m. on February 9, 2018.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was referred to CSE to cooperate on providing information on the absent parent.

2. On July 24, 2017, the CSE sent an Appointment Notice (Notice) requesting for the petitioner to go into its local office, on or before August 4, 2017 between the hours of 8:00 a.m. to 5:00 p.m. to provide information. The Notice instructed the petitioner that failure to cooperate with the CSE program may result in a reduction in her benefits. (*Respondent's Exhibit 2, page 15*).

3. The Department received a Data Exchange Alert on August 8, 2017 from the CSE to impose a sanction against the petitioner on its contention that the petitioner failed to cooperate with the agency (*Respondent's Exhibit 2, page 16*). The Respondent's Exhibit 2 includes the Running Records Comments (CLRC) dated August 9, 2017, which states: "Case Notes: DEALS cleared completed CSE sanction impose for "L, J" for "E, N" 08/08/17 per CSE ran aabc to update case…" On, or around, August 9, 2017, the Department imposed a CSE sanction against the petitioner, effective September 1, 2017, on its contention that she failed to cooperate with the CSE program.

4. On September 26, 2017, the petitioner completed an application to apply for Family-Related Medicaid for herself and her two children. The application does not list any other information regarding a designated representative applying for benefits for the petitioner (*Respondent's Exhibit 2, pages 6 through 11*). The Department explained that the processor sent to the petitioner the Notice of Case Action on October 18, 2017 to inform her that in order for her to receive Medicaid, she would need to contact CSE to "remove the sanction…and possibly increase…benefits…" (*Respondent's Exhibit 2, pages 21 through 22*). The Notice of Case Action dated October 18, 2017 (*Respondent's Exhibit 2, pages 21 through 22*) and CLRC notes (*Respondent's Exhibit 2, page 17*) dated October 18, 2017 do not indicate that there were other verifications requested. The Respondent's Exhibit 2, pages 12 through 13, includes a copy of the ACCESS Management System (AMS) screen to show that the petitioner was advised to contact CSE in order to remove her existing CSE sanction. The Department's evidence

shows that the case was denied the same day per the Notice of Case Action dated October 18, 2017 (*Respondent's Exhibit 1*).

5. The petitioner's representative is seeking Medicaid coverage for the month of September 2017. The petitioner's representative argues that the Department sent the Notice of Case Action on October 18, 2017 to request for the petitioner to cooperate with the CSE program and denied the application on the same day. The petitioner's representative argues that she did not get a copy of the Notice of Case Action informing the petitioner to lift the sanction; however, she acknowledges that she is not listed on the application as the designated representative. The petitioner's representative argues that the designated representative form was submitted to the Department at a later date; therefore, she believes the Department should have been aware that she was representing the petitioner.

6. The petitioner's representative believes the petitioner is not pregnant. The petitioner's representative is not aware of any type of domestic violence or abuse situation from the noncustodial parent that would prevent the petitioner from cooperating with the CSE program.

7. The Department's witness contends that the petitioner did not cooperate with the CSE program. The Department's witness contends that its business records do not indicate that any mail that was mailed to the petitioner's address on file was returned as undeliverable. The Department's witness contends that it has a tracking system in place, called E-Services, which is an online webchat system for its clients to use to communicate with the agency. The Department's witness explained that its tracking

system does not indicate that the petitioner attempted to contact the agency regarding the appointment.

8. The Department explained that the petitioner's CSE sanction was already imposed effective September 1, 2017 and could not be automatically lifted when the new application was filed. The Department acknowledges that the petitioner's case was not touched until October 18, 2017 due to delays caused by Hurricane Irma, but contends that the sanction remains until it receives notification that she has cooperated with CSE. The Department explained that the only way it would have been able to lift the CSE sanction and authorize the requested month of Medicaid coverage would be if it had received notification from CSE that the petitioner had cooperated with the program at any time during the month of September 2017.

9. The petitioner's representative argues that because the Department failed to submit a pending notice in a timely manner, the petitioner did not have ample time to cooperate with the CSE program in order to be approved for Medicaid coverage for the period in question. Therefore, the petitioner's representative believes that the Department should reopen the petitioner's case and allow time for the petitioner to cooperate with the CSE program. The petitioner's representative contends that she has not been able to get in contact with the petitioner to discuss the denial notice; therefore, she does not know if the petitioner would have cooperated with the CSE program if she were able to get in touch with her.

10. The Department explained that the Notices of Case Action to inform the petitioner of the imposed CSE sanction, were mailed to the petitioner on October 18,

2017, and that its records indicate that she has not yet cooperated with CSE. The Department explained that even if the petitioner were to now cooperate with the CSE program, it cannot retroactively lift the sanction for the month of September 2017 unless she cooperated with CSE in September 2017. The Department's witness contends that its records show that, as of the date of the hearing, the petitioner has not attempted to contact CSE in order to cooperate with its program.

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. Section 414.095, Florida Statutes states:

> (6) As a condition of eligibility for public assistance, the family must cooperate with the state agency responsible for administering the child support enforcement program in establishing the paternity of the child, if the child is born out of wedlock, and in obtaining support for the child or for the parent or caretaker relative and the child. Cooperation is defined as:
> (a) Assisting in identifying and locating a parent who does not live in the same home as the child and providing complete and accurate information on that parent;
> (b) Assisting in establishing paternity; and
> (c) Assisting in establishing, modifying, or enforcing a support order with respect to a child of a family member.

This subsection does not apply if the state agency that administers the child support enforcement program determines that the parent or caretaker relative has good cause for failing to cooperate.

14. Section 409.2572, Florida Statutes states in relevant part:

Cooperation.—(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 in: …
(2) Noncooperation, or failure to cooperate in good faith, is defined to include, but is not limited to, the following conduct:
(a) Refusing to identify the father of the child, or where more than one man could be the father of the child, refusing to identify all such persons.
(b) Failing to appear for two appointments at the department or other designated office without justification and notice.
(c) Providing false information regarding the paternity of the child or the obligation of the obligor.
(d) All actions of the obligee which interfere with the state's efforts to proceed to establish paternity, the obligation of support, or to enforce or collect support.
(e) Failure to appear to submit a DNA sample or leaving the location prior to submitting a DNA sample without compelling reasons.
(f) Failure to assist in the recovery of third-party payment for medical services.
(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.
(5) As used in this section only, the term "applicant for or recipient of public assistance for a dependent child" refers to such applicants

> and recipients of public assistance as defined in s. 409.2554(8), with the exception of applicants for or recipients of Medicaid solely for the benefit of a dependent child.

15. 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…

16. The Department's Program Policy Manual, CFOP 165-22, passage 1430.1708 Reasons for Good Cause (MFAM) states:

> Good cause is determined by Child Support Enforcement (CSE). Good cause may exist when cooperation in establishing paternity or securing child support could result in one of the following conditions:
> 1. Physical harm to the child - examples are broken bones, bruises, burns, lacerations, etc.;
> 2. Emotional harm to the child - examples are poor school performance, sleep disturbances, self-destructive behavior, eating disorders, etc.;
> 3. Physical harm to the parent or caretaker relative which reduces the individual's capacity to care for the child adequately (such as life threatening injury); or
> 4. Emotional harm to the parent or caretaker relative to such a degree that the individual's capacity to adequately care for the child is diminished (such as any psychological disorder or dysfunction which has a serious impact on the individual's abilities as a caretaker).
>
> Good cause may also exist under the following circumstances:
> 1. The child was conceived as a result of incest or forcible rape,
> 2. Legal proceedings for the adoption of the child are pending before a court, or

3. The parent or caretaker relative is being assisted by a public or licensed private social agency to determine whether or not to relinquish the child for adoption (this circumstance is valid for three months).

17. The above authorities explain that in order for an individual to receive Medicaid benefits, he or she must cooperate with CSE in establishing support, except when good cause exists or if she is pregnant. In this case, the findings show that the petitioner has not claimed good cause and is not pregnant. Therefore, the undersigned concludes that the petitioner was required cooperate with CSE to receive Medicaid benefits.

18. The Department's Program Policy Transmittal No.: P-12-02-0007, dated February 22, 2012, CSE Re-Referrals on Prior Non-Cooperative Individuals, effective upon receipt, states:

> This memorandum provides additional policy and procedural guidance to staff on the new CSE cooperation process for prior non-cooperative individuals. This applies to CSE sanctions prior to 1/9/2012 as well as current penalties received. This additional guidance is the result of questions received from recent training and not addressed in transmittal P-11-12-0022. **Note:** This new policy and procedure does not apply to DCF imposed penalties when customers refused or failed to up-front cooperate.
>
> **NEW POLICY**
> Individuals reapplying or requesting to be added to an existing benefit **who have not cooperated with CSE** either due to failure to demonstrate up-front cooperation or sanctioned for non-cooperation, must be referred to CSE to cure the sanction prior to receiving benefits. DCF must be notified by CSE of their cooperation before their eligibility for benefits can be restored (except for pregnant women applying for Medicaid who are not required to cooperate with CSE in order to be eligible).
> Until programming can be completed to initiate an electronic re-referral to CSE, **staff must advise the individual of the need to cooperate with CSE using the Automated Management System (AMS) notice. Provide this notice and take action to process the application or**

review. Do not hold an application or review pending for a sanctioned individual to cooperate with CSE (emphasis added).

19. The above authority clarifies the CSE referral process for individuals who have an existing CSE sanction and are applying for new or additional public assistance benefits. The Department is instructed to notify the individual of the need to cooperate with CSE by utilizing its AMS and to process the application or review. The Department is also instructed to not hold the application in a pending status to allow time for the sanctioned individual to cooperate with the CSE program. In this case, the findings show that the petitioner has an existing CSE sanction. The findings also show that the Department advised the petitioner to contact CSE in order to remove the CSE sanction and proceeded to process the application. Therefore, the undersigned concludes that the respondent followed the proper procedures in processing the petitioner's application for Medicaid.

20. Based on the above findings, conclusions of law, and evidence, the undersigned concludes that the Department is correct in its denial of the petitioner's application for Medicaid benefits. The undersigned concludes that the petitioner did not meet the burden of proof in establishing the respondent had incorrectly denied petitioner's request to authorize Medicaid benefits for the month of September 2017.

DECISION

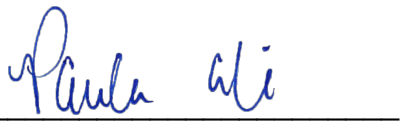
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

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 __07__ day of __March_____, 2018,

in Tallahassee, Florida.



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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

[redacted]

APPEAL NO. 17F-07537
APPEAL NO. 17F-07633

PETITIONER,

Vs.

CASE NO. [redacted]

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 January 17, 2018 at 10:08 a.m. in [redacted] and on February 21, 2018 at 1:27 p.m. in [redacted]

APPEARANCES

For Petitioner: [redacted] pro se
For Respondent: Ed Poutre, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUES

At issues are whether the respondent's action to deny the petitioner's application for Disaster Supplemental Nutrition Assistance Program (DSNAP) benefits for September 2017 and October 2017; to approve the petitioner Supplemental Nutrition Assistance Program (SNAP) benefits for January 2018 and ongoing; to deny the petitioner and her husband's Medicare Savings Program (MSP) benefits for January 2018 and ongoing; and to deny the petitioner and her husband 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 January 2018 and ongoing are correct. The petitioner carries the burden of proof by a preponderance of the evidence for all issues.

PRELIMINARY STATEMENT

The undersigned set an administrative hearing in the above-referenced matter on December 1, 2017. The respondent requested a continuance due to calendar conflict. The petitioner did not object, so the undersigned reset the hearing for December 18, 2017. For the December 18, 2017 hearing, the petitioner requested a continuance due to health issues. The continuance request was granted and the hearing was reset for January 17, 2018. The January 17, 2018 hearing could not be completed as the respondent requested a continuance to submit additional evidence. The petitioner did not object to the continuance, so the undersigned reset the hearing to February 14, 2018. Prior to the February 14, 2018 hearing, the undersigned continued the hearing due to the illness. The hearing was continued and reset for February 21, 2018.

The petitioner was present and testified at the January 17, 2018 and February 21, 2018 hearings. At the February 21, 2018 hearing, the petitioner submitted eight exhibits, which were marked and entered as Petitioner's Exhibits "1" – "8". At the January 17, 2018 and February 21, 2018 hearings, the respondent was represented by Ed Poutre, the Economic Self-Sufficiency Specialist II, with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). At the February 21, 2018 hearing, the respondent submitted nine exhibits, which were marked and entered as Respondent's Exhibits "1" – "9".

The record was left opened until March 7, 2018 to allow both parties to exchange and review additional information. The respondent did not submit additional evidence. On March 6, 2018, the petitioner submitted additional information that was marked and entered as Petitioner's Exhibit "9". The record closed on March 7, 2018.

FINDINGS OF FACT

1. The petitioner initially appealed the denial of her application for Disaster Supplemental Nutrition Assistance Program (DSNAP) benefits. Prior the February 21, 2018 hearing, the respondent reviewed the petitioner's DSNAP application and determined her eligible for $358 for September 2017 and $496 for October 2017. During the February 21, 2018 hearing, the petitioner explained all of her concerning her DSNAP appeal have been resolved; however, the petitioner did not want to withdrawal the appeal.

2. On October 25, 2017, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner's estimated MN Medicaid with an estimated SOC amount decreased from $2,037 per month to $2,032 per month effective January 1, 2018. The notice also indicated the petitioner's Qualifying Individual 1 (QI1) application dated October 20, 2017 was denied as "Your household's income is too high to qualify for this program".

3 On December 12, 2017, the petitioner completed a recertification application for SNAP and SSI-Related Medicaid benefits. The application listed the petitioner, her husband, and their adult son; the petitioner and her husband's Social Security benefits; and the husband's self-employment income.

4. On December 26, 2017, the respondent mailed petitioner a Notice of Case Action requesting the petitioner complete a phone interview on or before January 2, 2018 with the respondent. The notice also requested the petitioner submit the following information: "Proof of all gross income from the last 4 weeks using the "Verification of Employment/Loss of Income" form or you may send in your last 4 pay stubs. [redacted] will need to provide a loss and profit statement of self employment income as Carpenter for the last four weeks".

5. On January 4, 2018, the petitioner conducted a phone interview with the respondent. During the interview, she reported her, her husband, and their adult son lived in the household; her and her husband had Social Security income; her husband had self-employment income; her mortgage was $1,160 per month; and her electric bill was $175 per month.

6. On January 17, 2018, the respondent mailed the petitioner a Notice of Case Action indicating her SNAP benefits would end on January 31, 2018 as "we did not receive all the information requested to determine eligibility".

7. On January 17, 2018, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner and her husband are eligible for continued MN Medicaid benefits. The notice also indicated the petitioner's QI1 application dated December 12, 2017, was denied as "Your household's income is too high to qualify for this program".

8. On January 24, 2018, the petitioner completed a recertification application for SNAP benefits. The respondent did not submit a copy of the petitioner's January 24, 2018 application into evidence.

9. On January 25, 2018, the respondent mailed the petitioner a Notice of Case Action indicating her SNAP application dated January 12, 2018 was approved and she was eligible to receive $32 per month in SNAP benefits for February 2018 through July 31, 2018. The notice also indicated the petitioner's estimated SOC amount increased from $2,075 to $2,080 effective March 1, 2018. The notice further indicated the petitioner's QI1 application dated January 12, 2018 was denied as "Your household's income is too high to qualify for this program".

10. On February 7, 2018, the respondent mailed the petitioner a Notice of Case Action indicating her SNAP application dated February 6, 2018 was approved and she was eligible to receive $157 per month in SNAP benefits for January 2018 through July 31, 2018. The notice also indicated the petitioner's estimated SOC amount increased from $2,080 to $1,993 effective March 1, 2018. The notice further indicated the petitioner's QI1 application dated February 6, 2018 was denied as "Your household's income is too high to qualify for this program".

11. The petitioner's husband receives $1,254 (gross) per month in Social Security benefits. He pays for Medicare part A and B premiums. The petitioner receives $971 (gross) per month in Social Security benefits. The petitioner and her husband pay for Medicare part A and B premiums. The cost of their monthly Medicare premiums are $134 for each person or $268 total.

12. The respondent calculated in the petitioner's SNAP budgets the household's monthly excess medical expenses as $819.32. The respondent did not submit into evidence the medical bills utilized in the determination of the petitioner's ongoing medical expenses.

13. The petitioner incurred one-time medical expenses for the following dates and amounts: July 6, 2017 $742.90; July 12, 2017 $141; July 24, 2017 $24.94; July 25, 2017 $3.40; August 3, 2017; $603; August 9, 2017 $21.54; August 18, 2017 $8; October 5, 2017, $68.01; and October 24, 2017, $93.70. The petitioner's one-time medical expenses totaled $1,706.49.

14. 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's one-time medical expenses totaled $1,003.90.

15. The petitioner's husband incurred one-time medical expenses for the following dates and amounts: July 24, 2017 $50; July 24, 2017 $15; August 1, 2017 $155.53; August 25, 2017 $15; August 29, 2017 $57.72; September 7, 2017 $15; and September 13, 2017 $205. The husband's medical expenses totaled $513.25.

16. On June 12, 2017, the petitioner's dog, [redacted], became certified as a "USA Service Dog". On July 17, 2017, the petitioner paid $113.01 for Buddy's veterinary bill.

17. On November 29, 2017, the petitioner paid $35, 693.20 for solar panels. The monthly payment of the solar panels was $160.66.

18. 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.

19. 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.

20. The respondent determined in the petitioner's SNAP budgets that her husband's monthly gross self-employment income as $2,851.25 for January 2018 and ongoing.

21. The respondent determined the following self-employment expenses for January 2018 and ongoing SNAP budgets:

Advertising: $52.08 per month
Office Expenses: $96 per month
Rent/Lease Vehicles, Machines and Equipment: $13.50 per month
Taxes and Licenses: $35.58 per month
Insurance $90.08 per month
Car, Truck Vehicle Equipment Expense: $1,014.50 per month
Contract Labor: $46.67 per month
Legal and Professional Services: $12.50 per month
Cost of Raw Materials: $733 per month
Income counted in all programs $2,851.25 per month
Depreciation: $.29 per month
Other Business Property: $166.58 per month
Tax Preparation Fee for Business: $5.42 per month
Utilities: $174 per month

22. The respondent determined the husband's self-employment expenses for January 2018 and ongoing as $2,191.08 per month. The respondent determined the husband's net self-employment income as $660.17 per month ($2,851.25 - $2191.08).

23. The respondent determined the petitioner's SNAP benefit amounts for January 2018 and ongoing as follows:

Expenses/Income	**Dollar Amount**
Self-Employment income	$660.17
Unearned Income (SSA benefits)	+$2225.00
Total Household Income	$2885.17
Earned income deduction	-$ 132.03
Standard deduction for a household of 2&3	-$ 160.00
Excess Medical Expenses	-$ 819.32
Adjusted income after deductions	**$1773.82**
Total Medical Expenses	$ 854.32
Medical Deduction	-$ 35.00
Excess Medical Expense	**$ 819.32**
Rent/shelter	$1160.00
Standard utility allowance	+$ 347.00
Total rent/utility costs	**$1507.00**
Shelter standard (50% adjusted income)	-$ 886.91
Excess shelter deduction	**$ 620.09**
Adjusted income	$1773.82
Excess Shelter Deduction	-$ 620.09
Adjusted income after shelter deduction	**$1702.00**

24. The respondent took 30% of $1,702 to calculate the SNAP benefit reduction of $347. The benefit reduction of $347 was then subtracted from $504 (the maximum SNAP benefit amount for a household of three) to arrive at $157.

25. The respondent determined the petitioner and her husband's estimated monthly SOC amount effective January 2018 and ongoing as $1,993:

$2225.00 petitioner's and husband's Social Security income
-$20.00 unearned income disregard
$2205.00 petitioner's countable unearned income

$660.17 husband's self-employment income
-$65.00 earned income disregard
-$297.58 ½ remaining disregard
$297.58 petitioner's total countable earned income

$297.58 petitioner's total countable earned income
+$2205.00 petitioner's countable unearned income

$2502.59 petitioner's total countable income

-$241.00 medically needy income level for household size of two
$2261.59 share of cost

-$268.00 medical insurance premium
$1993.00 remaining share of cost

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

27. The respondent determined the petitioner and her husband not eligible for QI1 benefits as their net monthly income exceeded the QI1 income standard. The respondent explained that since the petitioner and her husband are over the income limit for the QI1 Benefits, then they would be over the income limit for all of the MSP programs as QI1 has the highest income limit for all three of the programs.

28. The petitioner did not agree with respondent's denial of her MSP benefits; the determination of her SNAP monthly benefit amount as $157 per month; and the determination of her and her husband's monthly SOC amount as $1,993 per month because she reported no changes in their income. Since she reported no changes in income, she argued her benefits should not change.

CONCLUSIONS OF LAW

29. 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.

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

31. The petitioner initially appealed the denial of her application for DSNAP benefits: however, the respondent reviewed the petitioner's DSNAP application and determined her eligible for $358 for September 2017 and $496 for October 2017. The petitioner explained at the February 21, 2018 hearing, all issues concerning the her DSNAP appeal have been resolved; however, she does not wish to withdrawal her DSNAP appeal so her DSNAP appeal shall be DISMISSED as moot.

Whether the petitioner's SNAP benefits for January 2018 and ongoing were correctly calculated.

32. 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. . .
>
> (ii) 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.

33. Pursuant to the above authority, the husband's self-employment income as well as the petitioner and her husband's Social Security incomes 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.

34. 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)

35. 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)

36. 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. . .

37. 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, depreciation, taxes, and tax related fees cannot be

included in her husband's self-employment expenses. The respondent correctly included the following self-employment expenses: Advertising, Office Expenses, Rent or Leasing of Vehicles, Supplies, Taxes and Licenses, Insurance, Car/Truck expenses, and Legal and Professional Services. However, the respondent incorrectly included depreciation and fees for taxes in the calculation of husband's self-employment

38. 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. . .

39. Pursuant to the above policy, the respondent subtracts petitioner's gross self-employment income from his allowable business expenses. The respondent correctly determined the husband's monthly gross self-employment income as $2,851.25. The respondent incorrectly determined the husband's monthly self-employment expenses as $2,191.08. The respondent also incorrectly determined the petitioner's monthly net self-employment income as $660.17 as expenses that should have not been included in the SNAP budgets were included in them. The undersigned determines the husband's monthly net self-employment expenses as $2,155.21 per month ($2,191.08 - $35.87 (monthly cost of taxes and depreciation)).

40. 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)…

41. 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.

42. The respondent determined the petitioner's ongoing medical expenses as their Part B Premiums, expenses related to a service dog, and various other medically related copayments.

43. 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.

44. Pursuant to the above policy, one-time medical expenses can be included in the petitioner's SNAP budgets. The evidence indicates incurred and paid $2,823.40 in one-time medical expenses and the husband paid and incurred $513.25 in one-time medical expenses. The petitioner's monthly medical expenses are $235.28; the husband's monthly medical expenses are $42.77; and their mutual monthly medical expenses are $268. Their monthly medical expenses total $546.05.

45. 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.

46. For January 2018 and ongoing, the respondent incorrectly calculated the husband's monthly net self-employment income and monthly medical expenses, but correctly calculated the gross self-employment income; shelter expense, utility expense, and all deductions allowed in the determination of SNAP benefits.

47. The petitioner's self-employment income was not considered for SNAP benefits as she did not earn any money during the year of 2016.

48. 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 determined her Supplemental Nutrition Assistance Program benefits as $157 per month. The undersigned can find no better outcome for the petitioner as the respondent determined a higher amount of SNAP benefits than the petitioner's household was eligible to receive effective January 2018 and ongoing.

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

49. 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.

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

51. 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).

52. Pursuant to the above authority, her husband's self-employment income is considered included income in the determination of their eligibility for Medicaid benefits.

53. 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…

54. Pursuant to the above authority, the petitioner and her husband's Social Security incomes are considered included income in the determination of their eligibility for full SSI-Related Medicaid benefits.

55. The husband's self-employment income should be considered in the determination of their full SSI-Related Medicaid Benefits; however, in this instance, the undersigned shall not consider the husband's self-employment income, but only consider their Social Security incomes.

56. 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.

57. Effective January 2018 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.

58. 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.

59. Fla. Admin. Code R. 65A-1.701, Definitions which says:

> (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.

60. Pursuant to the above authority, an individual cannot receive both Medicare and Medicaid benefits at the same time. Since the petitioner and her husband both receive Medicare, they are also not eligible for Medicaid because they both receive Medicare. Even if their income was under the full SSI-Related Income limit, neither would be eligible for Medicaid. The respondent was correct to deny the petitioner and her husband full SSI-Related Medicaid benefits and was correct to enroll them in a MN Medicaid program with a monthly SOC amount.

61. 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 them full SSI-Related Medicaid benefits. Furthermore, the petitioner did not meet the burden of proof indicating the respondent incorrectly enrolled them in a MN SSI-Related Medicaid Program with a monthly SOC effective January 2018 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

62. 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.)

63. 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).

64. Pursuant to the above authority, the husband's self-employment income is considered included income in the determination of her eligibility for MSP Medicaid benefits.

65. 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…

66. 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.

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

68. 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.

69. 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."

70. The Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of two for January 2018 through March 2018 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.

72. The Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of two for April 2018 and ongoing as follows: the Income Standard for QMB as $1,012 the Income Standard for SLMB as $1,214; and the Income Standard for QI1 as $1,366.

73. 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 limits for the QMB, SLMB, and QI1 Programs; therefore, the respondent correctly denied the petitioner and her husband's MSP Medicaid benefits effective January 2018 and ongoing.

74. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner does not meet the burden of proof indicating her and her husband's MSP benefits were correctly denied effective January 2018 and ongoing.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's Supplemental Nutrition Assistance Program and SSI-Related Medicaid appeals are DENIED.

The petitioner's Disaster Supplemental Nutrition Assistance appeal is DISMISSED as moot as all issues have been resolved and the petitioner no longer wishes to pursue her DSNAP appeal.

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 March, 2018,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted]
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 17F-07598

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Charlotte
UNIT: 88345

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 29th, 2018, at 11:00 a.m. in [redacted]. The respondent appeared by telephone.

APPEARANCES

For the Petitioner: [redacted], pro se.

For the Respondent: Roneige Alnord, Economic Self Sufficiency Specialist for the Economic Self-Sufficiency Program.

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's application for Medicaid is correct. The petitioner carries the burden of proof by a preponderance of the evidence on this issue.

PRELIMINARY STATEMENT

The hearing was originally scheduled with another hearing officer on January 8th, 2018, at 1:00 p.m. by telephone. This hearing was cancelled due to the hearing officer's departure from the Office of Appeal Hearings.

The petitioner then requested to have an in-person hearing, and the request was granted. The hearing was rescheduled for March 29th, 2018, at 11:00 a.m. on location in [redacted], and conducted as described above.

Appearing as witness for the petitioner was her son, [redacted]

The petitioner did not submit any documents for the hearing.

The respondent's exhibits 1 through 8 were admitted into evidence.

By way of Notice of Case Action (NOCA) dated October 6th, 2017, the respondent notified the petitioner that, "your Medicaid application/review dated October 04, 2017 is denied for the following months: October 2017, November 2017. Reason: you or a member of your household do not meet the disability requirement; there are no eligible children that live in your home; no household members are eligible for this program." (Respondent's Exhibit 4.)

On November 6th, 2017, the petitioner filed a timely appeal to challenge this action.

FINDINGS OF FACT

1. On October 4th, 2017, the petitioner submitted a paper application to the respondent, applying for Medicaid for herself as a sixty-five-year-old single individual. (Respondent's Exhibit 3.)

2. On the application, the petitioner reported her place of birth as [redacted], and answered "no" for the question, "U.S. Citizen." The petitioner also reported a monthly salary of $500 by being employed at a restaurant. The petitioner reported expenses for telephone, medicine, and other household items. (Respondent's Exhibit 3.)

3. The respondent stated that since the petitioner stated no to the United States citizenship, as part of the eligibility process, it had to verify the petitioner's immigration status. On October 5th, 2017, it verified the petitioner's immigration status using the Systematic Alien Verification for Entitlements (SAVE) System, from the US Citizenship and Immigration Services (USCIS) with the Department of Homeland Security (DHS.) The response received from the data on file with USCIS, indicates that the petitioner was born in [redacted] on [redacted], [redacted], and the petitioner's Date of Entry as [redacted]. The system response was, "Lawful permanent resident-employment authorized, with COA code IR0, and admitted for an indefinite stay. (Respondent's Exhibit 5.)

4. The respondent also presented the petitioner's driver's license, from the State of Florida's Department of Highway Safety and Motor Vehicles, which also shows the petitioner as an immigrant born in [redacted]. (Respondent's Exhibit 6.)

5. Based on the petitioner's immigration status, the respondent determined that the petitioner would not qualify for any of the Department's programs, except Emergency Medicaid for Aliens (EMA.) The respondent denied the petitioner's application for Medicaid on October 6th, 2017, and issued a NOCA notifying the petitioner of the decision. (Respondent's Exhibit 4.)

6. The respondent stated that even though the NOCA stated the petitioner as not disabled, that was not a factor in its determination, since the petitioner is already sixty-five (65) years of age, and qualifies based on the age factor. A decision of disability by the Division of Disability Determination (DDD) was neither required nor requested.

7. The respondent also stated that the even if the petitioner had minor children in the household, she would not have qualified for Medicaid due to her immigration status. The primary reason for the denial was the petitioner's immigration status, and not disability or absence of minor children. Meeting the citizenship/qualified immigration status is a technical requirement to qualify for Medicaid, and the petitioner did not meet this criterion.

8. The respondent verified the petitioner's date of entry into the Unites States as [redacted]. The respondent presented the Department's policy indicating technical requirements for noncitizens. Its policy manual passage: 1440.0106, says which immigrant is eligible for program, and states, "a Lawful Permanent Resident (LPR) client would only be eligible if he/she had (1) entered prior to 8/22/96 and have remained continuously present, (2) on or after 8/22/96 under a prior asylee, refugee, Amerasian, deportation withheld, or Cuban/Haitian Entrant status, or (3) on or after 8/22/96 and have lived in the U.S. as a qualified noncitizen for at least five years." (Respondent's Exhibit 8, page 30.)

9. Since the petitioner entered on [redacted], the respondent determined that she was subject to a ban from eligibility for five (5) years from the date of entry, and calculated that that the petitioner would complete the five-year ban on [redacted]. (Respondent's Exhibit 1.)

10. The petitioner stated during the hearing that since the time she applied, she is no longer employed due to her ailments, and therefore, has no income. She suffers from many ailments such as [redacted]. The petitioner could see doctors before, but now to do so is prohibitively expensive, and she cannot afford the cost. The petitioner is unable to afford private medical insurance and believes she should receive Medicaid. The petitioner is aware of the Emergency Medicaid for Aliens (EMA); however, that does not meet her recurring medical needs.

11. The petitioner contends her date of entry is [redacted], and not [redacted]. The petitioner stated however, that she entered the United States on a visitor's visa and returned to India at the end of six months, and repeated this process many times. She received her qualified immigration status as a Lawful Permanent Resident (LPR) on [redacted]

12. The respondent stated that the five-year ban starts when the petitioner acquired the LPR status, or the actual date of entry with an immigration status. In the petitioner's case, it started on [redacted], because that is when the petitioner was granted a qualified immigration status as a Lawful Permanent Resident (LPR.) Prior to that, the petitioner was a visitor and that period would not count towards the five-year wait period (ban.)

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 § 409.285, Florida Statutes.

14. This order is the final administrative decision of the Department of Children and Families under § 409.285, Florida Statutes.

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

16. The Code of Federal Regulations at 7 C.F.R. § 273.4, Citizenship and alien status states in part:

> (a) *Household members meeting citizenship or alien status requirements.* No person is eligible to participate in the Program unless that person is:
>
> (1) A U.S. citizen[1];
>
> [1]For guidance, see the DOJ Interim Guidance published November 17, 1997 (62 FR 61344).
>
> (2) A U.S. non-citizen national[1]
>
> (3) An individual who is:
>
> (i) An American Indian born in Canada who possesses at least 50 per centum of blood of the American Indian race to whom the provisions of section 289 of the Immigration and Nationality Act (INA) (8 U.S.C. 1359) apply; or
>
> (ii) A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)) which is recognized as eligible for the special programs and services provided by the U.S. to Indians because of their status as Indians;
>
> (4) An individual who is:
>
> (i) Lawfully residing in the U.S. and was a member of a Hmong or Highland Laotian tribe at the time that the tribe rendered assistance to U.S. personnel by taking part in a military or rescue operation during the Vietnam era beginning August 5, 1964, and ending May 7, 1975;
>
> (ii) The spouse, or surviving spouse of such Hmong or Highland Laotian who is deceased, or
>
> (iii) An unmarried dependent child of such Hmong or Highland Laotian who is under the age of 18 or if a full-time student under the age of 22; an unmarried child under the age of 18 or if a full time student under the age of 22 of such a deceased Hmong or Highland Laotian provided the child was dependent upon him or her at the time of his or her death; or an

unmarried disabled child age 18 or older if the child was disabled and dependent on the person prior to the child's 18th birthday. For purposes of this paragraph (a)(4)(iii), child means the legally adopted or biological child of the person described in paragraph (a)(4)(i) of this section, or

(5) An individual who is:

(i) An alien who has been subjected to a severe form of trafficking in persons and who is certified by the Department of Health and Human Services, to the same extent as an alien who is admitted to the United States as a refugee under Section 207 of the INA; or

(ii) An alien who has been subjected to a severe form of trafficking in persons and who is under the age of 18, to the same extent as an alien who is admitted to the United States as a refugee under Section 207 of the INA;

(iii) The spouse, child, parent or unmarried minor sibling of a victim of a severe form of trafficking in persons under 21 years of age, and who has received a derivative T visa, to the same extent as an alien who is admitted to the United States as a refugee under Section 207 of the INA; or

(iv) The spouse or child of a victim of a severe form of trafficking in persons 21 years of age or older, and who has received a derivative T visa, to the same extent as an alien who is admitted to the United States as a refugee under Section 207 of the INA; or

(6) An individual who is both a qualified alien as defined in paragraph (a)(6)(i) of this section and an eligible alien as defined in paragraph (a)(6)(ii) or (a)(6)(iii) of this section.

(i) A qualified alien is:

(A) An alien who is lawfully admitted for permanent residence under the INA;

(B) An alien who is granted asylum under section 208 of the INA;

(C) A refugee who is admitted to the United States under section 207 of the INA;

(D) An alien who is paroled into the U.S. under section 212(d)(5) of the INA for a period of at least 1 year;

(E) An alien whose deportation is being withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or whose removal is withheld under section 241(b)(3) of the INA;

(F) An alien who is granted conditional entry pursuant to section 203(a)(7) of the INA as in effect prior to April 1, 1980;

(G) An alien who has been battered or subjected to extreme cruelty in the U.S. by a spouse or a parent or by a member of the spouse or parent's family residing in the same household as the alien at the time of the abuse, an alien whose child has been battered or subjected to battery or cruelty, or an alien child whose parent has been battered;[2] or

[2]For guidance, see Exhibit B to Attachment 5 of the DOJ Interim Guidance published at 62 FR 61344 on November 17, 1997.

(H) An alien who is a Cuban or Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980.

(ii) A qualified alien, as defined in paragraph (a)(6)(i) of this section, is eligible to receive SNAP benefits and is not subject to the requirement to be in qualified status for 5 years as set forth in paragraph (a)(6)(iii) of this section, if such individual meets at least one of the criteria of this paragraph (a)(6)(ii):

(A) An alien age 18 or older lawfully admitted for permanent residence under the INA who has 40 qualifying quarters as determined under Title II of the SSA, including qualifying quarters of work not covered by Title II of the SSA, based on the sum of: quarters the alien worked; quarters credited from the work of a parent of the alien before the alien became 18 (including quarters worked before the alien was born or adopted); and quarters credited from the work of a spouse of the alien during their marriage if they are still married or the spouse is deceased.

(*1*) A spouse may not get credit for quarters of a spouse when the couple divorces prior to a determination of SNAP eligibility. However, if the State agency determines eligibility of an alien based on the quarters of coverage of the spouse, and then the couple divorces, the alien's eligibility continues until the next recertification. At that time, the State agency must determine the alien's eligibility without crediting the alien with the former spouse's quarters of coverage.

(*2*) After December 31, 1996, a quarter in which the alien actually received any Federal means-tested public benefit, as defined by the agency providing the benefit, or actually received SNAP benefits is not creditable toward the 40-quarter total. Likewise, a parent's or spouse's quarter is not creditable if the parent or spouse actually received any Federal means-tested public benefit or actually received SNAP benefits in that quarter. The State agency must evaluate quarters of coverage and receipt of Federal means-tested public benefits on a calendar year basis. The State agency must first determine the number of quarters creditable in a

calendar year, then identify those quarters in which the alien (or the parent(s) or spouse of the alien) received Federal means-tested public benefits and then remove those quarters from the number of quarters of coverage earned or credited to the alien in that calendar year. However, if the alien earns the 40th quarter of coverage prior to applying for SNAP benefits or any other Federal means-tested public benefit in that same quarter, the State agency must allow that quarter toward the 40 qualifying quarters total;

(B) An alien admitted as a refugee under section 207 of the INA;

(C) An alien granted asylum under section 208 of the INA;

(D) An alien whose deportation is withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or whose removal is withheld under section 241(b)(3) or the INA;

(E) An alien granted status as a Cuban or Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);

(F) An Amerasian admitted pursuant to section 584 of Public Law 100-202, as amended by Public Law 100-461;

(G) An alien with one of the following military connections:

(*1*) A veteran who was honorably discharged for reasons other than alien status, who fulfills the minimum active-duty service requirements of 38 U.S.C. 5303A(d), including an individual who died in active military, naval or air service. The definition of veteran includes an individual who served before July 1, 1946, in the organized military forces of the Government of the Commonwealth of the Philippines while such forces were in the service of the Armed Forces of the U.S. or in the Philippine Scouts, as described in 38 U.S.C. 107;

(*2*) An individual on active duty in the Armed Forces of the U.S. (other than for training); or

(*3*) The spouse and unmarried dependent children of a person described in paragraphs (a)(6)(ii)(G)(*1*) or (a)(6)(ii)(G)(*2*) of this section, including the spouse of a deceased veteran, provided the marriage fulfilled the requirements of 38 U.S.C. 1304, and the spouse has not remarried. An unmarried dependent child for purposes of this paragraph (a)(6)(ii)(G)(*3*) is: a child who is under the age of 18 or, if a full-time student, under the age of 22; such unmarried dependent child of a deceased veteran provided such child was dependent upon the veteran at the time of the veteran's death; or an unmarried disabled child age 18 or older if the child was disabled and dependent on the veteran prior to the child's 18th birthday. For purposes of this paragraph (a)(6)(ii)(G)(*3*), child means the

legally adopted or biological child of the person described in paragraph (a)(6)(ii)(G)(*1*) or (a)(6)(ii)(G)(*2*) of this section.

(H) An individual who is receiving benefits or assistance for blindness or disability (as specified in §271.2 of this chapter).

(I) An individual who on August 22, 1996, was lawfully residing in the U.S., and was born on or before August 22, 1931; or

(J) An individual who is under 18 years of age.

(iii) The following qualified aliens, as defined in paragraph (a)(6)(i) of this section, must be in a qualified status for 5 years before being eligible to receive food stamps. The 5 years in qualified status may be either consecutive or nonconsecutive. Temporary absences of less than 6 months from the United States with no intention of abandoning U.S. residency do not terminate or interrupt the individual's period of U.S. residency. If the resident is absent for more than 6 months, the agency shall presume that U.S. residency was interrupted unless the alien presents evidence of his or her intent to resume U.S. residency. In determining whether an alien with an interrupted period of U.S. residency has resided in the United States for 5 years, the agency shall consider all months of residency in the United States, including any months of residency before the interruption:

(A) An alien age 18 or older lawfully admitted for permanent residence under the INA.

(B) An alien who is paroled into the U.S. under section 212(d)(5) of the INA for a period of at least 1 year;

(C) An alien who has been battered or subjected to extreme cruelty in the U.S. by a spouse or a parent or by a member of the spouse or parent's family residing in the same household as the alien at the time of the abuse, an alien whose child has been battered or subjected to battery or cruelty, or an alien child whose parent has been battered;

(D) An alien who is granted conditional entry pursuant to section 203(a)(7) of the INA as in effect prior to April 1, 1980.

(iv) Each category of eligible alien status stands alone for purposes of determining eligibility. Subsequent adjustment to a more limited status does not override eligibility based on an earlier less rigorous status. Likewise, if eligibility expires under one eligible status, the State agency must determine if eligibility exists under another status.

(7) For purposes of determining eligible alien status in accordance with paragraphs (a)(4) and (a)(6)(ii)(I) of this section “lawfully residing in the

> U.S." means that the alien is lawfully present as defined at 8 CFR 103.12(a).
>
> (b) *Reporting illegal aliens.* (1) The State agency must inform the local INS office immediately whenever personnel responsible for the certification or recertification of households determine that any member of a household is ineligible to receive SNAP benefits because the member is present in the U.S. in violation of the INA. The State agency may meet this requirement by conforming with the Interagency Notice providing guidance for compliance with PRWORA section 404 published on September 28, 2000 (65 FR 58301).
>
> (2) When a household indicates inability or unwillingness to provide documentation of alien status for any household member, the State agency must classify that member as an ineligible alien. When a person indicates inability or unwillingness to provide documentation of alien status, the State agency must classify that person as an ineligible alien. In such cases the State agency must not continue efforts to obtain that documentation.

17. The above cited authority explains as to who would meet the requirement to be a US citizen or a qualified alien to receive benefits from the Department. The respondent must follow these federal guidelines while determining the eligibility for the petitioner's Medicaid. There are various exceptions cited to the five-year ban, however, the petitioner does not meet any of them.

18. The United States Code 8 U.S.C. § 1613, addresses Five-year limited eligibility of qualified aliens for Federal means-tested public benefit, and states in relevant part:

> (a) In general
> Notwithstanding any other provision of law and except as provided in subsections (b), (c), and (d) of this section, an alien who is a qualified alien (as defined in section 1641 of this title) and who enters the United States on or after August 22, 1996, is not eligible for any Federal means-tested public benefit for a period of 5 years beginning on the date of the alien's entry into the United States with a status within the meaning of the term "qualified alien".

19. The above-cited United States Code stipulates that qualified aliens entered the United States on or after August 22nd, 1996, is not eligible for any Federal means-tested public benefit for a period of five years, beginning with date the qualified alien status is established. Notwithstanding the petitioner's claim that she was entered initially in [redacted], findings show that the petitioner acquired the 'qualified immigration status on [redacted], and the five-year ban starts from that date. Medicaid is a means tested program, therefor the law applies in the petitioner's case.

20. The Florida Administrative Code R. 65A-1.301 discusses the requirement to verify citizenship status and states in part:

> (1) The individual whose needs are included must meet the citizenship and noncitizen status established in: P.L. 104-193, The Personal Responsibility and Work Opportunity Reconciliation Act of 1996; P.L. 105-33, the Balanced Budget Act of 1997; P.L. 105-185, the Agricultural Research, Extension, and Education Reform Act of 1998; P.L. 105-306, the Noncitizen Benefit Clarification and Other Technical Amendments Act of 1998; P.L. 109-171, the Deficit Reduction Act of 2005; and, the Immigration and Nationality Act.
>
> … (3)The eligibility specialist must verify the immigration status of noncitizens through the United States Citizenship and Immigration Service (USCIS), formerly the United States Bureau of Citizenship and Immigration Services. Verification will be requested electronically using the alien number, or based on a USCIS or prior Immigration and Naturalization Services (INS) document provided by the applicant. The system of verification is known as the Verification Information System-Customer Processing System (VIS-CPS), which is part of the Systematic Alien Verification for Entitlements (SAVE) Program. When the noncitizen provides neither an alien number nor USCIS document to indicate their status, the noncitizen must contact the USCIS to obtain documentation or verification of noncitizen status. The department will assist in obtaining documentation if requested. If the noncitizen provides any form of USCIS documentation, regardless of the expiration date, showing an eligible Immigration Act section, the eligibility specialist must accept the documentation and verify the individual's status. Electronic verification of an eligible immigration status is acceptable proof of the individual's eligible

> status for all programs. Automated verification is attempted first. If automated verification cannot be obtained, noncitizenship status must be verified manually (i.e., secondary verification) through use of a USCIS form. Benefits will not be withheld when VIS-CPS indicates secondary (i.e., manual) verification is required and response from the secondary verification is pending, provided all other technical factors of eligibility are met. Benefit recovery is required when such individuals are determined to not have been in an eligible noncitizen status.

21. The Code of Federal Regulations at 42 C.F.R. at § 435.406, Citizenship and non-citizen eligibility for Medicaid benefits, states in part:

> (a) The agency must provide Medicaid to otherwise eligible individuals who are—
>
> (1) Citizens and nationals of the United States, provided that—
>
> (i) The individual has made a declaration of United States citizenship, as defined in §435.4, or an individual described in paragraph (a)(3) of this section has made such declaration on the individual's behalf, and such status is verified in accordance with paragraph (c) of this section,
>
> (ii) For purposes of the declaration and citizenship verification requirements discussed in paragraphs (a)(1)(i) of this section, an individual includes applicants under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in its expenditures…
>
> (2) At State option, individuals who were deemed eligible for coverage under §435.117 or §457.360 of this chapter in another State on or after July 1, 2006, provided that the agency verifies such deemed eligibility. (2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified non-citizens), qualified non-citizens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified non-citizens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Non-Citizen status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is an non-citizen in a satisfactory immigration status.

> (ii) The eligibility of qualified non-citizens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.
>
> (3) For purposes of paragraphs (a)(1) and (2), of this section, a declaration of citizenship or satisfactory immigration status may be provided, in writing and under penalty of perjury, by an adult member of the individual's household, an authorized representative, as defined in §435.923, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant provided that such individual attests to having knowledge of the individual's status.
>
> (b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified non-citizens subject to the 5-year bar or who are non-qualified non-citizens who meet all Medicaid eligibility criteria, except non-qualified non-citizens need not present a social security number or document immigration status.
>
> (c) The agency must verify the declaration of citizenship or satisfactory immigration status under paragraph (a)(1) or (2) of this section in accordance with §435.956.

22. The above Federal Regulations state that qualified non-citizens are subject to a five-year ban from receiving Medicaid benefits unless they meet an exception. The petitioner does not meet an exception; therefore, she is subject to the five-year ban and not eligible for Medicaid benefits.

23. The Department’s Program Policy Manual (Policy Manual), CFOP 165-22, passages 1440.0101 through 1440.0118 addresses noncitizens, verification sources and requirements for noncitizens (MSSI.) It states, “The eligibility specialist must verify the immigration status of all noncitizens applying for or receiving Medicaid through the U.S. Citizenship and Immigration Service (USCIS). If a noncitizen does not wish for our Agency to contact USCIS to verify immigration status, the household must be given the option of withdrawing its application or

participating without that member." Additionally, it says, "VIS-CPS must be completed for noncitizens: 1. at application or reapplication, 2. when adding a noncitizen individual, and, 3. any time there is a change to alien status."

24. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1440.0106 addresses Lawful Permanent Resident (MSSI) and states:

> A lawful permanent resident (LPR) is a noncitizen who lawfully immigrates to the U.S. and has permission to live and work in the U.S. LPRs may be eligible for Medicaid based on citizenship if they entered the U.S.:
>
> 1. prior to 8/22/96 and have remained continuously present,
>
> 2. on or after 8/22/96 under a prior asylee, refugee, Amerasian, deportation withheld, or Cuban/Haitian Entrant status, or
>
> 3. on or after 8/22/96 and have lived in the U.S. as a qualified noncitizen for at least five years…
>
> **Note:** LPRs who entered after 8/22/96 are subject to the five-year ban, except lawfully residing children up to age 19.
>
> LPRs who are in the five-year ban may be eligible for Emergency Medicaid for Aliens, (EMA).

25. Additionally the Program Policy Manual (Policy Manual), CFOP 165-22, passage 1440.0106 addresses Assistance for Ineligible Noncitizens (MSSI), and states:

> Any noncitizen who does not have an eligible qualified noncitizen status is not eligible for Medicaid on the factor of citizenship. These noncitizens may be eligible for Medicaid through Emergency Medical Assistance for Aliens (EMA), if they meet all other eligibility criteria.

26. The above-cited federal, state and agency regulations state that an applicant for Medicaid benefit must meet either the United States citizenship or a qualified immigration

status to be eligible for the program. The petitioner does not meet either the United States citizenship criteria, or a qualified alien status.

27. The Florida Administrative Code R. 65A-1.715, Emergency Medical Services for Aliens, sets forth:

> (1) Aliens who would be eligible for Medicaid but for their immigration status are eligible only for emergency medical services. Section 409.901(10), F.S., defines emergency medical conditions.
>
> (2) The Utilization Review Committee (URC) or medical provider will determine if the medical condition warrants emergency medical services and, if so, the projected duration of the emergency medical condition. The projected duration of the emergency medical condition will be the eligibility period provided that all other criteria are continuously satisfied.
>
> (3) Emergency services are limited to 30 consecutive days without prior approval. For continued coverage beginning with the 31st day prior authorization must be obtained from the Agency for Health Care Administration (Medicaid Program Office).

28. The above regulation states that noncitizens who would otherwise be eligible for Medicaid except for their noncitizen status are eligible for emergency medical services. If the petitioner must seek emergency medical services, she can apply for Emergency Medical Assistance for Aliens (EMA) at any time.

29. The undersigned considered the petitioner's arguments, but there is nothing in the regulations which will provide a better outcome for the petitioner.

30. After reviewing the totality of the evidence and the controlling legal authorities, the undersigned concludes that the petitioner did not meet the burden of proof in this matter. The

respondent's action to deny the petitioner's Medicaid application dated October 4th, 2017, due to the petitioner not meeting an eligible immigration status was correct and within the rules.

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 April, 2018,

in Tallahassee, Florida.

Sajan George
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]
Office of Economic Self Sufficiency
[redacted]

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 17F-07620

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 28, 2018 at 4:05 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted], petitioner's mother

For the Respondent: Mary Triplett, supervisor

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for SSI-Related Medicaid benefits on the basis that he does not meet the disability criteria. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

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 Department of Health's Division of Disability Determinations (DDD) conducts disability reviews regarding medical eligibility for individuals applying for disability benefits under the federal Social Security and Supplemental Security Income programs and the state Medically Needy program. Once a disability review is completed, the claim is returned to DCF for a final determination of non-medical eligibility and effectuation of any benefits due.

The hearing was scheduled for December 14, 2017 at 3:30 p.m. The petitioner requested a continuance. The continuance was granted and the hearing was rescheduled for January 4, 2018 at 1:30 p.m. The petitioner requested a continuance to review the evidence which she had just received. The continuance was granted. The hearing was rescheduled for January 31, 2018. On January 31, 2018 all parties appeared. The respondent's witness from the Division of Disability Determination (DDD) had a scheduling conflict and was unable to attend. The hearing was rescheduled for February 28, 2018 at 4:00 p.m.

Consevilla Martinez, Operations Service Manager with DDD, appeared as a witness for the respondent. The petitioner submitted a one-page document, which was marked and entered as Petitioner's Exhibit 1. The respondent submitted a 95-page document, which was marked and entered as Respondent's Exhibits "1" through "5". The record closed the same day.

FINDINGS OF FACT

1. The petitioner is a 34-year-old male, with 12 years of education. He does not meet the aged criteria for SSI-Related Medicaid benefits. He has no minor children. He does not meet the technical criteria for the Family Related Medicaid category. The petitioner does not allege blindness. Disability must be established to determine Medicaid eligibility.

2. On August 26, 2016, the petitioner applied for Supplemental Security Income (SSI) with the Social Security Administration (SSA) alleging he is disabled. The petitioner's application was denied "Absent from the United States" (N03). The petitioner did not appeal the decision and he has not reapplied as of the day of the hearing (Respondent's Exhibit 3).

3. The petitioner is not currently employed. He has never been employed. The petitioner's history of [redacted] dates back to 2008, when the petitioner was diagnosed with [redacted] (Respondent's Exhibit 4).

4. On July 13, 2017, the petitioner submitted an application for the additional benefits of Medicaid alleging a disability. The information obtained from the petitioner was forwarded to the DDD for review (Respondent's Exhibit 2).

5. DDD reviewed the petitioner's medical records. On September 5, 2017, DDD conducted a phone interview with the petitioner to determine what activities of daily living (ADLs) he can complete. According to the Report of Contact, the petitioner reported he is able to provide his own personal care, cook normal meals, do household chores, and go grocery shopping. The petitioner further reported he has not been

hospitalized for [redacted] in the past two years, and he does not experience any symptoms form his illness when he takes his medications (Respondent's Exhibit 4).

6. On September 7, 2017, DDD found the petitioner not disabled. DDD determined that petitioner's condition was not severe enough to prevent him from engaging in substantial gainful activity (SGA), denial code N32 (Respondent's Exhibit 4).

7. DDD determined the petitioner's impairment did not meet the SSA Blue Book listings for s[redacted]:

[redacted]

[redacted]

OR
C.Your [redacted] in this listing category is "serious and persistent;" that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:
1.Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your [redacted] (see 12.00G2b); and
2.Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

8. Psychiatric Review Technique Form (PRTF) dated September 7, 2017 by [redacted]., pages 1-15, addresses the petitioner's [redacted] and states in part (Respondent's Exhibit 4):

> CONSULTANT'S NOTES
> …well documented hx of [redacted] that is responding very well to treatment. 7/17 contact notes claimant calm, well groomed, with no psychotic signs/symptoms. Some lapses in judgment indicated and claimant does have the benefits of a supportive family living situation. He is participating in a job training program and is hopeful that he will get a job soon. ADLs are adequate within his supported living situation…

9. A Mental Residual Functional Capacity (MRFC) Assessment dated September 7, 2017 indicates the following conclusion:

> FUNCTIONAL CAPACITY ASSESSMENT
> A. Understanding and Memory: Mild…
> B. Sustained Concentration and Persistence: Mild…
> C. Social: Mild…
> D. Adaptation: Moderate…
>
> SUMMARY: Claimant can understand, retain, and carry out complex instructions. Claimant can consistently and usefully perform familiar tasks on a sustained basis with minimal (normal) supervision, and can cooperate effectively with public and co-workers in completing simple tasks and transactions. Claimant can adjust to the metal demands of most new task settings. Functional restrictions beyond levels assessed above are not attributable to claimant's metal illness as reflected in the objective medical evidence in file.

10. On September 15, 2017, the respondent mailed the petitioner a Notice of Case Action informing him that his application for Medicaid was denied, "Reason: You are not 65 or older. 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).

11. The petitioner timely requested the appeal.

12. DDD explained the petitioner's impairment is not severe enough to limit his capacity for gainful activity. The petitioner participates in a job training program and has not been hospitalized in the past two (2) years. Further, the petitioner is responding to his current treatments.

13. During the hearing, the witness explained DDD's five-step evaluation process in detail. The following are the petitioner's results (in bold):

Step 1: Engaging in SGA. **N/A**
Step 2: Is there a MDI? **Yes**
Step 3: Does this impairment meet or equal a listing? **No**
Step 4: Is the claimant able to perform PRW? **N/A**
Step 5: Is the claimant able to perform other work? **Yes**

14. The respondent explained that since DDD has determined the petitioner does not meet its disability criteria, his Medicaid application was denied.

15. The petitioner's mother contends her son cannot work and although he has been making some progress, she insists he still cannot do simple things for himself. The petitioner's mother disagrees with the findings of the DDD evaluation.

16. During the hearing, the petitioner's mother submitted a letter from Henderson Behavioral Health claiming the petitioner is now experiencing [redacted]. The letter, dated February 26, 2018, states in the pertinent part (Petitioner's Exhibit 1):

[redacted]

17. The information provided at the hearing was never provided to the respondent or DDD for consideration. It was not used as a part of evaluating the petitioner's original application.

CONCLUSIONS OF LAW

18. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding, pursuant to Section 409.285, Fla. Stat.

19. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

21. 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, children, and pregnant women, and (2) Adult-Related (referred to as SSI-Related Medicaid) for disabled adults and adults 65 or older.

22. 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. 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.

23. The above cited authority explains an individual that is less than 65 years old, must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905.

24. Title 20 of the Code of Federal Regulations § 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.)

25. Federal Regulation 42 C.F.R. § 435.541 provides that a state Medicaid determination of disability must be in accordance with the requirements for evaluating evidence under the SSI program specified in 20 C.F.R. §§ 416.901 through 416.998.

26. Federal Regulation at 20.C.F.R. § 416.920, Evaluation of Disability of Adults, explains the five-step sequential evaluation process used in determining disability. The regulation states in part:

> (a) General—(1) Purpose of this section. This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 416.905.
> (2) Applicability of these rules. These rules apply to you if you are age 18 or older and you file an application for Supplemental Security Income disability benefits.
> (3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled.
> (4) The five-step sequential evaluation process. The sequential evaluation process is a series of five “steps” that we follow in a set order. 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 at 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 § 416.909, 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 to subpart P of part 404 of this chapter 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 paragraph (f) and (h) of this section and § 416.960(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 paragraph (g) of this section and § 416.960(c).)
> (c) You must have a severe impairment. If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience.

27. The above cited authority sets forth the five steps of sequential evaluation, used for evaluating the petitioner's claim of disability, as set forth in 20 C.F.R. § 416.920 is used.

28. In evaluating the first step, it has been determined the petitioner is not presently engaging in SGA. Therefore, the first step is considered met.

29. Social Security Program Operations Manual System (POMS) DI 24505.001 "Individual Must Have a Medically Determinable Severe Impairment" states in pertinent part:

> B. Definition of not Severe Impairment(s)
>
> At the second step of sequential evaluation, it must be determined whether medical evidence establishes a physical or mental impairment or combination of impairments of sufficient severity as to be the basis of a finding of inability to engage in any substantial gainful activity (SGA). When medical evidence establishes only a slight abnormality or a combination of slight abnormalities which would have no more than a minimum effect on an individual's ability to work, such impairment(s) will be found "not severe," and a determination of "not disabled" will be made without consideration of vocational factors.

30. In evaluating the second step, physical and mental impairments are considered severe when having more impact than a slight abnormality. The above cited authority considers an impairment "severe" if it is of sufficient severity as to be the basis of a finding of inability to engage in SGA. In view of this, the petitioner's mental impairment is considered severe. The second step is met.

31. The third step requires determining whether the petitioner's impairments meet or equal the "Listing of Impairments" indicated in Appendix 1 to subpart P of section 404 of the Social Security Act. Based on the cumulative evidence, the petitioner's impairments do not meet or equal the "Listing of impairments" of [redacted] and other [redacted].

32. Regarding listing [redacted] and other [redacted], the objective medical evidence failed to showed any one extreme limitation or marked limitation of two of the following areas of mental functioning: 1)

Understanding and Memory, 2) Sustained Concentration and Persistence, 3) Social (interaction with others), and 4) Adaption, which is a requirement of the listing.

33. The evidence also failed to show a medically documented history of a chronic mental disorder of at least two year's duration that has caused more than a minimal limitation of ability to do basic work activities with symptoms or signs currently attenuated by medication or psychosocial support. Accordingly, the petitioner's impairment does not rise to the level of severity required for the above listing.

34. The petitioner is taking medication for [redacted] The evidence indicates the petitioner is able to engage in ADLs and maintain social functioning. The petitioner reports no hospitalization within the past two years. The evidence further shows he is capable of functioning outside of the home with supervision. In light of this, the petitioner's [redacted] do not rise to the level of severity required to meet or equal the above listings.

35. The fourth step requires determining whether the petitioner can still do past relevant work based on his residual functional capacity. The petitioner has no past relevant work (PRW) history. No finding of PRW can be made at this time, therefore, it is appropriate to move on to step five.

36. The fifth step requires considering the petitioner's residual functional capacity, age, education, and work experience. The evidence indicates the petitioner is a 34-year-old male with 12 years of education, and no past PRW. The DDD assessment shows the petitioner would be capable of adjusting to other work in the national economy.

37. The petitioner's mother argues the petitioner has never worked and now his symptoms have worsened and he may not ever be able to work.

38. While the evidence shows the petitioner has some medically determinable impairments, these impairments should not preclude him from adjusting to other forms of work in the national economy. According to the Dictionary of Occupational Titles[1], such jobs may include Ticket Taker, code: 344.667-010; Usher, code: 344.677-014; and Cleaner, Housekeeping code: 323.687-014. In light of this, the petitioner is found not disabled at step five.

39. Although the petitioner's mother has provided a statement of new or worsening allegations, including [redacted], the letter does not provide an onset date of the new allegations and was not provided to the petitioner during the application consideration period. Further, the undersigned is affording little weight to the letter. When the petitioner completed his interview with DDD, he stated he is on his medication and experiences no symptoms from his illness.

40. In sum, the petitioner is not eligible for Medicaid under any of the Family-Related coverage groups because he has no minor children. He is not eligible for Medicaid under the SSI-Related Medicaid coverage group because he is not aged (over 65), blind, and does not meet the disability criteria because he is capable of SGA. Thus, the petitioner does not meet the technical criteria to receive Medicaid, as he is not considered to be disabled.

---

[1] 20 C.F.R. § 416.966. Work which exists in the national economy.
….
(d) Administrative notice of job data. When we determine that unskilled, sedentary, light, and medium jobs exist in the national economy (in significant numbers either in the region where you live or in several regions of the country), we will take administrative notice of reliable job information available from various governmental and other publications. For example, we will take notice of—

(1) Dictionary of Occupational Titles, published by the Department of Labor;

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is hereby 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 17 day of April, 2018, in Tallahassee, Florida.

Pamela B. Vance

Pamela B. Vance
Hearing Officer
Building 5, Room 255
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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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.
_____/

APPEAL NO. 17F-07682

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 13, 2018 at 8:30 a.m.

APPEARANCES

For the petitioner: [redacted], pro se

For the respondent: Marsha Shearer, ACCESS 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

A telephonic fair hearing was scheduled for December 11, 2017 at 10:45 a.m. The parties conducted a pre-hearing conference during which the undersigned was not present. The parties agreed to reconvene pending the outcome on the respondent to forward the petitioner's case to the office of Division of Disability Determination. The hearing was rescheduled for January 9, 2018 at 9:45 a.m. On January 9, 2018, the respondent and undersigned dialed in at the scheduled time and waited fifteen (15) minutes for the petitioner to dial in. The petitioner did not dial in. The undersigned dismissed the Department representative and coded the case as an abandonment. The petitioner called the office on January 23, 2018 and requested to reopen the appeal. The petitioner explained she was hospitalized. The undersigned determined good cause and reset the hearing on February 13, 2018 at 8:30 a.m. All parties dialed in at the scheduled time.

The petitioner did not submit any exhibits. The respondent submitted nine exhibits, which were entered into evidence as Respondent's Exhibits "1" through "9".

FINDING OF FACTS

1. Prior to the action under appeal, the petitioner (53) received Family-Related Medicaid coverage for herself and her children (both aged 18). On October 18, 2017, the respondent mailed the petitioner a Notice of Case Action (NOCA) indicating the Medicaid benefits for herself would end on October 31, 2017 because her children turned age 18. The petitioner no longer qualifies under Family-Related Medicaid due to no minor children under age 18 in the home.

2. On November 8, 2017, the petitioner filed an application through the Federally

Facilitated Marketplace[1]. On the application, the petitioner reported she's disabled.

3. On November 14, 2017, the respondent mailed the petitioner a Notice of Case Action denying the petitioner's application for Medicaid indicating "[redacted] IS INELIGIBLE FOR MEDICAID WITH THE DEPARTMENT AS YOUR CHILDREN ARE ALREADY AT THE AGE OF 18".

4. The respondent realized it had not explored other Medicaid coverage. Therefore, the respondent reviewed Medicaid coverage under Adult-Related Program. The respondent reviewed the State On-Line Recipient Query (SOLQ) [2]. The SOLQ shows the petitioner applied for disability with the SSA on July 27, 2017. SSA had not yet render its decision.

5. On December 11, 2017, the respondent mailed the petitioner a pending notice giving her a deadline of December 21, 2017 to complete the Division of Disability Determination packet. 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 information requested was not provided.

6. On January 12, 2018, the respondent mailed the petitioner a Notice of Case Action denying her Medicaid application on the basis of not receiving all the information requested to determine eligibility.

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[1] The Federally Facilitated Marketplace offers a single application that determines eligibility for multiple health care programs, including private Qualified Health Plans, Medicaid, and Florida Kid Care. The application is sent to the Department of Children and Families for eligibility determination.

[2] The Social Security Administration (SSA)provides real time access in the SSA's system and allows workers access to query on verification services under the Title II and Title XVI benefits.

7. The respondent explained during the hearing process that the respondent received a data report through the State of Florida On-Line Query. The SOLQ indicated SSA denied the petitioner's July 27, 2017 application on January 17, 2018 with a denial code N-31. Code N-31 means "Non-Pay-Capacity for substantial gainful activity-customary past work, no visual impairment". Therefore, the respondent must adopt the SSA denial decision based on the fact that SSA does not consider the petitioner to be disabled.

8. The respondent explained the correct reason for denying the Medicaid application was due to not meeting the disability requirement.

9. The petitioner argued she needs Medicaid benefits to get the necessary treatments to help with her medical conditions. Additionally, the petitioner explained SSA is not aware of her new condition, vision impairment. The petitioner filed a reconsideration of her SSA denial with SSA on February 2018 and that appeal remains pending.

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 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. SSA denied the petitioner's disability claim on January 17, 2018 because it determined she was not disabled under its rules. The petitioner testified of a new condition; visual impairment. However, no evidence was presented to declare that SSA has refused to review any new or worsening conditions.

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 from January 17, 2018. The respondent's action to deny the petitioner's application for Adult-Related (SSI) Medicaid 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 07 day of March, 2018,

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
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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

[redacted]

APPEAL NO. 17F-07709

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88692

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 31st, 2018, at 11:00 a.m., in [redacted]

APPEARANCES

For the Petitioner: [redacted], pro se.

For the Respondent: Sonya Ceason, Operations and Management Consultant for the Economic Self-Sufficiency Program.

STATEMENT OF ISSUE

At issue is whether the respondent's action to enroll the petitioner's son in the Medically Needy program with an assigned share of cost at recertification is correct. The petitioner carries the burden of proof by a preponderance of the evidence on the issue.

PRELIMINARY STATEMENT

The hearing was originally scheduled for December 11th, 2017, at 2:30 p.m., but the petitioner requested to have an in-person hearing. The hearing was rescheduled and convened as described above.

Omar Clemente, Economic Self-Sufficiency Supervisor acted as a Spanish language interpreter for the proceeding.

The petitioner's composite exhibit one was admitted into evidence.

The respondent's exhibits 1 through 9 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated October 24th, 2017, the respondent notified the petitioner that it had enrolled her son in the Medically Needy program with an assigned Share of Cost (SOC.) (Respondent's Exhibit 8.)

On November 8th, 2017, the petitioner filed a timely appeal to challenge this action.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner's son "[redacted]" (born in [redacted]) received full Medicaid (no SOC assigned) through October 2017. The Medicaid should have been ended when "[redacted]" turned 19 years old in June 2017, but the respondent failed to take timely action on the case, and as a result, the petitioner's son "[redacted]" received four additional months of Medicaid for the period of July 2017 through October 2017. (Respondent's Exhibit 7.)

2. The petitioner applied for continued Family Related Medicaid (MFAM) on October 3rd, 2017, for a household size of two, listing herself and her son "[redacted]". The petitioner reported her only monthly income as $873 from the Social Security Administration (SSA.) (Respondent's Exhibit 1.)

3. Based on the information provided by the petitioner, the respondent processed the petitioner's Medicaid application, and determined that the petitioner's household does not meet the income threshold to qualify for Medicaid. The petitioner's son "[redacted]" was enrolled in the Medically Needy Program with an assigned Share of Cost (SOC) of $486.

4. On October 24th, 2017, the respondent issued a NOCA informing the petitioner that her son "[redacted]" was enrolled in the Medically Needy Program, and the SOC has decreased from $1086 to $486 effective December 2017. (Respondent's Exhibit 8, page 20.)[1]

5. The respondent completed the Medicaid budget for the petitioner's household in accordance with the guidelines set in its Policy Manual passage (Respondent's Exhibits 3), and the "Family Related Medicaid Income Limits" chart (Respondent's Exhibit 4.)

6 The respondent used the petitioner's SSA income of $873 as Unearned income for an Assistance Group (AG) size of two (2) including the petitioner and her son "[redacted]." The Family Related Medicaid Income (MFAM) chart shows for parents, caretakers, and children 19 and 20, the income limit to qualify for full Medicaid for a family size of two is set at $241. The petitioner's son is 19 years old, so he would be compared to the income standard of $241. Since the household's verified unearned income of $873 exceeded $241, the petitioner's household failed the initial Medicaid eligibility test. (Respondent's Exhibit 5.)

[1] The respondent erroneously budgeted "KR's" work study income, which had been corrected since, and was not subject to this appeal process, but explains the discrepancy in the SOC assigned on the NOCA.

7. As per the respondent's policy manual (Respondent's Exhibit 3), for those who fail the initial Medicaid eligibility test, a standard deduction based on the household size is afforded. After the standard deduction, if the remaining countable net income is less than or equal to the income standard for the Program category, the individual is eligible. As per the MFAM chart (Respondent's Exhibit 4), the standard deduction for a two-member household is $146. Deducting $146 from $873 still left the petitioner's household with an income higher than the Medicaid income limit of $241.

8. As per the respondent's policy manual (Respondent's Exhibit 3), for those who fail Medicaid after applying the standard deduction, a final deduction is afforded. This deduction is called the Modified Adjusted Gross Income (MAGI), and it is set at five percent (5%) of the Federal Poverty Level (FPL) based on Standard Filing Unit (SFU) size. As per the MFAM chart (Respondent's Exhibit 4), the MAGI disregard for a two-member household is $68. The respondent deducted the standard deduction of $146 and a MAGI disregard of $68 from the petitioner's countable income of $873, which left the petitioner with a countable net income of $659. Since this exceeded $241, the petitioner's household failed the Medicaid eligibility test. (Respondent's Exhibit 5.)

9. As per the respondent's policy manual (Respondent's Exhibit 3), individuals determined ineligible for Medicaid will be enrolled in the Medically Needy Program with an assigned SOC. The respondent enrolled the petitioner's son "[redacted]" in the Medically Needy Program with an assigned Share of Cost (SOC) and informed the petitioner of the same. (Respondent's Exhibit 8.)

10. The petitioner's son has [redacted] and other medical conditions which require ongoing medical attention and doctor visits. The petitioner stated that many doctors won't accept medically needy program. The petitioner is on a limited income, and she cannot afford to spend out-of-pocket expenses for her son's medical care if his SOC is not met. The petitioner understood how the process worked after the respondent explained the budget during the hearing, however, she still believes it is unfair to deny Medicaid for low-income households such as hers.

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 Florida Administrative Code R. 65-2.056.

13. Florida Administrative 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.

14. Florida Administrative 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…
>
> … . 2. The following income is considered in determining gross non-earned income of the coverage group: income of a parent living in the home with a child under age 18; or is under age 21 if in a coverage group for children under age 21; or income of the individual sponsor and the sponsor's spouse of certain non-citizens….

15. Florida Administrative 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*]** |

16. The authority cited sets forth the income limits for full Medicaid. The undersigned concludes petitioner's total countable net income of $659 exceeds the income standard of $241 for a household size of two. Therefore, the petitioner's household is not eligible for full Medicaid.

17. The Code of Federal Regulations 42 C.F.R. § 435.119 discusses Medically Needy coverage for individuals age 19 or older and under 65 at or below 133 percent FPL:

> (a) *Basis.* This section implements section 1902(a)(10)(A)(i)(VIII) of the Act.

(b) *Eligibility.* Effective January 1, 2014, the agency must provide Medicaid to individuals who:

(1) Are age 19 or older and under age 65;

(2) Are not pregnant;

(3) Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;

(4) Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and

(5) Have household income that is at or below 133 percent FPL for the applicable family size.

(c) *Coverage for dependent children.* (1) A State may not provide Medicaid under this section to a parent or other caretaker relative living with a dependent child if the child is under the age specified in paragraph (c)(2) of this section, unless such child is receiving benefits under Medicaid, the Children's Health Insurance Program under subchapter D of this chapter, or otherwise is enrolled in minimum essential coverage as defined in §435.4 of this part.

(2) For the purpose of paragraph (c)(1) of this section, the age specified is under age 19, unless the State had elected as of March 23, 2010 to provide Medicaid to individuals under age 20 or 21 under §435.222 of this part, in which case the age specified is such higher age.

[58 FR 48614, Sept. 17, 1993, as amended at 77 FR 17205, Mar. 23, 2012; 78 FR 42302, July 15, 2013]

18. 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*. For purposes of determining medically needy eligibility under this part, the agency must determine an individual's countable income as follows:

(1) For individuals under age 21, pregnant women, and parents and other caretaker relatives, the agency may apply—

(i) The AFDC methodologies in effect in the State as of August 16, 1996, consistent with §435.601 (relating to financial methodologies for non-MAGI eligibility determinations) and §435.602 (relating to financial

> responsibility of relatives and other individuals for non-MAGI eligibility determinations); or
>
> (ii) The MAGI-based methodologies defined in §435.603(b) through (f). If the agency applies the MAGI-based methodologies defined in §435.603(b) through (f), the agency must comply with the terms of §435.602, except that in applying §435.602(a)(2)(ii) to individuals under age 21, the agency may, at State option, include all parents as defined in §435.603(b) (including stepparents) who are living with the individual in the individual's household for purposes of determining household income and family size, without regard to whether the parent's income and resources would be counted under the State's approved State plan under title IV-A of the Act in effect as of July 16, 1996, if the individual were a dependent child under such State plan.

19. The ACCESS Florida Program Manual at 2030.1400, Medically Needy Coverage (MFAM) sets forth:

> The Medically 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 greater 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.

20. The above cited authority explains Medically Needy provides coverage for individuals who do not qualify for full Medicaid due to income. The respondent must follow these guidelines when processing eligibility for Family Related Medicaid.

21. The ACCESS Florida Program Policy Manual Appendix A-7, Family-Related Medicaid Income Limits chart sets forth a $387 Medically Needy Income Level (MNIL) for a household size of two. The respondent subtracted the $387 MNIL from $873 to arrive at the $486 share of cost for the petitioner.

22. The undersigned reviewed the respondent's determination of the petitioner's Medicaid eligibility, and did not find any errors in the determination. The assigned SOC for the Medically Needy Program was also reviewed and did not find any errors.

23. 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 undersigned concludes that the respondent's action to enroll the petitioner's household in the Medically Needy Program and determine a share of cost of $486 was within the rules of the program.

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 19 day of March, 2018,

in Tallahassee, Florida.

Sajan George
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

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 88007

RESPONDENT.
_____/

APPEAL NO. 17F-08003

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an in-person administrative hearing in the above-referenced matter on February 1, 2018, at 8:30 a.m., at [redacted].

APPEARANCES

For Petitioner: [redacted] pro se

For Respondent: Marsha Shearer, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner appeals Respondent's action approving her husband, [redacted]) for the Medically Needy Program (MNP) with a Share of Cost (SOC) of $1,008.00, rather than full Medicaid or a SOC of $0.00. Respondent carries the burden of proof by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Pursuant to notice, the undersigned initially scheduled this appeal for a telephonic administrative hearing for January 16, 2018 at 9:00 a.m. On December 1, 2017, Petitioner called the Office of Appeal Hearings to request an in-person hearing due to difficulties hearing. Pursuant to notice, the undersigned rescheduled the January 16, 2018 hearing for February 1, 2018 to accommodate Petitioner's request.

The undersigned initially assigned Petitioner the burden of proof at hearing. Upon further review, the undersigned concluded that the burden of proof should have been assigned to Respondent. The undersigned now assigns Respondent the burden of proof.

Petitioner submitted an evidence packet consisting of five exhibits, which were entered into evidence and marked as Petitioner's Exhibits "1" – "5." Respondent submitted an evidence packet consisting of seven exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" – "7." The record closed on February 1, 2018.

FINDINGS OF FACT

1. Prior to the action under appeal, [redacted] was enrolled in the MNP with a SOC of $0.00 (Petitioner's Exhibit 3).

2. On December 9, 2016, the Social Security Administration (SSA) mailed [redacted] an eligibility letter notifying him that he would receive $1,163.00 per month in Social Security Disability (SSDI) benefits effective March of 2017 (Petitioner's Exhibit 5, Page 3).

3. As part of the eligibility process, Respondent verified through the Department's State of Florida On-Line Query that [redacted] received $1,163.00 per month in SSDI benefits (Respondent's Testimony).

4. Respondent calculated [redacted]'s total countable income as $1,143.00, after a $20.00 unearned income disregard was subtracted from his $1,163.00 SSDI benefits (Respondent's Exhibit 5, Page 1).

5. To determine the SOC, Respondent determined the Medically Needy Income Level (MNIL) at the time of application and for a household size of one was $180.00, as indicated in the Department of Children and Families Program Policy Manual, Appendix A-9, effective April 1, 2017. This amount was subtracted from [redacted]'s $1,143.00 total countable income (*Id*.).

6. Respondent calculated Petitioner's SOC as follows:

Total unearned income:	$1,163.00
Unearned income disregard:	-$ 20.00
Total countable income:	**$1,143.00**
MNIL:	-$ 180.00
SOC:	**$ 963.00**

(*Id*.).

7. On October 9, 2017, Respondent mailed a Notice of Case Action (NOCA) to [redacted], at his address of record, notifying him that his SOC would increase from $0.00 to $963.00 effective November 1, 2017 (Petitioner's Exhibit 3). Respondent increased [redacted]'s SOC as it learned that he was receiving SSDI benefits, which increased his income (Respondent's Testimony).

8. Also on October 9, 2017, Petitioner submitted a paper application to Respondent for Supplemental Nutrition Assistance Program (SNAP), also known as Food Assistance, and Medicaid benefits (Respondent's Exhibit 2). Medicaid is the only issue.

9. On October 17, 2017, the Social Security Administration (SSA) mailed [redacted] an eligibility letter notifying him that his SSDI benefits would increase to $1,184.00 per month effective March of 2017 as the prior amount was incorrect (Petitioner's Exhibit 5, Page 1). [redacted] received $147.00 on, or about, October 25, 2017 as arrearage (*Id*.).

10. As part of the eligibility process, Respondent verified through the Department's State of Florida On-Line Query that [redacted] received $1,184.00 per month in SSDI benefits (Respondent's Exhibit 4).

11. Respondent calculated [redacted]'s total countable income as $1,164.00, after a $20.00 unearned income disregard was subtracted from his $1,184.00 SSDI benefits (Respondent's Exhibit 5, Page 2).

12. To determine the SOC, Respondent determined the MNIL at the time of application and for a household size of one was $180.00, as indicated in the Department of Children and Families Program Policy Manual, Appendix A-9, effective April 1, 2017. This amount was subtracted from [redacted]'s $1,164.00 total countable income (*Id.*).

13. Respondent calculated Petitioner's SOC as follows:

Total unearned income:	$1,184.00
Unearned income disregard:	-$ 20.00
Total countable income:	**$1,164.00**
MNIL:	-$ 180.00
SOC:	**$ 984.00**

(*Id*.).

14. On November 2, 2017, Respondent mailed a NOCA to Petitioner, at her current address of record, notifying her that [redacted]'s SOC would increase from $963.00 to $984.00 effective December 1, 2017 (Respondent's Exhibit 3, Page 2).

15. Effective January 1, 2018, [redacted]'s SSDI benefits increased from $1,184 per month to $1,208.00 per month (Respondent's Exhibit 4).

16. As part of the eligibility process, Respondent verified through the Department's State of Florida On-Line Query that [redacted] was scheduled to receive $1,208.00 per month in SSDI benefits effective January 1, 2018 (Respondent's Exhibit 4).

17. Respondent calculated [redacted]'s total countable income as $1,188.00, after a $20.00 unearned income disregard was subtracted from his $1,208.00 SSDI benefits (Respondent's Exhibit 5, Page 3).

18. To determine the SOC, Respondent determined the MNIL at the time of application and for a household size of one was $180.00 (Respondent's Exhibit 7, Page 1). This amount was subtracted from [redacted]'s $1,188.00 total countable income (Respondent's Exhibit 5, Page 3).

19. Respondent calculated Petitioner's SOC as follows:

Total unearned income:	$1,208.00
Unearned income disregard:	-$ 20.00
Total countable income:	**$1,188.00**
MNIL:	-$ 180.00
SOC:	**$1,008.00**

(*Id*.).

20. On December 8, 2017, Respondent mailed a NOCA to Petitioner, at her current address of record, notifying her that [redacted]'s SOC would increase from $984.00 to $1,008.00 effective January 1, 2018 (Respondent's Exhibit 3, Page 6).

21. Petitioner argued that she wanted [redacted] to have full Medicaid or a $0.00 SOC (Petitioner's Testimony).

22. Respondent argued that [redacted] was not eligible for full Medicaid as his income exceeded the $885.00 income limit for full Medicaid eligibility (Respondent's Testimony). In addition, [redacted]'s income required him to be enrolled in the MNP with a $1,008.00 SOC (*Id*.).

CONCLUSIONS OF LAW

23. 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.

24. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

25. Florida Administrative Code Rule 65A-1.710, SSI-Related Medicaid Coverage Groups, 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.

26. Florida Administrative Code Rule 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 expense.
> …
> (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…

27. The ACCESS Florida Program Policy Manual, effective April 1, 2017, sets forth the following:

Appendix A-9	88% Federal Poverty Level for an Individual is $885.00

28. The ACCESS Florida Program Policy Manual, effective January 1, 2018, sets forth the following:

Appendix A-9	88% Federal Poverty Level for an Individual is $885.00

29. The above cited authority explains that for eligibility in full Medicaid an individual's income cannot exceed 88% of the federal poverty line, which is $885.00. The MNP provides coverage with a SOC for individuals who do not qualify for full Medicaid.

30. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 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. If income is greater than the MNIL, share of cost is determined for appropriate members. Appropriate members are enrolled but cannot be eligible until the share of cost is met.

31. The Code of Federal Regulations Title 20, section 416.1124, defines unearned income that is not counted in SSI-Related Medicaid programs and states in part "(c) Other unearned income we do not count… (12) The first $20.00 of any unearned income in a month…"

32. Florida Administrative Code Rule 65A-1.716, Income and Resource Criteria, sets forth the MNIL for one person as $180.00.

33. In accordance with the above cited authorities, the undersigned concludes that Respondent correctly determined [redacted] ineligible for full Medicaid as his income exceeded 88% of the federal poverty level. Respondent then properly enrolled [redacted] in the MNP with a $1,008.00 SOC, effective January 1, 2018, after it deducted the $20.00 unearned income disregard and the $180.00 MNIL from MY's $1,208.00 SSDI benefits.

34. In careful review of the cited authorities and evidence, the undersigned concludes Respondent met its burden of proof to indicate it correctly determined [redacted] ineligible for full Medicaid and subsequently enrolled him in the MNP with a $1,008.00 SOC, rather than a $0.00 SOC or a SOC less than that calculated under mandate of law.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED. 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 March, 2018, in Tallahassee, Florida.

Erik Swenk, Esq.
Hearing Officer
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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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 Martin
UNIT: 66CIC

RESPONDENT.
_____/

APPEAL NO. 17F-08171

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 12, 2018 at 9:12 a.m. All parties appeared telephonically from different locations.

APPEARANCES

On behalf of petitioner: [redacted], Esq.

On behalf of respondent: Laurel Hopper, Esq. DCF Legal Counsel

STATEMENT OF ISSUE

At issue is whether Respondent, Department of Children and Families (DCF), acted correctly or erred in denying Petitioner's July 20, 2017 request for post adoption medical assistance according to Florida Administrative Code R. 65C-16.014. Petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Present as witnesses for Petitioner were the child's adoptive parents, [redacted] & [redacted]. Present as witnesses for Respondent were Cheri Sheffer, Chief Operating Officer with Devereux Community Based Care, Patricia (Trisha) West, former Children's Home Society Adoptions Case Worker, Michelle Payne, former Children's Home Society Adoptions Supervisor, and Aaron Gentry, DCF Adoptions Specialist.

Petitioner submitted nine (9) exhibits which were accepted and marked as Petitioner's Exhibits 1 through 9. Respondent submitted 13 exhibits which were accepted and marked as Respondent's Exhibits 1 through 13.

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 actions under appeal, Respondent held custody and responsibility for the care of the child (born [redacted]). A Behavior Analysis Services Program referral dated May 2, 2007, indicates that the child exhibited serious physical aggression by punching a teacher in the face. Another referral dated May 3, 2007, indicates that he was expelled from a previous daycare for throwing a chair at another student. A Comprehensive Assessment dated July 24, 2007, indicates that he has been placing his fingers down his throat to make himself throw up. He was issued referred to a Mental Health Service provider. A Behavior Analysis Services Program report dated August 27, 2007 indicates that he exhibited sexual aggression toward other children. On a Foster Home Child Placement Form dated September 6, 2007, the child was described as having "intact mental health" in need of structure and nurturing.

[redacted]s Notes entered on December 7, 2007, indicate that the child was breaking toys and uttering sexually explicit language, *see* Petitioner's Exhibits 3 through 8.

2. A Child Study Update document indicates the child has been in four different foster homes since coming in contact with the agency a year ago. He displayed serious developmental issues and he exhibited aggressive behavior. An updated Comprehensive Behavioral Assessment completed on February 22, 2008, diagnosed him with [redacted], *see* Respondent's Exhibit 1.

3. The child underwent multiple psychological evaluations and was diagnosed with [redacted] On March 23, 2008, a Subsidized Adoption Program Child's Summary indicates that the child was diagnosed with [redacted]

4. On March 22 and March 25, 2008, the parties signed an agreement for Respondent to provide a subsidy to the adoptive parents of $343 per month beginning on said date. The child was also provided with Medicaid benefits. No medical subsidy was included. Said agreement states in part at paragraph 3, "Adjustments in the amount of the maintenance subsidy will be made only with our concurrence and be based on changes in the needs of the child and/or circumstances of the family." Also, as part of said agreement, paragraph 8 states: "We must contact the department for approval of a non-Medicaid provider prior to obtaining a service from a non-Medicaid provider. Failure to do so may result in our being totally responsible for paying for the medical service." S*ee* Respondent's Exhibit 8.

5. Respondent has contracted with [redacted] (CBC) to provide services to the adoptive parents relating to the adoption, post adoption services or issues that arise with the care of petitioner. Petitioners were informed of these resources.

6. The CBC has been working in tandem with the adoptive parents in different capacities since 2016. During those contacts, the parents reported that the child was provided with an Individual Education Plan (IEP) to help him address his behavioral issues. He was transferred into an [redacted] (EBD) self-contain class room in January 2017 when the IEP appeared to be unsuccessful. Targeted Case Management (TCM) services were initiated to assist the family. The parents have contacted local government organizations seeking assistance with mental health and behavior services for the child. Petitioner's adoptive parents have been very involved with his treatment. They have participated in a [redacted] offered by [redacted] in an attempt to better their parenting skills to meet the child's needs.

7. The child had a brief stay at [redacted], a 12-bed shelter for troubled youth. On June 1, 2017, the child was transitioned to [redacted], a placement facility covered by Medicaid. The treatment team there felt he would benefit from a [redacted] concentrated program. The parents did not like [redacted] because they do not think the facility could provide the treatment necessary to address the child's needs.

8. The adoptive parents researched treatments on [redacted] and found the [redacted] in Colorado. The adoptive parents

concluded said facility was the right treatment for the child. That facility does not have a Florida Medicaid number.

9. On July 20, 2017, the adoptive parents requested an increase in the subsidy amount and medical assistance. On July 24, 2017, Petitioners maintenance subsidy was increased.

10 The child's adoptive parents indicated they did not know the extent of petitioner's emotional state and misbehaviors before adopting him. The parents were only aware that petitioner had diagnoses of [redacted] and [redacted] at time of adoption.

11. The child is eligible for Medicaid services. The adoptive parents have never had to utilize Medicaid before and indicated they had always been able to provide their family with everything they needed with their income.

12. On July 28, 2017, the child was discharged from the [redacted] facility. On July 30, 2017, he was taken to [redacted] to start his [redacted] at the [redacted] [redacted]. He is currently being treated for [redacted] [redacted]), and [redacted]

13. On August 4, 2017, [redacted] sent a letter to the parents indicating that they have recommended their request for medical assistance be denied. The notice was signed by Cheri Sheffer, Chief Operating Officer, *see* Respondent's Exhibit 12.

14. On September 25, 2017, Respondent mailed a notice to the parents informing them that that their request for medical assistance is denied, based on the recommendation of [redacted]. Mr. Gentry testified that the CBC's decision must be accepted by the Department. The notice explained that the

need for medical assistance was not established prior to the adoption placement. In addition, it explained that approval must be obtained from the CBC prior to initiating the services, *see* Respondent's Exhibit 13. On October 20, 2017, Petitioners timely requested a hearing challenging Respondent's action.

15. Ms. Sheffer testified the adoptive family was properly educated to identify the child's needs. [redacted] testified that she was aware of the child would need additional assistance, but it was up to UFF to approve any services. She acknowledged that the child was out of control and needed support, but denied withholding any relevant documents from the adoptive parents just to push the adoption through.

16. Petitioner argues as follows:

1. The reason the need for adoption medical assistance was not established at the time of the child's adoption or the Adoption Assistance Agreement, prior to the adoption placement was because the Department knew or should have known of the child's medical needs but willfully or negligently failed to disclose relevant facts regarding the child's history to the adoptive parents prior to, or at the time of, the child's placement.

2. The child's specific medical and mental health conditions and need for treatment could have been established prior to the adoption had the Department reasonably informed the adoptive parents of information it knew or should have known regarding the child.

3. The Department's negligence exacerbated the diagnosis and treatment of the child's serious condition and the resultant emergent need for treatment did not afford the family with the opportunity to request and get approval for medical assistance needed prior to starting treatment.

17. Respondent argues as follows: (1) that the need for medical adoption assistance was not established at the time of the child's adoption; (2) that the diagnosis of [redacted] was not identified on the Adoption Agreement and that Petitioner signed said Agreement that reflected no medical subsidy would be paid to them; (3) that the adoptive parents must obtain approval of the CBC agency or subcontractor agency prior the use of a service if the adoptive parents will be seeking reimbursement and they failed to do so.

18. Petitioner maintains that the Respondent's contracted providers did not make a full disclosure of information concerning the child's history and needs during the adoption process in March 2008. He argues in a time of crisis, there is no time to look into further placement or pre-approval. Respondent maintains that the parents received extensive disclosures throughout the adoption process. Respondent contends by signing the both the "Affidavit of Disclosure for Adoption" and the "Adoption Assistance Agreement Between the Department of Children and Families and Families and Adoptive Parents Regarding Subsidy Payments and Services", Petitioners accepted to adopt the child without a medical subsidy. Respondent maintains that Petitioners voluntarily commenced the medical services for the adopted child without receiving pre-approval from the CBC, therefore should not expect any reimbursement.

19. As of the day of this hearing, the adoptive parents have an outstanding balance of about $84,000 for the child's treatment.

CONCLUSIONS OF LAW

20. 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.

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

22. Section 409.166, Florida Statutes, Children within the child welfare system; adoption assistance program, states in relevant part:

> (1) LEGISLATIVE INTENT.—It is the intent of the Legislature to protect and promote each child's right to the security and stability of a permanent family home. The Legislature intends to make adoption assistance, including financial aid, available to prospective adoptive parents to enable them to adopt a child in the state's foster care system who, because of his or her needs, has proven difficult to place in an adoptive home.
> …
> (2)(b) "Adoption assistance" means financial assistance and services provided to a child and his or her adoptive family. Such assistance may include a maintenance subsidy, medical assistance, Medicaid assistance, and reimbursement of nonrecurring expenses associated with the legal adoption. The term also includes a tuition exemption at a postsecondary career program, community college, or state university.
> (c) "Child within the child welfare system" or "child" means a special needs child and any other child who was removed from the child's caregiver due to abuse or neglect and whose permanent custody has been awarded to the department or to a licensed child-placing agency.
> …
> (f) "Maintenance subsidy" means a monthly payment as provided in subsection (4).
> …
> (4) ADOPTION ASSISTANCE.—
> (a) A maintenance subsidy shall be granted only when all other resources available to a child have been thoroughly explored and it can be clearly established that this is the most acceptable plan for providing permanent placement for the child… This section does not prohibit foster parents from applying to adopt a child placed in their care. Foster parents or relative caregivers must be asked if they would adopt without a maintenance subsidy.
> …
> (c) The department may provide adoption assistance to the adoptive parents, subject to specific appropriation, for medical assistance initiated after the adoption of the child for medical, surgical, hospital, and related services needed as a result of a physical or mental condition of the child which existed before the adoption and is not covered by Medicaid, Children's Medical Services, or Children's Mental Health Services. Such assistance may be initiated at any time but shall terminate on or before the child's 18th birthday.

23. Fla. Admin. Code R. 65C-16.012, Types of Adoption Assistance, states in part:

> (1) The community-based-care (CBC) or sub-contractor agency adoption staff shall inform prospective adoptive parents of the availability of all of the benefits listed below.
> (2) Maintenance Subsidy. A monthly payment may be made for support and maintenance of a special needs child until the child's 18th birthday.
> (3) Post Adoption Services. Post adoption services shall include:
> (a) Temporary case management;
> (b) Adoptive parents' support groups or newsletters;
> (c) Information and referral requests; and,
> (d) Assistance to cover the cost of medical, surgical, hospital and related services needed as a result of a physical or mental health condition of the child which existed prior to the adoption.
> (4) Other Medical Services. Other medical services available may include on-going Medicaid coverage and continuing eligibility with Children's Medical Services for children who were receiving such services prior to adoption….

24. Fla. Admin. Code R. 65C-16.014 addresses Post Adoption Services and states in part:

> (1) After finalization, the adoptive family may require temporary case management support, information and referral assistance and related post adoption services. Each community-based-care (CBC) agency shall provide post adoption services that include the following:
> (a) At least one (1) full-time designated post adoption services staff;
> (b) At least one (1) monthly adoptive parent support group(s) or monthly newsletters; and,
> (c) Information and referral services.
> (2) **The need for medical assistance, formerly known as medical subsidy, must be established prior to the adoption placement, although the service might not actually be needed until a later date**. **The type of service and estimated cost must be documented on the signed initial Adoption Assistance Agreement prior to adoption finalization**. **When this need is not established prior to the placement and the adoptive parents feel they have been wrongly denied a service on behalf of an adopted child, they have the right to to appeal the denial pursuant to Chapter 120, F.S. If it is found the service was wrongfully denied, the effective date of the service will be the date the family officially requested the service. Retroactive payment dating back to the date of placement will not be approved**. [emphasis added]

> (3) An individualized service must be terminated when the condition for which it was granted no longer exists or on the child's 18th birthday, whichever occurs first. Children needing residential mental health services will be referred to the Department's Substance Abuse and Mental Health Program Office.
>
> (4) The cost for a service will not be paid when those costs can be or are covered by the adopting family's medical insurance, Children's Medical Services, Children's Mental Health Services, Medicaid, Agency for Persons with Disabilities or local school districts.
>
> (**5) The adoptive parents must obtain the approval of the CBC agency or subcontractor agency prior to planning for the use of a service if the adoptive parents will be seeking reimbursement.** [emphasis added]
>
> (a) Once approval has been obtained, the adoptive parents must submit a copy of the bill for the service to the CBC agency or subcontractor agency to initiate reimbursement. The bill must be clearly legible and must specify the name of the child, the service rendered, the date of the service, and the charge for the service.
>
> (b) If the adoptive parents and the CBC agency are in agreement, payments can be made directly to the service provider.
>
> (6) When a request for a post-adoption service(s) is denied, the CBC agency shall notice the Department of the denied service. The Department shall notify the adoptive parent(s) of any denial of post-adoption services and advise them of the option for review of the denial pursuant to the Administrative Procedures Act, Chapter 120, F.S.

25. The above authorities explain that the legislative intent of the maintenance adoption subsidy is help facilitate the adoption of children in the state's foster care system who have been proven difficult to place in an adoptive home without the assistance. They also explain that if after the adoption is finalized, the adopted child may require temporary case management support, information and referral assistance and related services. However, in this situation the adoptive parents must obtain approval of the community based care provider prior to planning for the use of a service. Additionally, the cost for a service will not be reimbursed when those costs can be covered by the family's medical insurance, Medicaid or other specified sources.

26. In this instant case, the adoptive parents signed the Adoption Assistance Agreement without a medical assistance subsidy. Additionally, they failed to obtain approval from the CBC agency or subcontractor prior to planning for the use of services for which they want reimbursement.

27. Section 39.812, Florida Statutes, Post disposition relief; petition for adoption.— states in part:

> (6)(a) Once a child's adoption is finalized, the community-based care lead agency must make a reasonable effort to contact the adoptive family by telephone 1 year after the date of finalization of the adoption as a postadoption service. For purposes of this subsection, the term "reasonable effort" means the exercise of reasonable diligence and care by the community-based care lead agency to make contact with the adoptive family. At a minimum, the agency must document the following:
> 1. The number of attempts made by the community-based care lead agency to contact the adoptive family and whether those attempts were successful;
> 2. The types of postadoption services that were requested by the adoptive family and whether those services were provided by the community-based care lead agency; and
> 3. Any feedback received by the community-based care lead agency from the adoptive family relating to the quality or effectiveness of the services provided.
> (b) The community-based care lead agency must report annually to the department on the outcomes achieved and recommendations for improvement under this subsection.

28. Section 63.085, Florida Statutes, Disclosure by adoption entity.-states in part:

> (2) DISCLOSURE TO ADOPTIVE PARENTS.—
> (a) At the time that an adoption entity is responsible for selecting prospective adoptive parents for a born or unborn child whose parents are seeking to place the child for adoption or whose rights were terminated pursuant to chapter 39, the adoption entity must provide the prospective adoptive parents with information concerning the background of the child to the extent such information is disclosed to the adoption entity by the parents, legal custodian, or the department. This subsection applies only if the adoption entity identifies the prospective adoptive parents and supervises the placement of the child in the prospective adoptive parents' home. If any information cannot be disclosed because the records

> custodian failed or refused to produce the background information, the adoption entity has a duty to provide the information if it becomes available. An individual or entity contacted by an adoption entity to obtain the background information must release the requested information to the adoption entity without the necessity of a subpoena or a court order. In all cases, the prospective adoptive parents must receive all available information by the date of the final hearing on the petition for adoption. The information to be disclosed includes:
> 1. A family social and medical history form completed pursuant to s. 63.162(6).
> …
> 3. A complete set of the child's medical records documenting all medical treatment and care since the child's birth and before placement.
> 4. All mental health, psychological, and psychiatric records, reports, and evaluations concerning the child before placement.
> …
> 6. Records documenting all incidents that required the department to provide services to the child, including all orders of adjudication of dependency or termination of parental rights issued pursuant to chapter 39, any case plans drafted to address the child's needs, all protective services investigations identifying the child as a victim, and all guardian ad litem reports filed with the court concerning the child.
> 7. Written information concerning the availability of adoption subsidies for the child, if applicable.

29. Petitioner argues that the adoptive parents were not properly informed throughout the adoption process and that Respondent failed to disclose pertinent information that would have prompted them to request medical assistance. Respondent argues that by signing the Adoption Agreement, the adoptive parents acknowledged receipt of extended disclosures before going forward with the adoption without medical assistance benefit.

30. The evidence shows that the adoptive parents failed to contact Respondent before obtaining non-Medicaid provider services for their adopted child per the Adoption Assistance Agreement. The evidence also shows that this adoption has placed a significant financial burden on his adoptive parents due to the diagnosed emotional and

behavioral problems. While the undersigned took notice of the financial hardship incurred by the family, he could not find anything within to rules to conclude that a medical subsidy should be approved for the child.

31. After considering the evidence, testimony from the witnesses, and the appropriate authorities cited above, the hearing officer concludes that Petitioner has failed to meet the burden that the child is eligible for medical assistance or any reimbursements for fees related to services already received. Additionally, there is no written agreement between the Department and the adoptive parents agreeing to any medical assistance.

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 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 April, 2018,

in Tallahassee, Florida.

Roosevelt Reveil
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Office of Economic Self Sufficiency
Laurel Hopper, Esq.
[redacted]

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 88007

RESPONDENT.
_____/

APPEAL NO. 17F-08413

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 21, 2018 at 1:00 p.m.

APPEARANCES

For Petitioner: [redacted], pro se

For Respondent: Susan Martin, Operations Management Consultant

STATEMENT OF ISSUE

Petitioner appeals Respondent's action denying her Medicaid Disability application dated August 2, 2017. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Pursuant to notice, the undersigned initially scheduled this appeal for a telephonic administrative hearing for January 25, 2018 at 2:30 p.m. On January 22, 2018, Petitioner contacted Respondent requesting a continuance as she had not yet

received its evidence packet. Pursuant to notice, the undersigned rescheduled the January 25, 2018 hearing for February 5, 2018 at 1:00 p.m.

On February 5, 2018, Respondent submitted additional evidence. All parties appeared telephonically. Petitioner requested a continuance to allow her time to receive and review Respondent's additional evidence. Pursuant to notice, the undersigned rescheduled the February 5, 2018 hearing for February 21, 2018 at 1:00 p.m.

Rebecca Sills, Program Operations Administrator, Division of Disability Determination (DDD), appeared as a witness on behalf of Respondent. Regina Bish, Examiner, DDD, and Priscilla Peterson, Hearing Officer, Office of Appeal Hearings, appeared as observers without party objection.

Petitioner did not submit any evidence. Respondent submitted an evidence packet consisting of nine exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" – "9." The record closed on February 21, 2018.

FINDINGS OF FACT

1. On August 2, 2017, Petitioner (age 33 at the time of application) submitted an online application for Cash, Food Assistance, and SSI-Related Medicaid Disability for herself (Respondent's Exhibit 3). Medicaid Disability is the only issue.

2. Petitioner alleges that she has been disabled and has not worked since 2013 (Petitioner's Testimony), and described her disabilities as [redacted], [redacted] (Respondent's Exhibit 5, Page 5).

3. On March 9, 2015, Petitioner applied for disability through the Social Security Administration (SSA) (Respondent's Exhibit 6).

4. On March 10, 2015, the SSA denied Petitioner's disability application with code N01 – Non-pay – countable income exceeds Title XVI federal benefit rate (*Id.*).

5. On July 20, 2015, the SSA again denied Petitioner's disability application on reconsideration (Respondent's Exhibit 9, Page 7).

6. On August 11, 2017, Petitioner attended a hearing to appeal her disability application denial by the SSA (*Id.*).

7. On October 12, 2017, the SSA denied Petitioner's disability appeal (Respondent's Exhibit 9, Pages 7 – 16) with code H1 (identical to N31) – Non-pay – capacity for substantial gainful activity – customary past work, no visual impairment (Respondent's Testimony).

8. Petitioner is currently represented by legal counsel, and is again currently appealing the SSA disability decision (Petitioner's Testimony).

9. DDD is responsible for determining disability eligibility on behalf of the Department.

10. DDD reviewed Petitioner's medical records from 2016 through 2017 (Respondent's Exhibit 5), and determined that her primary diagnosis was [redacted] and the secondary diagnosis was [redacted] (*Id.* at 1).

11. DDD utilizes a federal regulation five-step sequential evaluation in determining disability. The following are the steps and the items evaluated in each step:

Step 1 – Is the individual engaging in substantial gainful activity (SGA) (working and earning income that meets or exceeds set limits)
Step 2 – Is the medical disability impairment(s) (MDI) severe?
Step 3 – Does the MDI meet or equal a disability listing in the federal regulation?
Step 4 – Is the individual capable of returning to previous related work (PRW)?

Step 5 – Is the individual capable of performing any work in the national economy?

12. The following are Petitioner's results (in bold) of DDD's five-step evaluation:

Step 1: Engaging in SGA? (DDD's medical evaluation indicates it did not make a determination regarding this step)
Step 2: Is there a MDI? **Yes**
Step 3: Does this impairment meet or equal a listing? **No**
Step 4: Is the claimant able to perform PRW? **Expedited RFC**
Step 5: Is the claimant able to perform other work? **Yes**

(*Id.* at 5).

13. In Step One, DDD testified that it determined Petitioner was not engaging in substantial gainful activity (Respondent's Testimony), and proceeded to Step Two.

14. In Step Two, DDD determined Petitioner's disabilities were severe (*Id.*), and proceeded to Step Three.

15. In Step Three, DDD evaluated Petitioner's physical MDI level of severity from the federal regulation list of disability impairments. Petitioner's MDIs were in body system category [redacted] (Respondent's Exhibit 5, Page 5).

16. DDD determined Petitioner's physical MDI did not meet or equal a listing in the federal regulation (Respondent's Testimony), and proceeded to Step Four.

17. In Step Four, DDD expedited Petitioner's Residual Functional Capacity (RFC) in determining whether she could perform PRW (Respondent's Exhibit 5, Page 5). This meant DDD gave Petitioner the benefit of the doubt that she could not perform PRW (Respondent's Testimony), and proceeded to Step Five.

18. However, DDD did consider a physical exam performed on Petitioner, on January 6, 2017 (Respondent's Exhibit 5, Page 110), in its Physical RFC Assessment (*Id.* at 8) in determining she could maintain her own self-care, perform light work, walk for 10 to 15 minutes, and lift and carry five pounds (Respondent's Testimony). DDD also administered a Psychiatric Review Technique (Respondent's Exhibit 5, Pages 25 – 36), in its Mental RFC Assessment (*Id*. at 32) in determining she could perform simple repetitive tasks on a sustained basis; understand, retain, and carry out complex instructions; and cooperate effectively with the public (Respondent's Testimony). The Mental RFC Assessment indicated no "markedly limited" activities (Respondent's Exhibit 5, Pages 27 and Pages 30 – 31).

19. Petitioner's medical records dated [redacted]; [redacted]; and [redacted] indicate a history of [redacted] (*Id*. at 71, 76, and 103). However, the medical records do not indicate her [redacted] occur more than once a month or that she is receiving any prescribed [redacted] treatment (*Id*.).

20. In Step Five, DDD determined that Petitioner's RFC gives her the ability to perform light work and simple repetitive tasks, which allows her to perform work in the national economy and recommended jobs as sticker, nut sorter, and dial marker (*Id*. at 5 – 6).

21. DDD's Medical Evaluation, dated October 2, 2017, states:

> Data:
> Clmntt is a 33-year-old female w/ allegations of [redacted],
> [redacted]
>
> ADLs:

She is able to do her own self care and at times able to do hh chores. She has severe pain from [redacted]. She is able to walk for 10-15 minutes before stopping and does not use any assistive devices. She is unable to continuously go up and down stairs. She can go up one flight of stairs, but would then have to sit down. She is able to L&C 5 pounds.

MER:
Clmnt seen on 1/6/17 and diagnosed w/ [redacted] pain and [redacted]. Clmnt also has a hx of [redacted], and [redacted]

Mental:
Clmnt has a hx of [redacted]. She does not have any SI/HI. She is able to manage her own money, but does not have any bills. She enjoys spending time w/ others. She does not handle change in her routine well. Her mood changes very quickly and she likes to know what's going on. She has [redacted] at least once a week and does not know what triggers them other than traffic. They usually last a couple of minutes. According the PRTF by [redacted]. the clmnt has a mild degree of limitation in being able to understand, remember, or apply information and in interacting with others. There is a moderate degree of limitation concentration, persistence, and pace and mild degree of limitation in ability to be able to adapt or manage oneself. According to his MRFC the clmnt can understand, retain, and carry out complex instructions. [S]he can consistently and usefully perform familiar tasks on a sustained basis, with minimal (normal) supervision, and can cooperate effectively w/ public and co-workers in completing simple tasks and instruction. Clmnt can adjust to the mental demands of most new task settings. Functional restrictions beyond levels assessed above are not attributable to clmnt's mental illness as reflected in the objective medical evidence in file.

Summary/Decision:
The clmnt is assessed w/ a light RFC. A finding about the capacity for PRW has not been made. However, this information is not material because all potentially applicable medical-vocational guidelines would direct a finding of "not disabled" given the claimant's age, education, and RFC. Therefore, the claimant can adjust to other work. Case is denied N32.

(*Id*.).

22. On October 2, 2017, DDD denied Petitioner's Medicaid Disability with code N32 – Non-pay – capacity for substantial gainful activity – other work, no visual impairment (*Id*. at 1).

23. On October 6, 2017, Respondent mailed Petitioner a Notice of Case Action denying her August 2, 2017 Medicaid Disability application (Respondent's Exhibit 2, Page 2).

CONCLUSIONS OF LAW

24. 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.

25. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

26. The Code of Federal Regulations Title 20, Section 416.905, Basic definition of disability for adults, 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. 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.)
> …

27. The Code of Federal Regulations Title 20, Section 416.920, Evaluation of Disability of Adults, explains the five-step sequential evaluation process used in determining disability, and states in relevant part:

> (a) *General*
> …
> (4) *The five-step sequential evaluation process*. The sequential evaluation process is a series of five "steps" that we follow in a set order. 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 at 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 § 416.909, 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 to subpart P of part 404 of this chapter 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 paragraph (f) and (h) of this section and § 416.960(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 paragraph (g) and (h) of this section and § 416.960(c)
> …
> (b) *If you are working*. If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience.
> (c) *You must have a severe impairment*. If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience
> …
> (f) *Your impairment(s) must prevent you from doing your past relevant work*. If we cannot make a determination or decision at the first three steps of the sequential evaluation process, we will compare our residual functional capacity assessment, which we made under paragraph (e) of this section, with the physical and mental demands of your past relevant work. See paragraph (h) of this section and §416.960(b). If you can still do this kind of work, we will find that you are not disabled.

28. In accordance with the above authority, DDD utilized the five-step sequential evaluation process in determining Petitioner's disability.

29. Step One of the evaluation process determines if Petitioner is engaging in SGA (working). The facts and evidence indicate that Petitioner has not been employed since 2013 and is currently not employed. Therefore, Petitioner is not engaging in SGA.

30. Step Two of the evaluation process reviews whether Petitioner's MDIs are severe. The facts and evidence indicate that Petitioner's physical and mental MDIs were considered severe.

31. Step Three of the evaluation process evaluates whether Petitioner's physical MDIs meet or equal a list of disability impairments in Title 20 of the Code of Federal Regulations, Appendix 1.

32. The Code of Federal Regulations Title 20, Section 416.911, Definition of disabling impairment, states in relevant part:

> (a) If you are an adult:
> (1) A disabling impairment is an impairment (or combination of impairments) which, of itself, is so severe that it meets or equals a set of criteria in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter…

33. The Code of Federal Regulations Title 20, Part 404, Subpart P, Appendix 1, identifies [redacted] and states in relevant part:

> Part A
> Criteria applicable to individuals age 18 and over and to children under age 18 where criteria are appropriate.
> …
> [redacted], the criteria can be applied only if the impairment persists despite the fact that the individual is following prescribed [redacted] treatment…
> …
> [redacted] Category of Impairments, [redacted]
> *documented by detailed description of a typical [redacted] pattern, including all associated phenomena; occurring more frequently than once a month in spite of at least 3 months of prescribed treatment.* With:
> A. Daytime episodes ([redacted] and [redacted]) or
> B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.
> …
> [redacted]
> A. *Introduction*. The evaluation of disability on the basis of [redacted] requires documentation of a medically determinable impairment(s), consideration of the degree of limitation such impairment(s) may impose on your ability to work, and consideration of whether these

limitations have lasted or are expected to last for a continuous period of at least 12 months…

…

[redacted]:

In these [redacted] is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders…

A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:

a. Motor tension; or

b. Autonomic hyperactivity; or

c. Apprehensive expectation; or

d. Vigilance and scanning; or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Marked difficulties in maintaining concentration, persistence, or pace; or

4. Repeated episodes of decompensation, each of extended duration.

OR

C. Resulting in complete inability to function independently outside the area of one's home.

…

[redacted]

A. *What disorders do we evaluate under the* [redacted] *listings*?

1. *We evaluate* [redacted] *that cause dysfunction in one or more components of your* [redacted].

…

D. *How do we document and evaluate the listed autoimmune disorders*?

1. [redacted]

a. *General*. [redacted] is a chronic inflammatory disease that can affect any organ or body system…

b. *Documentation of* [redacted]. Generally, but not always, the medical evidence will show that your [redacted] satisfies the criteria in the current ‘‘Criteria for the Classification of [redacted]’’ by the American College of [redacted]…

…

[redacted]

a. General. The spectrum of [redacted] includes a vast array of disorders that differ in cause, course, and outcome…

…

d. *Documentation of* [redacted]

Generally, but not always, the diagnosis of [redacted] is based on the clinical features and serologic findings described in the most recent edition of the [redacted] published by the [redacted].

…

I. *How do we use the functional criteria in these listings*?

…

4. To satisfy the functional criterion in a listing, your immune system disorder must result in a ‘‘marked’’ level of limitation in one of three general areas of functioning: Activities of daily living, social functioning, or difficulties in completing tasks due to deficiencies in concentration, persistence, or pace…

5. When ‘‘marked’’ is used as a standard for measuring the degree of functional limitation, it means more than moderate but less than extreme…

6. Activities of daily living include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, or paying bills…

7. Social functioning includes the capacity to interact independently, appropriately, effectively, and on a sustained basis with others. It includes the ability to communicate effectively with others…

8. Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings…

…

[redacted]

As described in 1[redacted]. With:

A. Involvement of two or more organs/body systems, with:

1. One of the organs/body systems involved to at least a moderate level of severity; and

2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).

or

B. Repeated manifestations of [redacted], with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:
1. Limitation of activities of daily living.
2. Limitation in maintaining social functioning.
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.
…
[redacted]. As described in [redacted] With:
A. Persistent [redacted] or persistent [redacted] of:
1. One or more major peripheral weightbearing joints resulting in the inability to ambulate effectively (as defined in [redacted]); or
2. One or more major peripheral joints in each upper extremity resulting in the inability to perform fine and gross movements effectively (as defined in [redacted]).
or
B. [redacted] or [redacted] in one or more major peripheral joints with:
1. Involvement of two or more organs/body systems with one of the organs/body systems involved to at least a moderate level of severity; and
2. At least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss).
or
C. [redacted] or other [redacted], with:
1. [redacted] (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 45° or more of flexion from the vertical position (zero degrees); or
2. [redacted] (fixation) of the dorsolumbar or cervical spine as shown by appropriate medically acceptable imaging and measured on physical examination at 30° or more of flexion (but less than 45°) measured from the vertical position (zero degrees), and involvement of two or more organs/body systems with one of the organs/body systems involved to at least a moderate level of severity.
or
D. Repeated manifestations of [redacted], with at least two of the constitutional symptoms or signs (severe fatigue, fever, malaise, or involuntary weight loss) and one of the following at the marked level:
1. Limitation of activities of daily living.
2. Limitation in maintaining social functioning.
3. Limitation in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

34. The above cited authorities indicate that for [redacted], Petitioner must have [redacted] occurring more than once a month in spite of receiving at least three months of

prescribed treatment. The facts and evidence do not indicate Petitioner had [redacted] more than once a month. Therefore, the undersigned concludes Petitioner did not meet or equal this MDI listing.

35. The above cited authorities also indicate that for [redacted], Petitioner must meet two of the following requirements: Marked restriction of activities of daily living; marked difficulties in maintaining social functioning; marked difficulties in maintaining concentration, persistence, or pace; or repeated episodes of decompensation, each of extended duration. Or, Petitioner's mental state must result in complete inability to function independently outside the area of her home. The facts and evidence indicate that Petitioner was able to maintain her own self-care; perform light work and simple repetitive tasks on a sustained basis; walk for 10 to 15 minutes; lift and carry five pounds; cooperate effectively with the public; and understand, retain, and carry out complex instructions. Therefore, the undersigned concludes Petitioner did not meet or equal this MDI listing.

36. The above cited authorities lastly indicated that for [redacted], Petitioner's [redacted] must result in a ''marked'' level of limitation (meaning more than moderate) in one of three general areas of functioning: Activities of daily living, social functioning, or difficulties in completing tasks due to deficiencies in concentration, persistence, or pace. The facts and evidence indicate that Petitioner had no levels of limitation that were categorized as "marked." Therefore, the undersigned concludes Petitioner did not meet or equal these MDI listings.

37. Step Four of the evaluation process determined whether Petitioner was capable of returning to her PRW. DDD expedited this step and determined that Petitioner was not capable of returning to her PRW. However, DDD did determine that Petitioner was able to maintain her own self-care; perform light work and simple repetitive tasks on a sustained basis; walk for 10 to 15 minutes; lift and carry five pounds; cooperate effectively with the public; and understand, retain, and carry out complex instructions. Therefore, DDD assessed Petitioner with a light RFC.

38. The Code of Federal Regulations Title 20, Part 404, Subpart P, Appendix 2, Medical-Vocational Guidelines defines light RFC, and states in relevant part:

> 202.00 *Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s)*. (a) The functional capacity to perform a full range of light work includes the functional capacity to perform sedentary as well as light work. Approximately 1,600 separate sedentary and light unskilled occupations can be identified in eight broad occupational categories, each occupation representing numerous jobs in the national economy. These jobs can be performed after a short demonstration or within 30 days, and do not require special skills or experience.
> (b) The functional capacity to perform a wide or full range of light work represents substantial work capability compatible with making a work adjustment to substantial numbers of unskilled jobs and, thus, generally provides sufficient occupational mobility even for severely impaired individuals who are not of advanced age and have sufficient educational competences for unskilled work.
>
> TABLE NO. 2—Residual Functional Capacity: Maximum Sustained Work Capability Limited to Light Work as a Result of Severe Medically Determinable Impairments(s)

Rule	Age	Education	Previous work experience	Decision
202.19	Younger individual age 18-49	High school graduate or more	Unskilled or none	Not disabled

39. Step Five of the evaluation process assessed Petitioner's light RFC, age, education, and work experience to determine if she could perform other work in the national economy.

40. In accordance with the above authority, Petitioner failed the disability criterion on Step Five. DDD suggested three jobs in the national economy for Petitioner: 1) sticker, 2) nut sorter, and 3) dial marker.

41. In careful review of the cited authorities, evidence, and testimony, the undersigned concludes that Petitioner did not meet her burden of proof indicating Respondent erred in denying her Medicaid Disability application dated August 2, 2017.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED. 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 09 day of March, 2018,

in Tallahassee, Florida.

Erik Swenk, Esq.
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

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88701

RESPONDENT.
_____/

APPEAL NO. 17F-08565

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 22, 2018, at 10:48 a.m., in [redacted]

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Mary Triplett, supervisor

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

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 claim is returned to DCF for a final determination of eligibility.

The petitioner submitted a package of evidence, which was accepted into evidence and marked as Petitioner's Composite Exhibit 1. The respondent submitted a package of evidence, which was accepted into evidence and marked as Respondent's Composite Exhibit 1.

Present as a witness for the petitioner was [redacted], the petitioner's mother.

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. The petitioner is 41 years old. She does not meet the aged criteria for SSI-Related Medicaid benefits. She has no minor children and does meet the technical requirement for the Family-Related Medicaid category.

2. The petitioner alleges blindness as her disability. Disability must be established to determine Medicaid eligibility. The petitioner is not currently employed.

3. On July 21, 2014, the petitioner applied for disability benefits with the Social Security Administration (SSA). Her application was denied by SSA on August 4, 2014 citing N41. N41 means an individual has a slight impairment, medical conditions alone, visual impairment.

4. On March 12, 2015, the petitioner requested an appeal challenging SSA's decision. On March 14, 2017, SSA rendered another unfavorable decision at the Administrative Law Judge level, in response to the petitioner's appeal (Petitioner's

Composite Exhibit 1 and Respondent's Composite Exhibit 1, page 15). On August 7, 2017, SSA sent written notice acknowledging petitioner's intent to appeal the Administrative Law Judge decision.

5. On September 21, 2017, the petitioner applied for Medicaid benefits through the Department's SSI-Related Medicaid Program. On September 25, 2017, a disability package and Disability Determination and Transmittal was completed and forwarded to DDD for a determination (Respondent's Composite Exhibit 1, page 17).

6. On September 29, 2017, DDD returned a decision to the Department via Disability Determination and Transmittal. In box number 25 in the remarks section, the comment, "Hankerson, N42 by ALJ 3/17-same alleg" was written. N42 means an individual has the capacity for SGA [substantial gainful activity], customary past work, visual impairment.

7. The Department explained that it adopted SSA's decision as it was rendered within 12 months of the latest Medicaid application. The respondent explained that SSA's decision is binding and must be accepted by the Department.

8. On October 25, 2017, the Department mailed the petitioner a Notice of Case Action denying her application for SSI-Related Medicaid benefits. The reason given for the denial was that she did not meet the disability requirement (Respondent's Composite Exhibit 1, pages 1 and 2).

9. On December 6, 2017, the petitioner requested a hearing to challenge the respondent's action.

10. At the hearing, the petitioner alleged a new and disabling condition, [redacted]. No medical evidence was provided to support her allegation for

[redacted]. SSA had previously considered the petitioner's impairment of [redacted], [redacted] and a [redacted].

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. 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.

14. 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..."

15. 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;…
> (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).

16. 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.
> **When the individual files an application within 12 months after the last unfavorable disability determination by SSA and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial** (emphasis added).

17. 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. The petitioner alleged a new disabling condition, [redacted] However, she did not provide any medical evidence supporting such a medical condition.

18. After considering the evidence, testimony and appropriate authorities, the undersigned concludes the petitioner has not met her burden of proof. The Department's action to deny the petitioner SSI-Related Medicaid is correct.

19. The hearing officer explored all other Medicaid groups. The only other Medicaid group was Family-Related Medicaid Program benefits. The petitioner has no minor children residing with her. 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. It is concluded, the respondent's action to deny the 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 and the Department'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 __23__ day of __March_____, 2018,

in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Clay
UNIT: 88369

RESPONDENT.
_____/

APPEAL NO. 17F-08578

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 26, 2018 at 11:09 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Stephanie Ross, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of October 25, 2017 denying his application for SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The appeal was originally scheduled for hearing on January 29, 2018. The petitioner failed to appear that morning. The petitioner called on February 1, 2018 to inform the office that he had just received his Notice of Hearing by Telephone. The

petitioner advised this was a post office error. The petitioner requested his appeal be rescheduled. The hearing was rescheduled and convened on February 26, 2018.

The Department submitted evidence on January 25, 2018. The petitioner stated he had not received the evidence as of the date of the hearing. The petitioner elected to proceed with the hearing. The Department notified the undersigned that page 10 of the evidence does not belong to the petitioner's case. Page 10 of the evidence was deleted prior to entering the evidence into the record. The evidence was entered as Respondent's Exhibit 1.

The petitioner submitted evidence on February 5, 2018 which was entered as Petitioner's Exhibit 1.

The record was held open through March 9, 2018 for the petitioner to have opportunity to receive a second copy of evidence and submit any written rebuttal or evidence.

The Department submitted additional evidence on February 28, 2018. This was entered as Respondent's Exhibit 2.

The petitioner did not submit any additional evidence or written statement.

The record closed on March 9, 2018.

FINDINGS OF FACT

1. The petitioner filed an application for Medicaid on October 2, 2017. The application reflects one-person household. The application lists the petitioner's date of birth as [redacted] The petitioner was age 44 at the time of application. The application shows no individual in the household coded as disabled. (Respondent's Exhibit 1, pages 11 through 14)

2. The Department issued a Notice of Case Action to the petitioner on October 12, 2017. The notice informed the petitioner of the need for a telephonic interview for his Medicaid on October 24, 2017 and he would be called between 10:00 a.m. and 3:00 p.m. The notice also informed the petitioner of the requirement for him to apply for Social Security disability benefits and provide verification that he had applied. (Respondent's Exhibit 1, pages 2 through 6)

3. The Department issued a Notice of Case Action on October 25, 2017 denying the petitioner's application with a reason of "You or a member of your household do not meet the disability requirement". (Respondent's Exhibit 1, pages 7 through 9)

4. The Department recorded in case notes on October 24, 2017 that an interview with the petitioner was completed on October 24, 2017. The case notes reflect the petitioner's report that he is unable to do work for the next six months. (Respondent's Exhibit 1, page 19)

5. The Department recorded in the case notes on October 26, 2017 the petitioner's request for a hearing in this matter. The Department also recorded a comment on December 8, 2017 regarding a supervisor review completed as petitioner disagreed with the Department's decision on Medicaid. (Respondent's Exhibit 1, page 19)

6. The Department recorded in the case notes on December 13, 2017 that the petitioner called in reference to his hearing request. The Department recorded in the case notes that the petitioner had failed to submit his verification that he had applied for Social Security benefits. The Department indicated the petitioner was past the 60

days and would need to reapply for Medicaid and then provide verification he had applied for Social Security benefits. (Respondent's Exhibit 2, page 1)

7. The petitioner submitted his medical bills and summaries of some visits to be considered in this matter. (Petitioner's Exhibit 1)

8. The Department reported he has [redacted]. He was diagnosed with these conditions on September 26, 2017. The petitioner stated he is unable to walk more than 100 feet without pain. He has been back to the hospital three times since the diagnosis with no change in his condition.

9. The Department reported they now have a date of application for Social Security disability as February 9, 2018. The Department explained this date is beyond the 60th day following the date of the October 2, 2017 application for them to be able to reuse the application. The Department suggested the petitioner should file a new application for disability related Medicaid.

10. The petitioner stated he did not have proof he had filed for Social Security disability. He believes this to be the correct reason he was denied disability related Medicaid.

11. The Department concurred with the petitioner's belief. The Department explained that a technical factor of eligibility for disability determination for Medicaid made with the Department is to file for Social Security disability.

12. The petitioner stated he filed for disability online the first time, but he is not sure that he did it correctly. The petitioner stated he has now filed for Social Security disability with the assistance of a lawyer.

13. The petitioner stated he cannot get a primary doctor because he has no insurance or Medicaid.

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. The undersigned explored eligibility first under Family-Related Medicaid groups. The petitioner does not have a minor child in the home. The Family-Related Medicaid program benefit rules are set form in Florida Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for Medicaid under the program, the petitioner must have a minor dependent child residing in the home. The undersigned concludes the petitioner does not meet the criteria for Family-Related Medicaid program benefits.

17. The definition of MEDS-AD Demonstration Waiver is found in Florida Admin. Code R. 65A-1.701, Definitions, and states:

> (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.

18. Florida Admin. Code R, 65A-1.711, SSI-Related Non-Financial Eligibility Criteria, states in relevant 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), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.
> (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).

19. 20 C.F.R. § 416.905, Basic definition of disability for adults, 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. 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. The findings show the petitioner was age 44 at the time of his application for Medicaid. The undersigned concludes as the petitioner is under age 65, he must meet the disability requirement to qualify for SSI-Related Medicaid. The findings show the petitioner has not been established as disabled by the Social Security

Administration. The undersigned concludes the petitioner must therefore be determined as disabled prior to eligibility for SSI-Related Medicaid being established.

21. 42 C.F.R. § 435.608, Applications for other benefits, states:

> (a) As a condition of eligibility, the agency must require applicants and beneficiaries to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so.
>
> (b) Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation.

22. The above controlling authority shows that a requirement for determination of eligibility for SSI-Related Medicaid is the application for other benefits for which they may be entitled to receive. The findings show the petitioner did not apply for Social Security disability until February 9, 2018. The undersigned concludes as the petitioner did not submit verification he had applied for Social Security, the Department correctly denied the petitioner's application for SSI-Related Medicaid.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and 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 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 __29__ day of __March_____, 2018,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.
_____/

APPEAL NO. 17F-08619

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 23, 2018 at 1:00 p.m.

APPEARANCES

For the petitioner: [redacted], pro se

For the respondent: Sylma Dekony, ACCESS Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to terminate the petitioner's Family-Related Medicaid benefits effective October 31, 2017 due to her youngest child turning 18. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Witness for the petitioner was [redacted], family friend to the petitioner.

The petitioner did not present 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 (48) was receiving Family-Related Medicaid benefits for herself and her child (aged 18). The petitioner's certification period ended on [redacted]. The Department's system generates a Notice of Expiration (NOE) one month prior to the end of the Medicaid certification period.

2. On August 21, 2017, the respondent mailed the petitioner an NOE to reapply by September 5, 2017, or the Medicaid benefits may end. The petitioner did not reapply by the due date.

3. On October 18, 2017, the respondent mailed the petitioner a Notice of Case Action (NOCA) indicating the Medicaid benefits for herself would end on [redacted].

4. On October 27, 2017, the petitioner submitted an on-line application requesting Medicaid for herself and her two children (ages 18 and 26). On the application, the petitioner reported both of her children receives Social Security benefits. The respondent reviewed the case. The respondent determined, the petitioner no longer qualifies under Family-Related Medicaid due to no minor children under age 18 in the home. The respondent explored other Medicaid categories, under Adult-Related Program, however; the petitioner is not aged 65 or older or reported on her application to be disabled.

5. On November 20, 2017, the respondent mailed a NOCA denying Medicaid benefits for the petitioner and approved for the petitioner's child (18). The petitioner and her adult daughter (26) were ineligible (Respondent Exhibit 1).

6. The petitioner does not agree with the Department's action to terminate her Medicaid benefits. The petitioner explained she should be eligible for Medicaid and should not be based on a minor child under age 18 residing in the home which she would derive eligibility for the program. The petitioner is seeking an exception or reconsideration to the rules.

7. The respondent explained the petitioner's child turned 18 on July 2017. The Department extended the September 2017 certification periods for one month due to Hurricane Irma for all Programs. The petitioner was approved for Medicaid benefits through October 31, 2017.

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. Florida Admin. Code R. 65A-1.702, Special Provisions, states in relevant 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. 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.
>
> (7) Re-evaluating Medicaid Adverse Actions. The department shall re-evaluate any adverse Medicaid determination upon a showing of good cause by the individual that the previous determination was incorrect and that the individual did not request a hearing within the time prescribed in Chapter 65-2, Part IV, F.A.C. This provision applies only when benefits were terminated or denied erroneously or a share of cost or patient responsibility was determined erroneously.

11. The Department's Program Policy Transmittal No.: P-17-09-0018, dated September 15, 2017, discusses One Month Certification Extension due to Hurricane Irma and states in relevant part:

> The purpose of this memorandum is to provide information on extending the September certification expiration period for one month due to Hurricane Irma for all programs. The United States Department of Agriculture (USDA) Food and Nutrition Service (FNS) approved a waiver request to extend the certification period for food assistance for one month. Under current regulations, Medicaid, Temporary Cash Assistance, Relative-Caregiver, and Non-Relative Caregiver certifications can be extended without a waiver request due to an emergency beyond the department's control.
> Policy
> Households who have not recertified or completed the certification process for September will be extended through October 31, 2017. This allows households impacted by Hurricane Irma the opportunity to submit their certification application in a timely manner and prevent loss or a delay in benefits.
> The FLORIDA eligibility system will automatically extend any households who still have a September 30, 2017 certification period and have not recertified.

12. Fla. Admin. Code R. 65A-1.705, "Family-Related Medicaid General Eligibility Criteria" states in relevant part:

> (7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested. A fully deprived child is one who is not living with either birth parent due to reasons such as death, abandonment or incarceration. The following are illustrations of SFU determinations: … (c) …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.

13. The findings show the Department took action to close the petitioner's Medicaid based solely on the fact the petitioner's child turned 18. The undersigned concludes the Department was correct in the determination that the petitioner does not qualify for Family-Related Medicaid as she no longer has a child under 18 in the home.

14. The above controlling authorities also instruct that when a person's eligibility ends under one Medicaid coverage group, the Department must determine eligibility under any other coverage groups for Medicaid benefits. Both Family-Related Medicaid and SSI-Related Medicaid eligibility are determined based on available information. In this case, the petitioner did not allege being disabled.

15. Based on the findings and the above controlling authorities, the undersigned concludes the Department correctly determined petitioner was not eligible for Medicaid in the Family-Related program, as there was no child in the household under the age of 18 from which she would derive eligibility for the program.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and 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 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 March, 2018,

in Tallahassee, Florida.

Cassandra Perez
Hearing Officer
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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

[redacted]

APPEAL NO. 17F-08714

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 14 Washington
UNIT: 55143

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 19, 2018 at 11:16 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Tanya Layton, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of November 21, 2107 denying his application for Medicaid due to exceeding the asset limit. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing in this matter was originally scheduled to convene on February 15, 2018. The parties agreed to continue the matter until February 19, 2018 at 11:00am so that evidence sharing and a pre-hearing conference could be completed.

The petitioner submitted evidence on December 19, 2017 which was entered as Petitioner's Exhibit 1. The petitioner evidence on January 30, 2018 which was entered as Petitioner's Exhibit 2. The petitioner submitted evidence (banking records) on February 19, 2018 which was entered as Petitioner's Exhibit 3. The petitioner submitted legal records on February 19, 2018 which were entered as Petitioner's Exhibit 4.

The Department submitted evidence on February 10, 2018 which was entered as Respondent's Exhibit 1.

The record closed on February 19, 2018 at the close of the hearing.

FINDINGS OF FACT

1. The petitioner filed an application for SSI-Related Medicaid on November 2, 2017. The household consists of the petitioner only. The petitioner is disabled and receives Social Security disability. (Respondent's Exhibit 1, pages 1 through 7)

2. The petitioner received a worker's compensation settlement in September 2017. The settlement amount was $154,080. The petitioner received $142,709.76 after court costs and legal fees. (Respondent's Exhibit 1, page 24)

3. [redacted]

4. The petitioner reported two bank accounts on his application. One was a credit union account ending in 4762 with a balance of $432.30. The other was a checking account with a balance of $110. (Respondent's Exhibit 1, pages 3 and 4)

5. During the Department's review of the petitioner's assets a third account ending in 1914 was discovered with a balance of $9,080.24. The Department determined this account alone exceeded the asset limit of $5,000 for an individual requesting SSI-Related Medicaid. (Respondent's Exhibit 1, page 13)

6. The Department issued a Notice of Case Action on November 21, 2017 denying his application for SSI-Related Medicaid as “the value of your assets is too high for this program”. The Notice also denied his application for Medicaid to pay his Medicare premium for the same reason. (Respondent’s Exhibit 1, pages 8 through 12)

7. The petitioner provided the Affidavit, Release and Indemnity Agreement regarding the Final Settlement of his worker’s compensation claim. (Petitioner’s Exhibit 4)

8. The petitioner identified account ending 8443 as his personal checking account. The petitioner provided his bank statements for this account for October 2017 through January 2018. According to the bank statements, the balance in the account is as follows: (Petitioner’s Exhibit 3, pages 3 through 21)

Account	October 2017	November 2017	December 2017	January 2018
8443	$9374.36	$23.47	$17.42	$143.04

9. The petitioner provided the September 2017 bank statement for account ending in 1914. The beginning balance on the account was $142,709.96. The ending balance on the account was $9,080.17. (Petitioner’s Exhibit 1, page 27 through 29)

10. The petitioner explained when the deposit of his worker’s compensation settlement was received. The bank inadvertently put the full amount of his settlement into the account for his worker’s compensation set aside funds. However, this was corrected by September 8, 2017 by transfer of the funds to his checking account.

11. The petitioner provided a quarterly bank statement for the months of October 1, 2017 through December 31, 2017 on the account ending in 1914. The beginning balance of this account was $9.080.17. The ending balance in this account

was $9,080.40. The bank statement shows interest deposited into the account and no other activity on the account. (Petitioner's Exhibit 3, page 22 through 26)

12. The petitioner provided bank statements for October 2017 through January 2018 for account 4207. The account has a savings, basic checking, truck loan and camper loan. The balances were as follows for each month: (Petitioner's Exhibit 1, pages 30 through 37)

Account	October 2017	November 2017	December 2017	January 2018
Savings	$1,034.32	$434.43	$234.46	$134.46
Checking	$1,099.98	$297.34	$125.94	$42.32
Truck	$0.00	$0.00	$0.00	$0.00
Camper	$0.00	$0.00	$0.00	$0.00

13. The petitioner presented documentation showing how he spent much of the lump sum settlement. (Respondent's Exhibit pages 25 through 30)

14. The petitioner provided a letter from Centers for Medicare and Medicaid Services (CMS) dated July 17, 2017. The letter approves the petitioner's Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) in the amount of $9,080. The letter advises that Medicare will not pay for medical items or services, including prescription drugs, until the WCMSA is appropriately exhausted. The letter instructs the petitioner to place the WCMSA funds into an interest-bearing account, separate from all other funds. The letter further instructs the petitioner that the funds are only to be used for medical care that is Medicare approved and related to the worker's compensation claim. (Petitioner's Exhibit 1, pages 9 through 11)

15. The petitioner explained that the account ending in 1914 was set up for the purpose of separating his WCMSA funds from all other funds.

16. The Department explained they were not reviewing the spend down of the lump sum settlement, just the balances of the accounts beginning November 2017.

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 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

19. 20 C.F.R § 416.1207, Resources determinations, states in relevant part:

> (a) General. Resources determinations are made as of the first moment of the month. A resource determination is based on what assets an individual has, what their values are, and whether or not they are excluded as of the first moment of the month.

20. 20 C.F.R. § 416.1208, How funds held in financial institution accounts are counted, states in relevant part:

> (a) General. Funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can use the funds for his or her support and maintenance by looking at how the individual holds the account. This is reflected in the way the account is titled.
>
> (b) Individually-held account. If an individual is designated as sole owner by the account title and can withdraw funds and use them for his or her support and maintenance, all of the funds, regardless of their source, are that individual's resource. For as long as these conditions are met, we presume that the individual owns 100 percent of the funds in the account. This presumption is non-rebuttable.

21. 20 C.F.R. § 416.1247, Exclusion of a dedicated account in a financial institution, states in relevant part:

> (a) General. In determining the resources of an individual (or spouse, if any), the funds in a dedicated account in a financial institution established and maintained in accordance with §416.640(e) will be excluded from resources. This exclusion applies only to benefits which must or may be deposited in such an account, as specified in §416.546, and accrued interest or other earnings on these benefits. If these funds are commingled with any other funds (other than accumulated earnings or interest) this exclusion will not apply to any portion of the funds in the dedicated account.

22. The Department's Program Policy Manual, CFOP 165-22, section 1640.0308, General Availability, states in relevant part:

> 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 on the factor of assets. Assets are considered available to an individual when the individual has unrestricted access to the funds.
> 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 the individual's support and maintenance, even though the individual may not choose to do so.
> Assets not available due to legal restrictions or factors beyond an individual's control are not considered in determining total available assets. **The only exception to this rule occurs when the legal restrictions were caused or requested by the individual.**
> (emphasis added)

23. The findings show the petitioner requested a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) as a part of his worker's compensation settlement. The above controlling authorities require that all bank accounts held by an individual be considered available and counted in the resource determination for Medicaid eligibility. Additionally, the authorities allow the assets to be excluded IF there are legal restrictions on the account, but NOT if the legal restrictions were caused or

requested by the individual. The undersigned concludes the accounts cannot be excluded in the eligibility determination process.

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

> (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.,

25. Florida Admin. Code R. 65A-1.716, Income and Resource Criteria, sets for the resource limits for the Medically Needy program for a household of one as $5,000.

26. The findings show the petitioner has an account (ending in 1914) with a balance of $9,080.40. The findings show the petitioner had this account set up for his WCMSA settlement in September 2017. The undersigned concludes the balance in this account alone exceeds the resource limit for the Medically Needy Program. The undersigned further concludes the Department correctly denied the petitioner's application for Medicaid and Medically Needy.

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 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 __March_____, 2018,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 17F-08716

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 9, 2018 at 9:45 a.m.

APPEARANCES

For the petitioner: [redacted] appeared and [redacted], the petitioner's son represented the petitioner

For the respondent: Susan Martin, ACCESS, Operation Manager Consultant I

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

Pursuant to 42 C.F.R. § 431.224(a)(1), "the agency must establish and maintain an expedited fair hearing process for individuals to request an expedited fair hearing, if the agency determines that the time otherwise permitted for a hearing under § 431.244(f)(1) could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function."

On December 14, 2017, the petitioner's son requested an expedited fair hearing and submitted documentation to support the expedited request. On December 14, 2017, a determination was made that the petitioner met the criteria for an expedited fair hearing pursuant to 42 C.F.R. §431.224(a)(1). A telephonic expedited fair hearing was scheduled for December 18, 2017 at 9:30 a.m. The parties were notified of the hearing date, time and dialing instructions by electronic mail.

On December 18, 2017, the respondent and undersigned dialed in at the scheduled time and waited fifteen (15) minutes for the petitioner and her son to dial in. The petitioner and her son did not dial in. On December 18, 2017 and after the scheduled hearing, the undersigned received an email from the petitioner's son regarding missing the hearing. The undersigned granted a reschedule and reset the hearing for January 9, 2018. On January 9, 2018, all parties dialed in.

The petitioner submitted one exhibit, which was entered into evidence as Petitioner's Exhibit "1". The respondent submitted five exhibits, which were entered into evidence as Respondent's Exhibits "1" through "5".

FINDING OF FACT

1. The petitioner (41) filed an application for disability Medicaid on September 18, 2017 (Respondent Exhibit 1). On her 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 June 23, 2006 and May 4, 2017. The petitioner reported her disabling conditions to SSA. The petitioner was denied disability benefits through SSA with a denial code N-32 on June 20, 2017. Code N-32 means "Non-Pay-Capacity for substantial gainful activity-other work, no visual impairment." The petitioner filed a reconsideration with SSA on August 3, 2017 (Respondent Exhibit 4). That appeal remains pending.

3. On September 22, 2017, the respondent mailed the petitioner a pending notice giving her a deadline of September 25, 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 (352) 423 - 5025 on or before September 25, 2017 between the hours of 8:00 A.M and 4:00 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.

Please read the disability pamphlet
Please complete and sign the Authorization To Disclose Information Form

2Call for your interview at 352-423-5025 on the date above, or return 3 page medical questionnaire(being sent separately). 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 a list of your current medications. You will need to sign and date the Authorization to Disclose (ES 2514). Note: You must apply for Social Security disability benefits with the Social Security office and provide proof of application before Medicaid can be approved and diligently pursue to conclusion any benefit you may be entitled to receive. Please return signed forms to ACCESS PO Box 1770, Ocala, Fl. 34478.

4. 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 must complete the DDD medical questionnaire form before the case is referred to DDD. On October 5, 2017, the petitioner submitted a partially complete DDD medical questionnaire form to the respondent. No interview was completed.

5. On October 19, 2017, the respondent mailed the petitioner a Notice of Case Action denying her Medicaid application due to "you failed to complete an interview necessary for us to determine your eligibility for this program." (Respondent Exhibit 3).

6. The respondent explained the petitioner did not complete the DDD medical questionnaire form and failed to complete the interview, therefore; the petitioner's application was not referred to DDD.

7. The petitioner filed another application for disability Medicaid on December 12, 2017. No notice of Case Action was submitted to the undersigned regarding the decision of the December 12 ,2017 application for disability Medicaid.

8. The petitioner explained her current diagnosis reported to SSA is [redacted], [redacted]. The petitioner alleged a new condition, [redacted]. This condition has not been reported to SSA. The petitioner did not provide any evidence of what medical conditions were considered by SSA. No evidence was submitted to show that SSA refused to considered her new allegation.

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 Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 0640.0104, Expedited Service for Disability-Related Medicaid (MSSI, SFP) states:

> Screen applications for disability related Medicaid to see if an expedited interview is necessary. Provide eligible AGs expedited services regardless of whether or not they are requested.
> Individuals or families are entitled to expedited services if an AG member is:
> 1. under age 65 and claiming a disability; and
> 2. not currently receiving SSI or SSDI benefits from the Social Security Administration (SSA); …
> …
> Provide the individual a copy of the Screening for Expedited Medicaid Appointments form. Inform the individual that the Department uses all recorded information to determine eligibility for an expedited interview.
> Provide individuals eligible for expedited services with a notice of the time

and date of the scheduled interview.
Schedule an interview for an expedited applicant within three working days; conduct an interview and complete the disability packet within seven calendar days of the date of application. If the application is dropped off or mailed, contact the household by phone to tell them of the scheduled appointment, and mail a follow-up appointment notice. If unable to reach the applicant by phone, schedule the appointment five to seven calendar days from the application date**.**
Provide individuals with a brochure titled Notice of Disability Information and Request Form. The brochure includes a list of the information the individual will need to bring to the interview to complete the disability forms used by the Division of Disability Determinations to determine whether the applicant is disabled. The date of the scheduled interview is the verification due date for these households. The notice/brochure will also advise the individual that failure to show for the interview or to bring the requested information to the interview may delay application processing.

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

(1)(b) Time standards for processing applications vary by public assistance program in accordance with 7 C.F.R. § 273.2(g), 45 C.F.R. § 206.10(a) (3) (i) and 42 C.F.R. § 435.911. For Food Assistance and Cash Assistance Programs, time standards begin the date following the date the application was filed and end on the date the Department makes benefits available or mails a notice concerning eligibility. For the Medicaid Program, the time standard ends on the date the Department mails an eligibility notice. The Department must process and determine eligibility within the following time frames:

Program:	Application Processing Time Standards
Medical Assistance and State Funded Programs for individuals who apply on the basis of disability	90 days

….
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, or 60 days from the date of application, whichever is later.

14. Based on the policies and authority cited above, the petitioner's application for disability related Medicaid was screened as an expedited interview. In this case, the respondent received an application for the petitioner on September 18, 2017. On September 22, 2017, the respondent pended the case to conduct a phone interview and complete the DDD medical questionnaire form on or before September 25, 2017. The petitioner submitted a partial DDD medical questionnaire form on October 5, 2017 and no interview was completed.

15. The petitioner submitted another application on December 12, 2017. The respondent has not completed the eligibility determination process. The case is pending. Once the requested information is provided by the petitioner, the respondent can forward the case to DDD to make a disability determination. During the hearing, the petitioner's son explained that the petitioner has a new condition; [redacted]. The petitioner's new condition was not reported to SSA. The petitioner must report her new condition to SSA. The petitioner is encouraged to report her new condition to SSA.

16. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in denying the disability Medicaid application on September 18, 2017 due to not completing an interview and DDD medical form to determine eligibility for the program.

17. The respondent has not issued a notice to the petitioner regarding the December 18, 2017 application. The respondent will issue a written Notice of Case Action to the petitioner which will include appeal rights, upon completion of the disability Medicaid eligibility determination.

DECISION

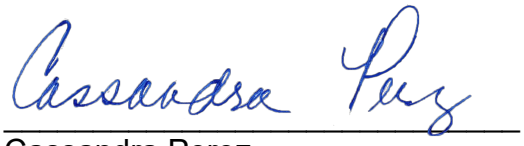
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

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 29 day of March, 2018,

in Tallahassee, Florida.



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Copies Furnished To: [redacted] Petitioner
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[redacted]

APPEAL NO. 17F-08738
APPEAL NO. 18F-00795

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Duval
UNIT: 88369

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 15, 2018 at 2:03 p.m.

APPEARANCES

For the Petitioner: The petitioner was present and represented himself.

For the Respondent: Ernestine Bethune, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

ISSUE

At issue is the Department's action on December 8, 2017 to continue the petitioner's enrollment in the Medically Needy (MN) program with a share of cost (SOC) in the amount of $1184.

Also at issue is the Department's action to approve the petitioner for $15, on or around September 1, 2017, in Supplemental Nutrition Assistance Program (SNAP) benefits.

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

PRELIMINARY STATEMENT

Evidence was received and entered as the Respondent's Exhibits 1 through 2.

The record was held open until 5:00 p.m. on February 22, 2018 to allow for the respondent to submit additional evidence.

Evidence was received and entered as the Respondent's Exhibit 3. Upon review of the Respondent's Exhibit 3, the undersigned determined that additional evidence was needed.

On March 5, 2018, an Order to Reopen Appeal and Supplement the Record was issued to request the complete Notice of Case for the issues under appeal. The respondent was to submit the additional evidence within 10 calendar days from the date of the Order.

Evidence was submitted and entered as the Respondent's Exhibit 4. The Respondent's Exhibit 4 includes the Letter of Eligibility (CNPE) screen, which indicates that the petitioner has a certification period that ends in September 2018. Since the evidence indicates that the petitioner requested a hearing regarding the SNAP benefit allotment on January 30, 2018, which was within the certification period, the undersigned concludes that the Office of Appeal Hearings has jurisdiction over the issue with the SNAP benefit allotment.

The record was closed as of March 12, 2018 at 5:00 p.m.

FINDINGS OF FACT

1. On September 1, 2017, the petitioner completed a manual application to recertify for Medicaid and SNAP benefits. The petitioner was approved for $15 in SNAP benefits (*Respondent's Exhibit 4*). The petitioner was also enrolled in the MN program with a SOC in the amount of $1157, which was increased to $1184 effective January 1, 2018 (*Respondent's Exhibit 1*).

2. The Department included in the SNAP budget, the petitioner's Social Security income in the amount of $1384. The standard deduction in the amount of $160 was subtracted from the total gross monthly income to result in the adjusted income of $1224. The adjusted net income was multiplied by .50 to result in a $612 shelter standard. The petitioner was given a shelter deduction in the amount of $850 for rent and a standard utility allowance (SUA) in the amount of $347, for a total shelter cost in the amount of $1197. The $612 shelter standard was subtracted from the $1197 total shelter cost to result in $585 excess shelter deduction. The excess shelter deduction of $585 was deducted from the $1224 adjusted net income, to result in an adjusted net income in the amount of $639. The adjusted net income was multiplied by 30% to result in a benefit reduction in the amount of $192. The maximum FAP benefit allotment for a household size of one is $192, which was reduced by the $192 benefit reduction to result in a monthly allotment in the amount of $0. However, since the petitioner meets the eligibility requirements, he is eligible to receive the minimum monthly FAP benefit allotment in the amount of $15.

3. The Department determined that the petitioner was not eligible for full-coverage Medicaid, as his income exceeded the Medicaid for Aged and Disabled (MEDS-AD) income limit in the amount of $885 for an individual. The Department calculated the MN budget by including the petitioner's total gross monthly Social Security income in the amount of $1384. The total gross income was subtracted by the unearned income disregard in the amount of $20 to result in $1364 total countable income. The total countable income was subtracted by the Medically Needy income limit (MNIL) in the amount of $180 to result in a monthly SOC in the amount of $1184.

4. The petitioner argues that $15 in SNAP benefits is not enough for him. The petitioner argues that his rent is high. The petitioner also argues that he would like to have Sunshine Health, which will cover the costs of his prescriptions. The petitioner does not dispute the income and expenses included in the Department's calculations. The petitioner argues that he spends approximately $64 in out of pocket medical expenses. The petitioner has Medicare. The petitioner does not receive any community or home based services.

5. The Department explained that the petitioner has been enrolled in the MN program since April 2016 and has been receiving the minimum SNAP benefit allotment since 2016. During the hearing, the Department completed a quick budget and included the $64 in out of pocket medical expenses that the petitioner reported during the hearing. The Department explained that the added expense of $29 ($64-$35 medical standard) out of pocket medical costs would not result in an increase in the SNAP benefit allotment.

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. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

The issue with the SNAP benefit allotment amount will be addressed:

8. Federal Regulations at 7 CFR § 273.9 Income and deductions states in relevant part:

> (b) *Definition of income.* Household income shall mean all income from whatever source excluding only items specified in paragraph (c) of this section.
> (2) Unearned income shall include, but not be limited to:
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits…old-age, survivors, or social security benefits…
> (d) Income deductions. Deductions shall be allowed only for the following household expenses:
> (1) Standard deduction…
> (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….
> (6) Shelter costs-
> (ii) Excess shelter deduction…
> (iii) Standard utility allowances…

9. The above authorities explain that unearned income includes Social Security income. The Department is to allow deductions, such as the standard deduction, to be

deducted from the household's income. The Department is to allow the excess medical deduction for households that include an elderly or disabled household member. In the petitioner's case, the petitioner, who is 64 years of age, has been determined disabled and is receiving Social Security income. The Department allowed a shelter deduction for rent, SUA, and excess shelter. Since the petitioner is elderly and disabled, he is eligible to receive a deduction for his excess medical expenses. The undersigned concludes that the Department was correct to include the petitioner's Social Security as income. The findings show that the petitioner is entitled to receive a $29 excess medical expense. However, the undersigned concludes that there is not a more favorable outcome for the petitioner by including his excess medical expense in the SNAP budget.

10. Federal Regulations at 7 CFR § 273.10 Determining household eligibility and benefit levels state:

> (c) *Determining income*—(1) *Anticipating income.* (i) For the purpose of determining the household's eligibility and level of benefits, the State agency shall take into account the income already received by the household during the certification period and any anticipated income the household and the State agency are reasonably certain will be received during the remainder of the certification period.
> …
> (e) *Calculating net income and benefit levels*—(1) *Net monthly income.* (i) To determine a household's net monthly income, the State agency shall:
> (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income. Net losses from the self-employment income of a farmer shall be offset in accordance with § 273.11(a)(2)(iii).
> (B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions. If the State agency

has chosen to treat legally obligated child support payments as an income exclusion in accordance with § 273.9(c)(17), multiply the excluded earnings used to pay child support by 20 percent and subtract that amount from the total gross monthly income.
(C) Subtract the standard deduction.
(D) If the household is entitled to an excess medical deduction as provided in § 273.9(d)(3), determine if total medical expenses exceed $35. If so, subtract that portion which exceeds $35.
(E) Subtract allowable monthly dependent care expenses, if any, up to a maximum amount as specified under § 273.9(d)(4) for each dependent.
(F) If the State agency has chosen to treat legally obligated child support payments as a deduction rather than an exclusion in accordance with § 273.9(d)(5), subtract allowable monthly child support payments in accordance with § 273.9(d)(5).
(G) Subtract the homeless shelter deduction, if any, up to the maximum of $143.
(H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.
(I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.
…
(2) *Eligibility and benefits.*
(i)(A) Households which contain an elderly or disabled member as defined in § 271.2, shall have their net income, as calculated in paragraph (e)(1) of this section (except for households considered destitute in accordance with paragraph (e)(3) of this section), compared to the monthly income eligibility standards defined in § 273.9(a)(2) for the appropriate household size to determine eligibility for the month…
(ii)(A) Except as provided in paragraphs (a)(1), (e)(2)(iii) and (e)(2)(vi) of this section, the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income as calculated in paragraph

> (e)(1) of this section. If 30 percent of the household's net income ends in cents, the State agency shall round in one of the following ways:
> (*1*) The State agency shall round the 30 percent of net income up to the nearest higher dollar; or
> (*2*) The State agency shall not round the 30 percent of net income at all. Instead, after subtracting the 30 percent of net income from the appropriate Thrifty Food Plan, the State agency shall round the allotment down to the nearest lower dollar…

11. The Department's Program Policy Manual 165-22, Appendix A-1 sets forth the 200% monthly gross income standard for an assistance group size of one at $2010, effective October 1, 2017.

12. Federal Food Assistance Regulations at 7 C.F.R. 273.10(e)(2)(ii)(C) states:

> Except during an initial month, all eligible one- and two-person households shall receive minimum monthly allotments equal to the minimum benefit…

13. The Department's Policy Transmittal No.: C-13-10-0007, dated October 11, 2013, effective upon receipt, and states in relevant part:

> **Minimum Benefit Policy**
>
> The AG is eligible for the minimum monthly food assistance benefit allotment if the assistance group meets all regular eligibility requirements and:
> • The AG has income less than or equal to the 200% gross income limit…

14. The above authority explains that assistance groups (AG) which consist of one or two household members are eligible for the minimum monthly FAP benefit allotment if the household meets all the regular eligibility requirements and has income less than or equal to the 200% gross income limit guidelines.

15. After carefully reviewing the governing authorities and evidence presented, the undersigned concludes that the Department was correct in its determination on or

around September 1, 2017 that the petitioner was eligible for SNAP benefits in the amount of $15.

The continued enrollment in the MN program will now be addressed:

16. Federal Regulations at 20 CFR § 416.1121 Types of unearned income 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, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

17. The above authority explains that unearned income, such as Social Security income, is included as income in determining eligibility for the Medicaid programs. The findings show that the petitioner is receiving Social Security income. Therefore, the undersigned concludes that the Department was correct to include the petitioner's Social Security income in its calculations.

18. Federal Regulations at 20 C.F.R. § 416.1124 "Unearned income we do not count" states:

> (a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the $20 general exclusion described in paragraph (c)(12) of this section.
> (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 other than income in the form of in-kind support and maintenance received in the household of another (see §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. The $20 exclusion does not apply to a benefit based on need that is totally or partially funded by the Federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions is excluded totally from income as described in §416.1124(c)(2). If you have less than $20 of unearned income in a month and you have earned income in that month, we will use the rest of the $20 exclusion to reduce the amount of your countable earned income;

19. 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, hospital services or home and community based services.

20. Fla. Admin. Code R. 65A-1.710 SSI-Related Medicaid Coverage Groups 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.

21. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the income standards for MEDS-AD for an individual, effective January 2017, as $885.

22. The above controlling authorities explain that the full coverage Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-Related program is for

individuals who are not receiving Medicare and whose income does not exceed 88% of the poverty level. The above authorities also explain that the Medically Needy program is for aged, blind or disabled individuals who do not qualify for full Medicaid due to their income. The income standard for the MEDS-AD program is set at $885 for an individual. The findings show that the petitioner's income is $1384 and that he receives Medicare. The findings also show that the petitioner is not receiving community or home-based services. Therefore, the undersigned concludes that the petitioner does not qualify for full-coverage Medicaid.

23. 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.
> (2) (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.

24. The Medically Needy income levels are set forth in the Fla. Admin. Code R. 65A-1.716 :

> (1) The monthly federal poverty level figures based on the size of the filing unit…
> (2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows…
> Size…1 Level $180…

25. According to the above authorities, the Department was correct to enroll petitioner in the MN Program and deduct $180 from petitioner's countable income before determining the share of cost.

26. A review of the rules did not find any exceptions to the income limits. The petitioner was enrolled in a Medicaid Medically Needy Program with a share of cost. The share of cost is gross monthly income less the Medically Needy Income Level (MNIL) for one. The gross monthly household unearned income of $1384, less the unearned income disregard of $20 and MNIL of $180, equals a share of cost of $1184. The hearing officer found no exception to this calculation. The undersigned concludes that the respondent's actions to enroll the petitioner in the Medically Needy Program and to determine the amount of the monthly share of cost as $1184, was a correct action.

DECISION

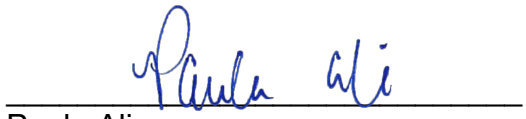
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

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 13 day of March, 2018,

in Tallahassee, Florida.



Paula Ali
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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

[redacted]

APPEAL NO. 17F-08747

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Hendry
UNIT: 88993

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 16, 2018 at 1:30 p.m.

APPEARANCES

For the Petitioner: [redacted], Authorized Representative

For the Respondent: Roneige Alnord, Economic Self-Sufficient Specialist 2
Department of Children and Families

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for Institutional Care Program (ICP) Medicaid benefits, due to an alleged improper transfer of assets. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The hearing in this matter had been previously scheduled for February 5, 2018. Prior to that hearing, the respondent filed a motion for continuance and a motion to dismiss alleging the petitioner's representative was not an authorized representative. The hearing officer granted the motion for continuance over the petitioner's objection and reserved ruling on the motion to dismiss, pending review of the documents submitted in this matter as well as a prior fair hearing involving the same parties (Appeal Hearing Case No. 17F-3063). After consideration, the hearing was rescheduled for March 16, 2018 and the motion to dismiss was denied.

The petitioner was represented by [redacted], who also provided testimony. The petitioner submitted a banking authorization form as evidence for the hearing, which was marked as Petitioner Exhibit 1. The petitioner also submitted documents pertaining to the prior fair hearing, which were marked as Petitioner Exhibit 2.

The respondent submitted a copy of a Medicaid Transfer Disposition Notice as evidence for the hearing, which was marked as Respondent Exhibit 1.

The hearing officer also informed the parties he would be taking administrative notice of all documents filed in the prior hearing 17F-3063, since the current hearing was essentially a continuation or follow-up of the prior hearing (as explained below).

FINDINGS OF FACT

1. The petitioner submitted an application for ICP Medicaid benefits on or about January 31, 2017. On or about March 2, 2017, the Department issued a notice of case action informing the petitioner his application for Medically-Needy Share-of-Cost

Medicaid had been approved. The Department did not determine the petitioner's ICP eligibility at that time because it claimed to not have enough information about a particular asset or investment owned by the petitioner. This issue became the subject of the prior hearing in Appeal Hearing Case Number 17F-3603.

2. The transaction at issue was described in the prior hearing's Final Order as follows:

> On October 31, 2016, the petitioner converted $100,000 to an equivalent amount of shares or units through [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 the 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:
>
> (1) Subscription is in the face amount of $100,000.
> (2) Subscription ownership is irrevocable upon issuance of the 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 is irrevocably assigned to: [redacted].

3. The outcome of the hearing in 17F-3063 was that the hearing officer concluded she could not rule on whether the Department correctly or incorrectly denied the petitioner's application for ICP benefits since the Department never issued a notice of action approving or denying the application. The Final Order (dated October 19, 2017) directed the Department to issue a notice of case action on that issue.

4. On or about November 20, 2017 the Department issued to the petitioner a Medicaid Transfer Disposition Notice. The notice stated the following:

> We determined that your application dated January 31st, 2017 for Nursing Home Coverage is approved for general Medicaid services only. This means that Medicaid may pay for a wide variety of services for you, such as physician's services, hospital services, medical supplies and equipment, laboratory, and others.
>
> Your application was not approved for Medicaid to pay for the long-term care services you received from January 1st, 2017 to December 17, 2017. These dates are pending as all factors of eligibility have not been met for January 1st, 2017 start date (verification of trust funding and pension is still needed), as you transferred assets (or income) without receiving fair compensation and you did not present clear and convincing evidence that you:
>
> - Gave away, reduced the value of, or sold the asset (or income) solely for a reason other than to receive Medicaid; or
> - Have an undue hardship situation and your life or health is endangered because you are unable to pay for food, clothing, a place to live, or medical care.
>
> We will review your case in the last month indicated above to redetermine your eligibility for Medicaid for long-term care services.
>
> This action is in accordance with Rule 65A-1.712, Florida Administrative Code

5. The above notice also advised the petitioner of his right to request a fair hearing. The petitioner thereafter timely requested a fair hearing on or about December 8, 2017, and this proceeding followed.

6. The petitioner's representative testified that the transaction at issue involved no transfer of assets, no change in ownership, no decrease in value, and no giving away or selling of an asset. He compared the transaction to the purchase of IBM stock and

once the purchase is made, the item purchased is then valued. He stated the petitioner retains ownership and control of the shares in this investment and he is being paid interest on the investment which does not involve any calculations based on life expectancy. Upon the petitioner's death, the investment would be payable to his heirs.

7. The Department's representative did not have specific knowledge of the issues presented in this hearing, but he stated the Department is still reviewing the petitioner's application for benefits and the Department has requested additional information to make its determination.

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, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

10. Fla. Admin. Code R 65A-1.712(3), SSI-Related Medicaid Resource Eligibility Criteria, defines the types of transfer of resources and states, in part:

> (3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the Department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for ICP, Institutional Hospice or HCBS Waiver Programs. The Department will mail a Notice of Determination of Assets (or Income) Transfer, CF-ES 2264, 02/2007, incorporated by reference, to individuals who report a transfer for less than fair market value, incorporated herein by reference), advising of the opportunity to rebut the presumption and of the opportunity to request and support a claim of undue hardship per

> subparagraph (c) 5. below. If the Department determines the individual is eligible for Medicaid on all other factors of eligibility except the transfer, the individual will be approved for general Medicaid (not ICP, Institutional Hospice or HCBS Waiver Programs) and advised of their penalty period using the Medicaid Transfer Disposition Notice, CF-ES 2358, 07/2013, http://www.flrules.org/Gateway/reference.asp?No=Ref-03212, incorporated herein by reference. Transfers of resources or income made prior to January 1, 2010 are subject to 36 month look back period, except in the case of a trust treated as a transfer in which case the look back period is 60 months. Transfers of resources or income made on or after January 1. 2010 are subject to a 60 month look back period.
> (a) The Department follows the policy for transfer of resources in accordance with 42 U.S.C. §§ 1396p and 1396r-5. Transfer policies apply to the transfer of income and resources.…

11. Pursuant to the above authority, the Department must determine if a transfer of assets is valid or invalid. The Department's November 20, 2017 Medicaid Transfer Disposition Notice made a determination that the petitioner had made an invalid asset transfer.

12. Section 1640.0606 of the Department's Program Policy Manual states the following concerning transfer of assets:

> A transfer occurs when an individual, their spouse, a legally authorized representative, or a joint owner of a jointly held asset does not receive fair compensation when:
>
> 1. disposing of an asset (by selling it or giving it away) or decreases the extent of the individual's or spouse's ownership interest in the asset; or
> 2. decreasing the value of a countable asset in the process of converting it to an excluded asset.

13. The petitioner's transaction described above should not have been determined to be an invalid asset transfer since there was actually no transfer of ownership or decrease in value involved in the transaction. The petitioner retains ownership and control of the asset and he did not transfer the asset to any other individual or entity.

The transaction was in the nature of a conversion of assets from cash in a bank account to shares in the investment and there was no change in ownership or decrease in value.

14. Based on the foregoing, the Department incorrectly denied the petitioner's application for ICP benefits based on the asset transfer rules for the transaction described above. The undersigned cannot make a determination that the petitioner is eligible for ICP benefits, however, since the Department must still evaluate whether he meets the other program requirements, such as asset and income limits.

DECISION

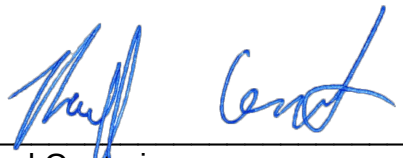
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED, to the extent the Department shall not consider the petitioner's transaction described herein to be an improper asset transfer.

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 ___April_____, 2018,

in Tallahassee, Florida.



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Copies Furnished To: [redacted] Petitioner
[redacted]

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

[redacted]

APPEAL NO. 17F-08777

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88223

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:00 p.m. on January 29, 2018.

APPEARANCES

For the Petitioner: [redacted], pro se

For the Respondent: Marsha Shearer, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to increase the petitioner's Medically Needy (MN) Share of Cost (SOC) from $1,369 to $1,524, 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 submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The record was closed on January 29, 2018.

FINDINGS OF FACT

1. Prior to the action under appeal the petitioner received MN with a $1,369 SOC.

2. On November 16, 2017, the petitioner submitted a redetermination application for Supplemental Nutrition Assistance Program (SNAP), also known as Food Assistance Program, Medicaid and Cash for her, her husband and two grandchildren (Respondent Exhibit 2). MN for the petitioner is the only issue.

3. The petitioner's husband is employed at [redacted] (Respondent Exhibit 5). The petitioner's husband also receives Social Security Retirement (SSR) (Respondent Exhibit 4), and a pension from [redacted] (Respondent Exhibit 5).

4. The respondent's representative explained the petitioner's husband SSR was $812.94 when the Department processed the petitioner's application, not $813 currently listed on Social Security State On-Line Query.

5. The following is the Department's calculation of the petitioner's household income.

$434.18	10/23/17 [redacted]
$384.88	11/06/17 [redacted]
$819.06	total earned income
$ 812.94	SSR
$ 583.00	BCTCM
$1,395.94	total unearned income

6. The following is the Department's calculation of the petitioner's SOC (Respondent Exhibit 4).

$ 819.06	earned income
$1,395.94	unearned income
$2,215.00	total household income
-$ 585.00	MN income limit for household size of four
$1,629.00	
-$ 104.90	Medicare premium for petitioner's husband
$1,524.00	SOC (cents dropped)

7. Subtracting $585 from $2,215 results in $1,630, not $1,629 (#6).

8. On December 15, 2017, the Department mailed the petitioner a Notice of Case Action, notifying the petitioner's SOC increased from $1,369 to $1,524, effective January 2018 (Respondent Exhibit 3).

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. *Florida Administrative 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…"

12. In accordance with the above authority, the Department determined the petitioner's Medicaid eligibility using her husband's earned income from [redacted] and non-earned income from SSR and BCTCM.

13. *Florida Administrative Code* R. 65A-1.716 Income and Resource Criteria explains: "(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size: Family Size 4 Monthly Income Level $364…"

14. The above authority explains, for the petitioner to be eligible for full Medicaid, the income for a household size of four, cannot exceed $364 monthly. The petitioner's $2,215 household income exceeds $364; therefore, the petitioner is not eligible for full Medicaid. The next available Program is MN with a SOC.

15. *Florida Administrative Code* R. (1)65A-1.707 Family-Related Medicaid Income and Resource Criteria, in part states:

> (1)(a) ...For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost…
> 2) The department considers income in excess of the medically needy income level available to pay for medical care and services. Available income from a one month period is used to determine the amount of excess countable income available to meet medical care and services. To be allowable, a paid expense may not have been previously deducted from countable income during a period of eligibility. The department deducts allowable medical expenses which are not subject to third party payment while unpaid and still owed, or paid during the current month, 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 from countable income that exceeds the medically needy income level, as follows:
> (a) Allowable health insurance costs such as medical premiums, other health insurance premiums…

16. The above authority explains the SOC is determined by subtracting the income level (MNIL) and medical premium from the gross income.

17. The Department's Program Policy Manual, at Appendix A-7, sets forth the MNIL at $585 for a household size of four.

18. In accordance with the above authorities, the Department calculated the petitioner's SOC by deducting $585 (MNIL) and $104.90, Medicare premium, to arrive at $1,524 SOC. The undersigned concludes that the Department's SOC calculation is in the petitioner's best interest.

19. In careful review of the above authorities and evidence, the undersigned concludes the Department met its burden of proof. The undersigned concludes the respondent's action to increase the petitioner MN SOC from $1,369 to $1,524, 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 __02__ day of __March_____, 2018,

in Tallahassee, Florida.

Priscilla Peterson

_____

Priscilla Peterson
Hearing Officer
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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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 Leon
UNIT: 88313

RESPONDENT.
_____/

APPEAL NO. 17F-08802

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 14, 2018 at 2:07 pm.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Tanya Layton, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of November 22, 2017 enrolling her in the SSI-Related Medically Needy Program with an increased share of cost. The petitioner is requesting full SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted a Request for Dismissal on January 2, 2018. The Department believed the appeal requested on December 19, 2017 was untimely filed.

The Notice of Case Action the Department believed under appeal was dated September 18, 2017 which was over 90 days prior to the hearing request. The undersigned denied the motion to dismiss on January 5, 2018 as the petitioner had other notices after September 18, 2017, which were not provided for the undersigned to review. The undersigned confirmed the denial of the Request for Dismissal during the hearing and accepted the Notice of Case Action dated November 22, 2017 as the Notice which was being appealed. (Respondent's Exhibit 1, pages 41 through 47)

The Department submitted evidence on February 10, 2018 which was entered as Respondent's Exhibit 1.

The petitioner did not submit evidence in this matter.

The record was held open through February 26, 2018 to allow additional information from the Department as well as petitioner response.

The Department submitted additional evidence on February 14, 2018 which was entered as Respondent's Exhibit 2.

The petitioner did not submit any evidence or written response post hearing.

The record closed on February 26, 2018.

FINDINGS OF FACT

1. The petitioner filed an application for SSI-Related Medicaid on September 8, 2017. The application reflects the petitioner's household of one. The application also reflects the petitioner is established as disabled effective October 1, 2012. (Respondent's Exhibit 1, pages 1 through 5)

2. The Department issued a Notice of Case Action on September 18, 2017 decreasing the petitioner's Food Assistance benefits and enrolling her in Medically Needy effective September 2017. (Respondent's Exhibit 1, pages 36 through 40)

3. The Department issued a Notice of Case Action on November 22, 2017 showing the petitioner's Food Assistance and Medically Needy Share of Cost adjustments effective January 2018 due to a change in her Social Security benefit. The Medically Needy Share of Cost increased to $796 effective January 2018. (Respondent's Exhibit 1, pages 32 through 35)

4. The Department issued a Notice of Case Action on December 1, 2017 showing the petitioner met her Medically Needy Share of Cost on November 24, 2017 and was eligible for Medicaid from November 24, 2017 through November 30, 2017. (Respondent's Exhibit 1, pages 29 through 31)

5. The Department issued a Notice of Case Action on December 15, 2017 showing the petitioner met her Medically Needy share of cost on December 13, 2017 and was eligible for Medicaid from December 13, 2017 through December 31, 2017. (Respondent's Exhibit 1, pages 26 through 28)

6. The Department provided a Notice of Case Action on the petitioner's Medically Needy showing that the petitioner met her share of cost on January 11, 2018 and was open for Medicaid for January 11, 2018 through January 31, 2018. (Respondent's Exhibit 1, pages 12 through 14)

7. The Department provided a Notice of Case Action dated February 5, 2018 showing the petitioner's Medicaid was opened for the month of January 2018. (Respondent's Exhibit 1, pages 6 through 8)

8. The petitioner's Social Security benefit in 2017 was $976 per month. The petitioner's Social Security benefit increased to $996 effective January 2018. (Respondent's Exhibit 2)

9. The Department explained the petitioner's eligibility was then reviewed under the Medically Needy program. The Department explained the petitioner is allowed a $20 unearned income disregard as well as the disregard of the Medically Needy Income Limit of $180 to reach the amount of her share of cost. The Department calculated the petitioner's share of cost each month in 2017 was $776. The Department explained the petitioner's share of cost increased effective January 2018 to $796.

10. The Department explained that rent and utilities expenses are not considered in the calculation of the share of cost program.

11. The petitioner reported she does not have Medicare. She will not be entitled to Medicare until 2019.

12. The petitioner does not have any other health insurance policies.

13. The Department explained the petitioner's income exceeds the income limit to receive full Medicaid.

14. The petitioner stated she received full Medicaid in Iowa and does not understand why she cannot receive full Medicaid in Florida. She understands the states are different, but she really needs the full Medicaid.

15. The petitioner is concerned because she is having to go to the hospital/emergency room to receive treatment and get her prescriptions. The petitioner stated she cannot get a doctor to see her with just the Medically Needy share of cost that the Department has approved.

16. The Department explained the Notices (listed in paragraph 4 through 7) are showing when her medical bills were tracked to meet her share of cost. The period each notice shows open is the period of time when her Medicaid is open due to meeting the share of cost.

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 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

19. The undersigned explored eligibility under Family-Related Medicaid groups. The petitioner does not have a minor child in the home. The Family Related Medicaid program benefit rules are set forth in Florida Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for Medicaid under that program, the petitioner must have a minor dependent child residing in the home. The undersigned concludes the petitioner does not meet the criteria for Family-Related Medicaid program benefits.

20. Florida Admin. Code R. 65A-1.701, Definitions, states in relevant 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.

> …
> (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.

21. Florida Admin. Code R. 65A-1.702, Special Provisions, states in relevant part: "(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."

22. Florida Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in relevant 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.
> …
> (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.

23. 20 C.F.R. § 416.1121, Types of Unearned Income, states in relevant part:

> 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.

24. 20 C.F.R. § 416.1124, Unearned income we do not count, states in relevant part:

> (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 other than income in the form of in-kind support and maintenance received in the household of

another (see §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.

25. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, SSI-Related Programs – Financial Eligibility Standards effective April 1, 2017, lists the following standards:

PROGRAMS & TYPES OF COVERAGE	INCOME		ASSETS	
	Individual	Couple	Individual	Couple
PROGRAMS MANAGED BY SOCIAL SECURITY				
*Supplemental Security Income (SSI) Federal Benefit Rate (FBR) Cash payment of SSI from SSA; Includes Full Medicaid	$735 (FBR)	$1,103 (FBR)	$2,000	$3,000
*Low Income Subsidy (LIS) or Extra Help (150% FPL) Helps with costs associated with Medicare Prescription Drug Plans Automatic with full Medicaid or Medicare Savings Programs (QMB, SLMB, QI1). Income limits change yearly	$1,508	$2,030	$13,640	$27,250
PROGRAMS FOR PEOPLE 65+ OR DISABLED (Community Medicaid Programs)				
*MEDS-AD (MM S) (88% FPL) Full Community Medicaid	$885	$1,191	$5,000	$6,000
*Medically Needy (No Income Limit) Medically Needy Income Level (MNIL) Full Community Medicaid **when** Share of Cost is met	Subtract $180 from gross income	Subtract $241 from gross income		

26. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, SSI-Related Programs – Financial Eligibility Standards effective January 1, 2018, lists the following standards:

PROGRAMS & TYPES OF COVERAGE	INCOME		ASSETS	
	Individual	Couple	Individual	Couple
PROGRAMS MANAGED BY SOCIAL SECURITY				
*Supplemental Security Income (SSI) Federal Benefit Rate (FBR) Cash payment of SSI from SSA; Includes Full Medicaid	$750 (FBR)	$1,125 (FBR)	$2,000	$3,000
*Low Income Subsidy (LIS) or Extra Help (150% FPL) Helps with costs associated with Medicare Prescription Drug Plans Automatic with full Medicaid or Medicare Savings Programs (QMB, SLMB, QI1). Income limits change yearly	$1,508	$2,030	$13,640	$27,250
PROGRAMS FOR PEOPLE 65+ OR DISABLED (Community Medicaid Programs)				
*MEDS-AD (MM S) (88% FPL) Full Community Medicaid	$885	$1,191	$5,000	$6,000
*Medically Needy (No Income Limit) Medically Needy Income Level (MNIL) Full Community Medicaid **when** Share of Cost is met	Subtract $180 from gross income	Subtract $241 from gross income		

27. Florida Admin. Code R. 65A-1.716, Income Resource Criteria, (2) lists the Medicaid income and payment eligibility standards and Medically Needy income level for a household size of one as $180.

28. The findings show the petitioner's income is from Social Security. The undersigned concludes the Department correctly budgeted the petitioner's income as unearned income.

29. The findings show the petitioner's Social Security benefit was $976 per month in 2017. The above controlling authorities instruct the Department due deduct the first $20 of unearned income which leaves a countable income of $956 ($976 - $20 = $956). The above controlling authority shows the income limit for full Medicaid effective April 2017 was $885. The undersigned concludes the petitioner's countable income of $956 exceeded the income limit to receive full Medicaid in 2017.

30. The findings show the petitioner's Social Security benefit increased to $996 per month effective January 1, 2018. The above controlling authorities instruct the Department due deduct the first $20 of unearned income which leaves a countable income of $976 ($996 - $20 = $976). The above controlling authority shows the income limit for full Medicaid effective January 1, 2018 was $885. The undersigned concludes the petitioner's countable income of $976 exceeds the income limit to receive full Medicaid effective January 1, 2018.

31. The undersigned concludes the Department appropriately determined as the petitioner's income exceeds the income limit for full SSI-Related Medicaid, the eligibility must be explored under the SSI-Related Medically Needy program.

32. The undersigned reviewed the calculation of the share of cost for 2017. The petitioner's countable income of $956 less the Medically Needy Income Level of $180 leaves a share of cost of $776. The undersigned concludes the Department correctly calculated the petitioner's share of cost in 2017.

33. The undersigned reviewed the calculation of the share of cost for 2017. The petitioner's countable income of $956 less the Medically Needy Income Level of $180 leaves a share of cost of $776. The undersigned concludes the Department correctly calculated the petitioner's share of cost in 2017.

34. The undersigned reviewed the calculation of the share of cost beginning January 2018. The petitioner's countable income of $976 less the Medically Needy Income Level of $180 leaves a share of cost of $796. The undersigned concludes the Department correctly calculated the petitioner's share of cost beginning January 2018.

35. The findings show the petitioner has no other health insurance premium which could be utilized to reduce her Medically Needy Share of Cost.

36. The undersigned reviewed all controlling authorities and found no other deductions such as for rent or utilities allowed in the determination of SSI-Related Medicaid eligibility. The undersigned concludes the Department correctly determined the petitioner's eligibility for SSI-Related Medically Needy program.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and 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 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 March, 2018,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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Copies Furnished To: [redacted]
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 17F-08803

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 88582

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 14, 2018 at 1:00 p.m.

APPEARANCES

For Petitioner: [redacted] pro se

For Respondent: Marsha Shearer, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner appeals Respondent's action denying his Medicaid Disability application dated September 19, 2017. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

[redacted] Petitioner's mother, appeared as a witness on his behalf. Respondent produced no witnesses.

Petitioner did not submit any exhibits. Respondent submitted an evidence packet consisting of ten exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" – "10." The record closed on February 14, 2018.

FINDINGS OF FACT

1. On September 19, 2017, Petitioner, age 35, submitted a paper application for Relative Caregiver, Food Stamps, Medicaid and Medicaid Disability for himself (Respondent's Exhibit 10, Pages 2 – 6). Petitioner's Medicaid Disability denial is the only issue.

2. Petitioner described his disabling conditions as [redacted], [redacted], and [redacted] in his body due to a car accident that occurred on [redacted] (Petitioner's Testimony).

3. On [redacted], Petitioner applied for disability through the Social Security Administration (SSA) (Respondent's Exhibit 5).

4. On October 20, 2017, Respondent mailed Petitioner a Notice of Case Action (NOCA), to his address of record, notifying that his September 19, 2017 Medicaid application was denied, with the reason that he failed to complete an interview necessary for it to determine eligibility (Respondent's Exhibit 10, Page 8).

5. On [redacted], the SSA denied Petitioner's disability application (Respondent's Exhibit 5).

6. Petitioner is appealing the SSA denial through an attorney; an appeal hearing has not yet been scheduled as of the date of this hearing (Petitioner's Testimony).

7. On November 16, 2017, Petitioner requested a re-use of his September 19, 2017 Medicaid Disability application, as a Division of Disability Determination (DDD) Interview

packet and authentication was completed and received by Respondent prior to his September 19, 2017 Medicaid application denial (Respondent's Exhibit 8, Page 3).

8. On November 17, 2017, Petitioner submitted a paper application adding Medicaid Disability to the benefits he was already receiving (Respondent's Exhibit 2).

9. Also, on November 17, 2017, Respondent electronically sent to the DDD Petitioner's medical documents for review (Respondent's Exhibit 4, Page 1). DDD is responsible for making Medicaid Disability determinations for the Department.

10. On November 22, 2017, DDD denied Petitioner's disability application with denial code N32, which means "capacity for substantial gainful activity, other work, no visual impairment" (*Id.*). Respondent did not make an independent disability decision on Petitioner's Medicaid Disability application. Instead, it adopted the SSA decision and denied Petitioner's application based on that decision, as he did not meet the technical requirements of age (at least 65) or disability.

11. On November 27, 2017, Respondent mailed Petitioner a NOCA, to his address of record, notifying that his November 22, 2017 Medicaid Disability application was denied, with the reason that no household members meet the disability requirement (Respondent's Exhibit 3, Page 2).

12. Petitioner did not claim to have new or worsened medical conditions that the SSA was unaware of (Petitioner's Testimony).

13. Petitioner argued that he should be determined eligible for Medicaid Disability benefits or other Medicaid benefits under an exception (*Id.*).

14. Respondent argued that it has to adopt the SSA's disability decision regarding his Medicaid Disability eligibility, and that there are no exceptions that would allow for

Petitioner's Medicaid eligibility under other programs as he is not aged, a non-citizen, or caring for a child under the age of 18 (Respondent's Testimony)

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 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.

16. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

17. 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…

18. 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.
…

19. The above authority explains that the SSA determination is binding on the Department. Federal regulation prohibits Respondent from making an independent determination of disability if SSA has already made a disability determination.

Respondent is bound by the federal agency's decision until it changes its decision, or there is evidence of a new disabling condition not reviewed by SSA that it refuses to consider, or the individual meets the requirements for non-disability Medicaid eligibility.

20. In accordance with the above authority, Respondent denied Petitioner's September 19, 2017 Medicaid Disability application, due to adopting the SSA denial decision. The undersigned concludes Petitioner is appealing the [redacted] SSA denial through an attorney and has no new or worsened medical conditions that the SSA is unaware of.

21. Furthermore, Petitioner is not eligible for non-disability Medicaid as he is not aged, a non-citizen, or caring for a child under the age of 18.

22. The undersigned first explored eligibility under Family-Related Medicaid groups. Petitioner does not have a minor child in the home. The Family-Related Medicaid program benefit rules are set forth in Florida Administrative Code Rule 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rule sets forth that to be eligible for Medicaid under the program Petitioner must have a minor dependent child residing in the home. The undersigned concludes Petitioner does not meet the criteria for Family-Related Medicaid program benefits.

23. The undersigned next explored eligibility under Non-Citizen Related Medicaid groups. Petitioner is not a non-citizen of the United States. The Non-Citizen Related Medicaid program benefit rules are set forth in Florida Administrative Code Rule 65A-1.715, Emergency Medical Services for Aliens. The rule sets forth that to be eligible for Medicaid under the program Petitioner must be an alien who would be eligible for

Medicaid but for his immigration status. The undersigned concludes Petitioner does not meet the criteria for Non-Citizen Related Medicaid groups.

24. The undersigned lastly explored eligibility under Adult-Related Medicaid groups. Petitioner is not 65 years of age or older, or disabled as previously determined by SSA. The Adult-Related Medicaid program benefit rules are set forth in Florida Administrative Code Rule 65A-1.711, SSI-Related Non-Financial Eligibility Criteria. The rule sets forth that to be eligible for Medicaid under the program Petitioner must be age 65 or older or disabled. The undersigned concludes Petitioner does not meet the criteria for Adult-Related Medicaid program benefits.

25. In careful review of the cited authority and evidence, the undersigned concludes that Petitioner did not meet the burden of proof to indicate Respondent incorrectly denied his September 19, 2017 Medicaid Disability application. The undersigned concludes Respondent's action denying Petitioner's September 19, 2017 Medicaid Disability application is proper.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED. 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 09 day of March, 2018,

in Tallahassee, Florida.

Erik Swenk, Esq.
Hearing Officer
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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

[redacted]

APPEAL NO. 17F-08883

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 66032

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:31 a.m. on February 5, 2018.

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 Medicaid Disability, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing originally convened on February 2, 2018. Due to telephone difficulties, the hearing was reconvened on February 5, 2018. Leonard Jackson, Hearing Officer, appeared as an observer.

The petitioner did not submit exhibits. The respondent submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The record was closed on February 5, 2018.

FINDINGS OF FACT

1. The petitioner, age 47, relocated to Florida from Illinois in November 2017. The petitioner received Medicaid benefits in Illinois.

2. On December 21, 2017, the petitioner submitted a SSI-Related Medicaid Disability and Supplemental Nutrition Assistance Program, also known as Food Assistance, application for himself (Respondent Exhibit 3). Medicaid is the only issue.

3. The petitioner described his disabilities as [redacted] in the [redacted]. In Illinois, the petitioner saw a [redacted] monthly and a [redacted] weekly.

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) and/or the Division of Disability Determination (DDD).

5. DDD determines Medicaid disability eligibility on behalf of the Department.

6. On November 18, 2014, the petitioner applied for disability through SSA. SSA denied the petitioner disability on February 13, 2015. On August 23, 2017, the petitioner appealed the SSA denial; an appeal date has not been set (Respondent Exhibit 5).

7. On January 10, 2018, the Department forwarded the petitioner's medical documents to DDD for a disability review (Respondent Exhibit 4).

8. On January 16, 2018, DDD denied the petitioner disability, due to adopting the SSA denial decision (Respondent Exhibit 4).

9. On January 18, 2018, the Department mailed the petitioner a Notice of Case Action denying the petitioner Medicaid (Respondent Exhibit 2).

10. The petitioner stated that his disabilities are not worsening and he does not have new medical conditions that the SSA is not aware of.

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 *Florida Administrative Code* R. 65-2.056.

13. *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…"

14. Title 20 of the Code of Federal Regulations § 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.) …

15. In accordance with the above authorities, the petitioner must be age 65 or older or considered disabled to be eligible for SSI-Related Medicaid.

16. 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…

17. The above authority explains that the SSA determination is binding on the Department.

18. The petitioner testified that his disabilities are not worsening and he does not have new medical conditions that SSA is not aware of.

19. The evidence submitted establishes that the petitioner is appealing the SSA denial decision; an appeal date has not been scheduled.

20. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof. The Hearing Officer concludes 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 16 day of March, 2018,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
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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

[redacted]

APPEAL NO. 17F-08898

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88590

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 29, 2018, at 8:36 a.m.

APPEARANCES

For the Petitioner: [redacted], partner

For the Respondent: Rosalynd Beckford, supervisor

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

At the hearing, the respondent presented one exhibit which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not

present any exhibits. The record was held open until February 8, 2018, for the petitioner to provide his identification, immigration status/citizenship, proof that he applied for Medicare benefits with the Social Security Administration (SSA) and for the respondent to provide its policy on the pending information. Additionally, the respondent was to update the case and provide the results. The respondent submitted one additional exhibit which was accepted into evidence and marked as Respondent's Exhibit 2. The record was closed on February 8, 2018.

FINDINGS OF FACT

1. On October 9, 2017, the petitioner submitted an application for SSI-Medicaid benefits. He was 65 years old at the time of his application (Respondent's Composite Exhibit 1, page 2).

2. On October 23, 2017, the respondent mailed a pending letter requesting that the petitioner complete a telephone interview and provide proof of loans, contributions or gifts used to pay expenses. The requested information was due on November 6, 2017. The information was not provided and the application was denied (Respondent's Composite Exhibit 1, page 9).

3. On November 6, 2017, the respondent mailed a Notice of Case Action informing the petitioner that his Medicaid Application dated October 9, 2017, was denied. The reason given for the denial was that there were no eligible members for the program (Respondent's Composite Exhibit 1, page 14).

4. On December 20, 2017, the petitioner requested a hearing to challenge the respondent's action.

5. On December 28, 2017, the respondent mailed the petitioner a second pending letter requesting him to provide his identification, citizenship or Immigration Naturalization Status (INS) and proof that he applied for Medicare Part A and Part B through SSA. It was due on January 8, 2018. No information was received by the due date. The case remained closed (Respondent's Composite Exhibit 1, page 17).

6. At the hearing, the petitioner's partner stated that she did not understand the reason for the denial. The respondent explained that the Medicaid application was denied for failure to provide identification, citizenship or immigration status and proof that the petitioner applied to SSA for Medicare benefits. The respondent also agreed to reopen the case if information was provided prior to February 8, 2018. There is no evidence that the petitioner provided the requested information. The respondent did not provide any updates to the undersigned.

CONCLUSION 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. 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…
> (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, or 60 days from the date of application, whichever is later…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.
> (2) In accordance with 7 C.F.R. § 273.14, 45 C.F.R. § 206.10(a)(9)(iii), 42 C.F.R. § 435.916, and Section 414.095, F.S., the Department must determine eligibility at periodic intervals.
> (4) If an applicant or recipient does not keep an appointment without arranging another time with the eligibility specialist; or does not sign and date the applications described in subsection (1); or does not submit required documentation or verification the Department will deny benefits as it cannot establish eligibility.

10. The Department's Program Policy Manual CFOP 165-22 addresses Requests for Additional Information/Time Standards (MSSI, SFP) and 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

11. The above authority sets forth the requirement for the Department to verify certain information and give written notice with a deadline for its return. If the applicant does not provide the required verifications by the deadline date, the application will be denied.

12. The respondent did not provide the petitioner with a written request to provide his identification, INS and proof that he applied for Medicare Part A and Part B through SSA prior to the November 6, 2017 denial; however, it did provide him with a written request on December 28, 2017. This information was due on January 8, 2018. Additionally, the respondent was willing extend the pending period until February 8, 2018 and reopen the case if the petitioner provided the requested information. There is no indication that the petitioner provided the requested information.

13. After considering the evidence, testimony, and the appropriate authorities cited above, the undersigned concludes the respondent's action to deny the petitioner's application for SSI-Related Medicaid benefits is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and 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 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 __01__ day of __March_____, 2018,

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

[redacted]

PETITIONER,

APPEAL NO. 17N-00100

Vs.

[redacted]

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on January 26, 2018 at 1:45 p.m.

APPEARANCES

For the Petitioner: [redacted] Ombudsman

For the Respondent: [redacted], Administrator

ISSUE

At issue is the nursing home facility's intent to transfer and/or discharge the petitioner without providing him a Nursing Home Transfer and Discharge Notice. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. § 483.15.

PRELIMINARY STATEMENT

The undersigned set an administrative hearing on December 15, 2017 at 1 p.m. in [redacted]. The December 15, 2017 hearing was reset from a face-to-face hearing to a phone hearing as the petitioner no longer lived at the facility. The petitioner requested a continuance to the December 2017 hearing due to illness. The undersigned reset the hearing for January 26, 2018 at 1:30 p.m. in [redacted] Florida. The January 26, 2018 face-to-face hearing was then reset to a phone hearing for January 26, 2018 at 1:30 p.m.

[redacted] (hereafter "petitioner") was present and testified. The petitioner was represented by [redacted] Ombudsman with the [redacted] Ombudsman program. The petitioner submitted no exhibits at the hearings. The respondent was represented by [redacted], Administrator with [redacted] hereafter "facility" or "respondent"). The respondent submitted one exhibit, which was accepted into evidence and entered as Respondent's Exhibit "1".

FINDINGS OF FACT

1. The petitioner entered the facility in September 29, 2017 and remained a resident until October 7, 2017. The petitioner had Medicare part A. He also has Medicaid, which acted as a secondary payor. At the time of the petitioner's admission to the facility, he was placed in a dually certified bed.

2. On October 7, 2017, the petitioner showed symptoms of [redacted]. The facility's registered nurse and

physician determined the petitioner required hospitalization and had him transported to the hospital.

3 On October 9, 2017, the respondent explained the petitioner notified the hospital's case manager that he did not wish to return to the facility. The facility then placed another individual in the petitioner's bed.

4. On October 11, 2017, the hospital's case manager indicated to the facility's Admission Director that the petitioner changed his mind and wished to return to the facility. The Admission Director informed the case manager that the facility did not have an "open male dual certified bed" available for the petitioner.

5. On October 19, 2017, the petitioner was placed at [redacted] when he was discharged from the hospital. To the date of the Order, the petitioner resides at [redacted], but wishes to return to [redacted]. The petitioner was hospitalized for approximately twelve days.

6. The petitioner explained he was informed by the facility he would be able to return when he was discharged from the hospital. Furthermore, the petitioner explained the facility also informed him that even though he was discharged to [redacted] Center, he could still return to the facility when a bed became available.

7. The nursing home facility did not provide the petitioner with a written notice of its bed hold policy. The respondent explained that since Medicare was paying for his stay at the facility when he was hospitalized, the facility did not have to follow the bed hold policy. Furthermore, the bed hold policy would have only applied to the petitioner if Medicaid was paying for his stay at the facility or if he was privately paying for his stay.

8. The petitioner's testimony was more credible than the respondent's testimony as the respondent was not the Administer of the nursing home at the time the petitioner was hospitalized.

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 400.0255(15), Fla. Stat. In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.

10. The Code of Federal Regulations 42 C.F.R. § 483.15, limit the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was not provided written notice of the facility's bed-hold policy:

> (d) Notice of bed-hold policy and return—(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies—
> (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
> (ii) The reserve bed payment policy in the state plan, under §447.40 of this chapter, if any;
> (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
> (iv) The information specified in paragraph (e)(1) of this section.
>
> (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
> (e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.

> (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident
> (A) Requires the services provided by the facility; and
> (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.
> (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

11. Section 400.0255, Fla. Stat. addresses transfers and discharges that have appeal rights and states, in part:

> (1) As used in this section, the term:
> (a) "Discharge" means to move a resident to a noninstitutional setting when the releasing facility ceases to be responsible for the resident's care.
> (b) "Transfer" means to move a resident from the facility to another legally responsible institutional setting.
> (2) Each facility licensed under this part must comply with subsection (9) and s. 400.022(1)(p) when deciding to discharge or transfer a resident.
> (3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer….
> (c) If the hearing decision is favorable to the resident who has been transferred or discharged, the resident must be readmitted to the facility's first available bed….

12. Pursuant to the above authorities, when transfers and/or discharges are initiated by the facility, written notification of the transfer or discharge must be provided by the facility. The facility's registered nurse and physician determined the petitioner required hospitalization and had him transported to the hospital due to an illness. Furthermore, the facility did not provide the petitioner with written notification of its bed hold policy.

13. The controlling authorities require a higher standard of proof in nursing home discharge hearings; there must be substantial and credible evidence at the level of clear and convincing[1]. The undersigned concludes the respondent's evidence does not rise to the level of clear and convincing as the evidence submitted does not indicate the facility provided the petitioner with proper notification of its bed hold policy. The nursing home facility must readmit the petitioner to the facility when a bed becomes available.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED. The nursing home facility is ORDERED to readmit the petitioner to the facility when an "open male dual certified bed" is available to the petitioner.

[1] State v. Graham, 240 So.2d 486 (1974), states, "Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established. (Id. quoting Slomowitz v. Walker, 429 So.2d 797, 800 (Fla. 4th DCA 1983))."

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 __05__ day of __March_____, 2018,

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
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Copies Furnished To: [redacted]

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

[redacted]

APPEAL NO. 17N-00116

PETITIONER,

Vs.

[redacted]

[redacted]

_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 30, 2018 at 3:17 p.m. at the [redacted].

APPEARANCES

For the Petitioner: [redacted], pro se

For the Respondent: [redacted]

STATEMENT OF ISSUE

At issue is the facility's intent to discharge and transfer the petitioner is an appropriate action based on the federal regulations 42 C.F.R. § 483.15. The burden of proof was assigned to the respondent by clear and convincing evidence.

PRELIMINARY STATEMENT

By Nursing Home Transfer and Discharge Notice dated December 14, 2017, the respondent notified the petitioner he was to be discharged from its facility effective January 14, 2018. The Nursing Home Transfer and Discharge Notice indicates the discharge location as: [redacted]

[redacted], social worker and [redacted] social worker both appeared as witnesses for the respondent. The petitioner submitted a 7-page evidence packet which was marked and entered as Petitioner's Exhibits "1" through "3". The respondent submitted a 15-page evidence packet which was marked and entered as Respondent's Exhibit "1" through "3". The respondent submitted duplicate information, that was originally submitted by the petitioner. As it was duplicate information, it was not marked and entered into the record.

FINDINGS OF FACT

1. On April 14, 2017, the petitioner became a resident of the nursing facility due to suffering a [redacted] The petitioner was admitted for skilled services through Medicare (Petitioner's Exhibit 1).

2. The petitioner reached his 100 days of Medicare coverage on June 16, 2017.

3. In August 2017, the respondent verbally advised the petitioner his Medicare pay coverage ended in June and he was responsible for a portion of his care. He was also notified verbally that he had an outstanding balance for June 2017 and July 2017, after his Medicare pay coverage expired. No written notice was given to the petitioner.

4. The petitioner attests he knew he would eventually have to pay; he was not sure when he would have to start paying. The petitioner contends he was not notified of the pay requirements in June 2017 and July 2017 and he refuses to pay for those months because he was not notified.

5. The petitioner claims to have other outside expenses totaling $370 per month and he can only pay $950 towards his cost for care.

6. On October 19, 2017, an application for Institutional Care Program (ICP) was submitted. On October 26, 2017, the petitioner was approved with a patient responsibility of $1,397 effective September 2017 (Respondent's Exhibit 1).

7. The petitioner continued to pay $950 per month towards his monthly stay at the facility.

8. On November 13, 2017 a Notice of Case Action was sent to the petitioner approving him for additional months of ICP coverage, April 2017 through August 2017 (Respondent's Exhibit 2).

9. On December 14, 2017, the respondent issued as Nursing Home Transfer and Discharge Notice to the petitioner with an effective date of January 14, 2018. The petitioner was being discharged and transferred due to non-pay of bill for services and his health has improved sufficiently and no longer needs the services provided by the facility. (Petitioner's Exhibit 2).

10. The petitioner timely requested the appeal.

11. The petitioner does not deny he has failed to pay his full patient responsibility of $1,397 per month. He further states he wishes to find a facility that will also take a friend along with him at their facility.

12. The respondent states the petitioner has a selection of four (4) facilities that have all accepted him and are waiting on him to make a decision as to where he wants to live.

13. The petitioner further states he has recovered from his [redacted] but he wants to remain at the facility to continue using the facility on his own to assist with his right hip.

14. The respondent states the petitioner was not admitted to the facility for his right hip and the facility is only administering his medication at this time. He no longer requires skilled nursing.

15. The petitioner remains in the facility pending the hearing decision. The petitioner's outstanding balance to the facility as of the date of the hearing, was $8,037.93.

CONCLUSIONS OF LAW

16. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding, pursuant to Section 409.285, Fla. Stat.

17. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

19. Federal Regulations 42 C.F.R. § 483.15 addresses Transfer and discharge and sets forth the reasons a facility may involuntary 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**; (*emphasis* added) or
> (F) The facility ceases to operate.

20. In this instant case, the petitioner has been approved for ICP Medicaid with a patient responsibility of $1,397. The petitioner has refused to pay the patient responsibility portion. He continues to pay $950, accumulating a balance each month. The petitioner does not deny he has not paid the full $1,397.

21. Based on the evidence and testimony, the respondent has established the petitioner has refused to pay his stay at the facility. This is one of the six (6) 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 the petitioner’s desire to move into a facility with a friend; however, there is no provision within the regulation to reverse the discharge. The respondent has met its burden.

22. 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.

23. 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

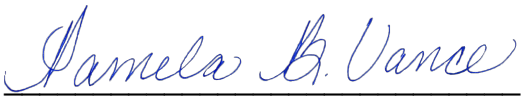
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is hereby denied, as the facility's action to discharge the petitioner is correct and in accordance with Federal Regulations. The facility may proceed with the discharge as discussed in the Conclusions of Law, in accordance 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 __01___ day of __March_____, 2018,

in Tallahassee, Florida.



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

[redacted]

APPEAL NO. 18F-00122
18F-00123
18F-00124
18F-00125

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 88324

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 28, 2018, at 2:05 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Sheila Hunt, DCF Hearings Specialist

STATEMENT OF ISSUE

At issue is whether Respondent's action denying Petitioner's Medicaid benefits through the Family Related Medicaid Program on the basis that it did not receive all the

information necessary to determine eligibility. Petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On January 4, 2018, Petitioner requested an appeal challenging her Medicaid denial.

Alma Patino, 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 October 16, 2017, Petitioner submitted an online application requesting Medicaid benefits for her household. The household comprised of Petitioner, her husband and their three mutual children (ages 0-3). On that application, Petitioner reported that she was pregnant with one unborn child. She also reported her husband's $2,400 monthly earnings from [redacted] as the household's only income. Additionally, she reported to have insurance coverage with Tricare for $217 monthly premiums. Respondent determined that no interview was required. The application was processed and Petitioner was assigned case number [redacted].

2. On October 25, 2017, Respondent sent Petitioner a pending notice requesting documents necessary for the Department to make a determination. It requested in addition to other things, "Proof of all gross income from last 4 weeks using the Verification of Employment /Loss of Income" form or you may send in your last 4 pay stubs". The notice explained that the information should be received by November 6, 2017, *see* Respondent's Composite Exhibit 1, pages 13-16.

3. On November 6, 2017, Petitioner submitted an online application requesting Supplemental Nutrition Assistance Program (SNAP) benefits for her household. On that application, Petitioner reported that her husband receives a monthly $200 drill pay as an [redacted] with the [redacted], in addition to his earnings from [redacted]. Respondent determined that an interview was required. The application was processed and Petitioner was assigned case number [redacted]

4. DCF applications are good for 60 days. The 60th day of the October 16, 2017 application is December 15, 2017. It is January 5, 2018 for the November 6, 2017 application.

5. On November 9, 2017, Petitioner faxed an income verification form from [redacted] as verification of her husband's employment with that agency, *see* Respondent's Composite Exhibit, pages 52-53.

6. On November 13, 2017, Respondent sent Petitioner a notice indicating that she needed to call 904-485-9837 for a telephone interview by November 20, 2017, between 10:00 a.m. and 1:00 p.m. The notice also indicated a pending list of documents on the SNAP case that could be needed for the Department to make a determination. It

requested in addition to other things, “Proof of all gross income from last 4 weeks using the Verification of Employment /Loss of Income” form or you may send in your last 4 pay stubs”.

7. On November 15, 2017, Medicaid benefits were denied for Petitioner and her children. A Notice of Case Action (NOCA) was sent to Petitioner on November 16, 2017 informing her that Medicaid benefits for herself and the children were denied because it did not receive all the information necessary to make a determination. Petitioner’s husband was enrolled in the Medically Needy Program, *see* P Composite 1, pages 48.

8. On November 16, 2017, Respondent completed a telephone interview with Petitioner. The Department running record comments (CLRC) entered that day (under case # 1[redacted]) indicate that during the interview, Petitioner mentioned to the interviewer that she was applying for “FS” (SNAP) and “MED” (Medicaid), see Respondent’s Composite Exhibit 1, page 48.

9. On December 7, 2017, the Department sent a NOCA to Petitioner informing her that her November 6, 2017 application for SNAP benefits was denied because “we did not receive proof of earned income necessary to make an eligibility determination”.

10. The Department CLRC comments dated December 26, 2017 (under case # [redacted]) indicate that Petitioner called the customer call center to inquire about the denial, she was explained that she needed to provide her husband’s income from the Navy. Comments dated January 4, 2018 indicate that Respondent became aware that Petitioner has to different cases. A message was sent to “worker and supervisor to

review the case for reuse". Additional comments by CCC supervisor documented that Petitioner expressed "confusion about the case and pending information", *see* Respondent's Composite Exhibit 1, page 47.

11. On January 3, 2018, Petitioner provided verification of her husband's income from the [redacted] indicating he receives $355.82, *see* Petitioner's Composite Exhibit 1, page 16.

12. On January 7, 2018, Petitioner SNAP benefits were approved under the Medicaid case number (1535752149). On January 8, 2018, she was sent a NOCA indicating she was approved for SNAP benefits effective January 3, 2018. Petitioner is not challenging the SNAP benefits level.

13. Respondent explained that Petitioner's Medicaid application was partly denied because the department did not receive the actual income information needed to make an eligibility determination. She explained that The Department is not required to verify actual income on MN eligibility, resulting in Petitioner's husband enrollment in program with an estimated SOC. She explained that Petitioner's applications were assigned two different case numbers, and the cases were assigned to two different workers. The Department only became aware of Petitioner having two cases after she requested an appeal. Respondent acknowledged the possible confusion created by Petitioner having two different cases, but explained that her Medicaid case was timely and correctly denied because the last verification was received after sixty (60) days from the October 16, 2017 Medicaid application date. She maintains that the information could

not be used to approve Medicaid for Petitioner and her children and advised Petitioner to submit another Medicaid application.

14. Petitioner explained that she has had several contacts with the Department and received different versions of what was needed to get her case approved. She asserted as follows: (1) that when she was interviewed on November 16, 2017 and was told that her husband's income verification was received and that she did not need to provide any other information; (2) that she was confused when she received a notice informing her that only her husband was approved for MN; (3) that she found out that she needed to provided her husband's income from the [redacted] during a phone call she placed to the Customer Service line on December 6, 2018; (4) that she was told she had 30 days to provide that verification from December 6, 2017; (5) that she provided the verification on January 3, 2018, and (6) that she called DCF on January 4, 2018 to confirm receipt only to be told that she was assigned two different case numbers and that she was misinformed when she was told she had 30 days to submit that information. She was advised to request a hearing.

15. As of the day of this hearing, Petitioner's husband is still enrolled in the MN Program with an estimated share of cost. Petitioner believes the respondent was wrong for denying her October 16, 2017 Medicaid application. She has refused to submit a new application for Medicaid. She is seeking Medicaid for the rest of the household based on the October 16, 2017 application.

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.

> (2) The hearing officer must determine whether the Department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the Department in making its decision.

18. The above controlling authority sets forth the de novo nature of the hearing; either party may present new or additional relevant evidence not previously considered by the Department in making its decision.

19 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.

20. 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.

21. Fla. Admin. Code R. 65A-1.205 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 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…
> (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.

22 The above authority indicates that, as the applicant for benefits, Petitioner has the ultimate responsibility to provide the verification necessary for Respondent to make a determination. Respondent partly denied Petitioner's October 16, 2017 Medicaid application because it did not receive the necessary information to make a determination within 30 days. Additionally, Petitioner's Medicaid eligibility was not reassessed because the last verification was received after more than 60 days have passed.

23. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22, Passage number 0630.0401 Requests for Additional Information/Time Standards (MFAM) 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. 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 if requested, 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.

24. The above policy requires Petitioner to file a new application when the last verification is received after 60 days from the initial application. In this instant case, Petitioner was assigned two different cases on two separate applications. The

undersigned believes the confusion created by those two case numbers was partly to blame for Petitioner's missing her deadline. The undersigned took notice of respondent's mishap but could not find anything within the rule to reverse the denial of the October 16, Medicaid application.

25. Respondent maintains that Petitioner must submit another Medicaid application for her benefits to be processed. However Respondent's CLRC indicates that Petitioner requested SNAP and Medicaid when she was interviewed on November 16, 2017.

26. The Department's Program Policy TRANSMITTAL NO.: I – 11-12-0020 (December 13, 2011)- **SUBJECT:** Applications for Other Program Benefits states:

> **EFFECTIVE:** Upon Receipt
> This memorandum provides clarification to staff about households applying for other programs benefits when they have a pending application for a different benefit. There have been many questions about this subject because of the recent release of the pick-a-benefit process in the web application.
>
> **Application Policy:**
> When a household applies for benefits using the web application specifying the program(s) they are requesting, they may request to apply for other benefits during the eligibility process for the original application.
>
> > **• If the applicant lets us know they are interested in applying for other benefits any time through the time of the interview, the household will not need to submit another application and the date of application for the new benefit will be the same as the original date of application.** (emphasis added)

27. The above transmittal explains that when applicants let the Department know they are interested in applying for other benefits any time during the interview they will not need to submit another application. In this instant case, Respondent documented that Petitioner requested SNAP and Medicaid when she was interviewed on November

16, 2017. Therefore, Petitioner does not need to submit a new application as she submitted all the necessary information within 60 days of the November 6, 2017.

28. After considering the evidence, testimony, and the appropriate authorities cited above, the hearing officer concludes that Respondent's action is incorrect. Petitioner has met her burden in establishing that Respondent incorrectly denied Medicaid benefits for herself and her children. The case is remanded to Respondent to reinstate Petitioner's Medicaid application effective November 6, 2017 and determine eligibility accordingly.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, Petitioner's appeal is decided as follows:

1. Denied in part as Petitioner's October 16, 2017 was correctly denied.
2. GRANTED in part as Petitioner was not reassessed for Medicaid based on the November 6, 2017 application. **This case is remanded to the Department to determine Petitioner's eligibility for Medicaid benefits, including retro months, protecting effective the November 6, 2017 application**. Once eligibility is re-determined and a decision is made, a new notice should be issued informing her 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 30 day of March, 2018,

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

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88701

RESPONDENT.
_____/

APPEAL NO. 18F-00131

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 24, 2018 at 11:45 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Marya Fuentes, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to close his Medicare Saving Plan (MSP)/Special Low Income Benefits (SLMB). The burden of proof was assigned to the respondent by a preponderance of evidence.

PRELIMINARY STATEMENT

At the hearing, the respondent presented a package of documents which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not present any exhibits.

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/SLMB in a prior certification beginning July 2017.

2. On October 11, 2017, the respondent received an email from the Agency of Health Care Administration (AHCA) requesting that the petitioner's MSP/SLMB be closed as he was "not self-paying the part A premiums." The respondent explained that in order for an individual to receive Medicare Part B, the individual must be receiving Part A (Respondent's Composite Exhibit 1, page 29).

3. On October 13, 2017, the respondent mailed a Notice of Case Action to the petitioner informing him that he was no longer eligible for the SLMB Medicare Part B program effective October 31, 2017.

4. On January 5, 2018, the petitioner requested a hearing to challenge the respondent's action.

5. At the hearing, the petitioner confirmed he requested that Social Security Administration (SSA) close his Part A Medicare benefits because he could not afford to pay the premium (Respondent's Composite Exhibit 1, page 35, 36, and 37).

6. The respondent reviewed the petitioner's income to determine if he was eligible for MSP/QMB as QMB pays for Medicare Part A. His income was over the income limit of $1,005 to qualify for QMB (Respondent's Composite Exhibit 1, page 28). The Department determined the petitioner's earned income to be $3,742.40 and his

unearned income to be $400. The following deductions were allowed resulting to his monthly countable income.

Unearned Income	$400
Unearned income Disregards	($20)
Total Household Unearned Income	$380
Total Earned Income (SB and ABM)	$3,742.40
Earned Income Disregards	($65)
l/2 Remaining Income	$1,838.70
Countable Earned Income	$1.838.70
Countable Unearned Income	$380
Total Countable Earned and Unearned Income	$2,218.70
Income Standard for QMB	$1,005
Income Standard for SLMB	$1,206
Income	over Income Standards

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 Medicare Savings Plan program is set forth in Fla. Admin. Code R. 65A-1.702 and states in 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. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application.

> (c) Working Disabled (WD). Under WD coverage, individuals are only entitled to payment of their Medicare Part A 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.)

10. Federal Regulation at 20 C.F.R. § 416.1104 defines what income we count as follows:

> We have described generally what income is and is not for SSI purposes (§416.1103). There are different types of income, earned and unearned, and we have rules for counting each. The earned income rules are described in §§416.1110 through 416.1112 and the unearned income rules are described in §§416.1120 through 416.1124...

11. The above states that we count both earned and unearned income.

12. Federal Regulation at 20 C.F.R. § 416.1112 addresses what earned income we do not count.

> (a) General. While we must know the source and amount of all of your earned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your income in the month. We never reduce your earned income below zero or apply any unused earned income exclusion to unearned income…
> (4) Any portion of the $20 monthly exclusion in §416.1124(c)(10) which has not been excluded from your unearned income in that same month;
> (5) $65 of earned income in a month;
> (7) One-half of remaining earned income in a month…

13. 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…

14. The above-cited authorities state that pension payments are to be included as unearned income.

15. 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.

16. 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)...

17. The above authority explains in order to be eligible for QMB "income must be less than or equal to the federal poverty level."

18. The Policy Manual at Appendix A-9 sets forth the income limit for an individual, effective April 1, 2017, for QMB as $1,005 and for SLMB as $1,206.

19. 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 $380 as his countable unearned income.

20. The Policy Manual set forth MEDS-AD, QMB, SLMB, QI1 and Working Disabled Eligibility Test (MSSI) at section 2640.0126 and states:

> **Step 1** - Add unearned income except for excluded income and income based on need.
> **Step 2** - Subtract allowable deductions.
> **Step 3** - Add income based on need to get total unearned income.
> **Step 4** - Determine earned income and subtract allowable exclusions and work related expenses.
> **Step 5** - Add unearned income and earned income to get total countable income.
> **Step 6** - Compare total countable income limit - see chart in Appendix A-9.

21. The Policy manual at section 2040.0816 addresses the working disabled (MSSI) and states:

> Most individuals with disabilities who work will continue to receive at least 93 consecutive months of hospital (Part A) and medical (Part B) insurance under Medicare. They pay no premium for Part A. After premium-free Medicare Part A coverage ends, they can continue receiving Medicare, as long as they remain medically disabled and continue to work, but must pay

> a premium for Part A. The state can pay the Medicare Part A premium for qualified individuals who meet all of the following eligibility criteria:
> 1. Are enrolled in Medicare Part A under this special extended coverage (as confirmed by SSA)
> 2. Are under age 65,
> 3. Have assets at or below $4,000 for an individual and $6,000 for a couple,
> 4. Have income at or below 200% of the federal poverty level (individual or couple),
> 5. Are U.S. citizens or qualified noncitizens,
> 6. Take necessary steps to access any other benefits to which they may be entitled

22. The program manual at section 2040.0817 Qualified Medicare Beneficiaries Medicaid (MSSI) states:

> To be eligible to receive Medicaid through the Qualified Medicare Beneficiaries Program (QMB), an individual must meet all the following criteria:
> 1. Be enrolled (or conditionally enrolled) in Medicare Part A;
> 2. Have income that does not exceed 100% of the federal poverty level;
> 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; and
> 5. Take necessary steps to access any other benefits to which they may be entitled

23. The above states that to be eligible for QMB an individual must be enrolled in Medicare Part A. The petitioner is not enrolled in Medicare Part A as he requested SSA to close Medicare Part A as he could not afford to pay the premium.

24. The respondent followed the above steps to determine the petitioner's eligibility for QMB and found him ineligible as his income was too high for the program.

25. In careful review of the cited authorities and evidence, the undersigned concludes that the respondent followed the rules when it closed the petitioner's SLMB

benefits. It is also concluded the petitioner is ineligible for the MSP/QMB as his 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 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 April, 2018, in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
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Tallahassee, FL 32399-0700
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Fax: 850-487-0662
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Copies Furnished To: [redacted]
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 18F-00171

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 27, 2018, at 11:05 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted], represented Petitioner.

For the Respondent: Rosalynd Beckford, DCF supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action of denying her Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that she does not meet the disability criteria. The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

By a Notice of Case Action dated October 30, 2017, the respondent informed the petitioner that her SSI-Related Medicaid Program benefits were being denied because she did not meet the disability requirement of the Program. On January 5, 2018, the DR timely requested a hearing challenging the respondent's action. The appeal was continued from February 21, 2018 per respondent's request.

The petitioner submitted an evidence packet which was accepted and marked as Petitioner's Composite Exhibit 1. The respondent's evidence was accepted and marked as Respondent's Composite Exhibit 1. The record was left open through end of business day for the respondent to submit additional information for consideration. The information was timely received and marked as Respondent's Composite Exhibit 2 and the record was closed.

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. Prior to the action under appeal, the petitioner has been receiving Supplemental Nutrition Assistance Program (SNAP) benefits from the Department.

2. The petitioner [redacted] is 60. She does not meet the aged criteria for SSI-Related Medicaid benefits. She is not pregnant, has no minor children and does meet the technical requirement for Family-Related Medicaid. The petitioner did not allege blindness. Disability must be established to determine Medicaid eligibility.

3. On October 13, 2017, the petitioner applied for disability with the Social Security Administration (SSA), see Petitioner Composite Exhibit 1. The petitioner's SSA

disability application indicates she suffered from a variety of medical ailments: [redacted]. It also indicates that she has sustained a [redacted] as a result of a fall.

4. The petitioner has received medical care at [redacted] during various visits in October 2017 and has incurred some medical expenses.

5. 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 for individuals applying for disability benefits under the state Medically Needy Program. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and effectuation of any benefits due.

6. On October 16, 2017, the petitioner submitted an online application requesting Medicaid benefits through the Department's SSI-Related Medicaid Program. The Department did not initiate a disability review.

7. On October 30, 2017, the Department sent the petitioner a Notice of Case Action indicating that her October 16, 2017 application for SSI-Related Medicaid was denied due to not meeting the disability criteria, *see* Respondent's Composite Exhibit 1, p 8. No notice was sent to the DR.

8. On December 11, 2017, the DR sent a spreadsheet to the Department requesting a status update on the October 16, 2017 application and found out that the case was denied.

9. On February 6, 2018, SSA denied the petitioner's application with reason code N 36 (NONPAY Insufficient or no medical data furnished, no visual impairment.), *see* Respondent's Composite Exhibit 1, p 12.

10. Information obtained from the petitioner was forwarded to DDD for review on February 13, 2018, but was returned to the Department for further action. The packet was resent to DDD on March 15, 2017.

11. On March 22, 2018, DDD denied the petitioner's claim of disability by adopting the SSA denial (N36), *see* Respondent's Composite Exhibit 2. DDD did not make an independent determination.

12. The respondent explained that it denied the petitioner's SSI Related Medicaid application because SSA has determined that the medical information she submitted was not sufficient enough for them to determine whether or not she was disabled and DDD has adopted the decision. The respondent explained that SSA decision is binding and must be accepted by the Department as final. She did not explain why the Department did not take initiate a disability review when the application was received in October 2017.

13. The petitioner's representative argued as follows: (1) the Department intentionally delayed its action to initiate a disability review, (2) that the Department's action to wait SSA denied the petitioner the opportunity to be evaluated by DDD for an independent disability decision and (3) that the petitioner would have received a favorable decision from DDD has the Department timely processed by the petitioner's case. The representative maintains the Department's action is improper. He was not aware of the most recent SSA decision related to insufficient medical information. He

was advised to contact SSA to find out what the petitioner can do to address the recent SSA decision.

14. As of the day of the hearing, the petitioner has not appealed the SSA decision. Decision. The representative is not claiming a new condition. He is seeking Medicaid coverage to cover the petitioner's stays at [redacted].

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. 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. 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.

18. 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..."

19. 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...
> (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 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.

20. 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.
> When the individual files an application within 12 months after the last unfavorable disability determination by SSA and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial.

21. 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).
> 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.
>
> 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.

22. 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 the petitioner's medical information was insufficient to determine whether or not she was disabled.

23. 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 Medicaid under the SSI-Related Medicaid coverage group is correct.

24. The hearing officer explored all other Medicaid groups. The only other Medicaid group was Family-Related Medicaid Program benefits. The petitioner has no minor children residing with her and is not pregnant. 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. It is concluded, the respondent's action to deny the petitioner's application for Medicaid Program benefits was within the rules of the Program. The petitioner has failed to meet her burden that she is eligible for any Medicaid benefits.

25. At the hearing the DR brought up allegations of non-cooperation and obstruction 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 Department action, or failure to act with reasonable promptness, on a claim of financial assistance, social services, medical assistance, Temporary Assistance of Needy Families (TANF), or Supplemental Nutrition Assistance Program (SNAP) benefits, which includes delay in reaching a decision on eligibility in both initial and subsequent determination, or in making a payment, the amount of payment, change in payments, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.

(2) The hearing officer must determine whether the Department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the Department in making its decision.

The hearing officer has no jurisdiction over customer service issues. You may contact the Northeast Region's Client Relations office at 1- 954-375-3338 to discuss the issues raised regarding customer service if you choose.

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 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 April, 2018,

in Tallahassee, Florida.

Roosevelt Reveil

Roosevelt Reveil
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

[redacted]

APPEAL NO. 18F-00195

PETITIONER,

Vs.

CASE NO. 1[redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88681

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-styled matter on February 14, 2018 at approximately 1:00 p.m.

APPEARANCES

Petitioner: [redacted], pro se

For Respondent: Joseph Austrie
Operations Management Consultant
Department of Children and Families

STATEMENT OF ISSUE

At issue is whether or not Respondent's action in enrolling Petitioner in the Medically Needy ("MN") Program amount, rather than approving full Medicaid benefits, was correct. The burden of proof is assigned to Petitioner.

PRELIMINARY STATEMENT

The Department of Children and Families ("Respondent" or "Department") moved Composite Exhibits 1 into evidence. The Petitioner did not present any evidence.

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 December 7, 2017, Petitioner applied for SNAP and Medicaid benefits. The only issue addressed at hearing and in this Order relates to Medicaid. Petitioner's SNAP appeal has since been abandoned.

2. Petitioner is gainfully employed. Petitioner reported her employment at [redacted], earning a weekly income of $337.00. Petitioner's monthly income amount by State Wage Information Collection Agency (SWICA) was $1,614.00

3. On December 8, 2017 and December 11, 2017, the Department sent Petitioner a Notice of Case Action regarding both her SNAP and Medicaid benefits. (Resp. Comp. Exhibit 1). As to Petitioner's Medicaid benefits, the letter stated Petitioner was approved for enrollment in the MN Program, which a Share of Cost ("SOC") of $1,128.00.

4. On January 9, 2018, Petitioner timely appealed her enrollment into the Medically Needy program and the denial of full Medicaid coverage for herself.

5. To determine the Medically Needy SOC, the Department determined that Petitioner's Medicaid Standard Filing Unit (SFU) size is three (3) and consists of Petitioner and her two children. The household income was then compared to the income limit for an adult with a household size of three ($303). The income exceeded the maximum limit, resulting in Petitioner being found ineligible for full Medicaid benefits.

6. As Petitioner was determined ineligible for full Medicaid based on her income, the Department enrolled her in the Medically Needy Program. To determine the

estimated SOC for Petitioner, the Medically Needy Income Level (MNIL) of $486 for a standard filing unit size of three was subtracted from the MAGI, resulting in an estimated SOC of $1,128.00.

7. Petitioner is seeking full Medicaid benefits for herself and is challenging her enrollment in the Medically Needy Program.

8. During the hearing, Petitioner stated that her child support started again in January of this year. The Department representative advised Petitioner to report as soon as possible.

9. Petitioner did not dispute the income used to determine the SOC. Petitioner stated that after paying her bills, paying for transportation and taking care of her children she cannot afford the share of cost amount. Petitioner stated that her [redacted] medicine costs approximately $ 50 monthly and her [redacted] medicine cost approximately $75 monthly. Petitioner stated she is unable to afford her medical bills.

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 under Section 409.285, Florida Statutes. This Order is the final administrative decision of the Department of Children and Families, pursuant to the Statute.

11. This hearing was held as a *de novo* proceeding pursuant to Rule 65-2.056 of the *Florida Administrative Code*.

12. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence," (Black's Law Dictionary at 1201, 7th Ed.).

13. The Family-Related Medicaid income criteria is set forth in Federal regulations at 42 C.F.R 435.603. 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.

14. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (f) defines a Household for Medicaid. It states:

> 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.
> …
> (3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual— (i) The individual's spouse; (ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and (iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section. (iv)The age specified in this paragraph is either of the following, as elected by the agency in the State plan— (A) Age 19; or (B) Age 19 or, in the case of fulltime students, age 21.
> …
> (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.

15. The Department's Program Policy Manual CFOP 165-22 (the Policy Manual) at passage 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 fulltime.

16. In accordance with the above controlling authorities, the Medicaid household group is Petitioner and her two children (three members). The findings show the Department determined Petitioner's eligibility with a household size of three for Medicaid. The undersigned concludes the Department correctly determined the Petitioner's household size as three for Medicaid.

17. Federal regulations at 42 C.F.R. § 435.603(d) Application of modified gross income (MAGI) defines Household Income and 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.

18. The Policy Manual at passage 1830.0200 addresses Earned Income (MFAM) states:

> Earned income includes all gross (before taxes or other deductions) wages and salaries including income derived from the sale of blood or plasma, tips from performance of work, wages deferred that are beyond the individual's control, Federal Work Study and National and Community Services Trust Act living allowances through the Peace Corp, VISTA, Americorps, Foster Grandparent Program, Service Corps of Retired Executives and other volunteer programs. Wages are included as income at the time they are received rather than when earned. Wages are considered earned income even when withheld at the request of the employee or provided as an income advance on income expected to be earned at a future date.

19. 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).

20. 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”.

21. 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.

22. The Policy Manual at passage 2630.0502 Enrollment (MFAM) states:

> If an individual meets the Medically Needy Program’s technical eligibility criteria, he is enrolled into the program. There is no income limit for enrollment. The individual is only eligible (entitled to Medicaid) when he has allowable medical bills that exceed the SOC. The income for an enrolled assistance group need not be verified. Instead, an estimated SOC is calculated for the assistance group. If after bill tracking, it appears the assistance group has met his "estimated" SOC, the unverified income must be verified before the Medicaid can be authorized. An individual is eligible from the day their SOC is met through the end of the month.

23. 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.

24. In accordance with the above controlling authorities, respondent determined petitioner's SFU as a household of three.

25. The Policy Manual at Appendix A-7, effective April 2016, indicates that the Family-Related Medicaid Income Limit for a household size of 3 is $303 and the Medically Needy Income Level (MNIL) to be $486. The MNIL includes the standard deduction for the household.

26. In accordance with the above controlling authorities, the undersigned review the Medicaid eligibility for Petitioner. The undersigned concludes that Petitioner is not eligible for full Medicaid under the Family-Related Medicaid Program. The Department proceeded to explore the Medically Needy Program. The undersigned recognizes Petitioner's concerns with being able to afford her prescriptions. However, the controlling legal authorities do not allow for any more favorable outcome. The Department's action to deny Petitioner full Medicaid under the Family-related Medicaid coverage group and her enrollment in the Medically Needy Program is correct.

DECISION

Based upon the foregoing, Petitioner's appeal is DENIED and 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 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 March, 2018,

in Tallahassee, Florida.

Stephanie Twomey
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. 18F-00234

PETITIONER,

Vs.

CASE NO. [redacted]

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 February 21, 2018, at 1:00 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted], mother

For the Respondent: Jenny JeanSimon, DCF economic self-sufficiency specialist II

STATEMENT OF ISSUE

At issue is whether the Department is correct to enroll Petitioner in the Medically Needy (MN) Program with a high estimated share of cost (SOC). Petitioner is seeking full Medicaid coverage or a lower SOC. Petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

On January 9, 2018, Petitioner's representative requested an appeal challenging his enrollment in the MN Program. On January 31, 2018, Respondent forwarded a statement from the Petitioner's representative withdrawing the appeal. The appeal was closed. On February 16, the Office of Appeal Hearings received a statement from the representative rescinding the withdrawal. The appeal was reopened and the hearing was convened as previously scheduled.

During the hearing, Petitioner's representative submitted a document packet which was accepted into evidence and marked as Petitioner's Composite Exhibit 1. Respondent submitted five (5) exhibits which were accepted and marked as Respondent's Exhibits "1" through "5". The record was left open through February 22, 2018 for Respondent to submit additional information. The document was timely received and marked as Respondent's Exhibit 6 and the record was closed.

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. Prior to the action under appeal, Petitioner was determined disabled by SSA since 2006 and has been receiving Medicaid through Social Security Administration (SSA) for being a Supplemental Security Income (SSI) benefits recipient.

2. Petitioner, [redacted], is 30-year-old adult male with a history of [redacted]. He has been receiving [redacted] as part of his treatment.

3. In April 2017, Petitioner's father filed for early retirement benefits. The father was advised that Petitioner could receive Social Security benefits based on his work record. On August 4, 2017, SSA notified Petitioner that his SSI benefits would decrease from $490 to $0.00 and that he would receive $1,194 in Social Security disability (SSD) effective September 2017. Petitioner was still considered disabled by SSA standard and last received SSI Medicaid in October 2017. His SSD increased to $1,221 effective January 2018, *see* Petitioner's Composite Exhibit 1, pages 42-43.

4. Petitioner lives with his mother in the community and does not participate in the Hospice Program, Home and Community Based Services Medicaid Waiver Program or the Institutional Care Program.

5. On November 13, 2017, Petitioner submitted an application requesting SSI-Related Medicaid. To begin the budgeting process for Medicaid eligibility process, Petitioner's monthly SSD income of $1,221 was reduced by a $20 standard income disregard. The result was compared to the Eligibility Standard for SSI-Related Programs income limit for a household of one ($885), *see* Respondent's Exhibit 4. Since Petitioner's income after the deduction is $1,201 ($1,221 minus $20) exceeds that amount, the Department denied full Medicaid for Petitioner and proceeded to explore his eligibility for MN. Respondent further Medicaid deducted the $180 Medically Needy Income Level (MNIL) deduction for one person to arrive at the estimated share of cost of $1,021 effective December 2017, *see* Respondent's Exhibit 3.

6. On January 9, 2018, Respondent mailed a Notice of Case Action to Petitioner informing him he was enrolled in the Medically Needy Program with a $1,021 effective

December 2017, *see* Petitioner's Composite Exhibit 1, pages 6-7. Petitioner's representative filed an appeal challenging the Department's action.

7. During the hearing, Respondent acknowledged that no eligibility was explored for November 2017 and agreed to process and provide verification to the undersigned.

8. On February 22, 2018, the undersigned received a Notice of Case Action from Respondent indicating that Petitioner was approved for the MN for November 2017 with a $1,021 SOC, *see* Respondent's Exhibit 6.

9. Respondent explained that Petitioner was not eligible for full Medicaid because his countable income ($1,201) exceeded the 88% FPL limit ($885). She explained the action to enroll Petitioner in the Medically Needy Program with a share of cost. Additionally, she explained that the share of cost amount is directly dependent on Petitioner's income.

10. Petitioner's representative did not dispute the income amount used by the Department in the eligibility process. During the hearing she asserted as follows: That petitioner was disabled before he was 22 years old and was told by the SSA office he would be eligible for Medicaid under a special state program. That Petitioner has serious [redacted] issues that require him to undergo [redacted] every other month costing $5,000-$7,000. That he is taking [redacted] to help with his memory and [redacted] that requires monthly bloodwork. That he has to get therapy weekly and see his [redacted] every three months. That Petitioner incurs an additional $300 in recurring medical expenses. That he constantly battles [redacted] and constantly [redacted]. The representative maintains without full Medicaid; Petitioner will go without treatment which will cause him to end up in the hospital.

11. Respondent explained how the share of cost was determined and how it could be met. Respondent advised Petitioner's representative to submit all outstanding medical bills to the Department so that it can be determined when the share of cost is met and when Medicaid coverage could begin, but she declined. She was also offered to submit invoices from the [redacted] provider to the Department for tracking so the [redacted] treatments can be covered, but she declined as well.

12. Petitioner's representative maintains that anything less than full Medicaid is a hardship on the family and that she cannot afford to go back and forth between medical providers and the Department. She is seeking full Medicaid to cover all of Petitioner's medical expenses.

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 Fla. Admin. Code R. 65-2.056.

15. Federal Regulations at 42 C.F.R. §435.500 sets forth the regulations for requirements for determining the eligibility of both categorically and medically needy individuals.

16. For the SSI-Related Medicaid Programs, an individual must either be aged 65 or older or determined disabled by the SSA or the Department. In this instant case, Petitioner was considered for the SSI-Related Medicaid Programs for being disabled.

The Department determined Medicaid eligibility for Petitioner and approved him for SSI-Related Medically Needy Program benefits with a $1,121 estimated SOC.

17. 42 U.S. Code § 1383c -addresses Eligibility for medical assistance of aged, blind, or disabled individuals under State's medical assistance plan and states:

> (c) LOSS OF BENEFITS UPON ENTITLEMENT TO CHILD'S INSURANCE BENEFITS BASED ON DISABILITY. If any individual who has attained the age of 18 and is receiving benefits under this subchapter on the basis of blindness or a disability which began before he or she attained the age of 22—
>
> (1) becomes entitled, on or after the effective date of this subsection, to child's insurance benefits which are payable under section 402(d) of this title on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable, and
>
> (2) ceases to be eligible for benefits under this subchapter because of such child's insurance benefits or because of the increase in such child's insurance benefits, such individual shall be treated for purposes of subchapter XIX as receiving benefits under this subchapter so long as he or she would be eligible for benefits under this subchapter in the absence of such child's insurance benefits or such increase.

18. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22 at passage 2040.0808 addresses Protected Medicaid for Disabled Adult Children (MSSI) and states:

> Effective July 1, 1987, disabled adult children who lose their SSI benefits because of an increase in or receipt of Social Security disability benefits under one of their parent's work records, may continue to be eligible for Medicaid if: the disabled adult child meets all SSI criteria except for income; and has income equal to or below the SSI FBR when, beginning July 1, 1987, any increase in SSA benefits or receipt of SSA benefits is subtracted from other income**.**

19. The above cited provide for disabled adult children who stopped receiving SSI benefits due to Social Security income they receive on a parent's record to receive Protected Medicaid if all other eligibility requirements are met.

20. In this instant case, Petitioner was denied full Medicaid and was enrolled in the Medically Needy Program due to SSD benefits received from his father. Petitioner was disabled before the age of 22 and was received SSI cash benefits. His benefits stopped when his father became eligible for retirement benefits. The undersigned concludes that Petitioner should be considered for the Protected Medicaid coverage group.

21. The Department's Program Policy TRANSMITTAL NO.: I-08-12-0026 (dated December 10, 2008) addresses Protected Medicaid for Disabled Adult Children (DAC) and explains how to complete the necessary screens to create the appropriate coverage.

BACKGROUND:

Some individuals may be protected from losing Medicaid when they receive increases in Social Security payments that cause them to become ineligible for Supplemental Security Income (SSI). The Medicaid coverage available to these individuals is called Protected Medicaid.

The Medicaid of adults 18 years old or older who became disabled before age 22, and who become ineligible for SSI and SSI Medicaid when they start receiving Social Security benefits on a parent's record may be protected. These individuals may be eligible for Protected Medicaid for Disabled Adult Children coverage under the MTD category on FLORIDA (MIP if in a nursing home and MHP if Hospice elected). These individuals do not receive SSI, but they are considered SSI recipients for Medicaid purposes as long as they meet all eligibility criteria for SSI (after excluding Social Security income they receive on a parent's record).

Eligibility for Protected

To qualify for DAC Protected Medicaid, the individual must meet all of the following requirements:

- Must be age 18 or older.
- Must have become disabled before the age of 22.
- Continue to be disabled.
- Be entitled to Title II benefits on a parent's record due to the parent's retirement, death, or disability, and lose SSI due to that SSA receipt or increase.

- Have assets within the SSI asset limit ($2000).
- Have income equal to or less than the SSI Federal Benefit Rate after deducting the Social Security amount received on a parent's record.
- Be a US citizen or qualified noncitizen.
- Meet all other financial and technical factors of eligibility for SSI.

Identifying Potential DAC Customers

An individual who receives Social Security benefits under an SSN other than their own with a "C" suffix became disabled as a child. Review SOLQ and BENDEX for the Social Security claim number.
Evaluate the above individuals for DAC Medicaid:
• During the SSI Ex - Parte process.
• When the recipient loses Medicaid under any other category and DAC eligibility has not previously been reviewed.

FLORIDA Instructions for Processing Protected Medicaid for DAC

Enter the income on AFMI as:

- SSDC (disabled parent)
- SSRC (retired parent)
- SSSC (deceased parent)
- SS_ _ (if unknown)

The FLORIDA system will disregard Social Security entries in the SSI-MA and HHIP fields for the MTD budget when one of the above subtypes is entered or the subtype field is blank. The FLORIDA system will count SS entries with any other subtype entered.

To build the DAC category (MTD for community, MIP if ICP, or MHP if Hospice case) on the FLORIDA system, complete the AFMI, ASEV, and ASPV screens as indicated on the attached screen prints. The highlighted areas are necessary to create the protected Medicaid categories. If the individual is not eligible for MTD, MIP, or MHP despite the disregard of the income received on the parent's record, evaluate eligibility under other categories of Medicaid coverage.

22. The above cited explained how to build the proper DAC category. In this instant case, Petitioner resides in the community; therefore, he is eligible under the MTD coverage group.

23. Based on the evidence, testimony, and the controlling authorities, the undersigned concludes that the Department erred when it determined that Petitioner was not eligible for full Medicaid benefits and enrolled him in the Medically Needy Program. Petitioner's representative has met her burden that Petitioner is eligible for full Medicaid under the state Protected Medicaid Program for disabled adult children. This case is remanded to the Department to follow the steps in TRANSMITTAL NO.: I-08-12-0026 to generate and approve the appropriate Protected Medicaid (MTD) coverage for Petitioner.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and the Department's action reversed. **The Department is ordered to take corrective action as outlined in the transmittal mentioned above to approve Petitioner's MTD, protecting the November 2017 application.**

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 March, 2018,

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
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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

[redacted]

APPEAL NO. 18F-00266
18F-00267

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 St. Lucie
UNIT: 88088

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 14, 2018, at 11:06 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted], pro se

For the Respondent: Sue-Jay Collins, Operations & Management Consultant (OMC)

STATEMENT OF ISSUE

At issue is whether the Department approved the correct amount of Supplemental Nutrition Assistance Program (SNAP) benefits, formerly known as Food Assistance Program (FAP) for the petitioner effective February 2018. Also at issue is whether the Department is correct to enroll the petitioner in the Medically Needy (MN)

Program with a high estimated share of cost (SOC). The petitioner is seeking full Medicaid or a lower SOC. The petitioner carries the burden of proof by a preponderance of evidence for both programs.

PRELIMINARY STATEMENT

On November 30, 2017, the petitioner requested an appeal challenging her SNAP benefits level.

During the hearing, the petitioner provided no exhibits. The respondent submitted seven (7) exhibits which were accepted and marked as Respondent's Exhibits "1" through "7".

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. Prior to the action under appeal, the petitioner has been receiving $18 in SNAP benefits for himself and his wife and was enrolled in the MN Program with a $1,637 SOC, *see* Respondent's Exhibit 16-19.

2. On January 5, 2018, the petitioner submitted a change removing his wife from the case. On that application, he reported $700 for rent in addition to utilities, *see* Respondent's Exhibit 3.

3. Effective January 2018, the petitioner receives $1,485 in monthly Social Security (SS) benefits. He is Medicare eligible and is responsible for his Part B premiums ($134). The petitioner is allowed excess medical expenses and is not subject to a shelter cap.

4. The case was updated with the most current information and benefits were reapproved for the petitioner only.

5. To begin the process, the petitioner's SS benefits was reduced by the standard income deduction of $160, followed by a $99 ($134-$35) excess medical expenses to arrive at the adjusted income of $1,226, 50% of which becomes shelter standard ($613). With total shelter/utility costs of $1,047 ($700 for rent + $ 347 SUA), the petitioner was allowed $434 shelter deduction, resulting in the SNAP adjusted income to be downward adjusted to $792. A 30% benefit reduction occurred in the amount of $238 ($792 X 30%), resulting in a negative balance ($192 minus $238) when subtracted from the maximum allotment. The petitioner was assigned the minimum SNAP benefits ($15) effective February 2018, *see* Respondent's Exhibit 2, pages 19-20.

6. The petitioner was seeking full Medicaid or a lower SOC for himself. To begin the budgeting process for Medically Needy Program, Petitioner's monthly SS income of $1,485 was reduced by a $20 standard income disregard, followed by a $180 Medically Needy Income Level (MNIL) deduction for one person to arrive at the initial estimated share of cost of $1,285. It was further reduced by $109 (Part B premiums), resulting in the final estimated SOC to be $1,176, *see* Respondent's Exhibit 2, page 18.

7. On January 10, 2018, the respondent mailed a Notice of Case Action to the petitioner informing him that his SNAP benefits were approved for $15 from February 1, 2018 through October 31, 2018. The notice also informed the petitioner that he was enrolled in the Medically Needy Program with a $1,176 effective February 1, 2018, *see* Respondent's Exhibit 1. The petitioner filed an appeal challenging the Department's actions.

8. The respondent explained that the SNAP benefits level is based on the petitioner's SS benefits and his reported expenses at the time of action. The petitioner is receiving the minimum benefit, which is 8% of the maximum allotment for one person, of $15 SNAP benefits, as her income is below the 200% of the federal Poverty Level (FPL). She explained its action to enroll the petitioner in the Medically Needy Program with a share of cost. The share of cost amount is directly dependent on the petitioner's SS benefits minus allowable deductions.

9. During the hearing, the respondent explained that the case has since been updated with $134 as petitioner's Part B premium. She explained that with this change, the petitioner's most recent MN budget shows this amount ($134) was deducted the initial estimated SOC ($1,285), resulting in the petitioner's updated SOC to be $1,151 for March 2018.

10. The representative explained how the share of cost was determined and how it could be met. Petitioner was advised to submit all outstanding medical bills to the Department so that it can be determined when the share of cost is met and when Medicaid coverage could begin. The representative explained that all unpaid medical bills not previously used can be considered to track any future months for which eligibility is needed.

11. The petitioner did not dispute the income amount used by the Department in the eligibility process, but asserted as follows: That he expected more benefits with his wife's SS benefits no longer available. That he does not have enough money to buy food and put gas in his car. That he cannot buy anything with $15. That he needs to have Medicaid to get medical care. That his SOC is too high and that he cannot afford

that much monthly expense on a fixed income. During the hearing, the petitioner mentioned he did not incur any recurring medical expenses. He is seeking to have an increase in his SNAP benefits and full Medicaid to cover all of his medical expenses or a lower SOC.

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.

The SNAP benefits level will be addressed first.

14. The federal regulation 7 C.F.R. § 273.12(c) addressees reported changes and states:

> (2) *Decreases in benefits.* (i) If the household's benefit level decreases or the household becomes ineligible as a result of the change, the State agency shall issue a notice of adverse action within 10 days of the date the change was reported unless one of the exemptions to the notice of adverse action in §273.13 (a)(3) or (b) applies. When a notice of adverse action is used, the decrease in the benefit level shall be made effective no later than the allotment for the month following the month in which the notice of adverse action period has expired, provided a fair hearing and continuation of benefits have not been requested. When a notice of adverse action is not used due to one of the exemptions in §273.13 (a)(3) or (b), the decrease shall be made effective no later than the month following the change. Verification which is required by §273.2(f) must be obtained prior to recertification.

15. In this instant case, the petitioner reported a change in January 2018 and the change was made effective February 2018. The change resulted in a decrease in the petitioner's SNAP benefits. A notice was sent to the petitioner on January 10, 2018 confirming the outcome.

16. Federal regulation 7 C.F.R. § 273.9 addresses income/allowable deductions budgeting in the SNAP in part and states as follows:

> (a) *Income eligibility standards.* Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet. Households which contain an elderly or disabled member shall meet the net income eligibility(sic) standards for SNAP. Households which do not contain an elderly or disabled member shall meet both the net income eligibility standards and the gross income eligibility standards for SNAP. Households which are categorically eligible as defined in §273.2(j)(2) or 273.2(j)(4) do not have to meet either the gross or net income eligibility standards. The net and gross income eligibility standards shall be based on the Federal income poverty levels established as provided in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)).
>
> (2) The net income eligibility standards for SNAP shall be as follows:
>
> (i) The income eligibility standards for the 48 contiguous States and the District of Columbia, Guam and the Virgin Islands shall be the Federal income poverty levels for the 48 contiguous States and the District of Columbia.
> (b) Definition of income…
> (1) Earned income shall include:
> (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…
> (2) Unearned income shall include, but not be limited to: …
> (ii) 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…
> (d) *Income deductions.* Deductions shall be allowed only for the following household expenses:
> (1) *Standard deduction—*

> (2) Earned income deduction.
> (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.…
> (4) Dependent care.
> (5) Optional child support deduction.
> (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(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,
> (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.

17. The respondent must follow these federal budgeting guidelines when determining eligibility. The regulation directs the Department to consider SSD as income that must be included in the eligibility determination.

18. The federal regulation 7 C.F.R. § 273.10 (e) addresses "Calculating net income and benefit levels" as follows:

> (1) Net monthly income. (i) To determine a household's net monthly income, the State agency shall:
> (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income. Net losses from the self-employment income of a farmer shall be offset in accordance with Sec. 273.11(a)(2)(iii).
> (B) Multiply the total gross monthly earned income by 20 percent and

> subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions.
> (C) Subtract the standard deduction.
> (D) If the household is entitled to an excess medical deduction as provided in Sec. 273.9(d)(3), determine if total medical expenses exceed $35. If so, subtract that portion which exceeds $35.
> …
> (H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.
> (I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.

19. The above-cited regulation describes the eligibility process and defines deductions and shows the steps in determining net income. The petitioner was credited with a standard deduction, excess medical expenses and an excess shelter deduction from his gross income to equal his net income. There is no indication that the petitioner was eligible for any other deductions.

20. The SNAP standards for income and deductions appear in the Department's Program Policy Manual (The Policy Manual) CFOP 165-22, at Appendix A-1. Effective October 1, 2017, the standard deduction for a one-person assistance group is $160 and the maximum SNAP benefits is $192. The minimum benefit is $15.

21. The Policy Manual at passage 2610.0103 addresses Budgets and Tests Calculation (FS) and states:

> Assistance groups must meet the gross income standards to be eligible for food stamps with the following exceptions:
>
> 1. assistance groups that contain an elderly or disabled member and are not categorically eligible must meet the net income limits; and
> 2. standard filing units (SFUs) that are broad-based categorically eligible must meet the 200% gross income limits.

22. The petitioner is a broad-based categorically eligible (BBCE) household and needs only to have gross income at or less than 200% of the federal poverty level (FPL) to be eligible for the SNAP.

23. The Policy Manual at 2610.0106.02 addresses Minimum Benefit (FS) for recurring months and states that eligible households of one or two persons are eligible for eight percent of the maximum SNAP benefits for a one-person assistance group.

24. The above cited explains that assistance groups that consists of one or two household members are eligible for the minimum monthly SNAP benefits allotment if the household meets all the regular eligibility requirements. The maximum SNAP benefits amount for one is $192 effective October 2017. After the reported change, the petitioner SNAP benefits decrease to $15 effective February 2018. He received $15 because his income is below the $2,010 limit. The undersigned reviewed the Department's budget calculation and found no mathematical errors.

25. After considering the evidence, testimony, and the appropriate authorities cited above, the hearing officer concludes that the Department's action to approve $15 effective February 2018 is correct. The hearing officer cannot conclude that the petitioner is eligible for any additional benefits based on the income and expenses

presented and the above-cited rules. The petitioner has failed to meet his burden that he is eligible for any additional SNAP benefits with the income and expenses reported.

Enrollment in the Medically Needy Program will now be addressed.

26. Federal Regulations at 42 C.F.R. §435.500 sets forth the regulations for requirements for determining the eligibility of both categorically and medically needy individuals.

27. In this instant case, the petitioner was considered for the SSI-Related Medicaid Programs for being aged. Based on this regulation, the Department determined Medicaid eligibility for the petitioner and approved him for SSI-Related Medically Needy Program benefits.

28. Fla. Admin. Code R. 65A-1.701, Definitions, states:

> (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…

29. 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 ($885).

30. Federal regulations at 20 C.F.R. § 416.1124, Unearned income we do not count, "(c) (12). The first $20 of any unearned income in a month…"

31. The above-cited rules explain the budgeting procedure to determine the share of cost. The petitioner's SS income is reduced by a standard deduction ($20) to arrive at $1,465 as countable income.

32. The Eligibility Standards for SSI-Related Programs appear in the Department's Program Policy Manual CFOP 165-22 (the Policy Manual), at Appendix A-9. Effective July 1 2017, the limit for one member household is $885. The Department determined the petitioner's countable income after all deductions to be $1,465 during the application at issue. His countable income is over the $885 income limit. Additionally, he is a Medicare recipient; therefore, not qualified for full Medicaid. He was then evaluated for the Medically Needy Program.

33. The Medically Needy Program provides coverage for individuals who meet the technical requirements for Medicaid but whose income or assets exceed the income limits.

34. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, 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…
> (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.

35. The above authorities also define Medically Needy and 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. This program is available for aged or disabled individuals or eligible couples who do not qualify for the MEDS-AD Program.

36. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the MNIL for an individual at $180.

37. Since Petitioner was not eligible for full Medicaid, the Department proceeded to explore further Medicaid eligibility by deducting the $180 Medically Needy Income Level deduction for one from his resulting income. After these deductions, the share of cost was determined to be $1,285. It was further reduced by a $109 medical insurance premium to arrive at $1,176 remaining SOC for February 2018. It was reduced by a $134 medical insurance premium to arrive at $1,151 remaining SOC effective March 2018.

38. The evidence shows that in February 2018, the petitioner's Part B premium was $134. The undersigned reviewed the petitioner's SOC for that month and found that the Department erred when it used $109 as opposed to $134 as total medical costs to reduce the petitioner's SOC. The undersigned concludes that the petitioner's estimated SOC for February 2018 is $1,151.

39. Based on the evidence, testimony, and the controlling authorities, the undersigned concludes that the Department correctly determined that the petitioner is not eligible for full Medicaid benefits and should be enrolled in the Medically Needy Program. The petitioner has failed to meet his burden that he was eligible for full Medicaid or a lower share of cost effective March 2018. However, the share of cost for February 2018 is overstated.

DECISION

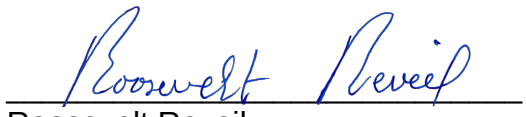
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied in part and granted in part. The Department correctly denied full Medicaid and enrolled the petitioner in the Medically Needy Program effective February 2018. However, the Department erred in its SOC calculation for February 2018 as outlined in the Conclusions of Law. **The Department is ordered to adjust the share of cost amount for the month February 2018 as stated 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 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 __01__ day of __March_____, 2018,

in Tallahassee, Florida.



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

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

[redacted]

APPEAL NO. 18F-00272
18F-00673

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 03 Madison
UNIT: 88323

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 7, 2018 at 1:08 p.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Sheron Mickens, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of January 26, 2018 enrolling her in the SSI-Related Medically Needy program rather than approving full Medicaid. The petitioner also appeals the denial of Temporary Cash Assistance. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

[redacted]., father of the petitioner's child, appeared as a witness for the petitioner.

The Department submitted evidence in the matter on February 28, 2018 which was entered as Respondent's Exhibit 1.

The petitioner submitted six faxes of medical billing records on March 6, 2018. The faxes were merged and entered as Petitioner's Composite Exhibit 1.

The record was held open through March 14, 2018 for additional information from the Department. This was received on March 12, 2018 and entered as Respondent's Exhibit 2.

The petitioner requested a review of her Supplemental Nutritional Assistance Program (SNAP) benefits during the course of the hearing held on March 7, 2018. The Department was unaware of the request for hearing on the SNAP benefits prior to the hearing. The undersigned instructed the Department to enter the appeal for SNAP benefits. The undersigned advised the petitioner the appeal for SNAP benefits will be held at a later date. Subsequent to the hearing the undersigned received the appeal for SNAP 18F-01874. A hearing for that matter is scheduled for April 4, 2018. The undersigned will issue an order on that matter separately.

The record for appeals 18F-00272 and 18F-00673 closed on March 14, 2018.

FINDINGS OF FACT

1. The petitioner filed an application for recertification of Temporary Cash Assistance, SNAP, SSI-Related Medicaid and Medicare Savings Program benefits on January 19, 2018. The application lists a household of one. The application also

reflects the petitioner's household income consisting of Social Security in the amount of $1,079.70. (Respondent's Exhibit 1, pages 8 through 22)

2. The Department issued a Notice of Case Action on January 26, 2018 informing the petitioner that her Medically Needy Share of Cost (SOC) would increase from $756 to $881 effective March 1, 2018. The Notice also informed the petitioner that she is eligible for Special Low-Income Medicare Part B Medicaid (SLMB). (Respondent's Exhibit 1, page 1 through 3)

3. The Department recorded in case notes the petitioner's request for "straight Medicaid rather than share of cost" due to being chronically ill and having multiple medical conditions causing high medical costs. (Respondent's Exhibit 1, page 23)

4. The Department provided verification of the petitioner's Social Security disability income (SS DI) received by data exchange with the Social Security Administration. The verification reflects the petitioner's receipt of SS DI in the amount of $1,081 effective December 2017. The verification also reflects the update effective February 2018 to $1,079.70. (Respondent's Exhibit 1, page 29)

5. The petitioner confirmed the SS DI income amounts to be accurately reported.

6. The petitioner confirmed she receives Medicare. The petitioner understands the state is paying her Medicare premium through the SLMB program. The petitioner has no other health insurance beyond Medicare.

7. The Department explained that the petitioner's income of $1,079 exceeds the income standard of $885 to received straight SSI-Related Medicaid. (Respondent's Exhibit 1, pages 30 and 32)

8. The Department explained that because the petitioner has Medicare, she does not qualify to receive Medicaid under the SSI-Related Medicaid program. The Department provided the policy transmittal explaining this policy as well. (Respondent's Exhibit 1, pages 36 through 42)

9. The Department explained the SSI-Related Medicaid share of cost was calculated by using the petitioner's gross unearned income of $1,081 less the $20 unearned income disregard to reach a countable unearned income of $1,061. The Department subtracts the Medically Needy Income Level of $180 from the countable unearned income of $1,061 to reach the Medically Needy SOC of $881. (Respondent's Exhibit 1, page 31)

10. The Department reported that some of the petitioner's bills have previously been tracked. The Department further stated that as the bills were just received the day prior to the hearing, she would need to review all of the submitted bills to ensure they were properly tracked and that any months in which the share of cost was met the providers were notified of eligibility.

11. The petitioner provided several CVS receipts which did not include the date of service. The petitioner advised she did not realize the date of service was not on the receipts, but could get the report from CVS of her prescription costs.

12. The Department advised the paid CVS prescription costs could be averaged to assist with her SNAP eligibility.

13. The petitioner was concerned that she was told that she had to choose between the medical expenses that could count in either the Medicaid or the SNAP eligibility determination but not both.

14. The petitioner questioned where her rent and utilities were considered in her Medicaid eligibility determination.

15. The Department explained that rent and utility expenses are not considered deductions in the Medicaid or Medically Needy program.

16. The Department issued a manual Notice of Case Action on Temporary Case Assistance Program benefits on February 28, 2018. The Notice informs the petitioner she is ineligible for Temporary Cash Assistance as she has no minor child residing in her home. (Respondent's Exhibit 1, pages 4 and 5)

17. The petitioner reported that her son is in her home every other week. She believes she should be able to include her son in her household for benefit determination.

18. The Department reported that during the course of the supervisory review the child's father was contacted. The Department recalled the child's father reporting the child was with him primarily and at his mother's every other weekend.

19. [redacted] reported through direct testimony that when the petitioner has had surgery or is sick, their son stays primarily with him. However, the general arrangement is that the child spends a week at a time with each parent. He further stated that due to them being neighbors, the child can move easily between the homes.

20. [redacted] advised he does not receive Temporary Cash Assistance for his son, but does receive Food Assistance and Family-Related Medicaid.

CONCLUSIONS OF LAW

21. 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.

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

TEMPORARY CASH ASSISTANCE

23. Section 414.095, Florida Statutes, Determining eligibility for temporary cash assistance, states in relevant part:

> (1) ELIGIBILITY.—An applicant must meet eligibility requirements of this section before receiving services or temporary cash assistance under this chapter, except that an applicant shall be required to register for work and engage in work activities in accordance with s. 445.024, as designated by the local workforce development board, and may receive support services or child care assistance in conjunction with such requirement. The department shall make a determination of eligibility based on the criteria listed in this chapter.
> …
> (2) ADDITIONAL ELIGIBILITY REQUIREMENTS.—
> (a) To be eligible for services or temporary cash assistance and Medicaid:
> …
> 4. A minor child must reside with a parent or parents, with a relative caretaker who is within the specified degree of blood relationship as defined by 45 C.F.R. part 233, or, if the minor is a teen parent with a child, in a setting approved by the department as provided in subsection (14).
> 5. Each family must have a minor child and meet the income and resource requirements of the program. All minor children who live in the family, as well as the parents of the minor children, shall be included in the eligibility determination unless specifically excluded.
> …
> (8) APPLICATIONS.—The date of application is the date the department or authorized entity receives a signed and dated request to participate in the temporary cash assistance program.

…

(10) DETERMINATION OF LEVEL OF TEMPORARY CASH ASSISTANCE.—Temporary cash assistance shall be based on a standard determined by the Legislature, subject to availability of funds. There shall be three assistance levels for a family that contains a specified number of eligible members, based on the following criteria:

(a) A family that does not have a shelter obligation.

(b) A family that has a shelter obligation greater than zero but less than or equal to $50.

(c) A family that has a shelter obligation greater than $50 or that is homeless.

The following chart depicts the levels of temporary cash assistance for implementation purposes:

THREE-TIER SHELTER PAYMENT STANDARD

Family Size	Zero Shelter Obligation	Greater than Zero Less than or Equal to $50	Greater than $50 Shelter Obligation
1	$95	$153	$180
2	$158	$205	$241

24. Section 414.085, Florida Statutes, Income eligibility standards, states in relevant part:

(1) For purposes of program simplification and effective program management, certain income definitions, as outlined in the food assistance regulations at 7 C.F.R. s. 273.9, shall be applied to the temporary cash assistance program as determined by the department to be consistent with federal law regarding temporary cash assistance and Medicaid for needy families, except as to the following:

(a) Participation in the temporary cash assistance program shall be limited to those families whose gross family income is equal to or less than 185 percent of the federal poverty level established in s. 673(2) of the Community Services Block Grant Act, 42 U.S.C. s. 9901(2).

(b) Income security payments, including payments funded under part B of Title IV of the Social Security Act, as amended; supplemental security income under Title XVI of the Social Security Act, as amended; or other income security payments as defined by federal law shall be excluded as income unless required to be included by federal law.

25. The findings show the petitioner's son was not included on her application. The findings also show the petitioner's son lives in a "shared custody" arrangement where he is in her home part of the time and in his father's home part of the time. The findings further show the petitioner's son receives benefits on his father's case.

26. The undersigned concludes that the petitioner has not filed an application with a minor child included to receive Temporary Cash Assistance. The undersigned further concludes as there is no minor child in the home on her application, she does not meet the technical criteria of the above controlling authority requiring a minor child in the home to receive Temporary Cash Assistance. The undersigned concludes the Department correctly denied the petitioner's request for Temporary Cash Assistance on the technical factor of no minor child in the home due to no child listed on the application for benefits.

27. The undersigned reviewed the case a step further. If the petitioner had filed an application for Temporary Cash Assistance with the child living in the home, the petitioner's Social Security disability income of $1,079 would be included in the benefit calculation. In accordance with the above controlling authority, the benefit allotment for two with more than $50 of shelter obligation is $241. As the petitioner's Social Security disability income exceeds this amount, the petitioner would not be entitled to any Temporary Cash Assistance benefit.

SSI-RELATED MEDICAID

28. Florida Admin. Code R. 65A-1.701, Definitions, states in relevant 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.
> …
> (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.

29. The findings show the petitioner is a recipient of Medicare. The undersigned concludes she cannot receive Medicaid under the MEDS-AD program. The undersigned concludes the Department correctly proceeded to determine the petitioner's eligibility under the Medically Needy Program.

30. 20 C.F.R. § 416.1121, Types of unearned income, states in relevant part,

> 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.

31. 20 C.F.R. § 416.1124, Unearned income we do not count, states in relevant part:

> (a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount.
> …
> (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 other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need.

32. The Department's Program Policy Manual (165-22), Appendix A-9, SSI-Related Programs, effective July 2017 lists the income limit for an individual to receive

MEDS-AD is $885. The Appendix is updated effective January 2018. The income limit for a couple to receive MEDS-AD remained $885.

33. Florida Admin. Code R. 65A-1.702, Special Provisions, states in relevant 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.

34. Florida Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in relevant part:

> (4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. §1396 (2000 Ed., Sup. IV) (incorporated by reference), or another less restrictive option is elected by the state under 42 U.S.C. §1396a(r)(2) (2000 Ed., Sup. IV) (incorporated by reference).
> …
> (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.
> (emphasis added)

35. Florida Admin. Code R. 65A-1.716, Income Resource Criteria" (2) lists the Medicaid income and payment eligibility standards and Medically Needy income level for a household size of one as $180.

36. The findings show the petitioner's SS DI income was $1,081 in January 2018. The petitioner's income less the $20 unearned income disregard as allowed in the above controlling authorities leaves the countable income of $1,061. The countable income of $1,061 less the Medically Needy Income level of $180 leaves a share of cost of $881.

37. The findings show the petitioner's SS DI income was $1,079 beginning February 2018. The petitioner's income less the $20 unearned income disregard as allowed in the above controlling authorities leaves the countable income of $1,059. The countable income of $1,0591 less the Medically Needy Income level of $180 leaves a share of cost of $879.

38. The undersigned concludes the Department correctly calculated the petitioner's Medically Needy Share of Cost.

39. The undersigned found no requirement in the above controlling authorities limiting the use of medical bills in tracking for meeting the share of cost to only one

program. However, the above controlling authority does limit paid medical bills to being used in the month the bill was paid.

40. The findings show the petitioner submitted multiple medical bills and possibly multiply copies of medical bills the day prior to the hearing. The Department had not had opportunity to review the bills to ensure all bills had been tracked. The Department is to review the bills to determine which bills have been tracked and can be paid by Medicaid. The Department is to issue appropriate notices to the petitioner to allow her to know which months she has met her share of cost. The Department is to also notify providers as appropriate to bill Medicaid if the petitioner has met the share of cost.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and 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 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 __19__ day of __March_____, 2018,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
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

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

[redacted]

APPEAL NO. 18F-00326
18F-00327
18F-00512

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 88328

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 17, 2018, at 12:31 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Stephanie Ross, DCF Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether Respondent's (or the Department) action to deny Petitioner SSI-Related Medicaid and Medicare Savings Plan (MSP) is proper. Petitioner carries the burden of proof by a preponderance of the evidence for both programs.

PRELIMINARY STATEMENT

Pursuant to 42 C.F.R. § 431.224(a)(1), "the agency must establish and maintain an expedited fair hearing process for individuals to request an expedited fair hearing, if the agency determines that the time otherwise permitted for a hearing under § 431.244(f)(1) could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function." On January 11, 2018, Petitioner requested an expedited fair hearing. On January 12, 2018, Petitioner submitted documentation to support his expedited request and a determination was made that Petitioner met the criteria for an expedited fair hearing pursuant to 42 C.F.R. § 431.224(a)(1). A telephonic expedited fair hearing was scheduled for January 17, 2018 at 12:30 p.m. The parties were notified of the hearing date, time and dialing instructions by electronic mail. During the hearing, the undersigned determined that Petitioner did not meet the requirements for the fair hearing process, but allowed the proceedings to go forward as scheduled.

At the hearing, Petitioner provided no exhibits. Respondent submitted a 34-page document which was accepted and marked as Respondent's Composite Exhibit 1. The record was left open through January 31, 2018 for the parties to submit an additional exhibit. Respondent's information was timely received and entered into evidence as Respondent's Composite Exhibit 2. Petitioner did not provide any additional information, nor did he contact the hearing officer for additional time. The record was closed on January 31, 2018.

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. Prior to the action under appeal, Petitioner had been receiving Supplemental Nutrition Assistance Program (SNAP) and Medically Needy (MN) benefits for himself and his wife. The couple is eligible for Medicare and last received MSP in May 2017. MSP benefits pay for the Medicare Part B premiums and include three types: Qualified Medicare Beneficiary (QMB), Special Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual 1 (QI1), each with a different income limit. QI1 has the highest income limit.

2. On October 16, 2017, a Notice of Eligibility Review was sent to Petitioner informing him that November 2017 would be the last month he would receive benefits unless he reapplies.

3. On October 25, 2017, a simplified application was sent to Petitioner advising him to complete and return it by November 6, 2017 to continue his current benefits.

4. On November 10, 2017, Petitioner submitted a manual application requesting SNAP, SSI-Related Medicaid and MSP for himself and his wife. The application was assigned a received date of November 13, 2017 in the Department's application system.

5. On November 29, 2017, Respondent sent Petitioner a notice indicating that he needed to call 407-317-7048 for a telephone interview on or before December 8, 2017 between 8:00 a.m. and 5:00 p.m. The notice also indicated a pending list of documents that could be needed for the Department to make a determination. It requested in

addition to other things, “Proof of all gross income from last 4 weeks using the Verification of Employment /Loss of Income” form or you may send in your last 4 pay stubs”.

6. On December 14, 2017, Petitioner was interviewed by Respondent and the case was processed. A NOCA was sent to Petitioner on December 15, 2017 informing him that his application for SNAP and Qualifying Individual 1 (QI1) benefits were denied because “Your household’s income is too high to qualify for the program”. The notice also informed him that he and his wife were approved for the MN Program with an estimated SOC, see Respondent’s Composite Exhibit 1, pages 9-12.

7. On December 29, 2017, Petitioner submitted a new application for benefits. On that application, he reported $988 in monthly Social Security (SS) benefits for himself and $473 for his wife, a total of $1,461. Additionally, he reported that his employment with [redacted] was terminated. He reported that he and his wife were getting payments for participating in a research study with [redacted] *see* Respondent Composite Exhibit 1, pages 25-26.

8. Petitioner’s gross SS benefits is $1,028.16, his wife’s is $491.64. Respondent explained its action to deny Petitioner’s November 13, 2017 application. During the hearing, Respondent explained that the couple has just been approved for MN and QI1 benefits; Petitioner was not eligible for full Medicaid due to income and that the share of cost amount is directly dependent on the couple’s income minus allowable deductions. The QI1 benefit for December 2017 was currently denied due to excess income, but can be revisited if actual income received by the couple from the research facility was submitted before making a determination for that month.

9. Petitioner acknowledged his MSP being terminated, but explained he went to the Social Security Administration (SSA) office to get it resolved when their SS benefits were suddenly being recouped for $77 each for 3 months. Petitioner asserted as follows: (1) that SSA explained that he needed to go back to DCF and get approved for the MSP before their SS benefits can be adjusted, and (2) that they had received no income from the research company in December 2017. The wife argued that she has [redacted] and that she needs Medicaid to have the necessary surgery. The couple agreed with Respondent's most recent action approving their MSP and declined to challenge the SOC amount. However, Petitioner maintains he is still seeking full Medicaid and MSP for himself and his wife going back to August 2017 to cover their Part B premiums based on his applications.

10. The record was left open for the parties to contact the research agency to verify any payments received by the couple. On January 31, 2018, the undersigned received additional document from Respondent, *see* Respondent's Composite 2. Included in this exhibit is a NOCA, dated January18, 2018, confirming that the couple was approved each with an estimated $1,220 SOC for November 2017 and $1,320 for December 2017. The notice also informed Petitioner that his December 29, 2017 application for MSP was approved for the QI1 Program from September 2017 through November 2017 and again effective January 2018 forward. December 2017 was denied due to excess income, *see* Respondent's Composite Exhibit 2, pages 1-4.

11. Petitioner was seeking full Medicaid and MSP for himself and his wife going back to August 2017. With Respondent's most recent action, the undersigned's decision is

now limited to the whether the couple is eligible for full Medicaid effective December 2017 and MSP for August 2017 and December 2017 based on his applications.

12. Included in Respondent's Composite Exhibit 2 is a verification of payments from the research facility previously submitted by the couple. "[redacted]-Patient Payments History" (printed on 10/30/ 2017 & 11/2/2017 respectively) shows [redacted] received a total of $300 in August 2017, with no scheduled dates or payments reported thereafter. Payments history for [redacted] shows he received a total of $475 in August 2017, for a household total of $775 for the month. His last relevant payment for 2017 was received on November 7, 2017. No scheduled dates or payments were reported for December 2017. The document shows Petitioner has more appointments scheduled in January 2018, *see* Respondent's Composite Exhibit 2, pages 22-30. The undersigned finds the couple received no payments from the research facility in December 2017.

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 Fla. Admin. Code R. 65-2.056.

FULL MEDICAID ISSUE

15. Federal Regulations at 42 C.F.R. §435.500 sets forth the regulations for requirements for determining the eligibility of both categorically and medically needy individuals.

16. In this instant case, the couple was considered for the SSI-Related Medicaid Programs for being aged. Based on this regulation, the Department determined Medicaid eligibility for the couple and approved them for SSI-Related Medically Needy Program benefits.

17 Fla. Admin. Code R. 65A-1.701, Definitions, states:

> (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…[emphasis added]

18. 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 ($1,191 for a couple), and are not receiving Medicare. The petitioner and his wife are receiving Medicare; therefore, they are not eligible for full Medicaid benefits.

19. Based on the evidence, testimony, and the controlling authorities, the undersigned concludes that the Department correctly determined that Petitioner is not eligible for full Medicaid benefits. Petitioner has failed to meet his burden that he and his wife are eligible for full Medicaid based on his applications.

MEDICARE SAVINGS PLAN ISSUE

20. 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.)…

21. Fla. Admin. 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…

22. The Policy Manual, CFOP 165-22, Appendix A-9 (July 2017), identifies the following MSP Program income standards for a couple. QI1 has the highest income limit. Effective July 1 2017, the limit is $1,827. In this instant case, the couple was approved for QI1 from September 2017 through November 2017 and again effective January 2018 forward. The couple's QI1 was denied for August 2017 due to excess

income. Additionally, December 2017 due to excess income because respondent could not could verify that no income was received for that month.

23. Petitioner's gross SS benefits is $1,028.16, his wife's is $491.64. The undersigned completed his own budget for QI1 for August 2017. The couple's earned income ($775) was added to their reported SS benefits ($1,519.80) to arrive at $2,294.80 total household's income. At the time of Respondent's action, the income limit for a couple to be eligible for QI1 was $1,827. The couple's income exceeded that amount after the $20 disregard. Eligibility for QI1 for August 2017 was not found.

24. The couple's QI1 benefit was denied for December 2017 due to excess income because Respondent could not verify they did not receive any payments with a representative from the research facility. However, [redacted]-Patient Payments History previously submitted by Petitioner to the Department indicates the couple received no payments from the facility for the month at issue. The QI1 income limit for a couple for the month at issue was $1,827 for the month at issue. The couple's total SS benefits ($1,519.80) was less than the established income limit to be eligible for that benefit. The undersigned concludes that Respondent had proof that the couple received no payments from the research facility when they were denied QI1 for December 2017 due to excess income.

25. In careful review of the cited authorities and evidence, the undersigned concludes the Department's action to deny Petitioner MSP (QI1) for August 2017 is proper. Petitioner has failed to meet his burden that he and his wife are eligible for QI1 for that month. However, the undersigned concludes that Respondent erred when it

denied QI1 for Petitioner and his wife for December 2017. Petitioner has met his burden that he and his wife are eligible for QI1 for the month at issue.

DECISION

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

The MSP appeal is denied in part and **GRANTED** in part. The Department correctly denied Petitioner's QI1 for August 2017. However, Department erred in its action to deny Petitioner's QI 1 for December 2017 as outlined in the Conclusions of Law. **Respondent is ordered to approve QI 1 for Petitioner and his wife for December 2017 as stated 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 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 April, 2018,

in Tallahassee, Florida.

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Hearing Officer
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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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Clay
UNIT: 88213

RESPONDENT.
_____/

APPEAL NO. 18F-00390

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 13, 2018 at 1:29 p.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Stephanie Ross, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of November 17, 2017 terminating her Family-Related Medicaid. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department did not submit evidence prior to the hearing. The petitioner chose to proceed with the hearing without the evidence provided. The record was held

open through March 23, 2018 for the Department to issue the evidence and allow the petitioner to submit any evidence and rebuttal statement prior to the record closing.

The Department submitted evidence on March 19, 2018. The evidence was entered as Respondent's Exhibit 1.

The petitioner submitted no evidence or rebuttal statement.

The record closed on March 23, 2018.

FINDINGS OF FACT

1. The petitioner filed an application for recertification of Food Assistance and Family Medicaid on November 9, 2017. The petitioner listed the household members as herself, her son (JT, age 26), her daughter (ET, age 24) and daughter (VT, age 18). The petitioner did not indicate she was disabled on her application. (Respondent's Exhibit 1, pages 8 through 17)

2. The Department reported a Notice of Case Action was issued to the petitioner on November 17, 2017. The Notice explained the petitioner was terminated from Family-Related Medicaid effective December 1, 2017 due to the petitioner's youngest child turning 18 in October 2017.

3. The petitioner confirmed her daughter VT was born on [redacted] and turned [redacted].

4. The Department issued a Notice of Case Action on December 20, 2017 the Notice shows the petitioner listed as "ineligible" for Medicaid. The Department pointed out the Notice includes informs the petitioner of her right to file an appeal within 90 days of the date of the Notice. (Respondent's Exhibit 1, pages 2 through 5)

5. The petitioner filed this appeal of the termination of her Family-Related Medicaid on January 18, 2018.

6. The Department explained the petitioner was no longer eligible for Family-Related Medicaid as her youngest child had turned 18 in [redacted].

7. The Department stated the petitioner did not report her belief she may be disabled until December 7, 2017.

8. The Department provided the SSI Title II Inquiry showing the petitioner applied for SSI on December 7, 2017. The inquiry shows a decision has not been made on her eligibility.

9. The petitioner stated that she thought because she has so many health problems her Medicaid would just continue.

10. The petitioner stated she did not know that she could appeal the decision to terminate her Medicaid until she called the Customer Call Center.

11. The petitioner filed an application for SSI-Related Medicaid on January 31, 2018.

12. The Department reported the petitioner's application for SSI-Related Medicaid is presently pending with the Division of Disability Determinations (DDD). The Department explained the DDD decision may take up to 90 days.

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 Fla. Admin. Code R. 65-2.056.

15. Florida Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria, states in relevant part:

> (1) Technical eligibility criteria of living in the home of a specified relative, age, residence, citizenship and deprivation apply to coverage groups as follows.
> (2) Coverage groups must meet the deprivation criterion only to the extent that children and parents or caretaker relatives meet payment standard income criteria [Refer to subsection 65A-1.716(2), F.A.C.].
> …
> (7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested. A fully deprived child is one who is not living with either birth parent due to reasons such as death, abandonment or incarceration. The following are illustrations of SFU determinations:
> …
> (d) If assistance is requested for the parent of a child in an intact family, the parent, the mutual child's other parent, the mutual child and all siblings of the mutual child who have no income must be included in the SFU. Any siblings who have income, or any other related fully deprived children, are optional members of the SFU. **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.**
> (emphasis added)

16. The above controlling authority describe the situation in which a parent can receive Family-Related Medicaid. In the instant case, the petitioner does not have a child under age 18 residing in the home to be a part of her SFU. The undersigned concludes the Department correctly determined the petitioner no longer qualifies for Family-Related Medicaid.

17. Florida Admin. Code R 65-2.048, Action to Reduce or Discontinue Assistance or Service, states in relevant part:

> (1) In all programs other than the Supplemental Nutrition Assistance Program (SNAP), a hearing request filed within ten (10) days after the

> date of mailing or hand delivery of the notice either orally or written, requires that assistance be continued at the current level until the final written decision of the hearings officer is rendered; unless, a change affecting the appellant's grant occurs while the hearing decision is pending and the recipient fails to request a hearing after notice of the change.

18. The findings show the petitioner's Family-Related Medicaid was terminated on November 17, 2017 effective December 1, 2017. The findings also show the appeal of the termination was not filed until January 16, 2018. In accordance with the above controlling authorities, the undersigned concludes the petitioner did not request a hearing within 10 days of the date of the mailing date of her Notice terminating her Family-Related Medicaid. The undersigned further concludes the Department could not continue Family-Related Medicaid benefits pending the outcome of this appeal.

19. Florida Admin. Code R. 65A-1.702, Special Provisions, states in relevant 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. 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.

20. The findings show the petitioner did not identify herself as disabled or potentially disabled on her application November 9, 2017. The undersigned concludes the Department properly terminated the petitioner's Family-Related Medicaid based on the available information.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and 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 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 April, 2018, in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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Copies Furnished To: [redacted]
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 St. Lucie
UNIT: 88651

_____/

APPEAL NO. 18F-00410

CASE NO. [redacted]

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 16, 2018 at 1:04 p.m. All parties appeared telephonically from different locations.

APPEARANCES

On behalf of petitioner: [redacted]

On behalf of respondent: Laurel Hopper, Esq. DCF Legal Counsel

STATEMENT OF ISSUE

At issue is whether Respondent's action (or the Department) denying Petitioner's October 20, 2017 application for Nursing Home Medicaid coverage, also known as Institutional Care Program (ICP) is correct. Petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By a Notice of Application Disposition dated November 14, 2017, Respondent notified Petitioner that the October 20, 2017 ICP application for her husband was denied due to not meeting citizenship requirement. On January 17, 2018, Petitioner timely requested an appeal challenging Respondent's action.

The appeal was continued from March 19, 2018 and April 4, 2018 per Respondent's request.

[redacted]r appeared as a witness for Petitioner. Judy Sickles, Senior Human Services Program Specialist (SHSPS), appeared as a witness for Respondent.

Petitioner submitted seven (7) exhibits which were accepted and marked as Petitioner's Exhibits 1 through 7. Respondent submitted ten (10) exhibits which were accepted and marked as Respondent's Exhibits 1 through 10.

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. Petitioner and her husband have been married for almost 20 years. The husband is aged and receives Social Security and Medicare benefits through Petitioner.

2. On [redacted], the husband became a lawful permanent resident (LPR) of the United States. The husband has not served in the US military. He is subject to a five-year ban for Medicaid purposes, except for Emergency Medicaid for Aliens (EMA). EMA does not cover ICP services, it only covers emergency medical services in the community. ICP Medicaid covers the institutional provider payment for skilled nursing home care.

3. Petitioner's husband suffers from [redacted],

[redacted]

4. On September 5, 2017, Petitioner's husband was hospitalized at [redacted] and was diagnosed with [redacted] due to [redacted]. On October 7, 2017, he was admitted at [redacted] ie, *see* Petitioner's Exhibits 1 thorough 3.

5. On October 20, 2017 Petitioner submitted an application requesting ICP Medicaid to cover her husband's stay at the facility, *see* Respondent's Exhibit 3.

6. As part of the eligibility determination process, Respondent must verify the citizenship status, or qualified noncitizens status for all applicants before they can be approved for benefits.

7. Respondent submitted the husband's Immigration and Naturalization Service (INS) number to Systematic Alien Verification for Entitlements (SAVE) to verify his current immigration status. The response was displayed as follows: Date of entry: [redacted], Status: Lawful Permanent Resident – Employment Authorized, Code: IR6, *see* Respondent's Exhibit 6.

8. Respondent's Exhibit 10 describes IR6 coded aliens as individuals who do not have qualified noncitizens. They are subject to a five-year ban before they can be eligible for ICP Medicaid coverage.

9. The case was processed and the husband's ICP was denied for not being a citizen of the US, or for not meeting specific federal non-citizen criteria. A Notice of

Application Disposition was sent to Petitioner on November 14, 2017 informing Petitioner of the decision, *see* Respondent's Exhibits 7 and 8.

10. Respondent's representative argues that the husband's application for ICP was denied because he is a Lawful Permanent Resident under a five-year ban (due 5/28/2020) and does not meet any exemptions. Respondent's witness explained that she had received several "trackers" on this case and had consulted Program Offices statewide to determine if ICP could have been approved under this scenario, but could not find an exemption. She maintains until a final decision is reached on the husband's citizenship application, he is still considered a non-citizen subject to a five-year ban for ICP Medicaid eligibility purposes. Therefore, he does not meet citizenship requirement to be eligible for ICP Medicaid coverage. She explained, once the husband's citizenship is approved, Petitioner should file a new application for ICP and have the husband's eligibility determined.

11. Petitioner's representative argues that the "spirit" of the law concerning Long Term Care Medicaid benefits is fundamentally meant to protect the financial security and wellbeing of the community spouse, who is a US citizen. She argues that Petitioner's husband is a Lawful Permanent Resident who has applied for US Citizenship and is awaiting approval. Additionally, she maintains that it is cruel and inhumane to subject the applicant to this unnecessary wait period. Petitioner maintains that her husband has already completed his biometrics for processing and is technically a US citizen, therefore his ICP Medicaid should be approved, *see* Petitioner's Exhibit 5.

Petitioner believes the application for citizenship should be considered sufficient to meet this requirement.

12. Petitioner feels that some form of compassionate allowance should be applied in this case. She is seeking to have her husband found eligible for ICP based on the October 20, 2017 application.

CONCLUSIONS OF LAW

13. Pursuant to Section 409.285, Florida Statutes, the Department of Children and Families' Office of Appeal Hearings has jurisdiction over this proceeding. This order is the final administrative decision of the Department of Children and Families pursuant to Section 409.285(2), Florida Statutes.

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

15. Fla. Admin. Code § 65A-1.710 "SSI-Related Medicaid Coverage Groups" states in relevant part:

> The Department covers all mandatory coverage groups and the following optional coverage groups:
> …
> (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.

16. Fla. Admin. Code R. 65A-1.301 addresses Citizenship requirement and states in the pertinent part:

> (1) The individual whose needs are included must meet the citizenship and noncitizen status established in: P.L. 104-193, The Personal Responsibility and Work Opportunity Reconciliation Act of 1996; P.L. 105-

> 33, the Balanced Budget Act of 1997; P.L. 105-185, the Agricultural Research, Extension, and Education Reform Act of 1998; P.L. 105-306, the Noncitizen Benefit Clarification and Other Technical Amendments Act of 1998; P.L. 109-171, the Deficit Reduction Act of 2005; and, the Immigration and Nationality Act.
>
> (3) The eligibility specialist must verify the immigration status of noncitizens through the United States Citizenship and Immigration Service (USCIS), formerly the United States Bureau of Citizenship and Immigration Services. Verification will be requested electronically using the alien number, or based on a USCIS or prior Immigration and Naturalization Services (INS) document provided by the applicant. The system of verification is known as the Verification Information System-Customer Processing System (VIS-CPS), which is part of the Systematic Alien Verification for Entitlements (SAVE) Program…

17. The above cited authority states that the Department must verify the immigration status of noncitizens through the SAVE system. In this instant case, Petitioner's husband attained LPR on May 28, 2015. Respondent determined he is subject to a five-year ban and denied his ICP Medicaid coverage.

18. 42 C.F.R. §435.956-Verification of other non-financial information states in part:

> (a) *Citizenship and immigration status.* (1)(i) The agency must—
> (A) Verify citizenship status through the electronic service established in accordance with §435.949 or alternative mechanism authorized in accordance with §435.945(k), if available; and….
> (3) For purposes of the exemption from the five-year waiting period described in 8 U.S.C. 1613, the agency must verify that an individual is an honorably discharged veteran or in active military duty status, or the spouse or unmarried dependent child of such person, as described in 8 U.S.C. 1612(b)(2) through the electronic service described in §435.949 or alternative mechanism authorized in accordance with §435.945(k). If the agency is unable to verify such status through such service the agency may accept self-attestation of such status.

19. Title 8 U.S.C. **§**1613 (1996) Five-year limited eligibility of qualified aliens for Federal means-tested public benefit and states in part:

> **(a) In general**

> Notwithstanding any other provision of law and except as provided in subsections (b), (c), and (d) of this section, an alien who is a qualified alien (as defined in section 1641 of this title) and who enters the United States on or after August 22, 1996, is not eligible for any Federal means-tested public benefit for a period of 5 years beginning on the date of the alien's entry into the United States with a status within the meaning of the term “qualified alien”.
> **(b) Exceptions**
> The limitation under subsection (a) of this section shall not apply to the following aliens:
> **(1) Exception for refugees and asylees**
> (A) An alien who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act [8 U.S.C. 1157].
> (B) An alien who is granted asylum under section 208 of such Act [8 U.S.C. 1158].
> (C) An alien whose deportation is being withheld under section 243(h) 1 of such Act [8 U.S.C. 1253].
> **(2) Veteran and active duty exception**
> An alien who is lawfully residing in any State and is—
> (A) a veteran (as defined in section 101 of title 38) with a discharge characterized as an honorable discharge and not on account of alienage,
> (B) on active duty (other than active duty for training) in the Armed Forces of the United States, or
> (C) the spouse or unmarried dependent child of an individual described in subparagraph (A) or (B).

20. The Department’s Program Policy Manual (The Policy Manual), CFOP 165-22 at passage number 1440.0106 Lawful Permanent Resident (MSSI, SFP) states in part:

> A lawful permanent resident (LPR) is a noncitizen who lawfully immigrates to the U.S. and has permission to live and work in the U.S. LPRs may be eligible for Medicaid based on citizenship if they entered the U.S.:
> 1. prior to 8/22/96 and have remained continuously present,
> 2. on or after 8/22/96 under a prior asylee, refugee, Amerasian, deportation withheld, or Cuban/Haitian Entrant status, or
> 3. on or after 8/22/96 and have lived in the U.S. as a qualified noncitizen for at least five years.
> Proof of this status includes:
> 1. resident alien card, (I-551)(commonly referred to as a "green card");
> 2. re-entry permit (I-327), or
> 3. foreign passport with a stamp stating "temporary evidence of lawful permanent resident status".

Note: LPRs who entered after 8/22/96 are subject to the five-year ban, except lawfully residing children up to age 19.

LPRs who are in the five-year ban may be eligible for Emergency Medicaid for Aliens, (EMA).

21. The above authorities and the Policy Manual explain that a non-citizen must provide verification of immigration status. Those noncitizens that entered the United States after August 22, 1996, must have resided in the United States as a Legal Permanent Resident (LPR) for a period of five years to be eligible for Medicaid benefits, unless they meet an exception.

22. The evidence shows that Petitioner's husband became a LPR on May 28, 2015 and is therefore subject to a five-year ban, or until his citizenship process has been finalized before he can be eligible for ICP Medicaid. While the undersigned took notice of the physical and emotional hardship incurred by Petitioner, he could not find anything within to rules to conclude that ICP Medicaid should be approved for her husband.

23. After considering the evidence, testimony from the witnesses, and the appropriate authorities cited above, the hearing officer concludes that Petitioner has failed to meet the burden that her husband is eligible for ICP Medicaid benefits.

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 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 April, 2018, 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]r, Petitioner
Office of Economic Self Sufficiency
Laurel Hopper, Esq.
[redacted], Esq.

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

[redacted]

APPEAL NO. 18F-00614
18F-00973
18F-00974

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55207

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at 1:26 p.m. on February 15, 2018, in [redacted]

APPEARANCES

For the Petitioner: [redacted], pro se

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:

(A) Supplemental Nutrition Assistance Program (SNAP) benefits, also known as Food Assistance Program,
(B) Temporary Cash Assistance (TCA) and
(C) Medicaid benefits, 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 10 exhibits, entered as Respondent Exhibits "1" through "10". The record remained open until February 22, 2018, for additional evidence from both parties. The respondent's evidence was received timely and entered as Respondent Exhibit "11". The petitioner did not submit additional evidence. The record was closed on February 22, 2018.

FINDINGS OF FACT

1. The petitioner's household includes the petitioner and her two children. The petitioner and her children are noncitizens. The petitioner is married to a U.S. citizen and is currently separated from her husband.

2. The petitioner asserted that her and her children entered the U.S. from [redacted] starting in 2012 on tourist visas. And were "back and forth between [redacted] and the U.S. until August 2016." In August 2016, the petitioner returned to the U.S. and has remained in the U.S.

3. On May 8, 2017, the petitioner filed a petition with The Department of Homeland Security (DHS), U.S. Citizenship and Immigration Services, for Amerasian, Widow or Special Immigrant (Respondent Exhibit 7).

4. DHS reviewed the petitioner's petition (I-797 Notice of Action) and determined "establishment of prima facie case" for classification under the self-petitioning provisions of the Violence Against Women Act (I-360). The petitioner's petition has not been approved and will expire on March 18, 2018.

5. As part of the application process the Department verified the petitioner's and her children's immigration status through DHS, SAVE Program, using the petitioner's and her children's Alien Number's (given by DHS) and a third party verification. DHS response was that the petitioner and her children have an "application pending," no INS status was given (Respondent Exhibit 5).

6. On October 13, 2017, the petitioner applied for Social Security Numbers (SSNs). SSNs were given, however the cards state "valid for work only with DHS authorization" (Petitioner Exhibit 1).

7. On October 30, 2017, the petitioner applied for SNAP, TCA and Medicaid for her and her children (Respondent Exhibit 3, page 20).

8. On December 18, 2017, the Department denied the petitioner's October 30, 2017, application, for failing to completed the required interview (Respondent Exhibit 2, page 14).

9. To be eligible for SNAP and TCA benefits, the petitioner and her children must have a qualified alien status or must have resided in the U.S. as Lawful Permanent Residents (LPR) for a period of five years. The petitioner and her children do not have a qualified alien status and have not resided in the U.S. as LPRs. Additionally, the petitioner's petition for Qualified Alien based on Battered Spouse of US Citizen and Children of Battered Spouse of US citizen, which has not been approved.

10. To be eligible for Medicaid, the petitioner must also have a qualified alien status or must have resided in the U.S. as LPR for a period of five years. The petitioner does not have a qualified alien status and has not resided in the U.S. as a LPR.

11. In July 2016, House Bill 5101 was passed allowing Medicaid eligibility for lawfully residing noncitizen children (to age 19), with valid visas. Therefore, the petitioner's children are eligible for Medicaid.

12. On December 28, 2017, the Department reused the petitioner's October 30, 2017 application (Respondent Exhibit 3).

13. On January 11, 2018, the Department mailed the petitioner a Notice of Case Action, notifying: (1) SNAP and TCA were denied for the petitioner and her children (2) Medicaid was denied for the petitioner and (3) Medicaid was approved for the petitioner's children (Respondent Exhibit 2).

14. The petitioner argued that in accordance with DHS I-797, her and her children are in the U.S. legally and should be eligible for public benefits.

15. The petitioner further argued that the I-797 specifically states "THIS NOTICE MAY BE USED TO ASSIST YOU IN RECEIVING PUBLIC BENEFITS".

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 *Florida Administrative Code* R. 65-2.056.

18. The evidence submitted establishes that the petitioner and her children are noncitizens.

19. The Florida Administrative Code R. 65A-1.301 discusses the requirement to verify citizenship status and states in part:

> (1) The individual whose needs are included must meet the citizenship and noncitizen status established in: P.L. 104-193, The Personal Responsibility and Work Opportunity Reconciliation Act of 1996; P.L. 105-33, the Balanced Budget Act of 1997; P.L. 105-185, the Agricultural Research, Extension, and Education Reform Act of 1998; P.L. 105-306, the Noncitizen Benefit Clarification and Other Technical Amendments Act of 1998; P.L. 109-171, the Deficit Reduction Act of 2005; and, the Immigration and Nationality Act…
> (3) The eligibility specialist must verify the immigration status of noncitizens through the United States Citizenship and Immigration Service (USCIS), formerly the United States Bureau of Citizenship and Immigration Services. Verification will be requested electronically using the alien number, or based on a USCIS or prior Immigration and Naturalization Services (INS) document provided by the applicant. The system of verification is known as the Verification Information System-Customer Processing System (VIS-CPS), which is part of the Systematic Alien Verification for Entitlements (SAVE) Program…

20. In accordance with the above authority, the Department verified the petitioner's and her children's immigration status electronically, through the DHS, SAVE Program. The SAVE Program response was that the petitioner and her children have an "application pending," no INS status was given by DHS.

SNAP ISSUE

21. The Code of Federal Regulations at 7 C.F.R. § 273.4, Citizenship and alien status states in part:

> (a) Household members meeting citizenship or alien status requirements. No person is eligible to participate in the Program unless that person is:
> (1) A U.S. citizen…
> (2) A U.S. non-citizen national…
> (4) An individual who is:
> (i) Lawfully residing in the U.S. and…
> (5) An individual who is:
> (i) An alien who has been subjected to a severe form of trafficking in persons and who is certified by the Department of Health and Human

Services, to the same extent as an alien who is admitted to the United States as a refugee under Section 207 of the INA

(6) An individual who is both a qualified alien as defined in paragraph (a)(6)(i) of this section and an eligible alien as defined in paragraph (a)(6)(ii) or (a)(6)(iii) of this section. (emphasis added)

(i) A qualified alien is:

(A) An alien who is lawfully admitted for permanent residence under the INA;

(B) An alien who is granted asylum under section 208 of the INA;

(C) A refugee who is admitted to the United States under section 207 of the INA;

(D) An alien who is paroled into the U.S. under section 212(d)(5) of the INA for a period of at least 1 year;

(E) An alien whose deportation is being withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or whose removal is withheld under section 241(b)(3) of the INA;

(F) An alien who is granted conditional entry pursuant to section 203(a)(7) of the INA as in effect prior to April 1, 1980;

(G) An alien who has been battered or subjected to extreme cruelty in the U.S. by a spouse or a parent or by a member of the spouse or parent's family residing in the same household as the alien at the time of the abuse, an alien whose child has been battered or subjected to battery or cruelty, or an alien child whose parent has been battered; or…

(ii) A qualified alien, as defined in paragraph (a)(6)(i) of this section, is eligible to receive SNAP benefits and is not subject to the requirement to be in qualified status for 5 years as set forth in paragraph (a)(6)(iii) of this section, if such individual meets at least one of the criteria of this paragraph (a)(6)(ii): (emphasis added)

(A) An alien age 18 or older lawfully admitted for permanent residence under the INA who has 40 qualifying quarters as determined under Title II of the SSA, including qualifying quarters of work not covered by Title II of the SSA, based on the sum of: quarters the alien worked; quarters credited from the work of a parent of the alien before the alien became 18 (including quarters worked before the alien was born or adopted); and quarters credited from the work of a spouse of the alien during their marriage if they are still married or the spouse is deceased.

…

(B) An alien admitted as a refugee under section 207 of the INA;

(C) An alien granted asylum under section 208 of the INA;

(D) An alien whose deportation is withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or whose removal is withheld under section 241(b)(3) or the INA;

(E) An alien granted status as a Cuban or Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);

(F) An Amerasian admitted pursuant to section 584 of Public Law 100-202, as amended by Public Law 100-461;

(G) An alien with one of the following military connections…
(H) An individual who is receiving benefits or assistance for blindness or disability (as specified in §271.2 of this chapter).
(I) An individual who on August 22, 1996, was lawfully residing in the U.S.; and was born on or before August 22, 1931; or
(J) An individual who is under 18 years of age.
(iii) The following qualified aliens, as defined in paragraph (a)(6)(i) of this section, must be in a qualified status for 5 years before being eligible to receive food stamps. The 5 years in qualified status may be either consecutive or nonconsecutive. (emphasis added)
Temporary absences of less than 6 months from the United States with no intention of abandoning U.S. residency do not terminate or interrupt the individual's period of U.S. residency. If the resident is absent for more than 6 months, the agency shall presume that U.S. residency was interrupted unless the alien presents evidence of his or her intent to resume U.S. residency. In determining whether an alien with an interrupted period of U.S. residency has resided in the United States for 5 years, the agency shall consider all months of residency in the United States, including any months of residency before the interruption:
(A) An alien age 18 or older lawfully admitted for permanent residence under the INA…
(B) An alien who is paroled into the U.S. under section 212(d)(5) of the INA for a period of at least 1 year;
(C) An alien who has been battered or subjected to extreme cruelty in the U.S. by a spouse or a parent or by a member of the spouse or parent's family residing in the same household as the alien at the time of the abuse, an alien whose child has been battered or subjected to battery or cruelty, or an alien child whose parent has been battered; (emphasis added)
(D) An alien who is granted conditional entry pursuant to section 203(a)(7) of the INA as in effect prior to April 1, 1980.
(iv) Each category of eligible alien status stands alone for purposes of determining eligibility. Subsequent adjustment to a more limited status does not override eligibility based on an earlier less rigorous status. Likewise, if eligibility expires under one eligible status, the State agency must determine if eligibility exists under another status.
(7) For purposes of determining eligible alien status in accordance with paragraphs (a)(4) and (a)(6)(ii)(I) of this section “lawfully residing in the U.S.” means that the alien is lawfully present as defined at 8 CFR 103.12(a)…

22. In accordance with the above authority, noncitizens must meet qualified alien status and at least one alien criteria to be eligible for SNAP benefits.

23. The evidence submitted establishes that the petitioner and her children do not have alien status, nor "5 years in qualified status." The petitioner petitioned for Qualified Alien based on Battered Spouse of US Citizen and Children of Battered Spouse of US Citizen; however, the application is still pending.

TCA ISSUE

24. Section 414.095, Florida Statutes, Determining eligibility for temporary cash assistance, in part states:

> (1) ELIGIBILITY.—An applicant must meet eligibility requirements of this section before receiving services or temporary cash assistance under this chapter…
> (2) (a)To be eligible for services or temporary cash assistance…
> 1. An applicant must be a United States citizen, or a qualified noncitizen, as defined in this section…
> (3) ELIGIBILITY FOR NONCITIZENS.—A "qualified noncitizen" is an individual who is admitted to the United States as a refugee under s. 207 of the Immigration and Nationality Act or who is granted asylum under s. 208 of the Immigration and Nationality Act; a noncitizen whose deportation is withheld under s. 243(h) or s. 241(b)(3) of the Immigration and Nationality Act; a noncitizen who is paroled into the United States under s. 212(d)(5) of the Immigration and Nationality Act, for at least 1 year; a noncitizen who is granted conditional entry pursuant to s. 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980; a Cuban or Haitian entrant; or a noncitizen who has been admitted as a permanent resident. In addition, a "qualified noncitizen" includes an individual who, or an individual whose child or parent, has been battered or subject to extreme cruelty in the United States by a spouse, a parent, or other household member under certain circumstances, and has applied for or received protection under the federal Violence Against Women Act of 1994, Pub. L. No. 103-322, if the need for benefits is related to the abuse and the batterer no longer lives in the household. A "nonqualified noncitizen" is a nonimmigrant noncitizen, including a tourist, business visitor, foreign student, exchange visitor, temporary worker, or diplomat. In addition, a "nonqualified noncitizen" includes an individual paroled into the United States for less than 1 year. A qualified noncitizen who is otherwise eligible may receive temporary cash assistance to the extent permitted by federal law. The income or resources of a sponsor and the sponsor's spouse shall be included in determining eligibility to the maximum extent permitted by federal law.

> (a) A child who is a qualified noncitizen or who was born in the United States to an illegal or ineligible noncitizen is eligible for temporary cash assistance under this chapter if the family meets all eligibility requirements…

25. In accordance with the above authority, to be eligible for TCA benefits, the petitioner and her children must be qualified noncitizens.

26. The evidence submitted establishes that the petitioner and her children are not qualified noncitizens. They do not have alien status. The petitioner petitioned for Qualified Alien based on Battered Spouse of US citizen and Children of Battered Spouse of US citizen; however, the application is still pending.

MEDICAID ISSUE

27. The Code of Federal Regulations at 42 C.F.R. at § 435.406, Citizenship and noncitizen eligibility for Medicaid benefits, states in part:

> (a) The agency must provide Medicaid to otherwise eligible individuals who are—
> (1) Citizens and nationals of the United States, provided that—
> (i) The individual has made a declaration of United States citizenship, as defined in §435.4, or an individual described in paragraph (a)(3) of this section has made such declaration on the individual's behalf, and such status is verified in accordance with paragraph (c) of this section; and
> (ii) For purposes of the declaration and citizenship verification requirements discussed in paragraphs (a)(1)(i) of this section, an individual includes applicants under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in its expenditures.
> …
> (2) At State option, individuals who were deemed eligible for coverage under §435.117 or §457.360 of this chapter in another State on or after July 1, 2006, provided that the agency verifies such deemed eligibility.
> (2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified non-citizens), qualified non-citizens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified non-citizens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Non-Citizen status, which status has been verified with the Department of Homeland

> Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is an non-citizen in a satisfactory immigration status.
> (ii) The eligibility of qualified non-citizens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.
> (3) For purposes of paragraphs (a)(1) and (2), of this section, a declaration of citizenship or satisfactory immigration status may be provided, in writing and under penalty of perjury, by an adult member of the individual's household, an authorized representative, as defined in §435.923, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant provided that such individual attests to having knowledge of the individual's status.
> (b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified non-citizens subject to the 5-year bar or who are non-qualified non-citizens who meet all Medicaid eligibility criteria, except non-qualified non-citizens need not present a social security number or document immigration status.
> (c) The agency must verify the declaration of citizenship or satisfactory immigration status under paragraph (a)(1) or (2) of this section in accordance with §435.956.

28. 8 U.S.C. § 1613, Five-year limited eligibility of qualified aliens for Federal means-tested public benefit, in part states:

> (a) In general
> Notwithstanding any other provision of law and except as provided in subsections (b), (c), and (d) of this section, **an alien who is a qualified alien (as defined in section 1641 of this title) and who enters the United States on or after August 22, 1996, is not eligible for any Federal means-tested public benefit for a period of 5 years beginning on the date of the alien's entry into the United States** (emphasis added) with a status within the meaning of the term ''qualified alien''…

29. 8 U.S.C. § 1641, Definitions, in part states:

> (b) Qualified alien. For purposes of this title, the term "qualified alien" means an alien who, at the time the alien applies for, receives, or attempts to receive a Federal public benefit, is--
> (1) an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act,
> (2) an alien who is granted asylum under section 208 of such Act [8 USCS § 1158],

> (3) a refugee who is admitted to the United States under section 207 of such Act [8 USCS § 1157],
> (4) an alien who is paroled into the United States under section 212(d)(5) of such Act [8 USCS § 1182(d)(5)] for a
> period of at least 1 year,
> (5) an alien whose deportation is being withheld under section 243(h) of such Act [8 USCS § 1253(h)] (as in effect
> immediately before the effective date of section 307 of division C of Public Law 104-208) or section 241(b)(3) of such
> Act [8 USCS § 1251(b)(3)] (as amended by section 305(a) of division C of Public Law 104-208),
> (6) an alien who is granted conditional entry pursuant to section 203(a)(7) of such Act [8 USCS § 1153(a)(7)] as in
> effect prior to April 1, 1980; or
> (7) an alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act
> of 1980 [8 USCS § 1522 nt.]).
> (c) Treatment of certain battered aliens as qualified aliens For purposes of this chapter, the term "qualified alien" includes— (1) an alien who—
> (A) has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the alien and the spouse or parent consented to, or acquiesced in, such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and
> (B) has been approved or has a petition pending which sets forth a prima facie case for—
> (i) status as a spouse or a child of a United States citizen pursuant to clause (ii), (iii), or (iv) of section 204(a)(1)(A) of the Immigration and Nationality Act [8 U.S.C. 1154(a)(1)(A)(ii), (iii), (iv)],

30. The above authorities explain the petitioner must have a qualified alien status and must have resided in the U.S. as a qualified alien for five years to be eligible for Medicaid.

31. The evidence submitted establishes that the petitioner does not have a qualified alien status and has not resided in the U.S. as a qualified alien for five years. The petitioner petitioned for Qualified Alien based on Battered Spouse of US Citizen and Children of Battered Spouse of US citizen; however, the application is still pending.

32. The ACCESS Program TRANSMITTAL NO.: P-16-06-0005 Medicaid Eligibility for Lawfully Residing Noncitizen Children up to age 19, dated July 14, 2016, in part states:

> This memorandum provides new policy about Medicaid and Children's Health Insurance Program (CHIP) coverage for noncitizen children, up to age 19, who are lawfully residing in the United States and meet all other technical and financial eligibility criteria.
>
> **New Policy:**
> This policy change applies to all new or pending applications, renewals, additional benefit requests, and requests to add an individual to an existing benefit that include a Medicaid eligibility determination for a noncitizen child, completed on or after July 1, 2016.
> Effective July 1, 2016, all lawfully residing noncitizen children, up to age 19, are:
> □ Potentially eligible for Medicaid (Family-Related, Child In Care and SSI-Related), including Medically Needy, regardless of their date of entry as long as they are in an immigration status considered "lawfully residing" as shown in Attachment 1
> □ All other technical and financial eligibility requirements such as residency, (application for) a social security number, Standard Filing Unit (SFU) rules, and household income rules must be met prior to providing Medicaid coverage and
> □ Exempt from deeming of income from sponsors
> Apply the policy for Continuous Medicaid, Transitional Medical Assistance, a reasonable opportunity period (Provisional Coverage), etc., the same as applied for any other Medicaid eligible child. In addition, an ex-parte is required when a lawfully residing child turns age 19 to determine ongoing eligibility.

33. Pursuant to the above transmittal, the petitioner's children are eligible for Medicaid benefits.

HEARING OFFICER CONCLUSIONS

34. In careful review of the cited authorities and evidence, the undersigned concludes:

A. The Department's action to deny the petitioner and her children SNAP and TCA benefits, is proper.
B. The Department's action to deny the petitioner Medicaid benefits, is proper.
C. The Department's action to approve the petitioner's children Medicaid benefits, is proper.
D. The petitioner did not meet the burden of proof.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are 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 __March_____, 2018, in Tallahassee, Florida.

Priscilla Peterson
_____

Priscilla Peterson
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

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

[redacted]

APPEAL NO. 18F-00648

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88690

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 3rd, 2018, at 11:30 a.m.

APPEARANCES

For the Petitioner: [redacted], pro se.

For the Respondent: Bertha Diaz, Operations and Management Consultant for the Economic Self-Sufficiency program.

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 carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as an impartial observer was Alma Patino of the Office of Appeal Hearings.

The petitioner did not submit any documents for the hearing.

The respondent's exhibits 1 through 13 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated January 5th, 2018, the respondent notified the petitioner that she had met the Medically Needy Share of Cost (SOC) and is eligible for Medicaid for November 30, 2017. (Respondent's Exhibit 3.)

By way of a Notice of Case Action (NOCA) dated February 2nd, 2018, the respondent notified the petitioner that her application for Medically Needy dated February 1st, 2018, is approved, and she is enrolled with an estimated Share of Cost (SOC) of $314, for the month of February 2018. (Respondent's Exhibit 4.)

By way of a Notice of Case Action (NOCA) dated February 26th, 2018, the respondent notified the petitioner that she had met the Medically Needy Share of Cost (SOC) and is eligible for Medicaid for the period of January 3rd, 2018 through January 31st, 2018. (Respondent's Exhibit 5.)

On January 25th, 2018, the petitioner filed an appeal to challenge the respondent's action to enroll her in a SOC instead of full-coverage Medicaid. The appeal is considered filed timely.

FINDINGS OF FACT

1. On October 31st, 2017, the petitioner applied for Family Related Medicaid (MFAM) with the respondent for a household size of three, listing herself and her two daughters; fifteen-year-old "TM", and twelve-year-old "AM." (Respondent's Exhibit 2.)

2. On the application, the petitioner reported income from Independent Contract Position with [redacted], with a weekly amount of pay of $150. The petitioner also reported a monthly income of $800 from self-employment. (Respondent's Exhibit 2, page 13.)

3. The petitioner provided verification of income from [redacted]t to the respondent. The income verification shows that she earned $369.64 for the week of October 2nd, 2017 to October 8th, 2017; $194.56 for the week of October 16th, 2017 to October 22nd, 2017; $290.18 for the week of October 23rd, 2017 to October 29th, 2017; and $169.73 for the period of October 30th, 2017. The respondent used these as the most recent four week's payments starting from October 2nd, 2017 to November 5th, 2017. The respondent added these four payments and arrived at $1024.11 to be budgeted as the petitioner's monthly income from [redacted]. (Respondent's Exhibit 12.)

4. In addition to the income from [redacted], the petitioner reported $800 from self-employment. The respondent added $800 from self-employment to $1,024.11 from [redacted] to arrive at a total income of $1,824.11, and used this gross income in the determination of the petitioner's eligibility for Medicaid. (Respondent's Exhibits 7 and 8 respectively.)

5. The budget submitted by the respondent shows the petitioner's income from [redacted] as $1,024.11 and self-employment income as $800, arriving at a total gross income of $1,824.11, when added together. The petitioner's Standard Filing Unit (SFU) size is three (3) including the petitioner and her two children. The Medically Needy Income Level (MNIL) for an SFU size of three (3) is $486, which was deducted from the petitioner's gross income of $1,824.11. This left the petitioner with a monthly SOC of $1,338 (Respondents' Exhibit 10.)

6. In January 2018, the petitioner reported a change to the respondent stating that her income from [redacted] has ended. The respondent terminated the petitioner's income from [redacted] effective the month of January 2018. (Respondents' Exhibit 7.)

7. The respondent recalculated the SOC for the petitioner after terminating the income from [redacted] in January 2018, and budgeting $800 from self-employment as the only income for the petitioner. The petitioner's Standard Filing Unit (SFU) size is three (3) including the petitioner and her two children. The Medically Needy Income Level (MNIL) for an SFU size of three (3) is $486, which was deducted from the petitioner's gross income of $800. This left the petitioner with the new monthly SOC of $314. (Respondents' Exhibit 9.)

8. The respondent enrolled the petitioner in the Medically Needy with an assigned SOC of $314 effective February 2018, and notified her of the same by issuing a NOCA on February 2nd, 2018. (Respondent's Exhibits 6 and 4 respectively.)

9. The respondent presented into evidence the "Family Related Medicaid Income Limit" chart which shows that for a family size of 3, the maximum income limit for a parent, caretaker, or children 19 & 20 to qualify for Medicaid is $303 a month. Once the applicant fails the $303 income threshold, the only applicable deduction available is a MNIL of $486, which the petitioner was afforded. No other expenses such as shelter, utilities, or dependent care (except allowable medical expenses) are allowed in the Medically Needy budget calculation. (Respondent's Exhibits 1 and 11.)

10. The respondent's business record shows a bill tracking was completed for the petitioner from [redacted] on January 4th, 2018, for the period of November 30th, 2017. (Respondent's Exhibit 13, page 43.)

11. The respondent notified the petitioner of her meeting the SOC for November 30th, 2017, by issuing a NOCA on January 5th, 2018. (Respondent's Exhibit 3.)

12. The respondent's business record shows another bill tracking was completed for the petitioner from [redacted] on February 23rd, 2018, for the period of January 3rd, 2018 to January 31st, 2018. (Respondent's Exhibit 13, page 39.)

13. The respondent notified the petitioner of her meeting the SOC on January 3rd, 2018, and for the reminder of the month by issuing a NOCA on February 26th, 2018. (Respondent's Exhibit 5.)

14. The petitioner contests the respondent enrolling her in the Medically Needy program with a SOC. The petitioner believes she should be eligible for Medicaid. The petitioner stated that she has medical needs including to pay for her [redacted], and other medical procedures, and the doctors do not accept the Medically Needy. The petitioner expressed difficulty in meeting the SOC, since it resets every month. Additionally, the petitioner states meeting the SOC for November 2017, in January 2018, is not doing her any good. The petitioner contends that the SOC should be processed in a current month, not in a month which had already passed.

15. The respondent stated that the petitioner's SOC has decreased from $1,338 to $314. The medical bills are tracked in the order it is incurred, and not all months would have

enough bills to meet the SOC. Depending on the petitioner's circumstances, there would be months when a SOC is met, and others when it is not. The respondent informed the petitioner to submit all medicals bills as they incurred.

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 § 120.80, Fla. Stat.

17. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

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

19. 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.

20. 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.

21. 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
3	**$303** *[emphasis added]* …

22. The above-cited authority sets forth the income level to qualify for full Medicaid. The undersigned reviewed the respondent's determination of the petitioner's gross income at the time of her application on October 31st, 2017. The findings show that respondent combined income from the four most recent paychecks the petitioner received from [redacted]. The respondent added (369.64+$194.56+290.18+169.73) to arrive at $1,024.11. The petitioner's income of $800 from self-employment was added to $1,024.11 to arrive at a total gross income of $1,824.11. The petitioner's gross income of $1,824.11 exceeds the income standard of $303 for a Standard Filing Unit (SFU) size of three (3.) Therefore, the petitioner was not eligible for full Medicaid. The undersigned did not find any errors in the respondent's calculations.

23. 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…

24. 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.

25. The above cited federal and state authorities explain Medically Needy provides coverage for individuals who do not qualify for full Medicaid due to income. The respondent must follow these guidelines when processing eligibility for Family Related Medicaid for an applicant. The evidence presented by the respondent shows that it followed the above-cited guidelines in determining whether the petitioner qualifies for full Medicaid or Medically Needy with a Share of Cost (SOC.)

26. The ACCESS Florida Program Policy Manual Appendix A-7, Family-Related Medicaid Income Limits chart sets forth a $486 Medically Needy Income Level (MNIL) for a household size of three (3.) The respondent subtracted the $486 MNIL from the petitioner's gross income of $1,824.11 to arrive at $1,338 as the remaining share of cost for the petitioner.

27. In January 2018, the petitioner reported termination of her income from [redacted], and the respondent redetermined eligibility for the petitioner's Medicaid. The petitioner's self-employment income of $800 still exceeded the Medicaid income standard of $303 for a Standard Filing Unit (SFU) size of three (3) (the petitioner and her two children), and the petitioner failed for Medicaid. The respondent then recalculated the petitioner's share of cost by subtracting the MNIL of $486, and arrived at the new share of cost of $314. The previous share of cost was $1,338.

28. The undersigned reviewed the respondent's determination of the petitioner's Medicaid eligibility at the time of application, and later when the change was reported, and did not find any errors in the determination. The undersigned also reviewed the share of cost assigned to the petitioner at the time of application ($1,338), and after the change was reported ($314), and did not find any errors in those calculations.

29. The petitioner's arguments were considered; however, 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, and the controlling legal authorities, the undersigned concludes that the respondent's action to enroll the petitioner in the Medically Needy Program and determine a share of cost of $1,338 initially, and $314 afterwards 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 ___23_ day of ___April_____, 2018,

in Tallahassee, Florida.

Sajan George
Hearing Officer
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Copies Furnished To: [redacted]
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 18F-00674

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 an administrative telephonic hearing in the above-referenced matter on March 19, 2018 at 1:34 p.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Stacy Ann Mills, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the termination of full Medicaid benefits and enrollment in the Medically Needy Program with an estimated share of cost (SOC) at recertification. The burden of proof was originally assigned to the petitioner. After further review, it is reassigned to the Department by a preponderance of evidence.

PRELIMINARY STATEMENT

The respondent presented six exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 6. The petitioner did not present any exhibits.

FINDINGS OF FACT

1. The petitioner was receiving full Medicaid from a prior application.

2. On January 5, 2018, the petitioner submitted a recertification application for SSI-Related Medicaid benefits. She is the only household member. The petitioner receives Social Security Disability Income (SSDI) of $819 and her Medicare Part B premium is paid by the state. She began receiving Medicare Part B in April 2017. The respondent determined she was ineligible for full Medicaid at her recertification, but was eligible for the Medically Needy Program with a share of cost.

3. The respondent denied full Medicaid and proceeded to determine eligibility in the Medically Needy Program. A $20 unearned income disregard was subtracted from her gross income of $819 resulting in the petitioner's countable income being $799. The medically needy income level (MNIL) of $180 was subtracted resulting in a SOC of $619.

4. On January 16, 2018, the respondent mailed a Notice of Case Action to the petitioner informing her that her application dated January 5, 2018 was approved. The notice informed her she was enrolled in the Medically Needy Program with an estimated SOC of $619 effective February 2018. The petitioner received her last month of full Medicaid in January 2018.

5. On January 25, 2018, the petitioner requested a hearing to challenge the respondent's action.

6. The petitioner does not dispute the gross income included in the Department's calculations. The petitioner argued that her income has not changed from when she was receiving full Medicaid.

7. The respondent explained that it did not count the petitioner's income in her prior recertification.

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, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

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

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

11. The Department's Program Policy Manual (Policy Manual), CFOP 165-22 at Appendix A-9, shows the income standard for full Medicaid benefits for an individual who is aged or disabled as $885 effective January 2018.

12. 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. (emphasis added)

13. The above authority explains that the full Medicaid for an aged or disabled person has an income limit of 88% of the federal poverty level and in addition to meeting that limit, the person **must not have Medicare**. The petitioner receives Medicare; therefore, she is not eligible to receive full Medicaid benefits even though her income is below the income limit of $885.

14. 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…"

15. Fla. Admin. Code R. 65A-1.702 (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."

16. Fla. Admin. Code R. 65A-1.701 (30) states, "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."

17. The methods of determining the share of cost for Medically Needy Program benefits is set forth in the Fla. Admin. Code R. 65A-1.713. It states:

> (1)(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 cost…

18. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, states, "Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: Size 1 Level $180."

19. The Policy Manual at passage 2440.0102 addresses 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.

20. The undersigned reviewed the respondent's budget calculations and the petitioner's reported income using the rules cited above and did not find a more favorable outcome other than the SOC assigned by the respondent. Eligibility for full Medicaid is not found.

21. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program with the estimated SOC of $619 is within the rules of the Program.

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 April, 2018,

in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
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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

[redacted]

APPEAL NO. 18F-00739
APPEAL NO. 18F-00741
APPEAL NO. 18F-00570

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88094

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 12, 2018 at 1:43 p.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Philippe Antoine, supervisor

STATEMENT OF ISSUE

The petitioner is appealing the Department's action to deny her application for Temporary Cash Assistance (TCA). The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

At the hearing, the respondent presented five exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 5. The petitioner did not

present any exhibits. There were two additional requests for hearings, appeals 18F-00570 for Supplemental Nutrition Assistance Program (SNAP) and 18F-00741 for Medicaid. Both issues were resolved and withdrawn on record. The only issue before the undersigned hearing officer is TCA.

FINDINGS OF FACT

1. On December 11, 2017, the petitioner submitted an application for Temporary Cash Assistance (TCA), Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits for herself. She was the only household member listed on the application. She was approved for expedited SNAP benefits and was required to comply with work requirements. She failed to comply and the SNAP benefits were terminated.

2. On January 2, 2018, the petitioner submitted a second application. On this application she listed herself, her husband and their five children. The petitioner's husband was employed with [redacted] and was paid on a weekly basis.

3. On January 22, 2018, the petitioner requested a hearing as she did not get an update from the respondent regarding her SNAP, TCA and Medicaid application for herself and family.

4. The respondent reviewed the petitioner's second application, her household income and expenses, and determined eligibility for TCA benefits. The respondent used the husband's wages in December 2017 and a conversion factor of 4.3 to determine the petitioner's household's gross monthly income. The household's gross monthly income was determined to be $1,057.71. A $90 standard deduction was subtracted resulting to $967.71. It was then compared to the TCA payment standard for

a household size of seven ($549) with a shelter expense of at least $50.01. The petitioner's monthly household income ($967.71) was over the TCA payment standard. She was found ineligible for TCA benefits.

5. On January 29, 2018, the respondent mailed a Notice of Case Action informing the petitioner that her TCA application was denied. The reason given for the denial was that her household's income was too high for the program.

6. At the hearing, the petitioner stated that her husband's income was determined incorrectly as the respondent used wages from her husband's old position. She argued that the respondent should have used her husband's new wages. The check with his new position was dated January 30, 2018 and it was for $184.38. Checks prior to January 30, 2018 were old wages or a combination of old wages and new wages and do not represent her husband's income accurately. She also argued that the respondent should not have used the gross pay as it is not the take home income. The petitioner also questioned the guidelines used to determine her household's TCA eligibility.

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. Fla. Admin Code R. 65A-4.209 states as follows:

> (1)Income is cash received at periodic intervals from any source such as wages, benefits, contributions, rental property, etc. Cash is money or an equivalent, such as a check, money order or other negotiable instrument. Income must be substantiated, verified or documented as a condition of eligibility for Temporary Cash Assistance (TCA) as in subsection 65A-1.205(5), F.A.C.
> (2) **To be financially eligible for TCA, the total average gross monthly income less any applicable disregards of the standard filing unit cannot exceed the applicable payment standard for the assistance group**. These standards and disregards are found in Sections 414.095(10) and (11), F.S. Monthly net income is calculated based on average gross monthly family income, earned and unearned, less any applicable disregards in accordance with Section 414.095(12)(a), F.S. The monthly amount of the TCA payment is determined by subtracting the monthly net income from the applicable payment standard.
> (b) Total gross monthly income includes earned and unearned income from all sources.
> (3) The Department considers only the income of the following individuals:
> (a) All standard filing unit members. (emphasis added)

10. Fla. Admin. Code R. 65A-1.716(2) sets forth that the maximum monthly Cash Assistance Program benefit for a household size of seven with rent expense of $50.01 or higher as $549.

11. The Code of Federal Regulations at 45 C.F.R. § 233.20, Need and amount of assistance, sets forth, “(v) In determining need and the amount of payments for AFDC, all income and resources of an individual required to be in the assistance unit…are considered available to the assistance unit…”

12. The Department’s Program Policy Manual, CFOP 165-22 at Appendix A-5 set forth the following income standards and payment standard for December 2017 ongoing.

Temporary Cash Assistance Income Standards					
			TIER I	TIER II	TIER III
			$50.01/UP	.01-$50	0
Filing Unit Size	185% of FPL	CNS (100 % of FPL)	Payment Standard	Payment Standard	Payment Standard
0.5	1,860	1,005	90	77	48
1			180	153	95
1.5	2,504	1,354	211	179	119
2			241	205	158
2.5	3,149	1,702	272	231	182
3			303	258	198
3.5	3,793	2,050	334	284	222
4			364	309	254
4.5	4,437	2,399	395	335	278
5			426	362	289
5.5	5,082	2,747	457	388	313
6			487	414	346
6.5	5,726	3,095	518	440	370
7			549	467	392

13. The respondent had determined the petitioner's household eligibility for TCA prior to her husband receiving his first check with his new position and the denial Notice of Case Action was mailed on January 29, 2018.

14. The undersigned consider de novo authority and re-determined eligibility for TCA using the husband's pay dated January 30, 2018 for $184.38. The household's income was converted from weekly to monthly by multiplying $184.38 by a conversion factor of 4.3 to get $792.83. A $90 standard deduction was subtracted which resulted to $702.83. This was then compared to the standard payment ($549) for seven people with a shelter expense of at least $50.01. The household's income was over the payment standard making the petitioner's household ineligible to TCA benefits.

15. In careful review of the cited authorities and evidence, the undersigned concludes the respondent's denial of TCA benefits due to excess income is within the rules of the Program and is 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 16 day of March, 2018, in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
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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

[redacted]

APPEAL NO. 18F-00798

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pasco
UNIT: 88267

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 21, 2018 at approximately 1:25 p.m. CST.

APPEARANCES

For the Petitioner: [redacted], *pro se*

For the Respondent: Ronege Alnord, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of January 16, 2018. At issue is whether the respondent's action denying full Medicaid benefits for the petitioner and her enrollment in the Medically Needy (MN) Program with a share of cost (SOC) are correct. 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 "10".

FINDINGS OF FACT

1. On January 12, 2018, the petitioner applied with the respondent by web application for cash assistance, SNAP (Supplemental Nutrition Assistance Program) benefits, and family Medicaid. The household consisted of the petitioner and her two minor daughters. At the eligibility determination interview held January 16, 2018, the petitioner reported that she did not intend to file taxes. This hearing pertains to the Medicaid determination for the petitioner. Her daughters are Medicaid eligible in a category different than hers (Respondent/Petitioner testimony and Respondent's Exhibit 2).

2. The application was approved for SNAP and family Medicaid January 16, 2018. The petitioner was enrolled in MN with a SOC. After a case review, the SOC was recomputed, resulting in the petitioner's SOC being $1,200 (Respondent's Exhibits 1 and 7).

3. The income used to reach the monthly gross income average and the calculation of SOC is as follows:

PAY DATE	GROSS EARNINGS
January 4, 2018	$520.00
January 11, 2018	$347.75
January 18, 2017	$396.50
January 25, 2018	$422.50
TOTAL	$1,686.75

$1,686.75 - $486 (MNIL for Household of 3) = $1,200 SOC. The respondent submitted income verification from The Work Number. The petitioner did not object to the veracity of the figures used to do the calculation (Respondent's Exhibit 7 and 8). The undersigned recognizes that Exhibit 7 shows the income amount used is $1,686.76 rather than $1,686.75 and that the $0.01 difference does not affect the outcome.

4. The petitioner states that she understands that there are Medicaid guidelines, protocols, and rules; however, without the support from full Medicaid eligibility she cannot afford medical treatment for her medical conditions [redacted] which are severe enough to cause her to regularly miss work; therefore, she believes she should be able to receive full Medicaid benefits.

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.

6. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

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

8. The Family-Related Medicaid income criteria is set forth in 42 C.F.R 435.603. 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.

9. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (f) defines a Household for Medicaid. It states:

> (3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—
> (i) The individual's spouse;
> (ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and
> (iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section.
> (iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—
> (A) Age 19; or
> (B) Age 19 or, in the case of full-time students, age 21.
> …
> (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.

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

11. In accordance with the above controlling authorities, the Medicaid household group is the petitioner and her two minor children (three members). The findings show the Department determined the petitioner's eligibility with a household size of three to determine her eligibility for Medicaid.

12. 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.

13. 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).

14. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit as $303 and a Standard Disregard of $183 for an adult with two minor children to be eligible for full Family-Related Medicaid Program. It also indicates the MNIL to be $486.

15. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner. Step 1: The total income counted in the budget is $1,686.76. Step 2: There are no deductions provided as there was no tax return. Step 3: The total income of $1,686.76 less the standard disregard of $183 is $1,503.76. Step 4: The balance of $1,503.76 is greater than the income limit of $303 for the mother with two minor children to receive full Medicaid for herself. Step 5: With no MAGI disregard applied, the countable balance remains $1,503.76. This amount was greater than the income limit of $303. The undersigned concludes that the petitioner is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored.

16. Fla. Admin. Code R. 65A-1.701 (30), Share of Cost (SOC), states: 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."

17. The Fla. Admin. Code R. 65A-1.703 explains MN income standards as follows:

> (6) Medically Needy. To be eligible for this coverage group the individual must meet the general requirements prescribed in Rule 65A-1.705, F.A.C.
> …
> (b) The following provisions apply to Medically Needy.
> 1. The individual or family must have income equal to or less than the respective Medically Needy income standards prescribed in subsection 65A-1.716(2), F.A.C. If income exceeds the Medically Needy income standards refer to subsection 65A-1.707(2), F.A.C. Refer to Rule 65A-1.713, F.A.C., for additional income criteria applicable to the Medically Needy Program.

18. The Fla. Admin. Code R. 65A-1.707(2) explains income in excess of the MNIL as follows:

> The department considers income in excess of the medically needy income level available to pay for medical care and services. Available income from a one month period is used to determine the amount of excess countable income available to meet medical care and services. To be allowable, a paid expense may not have been previously deducted from countable income during a period of eligibility. The department deducts allowable medical expenses which are not subject to third party payment while unpaid and still owed, or paid during the current month, 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 from countable income that exceeds the medically needy income level, as follows:
> (a) Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,
> (b) 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.

19. The Policy Manual at passage 2630.0502 Enrollment (MFAM) states:

> If an individual meets the Medically Needy Program's technical eligibility criteria, he is enrolled into the program. There is no income limit for enrollment. The individual is only eligible (entitled to Medicaid) when he has allowable medical bills that exceed the SOC.
> The income for an enrolled assistance group need not be verified. Instead, an estimated SOC is calculated for the assistance group. If after bill tracking, it appears the assistance group has met his "estimated" SOC, the unverified income must be verified before the Medicaid can be authorized. An individual is eligible from the day their SOC is met through the end of the month.

20. 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.

21. Effective January 2014, Appendix A-7 indicates that for the parent of two minor children the MNIL is $486.

22. To determine petitioner's SOC the respondent determined the petitioner's household monthly to be $1,686.76. The Medically Needy Income Level of $486 for a standard filing unit size of three was subtracted resulting to the petitioner SOC of $1,200 effective January 2018.

23. The hearing officer found that no exception to these calculations. It is concluded that a more favorable share of cost could not be determined. Eligibility for full Medicaid was not found. The petitioner has failed to meet her burden that she is eligible for full Medicaid.

DECISION

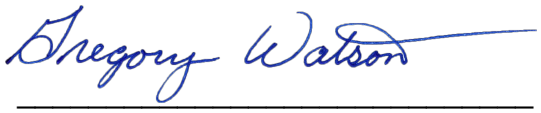
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

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 05 day of March, 2018,

in Tallahassee, Florida.



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OFFICE OF ECONOMIC SELF SUFFICIENCY

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

[redacted]

APPEAL NO. 18F-00859
APPEAL NO. 18F-02731

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Flagler
UNIT: 88882

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 4, 2018 at 10:31 a.m. at the respondent's facility located in [redacted].

APPEARANCES

For the Petitioner: The petitioner was present and represented herself.

For the Respondent: Stephanie Ross, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

ISSUE

At issue is the respondent's action on December 13, 2017 to deny the petitioner's application for Supplemental Nutrition Assistance Program (SNAP) benefits on its contention that her income is too high for the program.

Also at issue is the respondent's action on December 13, 2017 to deny the petitioner's application for Family-Related Medicaid on its contention that she did not meet the disability requirement.

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

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene telephonically on March 6, 2018 at 3:15 p.m.

On February 21, 2018, the petitioner contacted the Office of Appeal Hearings and requested to reschedule to an in-person hearing. The appeal was granted and was rescheduled to an in-person hearing on April 4, 2018 at 10:00 a.m.

The hearing convened as scheduled.

Appearing as an observer for the petitioner was her brother in law, [redacted]

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 April 4, 2018 to allow the respondent to provide additional evidence. The respondent submitted the additional evidence by email on April 4, 2018 at 7:48 p.m. The respondent notated that she was unable to submit the evidence by 5:00 p.m. on April 4, 2018 due to technical difficulties. Due to the respondent's technical difficulties, the undersigned allowed an extension of the deadline date. The evidence was received and entered as the Respondent's Exhibit 3.

The record was closed at 5:00 p.m. on April 5, 2018.

FINDINGS OF FACT

1. On November 29, 2017, the petitioner (age 52) completed an application for SNAP and Family-Related Medicaid benefits. The petitioner was the only household member listed on the application. The petitioner notated on the application that she is not disabled. The petitioner listed on her application that she is employed with [redacted] and earns $1846 every two weeks. The petitioner also listed that she is employed with [redacted] and earns $800 every two weeks (*Respondent's Exhibit 2, pages 14 through 19*).

2. On December 11, 2017, the Department mailed to the petitioner the Notice of Case Action (NOCA) to request verifications needed to determine her eligibility for SNAP benefits (*Respondent's Exhibit 2, pages 2 through 3*). The NOCA states:

> We need the following information by December 21, 2017...Proof of all gross income from the last 4 weeks using the "Verification of Employment/Loss of Income" form or you may send in your last 4 pay stubs…Please provide verification of most recent 4 weeks of gross income for [redacted] as reported on application from 11/29/17. If no longer working there please provide verification of loss of income/employment.

3. The respondent contends that the petitioner provided verification of her income from [redacted] but did not receive verification of income, or loss of income, from [redacted]. The Department contends that since the income, or loss of income, from [redacted] was not provided, it determined the petitioner's eligibility for SNAP benefits based on the information that was included on the petitioner's application. The Department included in the SNAP budget gross income

in the amount of $1702 from [redacted] and $3904 from [redacted], for a total gross income of $5624.40. The Department contends that the petitioner's income of $5624.40 exceeded the gross income limit in the amount of $2010 for a household size of one person. On December 13, 2017, the Department denied the petitioner's application for SNAP benefits on its contention that her gross income exceeded the gross income limit.

4. The Department explained that the petitioner's application for Family-Related Medicaid was denied, as she does not have a child under the age of 18, and because she listed on her application that she is not disabled; therefore, a disability determination was not completed. On December 13, 2017, the Department denied the petitioner's application for Family-Related Medicaid on its contention that she does not meet the disability requirement.

5. The petitioner disputes the denial of her application for SNAP benefits. The petitioner argues that she stopped working for [redacted] in February 2016. The petitioner contends that she informed the interviewer that she stopped working for [redacted] during the interview that was conducted on November 30, 2017. The petitioner contends that she believed that the Department would verify her information regarding terminated employment. The petitioner contends that she thought that the pay stubs she provided from [redacted] would prove that she was not working two jobs since she was employed full-time. The Petitioner's Exhibit 1 includes a memo dated February 19, 2016, from [redacted], which is addressed to the petitioner and states: "You are hereby

given notice that your employment is suspended…until the close of business on February 26, 2016, at which time your employment is terminated." The petitioner acknowledges that she did not submit the letter to the Department prior to the hearing date.

6. The petitioner does not dispute the income from [redacted], as she was paid $10 per hour at 40 hours per week. The petitioner explained that she is getting a raise and will be paid $10.35 per hour, for approximately $440 each week, or $880 paid biweekly. The petitioner contends that her mortgage is $598.54 each month. The petitioner contends that her property taxes are approximately $1500 each year and are not included in her mortgage. The petitioner contends that her homeowner's insurance is approximately $1000 each year and is not included in her mortgage. The petitioner contends that she lives alone and is not disabled.

7. The Department contends that the petitioner was pended for verification of income from [redacted], as the income was listed on her application and was not showing as terminated in its system. The Department explained that the Federal Data Services Hub verified that there was income from [redacted]. The Respondent's Exhibit 3 includes Transmittal No.: P-17-05-0010 (Transmittal), dated May 16, 2017, effective May 25, 2017, subject Federal Data Services Hub (FDSH) Medicaid Wage Verification (Full Launch) Revised. The Transmittal includes a sentence underlined by the Department, which states: "With this change, the FDSH will provide available earned income verification for applications, renewals, and requests for additional benefits when received electronically." The Transmittal includes another

sentence underlined by the Department, which states: “Income verified through FDSH is not considered verified upon receipt for the Food Assistance…and **must not** be used when determining eligibility for these programs…” The Department notated on the side of this sentence “**but client failed to provide verification requested.” The Department was not able to explain why the petitioner’s application for SNAP benefits was denied on December 13, 2017 but the pending NOCA gave the petitioner until December 21, 2017 to return verification of loss of income from [redacted]

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.

The Food Assistance Program denial will be addressed:

10. Fla. Admin. Code R. 65A-1.205 explains the eligibility determination process and states in part:

> Eligibility Determination Process:
> (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.

(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 (**emphasis added**).

11. Federal Regulations at 7 CFR § 273.2 Office operations and application processing states:

(5) *Notice of Required Verification.* The State agency shall provide each household at the time of application for certification and recertification with a notice that informs the household of the verification requirements the household must meet as part of the application process. The notice shall also inform the household of the State agency's responsibility to assist the household in obtaining required verification provided the household is cooperating with the State agency as specified in (d)(1) of this section. The notice shall be written in clear and simple language and shall meet the bilingual requirements designated in § 272.4(b) of this chapter. At a minimum, the notice shall contain examples of the types of documents the household should provide and explain the period of time the documents should cover.
(f) *Verification.* Verification is the use of documentation or a contact with a third party to confirm the accuracy of statements or information. The State agency must give households **at least 10 days** to provide required verification. Paragraph (i)(4) of this section contains verification procedures for expedited service cases (**emphasis added**).
(1) *Mandatory verification.* State agencies shall verify the following information prior to certification for households initially applying:
(i) *Gross nonexempt income.* Gross nonexempt income shall be verified for all households prior to certification. However, where all attempts to verify the income have been unsuccessful because the person or organization providing the income has failed to cooperate with the household and the State agency, and all other sources of verification are unavailable, the eligibility worker shall determine an amount to be used for certification purposes based on the best available information.
(2) *Verification of questionable information.*
(i) The State agency shall verify, prior to certification of the household, all other factors of eligibility which the State agency determines are questionable and affect the household's eligibility and benefit level. The State agency shall establish guidelines to be followed in determining what shall be considered questionable information.

> (5) *Responsibility of obtaining verification.* (i) The household has primary responsibility for providing documentary evidence to support statements on the application and to resolve any questionable information. The State agency must assist the household in obtaining this verification provided the household is cooperating with the State agency as specified under paragraph (d)(1) of this section.
> (3) *Denying the application.* Households that are found to be ineligible shall be sent a notice of denial as soon as possible but not later than 30 days following the date the application was filed. If the household has failed to appear for a scheduled interview and has made no subsequent contact with the State agency to express interest in pursuing the application, the State agency shall send the household a notice of denial on the 30th day following the date of application. The household must file a new application if it wishes to participate in the program. In cases where the State agency was able to conduct an interview and request all of the necessary verification on the same day the application was filed, and no subsequent requests for verification have been made, the State agency may also deny the application on the 30th day if the State agency provided assistance to the household in obtaining verification as specified in paragraph (f)(5) of this section, but the household failed to provide the requested verification.
> (C) In cases where verification is incomplete, the State agency must have provided the household with a statement of required verification and offered to assist the household in obtaining required verification and allowed the household sufficient time to provide the missing verification. Sufficient time shall be at least 10 days from the date of the State agency's initial request for the particular verification that was missing.

12. The above authorities explain that the Department is to complete an eligibility determination at application. The Department is responsible for notifying applicants of the required verifications to determine the applicant's eligibility for SNAP benefits. The Department is also responsible for assisting households in obtaining the necessary verifications. The household is responsible for providing the requested verifications. The Department must allow at least 10 days for households to provide requested verifications. An application may be denied on the 30th day from the date of the application if the Department has assisted the applicant in obtaining the required

verifications but the applicant has not cooperated. If verifications are incomplete, the Department **must** provide the household with a statement of the required verifications that are missing, assist the household in obtaining the verifications, and allow 10 days from the date of the initial request for the missing verifications.

13. The Department argues that because the petitioner was mailed the NOCA requested verification of loss of income from [redacted] but failed to provide the verification, it used the income included on her application to deny her for SNAP benefits due to her gross income exceeding the SNAP income limit for a household size of one person. The petitioner provided verification of loss of income from [redacted] during the hearing and acknowledges that she did not provide the missing verification to the Department prior to the hearing. The findings show that the petitioner was issued the NOCA on December 11, 2017 to provide verification of terminated employment from the [redacted] by December 21, 2017. The findings show that the petitioner's application dated November 29, 2017 was denied on December 13, 2017, which was before the due date for the verifications to be submitted. Although the petitioner acknowledges that she did not provide the missing verification until the hearing, the undersigned concludes that the Department prematurely denied the petitioner's November 29, 2017 application for SNAP benefits. Based on the above authorities and the evidence presented during the hearing, the undersigned concludes that the Department did not allow the petitioner at least 10 days to provide the verification (loss of income from [redacted] needed to determine her eligibility for SNAP benefits before the denial of her

application on December 13, 2017. The undersigned further concludes that the Department did not issue a statement to the petitioner to inform her of any missing verifications and did not allow a sufficient amount of time to provide any missing verifications.

14. In careful review of the cited authorities and evidence, the undersigned concludes that the Department was incorrect in its denial of the petitioner's November 29, 2017 application for SNAP benefits. Therefore, the Department is remanded with instructions to determine the petitioner's eligibility for SNAP benefits, to not include the petitioner's terminated income from [redacted], from the date of the November 2017 application.

<u>The denial of the petitioner's application for Family-Related Medicaid will now be addressed:</u>

15. Fla. Admin. Code R. 65A-1.705, "Family-Related Medicaid General Eligibility Criteria" states in relevant part:

> (7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested. A fully deprived child is one who is not living with either birth parent due to reasons such as death, abandonment or incarceration. The following are illustrations of SFU determinations: … (c) …**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.

16. The above controlling authorities state that there must be at least one child under age 18 in the household for the parent to eligible for coverage in the Family-Related Medicaid program. The findings show that the petitioner lives alone; therefore, the petitioner does not have a child under the age of 18 residing in her home.

17. The findings show that the petitioner is not disabled and did not apply for SSI-Related Medicaid. Therefore, the undersigned concludes that the Department was correct to not forward the petitioner's application to the DDD for review.

18. Based on the findings and the above controlling authorities, the undersigned concludes the Department correctly determined petitioner was not eligible for Medicaid in the Family-Related program, as there was no child in the household under the age of 18 from which she would derive eligibility for the program.

DECISION

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

The appeal is granted in that the Department was incorrect to deny the petitioner's application dated November 29, 2017 for SNAP benefits. Therefore, the Department is remanded with instructions to complete an eligibility determination and issue written notice, to include appeal rights, once the determination is made.

The appeal is denied in that the Department's action to deny the petitioner's application for coverage under the Family-Related Medicaid program is correct.

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 __20__ day of __April_____, 2018,

in Tallahassee, Florida.

Paula Ali
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]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Sumter
UNIT: 88007

RESPONDENT.
_____/

APPEAL NO. 18F-00865

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on March 7, 2018 at 8:30 a.m.

APPEARANCES

For Petitioner: [redacted], pro se

For Respondent: Sylma Dekony, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner appeals Respondent's action denying her Medicaid Disability application dated December 26, 2017. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Petitioner did not submit any exhibits. Respondent submitted an evidence packet consisting of nine exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" – "9." The record closed on March 7, 2018.

FINDINGS OF FACT

1. On December 26, 2017, Petitioner, age 45, submitted an on-line application for Medicaid Disability for herself (Respondent's Exhibit 3). Petitioner's Medicaid Disability denial is the only issue.

2. Petitioner described her disabling conditions as [redacted] (Respondent's Exhibit 5, Page 2).

3. On June 20, 2016, Petitioner applied for disability through the Social Security Administration (SSA) (Respondent's Exhibit 6).

4. On August 12, 2016, the SSA denied Petitioner's disability application with denial code N32, which means "capacity for substantial gainful activity, other work, no visual impairment" (*Id*.).

5. Petitioner is appealing the SSA denial through an attorney; an appeal hearing has not yet been scheduled as of the date of this hearing (Petitioner's Testimony).

6. Petitioner reported on her December 26, 2017 Medicaid Disability application that her health condition had not changed since the August 12, 2016 SSA disability denial (Respondent's Exhibit 3, Page 5).

7. Respondent did not make an independent disability decision on Petitioner's Medicaid Disability application. Instead, it adopted the SSA decision and denied Petitioner's application based on that decision, as she did not meet the technical requirements of age (at least 65) or disability (Respondent's Exhibit 7, Page 3).

8. On January 2, 2018, Respondent mailed Petitioner a Notice of Case Action notifying that her December 26, 2017 Medicaid Disability application was denied, with

the reason that no household members meet the disability requirement (Respondent's Exhibit 2, Page 2).

9. Petitioner did not claim to have new or worsened medical conditions that the SSA was unaware of, as she did not have the finances to seek medical evaluation to determine whether she has any new or worsened medical conditions (Petitioner's Testimony).

10. Petitioner argued that when the SSA denied her disability she received a notice that indicated she may be eligible for state Medicaid (Petitioner's Testimony).

11. Respondent argued that Petitioner could be eligible for state Medicaid if SSA denied her disability application for being over assets or income (Respondent's Testimony). However, SSA denied Petitioner's disability application based on a determination that she is not disabled, rather than being over assets or income (*Id*.).

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 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.

13. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

14. 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…

15. 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.
> …

16. The above authority explains that the SSA determination is binding on the Department. Federal regulation prohibits Respondent from making an independent determination of disability if SSA has already made a disability determination. Respondent is bound by the federal agency's decision until it changes its decision, or there is evidence of a new disabling condition not reviewed by SSA that it refuses to consider.

17. In accordance with the above authority, Respondent denied Petitioner's December 26, 2017 Medicaid Disability application, due to adopting the SSA denial decision.

18. Petitioner is appealing the August 12, 2016 SSA denial through an attorney and has no new or worsened medical conditions that the SSA is unaware of.

19. In careful review of the cited authority and evidence, the undersigned concludes that Petitioner did not meet the burden of proof to indicate Respondent incorrectly denied her December 26, 2017 Medicaid Disability application. The undersigned

concludes Respondent's action denying Petitioner's December 26, 2017 Medicaid Disability application is proper.

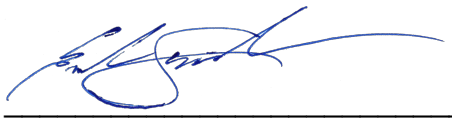
DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED. 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 __April_____, 2018, in Tallahassee, Florida.



Erik Swenk, Esq.
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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

[redacted]

APPEAL NO. 18F-00922

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 13 Hillsborough
UNIT: 88692

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on April 3, 2018 at 10:42 a.m.

APPEARANCES

For Petitioner: [redacted] pro se

For Respondent: Roneige Alnord, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate the petitioner's full SSI-Related Medicaid benefits and enroll her in the Medically Needy (MN) program with a monthly share of cost (SOC) amount effective November 1, 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 petitioner presented one witness who testified: [redacted], the petitioner's husband. The respondent was represented by Roneige Alnord, Economic Self Sufficiency Specialist II, with the Department of Children and Families ("DCF" or "Agency" or "respondent"). Mr. Alnord testified. The respondent submitted eight exhibits at the hearing, which were marked and entered as Respondent's Exhibits "1" – "8".

FINDINGS OF FACT

1. On October 23, 2017, the petitioner completed a recertification application for Supplemental Nutritional Assistance Program (SNAP) and SSI-Related Medicaid benefits. SNAP benefits are not an issue under appeal. The household consisted of the petitioner and her husband and their Social Security Disability Insurance (SSDI) as their only source of income. The petitioner's SSDI amount was $611 (gross) per month and her husband's SSDI amount was $1,081 (gross).

2. On November 1, 2017, during a reported change, the respondent terminated the petitioner's full SSI-Related Medicaid benefits and enrolled her in the SSI-Related MN Medicaid benefits with a monthly SOC amount.

3. The respondent determined the petitioner's MN estimated SOC amount as $1,431 effective November 2017 through December 2017 as follows:

$1692.00	petitioner and her husband's SSDI incomes
-$ 20.00	unearned income disregard
$1672.00	total countable unearned income

$1672.00	total countable income
-$ 241.00	MNIL for a household of two
$ 1431.00	estimated share of cost

4. On November 2, 2017, the respondent mailed the petitioner a Notice of Case Action indicating she was approved for MN with an estimated monthly SOC amount of $1,431 effective November 1, 2017 and ongoing.

5. Effective January 2018, the petitioner's SSDI amount increased to $624 (gross) per month. The petitioner does not receive Medicare Part A and B. The petitioner's husband's SSDI amount increased to $1,102 (gross) per month. He receives Medicare Part A and B and the respondent pays his monthly Medicare premium.

6. The respondent re-determined the petitioner's MN estimated SOC amount as $1,464 effective January 2018 and ongoing as follows:

$1725.00	petitioner and her husband's SSDI incomes
-$ 20.00	unearned income disregard
$1705.00	total countable unearned income

$1705.00	total countable income
-$ 241.00	MNIL for a household of two
$ 1464.00	estimated share of cost

7. The respondent determined that since the petitioner's husband is eligible for SSI-Related Medicaid benefits, his SSDI income must be included in the determination of the petitioner's monthly SOC amount.

8. The petitioner does not agree with the respondent's determination that she is not eligible for full SSI-Related Medicaid benefits as she is not able to pay for all of her medical expenses as well as all of her household expenses.

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 and her husband are eligible for the SSI-Related Medicaid programs as they are considered disabled.

13. 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…

14. Pursuant to the above authority, the petitioner and her husband's SSDI incomes are considered included income in the determination of their eligibility for full SSI-Related Medicaid benefits.

15. 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.

16. 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."

17. Effective November 2017 through March 2018, the Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for a couple for MEDS-AD as $1,191.

18. Effective April 2018 and ongoing, the Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for a couple for MEDS-AD as $1,208.

19. Pursuant to the above authority and policies, the petitioner and her husband's monthly SSDI incomes ($1,725 or $1,102 + $624) exceed the Medicaid income standard for them to receive full SSI-Related Medicaid benefits.

20. 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 she was correctly enrolled in

the SSI-Related Medically Needy Program with a monthly share of cost amount

effective November 1, 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 __18__ day of __April_____, 2018,

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. 18F-00982

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 a telephonic administrative hearing in the above-referenced matter on April 12th, 2018, at 8:30 a.m.

APPEARANCES

For the Petitioner: [redacted]r, pro se.

For the Respondent: Shalonda Hill, Supervisor for the Economic Self-Sufficiency Program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action of September 28th, 2017 to deny her application for Medicaid. The petitioner is also appealing the respondent's action of April 2nd, 2018 to enroll her family in the Medically Needy program with an assigned Share of Cost (SOC.) The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents for the hearing.

The respondent's exhibits 1 through 12 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated September 28th, 2017, the respondent notified the petitioner that her Medicaid application dated August 28th, 2017 is denied due to the household's income being too high to qualify for the program. (Respondent's Exhibit 4.)

By way of a Notice of Case Action (NOCA) dated April 2nd, 2018, the respondent notified the petitioner that, "your application for Medically Needy dated March 22nd, 2018, is approved. You are enrolled with an estimated share of cost for the months of March, April, May 2018 and ongoing months for a Share of Cost of $3,298." (Respondent's Exhibit 10.)

On February 7th, 2018, the petitioner requested an appeal to challenge the respondent's action to deny her Medicaid.

Prior to addressing the merits of the case, it is necessary to determine whether or not the appeal was filed timely.

FINDINGS OF FACT

1. The above-mentioned notice dated on September 28th, 2017, was issued to the mailing address reported by the petitioner on the application at: [redacted], which was the petitioner's address on record at the time. The notice informs the petitioner of the respondent's action. The notice also informs the petitioner that she has a

right to ask for a fair hearing, but that the hearing must be requested within ninety (90) days from the date of the notice. (Respondent's Exhibit 4.)

2. The petitioner stated she received the notice and made subsequent calls to the Customer Call Center (CCC) regarding Medicaid eligibility for the household. The petitioner's most recent call on this issue occurred on February 7th, 2018, the date she filed this appeal. This date is beyond the 90-day time limit of the September 28th, 2017 NOCA, which would have been December 26th, 2017. Therefore, due to regulations cited below, the issue of the denial of the August 28th, 2017 application is not within the undersigned's jurisdiction, and will not be further addressed.

3. On March 22nd, 2018, the petitioner reapplied for Medicaid for the same household, listing herself and her two daughters; thirteen-year-old "JW", and nine-year-old "KW." (Respondent's Exhibit 5.)

4. On the application, the petitioner reported earned income from her employment with [redacted]. The petitioner reported the amount of pay as $1,800 paid twice a month. The application shows the State Wage Information Collection Agency (SWICA) verified her monthly income as $3,730.76. The petitioner reported that she is [redacted]. (Respondent's Exhibit 5, pages 32 and 33.)

5. As for expenses, the petitioner listed expenses for rent and utilities, and medical expenses for her daughter "KW." (Respondent's Exhibit 5, pages 34 and 35.)

6. On March 23rd, 2018, the respondent issued a NOCA to the petitioner, requesting to have a phone interview, and to provide proof of all gross income from the last four weeks, no later than April 2nd, 2018. (Respondent's Exhibit 6.)

7. On March 26th, 2018, the respondent issued another NOCA to the petitioner, requesting to provide proof of all gross income from the last four weeks, and proof of medical expenses no later than April 5th, 2018. (Respondent's Exhibit 7.)

8. On March 29th, 2018, the petitioner provided four most recent paystubs as verification of her earned income. The paystubs, dated 02/09/2018; 02/23/2018, 03/09/2018, and 03/23/2018 show consistent rate of pay in the gross amount of $1,941.74. (Respondent's Exhibit 8.)

9. The respondent's business record shows it used the petitioner's payments received on 02/09/2018 for $1,941.74 and on 02/23/2018 for $1,941.74 as representative. (Respondent's Exhibit 11, page 62.) The respondent added the two paystubs of $1,941.74 to arrive at a monthly total of $3,883.48, and budgeted the amount as the petitioner's monthly income. (Respondent's Exhibit 9.)

10. Using the program policy guidelines related to Medicaid, and the Family Related Medicaid Income Limits chart, the respondent determined the petitioner's Medicaid eligibility. Since the petitioner is now reported as [redacted], the Standard Filing Unit (SFU) size increased from three (3) to four (4.) The income chart shows in order to qualify for Medicaid, the income limit for a family size of four is set at $364. Since the petitioner's income is $3,883.48, she failed the Medicaid income test. The respondent then tested the petitioner's children for

Medicaid. The income standard for children aged 6 through 18 for a family size of three (3) is set at $2,304, and for four (4) at $2,782. The petitioner's children are between the ages of six (6) and 18, and both children failed the Medicaid income test. (Respondent's Exhibit 12.)

11. On March 30th, 2018, the respondent processed the petitioner for Family Related Medically Needy coverage. The Medically Needy Income Level (MNIL) for a Standard Filing Unit (SFU) size of four (4) is $585. The respondent deducted $585 from the petitioner's countable net income of $3,883.48 to arrive at a Share of Cost (SOC) of $3,298, and enrolled her both children in the Medically Needy program. Since the petitioner [redacted], she is enrolled in the [redacted] Medicaid (MM P.) (Respondent's Exhibit 9.)

12. On April 2nd, 2018, the respondent issued a NOCA to the petitioner stating, "your application for Medically Needy dated March 22nd, 2018 is approved. You are now enrolled with an estimated share of cost for the months listed below: March, April, May 2018 and ongoing; Share of Cost: $3,298." (Respondent's Exhibit 10.)

13. The petitioner's application dated March 22nd, 2018, was submitted after the hearing request was made. The petitioner's daughter "KW" has medical needs, and the family cannot afford to meet the monthly SOC of $3,298. The petitioner stated that her daughter used to receive Medicaid from Social Security Administration, however, the daughter lost her coverage due to the petitioner's income.

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 § 120.80, Fla. Stat.

15. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

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

17. Fla. Admin. Code 65-2.046, sets forth time limits in which to request a hearing and states in part:

> (1) The appellant or authorized representative must exercise their right to appeal within 90 calendar days in all programs…The time period begins with the date following:
>
> (a) The date on the written notification of the decision on an application.
>
> (b) The date on the written notification of reduction or termination of program benefits.
>
> (c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.
>
> (2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.

18. The evidence shows that the respondent issued the NOCA to the petitioner's mailing address reported on the application. The notice was issued on Septermber 28th, 2017, notifying the petitioner of the denial of her Medicaid application dated August 28th, 2017. The notice informed the petitioner of her right to file for a hearing, but that the request must be received within 90 days of the date the notice was issued. The findings establish that the petitioner called the respondent after receiving the notice to discuss eligibility. The filing date

of February 7th, 2018, is beyond the 90-day time limit to request a hearing on the denial, and therefore, not within the jurisdiction of the undersigned hearing officer. Therefore, this portion of the appeal is hereby dismissed.

19. Fla. Admin. Code R. 65-2.056 set forth the basis of hearings, and states:

> The hearing shall include consideration of:
>
> (1) Any Department action, or failure to act with reasonable promptness, on a claim of financial assistance, social services, medical assistance, Temporary Assistance of Needy Families (TANF), or Supplemental Nutrition Assistance Program (SNAP) benefits, which includes delay in reaching a decision on eligibility in both initial and subsequent determination, or in making a payment, the amount of payment, change in payments, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.
>
> (2) The hearing officer must determine whether the Department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the Department in making its decision.

20. The above-cited authority grants a hearing officer jurisdiction on issues based on *de novo* evidence. The petitioner reapplied for benefits on March 22nd, 2018; after the hearing request was filed, but before the hearing was conducted. This grants the hearing officer juridsciton to address the merits of the case, based on the application submitted by the petitioner on March 22nd, 2018, and the subsequent action(s) by the respondent, and the issuance of the NOCA on April 2nd, 2018.

21. 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.

22. 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.

23. 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 |
> | 3 | $303 |
> | **4** | **$364** *[emphasis added]* … |

24. The above-cited authority sets forth the income level to qualify for full Medicaid. The undersigned reviewed the respondent's determination of the petitioner's gross income, which

was provided for her application on March 22nd, 2018. The petitioner provided four (4) bi-weekly paystubs dated: 02/09/2018; 02/23/2018, 03/09/2018, and 03/23/2018 on March 29th, 2018. The respondent should have used the most recent two paystubs dated 03/09/2018 and 03/23/2018, however it used the paystubs for 02/09/2018 and 02/23/2018. It did not make a difference however, since the petitioner's income is steady and all four paystubs are representative. The evidence shows that the respondent added $1,941.74 each from the two bi-weekly paystubs received on 02/09/2018 and 02/23/2018 to arrive at a gross monthly income of $3,883.48. The petitioner's gross income of $3,883.48 exceeds the income standard of $364 for a Standard Filing Unit (SFU) size of four (4.) Therefore, the petitioner was not eligible for full Medicaid. The undersigned did not find any errors in the respondent's calculations.

25. 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…

26. 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.

27. The above cited federal and state authorities explain Medically Needy provides coverage for individuals who do not qualify for full Medicaid due to income. The respondent must follow these guidelines when processing eligibility for Family Related Medicaid for an applicant. The evidence presented by the respondent shows that it followed the above-cited guidelines in determining whether the petitioner qualifies for full Medicaid or Medically Needy with a Share of Cost (SOC.)

28. The ACCESS Florida Program Policy Manual Appendix A-7, Family-Related Medicaid Income Limits chart sets forth a $585 Medically Needy Income Level (MNIL) for a household size of four (4.) The respondent subtracted the $585 MNIL from the petitioner's gross income of $3,883.48 to arrive at $3,298 as the remaining share of cost for the petitioner.

29. The undersigned reviewed the respondent's determination of the petitioner's enrollment in the Medically Needy Program, and did not find any error in the eligibility determination. The undersigned also reviewed the respondent's calculation of the petitioner's assigned share of cost of $3,298, and did not find any errors in those calculations.

30. The petitioner's arguments were considered; however, 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, and the controlling legal authorities, the undersigned concludes that the respondent's

action to enroll the petitioner in the Medically Needy Program and determine a share of cost of $3,298 was within the rules of the program.

DECISION

Based upon the foregoing Findings of Fact and the Conclusions of Law, the undersigned rules as follows:

A. As to the issue of the September 28th, 2017 denial of the Medicaid application dated August 28th, 2017, the request for hearing was not filed timely, and therefore, the appeal is dismissed as non-jurisdictional.

B. As to the issue of the April 2nd, 2018 enrollment of Medically Needy with share of cost of $3,298, 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 __24__ day of __April_____, 2018,

in Tallahassee, Florida.

Sajan George
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. 18F-01053

PETITIONER,

Vs.

CASE [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 12 Sarasota
UNIT: 88326

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, on March 9, 2018, at 10:18 a.m., the undersigned convened a telephonic administrative hearing in the above-referenced matter. All parties appeared by telephone from different locations.

APPEARANCES

For the Petitioner: [redacted], Benefits Coordinator

For the Respondent: Teshia Green, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is the Respondent's decision to deny the Petitioner's application for the Medically Needy Medicaid Program due to assets in excess of program limits. The Petitioner holds the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The Respondent submitted nine exhibits which were accepted into the record and marked as Respondent's Exhibits "1" through "9". The record was held open for the Petitioner to submit the bank statement for the month in question. The bank statement was received on March 19, 2018 and entered into the record as Petitioner's Exhibit 1. The record was closed on March 19, 2018.

Leonard Jackson, Hearing Officer with the Office of Appeal Hearings was present as an impartial observer without any objections.

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 December 21, 2017, a web application for SSI-Related Medicaid was submitted on the Petitioner's behalf, *see* Respondent's Exhibit 3.

2. The Petitioner, [redacted], is 52 years old. Her household consists of herself, her husband, [redacted], and her 20 year old son, [redacted], *see* Respondent's Exhibit 4.

3. The Petitioner is not aged or blind and has not been determined disabled by the Social Security Administration or the Division of Disability Determinations, *Ibid.*

4. On January 10, 2018, the Department via a Notice of Case Action informed the Petitioner that her application for Medically Needy Medicaid (MN) was approved for her son with a Share of Cost of $6, 253, *see* Respondent's Exhibit 4.

5. On January 10, 2018, a second Notice of Case Action was mailed to the Petitioner notifying her that she, her husband and her son were ineligible for MN due to the value of their assets, *see* Respondent's Exhibit 4.

6. On January 24, 2018, a timely appeal of this decision was filed with the Office of Appeal Hearings.

7. The Petitioner and her husband are owners of [redacted]), an income driven business asset, *see* Respondent's Exhibit 9.

8. The monthly balance in the business checking account, after all expenses were paid, exceeded $20,000. The balance in the business checking account on November 1, 2017 (month in question) was $37,924.13. The ending balance, after salaries and expenses were paid for the month, was $24,687.11, *see* Respondent's Exhibit 9 & Petitioner's Exhibit 1.

9. The Petitioner has access to the business checking account. The Petitioner and her husband are the "sole members" of the LLC, *see* Respondent's Exhibit 9.

10. The Petitioner believes that the business account should be excluded from the household's budget as the funds are designated for business purposes only.

11. The Respondent asserts that the business checking account does not meet an exclusion in policy. The Respondent asserts that her Program Office reviewed the information and confirmed that the checking account does not meet an exclusion.

12. The balance in the business checking account on November 1, 2017 (month in question) was $37,924.13. The ending balance, after salaries and expenses were paid for the month, was $24,687.11, *see* Respondent's Exhibit 9 & Petitioner's Exhibit 1.

13. The Petitioner sets forth that the account's balance must stay at that level to maintain the business' solvency and that those funds are solely for the business expenses, *see* Respondent's Exhibit 9.

14. The asset limit for a couple is $6,000, *see* Respondent's Exhibit 7. .

15. The ending balance of $24,687.11 - $6,000 asset limit for a couple = $18,687.11 in excess over the asset limit, *see* Petitioner's Exhibit 1.

16. The Petitioner believes that the respondent denied the application for Medically Needy benefits in error.

CONCLUSIONS OF LAW

17. Pursuant to Section 409.285, Florida Statutes, the Department of Children and Families' Office of Appeal Hearings has jurisdiction over this proceeding.

18. This order is the final administrative decision of the Department of Children and Families pursuant to Section 409.285(2), Florida Statutes.

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

20. Fla. Admin. Code R. 65A-1.710(5) defines a Medically Needy Program as, "A Medicaid coverage group, as allowed by 42 U.S.C. 139a and §1963d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources.

21. According to 65A-1.712 SSI-Related Medicaid Resource Eligibility Criteria (e) For Medically Needy, an individual or couple cannot have resources exceeding the applicable Medically Needy resource limit set forth in subsection 65A-1.716(3), F.A.C.

(3) The resource limits for the Medically Needy program are as follows:

Family Size	Monthly Asset Level
1	$5,000
2	$6,000
3	$6,000
4	$6,500
5	$7,000
6	$7,500

7	$8,000
8	$8,500
9	$9,000
10	$9,500

For each additional person add $500….

22. In this instant case, the Department maintains that the Petitioner's uncontested balances in their business account is in excess of the $6,000 limit for couples, and would disqualify the Petitioner from participation in the Medically Needy Program, if no exclusions apply.

23. The Fla. Admin. Code R. 65A-1.303, Assets states in pertinent parts:

> (1) Specific policies concerning assets vary by program and are found in federal statutes and regulations and Florida Statutes.
> (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. **(emphasis mine)**

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

> …
> (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).

25. Federal Regulations at 20 C.F.R. § 416.1210 “Exclusions from resources; general” states:

> In determining the resources of an individual (and spouse, if any), the following items shall be excluded:
> (a) The home (including the land appertaining thereto) to the extent its value does not exceed the amount set forth in §416.1212;
> (b) Household goods and personal effects as defined in §416.1216;
> (c) An automobile, if used for transportation, as provided in §416.1218;
> (d) Property of a trade or business which is essential to the means of self-support as provided in §416.1222;
> (e) Nonbusiness property which is essential to the means of self-support as provided in §416.1224;
> (f) Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support as provided in §416.1226;
> (g) Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act (see §416.1228);
> (h) Life insurance owned by an individual (and spouse, if any) to the extent provided in §416.1230;
> (i) Restricted allotted Indian lands as provided in §416.1234;
> (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 as provided in §416.1237;
> (l) Burial spaces and certain funds up to $1,500 for burial expenses as provided in §416.1231;
> (m) Title XVI or title II retroactive payments as provided in §416.1233;
> (n) Housing assistance as provided in §416.1238;
> (o) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit, as provided in §416.1235;
> (p) Payments received as compensation for expenses incurred or losses suffered as a result of a crime as provided in §416.1229;
> (q) Relocation assistance from a State or local government as provided in §416.1239;

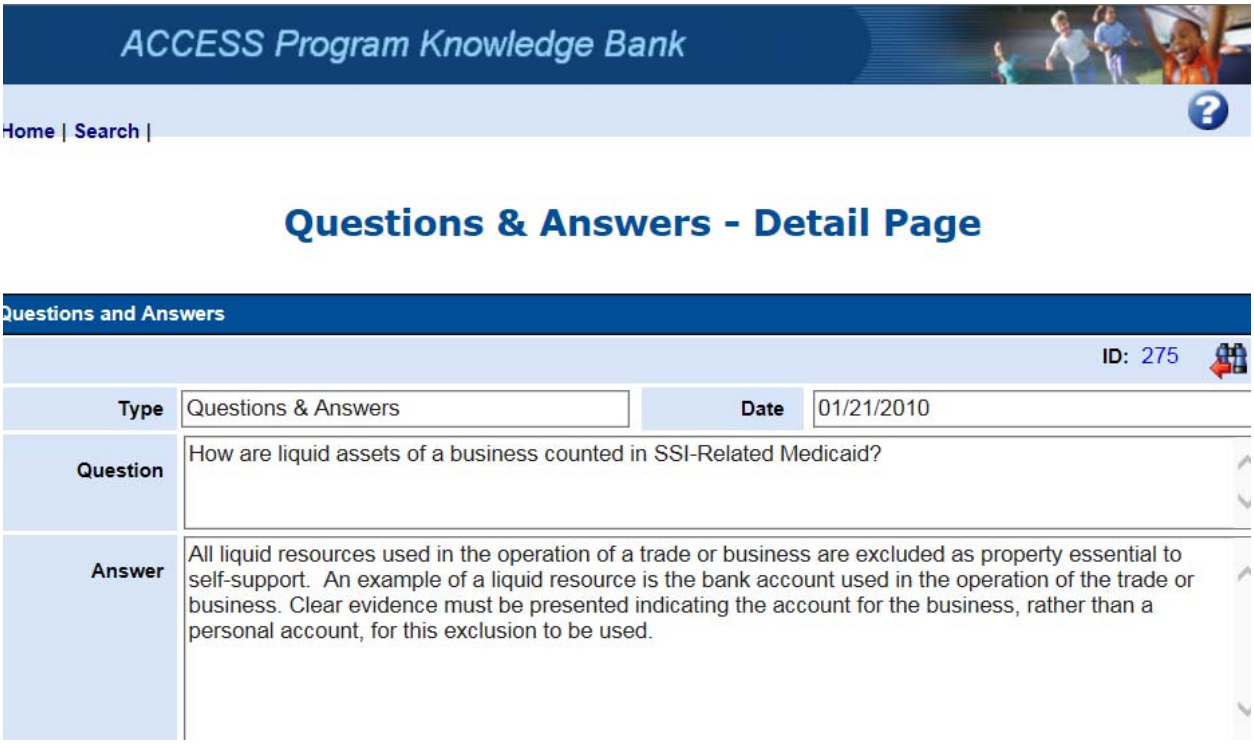
26. Based on the requirements of the above regulations, the asset’s ownership has been established as belonging to the Petitioner and her husband. Both have access to the funds but have established through oral and documentary evidence that the funds are solely used for business purposes.

27. The findings show that the [redacted] business account at Bank of America could be considered essential to self-support and thus considered excluded resources.

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

> (f) **Property that is essential to the individual's self-support shall be excluded from resources if it is producing income available to the individual which is consistent with its fair market value.** This includes real and personal property used in a trade or business; non-business income-producing property; and property used to produce goods or services essential to an individual's daily activities. **Liquid resources other than those used as part of a trade or business are not property essential to self-support. (Emphases mine)**

29. According to the Question and Answer section of the Department's online Knowledge Bank, the liquid resources in the bank account are property considered "essential to self-support" and may be excluded if verification is provided.



30. The Petitioner provided the business records and the bank statement to verify that the funds are used for the business only and that the funds are needed to sustain the business. The Petitioner provided clear evidence that the account is a business and not a personal account. The evidence shows that the business bank account meets the criteria for exclusion as a resource.

31. The undersigned concludes that the Petitioner's business account meets this exclusion and the Department is therefore prohibited from counting the liquid assets in the business bank account as funds available to the Petitioner.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is **GRANTED**. The Department's denial action is reversed. The Department is to take corrective action and determine the petitioner's eligibility on all factors for the month of November 2017 ongoing. The Department is to issue a notice once the corrective action is taken, giving 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 __24__ day of __April_____, 2018,

in Tallahassee, Florida.

Ursula Lett-Robinson
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

[redacted]

APPEAL NO. 18F-01152
18F-01153

PETITIONER,

Vs.

CASE NO. [redacted]

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on March 13, 2018 at 8:46 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Roneige Alnord
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to approve $20 in Supplemental Nutrition Assistance Program ("SNAP") benefits at recertification for March 2018 and ongoing is correct. Also at issue is whether the respondent's action to deny both adult household members full Medicaid and instead enroll them in the Medically Needy

Program with a share of cost ("SOC") is proper. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

[redacted], the petitioner's wife, was present and provided testimony.

The petitioner submitted no exhibits. The respondent submitted a packet of documents which was marked and entered as Respondent's Exhibit "1" through "11." The record was left open through March 16, 2018, for the respondent to provide additional information including the Notice of Case Action ("NOCA") for March 2018 benefits, the Work number verification and Medicaid budget screens. On March 13, 2018, the above-mentioned information was received, marked and entered as Respondent's Exhibits "12" through "19." The record was closed the same day.

FINDINGS OF FACT

1. On January 10, 2018, the petitioner recertified for SNAP assistance and applied for additional benefits Medicaid (Resp. Exh. 2).

2. The household consists of two adults and two children. The petitioner is currently employed at [redacted] and paid biweekly and both children receive Supplemental Security Income ("SSI") of $740 a month. There are monthly household expenses of rent $1300, electric $80-100 and phone of $30.

3. On January 16, 2018, the respondent mailed a NOCA to the petitioner stating that verification of all gross income from the last four weeks was needed by January 26, 2018 (Resp. Exh. 3).

4. On February 2, 2018, the respondent received one paystub from the petitioner dated January 11, 2018 in the amount of $695.36 (Resp. Exh. 5). The respondent used

this paystub as the best available information to determine SNAP and Medicaid benefits for the household. The respondent verified the SSI income of $740 a month for each child through the State Online Query (Resp. Exh. 4).

5. On February 5, 2018, the respondent mailed a NOCA to the petitioner stating that SNAP benefits will decrease from $12 to $6 a month effective March 2018 through July 2018 and that [redacted] were both enrolled in a SOC of $805 per month (Resp. Exh. 6).

6. On February 12, 2018, the petitioner timely requested a hearing.

7. On February 19, 2018, the respondent reviewed the hearing request and was able to access gross earning pay dates from the Work number for the petitioner. The respondent used pay dates from February 8, 2018 of $611.07 and February 22, 2018 for $741.95 (Resp. Exh. 12). The respondent determined that both paychecks were representative of the petitioner's normal hours worked and the petitioner's earned income for SNAP benefits for March 2018 and ongoing was calculated as $1454.50. ($611.07+ 741.95= 1353.02/2= 676.51 x 2.15= $1454.50)

8. The respondent determined the petitioner's SNAP budget as follows: (Resp. Exh. 13)

$1454.50	total earned income
+1480.00	total unearned income
$2934.50	total gross income
$2934.50	total gross income
- 290.90	earned income deduction
- 170.00	standard deduction
$2473.60	adjusted income
$1300.00	shelter cost
+ 347.00	utility allowance (standard utility allowance)
$1647.00	shelter/utility cost

- 1236.80	shelter standard (50% if adjusted income)
$ 410.20	excess shelter/deduction
$2473.60	adjusted income
- 410.20	shelter deduction (uncapped)
$2063.40	food stamp adjusted income
$ 640.00	thrifty food plan for household of four
- 620.00	benefit reduction (30% of $2063.40)
$ 20.00	monthly allotment

9. The respondent stated that both children currently receive SSI, making them ineligible for DCF Medicaid, so the Department determined Medicaid coverage for both adults in the household. The respondent determined the earned income of the petitioner by adding the two pays received in February 2018 ($611.07+ 741.95= $1353.02). The countable household income of $1353.02 was compared to the Family-Related Medicaid income limit for a parent in a household size of four ($364), the respondent determined the petitioner was not eligible for full Medicaid benefits as the household income exceeded the Medicaid income limits. The respondent then calculated the Medically Needy SOC amount by subtracting the Medically Needy Income Limit for a household of four of $585 from the earned income of $1353.02 to get $768.

10. The petitioner is not disputing the SOC amount because he is seeking full Medicaid benefits. The petitioner did not dispute the paystubs the respondent used to calculate the income in the SNAP and Medicaid budgets or the SSI amount the department used.

11. On March 2, 2018, the respondent mailed a request for information to the petitioner asking to provide proof of insurance with [redacted] by March 12, 2018 (Resp. Exh. 10). The petitioner clarified during the hearing that they are no longer

paying for health coverage and that their only medical expense that they are currently paying for is a dental premium of $15 a month. The department informed the petitioner that the $15 a month would not count as a deduction in the budgets as the amount is less than $35 a month. He stated that if the household's out of pocket medical expenses do exceed $35 a month, let the Department know so they can recalculate their benefits.

12. The petitioner's wife does not agree that the entire shelter expense is not counted and that with $20 a month in SNAP benefits, they still have to go to the food bank three to four times a month to get by. The respondent explained that the shelter expenses are not counted dollar for dollar and that instead the state uses deductions.

CONCLUSIONS OF LAW

13. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding, pursuant to § 409.285, Fla. Stat.

14. 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.

FOOD ASSISTANCE AMOUNT WILL NOW BE ADDRESSED:

16. 7 C.F.R. § 273.9, defines income and deductions. It states:

> (a) *Income eligibility standards.* Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet.
> ….
> (b) *Definition of income.* Household income shall mean all income from whatever source…

(1) Earned income shall include: (i) All wages and salaries of an employee.
….
(2) Unearned income shall include, but not be limited to:
(i) Assistance payments from Federal or federally aided public assistance programs, such as supplemental security income (SSI)…
….
(d) *Income deductions.* Deductions shall be allowed only for the following household expenses:
(1) Standard deduction…
…
(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…
(3) *Excess medical deduction.* **That portion of medical expenses in excess of $35 per month** *(emphasis added)*, 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.
…
(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…
…
(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);

17. The controlling authority above directs the Department on what to include as income and expenses in the SNAP budget. Only medical expenses in excess of $35 a month are to be included as a deduction.

18. The petitioner's SNAP budget includes the petitioner's earnings, a 20% exclusion of the petitioner's earnings, the children's SSI, the shelter costs, the standard deductions and the Standard Utility Allowance.

19. The Department's Program Policy Manual, CFOP 165-22, Appendix A-1, sets forth a $170.00 standard deduction for a household size of four. Fla. Admin. Code R. 65A-1.603 sets forth a standard utility allowance of $347.

20. 7 C.F.R. § 273.10(c), addresses determining household eligibility and benefit levels:

> (2) Income only in month received. (i) Income anticipated during the certification period shall be counted as income only in the month it is expected to be received, unless the income is averaged. Whenever a full month's income is anticipated but is received on a weekly or biweekly basis, the State agency shall convert the income to a monthly amount by multiplying weekly amounts by 4.3 and biweekly amounts by 2.15, use the State Agency's PA conversion standard, or use the exact monthly figure if it can be anticipated for each month of the certification period. Nonrecurring lump-sum payments shall be counted as a resource starting in the month received and shall not be counted as income.
> ….
> (3) Income averaging. (i) Income may be averaged in accordance with methods established by the State agency to be applied Statewide for categories of households. When averaging income, the State agency shall use the household's anticipation of monthly income fluctuations over the certification period. An average must be recalculated at recertification and in response to changes in income, in accordance with §273.12(c), and the State agency shall inform the household of the amount of income used to calculate the allotment. Conversion of income received weekly or biweekly in accordance with paragraph (c)(2) of this section does not constitute averaging.

21. 7 C.F.R. § 273.10(e), covers calculating net income and benefit levels in SNAP and states:

> To determine a household's net monthly income, the State agency shall: (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income. (B)

> Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; (C) Subtract the standard deduction… (H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.
>
> (I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.
> …
> (2) *Eligibility and benefits.* (i)(A) Households which contain an elderly or disabled member as defined in §271.2, shall have their net income, as calculated in paragraph (e)(1) of this section (except for households considered destitute in accordance with paragraph (e)(3) of this section), compared to the monthly income eligibility standards defined in §273.9(a)(2) for the appropriate household size to determine eligibility for the month.
> ….
> (ii)(A) Except as provided in paragraphs (a)(1), (e)(2)(iii) and (e)(2)(vi) of this section, the household's monthly allotment shall be equal to the maximum SNAP allotment for the household's size reduced by 30 percent of the household's net monthly income as calculated in paragraph (e)(1) of this section. If 30 percent of the household's net income ends in cents, the State agency shall round in one of the following ways:
> (*1*) The State agency shall round the 30 percent of net income up the nearest higher dollar

22. The Department's Program Policy Manual, CFOP 165-22, Appendix A-1, sets forth the following income limits and maximum SNAP benefit for a household size of four:

$4,100 Gross Income Limit[1]
$640 maximum SNAP benefit amount

23. In accordance with the above cited authorities, the petitioner's earned income of $1454.50 in addition to the SSI of $1480 was counted in the SNAP determination and is less than or equal to the 200% gross income limit, making the household eligible for SNAP benefits. The appropriate allowable deductions were then taken into consideration to determine that the household is eligible for $20 a month in SNAP benefits.

24. After considering the evidence, testimony and the appropriate authorities cited above, the hearing officer concludes that the respondent's action to approve $20 for March 2018 and ongoing is correct. The undersigned cannot find a more favorable outcome for the petitioner.

FULL MEDICAID BENEFITS WILL NOW BE ADDRESSED:

25. 42 C.F.R. § 435.603(c) explains "the agency must determine financial eligibility for Medicaid based on "**household income**" as defined in paragraph (d) of this section (emphasis added)."

26. Fla. Admin. Code R. 65A-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…"

[1] 7 C.F.R. § 273.2(j)(2) establishes the broad-based categorically eligible standard which requires participants to have a gross monthly income at or below 200 percent of the Federal poverty level.

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

28. Fla. Admin. Code R. 65A-1.716, Income and Resource Criteria explains: "(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size…"

29. The Department's Program Policy Manual, CFOP 165-22 at 2230.0400 Standard Filing Unit (MFAM) states:

> The SFU is determined for each individual by following one of three rules based on intended tax filing status for the upcoming tax year as reported by the applicant/recipient. Individuals cannot receive Medicaid benefits under more than one assistance group, but can have their income included in more than one assistance group.
> …
> Tax Dependent Rule: If the individual being tested for eligibility expects to be claimed as a tax dependent for the tax year in which eligibility is being determined, the SFU includes the:
>
> 1. individual,
> 2. individual's spouse, even if the individual and the individual's spouse are living separately and filing a joint return,
> 3. tax filer,
> 4. tax filer's spouse, if any, even if the tax filer and tax filer's spouse are living separately and filing a joint return, and
> 5. all claimed tax dependents of the tax filer living inside or outside of the household.

30. In accordance with the above cited authority and The Policy Manual, the respondent correctly determined the petitioner's eligibility with a household size of four, including the petitioner, his wife and their two mutual children.

31. 42 C.F.R. § 435.603, Application of modified adjusted gross income ("MAGI"), defines Household Income for Medicaid:

(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.
(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.

32. The Department’s Program Policy Manual, CFOP 165-22 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).

33. The Department's Program Policy Manual at Appendix A-7, effective February 14, 2017, lists the Family Related Medicaid income limits for a household of four for parents as follows.

> $364 income standard
> $221 standard disregard
> $585 MNIL (Medically Needy Income Limit)
> $103 MAGI disregard

34. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for both adults in the household. Step 1: The total income counted in the budget is $1353.02. Step 2: There were no deductions provided. Step 3: Counted net income is determined by taking $1353.02- 221= $1132.02. Step 4: The $1132.02 is greater than the income limit of $364 for parents in a household size of four. Step 5: The income of $1132.02 less the MAGI disregard of $103 is $1029.02. The amount is greater than the income limit of $364. The undersigned concludes that the petitioner is not eligible for full coverage Medicaid and the respondent was correct in exploring Medically Needy coverage.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal related to the March 2018 and ongoing Supplemental Nutrition Assistance Program benefits is hereby denied and the respondent's action is affirmed. The appeal related to

the full coverage Medicaid benefits is hereby 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 11 day of April, 2018, in Tallahassee, Florida.

Ashley Brunelle

Ashley Brunelle
Hearing Officer
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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

[redacted]

APPEAL NO. 18F-01158

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 Polk
UNIT: 88991

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on March 28, 2018, at 3:30 p.m. The hearing was reconvened telephonically on April 3, 2018 at 11:02 a.m.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Stanley Jones, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of December 14, 2017 denying Institutional Care Program (ICP) Medicaid. She is seeking ICP coverage for

December 2016 through August 2017. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner passed away on August 31, 2017 and was represented by [redacted] the facility (nursing home).

The hearing record was held open through April 3, 2018 for the petitioner's representative to furnish an authority for a potential, alternative program to cover facility payments. This information was not received and the record closed.

At the reconvened hearing on April 3, 2018, the same two representatives from the initial hearing were present by teleconference. In addition, the petitioner had two observers for the reconvened hearing: [redacted], both of the nursing home.

Evidence was entered during the initial hearing as Hearing Officer Exhibit 1, Respondent's Composite Exhibit 1 and Respondent's Exhibit 2. At the reconvened hearing, there was a withdrawal of page 7 of Hearing Officer Exhibit 1 due to an inadvertent name and date error; that page has been excluded. The corrected page has been entered as Petitioner's 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 was admitted to the nursing home on December 13, 2016. Prior to this admission, the petitioner lived in the facility's independent living apartments and was "in and out" at various times. Petitioner passed away August 31, 2017.

2. [redacted]d was the petitioner's authorized representative for the department's ICP eligibility determination.

3. [redacted] applied for the petitioner for ICP coverage with the department on November 13, 2017. Retroactive ICP coverage was also requested. There were previous ICP applications that resulted in denials. The last denial prior to the one under appeal was September 18, 2017.

4. The petitioner was a single individual and her income consisted of Social Security and Florida State Retirement. Her total gross combined income of $2219.68 exceeded the ICP income limit of $2205 for 2017, even before the Cost of Living Adjustment (COLA) occurred for her Florida State Retirement income. The COLA increase occurs annually every July.

5. A medical Level of Care was determined effective May 2017, establishing that the nursing home placement was appropriate based on petitioner's condition. This is a requirement for ICP eligibility. There were timely applications filed that would have allowed ICP coverage beginning May 2017 if sufficient income had been placed in a qualified income trust and proof provided to the department.

6. [redacted] realized during July 2017 that an income trust would need to be established before ICP eligibility could be achieved. The income trust was not created as [redacted] believed the petitioner did not have sufficient funds for this procedure.

7. The department issued a notice identifying the items required to determine ICP eligibility. The Notice of Case Action was dated November 15, 2017 and stated,

> We need the following information by November 27, 2017. Proof of income and assets for each month you are requesting retroactive Medicaid…Please provide proof of ALL income, bank statements for ALL accounts from 3 months prior to admission to current, income trust and proof of funding. Thanks…If you do not contact us or provide the requested information, we will be unable to determine your eligibility. We will deny your application or your benefits may end.

8. The department did not receive proof of the Florida State Retirement COLA increase for July 2017 (and forward) and did not receive proof that an income trust had been established. There was no request for assistance obtaining the information and no request for additional time to comply with the request.

9. The department's representative acknowledged he could have obtained the increased amount of the Florida State Retirement income if it had been the only lacking verification to establish ICP eligibility. The staff who determine Medicaid eligibility are unable to assist applicants with legal affairs, such as establishing income trusts.

10. The department issued a denial notice on December 14, 2017 which stated it had not received all of the information requested to determine eligibility. This action was timely appealed on February 13, 2018.

11. The petitioner's representative believes the department should use more detail when it requests additional verifications. During the application process, she was unaware that the COLA increase in petitioner's Florida State Retirement needed to be verified.

12. [redacted] is seeking a hardship exception on petitioner's behalf as the facility provided long term care in good faith for approximately eight months with an outstanding bill of $81,817.35. The petitioner is only slightly over the ICP income limit. Due to declining health, petitioner was unable to participate in the eligibility process and as a result, did not have the resource (ICP Medicaid) to cover the cost of her care.

13. The petitioner's treating physician, [redacted] provided a written statement dated February 2, 2018. [redacted] opinion was that petitioner needed indefinite long term care. He stated, "Due to her declining health and state of mind, it would have been detrimental to her health and well-being if she did not have Medicaid benefits and a place to live where her needs could be met."

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

15. Fla. Admin. Code R. 65A-1.710, "SSI-Related Medicaid Coverage Groups" states in part:

> The Department covers all mandatory coverage groups and the following optional coverage groups: … (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.

16. The above-cited department rule shows that the ICP program is an optional coverage group elected by the State of Florida. ICP coverage pays the nursing home provider for skilled nursing facility care.

17. The ICP Medicaid program has an income limitation as shown in Title 42 of the Code of Federal Regulations Section 435.236, "Individuals in institutions who are eligible under a special income level." This passage states in part:

> (a) If the agency provides Medicaid under §435.211 to individuals in institutions who would be eligible for AFDC, SSI, or State supplements except for their institutional status, it may also cover aged, blind, and disabled individuals in institutions who—
> (1) Because of their income, would not be eligible for SSI or State supplements if they were not institutionalized; but
> (2) Have income below a level specified in the plan under §435.722. (See §435.1005 for limitations on FFP in Medicaid expenditures for individuals specified in this section.)

18. 42 C.F.R. § 435.1005 "Beneficiaries in institutions eligible under a special income standard" states:

> For beneficiaries in institutions whose Medicaid eligibility is based on a special income standard established under §435.236, FFP is available in expenditures for services provided to those individuals only if their income before deductions, as determined by SSI budget methodology, does not exceed 300 percent of the SSI benefit amount payable under section 1611(b)(1) of the Act to an individual in his own home who has no income or resources.

19. According to the above controlling federal authority, Medicaid eligibility for institutionalized individuals (ICP) is available if the income **before** deductions does not exceed 300 percent of the SSI benefit amount for an individual living in the community.

20. The department publishes the federal income limits in its Program Policy Manual, CFOP 165-22, Appendix A-9. This appendix, "SSI-Related Programs -- Financial

Eligibility Standards: **July 1, 2017"** (emphasis added) shows the SSI Federal Benefit Rate for an individual at $735 and the ICP income limit for an individual at $2205 (300% of $735). The 2018 income eligibility standards are irrelevant to this appeal.

21. 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: … (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. … (4) Income Budgeting Methodologies… (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.

22. The above department rule reiterates the federal law and states gross income cannot exceed 300 percent of the SSI Federal Benefit Rate. It also establishes that for individuals with income over this limit, institutional care services may still be available if an income trust meeting certain criteria is established. Once the income trust is established, the individual's total gross monthly income is then considered, after excluding any income placed in the qualified income trust for the month the income is received. If the remaining income (outside of the trust) is under the ICP income limit, the individual is eligible for ICP for the month income was received and placed in the trust.

23. The Findings of Fact show that the petitioner had monthly gross income that exceeded the applicable ICP income limit for 2017 at the time of the application denial at issue. Petitioner exceeded the applicable limit by at least $14.68. As a result, the department issued a Notice of Case Action informing the representative that proof of an income trust and proof of funding was needed before eligibility could be established.

24. Fla. Admin. Code R. 65-2.046, “Time Limits in Which to Request a Hearing” states in part:

> (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs except the Road to Independence (RTI) Program under Section 409.1451(4), F.S., and the Adoption Subsidy Program under Sections 120.569 and 120.57, F.S.

25. Petitioner is seeking ICP coverage beginning December 2016. She is seeking a hardship exception to the rules preventing eligibility. While petitioner had previous applications and ICP denials, the most recent denial action taken just prior to the one under appeal was September 18, 2017. The undersigned concludes the September 2017 denial action cannot be reviewed as there was no appeal filed within 90 days of that action.

26. The Findings show that both the application and the application denial at issue were dated after petitioner’s death. The Findings also show that retroactive Medicaid was requested.

27. Fla. Admin. Code R. 65A-1.702 “Special Provisions” states:

> (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.

28. According to the above authority, retroactive Medicaid can be considered for the three months prior to the month of application. The Findings show that the month of the ICP application was November 2017; retroactive ICP Medicaid could have been approved for August, September and October 2017 had all eligibility requirements been met. The last month of ICP coverage needed was August 2017 due to petitioner's demise in that month. Therefore, the undersigned concludes that August 2017 is the only month at issue that can be reviewed as this retroactive month is associated with the last application denial, which was timely appealed.

29. Fla. Admin. Code R. 65A-1.205, "Eligibility Determination Process" states in 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.

30. The above rule sets forth the provision for the department to issue written notice when it is determined that additional verification is needed during the application process. The Findings show that the application was dated November 13, 2017 and the notice to request additional verification was dated November 15, 2017. The deadline given to provide the needed verifications was November 27, 2017. The Findings show that the only verification lacking to establish ICP eligibility (that could not be obtained by the department) was proof that an income trust had been established and funded. However, the undersigned concludes there was no way by the time the application was

filed in November 2017, to achieve eligibility on this factor, as petitioner passed away in August 2017. Based on the controlling law and policy, the undersigned concludes that an income trust cannot be established retroactively after the applicant's death; the trust must be funded with the applicant's income received in the month that eligibility is desired.

31. Petitioner is seeking a hardship exemption from the policy that prevented ICP eligibility. No exemption provision or authority was provided by petitioner to support this request. The income trust provision is to allow ICP eligibility for applicants with income exceeding the federal income limit, as in this case. Without that in place, petitioner was ineligible for ICP due to excess income (outside of the trust).

32. The undersigned researched the Medically Needy Program to determine if there is coverage for the institutional payment for a resident of a long-term care facility whose income exceeds the limit for ICP. Fla. Admin. Code 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.

33. According to the above department rule, even though the Medically Needy Program is for aged, blind or disabled individuals who do not qualify for assistance due to their level of income, it does not cover nursing facility care or other long-term care services. In addition, there is a category of Medicaid for an individual ineligible for ICP

due to improperly transferring assets; however, this is not petitioner's situation and that program does not cover the vendor payments to the facility.

34. Petitioner's treating physician's statement indicated a need for skilled nursing home placement; this was not at issue as she met the Level of Care needed for ICP eligibility. He also believed she needed Medicaid placement to prevent a detriment to her health and well-being. However, at the time of [redacted], petitioner had already passed away and skilled nursing care had been provided by the facility, outside of Medicaid eligibility.

35. Federal Medicaid Regulations at 42 C.F.R. §431.244, **Hearing Decisions,** states in part:

> (d) In any evidentiary hearing, the decision must be a written one that—
> (1) Summarizes the facts; and
> (2) Identifies the regulations supporting the decision.
> (e) In a *de novo* hearing, the decision must—
> (1) Specify the reasons for the decision; and
> (2) Identify the supporting evidence and regulations.

36. As stated in the above federal regulation, a Medicaid hearing decision must identify the regulations supporting the decision. The undersigned is bound by the applicable law controlling the program at issue and does not have the power to grant an exception or exemption to the law or policy. No exception provision in the law could be found to allow ICP eligibility in petitioner's situation.

37. Petitioner failed to meet her burden of proof to show eligibility for ICP Medicaid for August 2017.

DECISION

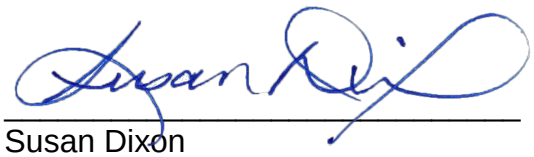
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal for retroactive ICP coverage for August 2017 is denied.

The appeal for earlier months of ICP coverage is non-jurisdictional and therefore not addressed in this decision.

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 April, 2018, in Tallahassee, Florida.



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Copies Furnished To: [redacted] for Petitioner
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STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[redacted]

PETITIONER,

Vs.

APPEAL NO. 18F-01358

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 Polk
UNIT: 88586

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on April 18, 2018 at 3:01 p.m.

APPEARANCES

For the Petitioner: [redacted], [redacted]

For the Respondent: Jennie Rivera, Economic Services
Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of February 23, 2018 addressing denials beginning January 2018. Petitioner is also appealing the department's non-action on the retroactive request for November 2017. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Evidence was received from both parties. The respondent submitted 42 pages, entered as Respondent Exhibits "1" through "16." The petitioner submitted two documents. However, one was a duplicate of Respondent Exhibit "15" and was not entered; the other document was entered as Petitioner's Exhibit "1."

The petitioner's representative for the hearing was also the authorized representative for the department's eligibility determination, for the application at issue.

FINDINGS OF FACT

1. Petitioner signed an Appointment of a Designated Representative form on January 17, 2018 (Respondent Exhibit "6").

2. A paper application for Medicaid was filed on January 22, 2018 by Petitioner's authorized representative. The Authorized/Designated Representative field indicated a name, address and phone number for the representative. The request included the retroactive month of November 2017 for both Petitioner and her child, born in November 2017 (Respondent Exhibit "3").

3. The department issued a Notice of Case Action on January 25, 2018 to Petitioner only. The notice stated, "Please take a copy of your photo ID to your local storefront to be authenticated. [redacted]." The due date was February 5, 2018.

4. The department's Running Record Comments show that on February 12, 2018, a 20-day case review was done. An attempt was made to call the petitioner which resulted in a non-working number. On February 21, 2018, a 29-day case review was

done notating that there was nothing on document imaging and the case remained in a pending status due to lack of authentication (Respondent Exhibit "12").

5. The department denied the application on February 23, 2018 and issued a Notice of Case Action to Petitioner only. The notice states, "Your Medicaid application/review dated January 23, 2018 is **denied** for the following months…Jan, 2018; Feb, 2018; Mar, 2018; Apr, 2018." The reason shown for the denial was the information requested to determine eligibility was not received. No notice was issued to address the November 2017 retroactive Medicaid request.

6. Petitioner herself previously applied for Medicaid and Food Assistance on November 8, 2017. The application was denied on December 8, 2017. Authentication was not accomplished for this application.

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. Fla. Admin. Code R. 65A-1.203 "**Administrative Definitions"** states in part, "(9) Authorized/Designated Representative: An individual who has knowledge of the assistance group's circumstances and is authorized to act responsibly on their behalf."

10. Fla. Admin. Code R. 65A-1.704, "**Family-Related Medicaid Eligibility Determination Process"** states in part, "(1) Public assistance staff determine eligibility

for Family-related Medicaid at application, when a change in conditions of eligibility is reported, or, on not greater than a 12-month cycle. The individual or the designated representative is required to assist the Department in completing the determination or redetermination of Medicaid eligibility."

11. The department's eligibility rules cited above define an authorized representative and state the authorized representative is required to assist the department in completing the Medicaid eligibility determination.

12. The department's Program Policy Manual, CFOP 165-22, passage **0630.0109 Designated Representatives (MFAM),** 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 organization cannot self-designate, but an individual employee of an organization may continue to self-designate. If the individual employee of an organization self-designates, the preferred method is to complete the CF-ES 2505 form. If this is done, only that employee may communicate with the Department and not any other employee of the organization. The designated representative is authorized in writing prior to eligibility determination or anytime during the review period… Designated representatives assume responsibility for the accuracy of the information provided and are subject to the same disqualification penalties and possible prosecution as responsible household members.

13. The department's policy manual sets forth the reasons for a designated or authorized representative to be appointed. These include assisting with the application and redetermination of eligibility and other ongoing communication with the department. A representative may be appointed or self-designated to act on behalf of the household.

Representatives also assume responsibility for the accuracy of the information given to the department.

14. The department's Program Policy Manual, CFOP 165-22, passage **3230.0100 REPRESENTATIVES AND PAYEES (MFAM)**, states, "Individuals may designate a non-assistance group or assistance group member to make application and/or receive benefits on behalf of the assistance group."

15. The department's policy manual sets forth procedures for an authorized representative to make an application and/or receive benefits for an applicant.

16. The department's ACCESS Customer Service Center Guide, page 16, addresses interview requirements and states in part, "**Designated/Authorized Representatives** It is allowable to conduct an interview with the customer or a designated or authorized representative for all programs. Designated and authorized representatives should be listed on the AGAR screen. Send Interim Contact notices to the representative."

17. The department has a variety of procedural and policy guides in addition to its policy manual. The above guide explains that it is allowable to conduct an interview with the representative for all programs. It also states that an authorized representative should be listed on the department's computer system, specifically the AGAR screen.

18. The department's ACCESS Management System (AMS) Work Management (WM) Guide, June 2012, states,

> For FLORIDA generated notices, an authorized representative notice will still be mailed in batch if the AGAR screen says "Send Client Notices = Y". A notice will still be mailed to the customer if the nursing home notice is printed online.
> For AMS generated notices, an authorized representative notice will still be mailed in batch if an authorized representative name and address was entered on the notice detail page.

19. The department's guide above explains how system generated notices are issued when the authorized representative screen (AGAR) reflects a code for yes to generate a copy of the notice to the representative. In addition, if the authorized representative's name and address is entered on the AMS system, specifically on the notice detail page, a notice is generated to the representative.

20. The findings show the authorized representative was designated in writing by the petitioner prior to the date that the paper application was filed. The paper application was filed by the authorized representative and reflected the representative's name, address and phone number. The findings show that the application was processed without the representative being aware of the department's action due to no notices being issued to the representative. Contact was attempted with the petitioner and not the representative (prior to the denial action).

21. The petitioner's authorized representative filed the application for both retroactive and ongoing Medicaid for Petitioner and her newborn. The undersigned concludes the department erred in not including the representative in the eligibility process, prior to the denial action, by not issuing notices to him. Due to this, he was prevented from assisting the department in completing the Medicaid eligibility determination and was not informed of the outcome of the application he submitted.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The department is to take corrective action and reopen the January 2018 application, properly send interim notices to the authorized representative and determine eligibility (for both the retroactive request for November 2017 and ongoing

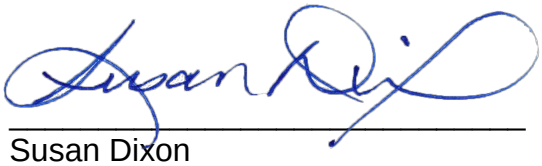
Medicaid eligibility) for Petitioner and her child. Upon completion of the eligibility determination, the department is to copy all notices informing of the results to the authorized representative, including the retroactive month of November 2017.

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 26 day of April, 2018,

in Tallahassee, Florida.



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Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 18F-01609
18F-01610

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:41 a.m. on April 2, 2018.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Sylma Dekony, ACCESS
Self-Sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner requested two appeals: (1) Supplemental Nutrition Assistance Program (SNAP), also known as Food Assistance Program and (2) Medically Needy (MN). On record, the petitioner stated that she no longer had an issue with the SNAP. Therefore, the SNAP appeal, 18F-01609, is dismissed.

At issue is whether the respondent's (Department) action to increase the petitioner's MN share of cost (SOC) to $855, is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Leonard Jackson, Hearing Officer, appeared as an observer. The petitioner did not submit exhibits. The respondent submitted eight exhibits, entered as Respondent Exhibits "1" through "8". The record was closed on April 2, 2018.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received MN with a $316 SOC.

2. On February 13, 2018, the petitioner submitted a SNAP and Medicaid redetermination web application for her, three sons (ages 23, 20, 17) and two daughters (ages 13 and 10) (Respondent Exhibit 3, page 28).

3. The application lists the petitioner employed at [redacted] and her 17-year-old son employed at [redacted] (Respondent Exhibit 3, page 38).

4. The Department determined, through "The Work Number", that the 20-year-old son was employed at [redacted] and [redacted] (Respondent Exhibit 5).

5. The Department included the petitioner's income, her 20-year-old and 17-year-old sons' income in the petitioner's MN SOC determination, which increased the petitioner's SOC to $2,805 (Respondent Exhibit 6, page 58).

6. On February 26, 2018, the petitioner submitted a change request, reporting that her 20-year-old son was no longer in the household (Respondent Exhibit 3).

7. The petitioner reported earning $540 bi-weekly (Respondent Exhibit 4, page 44) for a total of $1,080 monthly ($540 + $540). The petitioner's 17-year-old son earns $90 weekly (Respondent Exhibit 3, page 38) for a total of $360 monthly ($90 X 4).

8. The petitioner's 23-year-old son was not included in the petitioner's MN SOC determination, due to his age. The petitioner is a tax filer and the three children (ages 17, 13 and 10) are the petitioner's tax dependents.

9. The Department recalculated the petitioner's MN SOC to remove the petitioner's 20-year-old son and his income (Respondent Exhibit 6). The SOC calculation is as follows:

$1,080	petitioner's earned income
+$ 360	petitioner's 17-year-old son's earned income
$1,440	total household earned income
-$ 585	MN income limit (MNIL) for household size of four
$ 855	SOC

10. On March 6, 2018, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying the petitioner's MN SOC decreased from $2,805 to $855, effective April 1, 2018 (Respondent Exhibit 2, page 9).

11. The respondent's representative said the decrease was effective March 1, 2018, not April 1,2018.

12. The petitioner argued that in accordance with the Department's Appendix A-7 (Respondent Exhibit 8, page 93), $2,092 is the income limit, for a household size of four, to be eligible for full Medicaid.

13. The respondent's representative explained the correct column on Appendix A-7 that applies to the petitioner is "Parents, Caretakers, Children 19 & 20", which lists $364 as the Medicaid income limit for a household size of four.

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. Federal Regulations at 42 C.F.R. § 435.603, "Application of modified adjusted gross income (MAGI)", in part 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…
> (f) 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.** (emphasis added)
> (3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination **or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual…**
> **(ii) The individual's children under the age specified in paragraph (f)(3)(iv) of this section; and**
> (**iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—**
> **(A) Age 19; or**
> **(B) Age 19 or, in the case of full-time students, age 21**… (emphasis added)

17. In accordance with the above authority, the petitioner's 23-year-old son was not included in the petitioner's Medicaid eligibility determination.

18. *Florida Administrative Code* R. 65A-1.716, Income and Resources Criteria, in part states, "(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: Family Size 3 Monthly Income $303, Family Size 4 Monthly Income $364..."

19. In accordance with the above authority, for the petitioner to be eligible for full Medicaid her income cannot exceed $303 for household size of three or $364 for a household size of four.

20. The evidence submitted establishes that the petitioner's $1,080 monthly income exceeds $303 and $364; therefore, she is not eligible for full Medicaid. The next available program is MN with SOC.

21. *Florida Administrative Code* R. 65A-1.707 Family-Related Medicaid Income and Resource Criteria, in part states, "(1)(a) ...For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost…"

22. The above authority explains the SOC is determined by subtracting the income level (MNIL) from the gross income.

23. The Department included the petitioner, her income, her 17-year-old son, his income and her two other children (ages 13 and 10) in the petitioner's MN SOC determination.

24. The ACCESS Program TRANSMITTAL NO.: P-15-09-0009, dated September 18, 2015, Medically Needy Budgeting for Family-Related Medicaid, in part states:

> **SFU/Counting Income for Medically Needy**
> Staff will continue to determine the Medicaid Standard Filing Unit (SFU) based on expected tax filing information as provided by the individual. If an assistance group (AG) is ineligible for full Medicaid coverage due to income, eligibility for Medically Needy coverage must be determined.
>
> **A child with countable income must be excluded from the Family-Related Medically Needy AG if inclusion is not beneficial to the individual whose eligibility is being determined**… (emphasis added)

25. In accordance with the above transmittal, a child with income must be excluded from the MN determination if it "is not beneficial to the individual whose eligibility is being determined".

26. The Department's Program Policy Manual, CFOP 165-22, Appendix A-7, sets forth the MNIL at $585 for a household size of four and at $486 for a household size of three.

27. In this case, it is not beneficial to include the petitioner's 17-year-old son and his income in the petitioner's MN SOC determination. Removing the petitioner's 17-year-old and his income decreases the petitioner's SOC to $594 ($1,080 petitioner's income - $486 MNIL for a household of three).

28. In careful review of the cited authorities and evidence, the undersigned concludes the Department did not meet the burden of proof. Therefore, the Department is ORDERED to remove the petitioner's 17-year-old son and his income from the petitioner's MN SOC determination; decreasing the petitioner's SOC to $594, effective March 2018. The Department is to mail the petitioner a NOCA, notifying of the $594 SOC, effective March 2018.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted in accordance with 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 26 day of April, 2018, in Tallahassee, Florida.

Priscilla Peterson
Priscilla Peterson
Hearing Officer
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Copies Furnished To: [redacted], Petitioner
Office of Economic Self Sufficiency