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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 07F-00431

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 10 Broward
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on February 7, 2007, at 9:05 a.m., at the Sony Service Center, in Ft. Lauderdale, Florida. The petitioner was not present, but was represented at the hearing by the petitioner's sister, . _ . The agency was represented by Nicole Griffin, program administrator, Agency For Health Care Administration (AHCA). Present as witness for the agency, via the telephone, was Dr. Marcelino Oliva, physician reviewer, from KePRO South. Also present, via the telephone, as witnesses for the agency was Susan Ziebell, review operation manger, from KePRO. KePRO is located in Tampa, Florida.

ISSUE

At issue is the agency's action of December 1, 2006, to deny the petitioner's request for acute rehabilitation admission and stay services for the period of November 30, 2006 through December 7, 2006. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner, who is currently about thirty nine years of age, has severe and numerous medical problems that requires medical services as provided through the Agency For Health Care Administration's (AHCA) Medicaid State Plan. The petitioner's condition(s) are outlined in Respondent Composite Exhibit 1. AHCA as noted above, will be further addressed as the "agency". The petitioner is currently residing in a nursing home in the Florida panhandle.

KePRO has been authorized to make Prior (service) Authorization Process decisions for the agency. The Prior Authorization Process was completed for the petitioner by KePRO. KePRO determined on December 1, 2006, that the petitioner's request for acute rehabilitation admission and stay for the period of November 30, 2006 through December 7, 2006 would be denied. The agency's witness indicated that after review of the information provided to KePRO, from the petitioner's service provider(s), the information did not indicate a need for acute rehabilitation service for the petitioner.

The Internal Focus Review Findings from KePRO states in part; "...Pt. with full rehab prior with multiple contracture and appears to be low level with no significant progress noted. No medical issues that require inpatient rehab. Issues can be addressed in alternative setting."

The petitioner's (medical) providers had requested a reconsideration of the above agency decision. Additional information was provided to KePRO by the petitioner's providers. A different reviewer from KePRO reviewed this reconsideration, but still agreed with the agency's first decision for this case.

The petitioner submitted into evidence, Petitioner Composite Exhibit 1, which contains copies of a letter from the petitioner's neurologist; other medical information concerning treatment and a copy of a therapy report completed by a therapist. These reports and letters are dated in January and February 2007. The respondent did not object to their submission, but emphasized that the respondent's decision was based on information provided (by the petitioner's providers) at the time of the request for services. The respondent suggested the petitioner's representative could request the petitioner's providers to submit a new request for the rehabilitation service.

The above referenced petitioner's physician's (Dr. , dated January 30, 2007) letter states in part: "It is my strong belief that due to her age and cognitive function she should advance greatly given the appropriate rehabilitative environment. She needs aggressive physical and occupational therapy."

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010 states in part:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service...
Fla. Admin. Code 59G-4.290 discusses skilled services, and states in part:

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.
(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.

(e) Rehabilitative services. Individualized services prescribed by a health care professional that are designed to restore a recipient to self-sufficiency or to the highest attainable functional level in the shortest possible time following an illness or injury.

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.

(4) Skilled Rehabilitative Services. To be classified as skilled rehabilitative services, the services must meet all of the following conditions:

(a) Ordered by and remain under the supervision of a physician;

(b) Reasonable and necessary to the treatment of a recent or presently existing illness or injury;

(c) Performed by a physical therapist, occupational therapist, certified respiratory care practitioner/therapist;

(d) Required at least 5 days a week; and

(e) Reviewed and reevaluated at least every 30 days by the physician and the physical, occupational therapist or respiratory care practitioner/therapist.

(5) Examples of services that qualify as skilled rehabilitation services:

(a) Daily services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(b) Ongoing assessment of rehabilitation potential and needs in accordance with 59G-4.320, F.A.C.

1. Such services must be provided as an integral part of the management of the care plan; and

2. Must include results of tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, physical capacities, perceptual deficits, speech and language or hearing disorders.

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services must be ordered by the attending physician, and documented as medically necessary.

The agency, through KePRO, took action on December 1, 2007 to deny the petitioner's request for acute rehabilitation admission and stay for the period of November 30, 2006 through December 7, 2006. This decision was based on the information as provided by the petitioner's medical providers and the petitioner's medical necessity need of the request for the service at that time.

The petitioner's representative argued that the petitioner's providers, physicians; nurses and therapist strongly recommended that the petitioner receive the rehabilitation

service. Additionally, she argued that as her sister is very young; with the rehabilitation service she can again become independent. She also argued that her sister has gained a considerable amount of weight since she does not receive the service. She argued that she herself can only do so much, for her sister, as she lives in Broward County and her sister is in the panhandle. The respondent's witness suggested the petitioner's providers may request a new request for the rehabilitation services and supply any new information on the petitioner. The petitioner's representative argued that she may have difficulties with the above agency "suggestion" based on the petitioner not having the same "provider" as she had back in November 2006.

After considering the evidence, the Fla. Admin. Code Rule and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the agency's action of December 1, 2006, to deny the petitioner's request for acute rehabilitation admission and stay services for the period of November 30, 2006 through December 7, 2006.

DECISION

This appeal is denied and the Department's action affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 6th day of March, 2007,

in Tallahassee, Florida.

Robert Akel

Robert Akel
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-08169

PETITIONER,

Vs.

CASE NO. 1249906024

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 04 Nassau
UNIT: 88368

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on February 28, 2007, at 3:10 p.m., in Jacksonville, Florida. The petitioner was not present. However, she was represented by her son and Power of Attorney, The Department was represented by Teresa Harris, economic services self-sufficiency specialist.

ISSUE

At issue is the Department's action of November 6, 2006 to deny Institutional Care Program (ICP) Medicaid benefits for September 2006, due to excess income. The petitioner has the burden of proof.

FINDINGS OF FACT

The petitioner was placed in a nursing home in September 2006. The petitioner's representative submitted an on-line application for ICP Medicaid on August 21, 2006 at the Department of Children and Families Office in Green Cove Springs. The maximum income limit to receive ICP Medicaid was $1809. The petitioner's income consisted of $1290 in Social Security and a pension of $853.13 for a total gross monthly income of $2143.13. The petitioner's income was not disputed. Since the petitioner's income exceeded the maximum income limit, an income trust had to be set up and properly funded before the petitioner could be approved for ICP Medicaid benefits.

The petitioner's representative set up an income trust and funded it with $300 on September 6, 2006. On September 26, 2006, the petitioner's representative made contact with Rycha Redden to inquire about the status of his case. Ms. Redden reviewed the case and called the petitioner's representative back on September 29, 2006 to inform him that he needed to submit another application, which he did on September 29, 2006. The August application had been denied because the petitioner's living address was listed as . . . . The petitioner's representative had mistakenly listed his address as the petitioner's address and a non resident of Florida cannot receive ICP Medicaid in Florida.

The Department did not provide the petitioner with written notification of the denial of the August application. A telephone interview was conducted on October 2, 2006 wherein the funding procedures for the income trust were explained. The income

trust was properly funded in October and on November 6, 2006 ICP Medicaid was approved effective October 2006 and ongoing.

Based on the petitioner's income the income trust would have had to be funded with at least $343.13 to achieve ICP Medicaid eligibility. The Department's records showed that for September 2006, only $300 of the petitioner's income was deposited into the trust. All parties acknowledged at the hearing that during the month of September 2006, the income trust had not been properly funded and as a result, the petitioner's income was over the ICP Medicaid income limit of $1809.

The petitioner's representative believed that if he had been interviewed or contacted within 10 to 15 days of the August 21, 2006 application as stated on the application confirmation page then he would have known how much to put in the income trust and he would have been able to achieve eligibility for the month of September 2006.

CONCLUSIONS OF LAW

The argument of the petitioner's representative was that the petitioner should not be adversely affected due to miscommunications or inadequate information which resulted in the deficient funding of the income trust. The argument of agency staff was that all policy criteria must be fulfilled before ICP Medicaid benefits can be authorized and there are no provisions in the agency policy to make exception to meeting such criteria.

Fla. Admin. Code 65A-1.702 **Special Provisions** (15) "Trusts" in part states:

> (a) The Department applies trust provisions set forth in 42 U.S.C. § 1396p(d).

(b) Funds transferred into a trust or other similar device established other than by a will prior to October 1, 1993 by the individual, a spouse or a legal representative are available resources if the trust is revocable or the trustee has any discretion over the distribution of the principal. Such funds are a transfer of a resource or income, if the trust is irrevocable and the trustee does not have discretion over distribution of the corpus or the client is not the beneficiary. No penalty can be imposed when the transfer occurs beyond the 36-month look back period. Any disbursements which can be made from the trust to the individual or to someone else on the individual's behalf shall be considered available income to the individual. Any language which limits the authority of a trustee to distribute funds from a trust if such distribution would disqualify an individual from participation in government programs, including Medicaid, shall be disregarded.

(c) Funds transferred into a trust, other than a trust specified in 42 U.S.C. § 1396p(d)(4), by a person or entity specified in 42 U.S.C. § 1396p(d)(2) on or after October 1, 1993 shall be considered available resources or income to the individual in accordance with 42 U.S.C. § 1396p(d)(3) if there are any circumstances under which disbursement of funds from the trust could be made to the individual or to someone else for the benefit of the individual. If no disbursement can be made to the individual or to someone else on behalf of the individual, the establishment of the trust shall be considered a transfer of resources or income."

Fla. Admin. Code **65A-1.713 SSI-Related Medicaid Income Eligibility Criteria**, in part states:

"(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:...(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in 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(13)(a), F.A.C."
(To be eligible for ICP Medicaid, under Title XVI policy, the maximum income standard is $1,809.)

Fla. Integrated Pub. Policy Manual, 165-22, Section 1840.0110 further states:

"Income Trusts (MSSI)
The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and

Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.
To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

It is established on or after 10/01/93 for the benefit of the individual;
It is irrevocable;
It is composed only of the individual's income (social security, pensions, or other income sources); and
The trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The Economic Self-Sufficiency Specialist MUST forward all income trusts to their District Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.
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.**" (emphasis added)f

The above authorities provide for the establishment of an income trust by an Institutional Care Program applicant in order to reduce monthly income below the state income limitations. The Findings of Fact show that an income trust was established in September 2006 and funded with $300. Based on the petitioner's income the amount that was funded did not reduce the petitioner's income to at or below the maximum income limit for ICP Medicaid of $1809.

Since the petitioner's income for September 2006 exceeded the maximum limit, the Department denied ICP Medicaid benefits for that month. The Department's action

is consistent with the above cited authorities and there were no grounds presented to make an exception to this policy.

The petitioner's argument that he was not given all of the necessary information needed to properly fund the trust until after the month had passed is insufficient to justify the approval for ICP Medicaid benefits. Therefore, the Department correctly denied Institutional Care Program benefits for the month of September 2006.

The Department is hereby ordered to send the petitioner a notice denying the August 21, 2006 application since the record reflects that this was not done.

DECISION

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 Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 20th day of March, 2007,

in Tallahassee, Florida.

James Abdur-Rahman

James Abdur-Rahman
Hearing Officer
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OFFICE OF APPEAL HEARINGS
DEPT. OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-07059

PETITIONER,

Vs.

CASE NO.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 23 Manatee
UNIT: AHCA

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on January 26, 2007, at 11:32 a.m., in Bradenton, Florida. The petitioner was not present, but was represented by his mother, [illegible], who also testified. The respondent agency was represented by Sandra Barile, registered nurse specialist with the Agency for Health Care Administration (AHCA), who also testified. Dena Gay, also a registered nurse specialist with AHCA, was also present as a Department witness. Jodi Winter, licensed physical therapy consultant with the Bureau of Medicaid Services, appeared as a witness for the agency via telephone.

ISSUE

At issue is the Department's decision of September 20, 2006 to deny funding under the regular "State Plan" Medicaid Program for a requested standing device, specifically a Rifton Dynamic Standing Device.

FINDINGS OF FACT

The respondent agency generated notice to the petitioner on September 20, 2006 that a standing device without large wheels could be approved. This specific notice was not submitted as evidence.

The petitioner is one year old and was born on May 18, 2005. The petitioner is approved to receive eligible services under the Florida Medicaid Program. The petitioner lives with his mother. The petitioner diagnoses include cerebral palsy, microencephaly, with vision and hearing impairments. The petitioner receives physical therapy and ambulates with the assistance of a standing device.

On July 20, 2006, the petitioner's treating physical therapist sent clinical documentation to the agency for the requested stander, a Rifton Dynamic Standing device, as shown in Respondent Exhibit 3 and the Petitioner Exhibit 1. This specific standing device contains large wheels which facilitates increased speed of mobility. However, the ability to move a standing device does not impact the medical benefits of weight-bearing. The agency stipulated that the less costly standing device without large wheels could be approved, but asserts that the more costly standing device with large wheels does not meet defined medical necessity criteria.

CONCLUSIONS OF LAW

The Florida Administrative Code Rule 59G-1.010(166) addresses relevant definitions within the Medicaid Program, which are also applicable to this specific Medicaid decision regarding the request for the standing device with large wheels, at issue. Subsection (166) of the Florida Administrative Code Rule defines what constitutes "medically necessary" care, goods or services, as follows:

> "...means that the medical or allied care, goods, or services furnished or ordered must:
> (a) Meet the following conditions:
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide; and
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

Paragraph 2. of the above-cited Administrative Code Rule indicates that goods or services must be individualized, specific, consistent and must not be "in excess of the individual's needs." The Findings of Fact show that the requested stander with large wheels does not impact the medical benefits of weight-bearing. Therefore, the requested stander with large wheels is in excess of the petitioner's medical needs.

Paragraph 4. of the above F.A.C. Rule shows that needed goods or service must be provided in an effective, but least costly manner. Findings show that there is another standing device without the large wheels that would address the medical benefits of weight-bearing, which is less costly alternative to the device with larger wheels. This suggested alternative is a viable and less costly alternative to the standing device with large wheels.

Paragraph 5. of the above F.A.C. Rule shows that the requested goods or services must be "furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider." The Findings of Fact show that the provision of the requested stander with large wheels would primarily be provided for the convenience of the petitioner with greater speed of mobility.

Since the request for the standing device with large wheels does not meet the defined medical necessity criteria in paragraphs two, four, and five of F.A.C. Rule 59G-1.010(166), the respondent agency is correct to deny the requested stander with large wheels.

DECISION

This appeal is denied and the agency decision affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the

party resides. 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 petitioner's responsibility.

DONE AND ORDERED this 5th day of March, 2007,

in Tallahassee, Florida.

Jim Travis
Hearing Officer
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OFFICE OF APPEAL HEARINGS
DEPT OF CHILDREN & FAMILIES

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

APPEAL NO. 06F-07705

PETITIONER,

Vs.

CASE NO. 1171054360

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES (DCF)
DISTRICT: 12 Volusia
UNIT: 88216

RESPONDENT.
_______________________________/

FINAL ORDER

Pursuant to notice, and rescheduling request of the parties, an administrative hearing was convened before the undersigned hearing officer in Daytona Beach, Florida, at 11:40 a.m. on February 7, 2007. The petitioner was not present but was duly represented by , with testimony presented by , nursing home administrator and , business office manager. The respondent was represented by Ernestine Bethune, economic self-sufficiency supervisor, with testimony available from Susan Mauro, senior economic self-sufficiency specialist.

ISSUE

At issue was whether or not Institutional Care Program (ICP) Medicaid denial was correct due to insufficient follow through in the application process. As an applicant the petitioner had the burden of proof.

FINDINGS OF FACT

The petitioner does not have a legal guardian and has not been adjudicated incompetent. She is not in a coma. However, she is not fully capable and she is a resident in a long term care nursing facility due to medical need. Such is undisputed.

Due to a belief that possible exploitation may have occurred, a referral to the Adult Protective Investigative function within DCF was made by nursing facility staff regarding a family member. The situation also may have been referred for law enforcement action. The Economic Self-sufficiency function of DCF (the respondent's representative) was aware of the Adult Protective Investigation referral. No results were known from either referral source.

While residing at the nursing facility, costs are being incurred. To help meet those costs, and in the absence of full payment for such expenses, the nursing facility filed an application for ICP Medicaid coverage at the end of September 2006. However, facility staff were unaware (and are unaware) of the full financial circumstance of the petitioner. Thus the September 2006 application (and another one before it) faced obvious difficulty.

Some income of the petitioner is from the state's Florida Retirement System (FRS), but the exact amount is unknown and all efforts to verify allegedly have been unsuccessful, although full details and nature of such efforts were not in evidence. Substantive evidence did not establish how diligently, when, or by whom, verification was attempted. However, testimony of both the respondent's representative and the petitioner's representative was that efforts had repeatedly occurred, and all efforts were unsuccessful.

The FRS amount is believed to exceed $1000 monthly and total income of the petitioner is believed by both the petitioner's representative and the respondent's representative to exceed state income limits. Additional income is Social Security Administration (SSA) retirement in the amount of $839. Additionally, there may be property or asset ownership. On behalf of the petitioner, the nursing facility staff successfully obtained some financial information and the SSA pension was being directed to the facility at the time of the September-October 2006 ICP application process.

As the income was thought to exceed state ICP income limit of $1809, and was unverified, the application was pended on October 16, 2006 for further verification of income as shown in Respondent's Exhibit 2, with income trust information also given to the petitioner's nursing home/ICP representative. Deadline to submit information was October 26, 2006. Verification of all income was not received by DCF at any time, a trust was not established, and the application was denied on November 13, 2006 (Respondent's Exhibit 1), with a determination that the representative did "not follow through in establishing eligibility."

Between the first scheduled date of hearing (January 3, 2007) and the new date of hearing, efforts at issue resolution continued, without success. As of date of hearing, no party had verification of the FRS income and a trust had not been established, approved or funded.

CONCLUSIONS OF LAW

From the outset, the unique predicament and misfortune of this situation is noted. Nevertheless, appropriate eligibility requirements must be applied, they cannot be

ignored, and eligibility must only be authorized when and if all eligibility factors are met.

Accordingly, Fla. Admin. Code 65A-1.204 addresses **Rights and Responsibilities** in part as follows:

> (1) Any person has the right to apply for assistance, have his/her eligibility determined, and if found eligible, to receive benefits. The applicant for or recipient of public assistance must assume the responsibility of furnishing all necessary facts and documentation to establish eligibility, advise the Department of any changes in his/her circumstances which might affect eligibility and/or the amount of the public assistance benefit, and to provide the department with any channel of information concerning his/her affairs that may be determined necessary. If the information or documentation is difficult for the person to obtain, the department must provide assistance in obtaining the information or documentation when requested or when it appears necessary.

Additional guidelines appear at Fla. Admin. Code 65A-1.205, addressing the **Eligibility Determination Process.** The pertinent excerpt appears at subsection (1), as follows:

> (d) If the eligibility specialist determines at the interview or at any time during the application process that additional information or verification is required, or that an assistance group member is required to register for employment services, the specialist must grant the assistance group 10 calendar days to furnish the required documentation or to comply with the requirements. For all programs, the verifications are due 10 calendar days from the date of request (i.e., the date the verification checklist is generated) or 30 days from the date of application whichever is later. In cases where medical information is requested the return due date is 30 calendar days following the request or 30 days from the date of application whichever is later. If the verification due date falls on a holiday or weekend, the deadline for the requested information is the next working day. If the verification or information is difficult for the person to obtain, the eligibility specialist must provide assistance in obtaining the verification or information when requested or when it appears necessary. If the required verifications and information are not provided by the deadline date, the application is denied, unless a request for extension is made by the applicant or there are extenuating circumstances justifying an additional extension. The eligibility specialist makes the decision of whether to grant the request for extension based on extenuating circumstances beyond the control of the individual, such as sickness, lack of transportation, etc.

When all required information is obtained, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.

Argument on behalf of the petitioner was, in part, that the petitioner should not be so severely impacted by miscommunications or difficulties which have created the deficient verification and/or trust establishment. Argument of agency staff was that all criteria of policy needed to be fulfilled and no ability to authorize benefits existed until all criteria were completely fulfilled.

Fla. Admin. Code 65A-1.702 **Special Provisions** (15) "Trusts" in part states:

(a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).

(b) Funds transferred into a trust or other similar device established other than by a will prior to October 1, 1993 by the individual, a spouse or a legal representative are available resources if the trust is revocable or the trustee has any discretion over the distribution of the principal. Such funds are a transfer of a resource or income, if the trust is irrevocable and the trustee does not have discretion over distribution of the corpus or the client is not the beneficiary. No penalty can be imposed when the transfer occurs beyond the 36-month look back period. Any disbursements which can be made from the trust to the individual or to someone else on the individual's behalf shall be considered available income to the individual. Any language which limits the authority of a trustee to distribute funds from a trust if such distribution would disqualify an individual from participation in government programs, including Medicaid, shall be disregarded.

(c) Funds transferred into a trust, other than a trust specified in 42 U.S.C. § 1396p(d)(4), by a person or entity specified in 42 U.S.C. § 1396p(d)(2) on or after October 1, 1993 shall be considered available resources or income to the individual in accordance with 42 U.S.C. § 1396p(d)(3) if there are any circumstances under which disbursement of funds from the trust could be made to the individual or to someone else for the benefit of the individual. If no disbursement can be made to the individual or to someone else on behalf of the individual, the establishment of the trust shall be considered a transfer of resources or income.

Fla. Admin. Code 65A-1.713 in part states:

SSI-Related Medicaid Income Eligibility Criteria.

(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 paragraph 65A-1.702(15), F.A.C.

Consistent with these regulatory standards, Fla. Integrated Pub. Policy Manual 165-22 Appendix A-9 sets ICP income limit for an individual at $1,809 during the end of 2006 and at $1869 for the first part of 2007. Without income verification, it simply cannot be determined whether standards were met. Additionally, as related to trust situations when income exceeds standards, Fla. Integrated Pub. Policy Manual, 165-22, Section 1840.0110 further states:

Income Trusts (MSSI)
The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.
To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-8 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

It is established on or after 10/01/93 for the benefit of the individual;
It is irrevocable;
It is composed only of the individual's income (Social Security, pensions, or other income sources); and
The trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The Economic Self-Sufficiency Specialist must forward all income trusts to their District Program Office for review and submission to the District Legal