

**FILED**

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Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-00157

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 05 MARION  
UNIT: 88119

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 27<sup>th</sup>, 2017, at 2:43 p.m.

**APPEARANCES**

For the Petitioner: [REDACTED]

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

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to deny her SSI-Related Medicaid application. The petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

The hearing was initially scheduled for March 14<sup>th</sup>, 2017, at 8:30 a.m. All parties phoned in as scheduled, and the petitioner requested a continuance to allow the

respondent additional time to work on the case. The respondent had no objections. The request was granted, and the hearing was rescheduled for April 12<sup>th</sup>, 2017, at 8:30 a.m.

On April 12<sup>th</sup>, 2017, all parties phoned in as scheduled. The petitioner requested a continuance to allow her time to send additional information to the respondent, and the respondent had no objections. The request was granted and the hearing was rescheduled for May 23<sup>rd</sup>, 2017, at 1:00 p.m.

On May 23<sup>rd</sup>, all parties phoned in as scheduled, and the respondent requested a continuance due to just receiving information from the petitioner. The petitioner did not object. Therefore, the request was granted, and the hearing was rescheduled for June 22<sup>nd</sup>, 2017, at 8:15 a.m.

On June 22<sup>nd</sup>, all parties phoned in as scheduled and went on the record briefly. While on the record, the petitioner stated she did not receive the respondent's evidence and did not wish to continue with the hearing until having seen the evidence. Therefore, the hearing ceased and was rescheduled as detailed above.

On July 27<sup>th</sup>, the petitioner and the hearing officer phoned in as scheduled. However, the hearing officer had to locate a department representative. After a representative was located, the hearing resumed as scheduled.

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

Respondent's exhibits 1 through 6 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated December 27<sup>th</sup>, 2016, the respondent informed the petitioner that her application for Medicaid was denied

because no household members were eligible for the program. On January 3<sup>rd</sup>, 2017, the petitioner filed a timely request to challenge the respondent's action.

### **FINDINGS OF FACT**

1. The petitioner submitted a paper application for SSI-Related Medicaid on December 22<sup>nd</sup>, 2016. (See Respondent's Exhibit 2). As part of the application process, the respondent is required to explore and, if deemed necessary, verify certain factors of eligibility which includes technical eligibility requirements.
2. The petitioner is a single-person household and was 60 years of age at the time of the application. There are no children under the age of 18 living in the petitioner's household, and the petitioner considers herself disabled.
3. The petitioner applied for disability through the Social Security Administration (SSA) on July 11<sup>th</sup>, 2016. SSA denied the petitioner's application on August 25<sup>th</sup>, 2016 with the denial reason code N32. (See Respondent's Exhibit 5). According to the State Online Query guide (SOLQ), the denial code N32 means, "Capacity for substantial gainful activity – other work, no visual impairment." The petitioner appealed the SSA denial on October 17<sup>th</sup>, 2016, and the appeal date is accompanied with a code of "R." (See Respondent's Exhibit 5). The SOLQ guide explains the appeal code of "R" as, "Gearing – affirmation of prior decision."
4. The petitioner described her medical conditions as fibromyalgia, osteoarthritis, bipolar disorder, and depression. The petitioner asserts that all conditions were reported to SSA on the July 11<sup>th</sup>, 2016, application. According to the petitioner, the conditions are expected to last throughout her lifetime. The petitioner contends that the fibromyalgia has worsened since the SSA denial. The worsening pain began "a few

months ago.” However, the petitioner was unable to provide an exact month or timeframe of when the pain worsened.

5. The respondent forwarded the petitioner’s disability documents to the Department of Disability Determination (DDD) for review on April 12<sup>th</sup>, 2017. DDD denied the petitioner’s Disability Medicaid on April 18<sup>th</sup>, 2017, due to adopting the previous SSA denial decision.

6. The petitioner testified that she is unable to maintain a job due to pain. Additionally, the petitioner is unable to obtain her medications and seek medical care because she is uninsured. According to the petitioner, an attorney would not take her SSA case.

#### **CONCLUSIONS OF LAW**

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

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

9. The Code of Federal Regulations at 42 C.F.R. Section 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 Section 435.911 on the same issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA

automatically confers Medicaid eligibility... (b) Effect of SSA determinations. **(1)(i) An SSA disability determination is binding on an agency until the determination is changed by SSA...** *[Emphasis added]* (c) Determination 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 disability condition different from, or in addition to, that considered by SSA in making its determination...

10. The above federal regulation indicates that the Department may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in Section 435.911 on the same issues presented in the Medicaid application. The regulation also states that the Department must make a determination of disability if the individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA and alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination or alleges more than 12 months after the most recent SSA determination. The Department is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA.

11. The hearing officer must consider whether or not the respondent took the correct action on the petitioner's Medicaid application. As established in the Findings of Fact, the petitioner conditions are described as fibromyalgia, osteoarthritis, bipolar disorder, and depression. According to the petitioner, these conditions were reported to SSA at the time of the July 11<sup>th</sup>, 2016 application. The petitioner acknowledged no new conditions but did mention that the fibromyalgia worsened "a few months ago." However, the petitioner was unable to provide a specific timeframe to explain "a few

months ago." The respondent recently sent the petitioner's medical documentation to DDD for review, and DDD adopted the decision rendered by SSA. The hearing officer concludes that the respondent's action to deny the petitioner's SSI-Related Medicaid application was correct. The respondent is bound by the SSA determination.

**DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 06 day of June, 2017,

in Tallahassee, Florida.



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Kimberly Vargo  
Hearing Officer  
Building 5, Room 255  
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Tallahassee, FL 32399-0700  
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FINAL ORDER (Cont.)

17F-00157

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

Aug 01, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-00902

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 12 SARASOTA  
UNIT: 88521

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 26<sup>th</sup>, 2017, at 2:41 p.m.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se.

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

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to deny his SSI-Related Medicaid application. The petitioner carries the burden of proving his position by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

The hearing was originally scheduled for April 4<sup>th</sup>, 2017, at 8:30 a.m., and all parties phoned in as scheduled. The respondent requested a continuance in order to contact a representative from the Department of Disability Determination (DDD) as a

witness. The petitioner had no objections, and the request was granted. Therefore, the hearing was rescheduled for May 8<sup>th</sup>, 2017, at 2:30 p.m.

On May 8<sup>th</sup>, 2017, all parties phoned in as scheduled. The petitioner requested a continuance in order to send additional information to the respondent. The respondent had no objections, and the request was granted. The hearing was rescheduled as detailed above.

Appearing as a witness for the petitioner was his wife, [REDACTED]

Also appearing as a witness for the petitioner was [REDACTED], Eligibility Representative at [REDACTED].

At the beginning of the hearing, the petitioner stated that he had not received the respondent's evidence. However, he wished to proceed with the hearing as scheduled.

Petitioner's exhibit 1 was admitted into evidence.

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

The hearing officer allowed until the close of business July 6<sup>th</sup>, 2017, for Ms. Moyles to submit additional information and for the respondent to provide evidence to the petitioner. The hearing officer then allowed until the close of business July 17<sup>th</sup>, 2017, for both parties to respond to the information if they chose to do so. Neither party responded within the allotted timeframe. Therefore, the record was closed.

By way of a Notice of Case Action (NOCA) dated January 18<sup>th</sup>, 2017, the respondent informed the petitioner that his Medicaid application dated December 16<sup>th</sup>, 2016, was denied because a member of the household did not meet a disability requirement, and no household members were eligible for the program. On January 26<sup>th</sup>, 2017, the petitioner filed a timely request to challenge the respondent's action.

### **FINDINGS OF FACT**

1. The petitioner submitted an online application for SSI-Related Medicaid on December 16<sup>th</sup>, 2016. (See Respondent's Exhibit 2). As part of the application process, the respondent is required to explore and verify all technical factors of eligibility.
2. The petitioner's household includes himself, 49 years of age, and his spouse, 63 years of age. There are no children under the age of 18 living in the home, and the petitioner considers himself to be disabled.
3. The petitioner and [REDACTED] described the petitioner's condition as [REDACTED] and accompanying symptoms related to that condition. [REDACTED] testified that the petitioner needs to be placed on a [REDACTED] list but lacks funding. The petitioner contends that his condition is worsening which results in multiple infections, swelling, fatigue, no muscle mass, and increasing hospital visits. According to the petitioner, the condition is terminal, and he was only given three to five years to live. The petitioner reported the [REDACTED] and the need for a [REDACTED] to SSA at the time of application.
4. The petitioner applied for Supplemental Security Income (SSI) from the Social Security Administration (SSA) on August 23<sup>rd</sup>, 2016. The application was denied on October 11<sup>th</sup>, 2016, with a denial code of N32. (See Respondent's Exhibit 4). According to the State Online Query guide (SOLQ), the denial code of N32 means "Non-pay – Capacity for substantial gainful activity – other work, no visual impairment." [REDACTED] asserts that the petitioner appealed the SSA denial on December 16<sup>th</sup>, 2016. However, according to the respondent's evidence, the petitioner appealed the denial on November 30<sup>th</sup>, 2016, and lists an accompanying appeal code of "R." (See

Respondent's Exhibit 4). According to SOLQ, an appeal code of "R" means "Gearing – affirmation of prior decision." [REDACTED] contends that SSA has not made a decision regarding the appeal.

5. The respondent provided, as part of its evidence, a copy of its business notes (CLRC). A CLRC entry dated December 19<sup>th</sup>, 2016, indicates that the respondent completed a disability Medicaid interview with the petitioner and noted the worsening condition since applying for SSI. CLRC also makes mention that the petitioner's medical records were sent to DDD for review on January 11<sup>th</sup>, 2017. The respondent testified that DDD returned an unfavorable decision on January 17<sup>th</sup>, 2017. According to the respondent, DDD denied the disability Medicaid because it adopted the previous decision made by SSA in December 2016. (See Respondent's Exhibit 5). Neither the petitioner nor the respondent provided evidence of an SSA denial from December 2016.

6. A witness from DDD did not appear. However, the respondent contends that it made contact with a DDD representative on April 4<sup>th</sup>, 2017, and verified that the petitioner's worsening condition was reviewed.

### **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 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under 409.285, Fla. Stat.

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

9. The Code of Federal Regulations at 42 C.F.R. Section 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 Section 435.911 on the same issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility... (b) Effect of SSA determinations. **(1)(i) An SSA disability determination is binding on an agency until the determination is changed by SSA...** *[Emphasis added]* (c) Determination 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 disability condition different from, or in addition to, that considered by SSA in making its determination...

10. The above federal regulation indicates that the Department may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in Section 435.911 on the same issues presented in the Medicaid application. The regulation also states that the Department must make a determination of disability if the individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA and alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination or alleges more than 12 months after the most recent SSA determination. The Department is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA.

11. The hearing officer must consider whether or not the respondent took the correct action on the petitioner's Medicaid application. As established in the Findings of Fact,

the petitioner's condition was described as [REDACTED] and the accompanying symptoms with the need for a [REDACTED]. As stated in the Findings of Fact, DDD returned an unfavorable decision to the respondent on January 17<sup>th</sup>, 2017, citing that it was adopting the December 2016 denial from SSA. The evidence shows that the petitioner reported the worsening condition during the disability interview with the respondent on December 19<sup>th</sup>, 2016, and that the respondent provided medical documentation to DDD.

12. In conclusion, the undersigned concludes that the respondent's action to deny the petitioner's SSI-Related Medicaid application was correct. Based on the evidence and testimony, the petitioner's worsening condition was reported to the respondent and medical documentation was forwarded to DDD. Therefore, the information was accessible for DDD to review. DDD determined that the same conditions had already been reviewed by SSA. As stated in the above-cited authority, the respondent is bound by an SSA decision unless SSA changes the decision.

### **DECISION**

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

### **NOTICE OF RIGHT TO APPEAL**

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

FINAL ORDER (Cont.)  
17F-00902  
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funds to assist in this review.

DONE and ORDERED this 01 day of August, 2017,  
in Tallahassee, Florida.



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

**FILED**

Jul 28, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO.: 17F-01221

PETITIONER,

Vs.

HUMANA MANAGED CARE ORGANIZATION,  
AND AGENCY FOR HEALTH CARE ADMINISTRATION  
CIRCUIT: 12 Manatee  
UNIT: AHCA

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 19, 2017 at 9:34 a.m.

**APPEARANCES**

For Petitioner: 

For Respondent: Lauren Hernandez  
Complaints and Grievances Specialist  
DentaQuest

**STATEMENT OF ISSUE**

Petitioner is appealing the denial of Gingival Irrigation dental code D4921 and Periodontal services dental codes D4341 and D4342. Petitioner carries the burden of proving his position by a preponderance of the evidence in this appeal.

### **PRELIMINARY STATEMENT**

Petitioner did not submit any documentary evidence at the hearing.

Stacey Larson, Service Operations Specialist with Humana, appeared as a witness for Respondent. Lauren Hernandez, Complaints and Grievances Specialist with DentaQuest, appeared as a witness for Respondent.

Dianne Soderlind R.N. Specialist, Fair Hearing Liaison with the Agency for Health Care Administration (“AHCA”) appeared as an observer.

Respondent introduced Exhibits “1” to “12,” inclusive at the hearing, all of which were accepted into evidence and marked accordingly.

The undersigned-hearing officer left the record open for ten (10) days from the date of the final hearing for Petitioner to review Respondent’s additional evidence and submit a response. The record closed on June 29, 2017 and Petitioner did not file a response to Respondent’s additional evidence.

### **FINDINGS OF FACT**

1. Petitioner is a 56-year-old Medicaid recipient enrolled with Humana, a Florida Health Managed Care provider.
2. Humana requires prior authorization for services related to dental care and has contracted with DentaQuest to review prior authorization requests.
3. Petitioner’s dentist sent a prior authorization request for dental procedures D4341: periodontal scaling, and D4921: Gingival Irrigation. In support of his request, the dentist submitted an ADA Dental Claim Form and dental X-rays. On the form, he requested periodontal scaling using D4341 dental code, and gingival irrigation using D4921 dental code for all four quadrants. (See Respondent’s Exhibits 2 and 3).

4. DentaQuest received the request on January 26, 2017. (See Respondent's Exhibit 4).

5. DentaQuest made its determination on January 30, 2017 denying procedures D4921 for all four quadrants and D4341 periodontal scaling and root planning for his lower left quadrant. On January 31, 2017, DentaQuest issued a Notice of Action denying the request as not a covered benefit. The notice of action stated:

The facts that we used to make our decision are:

This is not a covered service. Our dentist looked at your x-rays and says that you do not have at least four (4) affected teeth in this section of your mouth to have this service. There is another kind of service you may have for less than four (4) affected teeth. We have told your dentist this and we are waiting for more information. (See Respondent's Exhibit 4 and 5).

6. DentaQuest's witness stated Petitioner's dentist had submitted the wrong dental code to conduct periodontal scaling and root planning on Petitioner's lower left quadrant because his lower left quadrant does not have four or more teeth. Petitioner admitted that his dentist did submit the wrong dental code for his lower left quadrant.

7. Petitioner's dentist submitted a new ADA Dental Claim Form with the correct dental code D4342 for Petitioner's lower left ("LL") quadrant. The dentist included dental code D4341 for Petitioner's lower right ("LR"), upper right ("UR"), and upper left ("UL") quadrants. (See Respondent's Exhibit 12).

8. DentaQuest received the new request on February 23, 2017. (See Respondent's Exhibit 11).

9. DentaQuest made its determination on February 23, 2017 denying procedures D4342 and D4341. On February 25, 2017, DentaQuest issued a Notice of Action denying the requested services as not a covered benefit. The notice of action stated:

The facts that we used to make our decision are:

You can only get this service once in thirty-six (36) months. Our records show you had this service less than thirty-six (36) months ago. (See Respondent's Exhibit 9 and 11).

10. Petitioner alleged that deep gum cleaning is necessary because he suffers from [REDACTED]. He is concerned about infection and losing his teeth if he does not have the deep gum cleaning as prescribed by his dentist.
11. Petitioner alleged that he lives on a fix income and cannot afford the procedure to clean his teeth.
12. DentaQuest's witness stated that Petitioner's dental plan under Humana offers periodontal scaling and root planning for adults on Medicaid. However, the periodontal scaling and root planning can only be done every thirty-six months using dental codes D4341, D4342 or D4355. Petitioner has already used dental code D4341 on February 2, 2017 to clean his LR, UR, and UL quadrants. Petitioner has to wait thirty-six months in order to receive another periodontal cleaning under dental code D4342 for his LL quadrant, which is periodontal cleaning for three teeth or less.
13. DentaQuest's witness stated under Petitioner's Medicaid Humana covered benefits, dental plan dental code D4921 gingival irrigation is not a covered benefit.
14. Petitioner admitted he is aware he can only receive periodontal cleaning every thirty-six (36) months.

#### **CONCLUSIONS OF LAW**

15. By agreement between the Agency for Health Care Administration ("AHCA") and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

16. The Florida Medicaid Program is authorized by Florida Statutes Chapter 409 and Chapter 59G, of the *Florida Administrative Code*. The Program is administered by AHCA.

17. This proceeding is a de novo proceeding pursuant to Rule 65-2.056, of the *Florida Administrative Code*.

18. This is a Final Order pursuant to Sections 120.569 and 120.57, Florida Statutes.

19. The standard of proof in an administrative hearing is a preponderance of the evidence pursuant to Rule 65-2.060(1), of the *Florida Administrative Code*.

20. Section 409.905, Florida Statutes, "Mandatory Medicaid Services," states, in relevant part: "Any service provided under this section shall be provided only when medically necessary and in accordance with state and federal law."

21. Sections 409.971- 409.973, Florida Statutes, establishes the requirement for Medicaid recipients to be enrolled in the statewide managed medical assistance program and the minimum benefits the managed care plans shall cover. Dental services are one of the benefits that must be provided.

22. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

23. Rule 59G-1.010(226) of the *Florida Administrative Code* defines "prior authorization" as: "Prior authorization" means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

24. The Florida Medicaid Dental Services Coverage Policy Handbook, May 2016, ("Handbook") is promulgated into law by Rule 59G-4.060 of the *Florida Administrative Code*.

25. Page one of the Handbook states:

Description -- Florida Medicaid dental services provide for the study, screening, assessment, diagnosis, prevention, and treatment of diseases, disorders, and conditions of the oral cavity.

....

Statewide Medicaid Managed Care Plans -- This Florida Medicaid policy provides the minimum service requirements for all providers of dental services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). **Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration's (AHCA) contract with the Florida Medicaid managed care plan.** The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies. (Emphasis Added).

26. Page two of the Handbook states:

Who Can Receive -- Florida Medicaid recipients requiring medically necessary dental services. Some services may be subject to additional coverage criteria as specified in section 4.0.

If a service is limited to recipients under the age of 21 years, it is specified in section 4.0. Otherwise, Florida Medicaid reimburses for services for recipients of all ages.

27. Page three of the Handbook states:

Specific Criteria

Florida Medicaid reimburses for the following services in accordance with the American Dental Association Current Dental Terminology Manual, the American Academy of Pediatrics Periodicity Schedule, and the **applicable Florida Medicaid fee schedule(s)**, or as specified in this policy: (Emphasis Added).

28. Page four of the Handbook states:

Periodontal Services

Florida Medicaid reimburses for periodontal services for recipients under the age of 21 years to diagnose and treat the diseases of the supporting and surrounding tissues of the teeth.

29. Page five of the Handbook states:

General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- **The Recipient does not meet the eligibility requirements listed in section 2.0**
- The service unnecessarily duplicates another provider's service (Emphasis Added).

Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- **Services that are not listed on the fee schedule** (Emphasis Added).

30. In the present case, Petitioner alleges that he requires periodontal cleaning in order to prevent losing his teeth due to gum disease.

31. Florida Medicaid's current Dental General Fee Schedule, promulgated on January 1, 2017<sup>1</sup>, shows procedures D4341 and D4342 are covered by Medicaid for recipients up to the maximum age of 20. Periodontal services are not a covered benefit for Petitioner because he is fifty-six years old pursuant to the Handbook.

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<sup>1</sup> Fla. Admin. Code R. 59G-4.002

32. The Florida Medicaid Program provides limited dental services for adults. Managed care plans, such as Humana, may provide benefits that exceeds Medicaid guidelines but cannot be more restrictive than the Medicaid guidelines contained in the Handbook. In the present case, Humana provides periodontal cleaning to adult Medicaid members. Humana's criteria requires one cleaning per patient every thirty-six (36) months using one of these dental codes: D4341, D4342, or D4355.
33. Petitioner received periodontal cleaning in February of 2017 using dental code D4341 for his UR, LR, and UL quadrants. Petitioner admits he did receive the service from his dentist. However, Petitioner's LL quadrant used a different dental code D4342 for three teeth or less.
34. Medical Necessity for procedure D4341 is not required because Petitioner has already received the requested services in February of 2017. Procedure D4921 is not a covered benefit under the Florida Medicaid Fee Schedule and Humana's covered benefits for adults on Medicaid. Therefore, a Medical Necessity review is not required for dental code D4921. Procedure D4342 is not covered because Petitioner has already exceeded his coverage benefits based on Humana's benefit coverage for adults on Medicaid.
35. Based on reviewing the totality of the evidence and controlling legal authorities, the undersigned concludes that Respondent's decision in this matter is correct.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency's action is 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 petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 28 day of July, 2017, in

Tallahassee, Florida.



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Allison Smith-Dossou  
Hearing Officer  
Building 5, Room 255  
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Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Humana Hearings Unit

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

**FILED**

Jul 17, 2017

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-01522

PETITIONER,

Vs.

CASE NO. 1 [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 20 LEE  
UNIT: 883CF

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 14<sup>th</sup>, 2017, at 1:00 p.m.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se.

For the Respondent: Ed Poutre, Senior Worker for the Department of Children and Families.

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to terminate his Medicaid waiver coverage. The respondent carries the burden of proving its position by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

The hearing was originally scheduled for April 20<sup>th</sup>, 2017, at 2:30 p.m. All parties phoned in as scheduled. The petitioner and the respondent held a brief pre-hearing conference, and the petitioner requested a continuance so he could contact another

agency in regards to continuing his benefits. The continuance was granted and the hearing was rescheduled for May 17<sup>th</sup>, 2017, at 2:30 p.m.

On May 17<sup>th</sup>, 2017, all parties phoned in as scheduled. The petitioner and the respondent held a brief pre-hearing conference, and the respondent requested a continuance in order to have time to contact another agency regarding actions taken regarding the petitioner's benefits. The petitioner had no objections, and the continuance was granted. The hearing was rescheduled as detailed above.

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

Respondent's exhibits 1 through 6 were admitted into evidence.

The respondent was allowed until the close of business June 20<sup>th</sup>, 2017, to provide additional information. The record would then be held open an additional 10 days to allow the petitioner an opportunity to respond to the new information if he chose to do so. On June 20<sup>th</sup>, 2017, the respondent requested an extension to have an additional three days to provide the information citing it was still waiting on the other agency. The extension was granted and the due date was extended until the close of business June 23<sup>rd</sup>, 2017. The deadline for the petitioner to respond was also extended until the close of business July 3<sup>rd</sup>, 2017. The respondent provided the information timely, and the documents were entered as respondent's exhibit 7. The petitioner did not respond to the additional information. Therefore, the record was closed at the close of business July 3<sup>rd</sup>, 2017.

By way of a Notice of Case Action (NOCA) dated February 15<sup>th</sup>, 2017, the respondent informed the petitioner that his Medicaid case was opened in error and has

been closed. The Medicaid benefits would end on February 28<sup>th</sup>, 2017. On February 15<sup>th</sup>, 2017, the petitioner filed a timely request to challenge the respondent's action.

### **FINDINGS OF FACT**

1. The petitioner submitted an online application to add to the additional benefits of SSI-Related Medicaid and Home and Community Based Services/Waivers to his current benefits on January 9<sup>th</sup>, 2017. (See Respondent's Exhibit 2). SSI-Related Medicaid is not an issue for this appeal. As part of the application process, the respondent is required to explore and verify all factors of eligibility.
2. The petitioner is a single-person household and was 49 years of age at the time of the application. According to the petitioner, he lives with his daughter who assists him with his daily living activities such as getting in and out of bed and bathing.
3. The petitioner receives Social Security Disability (SSD) in the amount of \$1,328 monthly and pays a Medicare B premium of \$132 per month.
4. According to the respondent, the petitioner was receiving waiver services through the Department of Elder Affairs CARES unit. CARES completed an assessment with the petitioner on September 7<sup>th</sup>, 2016. The notes from the assessment indicate that the petitioner lives alone and does not require assistance with his daily living activities. The notes also show that a second assessment was completed on September 13<sup>th</sup>, 2016, and indicate again that the petitioner lives alone and does not require assistance with his daily living activities. (See Respondent's Exhibit 7). However, the petitioner asserts that his daughter was being paid to care for him through a State program. According to

the petitioner, his daughter was paid for approximately one month before the waiver services were terminated.

5. The respondent received a notification that the petitioner no longer met the Level of Care (LOC) as of October 26<sup>th</sup>, 2016. (See Respondent's Exhibit 6). The respondent testified that the waiver coverage was closed but then reauthorized after receiving a new LOC. According to the respondent, it realized the coverage had been authorized in error, and it terminated the waiver a second time as of February 28<sup>th</sup>, 2017. At that time, the petitioner was enrolled in Medically Needy (MN) and approved for Qualifying Individual-1 (QI-1). (See Respondent's Exhibit 3).

6. The petitioner does not understand why CARES will not complete another assessment. The petitioner asserts that he is still in need of services and requires daily assistance from his daughter. The respondent contends that it cannot reauthorize the petitioner's waiver Medicaid without an approved LOC from CARES.

7. The respondent provided documentation and notes from the Department of Elder Affairs in lieu of witness testimony.

### **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 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under 409.285, Fla. Stat.

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

10. The Fla. Admin. Code R. 65A-1.701 defines the following terms:

(1) Aged and Disabled Adult Waiver Program/Home and Community-Based Services (ADA/HCBS): A Home and Community-Based Services (HCBS) waiver program for aged and disabled individuals in need of skilled or intermediate nursing care services.

(2) Appropriate Placement: Placement of an individual into a Medicaid-participating nursing facility that provides the type and level of care the department determines the individual requires; or the receipt of approved HCBS waiver services by an individual in accordance with an approved plan; or receipt of hospice services provided by a Medicaid-participating hospice provider by an individual in accordance with Title 42 U.S.C. § 1396d...

11. The 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.

12. Fla. Admin. Code R. Section 65A-1.711 SSI-Related Medicaid Non-Financial Eligibility Criteria states in part:

(4) To be eligible for a Home and Community Based Services Waiver program, an individual must meet the requirements of Rule 59G-13.080, F.A.C. An individual cannot receive waiver coverage and institutional care program coverage at the same time. An individual residing in a nursing home may apply for the waiver, but the individual's approval must be subject to their discharge and move into a community living arrangement. AHCA, in coordination with the program responsible for the daily operations of the waiver, requests the number of individuals to be served by the waiver as part of each waiver submission. The Centers for Medicare and Medicaid Services approve the request based on information provided by the state. Additionally, an individual must meet the criteria for one of the following waivers:

- (a) Be at least 65 years of age and meet the requirements of subsection 65A-1.701(5), F.A.C., to participate in the Channeling waiver; or
- (b) Be determined disabled in accordance with SSI disability criteria set forth in 42 C.F.R. §§ 435.540 (2007) and 435.541 (2007) (both incorporated by reference) and meet the requirements of subsection 65A-1.701(24), F.A.C., to participate in the Project AIDS Care waiver; or
- (c) Be age 65 or older, or be 18 years of age through 64 years of age and disabled in accordance with SSI disability criteria set forth in 42 C.F.R. §§ 435.540 (2007) and 435.541 (2007) (both incorporated by reference), and meet the requirements of subsection 65A-1.701(1), F.A.C., to participate in the ADA/Home and Community Based Services waiver program; or
- (d) Be disabled in accordance with SSI disability criteria set forth in 42 C.F.R. §§ 435.540 (2007) and 435.541 (2007) (both incorporated by reference) and meet the requirements of subsection 65A-1.701(10), F.A.C., to participate in the Developmental Services waiver program; or
- (e) Be age 60 or older and meet the requirements in subsection 65A-1.701(3), F.A.C., to participate in the Assisted Living waiver; or
- (f) Be age 18 through 64 and disabled in accordance with SSI disability criteria set forth in 42 CFR §§ 435.540 (2007) and 435.541 (2007) (both incorporated by reference) with a medical condition of traumatic brain injury or spinal cord injury in accordance with the Centers for Medicare and Medicaid Services approved Medicaid waiver.

13. As stated in the above-cited authorities, a person must be considered disabled by the Social Security Administration (SSA) in order to receive waiver services. The petitioner has been determined disabled by SSA. The Department of Elder Affairs CARES unit must also complete an assessment to determine whether or not the person requires assistance on a daily basis and at what level. CARES then forwards the information to the respondent who, in turn, makes an eligibility determination. In this instance, there is discrepant information in regards to the petitioner's testimony and the notations in CARES' documents. The petitioner testified that he resides with his

daughter, and she assists him with bathing and getting out of bed. Two separate CARES assessment indicate that the petitioner lives alone and needs no assistance with daily living tasks. CARES determined that the petitioner was no longer in need of waiver services through its agency. As of February 28<sup>th</sup>, 2017, the respondent terminated the petitioner's waiver coverage and enrolled him in MN and authorized QI-1. Despite the discrepant information, the undersigned affirms the respondent's action. Currently, there is not a LOC allowing for the authorization of Medicaid.

### **DECISION**

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

### **NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 17 day of July, 2017,

in Tallahassee, Florida.



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Kimberly Vargo  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard

FINAL ORDER (Cont.)

17F-01522

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Tallahassee, FL 32399-0700

Office: 850-488-1429

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Email: [Appeal.Hearings@myflfamilies.com](mailto:Appeal.Hearings@myflfamilies.com)

Copies Furnished To: [REDACTED], Petitioner

Office of Economic Self Sufficiency

Aug 21, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. [REDACTED]

PETITIONER,

Vs.

MANAGED CARE ORGANIZATION, AND  
AGENCY FOR HEALTH CAREADMINISTRATION  
CIRCUIT: 17 Broward  
UNIT: AHCA

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 20, 2017 at 1:45 p.m. in Fort Lauderdale, Florida. The hearing was reconvened on July 25, 2017 at 1:43 p.m. in Fort Lauderdale, Florida.

**APPEARANCES**

For the Petitioner: Claudia Gill, Mother

For the Respondent: Linda Latson,  
Registered Nurse Specialist,  
Agency for Health Care Administration

**STATEMENT OF ISSUE**

Petitioner is appealing the Agency for Health Care Administration’s (AHCA) decision, through managed care organization Humana Medical Plan, to deny his request for out of network, and out of state, Statewide Inpatient Psychiatric Program (SIPP) services at [REDACTED]. Because the issue under appeal involves a request for services, Petitioner bears the burden of proof.

**PRELIMINARY STATEMENT**

Appearing as witnesses from Humana Medical Plan (Humana) were: Dr. Ian Nathanson, Florida Medical Director, and Stacey Larsen, Service Operations Specialist. Appearing as an observer from Humana was Mindy Aikman, Grievance and Appeals Specialist.

Appearing as witnesses for Petitioner from [REDACTED] were: [REDACTED] Therapist; [REDACTED], Case Manager; [REDACTED] Parent Advocate; and [REDACTED], Clinical Supervisor (on July 25, 2017). Also appearing as a witness was [REDACTED], Petitioner's primary care physician.

Appearing as observers for Petitioner were: [REDACTED], Community Liaison from [REDACTED], Clinical Supervisor for [REDACTED] (on June 20, 2017); [REDACTED], Pastor; [REDACTED], Pastor's wife; [REDACTED] Friend; and [REDACTED].

Spanish interpretation for Petitioner was provided by [REDACTED] and [REDACTED] on June 20, 2017 and by Javier on July 25, 2017. The interpreters were provided by Humana.

Respondent's two exhibits were entered into evidence. Petitioner's six exhibits were entered into evidence.

**FINDINGS OF FACTS**

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 is a 13-year-old male Medicaid recipient enrolled with Humana Medical Plan (Humana), a Florida Health Managed Care provider. He is diagnosed with

██████████ (pediatric autoimmune neuropsychiatric disease associated with streptococcal infection), ██████████, and ██████████  
██████████.

2. Petitioner lives with his mother and 10-year-old sister.
3. Florida Medicaid requires prior authorization for out of state services.
4. Petitioner's request for Statewide Inpatient Psychiatric Program (SIPP) services at Cumberland Hospital is an out of state request.
5. On January 20, 2017, Humana received an authorization request from Petitioner's provider for admission to ██████████, which is located in ██████████  
██████████.
6. Molina denied the request on January 24, 2017 and sent a Notice of Action to the Petitioner on January 24, 2017. The notice explains the basis for the denial:

We determined that your requested services are **not medically necessary** because the services do not meet the reason(s) checked below: (See Rule 59G-1.010)

Must be individualized, specific, consistent with symptoms or diagnosis of illness or injury, and not be in excess of the patient's needs.

Must be able to be 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.

Must be furnished in a manner not primarily intended for convenience of the recipient, caretaker, or provider.

The facts that we used to make our decision are: You have requested to receive treatment at a hospital that is not part of Humana's network. The medical records were reviewed. You could have been treated at a hospital that is part of Humana's network. You have Medicaid HMO. Humana has providers and hospitals that can give you the care you need who are in Humana's network and are a reasonable distance from your residence. Your primary care physician can help you find an in-network

provider.

7. Petitioner filed an expedited appeal request with Humana on February 24, 2017.

On March 6, 2017, Humana sent its decision to Petitioner which states, in relevant part:

[Petitioner] has worsening behaviors whenever he gets sick. You are asking for him to be hospitalized at a special facility (Cumberland) that specializes in taking care of people with psychiatric and medical problems. His care is able to be provided by the network of physicians contracted with Humana. This does not meet the criteria established in the national guidelines for inpatient care and the Florida Administrative Code Chapter 59G for medical necessity. The original determination of inpatient admission denial is upheld.

8. Petitioner filed a request for a fair hearing on March 14, 2017.

9. Petitioner's doctor explained Petitioner's aggressive behavior occurs every time he gets sick. He noted his condition is episodic, but has improved with medication. He stated he requested Petitioner be admitted to [REDACTED] because he felt it was an ideal setting, based on cases for which he has consulted and have referred patients to this facility.

10. Petitioner's mother and witnesses explained in detail the need for Petitioner to receive proper medical care for his multiple medical conditions along with psychiatric care for his behavior problems.

11. During the July 25, 2017 proceeding, the Clinical Supervisor from [REDACTED] n [REDACTED] announced she had just received notice that [REDACTED] [REDACTED] has accepted Petitioner for admission. There is a four-week delay, while they discharge some of their current patients.

12. Humana's Medical Director explained [REDACTED] had previously denied admission for Petitioner, but subsequently Humana's Medical Director spoke with the

Medical Director for [REDACTED]. Humana's Medical Director explained the medical care and psychiatric care Petitioner needed. Humana's Medical Director explained the [REDACTED] Medical Director reversed the denial once he had complete information on Petitioner's medical conditions and needs.

13. Humana's Medical Director noted [REDACTED] hospital was near the mother's residence and opined how important family visits to the hospital are to assist in Petitioner's treatment.

14. Petitioner's mother expressed reservations that [REDACTED] could meet all the medical needs of Petitioner. Humana's Medical Director responded Petitioner would get good care at the hospital, but if he does not get the right care Humana can work with her to locate another SIPP hospital in Humana's network of providers.

#### **CONCLUSIONS OF LAW**

15. By agreement between the Agency for Health Care Administration and the Department of Children and Families, the Agency for Health Care Administration has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Chapter 120.80 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 Rule 65-2.056 of the *Florida Administrative Code*.

17. The standard of proof needed to be met for an administrative hearing is by a preponderance of the evidence, as provided by Rule 65-2.060(1) of the *Florida Administrative Code*.

18. Section 409.912, Florida Statutes, provides that the Agency may mandate prior authorization for Medicaid services.

19. *Florida Administrative Code* Rule 59G-1.010 defines “prior authorization” as:

(226) “Prior authorization” means the approval by the Medicaid office for a Medicaid provider, or by a prepaid health plan for its affiliated providers, to deliver Medicaid covered medical or allied care, goods, or services in advance of the delivery of the care, goods, or services.

20. *Florida Administrative Code* Rule 59G-1.010 (166) provides:

“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; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

....

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

21. *Florida Administrative Code* Rule 59G-1.053 establishes the Florida Medicaid Authorization Requirements Policy (Policy), July 2016. Section 2.1, When to Request Authorization, states “providers must obtain authorization prior to rendering Florida Medicaid-covered services, except in an emergency, when specified in the service-

specific coverage policy or the applicable Florida Medicaid fee schedule(s)", and "**when services will be performed out-of-state.**"

22. Section 2.1.1 of the Policy provides the following regarding Other Necessary Health Care Services – Early and Periodic Screening, Diagnosis, and Treatment (EPSDT):

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within a policy or the associated fee schedule may be approved, if medically necessary.

Providers must request authorization for proposed services for recipients under the age of 21 years that meet one or more of the following:

- The service is not listed in the service-specific coverage policy as a covered service
- The service is not listed in the applicable fee schedule(s)
- The amount, frequency, or duration of the service exceeds the coverage limits specified in the service-specific coverage policy or the applicable Florida Medicaid fee schedule(s)

23. The Petitioner's medical need for Statewide Inpatient Psychiatric Program (SIPP) services is not disputed. Therefore, compliance with the EPSDT requirements have been met. What is in dispute is where the services are to be provided.

24. Petitioner is requesting SIPP services at [REDACTED], based on a referral from his doctor. No documentation or testimony was provided to explain why no SIPP hospital in Florida can meet Petitioner's medical and psychiatric needs.

Moreover, the above cited authority makes it clear that the fact 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.

25. [REDACTED], a SIPP hospital in Humana's network, has accepted Petitioner as a patient.

26. Humana's Medical Director addressed the mother's concerns for the level of medical care her son (Petitioner) will receive a [REDACTED].

27. Because Petitioner's medical and psychiatric (SIPP) needs can be met at [REDACTED], medical necessity has not been established by Petitioner for SIPP services to be provided out-of-state.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED and the Agency action is 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 petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

FINAL ORDER (Cont.)

17F-02262

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DONE and ORDERED this 21 day of August, 2017, in Tallahassee,  
Florida.



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

Copies Furnished To: [REDACTED], Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Humana Hearings Unit

Jul 05, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-02360

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 05 Lake  
UNIT: 88125

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:23 a.m. on June 15, 2017.

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: Stan Jones, ACCESS  
Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

At issue is whether the respondent's (Department) action to first deny the petitioner's Medicaid application and then enroll her in the Medically Needy (MN) Program with a \$2,743 Share of Cost (SOC), is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The hearing was originally scheduled to convene, telephonically, on April 10, 2017. The petitioner requested that the hearing take place in-person. The petitioner's request was granted and the hearing was rescheduled to convene in-person on May 4, 2017. On April 4, 2017, the petitioner requested that the hearing be changed back to telephone. The petitioner's request was granted, the hearing was rescheduled by telephone for May 5, 2017. On May 5, 2017, both parties appeared, the parties requested that the hearing be rescheduled for the petitioner to submit an additional document. The request was granted and the hearing was rescheduled, telephonically, for June 12, 2017. On June 12, 2017, both parties again appeared and again requested that the hearing be rescheduled, as the petitioner needed an additional document. The request was granted and the hearing was rescheduled, telephonically, for June 15, 2017.

The petitioner did not submit exhibits. The respondent submitted eight exhibits, entered as Respondent Exhibits "1" through "8". The record remained open through end of business day on June 15, 2017, for the respondent's representative to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "9". The record was closed on June 15, 2017.

### **FINDINGS OF FACT**

1. On February 13, 2017, the Department received an incomplete paper Medicaid application from the petitioner; applying for herself (Respondent Exhibit 1).

2. On March 8, 2017, the Department received an electronic notification that the petitioner had \$7,514.54 in a money market account at PNC (Respondent Exhibit 3, page 29).
3. On March 9, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying her the February 13, 2017 application was denied, "due to value of undisclosed assets" (Respondent Exhibit 4, page 20).
4. On March 28, 2017, the respondent's representative completed a pre-hearing call with the petitioner, regarding her hearing request. And also mailed the petitioner a notice requesting income and asset verification (Respondent Exhibit 4, page 32).
5. The petitioner provided verification of: (1) \$54.60 monthly pension from AXA (Respondent Exhibit 8), (2) \$1,778 gross Workman's Compensation (WC) (Respondent Exhibit 7) and (3) PNC bank statements.
6. The respondent's representative verified the petitioner receives \$1,111 Social Security Disability (SSDI) (Respondent Exhibit 2).
7. The respondent's representative reused the petitioner's February 13, 2017 Medicaid application and determined the petitioner eligible for MN with a SOC. The following (Respondent Exhibit 9) is the Department's SOC calculation:

\$1,778.00	WC
+\$ 54.60	pension
+\$1,111.00	SSDI
<hr/>	
\$2,943.60	Total income
-\$ 20.00	unearned income disregard
-\$ 180.00	MN income limit (MNIL)
<hr/>	
\$2,743.00	SOC (cents dropped)

8. On June 15, 2017, the Department mailed the petitioner a NOCA, notifying she was approved MN with an estimated \$2,743 SOC, effective May 2017 (Respondent

Exhibit 9).

9. The petitioner disagrees with the \$1,778 WC amount used in the Department's SOC calculation. The petitioner said the amount she receives is \$1,509.20 (net) after a \$268.80 deduction. The petitioner asserts that the \$268.80 is a Social Security "offset" deduction. Although, the document provided from the petitioner only reads "less deductions" (Respondent Exhibit 7).

10. The respondent's representative stated that in accordance with the Department's policy, gross income is used, not net income, in the SOC determination.

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

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

(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level...

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

(4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and

services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service...To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months...

14. The above authority explains to be eligible for full SSI-Related Medicaid, income cannot exceed 88 percent of the federal poverty level (FPL). And MN provides coverage for individuals who do not qualify for full Medicaid, due to income.

15. The Department's Program Policy Manual, CFOP 165-22, appendix A-9 identifies \$885 as 88 percent of the FPL for an individual.

16. The petitioner's \$2,943.60 household monthly income exceeds the \$885 income limit full Medicaid.

17. The petitioner argued that her take home income from WC is \$1,509.20 (net) after a \$268.80 deduction. Which is the amount that needed to be used in the SOC calculation, instead of the \$1,778 gross amount.

18. The *Florida Administrative Code* R.65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, explains the type of income used in Medicaid eligibility and states in part:

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies...

(a) For MEDS-AD Demonstration Waiver, Protected Medicaid, Medically Needy, Qualified Working Disabled Individual, QMB, SLMB, QI1, and to compute the community spouse income allocation for spouses of ICP individuals, the following less restrictive methodology for determining **gross monthly income**... (emphasis added)

19. In accordance with the above authority, the Department correctly used the petitioner's gross income in determining Medicaid eligibility.

20. Title 20 of the Code of Federal Regulations Section 416.1124 explains unearned income not counted and states in part "(c) Other unearned income we do not count... (12) The first \$20.00 of any unearned income in a month..."

21. The *Florida Administrative Code* R. 65A-1.716 sets forth the MNIL at \$180 for a family size of one.

22. In accordance with the above authorities, the Department deducted \$20 and \$180 from the petitioner's \$2,943.60 household monthly income to arrive at \$2,743 SOC.

23. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes the respondent's action to approve the petitioner in the MN Program with a \$2,743 SOC, is proper.

### **DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this   05   day of   July  , 2017,

in Tallahassee, Florida.



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

Aug 02, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-02368

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 09 Orange  
UNIT: 88222

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 12, 2017 at 1:00 p.m., at [REDACTED], [REDACTED]

**APPEARANCES**

For the petitioner: [REDACTED] the petitioner's wife

For the respondent: Stan Jones, ACCESS Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

The petitioner is appealing Department's action to increase his patient responsibility amount from \$557.32 to \$1,560.32 in the Institutional Care Medicaid Program (ICP). The petitioner is seeking a higher amount be diverted to his community spouse. The respondent carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The hearing was originally scheduled for April 25, 2017 at 1:00 p.m. On April 25, 2017, the respondent did not appear at the [REDACTED]. The petitioner's wife appeared and agreed to reschedule the hearing. The undersigned rescheduled the hearing for May 8, 2017 at 12:45 p.m. On May 8, 2017, the petitioner's daughter, [REDACTED], contacted the office requesting to reschedule the hearing due to a death in the family. The undersigned granted the request and the hearing was rescheduled for June 12, 2017 at 1:00 p.m.

At the hearing on June 12, 2017, the petitioner was not present. His wife/community spouse, [REDACTED] represented the petitioner. Appearing as a witness for the petitioner was [REDACTED], the petitioner's daughter.

The petitioner presented one exhibit, which was marked as Petitioner's Exhibit "1". The respondent presented three exhibits, which was marked as Respondent's Exhibits "1" through "3".

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner was receiving ICP and Medicare Savings Plan (MSP) benefits. The petitioner's patient responsibility amount was \$557.32 and his wife's community spouse income allowance was \$1,121.56. The petitioner was residing in a nursing facility at [REDACTED]. The community spouse (CS) was receiving Medically Needy with a Share of Cost. The MSP and Medically Needy with a Share of Cost are not at issue.
2. On February 2, 2017, the petitioner's authorized representative from [REDACTED], submitted to the respondent an interim contact letter and the

CS's bi-weekly paystubs from [REDACTED]. The following paystubs were provided: November 10, 2016 gross pay \$1,320.00, November 25, 2016 gross pay \$400.00, December 9, 2016 gross pay \$400.00, December 23, 2016 gross pay \$800.00, January 6, 2017 gross pay \$900.00, and January 20, 2017 gross pay \$800.00.

3. The petitioner receives a monthly retirement pension of \$296.88 from Price Water. The respondent utilized the State of Florida Social Security Administration (SSA) State On-Line Query to verify information from the SSA. The Query screen indicated that the petitioner receives \$1,487.00 in Social Security income. The respondent reviewed the Query screen for the CS which indicated that she receives \$922.00 in Social Security income.

4. The respondent calculated the CS's monthly income by using her paystubs dated December 23, 2016 gross pay \$800.00 and January 20, 2017 gross pay \$800.00, this amount totaled \$1,600.00, then adding her SSA benefits of \$922.00. The total income was \$2, 522.00; however; the respondent utilized \$2,523.01 as the CS's monthly gross income in the determination of the petitioner's patient responsibility and the community spouse income allowance. The respondent explained to determine how much of the petitioner's income the CS can keep, the following budget was calculated:



ABSR

PATIENT RESPONSIBILITY BUDGET

04/21/2

CASE: [REDACTED] CAT: MI I SEQ: 1 AGNAME: [REDACTED] P44125 ;  
BEGIN: 04/01/2017 END: STATUS: OPEN, PASS A WO

PATIENT NAME: [REDACTED] SSN: 580220714

INCOME PROTECTED FIRST/LAST MONTH: N

TOTAL GROSS EARNED INCOME:	.00
TOTAL GROSS UNEARNED INCOME: +	1783.88
REPARATION PAYMENTS: +	.00
TOTAL INCOME: =	1783.88
PERSONAL NEED ALLOWANCE: -	105.00
MAINTENANCE NEED ALLOWANCE: -	118.56
1/2 THERAPEUTIC WAGES: -	.00
OTHER INCOME EXCLUDED FROM ELIGIBILITY DETERM.: +	.00
UNCOVERED MEDICAL EXPENSES: -	.00
PATIENT RESPONSIBILITY: =	1560.32

7. The respondent issued a Notice of Case Action to the petitioner on March 1, 2017 explaining the following, "Your gross countable income \$1,783.88, amount you keep for personal needs \$105.00, amount you may give to your community spouse/dependents \$118.56, amount you are expected to pay the nursing facility or provider \$1,560.32".

8. The respondent explained in the previous ICP budget, the CS's Social Security income was not included in the budget. The respondent was not aware of the CS's Social Security income because the income was not reported in the previous application. Additionally, the respondent explained the CS's earnings increased from the previous ICP budget.

9. The CS confirmed her hourly rate of pay from [REDACTED] is \$10.00 and that she works 40 hours per week. The CS does not directly dispute the respondent's calculations. However, the CS believes that she will be unable to afford medical treatments for herself if additional money is not diverted to her household.

**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-1.701 defines patient responsibility as, "(t)hat portion of an individual's monthly income which the department determines must be considered as available to pay for the individual's institutional care..."

13. Fla. Admin. Code R. 65A-1.712(4) discusses Spousal Impoverishment, noting, in pertinent part:

Spousal Impoverishment. The Department follows policy in accordance with 42 U.S.C. § 1396r-5 for resource allocation and income attribution and protection when an institutionalized individual, including a hospice recipient residing in a nursing facility, has a community spouse. Spousal impoverishment policies are not applied to individuals applying for, or receiving services under, HCBS Waiver Programs, except for individuals in the Long-Term Care Community Diversion Program, the Assisted Living Facility Waiver or the Cystic Fibrosis Waiver.

...

(d) After the institutionalized spouse is determined eligible, the Department allows deductions from the eligible spouse's income for the community spouse and other family members according to 42 U.S.C. § 1396r-5 and paragraph 65A-1.716(5)(c), F.A.C.

...

(f) Either spouse may appeal the post-eligibility amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist. Exceptional circumstances that result in extreme financial duress include circumstances other than those taken into account in establishing maintenance standards for spouses. An

example is when a community spouse incurs unavoidable expenses for medical, remedial and other support services which impact the community spouse's ability to maintain them self in the community and in amounts that they could not be expected to be paid from amounts already recognized for maintenance and/or amounts held in resources. Effective November 1, 2007, the hearing officers must consider all of the community spouse's income and all of the institutionalized spouse's income that could be made available to a community spouse. If the expense causing exceptional circumstances is a temporary expense, the increased income allowance must be adjusted to remove the expenses when no longer needed.

14. The above controlling authority sets forth a provision for couples, when one spouse is in a nursing facility and the other remains in the community, to appeal the community spouse income allowance determined by the Department. The hearing officer may adjust the allowance if proof is provided to show that exceptional circumstances have resulted in significant inadequacy of the CS income allowance to meet her needs. In a situation where proof is provided to show that an exceptional circumstance has caused a significant inadequacy, the diversion amount to the CS can be increased, resulting in a lower patient responsibility amount and a greater amount paid by Medicaid to the nursing facility. In this case, the petitioner did not present evidence of any exceptional circumstances that have caused extreme financial duress for the CS.

15. Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in 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). When averaging income, all income from the most recent consecutive four weeks shall be used if it is representative of future earnings. A longer period of past time may be used if necessary to provide a more accurate indication of anticipated fluctuations in future income.

...

(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.
2. If the individual's monthly income does not exceed the institutional care income standard in any month the department will prorate the income over the period it is intended to cover to compute patient responsibility, provided that it does not result in undue hardship to the client. If it causes undue hardship it will be counted for the anticipated month of receipt.

16. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, provides an overview of the Community Spouse Income Allowance in passage 2640.0119.01:

The following policy applies to the ICP... When an institutionalized individual has a community spouse whose gross income is less than the state's minimum monthly maintenance income allowance (MMMIA) plus the CS excess shelter expense cost, a portion of the individual's income may be allocated to meet the needs of his community spouse.

17. The Policy Manual, passage 2640.0119.03, sets forth the formula used to determine the community spouse allowance as follows: (State's MMMIA + community spouse's excess shelter costs) - (the community spouse's total gross income).

18. The Policy Manual, passage 2640.0119.04, describes a 3-step process for determining the community spouse's excess shelter costs.

Step 1 – Obtain verification of the community spouse's monthly assistance group expenses if questionable. Allowed expenses are limited to rent or mortgage payment (including principal and interest), taxes, insurance (homeowners or renters), maintenance charges if a condominium and mandatory homeowner's association fees. Do not include expenses paid by someone other than the community spouse. Add all of these expenses.

Step 2 – To the total obtained above, add the current food stamp standard utility disregard (refer to Appendix A-1) if the community spouse pays utility bills. Allowed utilities are limited to water, sewage, gas, and electric.  
Step 3 – To determine what portion of the total shelter costs is excess, subtract 30% of the state's income allowance, from the total costs. The difference is the community spouse's excess shelter costs.

19. The undersigned acknowledges that the CS has significant monthly expenses and appears to encounter difficulty in meeting these obligations. However, there was no evidence of exceptional circumstances presented to the hearing officer to justify the adjustment of the community spouse income allowance.

20. Appendix A-9 of the Policy Manual sets the MMMIA at \$2,003.00. Appendix A-1 sets the standard utility allowance at \$338.00 per month.

21. The respondent calculated the CS's gross income as \$2,523.01, by combining the CS's earnings of \$1,600.00 (pay dates - 12/23/2016 and 1/20/2017) and her Social Security income \$922.00. However, the correct calculation is \$2,522.00 (\$1,600.00 + 922). The undersigned concludes the respondent erred in the CS's gross monthly income calculation.

22. The evidence establishes the CS pays \$903.36 per month for mortgage; however, the respondent used \$901.57 in the calculation of the CS's total shelter costs. The undersigned concludes the respondent erred in the CS's total shelter costs calculation.

23. Therefore, this matter is hereby remanded to the Department for corrective action. The respondent is ordered to correct the CS's total shelter costs from \$1,239.57 to \$1,241.36 and her gross income from \$2,523.01 to \$2,2522.00. After these are corrected, the respondent is to recalculate the CS income allowance as well as the petitioner's patient responsibility beginning April 2017. Once this corrective action has

been completed, the respondent is to issue a new Notice of Case Action to the petitioner to notify him of the outcome, including his appeal rights.

**DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 02 day of August, 2017,

in Tallahassee, Florida.



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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

**FILED**

Jul 17, 2017

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-02577

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 June 13, 2017, at 3:05 p.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:

Belinda Lindsey, DCF supervisor.

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's decision that all medical bills incurred by her daughter in April 2016 are not covered by Medicaid because she was enrolled in the Medically Needy Program and not full Medicaid eligible. The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

On March 24, 2017, the petitioner requested an appeal challenging the effective date of her daughter's Medicaid eligibility for April 2016. Petitioner is seeking full Medicaid for April 2016, so all the medical bills can be covered.

During the hearing, the petitioner mentioned she had not received the evidence packet to date. The appeal was continued to allow the petitioner additional time to receive and review the evidence packet.

The petitioner did not provide any evidence for the undersigned to consider. The respondent submitted six (6) exhibits, which were marked as Respondent's Exhibits 1 through 6.

### **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. Petitioner was gainfully employed in April 2016. She is a tax filer with her then 10-year-old daughter as her tax dependent. She was paid weekly and provided the following paystubs: \$594 (4/1/16); \$744.84 (4/8/16); \$720 (4/15/16) and \$751.59 (4/22/16) and \$735.39 (4/29/16). Based on the income information, petitioner's household was approved for the Medically Needy benefits with a \$2,506 share of cost.
2. For the month of April 2016, the petitioner's daughter was enrolled in the Family-Related Medically Needy Program. Upon further review, the Department used paystubs petitioner received in January 2016 (1/22/16: \$629.85 & 1/29/16: \$657.90) and February 2016 (2/5/16: \$667.25) to re-evaluate the case. The Department averaged the three paystubs and the result was multiplied by 4 to arrive at \$2,606.68 modified

adjusted gross income (MAGI). The MAGI was then compared to the income limit for a child between 6 and 18 years old. The income exceeded the maximum limit, resulting in the daughter being found ineligible for full Medicaid benefits.

3. As the daughter was determined ineligible for full Medicaid, respondent enrolled her in the Medically Needy Program. To determine the estimated SOC for her, the Medically Needy Income Level (MNIL) of \$387 for a standard filing unit size of two was subtracted from the MAGI (\$2,606.68), resulting in an estimated SOC of \$2,219, see Respondent's Exhibit 3. The SOC was adjusted before the medical bills were tracked. The petitioner is not disputing the most recent Modified Adjusted Gross Income (MAGI) used by the Department.

4. The petitioner's daughter incurred the following medical expenses during April 2016. The expenses are as follows:

Invoice Date	Amount and Service Description
April 11, 2016	\$95 Crutches
April 11, 2016	\$641.50 Emergency Room & Pharmacy
April 11, 2016	\$821 Emergency Room Evaluation
April 16, 2013	\$671 [REDACTED]
Total bill	\$2,228

5. The petitioner has no medical bills (for April 2016) prior to April 11, 2016. The petitioner asserts as follows: That her daughter was receiving Medicaid under the Florida Healthy Kids Program. That she allowed her sister and her children to move in with her. That her daughter had an accident in April 2016 and ended up in the emergency room for medical treatments.

6. The petitioner began receiving medical bills and on February 28, 2017, which she sent to the respondent for tracking. She asserts that spoke with representatives (could

not recall individual names or dates) of the Department of Children and Families (DCF), and was told that there was a mix-up once between her case and her sister's case, causing her daughter to lose full Medicaid eligibility. She asserts that she told that once the mix-up is cleared up, her household would be eligible for full Medicaid and that all her daughter's medical bills would be covered. The bills were tracked and the SOC was met on April 18, 2016, see Respondent's Exhibit 5. On March 24, 2017, the petitioner contacted the Department to inquire about the bills and requested an appeal.

7. After the SOC was adjusted, the bills were re-tracked and the SOC was met on April 16, 2016, resulting in the daughter being eligible for Medicaid effective April 16, 2016. On April 6, 2017, a Notice of Case Action was sent to the petitioner explaining its decision.

8. The respondent explained that the daughter was not eligible for full Medicaid for April 2016 because of the petitioner's income exceeded the income limit for her household size (her and her daughter). She explained that that the daughter was enrolled in the Medically Needy Program with a share of cost. That the original SOC has been adjusted from \$2,506 to \$2,219 in favor of the petitioner. She explained that Medically Needy enrollees become Medicaid eligible on the day they incur allowable medical expenses that equal their share of cost. The enrollee must submit medical bills to DCF for tracking. The respondent explained that once the petitioner provided medical bills for the month at issue, the bills were tracked based on the dates of service starting with the earliest date. Once the bills are input and the SOC is met, the Medicaid is open effective the date the SOC is met. Once eligible, recipients remain eligible from that date until the end of the month.

9. The respondent explained that based on the above medical bills provided by the petitioner for the month at issue, share of cost is met on April 16, 2016.

10. The petitioner contends that her daughter should be eligible for Medicaid the entire month and not incur any out-of-pocket medical expenses. She maintains that all her medical bills should be paid by the respondent because she was given misinformation.

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

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

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

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

- (a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.
- (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.
- (d) Household income—(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household...

(1) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent...

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

17. 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.

18. The Department's Program Policy Manual (The 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).

19. The Policy Manual at passage 2430.0700 Income Conversion (MFAM) states:

Most income is received more often than monthly; that is; it is received weekly, biweekly, or semimonthly. Since eligibility and benefit amounts are issued based on a calendar month, income received other than monthly is to be converted to a monthly amount.

The following conversion factors based on the frequency of pay are used:

Weekly income (once a week): Multiply by 4.

Biweekly income (every two weeks): Multiply by 2.

Semimonthly income (twice a month): Multiply by 2.

20. Effective April 2016, the Family-Related Medicaid income standard appears in the Policy Manual at Appendix A-7. It indicates that the Family-Related Medicaid income limits for 10-year-old child residing with just her mother (household of two) as \$1,776 and the MAGI Disregard is \$67. The income limit for the adult is \$241 and the Standard Disregard is \$146. The Medically Needy Income Limit (MNIL) for the household is \$387.

21. The above allows for the use of the conversion factor of 4 if income is received weekly (and of 2 if received biweekly) for Medicaid eligibility determination. The undersigned could not find a better outcome in determining the household income.

22. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for petitioner's household did not find eligibility for full Medicaid as the household's MAGI is more than the income limit of \$1,776 for a household at issue. The undersigned concludes that daughter is not eligible for full Medicaid under the Family-Related Medicaid Program. The undersigned recognizes the petitioner's

concerns about her daughter's medical bills; however, the controlling legal authorities do not allow for a more favorable outcome. The undersigned further concludes Medically Needy (MN) eligibility must be explored.

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

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

24. 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.

25. 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.

26. In accordance with the above controlling authorities, respondent determined petitioner's standard filing unit as a household of two based on her tax filing status.

27. To determine the child's most recent SOC for April 2016, the respondent subtracted the Medically Needy Income Level of \$387 for a standard filing unit size of two from the household MAGI of \$2,606.68, resulting in an estimated SOC of \$2,219.

The hearing officer reviewed the most recent SOC calculation done by the Department and found no errors. A more favorable share of cost could not be determined.

28. 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.

29. The above rule explains that an enrolled individual must incur medical expenses each month that meets the share of cost before becoming eligible for Medicaid for the remainder of the month.

30. Medicaid will not cover all the medical expenses incurred by the petitioner during April 2016 because she had not met her share of cost and determined to be Medicaid eligible until April 16, 2016. Therefore, any bills prior to April 16, 2016 will not be paid.

31. The petitioner asserts that all of the claimed medical expenses should be paid by Medicaid because she was receiving full Medicaid benefits under the Healthy Kids Program prior to moving her nephews into her home. After reviewing the evidence and controlling legal authorities, the undersigned concludes that any bills used in full leading up to the petitioner meeting her share of cost, are not covered by Medicaid as they are incurred prior to petitioner becoming eligible. Medicaid eligibility prior to April 16, 2016 was not found. The petitioner has failed to meet her burden. Misinformation given to

petitioner by a Department employee does not allow the undersigned to ignore the controlling legal authorities.

**DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 17 day of July, 2017,

in Tallahassee, Florida.



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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

**FILED**

Jul 06, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-02750

PETITIONER,

VS.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 15 PALM BEACH  
UNIT: 88998

D - DDD - Disability

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 8, 2017 at 3:35 p.m.

**APPEARANCES**

For the Petitioner

[REDACTED]

For the Respondent:

Barbara Dean, supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of denying her application for SSI-Related Medicaid. The petitioner carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The Department of Children and Families (Department or DCF or respondent) determines eligibility for participation in the Florida Medicaid Program.

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 at the hearing on May 8, 2017.

After considering the evidence presented the undersigned found it necessary to further develop the record. A hearing was set to reconvene on June 6, 2017 but the petitioner was unable to attend. A second hearing was set to reconvene on June 20, 2017. The Department's representative and the undersigned were present on June 20, 2017 but the petitioner was not present. The hearing did not reconvene. The record was closed on June 20, 2017. The undersigned rendered a decision based on the available evidence and the authorities.

Lauren Miller, program operations administrator with the Division of Disability Determination (DDD) was present as a witness for the Department.

Present as an observer was Marylu Sanchez, medical disability examiner, DDD.

### **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 October 25, 2016, the petitioner (age 44) filed an application for SSI-Related Medicaid with the Department. She last worked in March 2017 (Respondent's Exhibit 3).
2. The petitioner is single; she does not have minor children who live in the home. Single adults without minor children are not eligible to participate in the Florida Medicaid Program unless they are elderly (age 65 or older) or have been determined disabled by the Social Security Administration (SSA) or the Department.

3. The petitioner alleges that she is disabled due to multiple physical illnesses such as [REDACTED]

[REDACTED]. Additionally, she alleges mental health issues such as [REDACTED]

[REDACTED]. Additionally, she asserted that her illness is the reason for her anti-social behavior and that she is withdrawn and isolated.

4. DDD performs disability determinations for the Department. The Department referred the petitioner's case to DDD for a disability determination on October 31, 2016. The DDD received the petitioner's application/package on November 10, 2016 and rendered a decision on March 29, 2017 (Respondent's Exhibit 2).

5. DDD completed a five-step sequential analysis to determine if an applicant is disabled: 1) The individual cannot be engaging in substantial gainful activity (working and earning income that meets or exceeds set limits); 2) the alleged impairment must be severe and intended to last 12 continuous months; 3) impairment(s) meets a disability listing set forth in federal regulations; 4) individual incapable of returning to previous work; 5) individual incapable of performing any work in the national economy.

6. DDD reviewed two diagnoses [REDACTED] [REDACTED]. DDD determined that the petitioner did not meet the disability criteria because her residual functional capacity shows she is capable of performing other less stressful work in the national economy such as a cleaner, housekeeping and collator operator and basket filler (Respondent's Exhibit 4)

7. DDD used the physical Residual Functional Capacity Assessment (PRFC) to evaluate the petitioner's physical impairments. She was evaluated for [REDACTED]. The PRFC found that the petitioner has "no deformities and walked with normal gait, HEENT, PERRLA, EOMI and hearing normal for conversation." Additionally, she was evaluated for her neck and she was found to have no carotid bruits, JVD adenopathy, or goiter and decreased ROM, CV, RRR, normal S1, S2 with no murmurs, gallops or rubs. Her breathing was normal, no wheezing. She has mild [REDACTED]. She has full lumbar ROM, normal hand grip and dexterity. [REDACTED]. It was also determined that the petitioner can lift 20 pounds occasionally and 10 pounds frequently. She can sit about 6 hours in an 8-hour workday. She has limited use in her upper and lower extremities.

8. DDD used the Psychiatric Review Technique (PRT) to evaluate the petitioner's mental impairments. The evaluation was based on category 1 [REDACTED]. The petitioner was found to have [REDACTED]. She was evaluated for areas of mental functioning, understanding, remember or apply information and interact with others. Her degree of limitation was mild. Additionally, her mental functioning to concentrate, persist or maintain pace was moderate and her ability to adapt or manage oneself was mild. The petitioner was determined to show symptoms only related to her mood disorder, there was no medical evidence of persisting cognitive changes post head injury in remote past. Her social interaction was also evaluated and was found not significantly limited (Respondent's Exhibit 4).

9. DDD explains its decision in the Case Analysis section of the petitioner's

Disability Report:

[REDACTED]  
[REDACTED] education: 11 grade.  
Language English. Past relevant work (PRW) in the last 15 years:  
receptionist, restaurant manager trainee. She had SGA in 12 of those 15  
years and less than SGA in 3 of the last 15 years.

PHYSICAL

The claimant has a history of a MVA about 16 years ago with [REDACTED]  
[REDACTED] including a head injury. She attended a CE exam with doctor  
[REDACTED] on March 21, 2017. The physical exam found blood  
pressure 130/76, height 5 feet 6 inches, weight 151 pounds. General well  
developed, nourished and groomed, normal habits, no deformities, walk  
with normal gait, normal hearing, normal conversation, neck, no carotid  
bruits breaths normal, no wheezing, neck pain mild, normal hand grip, ,  
shoulder pain noted, visual 20/25 and 20/40, left knee pain noted

ADLs

Self-reported ADLs per telephone call on February 6, 2017. She cannot  
raise left arm. She can do her personal care with limitations due to left  
arm restrictions. She can do household chores exception for arm  
restrictions. She can walk about 10 to 15 minutes before stopping due to  
fatigue and left knee pain. She uses prescribed cane. She can lift 5 to 10  
pounds with right arm and about 1 to 3 pounds with the left arm. She can  
drive. She can shop but cannot reach top shelves.

MENTAL

A mental PRTF by [REDACTED], dated 03/28/17 found the  
claimant reported remote prior head injury in motor vehicle accident but  
worked at a skilled job since, on a sustained basis (assistance manager,  
receptionist and others). Recent treatment records indicate long hx of  
[REDACTED]. She now shows signs only relating to  
her mood disorder, with no evidence of persisting cognitive changes post  
head injury in remote past.

A MRFC by [REDACTED] dated March 28, 2017 found claimant  
can understand, retain and carry out simple instructions. Claimant can  
consistently and usefully perform routine task on sustained basis with  
minimal supervision and can cooperate effectively with public and co-  
workers in completing simple task and transactions. Claimant can adjust  
to the mental demands of most new task settings.

SUMMARY

The claimant is a 44 year old female with a diagnosis of left knee pain, left shoulder pain and depression. She is able to perform the task required in a work setting with low stress level and limited social interaction.

She may not be able to perform PRW as a receptionist or restaurant manager trainee but she is able to do other less stressful work such as cleaner, housekeeping, collator operator and a basket filler.

DECISION

N32 Denial. Voc. Rule 202.18

10. On March 30, 2017, the Department issued a Notice of Case Action informing the petitioner that her Medicaid application was denied. The reason given for the denial was that she did not meet the disability requirement (Respondent's Exhibit 1)

11. On April 4, 2017, the petitioner requested a hearing to challenge the respondent's decision.

12. At the hearing, the petitioner argued that her Medicaid application should have been approved because of the severity of her physical and mental health, which impacts her level of functioning and has prevented her from being able to hold down a job. The petitioner believes she will not recover as she has been in the hospital at least 40 times.

13. The petitioner completed up to grade eleven of schooling. She alleges difficulty learning due to a learning disorder. She is unable to keep a long-term job because of maladaptive behaviors. She does not get along well with people. She has worked jobs as a receptionist and as a manager trainee.

14. DDD acknowledged that the petitioner's mental health issues are serious; however, the DDD representative argued that the petitioner's acute behaviors are not so severe, that they prevent her from working. DDD asserts that there are other jobs in the economy the petitioner can do.

### **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. The Fla. Admin. Code, Section 65A-1.710 et seq., 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.

18. The petitioner is not 65 years old and has not been determined disabled by SSA. The cited authority explains that 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. On behalf of the Department, DDD makes the disability determination when an individual has not been determined disabled by the SSA.

19. 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.) ...

20. Federal Regulations at 20 C.F.R. § 404.1520 addresses the disability evaluation:

(4) *The five-step sequential evaluation process.* The sequential evaluation process is a series of five “steps” that we follow in a set order. See paragraph (h) of this section for an exception to this rule. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and step five when we evaluate your claim at these steps. These are the five steps we follow:

- (i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)
- (ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in §404.1509, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)
- (iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 of this subpart and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)
- (iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. See paragraphs (f) and (h) of this section and §404.1560(b).
- (v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you

cannot make an adjustment to other work, we will find that you are disabled. See paragraphs (g) and (h) of this section and §404.1560(c).

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

22. Step one of the evaluation process determines if the petitioner is engaging in substantial gainful activity (SGA)/working, (20 C.F.R. § 404.1520(b) and 416.920(b)). The findings show that the petitioner has not been employed since March 2017. The petitioner meets step one.

23. Step two of the sequential analysis for disability is to determine if the individual has an impairment that is "severe" or a combination of impairments that is "severe" (20 C.F.R § 404.1520(c) and 416.920(c)). The petitioner alleges in addition to physical impairments, [REDACTED]." The evidence proves that the petitioner's physical impairments and mental health diagnoses is severe. The undersigned concludes that the petitioner's mental health issues/affective disorders are severe. The petitioner meets step two.

24. Step three of the sequential analysis for disability is to determine whether or not the individual's an impairment meet or equal a listed impairment in Title 20 of the Code of Federal Regulations, Appendix 1 of the Social Security Act.

25. Title 20 of the Code of Federal Regulations § 404 Subpart P, Appendix 1, identifies 1.01 Musculoskeletal System in relevant part states:

a. General. Regardless of the cause(s) of a musculoskeletal impairment, functional loss for purposes of these listings is defined as the inability to ambulate effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment, or the inability to perform fine and gross movements effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal

impairment. The inability to ambulate effectively or the inability to perform fine and gross movements effectively must have lasted, or be expected to last, for at least 12 months. For the purposes of these criteria, consideration of the ability to perform these activities must be from a physical standpoint alone. When there is an inability to perform these activities due to a mental impairment, the criteria in 12.00ff are to be used. We will determine whether an individual can ambulate effectively or can perform fine and gross movements effectively based on the medical and other evidence in the case record, generally without developing additional evidence about the individual's ability to perform the specific activities listed as examples in 1.00B2b(2) and 1.00B2c.

b. What we mean by inability to ambulate effectively.

(1) Definition. Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. Ineffective ambulation is defined generally as having insufficient lower extremity functioning (see 1.00J) to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities. (Listing 1.05C is an exception to this general definition because the individual has the use of only one upper extremity due to amputation of a hand.)

(2) To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. They must have the ability to travel without companion assistance to and from a place of employment or school. Therefore, examples of ineffective ambulation include, but are not limited to, the inability to walk without the use of a walker, two crutches or two canes, the inability to walk a block at a reasonable pace on rough or uneven surfaces, the inability to use standard public transportation, the inability to carry out routine ambulatory activities, such as shopping and banking, and the inability to climb a few steps at a reasonable pace with the use of a single hand rail. The ability to walk independently about one's home without the use of assistive devices does not, in and of itself, constitute effective ambulation.

c. What we mean by inability to perform fine and gross movements effectively. Inability to perform fine and gross movements effectively means an extreme loss of function of both upper extremities; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. To use their upper extremities effectively, individuals must be capable of sustaining such functions as reaching, pushing, pulling, grasping, and fingering to be able to carry out activities of daily living. Therefore, examples of inability to perform fine and gross movements effectively include, but are not limited to, the inability to prepare a simple meal and feed oneself, the inability to

take care of personal hygiene, the inability to sort and handle papers or files, and the inability to place files in a file cabinet at or above waist level.

d. Pain or other symptoms. Pain or other symptoms may be an important factor contributing to functional loss. In order for pain or other symptoms to be found to affect an individual's ability to perform basic work activities, medical signs or laboratory findings must show the existence of a medically determinable impairment(s) that could reasonably be expected to produce the pain or other symptoms. The musculoskeletal listings that include pain or other symptoms among their criteria also include criteria for limitations in functioning as a result of the listed impairment, including limitations caused by pain. It is, therefore, important to evaluate the intensity and persistence of such pain or other symptoms carefully in order to determine their impact on the individual's functioning under these listings. See also §§ 404.1525(f) and 404.1529 of this part, and §§ 416.925(f) and 416.929 of part 416 of this chapter.

C. Diagnosis and evaluation.

1. General. Diagnosis and evaluation of musculoskeletal impairments should be supported, as applicable, by detailed descriptions of the joints, including ranges of motion, condition of the musculature (e.g., weakness, atrophy), sensory or reflex changes, circulatory deficits, and laboratory findings, including findings on x-ray or other appropriate medically acceptable imaging. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radionuclear bone scans. "Appropriate" means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

2. Purchase of certain medically acceptable imaging. While any appropriate medically acceptable imaging is useful in establishing the diagnosis of musculoskeletal impairments, some tests, such as CAT scans and MRIs, are quite expensive, and we will not routinely purchase them. Some, such as myelograms, are invasive and may involve significant risk. We will not order such tests. However, when the results of any of these tests are part of the existing evidence in the case record we will consider them together with the other relevant evidence.

3. Consideration of electrodiagnostic procedures. Electrodiagnostic procedures may be useful in establishing the clinical diagnosis, but do not constitute alternative criteria to the requirements of 1.04.

D. The physical examination must include a detailed description of the rheumatological, orthopedic, neurological, and other findings appropriate to the specific impairment being evaluated. These physical findings must be determined on the basis of objective observation during the examination and not simply a report of the individual's allegation; e.g., "He says his leg is weak, numb." Alternative testing methods should be used to verify the abnormal findings; e.g., a seated straight-leg raising test in

addition to a supine straight-leg raising test. Because abnormal physical findings may be intermittent, their presence over a period of time must be established by a record of ongoing management and evaluation. Care must be taken to ascertain that the reported examination findings are consistent with the individual's daily activities.

26. The findings show that the petitioner's knee pain and neck fall in the body system category Musculoskeletal System.

27. To meet the disability criterion under listing [REDACTED], specifically [REDACTED] and [REDACTED] the petitioner must present with:

Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or
2. Catatonic or other grossly disorganized behavior; or
3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
  - a. Blunt affect; or
  - b. Flat affect; or
  - c. Inappropriate affect; or
4. Emotional withdrawal and/or isolation;

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. Medically documented history of a chronic schizophrenic, paranoid, or other psychotic disorder of at least 2 years' 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, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in

the environment would be predicted to cause the individual to decompensate; or

3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

28. The petitioner's medical evidence for her physical impairments does not prove that the petitioner's impairments such as [REDACTED],

[REDACTED] meet the cited disability criterion. The objective medical evidence did not show mental impairments such as bipolar disorder, memory loss, concentration loss and anxiety disorder. Additionally, the medical evidence shows she can understand, retain and carry out complex instructions. She can consistently and usefully perform familiar task on a sustained basis with minimal (normal) supervision, and can cooperate effectively with the public and co-workers in completing simple task and transactions. She can adjust to the mental demands of most new-task settings. The petitioner alleged impairments [REDACTED]

[REDACTED] 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 objective medical evidence 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 impairments do not rise to the level of severity required for the above listings

29. Step four of the sequential analysis for disability is to determine if the individual's impairments prevent her from performing past relevant work. The petitioner is 44 years old. Her past relevant work was that of a receptionist and restaurant manager trainee for the last 15 years. This type of work requires considerable movement, physical exertion and long hours of concentration. The evidence proves that the petitioner was no longer capable of returning to past work. She is no longer capable of more than light physical exertion. The petitioner meets step four criterion.

30. Step five step of the sequential analysis for disability requires the undersigned to determine whether the petitioner is able to do any work considering her residual functional capacity, age, education, and work experience in the national economy. The cumulative evidence shows the petitioner is 44-year-old female with 11 years (grade 11) of education and 15 years of past relevant history. She is literate and articulate. She can understand, retain and carry out simple instructions. The objective medical evidence shows the petitioner should be capable of performing light exertional activity and even sedentary exertional activity, in accordance with medical-vocational guideline 202.20, See 20 C.F.R. Part 404, Subpart P, Appendix 2.

31. The undersigned concludes that the petitioner fails the disability criterion at step five. She has no visual, hearing impairment or mental impairments which prevent her from being able to work. The medical evidence shows the petitioner is capable of work such as a cleaner, housekeeping (light), collator operator (light) and basket filler (light).

32. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner does not meet the SSI-Related Medicaid disability requirement. The Department's decision is upheld.

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

DONE and ORDERED this 06 day of July, 2017,

in Tallahassee, Florida.



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Christiana Gopaul-Narine  
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

**FILED**

Jul 11, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-02842

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 09 Osceola  
UNIT: 55291

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an in-person administrative hearing in the above-referenced matter on May 16, 2017 at 10:30 a.m. All parties appeared at [REDACTED].

**APPEARANCES**

For Petitioner: [REDACTED]

For Respondent: Sylma Dekony, Economic Self Sufficiency Specialist II.

**STATEMENT OF ISSUE**

Petitioner appeals Respondent's action terminating his Medically Needy (MN) and Medicare Savings Plan (MSP) benefits due to exceeding the asset limit. Respondent carries the burden of proof by a preponderance of the evidence in this appeal.

### **PRELIMINARY STATEMENT**

Pursuant to notice, this appeal was scheduled for a telephonic administrative hearing for May 8, 2017, at 1:30 p.m. That hearing was cancelled and continued, prior to convening, as Petitioner requested an in-person hearing. Pursuant to notice, that hearing was re-scheduled for May 16, 2017, at 10:30 a.m.

██████████, Petitioner's wife, appeared as witness for Petitioner.

Petitioner did not submit any exhibits. Respondent submitted evidence prior to hearing, which was not entered on the record. After the hearing, the undersigned entered Respondent's evidence into the record. Respondent submitted an evidence packet consisting of eleven exhibits, ten of which were entered into evidence and marked as Respondent's Exhibits "1" – "10." The undersigned did not enter Respondent's exhibit pages "2" – "4" into evidence as it consisted of notices created by the Office of Appeal Hearings and already included on the docket. The record closed on May 16, 2017.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, Petitioner and his wife received MN and MSP benefits (Respondent's Testimony).
2. On March 27, 2017, Petitioner submitted a paper SSI-Related Medicaid and MSP application for himself and his wife. The application listed a joint checking account with a balance of \$111.60, a joint savings account with a balance of \$696.21, and a jointly owned cash balance of \$100.00 (Respondent's Exhibit 4).
3. On March 30, 2017, Respondent processed the Data Exchange Asset Verification System, which indicated Petitioner was over assets for Medicaid benefits.

Respondent subsequently denied Petitioner's March 27, 2017 application based on this indication (Respondent's Exhibit 8, page 4).

4. On March 31, 2017, Respondent mailed a Notice of Case Action (NOCA) to Petitioner's address of record informing him that his and his wife's Medically Needy benefits would end on April 30, 2017 (Respondent's Exhibit 3, page 8).

5. On April 4, 2017, Petitioner visited Respondent's service center in Kissimmee and requested a reuse of his March 27, 2017 application (Respondent's Exhibit 8, page 4).

6. On April 5, 2017, Respondent reused Petitioner's March 27, 2017 application (Respondent's Exhibit 8, page 3).

7. On April 6, 2017, Respondent mailed a NOCA to Petitioner's address of record requiring proof of current account balances and bank statements for all bank accounts by April 17, 2017 (Respondent's Exhibit 3, page 5).

8. On April 7, 2017, Respondent received bank statements for a Chase checking and savings account from Petitioner (Respondent's Exhibit 8, page 2). The checking account indicated a balance of \$1,092.40 and the savings account indicated a balance of \$12,461.59 as of March 3, 2017, both in the names of [REDACTED] or [REDACTED] [REDACTED] (Respondent's Exhibit 6).

9. Eligibility for MN and MSP requires applicants not exceed the asset limits of each program. The couple asset limit for MN is \$6,000.00 and for MSP (QMB, SLMB, and QI1) is \$10,930.00 (Respondent's Exhibit 9, page 5 [Appendix A-9]).

10. On April 10, 2017, Respondent mailed a NOCA to Petitioner's address of record informing him that his Medically Needy application dated April 5, 2017, was denied for

both him and his wife for April and May, 2017. The reason stated: "The value of your assets is too high for this program" (Respondent's Exhibit 3, page 2).

11. Petitioner does not dispute the amount of funds in his savings account (Petitioner's Testimony).

12. Petitioner disputed that the amount in savings is considered an asset as it includes \$11,790.38 of funds received from an insurance claim to cover repairs to his roof (Respondent's Exhibit 2).

13. Respondent argued that both Petitioner and his wife are joint owners of the [REDACTED] accounts and both have full access to dispose of the funds as they choose (Respondent's Exhibit 6). As such, the full amount in the [REDACTED] count as an asset in determining MN and MSP eligibility (Respondent's Exhibit 9, pages 2 - 3).

#### **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 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.

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

16. Florida Administrative Code Rule 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., with the following exceptions:

...

(b) For Qualified Medicare Beneficiary (QMB), an individual cannot have resources exceeding three times the SSI resource limit with increases based on the Consumer Price Index.

...

(d) For Special Low Income Medicare Beneficiary (SLMB), an individual cannot have resources exceeding three times the SSI resource limit with increases based on the Consumer Price Index.

(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.

17. Florida Administrative Code Rule 65A-1.716, Income and Resource Criteria, states in relevant part:

...

(3) The resource limits for the Medically Needy program are as follows:

Family Size	Level	Monthly Asset
2		\$6,000

18. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, sets forth a \$10,930.00 asset limit for MSP (QMB, SLMB, and QI1) benefits for a couple.

19. The above cited authorities state that applicants cannot exceed the monthly asset limits for MN and MSP benefits. The asset limit for a household consisting of a couple cannot exceed \$6,000.00 for MN and \$10,930.00 for MSP benefits.

20. Florida Administrative Code Rule 65A-1.303, Assets, states in relevant part:

...

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

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

legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf.

21. Florida Administrative Code Rule 65A-1.205, Eligibility Determination Process, states in relevant part:

...  
(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.

...  
(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.

...  
(6) The Department conducts data exchanges with other agencies and systems to obtain information on each applicant and recipient. It uses data exchanges to validate or identify social security numbers, verify the receipt of benefits from other sources, verify reported information, and obtain previously unreported information.

...  
(b) The Department compares information found through the data exchanges with the information already on file. If the data exchange identifies new or different information than was previously available, the Department conducts a partial eligibility review to determine whether it must change benefit levels.

22. The above cited authority states that assets are considered available to an individual when the individual has unrestricted access to it. If a question arises as to an individual's access to an asset, Respondent must verify the information in question to substantiate its validity. Upon Petitioner's claim that his [REDACTED] accounts contained insurance funds set aside to repair his roof, Respondent requested bank statements to

verify his claim. The evidence submitted establishes Petitioner's funds in his [REDACTED] [REDACTED] are funds that he has unrestricted access to and are thus, available, despite \$11,790.38 of the funds coming from an insurance claim.

23. In careful review of the cited authorities and evidence, the undersigned concludes Respondent met its burden of proof. Respondent's action to terminate Petitioner's MN and MSP benefits due to exceeding the asset limits 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 Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 11 day of July, 2017,

in Tallahassee, Florida.



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Erik Swenk, Esq.  
Hearing Officer  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Jul 10, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-02912  
APPEAL NO. 17F-03442

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

The undersigned convened three administrative hearings by phone in the above-referenced matter on April 27, 2017 at 3:05 p.m.; on May 23, 2017 at 9:30 a.m.; and on June 14, 2017 at 1:00 p.m.

**APPEARANCES**

For Petitioner: [REDACTED]

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

**STATEMENT OF ISSUE**

At issue are whether the respondent's actions to decrease the petitioner's Food Assistance (FA) benefits from \$1,022 per month to \$770 per month effective January 2017 and ongoing; to approve the petitioner and his family Transitional Medicaid (MEI) benefits effective December 2016; and to deny the petitioner's request for reimbursement of medical expenses incurred from January 2017 through April 2017 are

correct. The respondent carries the burden of proof by a preponderance of the evidence for the FA and MEI issues. No burden of proof was assigned to the petitioner's request for reimbursement of medical expenses.

### **PRELIMINARY STATEMENT**

At all three hearings, the petitioner was present and testified. The petitioner submitted no exhibits at the hearings. At the April 27, 2017 and June 14, 2017 hearings, the respondent was represented by Teshia Green, Economic Self Sufficiency Specialist II, with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). At the May 23, 2017 hearing, the respondent was represented by Bruce Tunsil, Supervisor, with DCF. At the June 14, 2017 hearing, the respondent submitted eleven exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" – "11".

At the April 27, 2017 and the May 23, 2017 hearings, Alan from the Language Line translated the proceedings. At the June 14, 2017 hearing, Angie from the Language Line translated the proceeding. Two continuances were granted to the respondent.

### **FINDINGS OF FACT**

1. The petitioner's previous FA certification was from August 2016 through January 2017. The petitioner's current Medicaid certification was from August 2016 through July 2017. (Respondent's testimony)
2. On December 14, 2016, the petitioner reported he was employed. On the same day, he submitted an earned income form verifying he began working on November 28,

2016; is paid \$11.50 per hour; works forty hours per week; and is paid bi-weekly.

(Respondent's Exhibits 2 & 10)

3. On December 15, 2016, the respondent determined the petitioner's weekly earned income as \$460 ( $\$11.50 \times 40$ ). The respondent also determined the petitioner's monthly earned income amount as \$1,978.00 ( $\$460 \times 4.3$ ). (Respondent's Exhibit 10)

4. The petitioner does not dispute the respondent's calculation of his monthly earned income as \$1,978. (Petitioner's testimony)

5. Initially, the respondent reduced the petitioner's FA benefits to \$770 per month and enrolled him and his family in the MN Medicaid program effective January 2017 and ongoing. (Respondent's Exhibit 4)

6. On December 16, 2016, the respondent sent a Notice of Case Action to the petitioner indicating it reduced his FA benefits to \$770 and enrolled him and his family in the MN Medicaid Program. (Respondent's Exhibit 11)

7. On December 30, 2016, the petitioner submitted an application for Temporary Cash Assistance (TCA), FA, and Medicaid benefits. TCA benefits are not under issue. The application listed the petitioner, his wife, and their five children as the only household members; his terminated earned income as the only reported source of income for the household; rent as \$950 per month; and \$100 per month for electricity. (Respondent's Exhibit 1)

8. On January 9, 2017, the respondent conducted an interview with the petitioner during which he reported he was employed; paid \$950 per month in rent; paid \$100 for electric; and had a heating/cooling expense. (Respondent's Exhibit 10)

9. On April 27, 2017, the respondent determined the petitioner's FA benefits for January 2017 should have remained at \$1,022 as his reported earned income should not have been counted in the FA budget until February 2017. The respondent approved the petitioner an additional FA benefit amount of \$252 for the month of January 2017.

(Respondent's Exhibit 7)

10. On April 27, 2017, the respondent determined the petitioner and his family were incorrectly enrolled in a MN program. The respondent explained the petitioner and his family are eligible for MEI benefits from December 2016 through November 2017.

(Respondent's Exhibit 7)

11. At the June 14, 2017 hearing, the petitioner reported his rent increased to \$1,025 effective June 2017. Also at the June 14, 2017 hearing, the petitioner reported his rent amount from January 2017 to May 2017 was \$965 per month. He explained the reason he reported his rent as \$950 per month was a case manager told him to report his rent as \$950 and not \$965. He explained he did not know how much his monthly rent was from January 2017 to May 2017. (Petitioner's testimony)

12. The respondent calculated the petitioner's FA budget for February 2017 and ongoing as follows:

<b>Expenses/Income Dollar</b>	<b>Amount</b>
<b>Earned income</b>	\$1978.00
<u>Earned income deduction</u>	-\$ 395.60
<u>Standard deduction for a household of seven</u>	-\$ 226.00
<b>Total household income</b>	<b>\$1356.40</b>
<b>Adjusted income after deductions</b>	<b>\$1356.40</b>
Rent/shelter	\$ 950.00
<u>Standard utility allowance</u>	+\$ 338.00
<b>Total rent/utility costs</b>	<b>\$1288.00</b>

<u>Shelter standard (50% adjusted income)</u>	<u>-\$ 678.20</u>
<b>Excess shelter deduction</b>	<b>\$ 609.80</b>
Adjusted income	\$1356.40
<u>Excess Shelter Deduction</u>	<u>-\$ 517.00</u>
<b>Adjusted income after shelter deduction</b>	<b>\$ 839.40</b>

13. The respondent took 30% of \$839.40 to calculate the FA benefit reduction of \$252. The benefit reduction of \$252 was then subtracted from \$1,022 (the maximum FA benefit amount for a household of seven) to arrive at \$770. (Respondent's Exhibit 8)

14. Initially, the petitioner withdrew his FA appeal; however, he changed his mind and wanted to move forward with the merits of the FA appeal at the June 14, 2017 hearing.

15. The petitioner did not agree with the respondent's determination that he is eligible for FA benefits in the amount of \$770 per month. He requested his FA benefits return to \$1,022 per month effective February 2017 and ongoing. (Petitioner's testimony)

16. The petitioner did not agree with the respondent's determination that his MEI benefits were effective December 2016. He requested his MEI benefits begin effective May 2017. (Petitioner's testimony)

17. The respondent explained the petitioner's MEI Medicaid benefits were effective December 2016 as the aforementioned month is the first month the petitioner and his family were over the income limit for full Family-Related Medicaid benefits due to the petitioner's newly reported earned income. (Respondent's testimony)

18. The petitioner requested the respondent reimburse him for all medical expenses incurred when he and his family received MN Medicaid. The reimbursement request is for the months of January 2017 through April 2017. (Petitioner's testimony)

19. The respondent explained the agency that reimburses individuals for Medicaid expenses paid out-of-pocket is the Agency for Health Care Administration (AHCA). (Respondent's testimony)

### **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.

### **As to whether the respondent correctly determined the petitioner's reported change should be effective February 2017**

22. Federal Regulations at 7 C.F.R. § 273.12, Requirements for change reporting households states, in part:

(a) Household responsibility to report. (1) Monthly reporting households are required to report as provided in §273.21. Quarterly reporting households are subject to the procedures as provided in paragraph (a)(4) of this section. Simplified reporting households are subject to the procedures as provided in paragraph (a)(5) of this section. Certified change reporting households are required to report the following changes in circumstances:

(B) A change in the source of income, including starting or stopping a job or changing jobs, if the change in employment is accompanied by a change in income. . .

(2) Certified households must report changes within 10 days of the date the change becomes known to the household, or at the State agency's option, the household must report changes within 10 days of the end of the month in which the change occurred. For reportable changes of income, the State agency shall require that change to be reported within 10 days of the date that the household receives the first payment attributable to the change. For households subject to simplified reporting, the household must report changes no later than 10 days from the end of the calendar month in which the change occurred, provided that the household receives the payment with at least 10 days remaining in the month. If there are not 10 days remaining in the month, the household must report within 10 days from receipt of the payment. Optional procedures for reporting changes are contained in paragraph (f) of this section for households in States with forms for jointly reporting SNAP and public assistance changes and SNAP and general assistance changes. . .

(4) The State agency may establish a system of quarterly reporting in lieu of the change reporting requirements specified under paragraph (a)(1) of this section. The following requirements are applicable to quarterly reporting systems:

(v) Reduction or termination of benefits. If the household files a complete report resulting in reduction or termination of benefits, the State agency shall send an adequate notice, as defined in §271.2 of this chapter. The notice must be issued so that it will be received by the household no later than the time that its benefits are normally received. If the household fails to provide sufficient information or verification regarding a deductible expense, the State agency will not terminate the household, but will instead determine the household's benefits without regard to the deduction.

(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...

23. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 0810.0200, Simplified Reporting (FS), states, in part:

Effective November 1, 2009 all food stamp households are simplified reporting.

Simplified Reporting households must report when income exceeds the monthly income limit for the AG size...

Food stamp AGs that also receive TCA and/or Medicaid must report changes according to TCA and/or Medicaid Program requirements. Act on changes reported for TCA and/or Medicaid and make the change to affect all three programs. For beneficial changes, if the household fails to verify the information, leave the food stamp benefits the same. Do not act on reported adverse changes in food stamp only cases. In combination cases with food stamps, TCA, and/or Medicaid, process adverse changes based on the information provided by the household.

24. The Policy Manual, CFOP 165-22, passage 0810.0500, Changes (MFAM), states, in part:

A change (expected or unexpected) may affect eligibility or level of benefits. . .

Effective Date of Change: With the exception of the addition of new members, changes that result in a beneficial or adverse change are effective according to the following time frames:

1. Beneficial: the first day of the month the change is reported or becomes known to the Department.
2. Adverse: the first day of the next month the change can be made allowing for 10 days adverse action notice.

25. Pursuant to the above authorities, since the petitioner receives FA and Medicaid benefits he must report all changes, including new income, to the Department pursuant to the Medicaid program requirements. The effective date for an adverse change is the first day of the month following the month the individual reports the change.

Furthermore, for adverse changes, the respondent must allow ten (10) days for adverse action notice.

26. On December 14, 2016, the petitioner reported and verified his new earned income. On December 15, 2016, the respondent decreased the petitioner's FA benefits to \$770. Ten (10) days from December 15, 2016 is December 25, 2016. Therefore, January 1, 2017 is the first day of the month the petitioner's FA benefits should have decreased to \$770. The respondent was initially correct to decrease the petitioner's FA benefit amount effective January 2017.

27. The respondent increased the petitioner's January 2017 FA benefits to \$1,022 subsequent to the April 27, 2017 hearing. The respondent incorrectly increased the petitioner's FA benefits as his household receives FA and Medicaid benefits. Pursuant to Medicaid program requirement for adverse changes, the effective date of the petitioner's adverse change is January 1, 2017, not February 1, 2017.

28. In careful review of the cited authorities and evidence, the undersigned concludes the respondent erred in increasing the petitioner's FA benefits to \$1,022 for the month of January 2017. However, there is no better outcome the undersigned can provide to the petitioner for the month of January 2017.

**As to whether the respondent correctly determined the petitioner's FA benefits as \$770 per month effective February 2017**

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

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

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

(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...

(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...

(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)...

30. Pursuant to the above authority, the petitioner's earned income must be included in the determination of his household's monthly FA benefit amount. Furthermore, shelter costs, utilities, an earned income deduction, and a standard deduction must also be included in the determination of his household's monthly FA benefit amount.

31. At the June 14, 2017 hearing, the petitioner reported his rent was \$965 per month for the period of January 2017 through May 2017. He also reported his rent increased to \$1,025 per month effective June 2017. The respondent calculated the petitioner's monthly rent as \$950 for the months of January 2017 and ongoing.

32. Federal Regulations at 7 C.F.R. § 273.10 defines determining household eligibility and benefit levels and states, in part:

(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. If the amount of income that will be received, or when it will be received, is uncertain, that portion of the household's income that is uncertain shall not be counted by the State agency.

(ii) Income received during the past 30 days shall be used as an indicator of the income that is and will be available to the household during the certification period...

33. The Policy Manual, CFOP 165-22, passage 2410.0501, Averaging Fluctuating Income (FS), states, in part:

To average income, the eligibility specialist must consider the assistance group's anticipation of monthly income fluctuations over the certification period. When averaging income, use the most recent consecutive four weeks or the best available information when it is representative of the individual's future earnings.

34. Pursuant to the above authorities, the respondent must utilize the last four weeks of earned income when calculating the petitioner's monthly-earned income.

35. The Policy Manual, CFOP 165-22, passage 2410.0509, Income more often than monthly (FS), states, in part:

The following procedure to calculate the average of earned or unearned income received in varying amounts more frequently than monthly is the same for all programs:

1. Add the gross income amounts for the past four weeks to get the total.
2. If income is received weekly, add four pay periods and divide by four to get the weekly average.
3. If income is received biweekly, add two pay periods and divide by two to get the biweekly average.
4. If income is received semimonthly, add two pay periods and divide by two to get the semimonthly average.
5. If income is received monthly, use the most recent month if representative. The result of the above is called the averaged amount. With the exception of monthly amounts, the averaged amount described above must be converted to a monthly amount.

36. Pursuant to the above policy, the respondent utilizes the monthly gross income amounts to determine eligibility for FA benefits. To convert biweekly income to monthly income, the respondent first adds the past two pay periods of earned income, then divides the sum by two, and then multiplies the sum by 2.15. The respondent utilized the information from the earned income form to determine the petitioner's monthly earned income amount as the petitioner never submitted his paystubs. The respondent correctly calculated the petitioner's monthly earned income amount as \$1,978.

37. The Policy Manual, CFOP 165-22, Appendix A-1, sets forth the following Eligibility Standards for Food Assistance benefits effective October 2016:

- (1) \$1,022 maximum FA benefit for a household size of seven; (2) \$338.00 standard utility allowance; (3) \$226.00 standard deduction for a household size of seven; and (4) \$517 as the capped shelter deduction for AGs without elderly or disabled members.

38. Pursuant to the various aforementioned authorities, the respondent correctly calculated the petitioner's income, utility expense, and all deductions allowed in the determination of FA benefits.

39. However, the petitioner reported new rental amounts at the June 14, 2017 hearing. The respondent should determine the petitioner's correct monthly rent amounts for February 2017 and ongoing to determine if the newly reported rent amounts would increase his monthly FA benefit amount.

40. The respondent is hereby ordered to determine the petitioner's monthly rental amount to be counted in his Food Assistance budgets for February 2017 and ongoing. Once the new review is completed, the respondent is to issue a Notice of Case Action to the petitioner including his appeal rights.

41. In careful review of the cited authorities and evidence, the undersigned concludes the respondent did not meet the burden of proof indicating the petitioner's Food Assistance benefits were correctly calculated as \$770 per month effective February 2017 and ongoing.

**As to whether the respondent correctly determined the effective date of the petitioner's MEI benefits as December 2016**

42. Section 445.029, Florida Statutes, Transitional Medical benefits defines the criteria to receive MEI Medicaid and states, in part:

(1) A family that loses its temporary cash assistance due to earnings shall remain eligible for Medicaid without reapplication during the immediately succeeding 12-month period if private medical insurance is unavailable from the employer or is unaffordable.

43. Pursuant to the above authority, a family is eligible for up to twelve months of MEI benefits if the aforementioned criteria are met. The issue under appeal is not the petitioner and his family's eligibility for MEI benefits, but rather, the month his MEI benefits should begin.

44. The Policy Manual, CFOP 165-22, passage 2030.0203, Transitional Coverage (MFAM) states, in part:

Transitional coverage provides extended coverage for up to 12 months, beginning with the month of ineligibility...

Conditions that must be met:

1. The assistance group must be ineligible for Medicaid based on initial receipt of earned income or receipt of increased earned income by the parent or caretaker relative...

45. Pursuant to the above policy, the petitioner's MEI benefits should begin the first month he and his family are no longer eligible for full Family-Related Medicaid benefits. The petitioner's employment began in November 2016. The respondent determined the petitioner and his family were ineligible for full Family-Related Medicaid benefits effective December 2016. The evidence indicates the petitioner and his family are eligible for MEI benefits from December 2016 through November 2017.

46. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met the burden of proof indicating it correctly approved the petitioner and his family's Transitional Medicaid benefits effective December 2016.

**As to whether the respondent correctly denied the petitioner's request for reimbursement of medical expenses incurred when he received MN Medicaid**

47. The Policy Manual, CFOP 165-22, passage 0430.0611, Reimbursement (MFAM), states:

The area AHCA Medicaid office staff are responsible for determining if an applicant or recipient is eligible for direct reimbursement of paid medical services incurred after a case is denied and the decision is subsequently reversed. Refer inquiries to the AHCA area Medicaid office.

48. Pursuant to the above authority, reimbursement issues are under the jurisdiction of AHCA. The petitioner must request the reimbursements of all medical expenses for

the months of January 2017 through April 2017 from AHCA. The petitioner is encouraged to contact AHCA to determine if he is eligible for reimbursement of his medical expenses when he and his family received MN Medicaid.

49. The petitioner's reimbursement appeal is hereby dismissed as non-jurisdictional because the respondent does not have jurisdiction over reimbursement issues.

### **DECISION**

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

The appeal concerning the petitioner's Food Assistance benefit amount effective February 2017 and ongoing is GRANTED and REMANDED to the Department for further development as explained in the Conclusions of Law.

The appeal concerning the effective date of the petitioner's Transitional Medicaid benefits is DENIED.

The appeal concerning the petitioner's request for reimbursement of medical expenses is hereby DISMISSED as the respondent does not have jurisdiction over reimbursement issues.

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

DONE and ORDERED this 10 day of July, 2017,

in Tallahassee, Florida.

*Mary Jane Stafford*

---

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

**FILED**

Jul 03, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-02913

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 09 Orange  
UNIT: 88991

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 22, 2017 at 1:00 p.m.

**APPEARANCES**

For the petitioner: [REDACTED], the petitioner's granddaughter

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 Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The petitioner was present. Appearing as a witness for the petitioner was [REDACTED]  
[REDACTED], the petitioner's grandson.

The petitioner did not submit any exhibits at the hearing. The respondent submitted four exhibits, which were accepted into evidence and entered as Respondent's Exhibits "1" through "4". The record was held open until close of business on June 2, 2017 for submission of additional evidence from the parties. On May 25, 2017, additional evidence was received from the respondent, which was entered as Respondent's Exhibit "5". On May 26, 2017, evidence was received from the petitioner, which was entered as Petitioner's Exhibit "1". On May 31, 2017, additional evidence was received from the respondent, which was entered as Respondent's Exhibit "6". The record closed on June 2, 2017.

#### **FINDINGS OF FACT**

1. On December 22, 2016, the petitioner (94) applied for Adult-Related Medicaid benefits. On the application, the petitioner reported she was not a citizen of the United States (U.S.) and that she was disabled.
2. As part of the eligibility process, the respondent verified the petitioner's citizenship. The respondent used the Department of Homeland Security's SAVE Program. Based on the data, the respondent verified that the petitioner was born in India and had obtained her Lawful Permanent Resident (LPR) status on August 29, 2016.
3. On January 24, 2017, the respondent mailed the petitioner a Notice of Case Action denying her December 22, 2016 Medicaid application, "Reason: No household members are eligible for this program."
4. The respondent explained to be potentially eligible for Medicaid benefits, the petitioner must have resided in the U.S. as an LPR for a period of five years. The

petitioner has not been in the U.S. as an LPR for five years. Therefore, the respondent argued she is not eligible for the Medicaid benefits.

5. The petitioner's granddaughter is concerned about the petitioner's health. The petitioner is disabled and needs medical treatment. The respondent explained that Emergency Medicaid for Aliens (EMA) is available for individuals like the petitioner, who are ineligible for regular Medicaid benefits due to the five-year ban.

6. The petitioner's granddaughter explained the petitioner had obtained residency and received her LPR sometime in 1991. The petitioner moved to India sometime in 2000 and returned back to the U.S. in 2015. The record was left open to allow the petitioner an opportunity to submit her previous LPR card. The petitioner presented a Resident Alien card issued on August 30, 1994 and which expired on September 22, 2004. No other documents were provided by the petitioner.

#### **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 Florida Administrative Code R. 65-2.056.

9. 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...

10. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1440.0114, addresses Verification Requirements for Noncitizens (MSSI, SFP).

It states, "The eligibility specialist must verify the immigration status of all non-citizens applying for or receiving Medicaid through the U.S. Citizenship and Immigration Services (USCIS). The Verification Information System-Customer Processing System (VIS-CPS) is used to verify the immigration status".

11. 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,

(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.

12. According to the above-cited rules, 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 is not eligible for Medicaid benefits.

13. TITLE 8 of the United States Code (USC), ALIENS AND NATIONALITY, CHAPTER 12-IMMIGRATION AND NATIONALITY, SUBCHAPTER I-GENERAL PROVISIONS, § 1101, DEFINITIONS, states in part:

- ...
- (13)(A) The terms “admission” and “admitted” mean, with respect to an alien, the lawful entry of the alien into the United States after inspection and authorization by an immigration officer.
- (B) An alien who is paroled under section 1182(d)(5) of this title or permitted to land temporarily as an alien crewman shall not be considered to have been admitted.
- (C) An alien lawfully admitted for permanent residence in the United States shall not be regarded as seeking an admission into the United States for purposes of the immigration laws unless the alien—
- (i) has abandoned or relinquished that status,
  - (ii) has been absent from the United States for a continuous period in excess of 180 days

14. The petitioner’s granddaughter argued that her grandmother has been residing in the United States lawfully since 1991. Although the petitioner had been in the United States for over five years prior to 2015, she must have been a qualified noncitizen as defined above for Medicaid eligibility. The petitioner’s granddaughter presented the petitioner’s previous Resident Alien card which was issued on August 30, 1994 and expired on September 22, 2004. The findings show the petitioner moved to India sometime in 2000 and did not return to the U.S. until 2015. After her return to the U.S., the petitioner did not receive her LPR status until August 29, 2016. Therefore, based on the immigration documentation presented, she is not eligible for Medicaid benefits according to the above authorities. The petitioner must meet the five-year requirement, which she will complete on August 28, 2021. The petitioner’s granddaughter testified that the petitioner is aged and disabled.

15. 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).

16. 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 has to seek emergency medical services, she can submit an application for Emergency Medical Assistance for Aliens (EMA) and may apply for those benefits at any time.

17. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's action to deny the petitioner's application for Adult-Related Medicaid benefits, dated December 22, 2016, was within the rules.

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

DONE and ORDERED this 03 day of July, 2017,

in Tallahassee, Florida.



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

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

**FILED**

Jul 14, 2017

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-02964

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 hearing in the above-referenced matter on June 5, 2017 at 9:47 a.m., in West Palm Beach, Florida.

**APPEARANCES**

For the Petitioner: [REDACTED], Attorney

For the Respondent: Tanesha Baker, operations management consultant I

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to deny her March 23, 2017 application for disability-related Medicaid. The burden of proof is assigned to the petitioner. The standard of proof at a fair hearing is a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The respondent submitted four exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 4. The petitioner provided ten exhibits

which were entered into evidence and marked as Petitioner's Exhibits 1 through 10. The record was held open until June 15, 2017, for the petitioner to provide the letter from the Social Security Administration (SSA) showing what medical conditions were reviewed. On June 8, 2017, the petitioner provided one additional exhibit, a letter from SSA which was entered into evidence and marked as Petitioner's Exhibit 11. On June 9, 2017, the respondent provided one additional exhibit of policy which was entered into evidence and marked as Respondent's Exhibit 5. The record was closed on June 15, 2017.

### **FINDINGS OF FACT**

1. On March 23, 2017, the petitioner (age 54) applied for SSI-Related Medicaid (Respondent's Exhibit 2).
2. The petitioner is the only household member. As she is not yet 65 years of age and has no minor children in her household, the petitioner must meet the disability-related criteria in order to be considered for Medicaid.
3. On the above-mentioned application, the petitioner reported that she was disabled; therefore, a disability review was initiated. The respondent found the petitioner was denied Social Security Disability (SSD) by Social Security Administration (SSA) on February 7, 2017, with the reason code N35 (NONPAY Impairment is severe at time of adjudication but not expected to last 12 months, no visual impairment) (Respondent's Exhibit 3).
4. On June 12, 2016, the petitioner applied for disability at the SSA. On February 7, 2017, the SSA denied the petitioner's application. On February 17, 2017, the petitioner appealed the SSA decision and that appeal is currently pending. The disability packet

that the respondent filled out was not forwarded to the Division of Disability Determination (DDD) for independent review because the respondent adopted the SSA decision.

5. The petitioner was reviewed by SSA for [REDACTED]

[REDACTED]

[REDACTED]

6. On March 27, 2017, the respondent denied the petitioner's application and issued a Notice of Case Action informing the petitioner that her Medicaid application dated was denied. The reason cited for the denial was, "You or a member of your household do not meet the disability requirement. No household members are eligible for this program."

7. On April 10, 2017, the petitioner requested a hearing to challenge the respondent's decision.

8. The petitioner confirmed that she has no new medical conditions, but alleges her conditions have worsened or changed since the SSA denial. She still suffers from [REDACTED]

[REDACTED]

[REDACTED]. The petitioner alleges she cannot function or perform the basic functions such as, bathing, getting dressed and household activities. She also stated that she now uses a walker.

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

11. 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; ...

12. According to the regulations above, the Department is bound by the SSA decision unless there is evidence of a new disabling condition not reviewed by SSA.

The petitioner stated that she has no new condition but she claims deteriorating disabling conditions.

13. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, at passage 1440.1205 and addresses Exceptions to State Determination of Disability (MSSI, SFP) and states

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).

2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).

3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.

4. When an individual is no longer eligible for SSI solely due to institutionalization.

**5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).**

**6. When the individual files an application within 12 months after the last unfavorable disability determination by SSA, and the individual alleges no new disabling condition or claims a deterioration of an existing condition previously considered by SSA. Refer the individual to SSA for disability reconsideration or appeal (Only request a disability decision from DDD if:**

- a. SSA refuses (or has already refused) to reconsider the unfavorable disability decision, or
- b. the applicant no longer meets SSI non-disability criteria such as income or assets. **(emphasis added)**

14. The above authorities explain that if SSA has denied disability within the past year, or if the denial is under appeal, the SSA decision is to be adopted. The findings show that on February 7, 2017, SSA denied the petitioner's application for SSD benefits. On February 17, 2017, the petitioner requested an appeal to challenge SSA decision and that appeal is currently pending. Worsening of conditions or deterioration of conditions reviewed by SSA are referred back to SSA for reconsideration.

15. The hearing officer concludes that the petitioner must complete the appeal process with SSA, and that the respondent is bound by SSA's decision unless an exception as described above is met. The Department must not complete an independent review for disability as the petitioner met no exception to do so.

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

DONE and ORDERED this 14 day of July, 2017,  
in Tallahassee, Florida.

*Christiana Gopaul Narine*

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Christiana Gopaul-Narine  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
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Copies Furnished To: [REDACTED] Petitioner  
Office of Economic Self Sufficiency  
Marjorie Desporte, Esq.

Jul 21, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 17F-02986

PETITIONER,

Vs.

AGENCY FOR HEALTH  
CARE ADMINISTRATION  
CIRCUIT: 05 Marion  
UNIT: AHCA

AND

SUNSHINE HEALTH

RESPONDENTS.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 13, 2017 at 3:12 p.m.

**APPEARANCES**

For the Petitioner: 

For the Respondent: Dr. Andrew Russell, medical director, Sunshine Health

**STATEMENT OF ISSUE**

Whether respondent's action reducing the home health services the petitioner receives through Medicaid was correct. The respondent holds the burden of proof in this matter.

### **PRELIMINARY STATEMENT**

The Agency for Health Care Administration (AHCA or Agency or respondent) administers the Florida Medicaid Program. The respondent contracts with healthcare maintenance organizations (HMOs) to provide medical services to its program participants. Sunshine Health (Sunshine) is the contracted HMO in the instant case.

By notice dated February 28, 2017, Sunshine informed the petitioner that the home health services hours she receives through Medicaid were being reduced from 35 hours weekly to 19 hours weekly. In addition, home delivered meals were being reduced from 7 weekly to 5 weekly.

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

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

Present as witnesses from Sunshine: Kimberly Bouchette, clinical appeals coordinator; Louise Jeanty, clinical appeals coordinator; Donna Miller, long term care supervisor; Kizzy Alleyne, paralegal; and Tammi Swan, long term care director. Present as an observer from AHCA: Dianne Soderlind, registered nurse specialist. The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was closed on June 13, 2017.

### **FINDINGS OF FACT**

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

1. The petitioner (age 79) is a Florida Medicaid recipient. The petitioner's diagnoses include: [REDACTED]

[REDACTED]

[REDACTED] The petitioner is incontinent of bowel and bladder. The petitioner can walk short distances inside her home. She uses a power wheelchair outside the home. The petitioner is verbal, she feeds and takes medications by mouth. The petitioner requires partial to total physical assistance with all activities of daily living. (Petitioner testimony)

2. The petitioner is enrolled with Sunshine HMO's Long Term Care Program (LTCP). LTCP provides home health services to individuals who would otherwise require nursing home placement. (Respondent's Composite Exhibit 1)

3. The petitioner also participates in the Participant Directed Options (PDO) program. PDO allows participants to have more control over the provision and delivery of their services by choosing their own care providers. Participants may use community/outside care providers or have family members provide the services. The petitioner's grandson is her home health care provider (Kimberly Bouchette testimony and petitioner testimony)

4. Prior to the action under appeal, the petitioner received 35 hours of home health services weekly through Medicaid LTCP: Personal Care – 9 hours; Companion

Care – 6 hours; and Homemaking – 20 hours. She also received home delivered meals – 7 meals weekly. All Medicaid good and services must be medically necessary.

Sunshine conducts periodic service reviews to ensure that recipient services continue to be medically necessary. In February 2017, Sunshine reviewed the petitioner's services and determined that it was appropriate to reduce her home health services to 19 hours weekly: Personal Care – 9 hours; Companion Care – 0 hours/terminated service; and Homemaking – 10 hours weekly. Sunshine also reduced home delivered meals to 5 meals weekly. (Respondent's Composite Exhibit 1)

5. The petitioner timely requested a hearing to challenge Sunshine's decision.

6. Sunshine relied on its internal assessment tool referred to as the 701B Comprehensive Assessment (701B Assessment) to make the service decisions under challenge. The 701B Assessment describes the petitioner's functioning level, need for personal care assistance (assistance with the activities of daily living), need for home maker services (shopping, cleaning, cooking) and need for companion care (assistance with supervision and socialization). The 701B Assessment is completed by Sunshine staff who interview the recipient and/or the recipient's family and caregivers. The 701B Assessment used in the instant case was completed on January 25, 2017 and described the petitioner as "alert and oriented x 3. She is able to answer questions independently, make her own decisions and sign on her own behalf." (Respondent's Composite Exhibit 1)

7. The 701B Assessment noted that the petitioner required little to no physical assistance to complete the activities of daily living; she attends an adult day program

two days per week; and lives next door to her adult son. The assessment further noted that the Homemaker services being provided included lawn care. (Respondent's Composite Exhibit 1)

8. Sunshine determined that Homemaker services should be reduced from 20 hours weekly to 10 hours weekly because lawn care is not an included service; Medicaid rules prohibit the provision of excluded services. Sunshine determined that the petitioner no longer required Companion Care because her adult son lived next door and could provide that service for her; Medicaid rules prohibit the provision of services in excess of recipient need. Sunshine determined that it was appropriate to reduce home delivered meals from 7 weekly to 5 weekly because the petitioner attends an adult day program two days weekly and receives a meal at the program center; Medicaid rules prohibit provision of duplicative services. Sunshine made no change in the level of Personal Care services. (Testimonies of Dr. Andrew Russell and Kizzy Alleyne)

9. The petitioner asserted that she participated in the 701B interview in January 2017, but did not see what the case manager actually input into the computer and did not receive a copy of the assessment prior to the reduction decision. The petitioner asserted that the 701B Assessment does not correctly reflect her level of functioning or need for support services. Contrary to what is written in her 701B Assessment, the petitioner asserted that she is not capable of independently completing any of the activities of daily living; she requires partial to total assistance with all activities of daily

living. The petitioner asserted that she has no natural supports that she can consistently rely on to assist her. (Petitioner testimony)

10. Regarding Companion Care services, the petitioner explained that she lives in a wooded rural area and while it is correct that her adult son is her closest neighbor, he lives three acres away. The son works 10 hour days and has health issues of his own. The petitioner cannot rely on her son for Companion Care. She sees him approximately once per week, sometimes less. Their primary method of contact is by telephone. The petitioner explained further that the closest city, Ocala, is 40 minutes from her home. She cannot drive, she requires transportation and physical assistance with shopping, attending medical appointments, and other community appointments. She relies exclusively on Companion Care services to help her in the community. The petitioner argued that her Companion Care services should not be terminated. (Petitioner testimony)

11. Regarding Homemaker services, the petitioner explained that due to severe arthritis, allergies and incontinence issues, she requires more than average house cleaning and laundry assistance to maintain her health and safety. In addition, there is no government or private garbage service her rural area. She relies on Homemaking services to drive her garbage to the local dump twice a week. Failure to dispose of garbage results in increased rodent activity which endangers her health and safety. The petitioner argued that her Homemaking services should not be reduced. (Petitioner testimony)

12. Regarding home delivered meals, the petitioner explained that she only receives one meal daily through Medicaid. She relies on that one meal daily because she is not capable of cooking for herself. Warming food in the microwave is the extent of her cook capabilities. Due to numerous health issues, she is frequently too ill to attend the day program. She misses additional days at the day program because the transportation service she uses is unreliable, the driver routinely does not pick her up. In addition, the program center is closed for holidays. The petitioner argued that her home delivered meals should not be reduced. (Petitioner testimony)

13. The petitioner expounded her position in a letter. The letter reads in pertinent part:

[M]y case manager came to my home for an annual evaluation, everything was renewed for the next year....[Case manager] supervisor...informed me that they were cutting my homemaking hours & 2 meals per week. Said I had too many hrs. they were going from client to client and cutting hours, cutting two meals a week because of me attending Elder Care twice a week & getting a meal there. She did not take into consideration when transportation doesn't pick me up for weeks in a row, when I'm sick & don't go, when their [sic] closed for holidays, I have a Doctor appointment & can't go. She cut 10 hours homemaking saying worker not allowed anymore to cut my grass or weed eat around the house or clean up debris or take garbage to dump 2 x week, or knock down wasps nest all around entrances to house. These chores had been allowed in the past from cdc and were continued when I was transferred to cd. But it did not take 10 hours for the outside work, she also cut time from my inside care. I live in the country with woods behind me with snakes, rodents, wild animals, when grass gets high around house & garbage piles up they will come to house!! And if wasp's nests are not knocked down weekly, anyone coming or going to house will be stung. They also cut my 6 hours companion. Which I used to go to town for weekly grocery shopping as well as for other needs, nails, hair, etc. now I'm left without being able to get to town weekly. (Petitioner's Exhibit 1)

### **CONCLUSIONS OF LAW**

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

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

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

17. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the respondent. The standard of proof needed to be met is by 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, 7<sup>th</sup> Ed., 1999), or evidence that “more likely than not” tends to prove a certain proposition. See Gross v. Lyons, 763 So. 2d 276, 289, n.1 (Fla. 2000).

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

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

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

(a) Meet the following conditions:

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

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

....

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

20. Sunshine LTC Ancillary Service Criteria (LTC Criteria) is used in conjunction with Fla. Admin. Code R. 59G-1.010(166) to determine the appropriate level of home health services LTCP enrollees are eligible to receive.

### **COMPANION CARE**

21. Companion Care is addressed on page 9 of the LTC Criteria and reads:

Members who may benefit from Adult Companion Care, include those who:

- Live alone and have inadequate caregiver support
- Have someone in the home but has inadequate caregiver support
- Require assistance and/or supervision with meal preparation, shopping, light housekeeping as an incidence to care provided and/or laundry
- Require assistance or supervision to maintain safe living conditions in the home
- Require assistance to maintain independence due to functional status (i.e. member has difficulty with bending, twisting and ambulation or has a medical condition that affects endurance, such as a heart or breathing problem) and/or cognitive status (i.e. dementia)

22. Sunshine terminated the petitioner's Companion Care service because the 701B Assessment stated that her adult son lives next door; Sunshine concluded that he could provide Companion Care to the petitioner. The evidence proves that the 701B Assessment relied on by Sunshine to make the termination decision in this matter does not correctly reflect the petitioner's functioning level or need for support services. The petitioner's son is not available to provide Companion Care because he works 10 hour days and has health issues of his own. The petitioner sees him on average once a week. The evidence proves that the petitioner meets the LTC Criteria cited above and has no reliable natural supports.

23. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent did not prove by clear and convincing evidence that is no longer medically necessary for the petitioner to receive Companion Care.

### **HOMEMAKER SERVICES**

24. LTC Criteria addresses Homemaking services on page 18 and reads:

Housekeeping, and Chore Services are, for members whose regular caregiver is temporarily absent or unable to manage these activities.

Chore Services and Enhanced Chore Services are limited to:

- Chores that are necessary to maintain health, welfare and safety of the member temporarily, when the caregiver cannot perform those duties.
- Chores that are necessary for safe access to and egress from the member's home.

25. Sunshine reduced the petitioner's Homemaker services from 20 hours weekly to 10 hours weekly because the 701B Assessment stated that the service is used in-part for lawn care. Sunshine contends that lawn care is an excluded service.

Sunshine's argument is contradicted by program policy. LTC Criteria defines covered chores as those "that are necessary for safe access to and egress from the member's home." The evidence proves that the petitioner is not capable of performing any instrumental activities of daily living/ homemaking chores. She lives alone and has no consistent natural supports. The undersigned concludes that a well maintained lawn is necessary to safely enter and exit the petitioner's rural home, as allowed in program policy. Further, the evidence also proves that the 701B Assessment relied on by Sunshine to make the reduction decision in this matter does not correctly reflect the petitioner's functioning level or need for support services. The petitioner has extreme allergies and incontinence issues which require frequent cleaning and laundry services to ensure her health and safety.

26. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent did not meet its burden in this matter. The respondent did not prove by a preponderance of the evidence that it is no longer medically necessary for the petitioner to receive 20 hours of Homemaking service weekly.

#### **HOME DELIVERED MEALS**

27. Sunshine reduced the number of home delivered meals the petitioner receives from one daily/seven weekly to five weekly because the 701B Assessment stated that the petitioner attends an adult day program two days per week and receives a meal at the program center. The evidence proves that the 701B assessment relied on by Sunshine to make the reduction decision in this matter does not correctly reflect the

petitioner's functioning level or need for support services. Due to illness, community appointments, and unreliable transportation services, the petitioner is frequently unable to attend the adult day program. The petitioner is not capable of preparing her own meals and relies on the daily home delivered meal to meet her nutritional requirements.

28. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent did not meet its burden in this matter. The respondent did not prove by a preponderance of the evidence that it is no longer medically necessary for the petitioner to receive seven home delivered meals weekly.

### **DECISION**

The appeal is GRANTED. The respondent is hereby ordered to reinstate prior service levels for ALL impacted services.

### **NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 21 day of July, 2017,  
in Tallahassee, Florida.

*L. Green*

---

Leslie Green  
Hearing Officer  
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Tallahassee, FL 32399-0700  
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Copies Furnished To: [REDACTED] Petitioner  
AHCA, Medicaid Fair Hearings Unit  
Sunshine Hearings Unit

Jul 06, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-02992

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 11 Dade  
UNIT: 88075

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 8, 2017 at 1:37 p.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se

For the Respondent: John Roche, Operations Management Consultant I

**STATEMENT OF ISSUE**

At issue is the respondent's action to deny the petitioner's request for full Medicaid and enrolling her in Medically Needy (MN) with a Share of Cost (SOC). The burden of proof was assigned to the petitioner by a preponderance of evidence.

### **PRELIMINARY STATEMENT**

██████████, Designated Reviewer with the Department of Children and Families (DCF), provided interpreter services for the hearing. The petitioner did not object.

The petitioner provided no exhibits. The respondent submitted a 36-page evidence packet which was marked and entered as Respondent's Exhibits "1" through "13".

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner was receiving Medicaid coverage under the MN program with a \$1,579 SOC.
2. On March 9, 2017, the petitioner submitted an electronic web application requesting the additional benefit of Medicaid (Respondent's Exhibit 5).
3. The petitioner's household includes the petitioner (61 years old) and her husband, HH, (66 years old) (Respondent's Exhibit 6).
4. In June 2016, the petitioner was determined disabled by the Social Security Administration (SSA) and receives \$783 in Social Security Disability Income (SSDI) per month. HH receives \$1,224 in SSA income per month (Respondent's Exhibit 12).
5. The respondent determined the petitioner's total countable income to be \$2,007.
6. The petitioner does not dispute the income calculations used by the respondent.
7. HH receives Medicare Part A and Part B and pays \$126 per month for his Part B premium. The petitioner is not Medicare eligible at this time.
8. The petitioner's household income is over the income limit set for a household of two for full Medicaid (Respondent's Exhibit 13).

9. The MN Program is the Medicaid coverage for recipients that are over the income limit for full Medicaid.

10. The respondent determined the petitioner's SOC as follows (Respondent's Exhibit 8):

\$2,007		total	countable income
-	20	unearned	income disregard
\$1,987		countable	unearned income
-	241		medically needy income limit (MNIL)
\$1,746			share of cost (SOC)
-	126		medical insurance premium
\$1,620		remaining	SOC

11. On April 5, 2017, the respondent sent a Notice of Case Action (NOCA) informing the petitioner that she would continue to receive ongoing medical coverage.

12. The petitioner timely requested the hearing.

13. The petitioner states she cannot find a doctor that will take the MN coverage she has and she is in need of medical services.

### **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, Fla. Stat.

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

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

**Full Medicaid will be addressed first:**

17. The department determines Medicaid eligibility based on the household circumstances. When the household consists of parents and children, Medicaid eligibility is determined under Family-Related Medicaid policy. When the household consists of an elderly or disabled individual or couple, Medicaid eligibility is determined under Adult-Related Medicaid policy (also referred to as SSI-Related Medicaid or Medically Needy). Medicaid eligibility is based on federal regulations. The petitioner was evaluated under the SSI-Related Medicaid coverage group.

18. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI – Related Medicaid programs and states in the pertinent 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...

(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...

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied...

When averaging income, all income from the most recent consecutive four weeks shall be used if it is representative of future earnings. A longer period of past time may be used if necessary to provide a more accurate indication of anticipated fluctuations in future income.

19. Effective July 2016, The Department's Policy Manual (The Policy Manual), CFOP 165-22, Appendix A-9, sets forth 88% of the federal poverty level (FPL) for a household size of two as \$1,175.

20. Effective April 2017, the Policy Manual at Appendix A-9, sets forth 88% of the FPL for a household size of two as \$1,191.

21. In accordance with the above authority and the Policy Manual, the respondent must include the petitioner's SSDI and her husband's SSA income to determine the total household income, the petitioner's income cannot exceed 88% of the FPL, and she cannot be receiving Medicare unless she is receiving institutional services, hospice services, or home and community based services.

22. The petitioner's total countable income \$2,007 (\$1,224 + \$783) exceeds the \$1,175 FPL for a household of two effective July 2016. Therefore, the petitioner is not eligible for full Medicaid.

23. The undersigned concludes Medically Needy must be explored.

**Enrollment in Medically Needy and Share of Cost amount will now be addressed:**

24. 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."

25. The above authority explains MN provides coverage for individuals who do not qualify for full Medicaid due to income.

26. Fla. Admin. Code R. 65A-1.701 (30) states, "Share of Cost (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."

27. The Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income

Eligibility Criteria, states in part:

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

(4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs...

If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses...

Examples of recognized medical expenses include:

1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles...

28. The Federal Regulations at 20 C.F.R. § 416.1124 explains unearned income not counted and states, "(c) Other unearned income we do not count...(12) The first \$20.00 of any unearned income in a month..."

29. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at \$241 for a family size of two.

30. In accordance with the above cited authorities, the respondent deducted \$20 unearned income deduction and \$241 MNIL from the petitioner's \$2,007 total countable income to arrive at \$1,746 SOC. The respondent then deducted the Medicare Part B premium of \$122 to arrive at a \$1,620 SOC.

31. 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 than the SOC assigned by the respondent.

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

DONE and ORDERED this 06 day of July, 2017,

in Tallahassee, Florida.

*Pamela B. Vance*

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Pamela B. Vance  
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

Jul 10, 2017

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 17F-02997

PETITIONER,

Vs.

CASE FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 06 Pinellas  
UNIT: 88329RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 18, 2017 at approximately 3:34 p.m. CDT.

**APPEARANCES**For the Petitioner: , *pro se*

For the Respondent: Jonathan Daniels, economic self-sufficiency specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of termination at recertification of his Medicaid eligibility effective April 30, 2017. On record, the burden of proof was assigned to the petitioner. Upon further consideration, the burden of proof is assigned to the respondent by a 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 "13". The record was left open for the respondent to supply further documentation. This was received May 22, 2017 and was admitted into evidence and marked at Respondent's Exhibits "14" through "17". The record remained open to give the petitioner an opportunity to respond. No response was received. The record was closed June 1, 2017.

The petitioner was represented by [REDACTED].

### **FINDINGS OF FACT**

1. On March 21, 2017, the petitioner submitted an application for Medicaid coverage. The household consists of the petitioner only, a single male under the age of 65 with no employment, income or assets (Respondent's Exhibit 3).
2. On March 31, 2017, by notice of case action (NOCA), the respondent requested information required in order to submit a request for a disability determination from the Division of Disability Determination (DDD). Per the respondent, this information was requested because disability needed to be determined at this time because the Medicaid eligibility for the petitioner should have ended in September 2016, when the Social Security Administration (SSA) denied the petitioner's application with SSA for disability benefits (Respondent's Exhibits 4 and 5).
3. The petitioner testified that the SSA denied his Social Security Disability Insurance (SSDI) application in September 2016 because he did not have enough quarters.

4. The petitioner sought information numerous times from the customer call center about the status of his March 2017 application and was informed that the DDD time standard is 90 days (Respondent's Exhibit 13).

5. On April 17, 2017, the March 21, 2017 application with the respondent was denied, as a response had not been received from DDD.

6. The petitioner lives in a facility for the care of individuals with [REDACTED] and chronic homelessness. He is currently seeing a psychiatrist, a cardiologist and his primary physician is a pain management specialist.

7. On May 8, 2017, the petitioner requested his adult Medicaid be restored while the waiting for the decision from DDD.

8. The petitioner has received Title XIX Medicaid for the periods of January 1, 2011 through January 31, 2011 and March 1, 2011 through April 30, 2017 (Respondent's Exhibits 14 and 16).

9. The petitioner never received a NOCA concerning the closing of his Medicaid coverage. He was informed of its termination when one of his doctor's cancelled an appointment because the coverage had ended. The respondent agrees that there is no NOCA informing the petitioner of termination of Medicaid coverage.

10. The petitioner testified that he has received Medicaid since 2011 and at no time has he been determined to be a disabled person or received disability benefits.

#### **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.

12. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
13. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.
14. Medicaid eligibility is based on Federal Regulations. There are two categories of Medicaid that the respondent determines eligibility for: (1) Family-Related Medicaid for parents and children, and pregnant women, and (2) Adult-Related (referred to SSI-Related Medicaid) for disabled adults and adults 65 or older.
15. 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.
16. The Code of Federal Regulations at 42 C.F.R. § 435.000 sets forth the definition and determination of disability and states in relevant part: “Definition of disability (a) Definition. The agency must use the same definition of disability as used under SSI...”
17. Federal Regulations at 42 C.F.R. § 435.541 “Determination of Disability,” states:
  - (a) Determinations made by SSA. The following rules and those under paragraph
  - (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 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.

18. The above cited authorities explain when the respondent should and should not make an independent determination of disability. In this instant case, the SSA did not determine the petitioner's eligibility based upon his medical conditions. The Findings show that the denial of disability coverage was based on work history.

19. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, 1440.1204 Blindness/Disability Determinations (MSSI, SFP) states in part:

"If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien Programs."

20. The above cited manual passage explains that when there is no disability decision from SSA, then the DDD should make a determination. In this instant case, SSA's denial of disability was not based on medical evidence. It was based on the petitioner's lack of work history; therefore, the undersigned concludes the respondent should have conducted an independent disability determination.

21. Federal Regulations at 42 C.F.R. § 435.912(c), "Timely Determination of Eligibility," states in pertinent part: "(3) Except as provided in paragraph (e) of this

section, the determination of eligibility for any applicant may not exceed-(i) Ninety days for applicants who apply for Medicaid on the basis of disability...”

22. The Policy Manual at 0640.0400 Application Time Standards (MSSI, SFP) states in pertinent part:

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

23. The above cited authorities allow 90-calendar days for processing disability determinations. The undersigned concludes that the respondent erred in denying the application after 30 days.

24. Federal Regulations at 42 C.F.R. § 435.917, Notice of agency's decision concerning eligibility, benefits, or services, states in pertinent part:

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

25. The above cited authority explains that the respondent must give notice of case action to applicants and recipients. The undersigned concludes that the respondent erred by not providing notice of the closure of the petitioner's Medicaid effective April 30, 2017. The Department is ordered to reinstate the petitioner's Medicaid benefits, (pending a decision from DDD), as those benefits were terminated without proper notice.

26. The case is remanded to the respondent to update the disability packet and forward the packet to DDD for an independent determination of disability. Once DDD has made a decision, the respondent shall send the petitioner notice indicating the outcome, and said notice shall include appeal rights.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the respondent to take the corrective action as stated in the above Conclusions of Law. The petitioner's Medicaid is to be reinstated pending the DDD 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 Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)

17F-02997

PAGE -8

DONE and ORDERED this 10 day of July, 2017,

in Tallahassee, Florida.



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Gregory Watson  
Hearing Officer  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Jul 05, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-03058

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 May 31, 2017, at 10:15 a.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED].

For the Respondent: Gail Stewart, DCF supervisor.

**STATEMENT OF ISSUE**

At issue is the respondent's action to terminate full Medicaid for petitioner and her enrollment in Medically Needy (MN) with a Share of Cost (SOC) at recertification. The burden of proof was initially assigned to the petitioner. Upon further review, it has been re-assigned to the respondent by a preponderance of evidence.

### **PRELIMINARY STATEMENT**

The petitioner did not submit any exhibits for consideration. The respondent submitted 12 exhibits, which were accepted into evidence and marked as Respondent's Exhibits 1 through 12.

### **FINDINGS OF FACT**

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

1. Prior to the action under appeal the petitioner's household has been receiving Family-Related Medicaid benefits under the transitional coverage group (MEI). Transitional Medicaid is an additional 12-months of Medicaid coverage received after recipients are no longer eligible for full AFDC-Related Medicaid due to income. The household has been receiving MEI since June 1, 2016 until it was terminated on March 31, 2017.
2. On March 2, 2017 petitioner submitted an application to continue Food Assistance Program (FAP) and Medicaid benefits for her family. Her household comprises of herself and two children ages 14 & 15, see Respondent's Exhibit 1. She was interviewed on March 3, 2017.
3. Petitioner is gainfully employed. She is a tax filer with the children as her tax dependents. She gets paid weekly and provided the following paystubs; \$164.69 (3/3/17); \$288.97 (2/24/17); \$481.83 (2/17/17) and \$477.57 (2/10/17), see Respondent's Exhibits 9 & 10. Based on the income information, petitioner was approved for the Medically Needy benefits for herself. The children were approved for full Medicaid.

4. On March 21, 2017, the respondent sent the petitioner a Notice of Case Action informing her that her Medicaid benefits would end March 31, 2017 for not returning her periodic report form, see Respondent's Exhibit 6.

5. On March 28, 2017, the respondent sent the petitioner a Notice of Case Action informing her she was approved for the Medically Needy Medicaid with a \$927 SOC effective April 2017, see Respondent's Exhibit 7.

6. Petitioner is seeking full Medicaid benefits for herself and is challenging her enrollment in the Medically Needy Program. In determining eligibility for Medicaid for the petitioner, the respondent's used petitioner's four paystubs to get a weekly average. This amount was multiplied by 4 to arrive \$1,413.08 modified adjusted gross income (MAGI). Respondent counted three members in the petitioner's standard filing unit (SFU). 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.

7. As petitioner was determined ineligible for full Medicaid, respondent enrolled her in the Medically Needy Program. To determine the estimated SOC for the petitioner, the Medically Needy Income Level (MNIL) of \$486 for a standard filing unit size of three was subtracted from the MAGI (\$1,413.08), resulting in an estimated SOC of \$927, see Respondent's Exhibit 10. On April 14, 2017, the petitioner requested an appeal challenging the Department's action of denying her full Medicaid benefits and her enrollment in the Medically Needy Program with an estimate SOC of \$927.

8. Respondent explained that the transitional Medicaid has stopped because the household's income is above the income limit to continue receiving MEI. She explained that the petitioner was evaluated under the Family-Related Medicaid coverage group and since her household income exceeded the income limit, she was not eligible for full Medicaid. Additionally, she explained that petitioner's SOC amount is directly dependent on the household MAGI.

9. During the hearing, the petitioner explained that her income is not enough to cover her household expenses and she cannot afford any out-of-pocket medical expenses. That she did not have any income for the second half of March 2017 and the first half on April 2017 due to medical reasons. She has medical issues that require medical attention and had to postpone medical appointments because she does not have any Medicaid coverage. Petitioner contends that she cannot afford to spend \$927 on a monthly basis to get the Medical insurance she needs. The petitioner believes the SOC is wrong. Respondent explained how the Medically Needy Program works and advised the petitioner to submit medical bills every month for tracking to get her Medicaid activated.

#### **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.

**Termination of the Transitional Medicaid will be addressed first:**

12. The department determines Medicaid eligibility based on the household circumstances. When the household consists of parents and children, Medicaid eligibility is determined under Family-Related Medicaid policy.
13. Federal regulation 42 C.F.R. § 435.110 Parents and other caretaker relatives stated in pertinent part:
  - ...(b) Scope. The agency must provide Medicaid to parents and other caretaker relatives, as defined in §435.4, and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in the State plan, in accordance with paragraph (c) of this section.
14. Fla. Admin. Code R. 65-1.702 Special Provisions states in the pertinent part:
  - (4) Ex Parte Process.
    - (a) When a recipient's eligibility for Medicaid ends under one or more coverage groups, the department must determine their eligibility for medical assistance under any other Medicaid coverage group(s) before terminating Medicaid coverage...
    - (b) All individuals who lose Medicaid eligibility under one or more coverage groups will continue to receive Medicaid until the ex parte redetermination process is completed.
15. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at 2030.0203 Transitional Coverage (MFAM) defines transitional coverage and states in part:

Transitional coverage provides extended coverage for up to 12 months, beginning with the month of ineligibility. Changes during this period, other than the child turning 18 or loss of state residence, do not affect the transitional Medicaid period. An ex parte determination must be completed prior to cancellation at the end of the transitional period.
16. In accordance with the above cited authority and policy, the petitioner's income caused her to be determined ineligible for full Medicaid. The respondent determined the

petitioner's eligibility under a new Medicaid coverage, prior to terminating the full Medicaid. The petitioner received transitional Medicaid due to full Medicaid being terminated solely due to income. The respondent provided the transitional coverage beginning June 1, 2016 through March 2017. The respondent is required to provide Medicaid for a maximum of 12 months to all household members once the Medicaid has been lost due to income, based on Department policy.

17. Based on the testimony provided, the respondent provided the transitional Medicaid effective June 2016. It was terminated on March 2017. The undersigned concludes the transitional Medicaid was terminated prior to month 12. The respondent has failed to meet its burden of proof to show that petitioner's MEI was correctly terminated.

18. In careful review of the testimony and evidence, the undersigned concludes the petitioner was entitled to the transitional Medicaid through May 31, 2017. The respondent erred in terminating the Medicaid effective March 31, 2017.

**Full Medicaid will now be addressed**

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

20. The above cited authority explains Family-Related Medicaid eligibility is based on income, earned or unearned, received within the household. In accordance with the

above cited authority, the petitioner's earned income must be included in the Medicaid budget calculations.

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

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

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

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

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

(1) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent...

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

23. 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.

24. 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).

25. The Policy Manual at passage 2430.0700 Income Conversion (MFAM) states:

Most income is received more often than monthly; that is; it is received weekly, biweekly, or semimonthly. Since eligibility and benefit amounts are issued based on a calendar month, income received other than monthly is to be converted to a monthly amount.

The following conversion factors based on the frequency of pay are used:

Weekly income (once a week): Multiply by 4.

Biweekly income (every two weeks): Multiply by 2.

Semimonthly income (twice a month): Multiply by 2.

26. Effective April 2017, the Family-Related Medicaid income standard appears in the Policy Manual at Appendix A-7. It indicates that the Family-Related Medicaid income limits for a household of three for adults as \$303, the Standard Disregard is \$183, and the Medically Needy Income Limit (MNIL) is \$486.

27. The above allows for the use of the conversion factor of 4 if income is received weekly (and of 2 if received biweekly) for Medicaid eligibility determination. The undersigned could not find a better outcome in determining the household income.

28. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for petitioner did not find her eligible for full Medicaid as the household's MAGI is more than the income limit of \$303 for a household of three. The undersigned concludes that petitioner is not eligible for full Medicaid under the Family-Related Medicaid Program. The undersigned recognizes the petitioner's concerns about her medical needs. However, the controlling legal authorities do not

allow for a more favorable outcome. The undersigned further concludes Medically Needy (MN) eligibility must be explored.

29. 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".

30. 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.

31. 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.

32. In accordance with the above controlling authorities, respondent determined petitioner's SFU as a household of three based on her tax filing status.

33. The petitioner's SOC was estimated to be \$927. The hearing officer reviewed the respondent's SOC calculation and could not find a more favorable outcome.

34. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's action to deny the petitioner full Medicaid under the Family-Related Medicaid coverage group and her enrollment in the Medically Needy Program with a \$927 SOC is correct.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted in part and denied in part. The department incorrectly terminated the transitional Medicaid prior to May 31, 2017. However, the department correctly denied full Medicaid ongoing and enrolled the petitioner in the Medically Needy Program as outlined in the Conclusions of Law. **The respondent is ordered to restore full Medicaid eligibility for the months of April 2017 and May 2017.**

### **NOTICE OF RIGHT TO APPEAL**

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

FINAL ORDER (Cont.)  
17F-03058  
PAGE -12

DONE and ORDERED this 05 day of July, 2017,  
in Tallahassee, Florida.



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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

**FILED**

Jul 14, 2017

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 17F-03100

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 15 PALM BEACH  
UNIT: 88242

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 7, 2017 at 11:34 a.m.

**APPEARANCES**

For the Petitioner:



For the Respondent:

Sue Jay Collins, supervisor

**STATEMENT OF ISSUE**

At issue is the denial of full Medicaid and enrollment in the Medically Needy Program with an estimated share of cost (SOC). She is seeking full Medicaid.

The respondent carries the burden of proof by a preponderance of evidence.

**PRELIMINARY STATEMENT**

The respondent presented seven exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 7.

**FINDINGS OF FACT**

1. The petitioner was receiving SSI-Related Medicaid benefits. On February 21, 2017, the respondent received a data exchange alert informing them that the petitioner was receiving Social Security (SS) benefits of \$1,981. She is the only household member. She is not receiving Medicare benefits. The respondent updated the petitioner's case and found her ineligible for SSI-Related Medicaid benefits as her income was more than the income limit to qualify for the program. The maximum income limit to be eligible for SSI-Related Medicaid benefits is \$885. The respondent proceeded to enroll her in the Medically Needy program with an estimated SOC (Respondent's Exhibits 1 and 6).
2. The petitioner's SOC was determined as follows. The respondent subtracted a \$20 unearned income disregard from her monthly gross income of \$1,981. The Medically Needy Income Limit (MNIL) of \$180 for a household size of one was subtracted resulting in \$1,781 as the petitioner's SOC (Respondent's Exhibit 5).
3. On February 22, 2017, the respondent mailed the petitioner a Notice of Case Action informing her that her Medicaid benefits will end on March 31, 2017 and she was enrolled in the Medically Needy program with an estimated SOC of \$1,781 for April 2017 ongoing (Respondent's Exhibit 3).
4. On April 17, 2017, the petitioner requested a hearing to challenge the respondent's action.
5. The petitioner requested that her Medicaid benefits be reviewed. She is very ill and has medical expenses in excess of \$390 and cannot pay for those expenses.

6. The respondent explained that in the previous Medicaid budget there was no income counted. The petitioner is now receiving SS income and the respondent is obligated to count her SS income in the Medicaid budget. No medical documentation was provided as evidence of the petitioner's medical expenses.

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

10. 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.

11. 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.

12. The Department's Program Policy Manual CFOP 165-22 (Policy Manual) at Appendix A-9, lists the MEDS-AD income limit as \$885 for an individual effective April 2017. The undersigned concludes the respondent's action to deny full Medicaid

benefits is a correct action, as the petitioner's income exceeds the income limit for those benefits. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

**The Medically Needy share of cost will now be addressed:**

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

14. Fla. Admin. Code R. 65A-1.710 (5), SSI-Related Medicaid coverage Groups states. "Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources."

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

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

17. 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..."

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

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

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

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

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

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

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

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

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

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

The undersigned concludes the respondent correctly determined the SOC (\$1,981-\$20-\$180= \$1,781). The petitioner is not eligible for a lower SOC.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal for full Medicaid benefit is denied and enrollment in the Medically Needy Program with a \$1,781 SOC is correct. The respondent's action is upheld.

### **NOTICE OF RIGHT TO APPEAL**

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

FINAL ORDER (Cont.)  
17F-03100  
PAGE -7

DONE and ORDERED this 14 day of July, 2017,  
in Tallahassee, Florida.

*Christiana Gopaul Narine*

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Christiana Gopaul-Narine  
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

Jul 20, 2017

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGSAPPEAL NO. 17F-03154  
17F-05199

PETITIONER,

Vs.

CASE FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 02 Leon  
UNIT: 88632RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 16, 2017 at 3:03 p.m.

**APPEARANCES**For the Petitioner: 

For the Respondent: Cecilia Salter-Cassaberry, ACCESS Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of April 14, 2017 approving her for \$32 in Food Assistance Program (FAP) benefits. She believes she is entitled to receive more benefits. Petitioner also appeals the Department's determination of March 31, 2017 for her Medically Needy Share of Cost to be \$834. She believes her Share of Cost should be lower. The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The hearing was reconvened on June 15, 2017 at 2:58 p.m. at the petitioner's request. The same parties were present at the reconvened hearing.

The Department submitted evidence on May 8, 2017 which was entered as Respondent's Exhibit 1. The Department submitted supplemental evidence on May 22, 2017 which was entered as Respondent's Exhibit 2.

The record was held open for additional information, including the petitioner's submitted medical bills, through June 20, 2017. No additional information was received from either party.

The record closed on June 20, 2017.

### **FINDINGS OF FACT**

1. The petitioner filed an application for Food Assistance and SSI-Related Medicaid on February 6, 2017. The petitioner is a Medicare recipient. The petitioner reported her income is \$1,034 in Social Security disability income. The petitioner reported her prescription expense of \$60 per month on her application. The petitioner reported an unpaid high hospital bill of \$5,000 on her application. The petitioner reported her rental obligation of \$400 per month.

2. The petitioner advised during hearing that she resides with her 42-year-old daughter. They split the rent and her portion of the obligation is \$400. They have heating and cooling by air conditioner and split the electric bill expense.

3. The Department issued a Notice of Case Action on March 31, 2017 denying the petitioner's application for Food Assistance beginning February 2017 as she received benefits in another state. The Notice also informed the petitioner she was

enrolled in Medically Needy effective February 2017 with a share of cost of \$834. This Notice also shows the petitioner was approved for Special Low-Income Medicare Beneficiary effective February 2017.

4. The petitioner stated when she received benefits in Georgia, her Food Assistance was \$184 and her share of cost was \$649. She does not understand what the difference is between the two states in determining her eligibility.

5. The petitioner received Food Assistance in Georgia for the months of February 2017 through March 2017.

6. The Department issued a Notice of Case Action dated April 14, 2017 showing the petitioner was approved for \$32 in Food Assistance beginning May 2017.

7. The Department issued the petitioner a total of \$32 in Food Assistance benefits for the month of April 2017. Part of those benefits were issued by supplemental issuance.

8. The Department explained the petitioner's May benefits did not post properly, and as a result the total \$32 in Food Assistance for May 2017 was issued by supplemental issuance at the end of April 2017.

9. The Department explained the calculation of Food Assistance benefits as follows: The petitioner's Social Security Income of \$1,034 was included as unearned income. The Department allowed a standard deduction of \$157 for one person. The Department used the verified prescription expense of \$60 per month and subtracted a \$35 deduction to reach an excess medical expense of \$25. The total income of \$1,034 less the standard deduction of \$157 and the excess medical expense of \$25 left \$852 as the adjusted income ( $\$1,034 - \$157 - \$25 = \$852$ ). The Department multiplied the

adjusted income of \$852 by 50 percent to reach a shelter standard of \$426 ( $\$852 \times 50\% = \$426$ ). The Department allowed the petitioner the Standard Utility Allowance (SUA) of \$338 as she incurs the ability to heat and cool her home. The Department added the petitioner's rental obligation of \$400 and the SUA of \$338 to reach a total shelter expense of \$738 ( $\$400 + \$338 = \$738$ ). The total shelter expense of \$738 less the shelter standard of \$426 leaves an excess shelter deduction of \$312 ( $\$738 - \$426 = \$312$ ). The adjusted income of \$852 less the excess shelter deduction of \$312 leaves an adjusted net income of \$540 ( $\$852 - \$312 = \$540$ ). The Department multiplied the adjusted net income of \$540 by 30 percent to reach a benefit reduction amount of \$162 ( $\$540 \times 30\% = \$162$ ). The Department used the maximum Food Assistance allotment of \$194 for a household of one. The maximum Food Assistance allotment of \$194 less \$162 benefit reduction leaves a benefit amount of \$32 ( $\$194 - \$162 = \$32$ ).

10. The Department explained they were able to include the petitioner's prescription expense in the Food Assistance eligibility determination as they had a past history of payment on prescriptions that could be used to anticipate the continuing expense.

11. The Department explained they were unable to use her unpaid high hospital bill in the Food Assistance benefit as the petitioner did not verify the amount of the bill she was paying each month.

12. The Department recorded in the case notes on April 7, 2017 the review of the petitioner's medical bill submitted. This was only a collection letter. The Department documented that collection letters cannot be used in Food Assistance eligibility determination OR tracking to meet a share of cost.

13. The petitioner stated she only had to turn in her medical bill to Georgia and she got \$184 in Food Assistance. She did not understand why the Department is asking her to prove what she is actually paying on the bill she is incurring each month with her dialysis. She believes this practice is incorrect. The petitioner explained she never knew that she had to be making payments on the medical bills in Georgia.

14. The Department explained the petitioner must show the amount she is actually paying in medical expense in order for the expense to be included in her Food Assistance benefit.

15. The Department explained the petitioner's Medically Needy Share of Cost uses the full Social Security amount of \$1,034 as her Medicare premium is paid by the state. The Department subtracted a \$20 unearned income deduction and a \$180 Medically Needy Income Level deduction to reach the Medically Needy Share of Cost of \$834 ( $\$1,034 - \$20 - \$180 = \$834$ ).

16. The Department explained it does track the current unpaid medical bills as submitted so that the share of cost can be met as early in the month as possible.

17. The petitioner explained she has to pay on her doctor bills, dialysis expenses and transportation to the doctor or dialysis. She quoted the cost of going to dialysis as \$5 per day three days per week. She quoted the cost of going to her doctor as \$5 twice a month on a normal month.

18. The petitioner stated she does submit her medical bills as she receives them, with the exception of her transportation costs, to the Department for bill tracking.

19. The Department included three pages of Medical Bill Tracking, one of which shows a bill from [REDACTED] dated February 2, 2017 in the amount

of \$627.18 and a share of cost of \$834. The Department did not include any of the petitioner's submitted medical bills in either exhibit for the hearing officer's review.

### **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.

### **FOOD ASSISTANCE**

22. 7 C.F.R. § 273.2, Office Operations and application processing, states in relevant part:

(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.

(1) Mandatory verification. State agencies shall verify the following information prior to certification for households initially applying:

...

(iv) Medical expenses. The amount of any medical expenses (including the amount of reimbursements) deductible under §273.9(d)(3) shall be verified prior to initial certification. Verification of other factors, such as the allowability of services provided or the eligibility of the person incurring the cost, shall be required if questionable.

23. The above controlling authority requires the petitioner to verify the medical expenses, including the amount of reimbursements, to be included as deductible in the Food Assistance benefit determination.

24. 7 C.F.R. § 273.3, Residency, states in relevant part:

(a) A household shall live in the State in which it files an application for participation. The State agency may also require a household to file an application for participation in a specified project area (as defined in §271.2 of this chapter) or office within the State. No individual may participate as a member of more than one household or in more than one project area,

25. The findings show the petitioner continued to receive Food Assistance benefits in the state of Georgia for February 2017 and March 2017. The undersigned concludes the Department correctly determined the petitioner was not eligible for Food Assistance in Florida for these months as she received in another state.

26. 7 C.F.R. § 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; 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;

27. The findings show the Department included the petitioner's Social Security benefits as unearned income. The undersigned concludes the Department correctly determined the petitioner's income must be considered as unearned income.

28. 7 C.F.R. § 273.9, Income and deductions, states in relevant part:

(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.

...

- (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;
- ...
- (ix) Reasonable cost of transportation and lodging to obtain medical treatment or services;
- ...
- (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);

...  
(F) If a household lives with and shares heating or cooling expenses with another individual, another household, or both, the State agency shall not prorate the standard for such households if the State agency mandates use of standard utility allowances in accordance with paragraph (d)(6)(iii)(E) of this section. The State agency may not prorate the SUA if all the individuals who share utility expenses but are not in the SNAP household are excluded from the household only because they are ineligible.

29. 7 C.F.R. § 273.10, Determining household eligibility and benefit levels,

states in relevant part:

(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.

...  
(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.

...  
(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 to the nearest higher dollar;

30. The Department's Program Policy Manual, CFOP 165-22, section 2410.0357, Normally Recurring Medical Expenses (FS) states:

Normally recurring medical expenses shall be calculated based on medical expenses for which the assistance group (AG) expects to be billed or otherwise have due during the certification period less any expected reimbursements. **Anticipation of medical expenses shall be based on the most current bill if it is the best indication of the anticipated expense.** A history of past medical expenses can be used to anticipate continuing expenses.

(emphasis added)

31. The Department's Policy Manual, section 2410.0362, Verification of Medical Expenses (FS) states in relevant part:

**The amount of any medical expense shall be verified prior to certification provided the expense would actually result in a disregard.** If a portion of the expense is reimbursable, the amount to be reimbursed must be verified before the non-reimbursable portion can be allowed.

...

If medical expense or anticipated medical expense is reported at certification or recertification but verification is not provided at that time, the medical deduction will not be budgeted. However, when the verification is provided during the certification period, the household will then be allowed the medical deduction. The household will not be provided retroactive medical expenses deduction from the time of certification.

**Verification of other factors such as the allowable services provided or the eligibility of the individual incurring the cost shall be required if questionable.**  
(emphasis added)

32. The above controlling authorities show the requirement for the verification of recurring medical expenses. The findings show the petitioner has submitted bills to the Department for bill tracking since her application for Food Assistance. The findings show the Department did not include her current or recurring medical expenses, such as her dialysis bill prior to meeting her share of cost, in the calculation of excess medical expense deduction. The authorities listed do not show a requirement for the petitioner to verify the amount payment on a current or recurring bill. The undersigned concludes the Department failed to accurately include the petitioner's recurring medical expenses.

33. The Department's Policy Manual, Appendix A-1, Food Assistance Income Eligibility Standards and Deductions, lists the following standards effective October 1, 2016: The Standard Deduction for a one to three-person household is \$157. The Standard Utility Allowance is \$338. The appendix also lists the maximum allotment for a one-person household as \$194.

34. The undersigned began the review of the Department's calculations for Food Assistance eligibility beginning April 2017. The undersigned concludes the Department correctly included the petitioner's Social Security Income of \$1,034 as unearned income. The undersigned concludes the Department correctly included the standard deduction of \$157 for one person.

35. The findings show the petitioner has the ability to heat and cool her home. The above controlling authority requires the full allowance to be given to a Food Assistance group even if they split the utility expense. The undersigned concludes the Department allowed the petitioner the Standard Utility Allowance (SUA) of \$338 as she incurs the ability to heat and cool her home. The undersigned further concludes the Department correctly included the petitioner's rental obligation of \$400 to reach a total shelter expense of \$738 ( $\$400 + \$338 = \$738$ ).

36. The undersigned concludes the Department correctly used the maximum Food Assistance allotment of \$194 for a household of one.

37. The undersigned cannot complete the full review of the Food Assistance benefit calculation due to the incorrect calculation of excess medical expense. The undersigned therefore remands the Food Assistance appeal to the Department to correctly calculate the petitioner's Food Assistance allotment beginning April 1, 2017 with the verified medical expenses. The undersigned further concludes requirement of verifying the actual amount being paid on a medical expense is only necessary on expenses prior to the petitioner's application for Food Assistance in Florida.

#### SSI-RELATED MEDICAID/MEDICALLY NEEDY

38. 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.

39. The findings show the petitioner has Medicare. The above controlling authority explains full SSI-Related Medicaid or MEDS-AD is a Medicaid coverage group for those aged and disabled individuals who are not receiving Medicare. The undersigned concludes as the petitioner is a Medicare beneficiary, she does not qualify for MEDS-AD. The undersigned further concludes the Department correctly determined the petitioner's eligibility must be established under Medically Needy.

40. Florida Admin. Code R. 65A-1.702, Special Provisions, states in relevant part:

(12) Limits of Coverage.

...

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

...

(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."

41. 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:

...

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

42. 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.

43. 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.

44. The findings show the petitioner has \$1,034 in Social Security benefits.

The above controlling authority requires \$20 of this income to be disregarded. The undersigned concludes only \$1,014 of the petitioner's Social Security is countable in her eligibility determination for SSI-Related Medically Needy.

45. 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.

46. The undersigned concludes the petitioner's countable income of \$1,014 less the Medically Needy Income Level of \$180 leaves a share of cost of \$834 ( $\$1,014 - \$180 = \$834$ ). The undersigned concludes the Department correctly determined the petitioner's share of cost. The findings show the petitioner is approved for the Special Low Income Medicare Beneficiaries (SLMB) program. The above controlling authority shows that the SLMB program pays for the Medicare Part B premium. The undersigned

concludes as the petitioner's Medicare Part B premium is being paid by the state, the expense is not allowable in the calculation of her share of cost.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the Food Assistance appeal 17F-03154 is granted and remanded to the Department for correction of the Food Assistance benefit as noted above. Based upon the foregoing Findings of Fact and Conclusions of Law, the SSI-Related Medicaid appeal 17F-05199 is denied and the Department's action is affirmed.

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

FINAL ORDER (Cont.)  
17F-03154 and 17F-05199  
PAGE - 16

DONE and ORDERED this 20 day of July, 2017,  
in Tallahassee, Florida.

*Melissa Roedel*

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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

**FILED**

Jul 27, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-03160  
APPEAL NO. 17F-03161  
APPEAL NO. 17F-03162

PETITIONER,

Vs.

[REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 13 Hillsborough  
UNIT: 88283

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

The undersigned convened an administrative hearing in the above-referenced matter on June 2, 2017 at 1:06 p.m. in Tampa, Florida.

**APPEARANCES**

For Petitioner: [REDACTED]

For Respondent: Jonathan Daniels, Economic Self Sufficiency Specialist II

**STATEMENT OF ISSUE**

At issues are whether the respondent's actions to approve the petitioner's Food Assistance (FA) benefits in the amount of \$166 per month for the months of January 2017 through April 2017; to deny the petitioner full SSI-Related Medicaid benefits and instead enroll her in the Medically Needy (MN) Program effective January 2017 and ongoing; and to deny the petitioner Qualified Medicare Beneficiaries (QMB) and instead

approve the Special Low-Income Medicare Beneficiary Part B (SLMB) Medicaid effective January 2017 and ongoing are correct.

Initially, the petitioner carried the burden of proof by a preponderance of the evidence for the FA and MN Medicaid issues and the respondent carried the burden of proof by a preponderance of the evidence for the QMB issue. However, during the hearing and after reviewing the evidence, the undersigned shifted the burden of proof by a preponderance of the evidence to the respondent for all issues.

### **PRELIMINARY STATEMENT**

The petitioner was present and testified. The petitioner presented one witness who testified: [REDACTED], the petitioner's authorized representative. The petitioner submitted eight exhibits, which were accepted into evidence and marked as Petitioner's Exhibits "1" – "8". The respondent was represented by Jonathan Daniels, Economic Self Sufficiency Specialist II, with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). The respondent submitted six exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" – "6".

Lorry Beauvais, Economic Self Sufficiency Specialist II, with DCF, observed the proceedings.

The record was left open until June 19, 2017 to allow the respondent to submit additional information and to allow the petitioner to respond to the new additional information. The respondent did not submit any additional information to either the undersigned or the petitioner. On June 21, 2017 and after the record closed, the petitioner submitted additional information which was accepted into evidence and marked as Petitioner's Exhibit "9". The record closed on June 21, 2017.

**FINDINGS OF FACT**

1. The petitioner was receiving \$166 per month in FA benefits since January 2017 and her FA certification period was effective until July 2017. (Respondent's testimony)
2. On January 31, 2017, the petitioner tried to upload a paper application and various documents to the respondent's computer system, but could not upload her application and documents as she received an error message explaining her documents were too large. The petitioner believed her date of application should be January 31, 2017 because that is the date she tried to upload her application and documents to the respondent's computer system. (Petitioner's testimony)
3. On February 3, 2017, the petitioner mailed her paper application to the respondent. (Petitioner's testimony)
4. Sometime between February 3, 2017 and February 12, 2017, the respondent received the petitioner's application for FA benefits, SSI-Related Medicaid benefits, and the Medicare Savings Program (MSP). The respondent considered the application a duplicate application, so on February 12, 2017, the respondent disposed of the paper application and did not redetermine the petitioner's eligibility for any benefits. (Respondent's testimony)
5. The respondent explained the petitioner's date of application for the paper application was sometime in February 2017 as that is the month the respondent received the petitioner's application for benefits. (Respondent's testimony) The respondent did not submit the February 2017 application into evidence.
6. On March 6, 2017, the respondent received a paper application for FA, SSI-Related Medicaid benefits, and MSP benefits. (Respondent's Exhibit 6) The petitioner

resubmitted the February 2017 paper application in March 2017 because she had not received a response from the respondent. (Petitioner's testimony)

7. The respondent explained the petitioner's two paper applications should have been considered as reported changes and not an application for benefits.

(Respondent's testimony) The petitioner explained she submitted the two paper applications because she was reporting changes to her expenses. (Petitioner's testimony)

8. The petitioner's Social Security Disability Insurance (SSDI) amount is \$1,048 (gross) per month and she has Medicare Part A and B. (Petitioner's testimony)

9. The petitioner lived alone; received Social Security benefits; was eligible for the Standard Utility Allowance (SUA); paid \$370 per month in rent; and paid \$436 per month in medical expenses. (Respondent's Exhibit 6)

10. On March 8, 2017, the respondent requested the petitioner submit the following documentation, on or before March 20, 2017, "Proof of out-of-pocket medical expenses if you are receiving disability benefits or are over the age of 60. Other – please see comments below. PLEASE CALL 239-895-0475 OR 866-762-2237 TO VERIFY YOUR IDENTITY AND PROOF OF MEDICAL EXPENSES."

11. On April 5, 2017, the respondent calculated the petitioner's FA benefits as \$175 per month effective May 2017 through July 31, 2017. (Respondent's Exhibit 6)

12. On April 16, 2017, the petitioner requested a hearing as she did not agree with the respondent's calculation of her FA benefit amount. (Petitioner's Exhibit 8)

13. On May 4, 2017, the respondent recalculated the petitioner's medical expenses as \$463.15 per month and redetermined her FA benefit amount to be \$194 per month

effective April 2017 and ongoing. The respondent approved the petitioner \$28 in additional FA benefits for April 2017. (Respondent's Exhibit 6) The respondent did not submit into evidence how the petitioner's medical expenses were calculated as \$463.15.

14. On May 5, 2017, the respondent mailed the petitioner a Notice of Case Action indicating her FA benefits would increase to \$194 per month effective June 2017 and ongoing "due to a change in your household's circumstances". (Respondent's Exhibit 3)

15. On June 7, 2017, the petitioner received \$28 per month in additional FA benefits for the months of January 2017 through March 2017. (Petitioner's Exhibit 9)

16. The petitioner's SSI-Related Medicaid benefits certification period was from April 2016 through April 2017. (Respondent's testimony) The petitioner's monthly Share of Cost (SOC) from January 2017 through March 2017 was \$548. (Petitioner's Exhibit 1)

17. On April 6, 2017, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner's March 7, 2017 MN Medicaid application was denied effective January 2017 and ongoing as the petitioner failed to submit proof of her identity. (Respondent's Exhibit 3)

18. On May 4, 2017, the respondent determined the petitioner should not have been pended for identity for the MN SOC Program as the petitioner's identity can be verified through "[REDACTED]". On the same day, the respondent reopened the petitioner's MN Medicaid benefits. (Respondent's Exhibit 6)

19. The respondent determined the petitioner's MN SOC amount as \$848 effective March 2017 and ongoing as follows: (Respondent's testimony)

\$1048.00	petitioner's	SSDI income
<u>-\$ 20.00</u>	<u>unearned income</u>	<u>disregard</u>
\$1028.00	total countable	unearned income

\$1028.00	total countable	income
<u>-\$ 180.00</u>	<u>MNIL for a household of one</u>	
\$ 848.00	share of cost	

20. On May 5, 2017, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner's May 4, 2017 MN Medicaid application was approved effective March 2017 and ongoing. The notice also indicated the petitioner's monthly SOC was \$848. (Respondent's Exhibit 3)

21. The petitioner's monthly SOC amount increased from \$548 to \$848 as the petitioner's monthly medical expenses were not counted in the petitioner's monthly MN budgets. (Respondent's testimony)

22. The petitioner does not agree with the respondent's determination that she is not eligible for full SSI-Related Medicaid benefits as the respondent did not utilize the five percent Modified Adjusted Gross Income (MAGI) disregard in the determination of her eligibility for full SSI-Related Medicaid benefits. The petitioner explained the respondent should have utilized the five percent MAGI disregard in the determination of her eligibility for full SSI-Related Medicaid as she met all of the criteria except for income. (Petitioner's testimony)

23. The respondent explained the five percent MAGI disregard only applies to Family-Related Medicaid determinations and cannot be utilized in the determination of eligibility for SSI-Related Medicaid benefits. (Respondent's testimony)

24. The petitioner's MSP benefits certification period was from April 2016 through April 2017. (Respondent's testimony)

25. On April 6, 2017, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner's SLMB benefits would be terminated effective April 30, 2017 as the petitioner failed to submit proof of her identity. (Respondent's Exhibit 3)

26. On May 4, 2017, the respondent determined the petitioner should not have been pended for identity for the MSP as the petitioner's identity can be verified through [REDACTED]". On the same day, the respondent reopened the petitioner's SLMB benefits. (Respondent's Exhibit 6)

27. The respondent determined the petitioner's eligibility for SLMB benefits effective May 2017 and ongoing as follows:

\$1048.00	petitioner's SSDI income
<u>-\$ 20.00</u>	<u>unearned income disregard</u>
\$1028.00	total countable unearned income

The SLMB income standard for a household of one is \$1,206. (Respondent's Exhibit 4)

28. On May 5, 2017, the respondent mailed the petitioner a Notice of Case Action indicating the petitioner's May 4, 2017 SLMB application was approved effective May 2017 and ongoing. (Respondent's Exhibit 3)

29. The petitioner does not agree with the respondent's determination that she is not eligible for QMB benefits as the respondent did not utilize the five percent MAGI disregard in the determination of her eligibility for QMB benefits. The petitioner explained the respondent should have utilized the five percent MAGI disregard in the determination of her eligibility for QMB benefits as she met all of the criteria except for income. (Petitioner's testimony)

**CONCLUSIONS OF LAW**

30. 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.

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

**As to whether the respondent correctly determined the petitioner's FA benefits as \$166 effective January 2017 through March 2017**

32. The petitioner's FA appeal is no longer an issue as the respondent approved the petitioner \$194 per month in FA benefits, the maximum FA benefit allotment for a household of one, for January 2017 and ongoing. The petitioner requested the hearing as she did not agree with the respondent's calculation of her FA benefit amount. Prior to the hearing, the respondent approved the petitioner \$194 per month in FA benefits effective April 2017 and ongoing. Subsequent to the hearing, the respondent approved the petitioner \$194 in FA benefits for January 2017 through March 2017.

33. Since the respondent already approved the maximum FA benefit allotment for the petitioner effective January 2017 and ongoing, there is no better outcome the undersigned can provide to the petitioner. Therefore, the petitioner's FA appeal is dismissed as moot as the respondent has resolved the petitioner's FA issue.

**As to whether the five percent MAGI disregard is utilized in the determination of the petitioner's eligibility for SSI-Related Medicaid and MSP benefits**

34. The Code of Federal Regulations at 42 C.F.R § 435.603 addresses the type of Medicaid that utilizes the MAGI disregard and states, in part:

(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.** [emphasis added]

...

(j) Eligibility Groups for which MAGI-based methods do not apply. The financial methodologies described in this section are not applied in determining the Medicaid eligibility of individuals described in this paragraph. The agency must use the financial methods described in §435.601 and §435.602 of this subpart.

...

(3) Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled, including, but not limited to, individuals eligible under §435.121, §435.232 or §435.234 of this part or under section 1902(e)(3) of the Act, but only for the purpose of determining eligibility on such basis.

...

5) Individuals who are being evaluated for eligibility for Medicare cost sharing assistance under section 1902(a)(10)(E) of the Act, but only for purposes of determining eligibility for such assistance.

(6) Individuals who are being evaluated for coverage as medically needy under subparts D and I of this part, but only for the purpose of determining eligibility on such basis.

35. The Department's ACCESS Program TRANSMITTAL NO.: P-15-09-0009.

Medically Needy Budgeting for Family-Related Medicaid, dated September 18, 2015 explains that the MAGI methodologies are utilized in determining eligibility for Family-Related Medicaid, not SSI-Related Medicaid.

36. Pursuant to the above authority and policy, the respondent was correct in not utilizing the MAGI disregard in the determination of the petitioner's eligibility for SSI-Related Medicaid and MSP benefits.

**As to whether the respondent correctly determined the petitioner eligible for MN with a monthly SOC effective January 2017**

37. 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.

38. Pursuant to the above authority, the petitioner is eligible for the SSI-Related Medicaid Programs as she is considered disabled.

39. Fla. Admin. Code R. 65A-1.713 (2), SSI-Related Medicaid Income Eligibility Criteria, defines the types of included and excluded income and states, in part:

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:

(a) In-kind support and maintenance is not considered in determining income eligibility.

(b) Exclude total of irregular or infrequent earned income if it does not exceed \$30 per calendar quarter.

(c) Exclude total of irregular or infrequent unearned income if it does not exceed \$60 per calendar quarter.

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

(e) Interest and dividends on countable assets are excluded, except when determining patient responsibility for ICP, HCBS and other institutional

programs.

40. Pursuant the above authority, the petitioner's Social Security income is considered included income in the determination of her SSI-Related Medicaid Benefits.

41. 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.

42. Effective April 2016 through March 2017, the Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for an individual for MEDS-AD as \$872.

43. Effective April 2017 and ongoing, the Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for an individual for MEDS-AD as \$885.

44. Pursuant to the above authorities, the petitioner's monthly Social Security income exceeds the Medicaid income standard for her to receive full SSI-Related Medicaid benefits; therefore, she is correctly enrolled in the Medically Needy Program with a monthly share of cost effective January 1, 2017.

45. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met the burden of proof indicating the petitioner was correctly denied full SSI-Related Medicaid benefits. Furthermore, the petitioner was correctly enrolled in a MN SSI-Related Medicaid Program with a monthly SOC effective January 2017 and ongoing.

46. The petitioner requested full Medicaid benefits; however, she did not agree with the respondent's calculation that her monthly SOC amount is \$848. The respondent is encouraged to review policy concerning medical expenses that can be counted in the petitioner's MN SSI-Related Medicaid budget to reduce the petitioner's monthly SOC amount. Once the review is complete, the respondent is to issue the petitioner a notice that includes appeal rights.

**As to whether the respondent correctly determined the petitioner eligible for  
SLMB effective January 2017**

47. 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...

48. Pursuant to the above authorities, the petitioner's Social Security income is considered included income in the determination of her eligibility for MSP Medicaid benefits.

49. 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...

50. 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.

51. 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."

52. The Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of one for the month of April 2016 through March 2017 as follows: the Income Standard for QMB as \$990; and the Income Standard for SLMB as \$1,188.

53. The Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of one for the month of April 2017 and ongoing as follows: the Income Standard for QMB as \$1,005; and the Income Standard for SLMB as \$1,206.

54. The petitioner's Social Security income minus the first \$20 of her unearned income exceeds the income limit for the QMB Program; therefore, the respondent correctly approved the petitioner SLMB Medicaid benefits effective January 2017 and ongoing.

55. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met the burden of proof indicating the petitioner's QMB was correctly denied and her SLMB Medicaid benefits were correctly approved effective January 2017 and ongoing.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's Food Assistance appeal is DISMISSED as moot as the respondent has resolved the petitioner's FA issue. The petitioner's SSI-Related Medicaid benefits and Medicare Savings Program appeals are DENIED.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 27 day of July, 2017,

in Tallahassee, Florida.

*Mary Jane Stafford*

---

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

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

**FILED**

Jul 03, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-03393

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 19<sup>th</sup>, 2017, at 11:36 a.m.

**APPEARANCES**

For the Petitioner: The petitioner was not present but was represented by [REDACTED], friend of the petitioner.

For the Respondent: Teshia Green, Economic Self-Sufficiency Specialist II for the Department of Children and Families

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to deny her SSI-Related Medicaid application. The petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

Petitioner's exhibit 1 was admitted into evidence.

Respondent's exhibits 1 through 8 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated April 18<sup>th</sup>, 2017, the respondent informed the petitioner that her application for Medicaid dated April 6<sup>th</sup>, 2017, was denied because she did not meet the disability requirement. On April 26<sup>th</sup>, 2017, the petitioner filed a timely request to challenge the respondent's action.

### **FINDINGS OF FACT**

1. The petitioner submitted an online application to add SSI-Related Medicaid and Temporary Cash Assistance (TCA) to her open Food Assistance (FA) benefits on April 6<sup>th</sup>, 2017. (See Respondent's Exhibit 2). FA and TCA are not issues for this appeal.
2. The petitioner is a single-person household and was age 58 at the time of the application. There are no children under the age of 18 living in the petitioner's household. [REDACTED] contends that the petitioner is unable to work and cannot live on her own.
3. [REDACTED] asserts that the petitioner applied for disability through the Social Security Administration (SSA) in late September 2016. [REDACTED] is unsure of the exact conditions that were reported to SSA on the September 2016 application. According to [REDACTED] the application was denied because the caseworker processing the application failed to wait for a report from the petitioner's psychiatrist dated April 1<sup>st</sup>, 2017, that contained vital information which proves the petitioner is disabled. The petitioner appealed the SSA denial and has a pending hearing date of September 13<sup>th</sup>, 2017. (See Petitioner's Exhibit 1).
4. [REDACTED] described the petitioner's conditions as [REDACTED]. The [REDACTED]. The conditions are expected to be lifelong, and the arthritis issue just began over the last

few months. The petitioner was just recently informed that she will require a hip replacement in the future. [REDACTED] further testified that the petitioner has been involuntarily committed under the Baker Act twice, and her psychiatric appointments and medications have recently increased. According to [REDACTED], the arthritis did not become an issue until February or March 2017 and has worsened ever since. He is unsure of exactly what was included on the SSA application but is confident the psychiatric report was not reviewed.

5. The respondent provided, as part of its evidence, a copy of the SSA Notice of Disapproved Claim originally provided by the petitioner. The date listed on the denial notice is October 20<sup>th</sup>, 2016. (See Respondent's Exhibit 5 pg. 35). The respondent also provided, as part of its evidence, a Disability Determination and Transmittal. According to the respondent, the transmittal was submitted to the Department of Disability Determination (DDD) along with all other information and documentation provided by the petitioner during the SSI-Related Medicaid process. The transmittal and an entry in the department's business notes indicate that the petitioner's Medicaid request was sent to DDD on April 12<sup>th</sup>, 2017. (See Respondent's Exhibits 4 and 8). The information was reviewed by DDD to determine if the petitioner met the criteria for disability Medicaid. The transmittal was returned to the respondent on April 17<sup>th</sup>, 2017, with a denial code of N31 and a written note of "Hankerson." The transmittal indicates that the two main conditions reviewed were [REDACTED]. (See Respondent's Exhibit 4). The respondent testified that the denial code N31 means, "Non-pay – Capacity for substantial gainful activity – customary past work, no visual impairment." The respondent further explained that "Hankerson" meant DDD was

adopting the October 20<sup>th</sup>, 2016, denial decision of SSA. Furthermore, the respondent was not able to overturn DDD's determination.

6. A DDD witness was not present to provide testimony, and a DDD case analysis was not provided as evidence.

7. Mr. Pellegrino asserts that the petitioner should be eligible for Medicaid because she is unable to work and has little mobility. The petitioner is on several medications in which the doses continue to increase. However, without medical coverage, the petitioner cannot afford to purchase the prescriptions or receive treatments from health care professionals.

#### **CONCLUSIONS OF LAW**

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

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

10. The Code of Federal Regulations at 42 C.F.R. Section 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 Section 435.911 on the same issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility... (b) Effect of SSA determinations. **(1)(i) An SSA disability determination is binding on**

**an agency until the determination is changed by SSA...** *[Emphasis added]* (c) Determination 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 disability condition different from, or in addition to, that considered by SSA in making its determination...

11. The above federal regulation indicates that the Department may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in Section 435.911 on the same issues presented in the Medicaid application. The regulation also states that the Department must make a determination of disability if the individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA and alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination or alleges more than 12 months after the most recent SSA determination. The Department is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA.

12. The hearing officer must consider whether or not the respondent took the correct action on the petitioner's Medicaid application. As established in the Findings of Fact, the petitioner's conditions are described as b [REDACTED] [REDACTED]. As stated in the Findings of Fact, DDD returned an unfavorable decision to the respondent on April 17<sup>th</sup>, 2017, citing that it was adopting the October 20<sup>th</sup>, 2016, denial from SSA. The transmittal from DDD shows the conditions reviewed were inflammatory arthritis and affective disorder. [REDACTED] believes that if SSA had waited for the psychiatrist's report, the petitioner would have

been eligible. However, the SSA application was denied almost five months prior to the report being signed. Furthermore, the report was dated prior to the SSI-Related Medicaid application and would have been available for review by DDD.

13. In conclusion, the undersigned concludes that the respondent's action to deny the petitioner's SSI-Related Medicaid application was correct. Based on the evidence and testimony, all medical documentation was available prior to the SSI-Related Medicaid application. Therefore, the information was accessible for DDD to review. DDD determined that the same conditions had already been reviewed by SSA. As stated in the above-cited authority, the respondent is bound by an SSA decision unless SSA changes the decision.

### **DECISION**

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

### **NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this \_\_\_\_\_ day of \_\_\_\_\_, 2017,

in Tallahassee, Florida.

FINAL ORDER (Cont.)

17F-03393

PAGE -7



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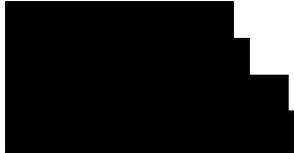
Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

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

**FILED**

Jul 26, 2017

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 17F-03416

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 18 Brevard  
UNIT: 88125

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:43 a.m. on June 14, 2017.

**APPEARANCES**

For the Petitioner:  er

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 full Family-Related Medicaid and instead approve SSI-Related Medically Needy (MN) with a \$2,191 Share of Cost (SOC), is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The hearing originally convened at 10:45 a.m. on June 2, 2017. The parties agreed to reconvene on June 14, 2017, for the parties to submit additional exhibits.

The petitioner submitted four exhibits, entered as Petitioner Exhibits "1" through "4". The respondent submitted 11 exhibits, entered as Respondent Exhibits "1" through "11". The record remained open until June 19, 2017, for the respondent to submit additional exhibits. The exhibits were received timely and entered as Respondent Exhibits "12" and "13". The record was closed on June 19, 2017.

### **FINDINGS OF FACT**

1. On April 24, 2017, AA submitted a Medicaid web application (Respondent Exhibit 2). Household members listed included AA, his wife, the petitioner (age five) and a minor daughter. AA is applying only for the petitioner. The application lists AA employed, earning \$4,106 biweekly.
2. The Department determines Family-Related Medicaid based on the Standard Filing Unit (SFU). SFU are members of the household whose needs and income must be included or excluded in determining Medicaid eligibility.
3. The SFU is determined by applying one of three rules: (1) Filer Rule, tax payer filing taxes and not claimed as a tax dependent, (2) Dependent Rule, claimed as a tax dependent and (3) Non-Filer Rule, will neither file a tax return nor be claimed as a tax dependent.
4. The Department applied the Dependent Rule to the petitioner, due to being age five and living with his parents. Therefore, the petitioner's parents and their income were included in the petitioner's Medicaid eligibility.

5. The income limit to be eligible for full Family-Related Medicaid for a household size of four which includes a child age five, is \$2,727.
6. Based on State Wage Information Collection Agency (SWICA) information, the Department determined \$10,818.65 as AA's monthly income; and denied the petitioner Medicaid for being over income (Respondent Exhibit 6, page 50).
7. On April 26, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA) denying the April 24, 2017 Medicaid application (Respondent Exhibit 5, page 17).
8. On May 3, 2017, the respondent's representative completed a pre-hearing call with AA and determined the Department's Medicaid denial was incorrect. The respondent's representative reused the petitioner's April 24, 2017 application (Respondent Exhibit 3) and determined the petitioner was eligible for Family-Related MN with a SOC.
9. The Department incorrectly calculated the petitioner's SOC using \$684 MN income limit (MNIL) disregard for a household size of five. Instead of the \$585 MNIL disregard for a household size of four (Respondent Exhibit 13).
10. On May 4, 2017, the Department mailed the petitioner a NOCA approving MN with a \$9,620 SOC (Respondent Exhibit 5, page 21). Had the Department calculated the petitioner's SOC using \$585 (correct MNIL), the petitioner's SOC would have been \$9,719.
11. Also on May 4, 2017, AA submitted a Medicaid disability application for the petitioner (Respondent Exhibit 4).
12. AA disagrees that the petitioner is not eligible for full Family-Related Medicaid.

13. AA asserts that the Department “incorrectly followed” its own Policy, 2230.0400.

AA alleges the petitioner should be determined Medicaid eligibility under the Filer Rule.

Because the petitioner is expected to receive approximately \$1,200 yearly unearned income, “gift(s)” from his grandparents (Petitioner Exhibit 4) and will file a tax return on his own.

14. AA alleges the petitioner will not be claimed by his parents on their tax return.

15. The respondent’s representative contends that the petitioner cannot be in his own SFU, due to his age and living with his parents.

16. AA argued that in accordance with the Department of Treasury Internal Revenue Service, Publication 929, Tax Rules for Children and Dependents (2016 Returns), the petitioner will file taxes on his own next year and will not be claimed by AA and his wife.

The Publication section AA referred to is:

**Table 1. 2016 Filing Requirements for Dependents**

If your parent (or someone else) can claim you as a dependent, use this table to see if you must file a return.

See the definitions of “dependent,” “earned income,” “unearned income,” and “gross income” in the *Glossary*.

**Single dependents**—Were you **either** age 65 or older **or** blind?

<input type="checkbox"/>	<p><b>No.</b> You must file a return if <b>any</b> of the following apply.</p> <ul style="list-style-type: none"> <li>• Your unearned income was over \$1,050.</li> <li>• Your earned income was over \$6,300.</li> <li>• Your gross income was more than the <b>larger</b> of—</li> </ul> <ul style="list-style-type: none"> <li>• \$1,050, or</li> <li>• Your earned income (up to \$5,950) plus \$350.</li> </ul>
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17. On May 25, 2017, the Division of Disability Determination (DDD) determined the petitioner disabled, primary diagnosis Autism (Respondent Exhibit 12).

18. Since the petitioner was determined disabled, the Department changed his eligibility from Family-Related Medicaid to SSI-Related Medicaid.

19. Unlike Family-Related Medicaid eligibility where all of AA's income is counted towards the petitioner; only a portion (referred to as "deemed income") is counted towards the petitioner in SSI-Related Medicaid eligibility.

20. The Department determined \$8,212 (\$4,106 X 2) as AA's monthly income, based on reported income on the April 24, 2017 application.

21. The following is the Department's calculation of AA's income deemed to the petitioner:

\$8,212.00	petitioner's father's income
<u>-\$ 368.00</u>	<u>petitioner's allocation</u>
\$7,844.00	countable income
<u>-\$ 20.00</u>	<u>standard disregard</u>
<u>-\$ 65.00</u>	<u>disregarded</u>
\$7,759.00	divided by two
<u>-\$3,879.50</u>	<u>(\$7,759/2)</u>
<u>-\$1,103.00</u>	<u>parent's allocation</u>
\$2,776.50	countable income (deemed income)

22. The SSI-Related income limit for the petitioner to be eligible for full Medicaid is \$885. The petitioner's \$2,776.50 deemed income is over the \$885 income limit. The next available program is MN with a SOC.

23. The Department determined the petitioner's MN SOC as follows:

\$2,776.50	deemed income
<u>-\$ 20.00</u>	<u>unearned income disregard</u>
<u>-\$ 180.00</u>	<u>MN income level for one</u>
<u>-\$ 385.50</u>	<u>medical insurance premium (\$128.50 X 3)</u>
\$2,191.00	SOC

24. On June 19, 2017, the Department mailed the petitioner a NOCA notifying approval of MN with a \$2,191 SOC (Petitioner Exhibit 13).

25. AA said he does not want MN with a SOC for the petitioner and stated the petitioner has medical insurance under his employer, but the medical insurance does not cover therapy.

### **CONCLUSIONS OF LAW**

26. 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.

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

28. Medicaid eligibility is based on Federal Regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents and children, and pregnant women, and (2) SSI-Related Medicaid for disabled individuals and adults age 65 or older.

### **FAMILY-RELATED MEDICAID**

29. The *Florida Administrative Code* R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria, in part states

(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...

(7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested...

**(b) If assistance is requested for a child in an intact family, the child, the child's parents, and all siblings who have no income must be**

**included in the SFU.** (emphasis added) Any siblings who have income or any other related fully deprived children are optional members...

30. The *Florida Administrative Code* R. 65A-1.203, Administrative Definitions, defines SFU, “(7) Standard Filing Unit: All individuals whose needs, income and/or assets are considered in the determination of eligibility for a category of assistance...”

31. The Department’s Program Policy Manual (Policy Manual), passage 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.

Filer Rule: If the individual being tested for eligibility expects to file a tax return for the tax year in which eligibility is being determined and does not expect to be claimed as a tax dependent by someone else, the SFU includes the:

1. individual,
2. individual’s spouse, if any, even if the individual and the individual’s spouse are living separately and filing a joint tax return, and
3. all claimed tax dependents of the individual living inside or outside of the household.

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.

Note: If one of the following exceptions apply, the individual’s SFU will be determined based on non-filer rules:

1. the individual is claimed as a tax dependent by someone other than a parent or their spouse.

2. the individual is a child living with both parents who expect to file separate tax returns.

3. the individual is a child claimed as a tax dependent by a non-custodial parent.

Non-Filer Rule: If the individual being tested for eligibility is an adult that does not expect to file a tax return and does not expect to be claimed as a tax dependent by someone else, the SFU includes the:

1. individual,

2. individual's spouse, if any, living in the household, and

3. individual's children (biological, adopted and step) living in the household that are under the age of 19, or age 19 or 20 enrolled in school full-time.

If the individual being tested for eligibility is a child that does not expect to file a tax return and does not expect to be claimed as a tax dependent by someone else, the SFU includes the:

1. individual,

2. individual's parents (biological, adopted and step) living in the household, and

3. individual's siblings (biological, adopted, step and half) living in the household that are under the age of 19, or age 19 or 20 enrolled in school full-time.

A tax filer and tax dependent's standard filing unit may contain a member(s) who is a tax dependent who does not reside inside the household of those applying for Family-Related Medicaid, but will be counted as part of the SFU based on tax rules. This individual is referred to as an outside of the household (OOTH) member. Individuals who are tax dependent and living outside of the household will not have an option to receive benefits as part of the application, but their needs and countable income will be included. The system will allow customers to define tax relationships between individuals on the application, including those individuals who are living outside of the household (OOTHs).

SSI recipients in the household are included in the Standard Filing Unit, but their SSI income is excluded. If the SSI recipient has any other income, it is included, subject to tax rules.

32. Title 42 of the Code of Federal Regulations, Section 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...

(c) Basic rule. Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on “household income” as defined in paragraph (d) 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...** (emphasis added) ...

(e) MAGI-based income. For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code,

(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...

(2) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (f)(3) of this section in the case of—

(i) Individuals other than a spouse or child who expect to be claimed as a tax dependent by another taxpayer; and

(ii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return...

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent...

33. The above authority explains Medicaid eligibility is determined using household income in accordance with one of three “rules”: (1) tax payer filing taxes and not

claimed as a tax dependent, (2) claimed as a tax dependent and (3) will neither file a tax return nor be claimed as a tax dependent.

34. Title 42 of the Code of Federal Regulations, Section 435.4, Definitions and use of terms, defines dependent child:

Dependent child means a child who meets both of the following criteria:  
(1) **Is under the age of 18**, (emphasis added) or, at State option, is age 18 and a full-time student...  
(2) Is deprived of parental support by reason of the death, absence from the home, physical or mental incapacity, or unemployment of at least one parent...

35. Additionally, Title 42 of the Code of Federal Regulations, Section 435.602, Financial responsibility of relatives and other individuals, in part states:

(2) (ii) In relation to **individuals under age 21** (as described in section 1905(a)(i) of the Act), **the financial responsibility requirements and methodologies that apply include considering the income and resources of parents** (emphasis added) or spouses whose income and resources will be considered if the individual under age 21 were dependent under the State's approved State plan under title IV-A of the Act...

36. In accordance with the above authorities, the Department included the petitioner's parents and their income in determining Medicaid eligibility for the petitioner (age five).

37. Policy Manual, Appendix A-7 (April 2017) lists \$2,727 as the Family-Related Medicaid income limit for a household size of four, which includes a child age five. And the MNIL at \$585 for a household size of four and \$684 for a household size of five.

38. AA's \$8,212 monthly income exceeds the \$2,727 income limit for the petitioner to be eligible for full Family-Related Medicaid.

39. AA argued that the Department incorrectly followed its own Policy 2230.0400 (#31).

40. AA argued the petitioner should be determined Medicaid eligibility under the Filer

Rule. Because the petitioner is expected to receive approximately \$1,200 yearly unearned income, “gift(s)” from his grandparents and will file a tax return on his own.

Therefore, the petitioner will not be claimed by his parents on their tax return.

41. AA further argued that in accordance with the Department of Treasury Internal Revenue Service, Publication 929, Tax Rules for Children and Dependents (2016 Returns), the petitioner will file taxes on his own next year and will not be claimed by AA and his wife. The Publication section AA referred to is:

**Table 1. 2016 Filing Requirements for Dependents**

**If your parent (or someone else) can claim you as a dependent, use this table to see if you must file a return.** (emphasis added)

See the definitions of “dependent,” “earned income,” “unearned income,” and “gross income” in the *Glossary*.

**Single dependents**—Were you **either** age 65 or older **or** blind?

<input type="checkbox"/>	<p><b>No.</b> You must file a return if <b>any</b> of the following apply.</p> <ul style="list-style-type: none"> <li>• Your unearned income was over \$1,050.</li> <li>• Your earned income was over \$6,300.</li> <li>• Your gross income was more than the <b>larger</b> of—</li> </ul>
	<ul style="list-style-type: none"> <li>• \$1,050, or</li> <li>• Your earned income (up to \$5,950) plus \$350.</li> </ul>

42. The above publication states “If your parent (or someone else) can claim you as a dependent, use this table to see if you must file a return.” The publication does not state that the parent cannot or should not claim the dependent.

43. The Glossary of the same Publication 929 defines dependent and unearned income:

Dependent. A person, other than the taxpayer or the taxpayer's spouse, for whom an exemption (defined later) can be claimed. You can generally claim an exemption for a dependent if the dependent:

1. Lives with or is related to you,
2. Is a U.S. citizen, a U.S. resident, or a resident of Canada or Mexico,
3. Does not file a joint return,
4. Does not have \$2,900 or more of gross (total) income (does not apply **to your child if under age 19** or a student under age 24), and
5. **Is supported (generally more than 50%) by you.** (emphasis added)

Unearned income. Income other than earned income. This is investment-type income and includes interest, dividends, and capital gains. Distributions of interest, dividends, capital gains, and other unearned income from a trust are also unearned income to a beneficiary of the trust.

44. The above Department of Treasury Internal Revenue Service, Publication 929, Tax Rules for Children and Dependents, Glossary, defines a dependent as a child under age 19 and supported more than 50%. In this case, the petitioner is age five and is supported by his parents.

45. Additionally, Policy Manual, CFOP 165-22, Section 1830.0101, Income (MFAM) in part states:

Taxable Unearned income is income for which there is no performance of work or services. Taxable unearned income may include:

1. retirement, disability payments, unemployment compensation;
2. annuities, pensions, and other regular payments;
3. alimony and spousal support payments;
4. dividends, interest, and royalties;
5. prizes and awards; or
6. Social Security income.

Excluded income is income (earned or unearned) that is not counted when determining eligibility.

46. In accordance with The Department of Treasury Internal Revenue Service, Publication 929, Tax Rules for Children and Dependents and the above Department Policy, the petitioner's \$1,200 yearly "gift" is not defined as unearned income.

47. The Findings of Fact establish that the Department did not count the petitioner's gift as unearned income.

#### SSI-RELATED MEDICAID

48. The petitioner is eligible under SSI-Related Medicaid because he has been determined disabled. The Department deemed a portion of AA's income towards to

the petitioner, prior to determining SSI-Related Medicaid eligibility.

49. Title 20 of the Code of Federal Regulations Section 416.1165, How we deem income to you from your ineligible parent(s), in part states:

- If you are a child living with your parents, we apply the deeming rules to you through the month in which you reach age 18...
- (d) Allocations for your ineligible parent(s). We next deduct allocations for your parent(s). We do not deduct an allocation for a parent who is receiving public income-maintenance payments (see §416.1142(a)). The allocations are calculated as follows:
- (1) We first deduct \$20 from the parents' combined unearned income, if any. If they have less than \$20 in unearned income, we subtract the balance of the \$20 from their combined earned income.
- (2) Next, we subtract \$65 plus one-half the remainder of their earned income.
- (3) We total the remaining earned and unearned income and subtract—
- (i) The Federal benefit rate for the month for a couple if both parents live with you; or
- (ii) The Federal benefit rate for the month for an individual if only one parent lives with you.
- (e)(1) When you are the only eligible child. If you are the only eligible child in the household, we deem any of your parents' current monthly income that remains to be your unearned income...

50. Policy Manual, CFOP 165-22, appendix A-9 (April 2017) identifies \$368 as a child allocation.

51. In accordance with the above authority, the Department deemed \$2,776.50 of AA's \$8,212 income towards the petitioner.

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

- (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level...
- (h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses...
- (4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of

cost”, shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service... To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months...

53. The above authority explains to be eligible for full SSI-Related Medicaid, income cannot exceed 88 percent of the federal poverty level (FPL). And MN provides coverage for individuals who do not qualify for full Medicaid, due to income.

54. Policy Manual, CFOP 165-22, appendix A-9 (April 2017) identifies \$885 as 88 percent of the FPL for an individual.

55. The petitioner’s \$2,776.50 deemed income is over the \$885 income limit to eligible for full SSI-Related Medicaid. The next available SSI-Related program is MN with a SOC.

56. Title 20 of the Code of Federal Regulations Section 416.1124 explains unearned income not counted and states in part “(c) Other unearned income we do not count... (12) The first \$20.00 of any unearned income in a month...”

57. The *Florida Administrative Code* R. 65A-1.716 sets forth the MNIL at \$180 for a family size of one.

58. The *Florida Administrative Code* R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in part “(4)(c) 1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges...”

59. In accordance with the above authorities, the Department deducted \$20 unearned income, \$180 MNIL and \$385.50 medical insurance premium from the petitioner's \$2,776.50 deemed income to arrive at \$2,191 SOC.

**HEARING OFFICER'S CONCLUSION**

60. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner (AA) did not meet the burden of proof. The undersigned concludes that the petitioner must be included with his parents as a dependent child in the Family-Related Medicaid eligibility determination.

61. The petitioner is a dependent child on his parents for daily financial support. Therefore, the parents and their income must be included in the Family-Related Medicaid eligibility; even if the IRS permits the petitioner to file income tax return on his gift(s) money.

62. The undersigned concludes that it is in the petitioner's best financial Medicaid interest, to be considered under the SSI-Related Medicaid eligibility. Even if the Department uses \$8,212 as AA's monthly income, instead of the \$10,818.65 SWICA income, in the Family-Related MN calculation; the petitioner's SOC would be higher than the SOC in the SSI-Related MN calculation.

63. The undersigned concludes the Department's action to approve the petitioner SSI-Related MN with a \$2,191 SOC is proper.

**DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 26 day of July, 2017,

in Tallahassee, Florida.



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Priscilla Peterson  
Hearing Officer  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Aug 22, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-03504

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 19 Martin  
UNIT: 88510

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on May 25, 2017 at 11:35 a.m. All parties appeared by telephone from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se

For the Respondent: Riphard Nicolas, Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of May 4, 2017 denying coverage in the Medicare Savings Qualified Individual 1 (QI1) program effective May 2017 due to an increase in his household's income. The petitioner carries the burden of proof by the preponderance of evidence.

On March 13, 2017, the undersigned heard a previous appeal, appeal 1F-01424, from the petitioner regarding the amount of Food Assistance Program benefits that his household received. The Department was upheld and the petitioner's appeal denied. The petitioner requested during this hearing that the undersigned reconsider that decision. Per Fla. Admin. Code R. 65-2.057 Conduct of Hearing, (10) A hearings officer shall not grant a motion for rehearing or reconsideration. The rehearing of an appeal once a decision has been made is out of the jurisdiction of the hearings officer.

### **PRELIMINARY STATEMENT**

The Department of Children and Families (Department or respondent) administers eligibility for the Medicaid Program for the state of Florida. This appeal was originally scheduled for June 7, 2017 at 12:00 p.m. The petitioner contacted the Office of Appeal Hearings and requested an earlier hearing date. The hearing was rescheduled to May 25, 2017.

During the appeal hearing on May 25, 2017, the petitioner asserted that he had not received the Department's evidence packet prior to the hearing. After discussing his right to reschedule, the petitioner agreed to continue with the hearing with the understanding that he could submit a written response to the Department's evidence packet when it was re-mailed to him.

The Department presented evidence which was marked and accepted as Respondent's Exhibits "1" through "11" respectively. The petitioner presented evidence that was marked as Petitioner's Exhibit "1" and Composite Exhibit "2". The petitioner acknowledged receiving the Department's evidence packet on June 7, 2017. As the packet was not received by the June 2, 2017 deadline established by the Hearing

Officer, the petitioner requested an extension to allow him time to review the packet. The request was granted. The petitioner had until June 16, 2017 to provide a response. The response was received June 16, 2017 and marked as Petitioner's Exhibit 3. The record was closed on June 16, 2017.

### **FINDINGS OF FACT**

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

1. The petitioner is 80 years old and his wife is 70 years old and they are the sole members of the assistance group, see Respondent's Exhibit 10 and Petitioner's testimony.
2. On May 3, 2017, the petitioner applied for SSI-Related Medicaid benefits including Medicare Savings Programs (MSP) for himself and his wife, see Respondent's Exhibit 2. The household's monthly income consists of gross Social Security Administration (SSA) benefits of \$1,286 for him and \$1,015 his wife for a combined gross monthly total of \$2,301, see Respondent's Exhibit 5 and Petitioner's Composite Exhibit 2. *Respondent's Exhibit 5 is the verification form DESO (Social Security online Data Exchange with FLORIDA).*
3. On May 4, 2017, the Department issued a Notice of Case Action (NOCA) to the petitioner informing him of the increase in the household's FAP benefits to \$286 and a decrease in their Medically Needy Share of Cost from of \$1,358 to \$1,300. His request for the MSP, specifically the Qualified Individual 1(QI1) Program was denied as their household is over the income limit for the program, see Respondent's Exhibit 5.

4. Prior to the May 3, 2017 application, the petitioner applied on February 8, 2017. That application for the QI1 program was denied for February, 2017 ongoing due to the household's income being too high for the program, see Respondent's Exhibit 2.
5. The gross monthly income limit for the MSP, specifically the Qualified Individual 1 Program is \$1,827 for a couple, see Respondent's Exhibit 7.
6. The petitioner believes that the household's net income and not the gross should be used to determine their eligibility for the QI1 program. The petitioner also believes that other household expenses should be considered in determining the household's eligibility for the QI1 program, Petitioner's testimony.
7. The Social Security Administration decreased the petitioner's and his wife's Social Security benefits by the amount needed to pay for their Medicare Part B, \$134 each, \$268 total monthly. The petitioner's net SSA income is \$1,152 and his wife's is \$881 for a combined total of \$2,033, see Respondent's Exhibit 5. The couple's net income exceeds the QI1 income limit of \$1,827 for a couple.
8. The Department calculated the couple's countable income using the following formula. The gross income of the petitioner and his wife is \$2,301 (his- \$1,286 + hers \$1,015 = \$2,301). The couple is eligible for a \$20 standard deduction of their gross income (\$2,301- \$20=\$2,281). Thus, \$2,281 is their countable income.
9. There are three programs, QMB, SLMB, and QI 1, which pay the Medicare premium. QMB, Qualified Medicare Beneficiaries, has an income limit for couples of \$1,354. SLMB, Special Low Income Beneficiaries, has an income limit for couples of \$1,624. QI 1, Qualifying Individuals 1, has an income limit for couples of \$1,827. The

petitioner's countable income of \$2, 281 exceeds each of the limits. The Department explained this is why the QI1 benefit was terminated for the petitioner and his wife.

### **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. 20 C.F.R. § 416.1120 defines unearned income and states. "Unearned income is all income that is not earned income. We describe some of the types of unearned income in §416.1121. We consider all of these items as unearned income, whether you receive them in cash or in kind."

13. 20 C.F.R. § 416.1121 describes types of unearned income and states in pertinent parts:

"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" (**emphasis added**).

14. 20 C.F.R. § 416.1123 instructs how to count the unearned income and states in relevant parts:

(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.

(1) We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see §416.1121) has been reduced to recover a previous overpayment. You are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of the debt reduction is also part of your unearned income.

...

**(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 (emphasis added).**

15. Fla. Admin. Code R. 65A-1.702, Specials 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. 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.)

16. Fla. Admin. Code R. 65A-1.713 (1) (j), SSI-Related Medicaid Income Eligibility

Criteria, sets forth the income limits for recipients of SSI-Related Medicaid and states in pertinent parts.

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

...

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

...

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

...

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

17. The Department's Policy Manual, Appendix A-9, SSI-Related Programs – Financial Eligibility Standards effective January 1, 2017 lists the Medicare Part B premium as \$134. Effective July 1, 2017 the income limits increased slightly but the Medicare Part B Premium remained the same.

18. In this instant case, the petitioner's household income is \$2,301 and is over the two-person income limit for QMB, SLMB and QI1.

19. The Department's Program Policy Manual CFOP 165-22 passage 2040.0819, Qualifying Individuals 1 (QI1) (MSSI) states that:

To qualify as a Qualifying Individuals 1 beneficiary, an individual must meet all the following eligibility criteria:

1. Be enrolled in Medicare Part A;
2. **Have income greater than 120% of the federal poverty level but equal to or less than 135% of the federal poverty level; (emphasis mine)**
3. Have assets not exceeding three times the SSI resource limit with annual increases based on the yearly Consumer Price Index (refer to Appendix A-9);
4. Be a U.S. citizen or qualified noncitizen;
5. Take necessary steps to access any other benefits to which they may be entitled; and
6. Does not qualify for Medicaid under any other Medicaid coverage group, except Medically Needy.

20. The above policy states that individuals must meet all of the eligibility criteria to be approved for Q11 program benefits. The above policy does not allow for other expenses to be included in the eligibility calculation for the MSP programs.

21. The findings show the petitioner and his wife receive Social Security benefits. The above controlling authorities describe these benefits as unearned income. The undersigned concludes the Department correctly included the incomes as unearned income.

22. The findings show the petitioner and his wife have their Social Security checks reduced due to payment of their Medicare Part B premiums. In accordance with the above controlling authorities, the undersigned concludes the gross amount of the Social Security benefits is the correct amount to include in the benefit calculations.

23. The undersigned reviewed the case using the April 1, 2017 income standard for Q11 as these standards were in effect at the time of the hearing. The above controlling authority shows the income standard for Q1 1 is now \$1,847. The undersigned concludes countable income for the household of \$2,281 exceeds the income limit for Q11. The undersigned concludes the household remains ineligible for Q11 based on income.

24. The undersigned reviewed all applicable rules and regulations to determine if there were any rule which allowed an exception to counting the income reported by the petitioner. The undersigned found no rule allowing an exception when the household's income exceeds the income standard.

25. Determined on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's action to deny the

petitioner and his wife's QI1 benefits is correct. The undersigned cannot find a more favorable outcome for the petitioner.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED and the Department's actions are upheld.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 22 day of August, 2017,

in Tallahassee, Florida.



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Ursula Lett-Robinson  
Hearing Officer  
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1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Jul 31, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-03519

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on May 30, 2017 at 12:04 p.m. The hearing was continued and reconvened on July 6, 2017 at 11:04 a.m. All parties appeared by telephone from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se

For the Respondent: Ronda Lanum, Economic Self-Sufficiency  
Specialist Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of February 3, 2017 denying ongoing coverage in the Qualified Individual 1 (QI1) program at her most recent recertification. The QI1 program is the Medicare Savings Program which paid her

Medicare premium. The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The Department of Children and Families (Department or respondent) administers eligibility for the Medicaid Program for the state of Florida. The hearing was scheduled to reconvene on July 3, 2017 at 9:00 a.m. to address the additional evidence provided by the Department. Due to a calendar conflict, the petitioner requested that the hearing be reconvened at a later time or on a different date. The hearing reconvened on July 6, 2017 at 11:00 a.m.

The Department presented evidence which was marked and accepted as Respondent's Exhibits "1" through "11" respectively. The petitioner presented evidence that was marked as Petitioner's Composite Exhibit "1".

The record was closed on July 6, 2017.

### **FINDINGS OF FACT**

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

1. The petitioner is 69 years old, disabled, and is the sole member of the assistance group, see Respondent's Exhibit 1 & Petitioner's Composite Exhibit 1.
2. On January 25, 2017, the petitioner applied for Food Assistance, Temporary Cash Assistance, SSI-Related Medicaid and Adult Medicaid benefits including Medicare Savings Programs (MSP) for herself, see Respondent's Exhibit 1. No income was reported on this application.

3. The Social Security Administration (SSA) notified the Department via a Data Exchange system alert that the petitioner was in receipt of Social Security Retirement Benefits (SSRE), see Respondent's Exhibit 2. The petitioner's gross monthly SSRE benefits are \$1,410, see Respondent's Exhibit 4 & Petitioner's Composite Exhibit 1.
4. The gross monthly income limit for the MSP, specifically the Qualified Individual 1 Program (QI1) is \$1,341, see Respondent's Exhibit 6.
5. On February 3, 2017, the Department issued a Notice of Case Action (NOCA) to the petitioner informing her of her approval for FAP benefits of \$16 and that she was enrolled in the Medically Needy Program with a Share of Cost of \$1,076. Her request for MSP was denied as she was over income for the program. The Department closed the MSP benefits effective March 2017, see Respondent's Exhibit 10.
6. The petitioner is not eligible for Temporary Cash Assistance as she has no minor children in the assistance group and she is not pregnant, see Respondent's Exhibit 1.
7. On March 9, 2017, the petitioner submitted a change request and reported a change of address, and an increase in shelter and utility expenses, see Respondent's Exhibit 2.
8. On March 9, 2017, the Department processed the change and the petitioner's FAP benefits increased, see Respondent's Exhibit 10. The petitioner thought the change would affect the MSP but she remained ineligible for QI1 benefits as her gross monthly income remained the same.
9. The petitioner appealed this action on May 2, 2017, as she believes that she is eligible for a Medicare Savings Program as her net SSRE income is less than the MSP income limit for the QI1 program.

10. The Department explained the budget calculation for the MSP. The petitioner's gross income is \$1,410 less a \$20 standard deduction. Petitioner's countable income is \$1,390. The income limit for the QI1 program at the time period in question was \$1,341, see Respondent's Exhibit 6. The Department explained this is why the MSP benefit was terminated for the petitioner.

### **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. Florida Admin. Code R. 65A-1.702, 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. 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.)

14. Fla. Admin. Code R. 65A-1.713 (1), SSI-Related Medicaid Income Eligibility

Criteria, sets forth the income limits for recipients of SSI-Related Medicaid and states in pertinent parts.

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

...

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

...

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

...

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

15. The Department's Program Policy Manual CFOP 165-22 Appendix A-9, SSI-Related Programs-Financial Eligibility Standards effective January 1, 2017 state that the monthly gross maximum income for eligibility in the MSP programs is \$992 for QMB, \$1,191 for SLMB and \$1,341 for QI1. Effective April 1, 2017 the monthly gross maximum income levels increased to \$1,005 for QMB, \$1,206 for SLMB and \$1,357 for QI1.

16. The Department's Program Policy Manual CFOP 165-22 at 2040.0819,

Qualifying Individuals 1 (QI1) (MSSI) states that:

To qualify as a Qualifying Individuals 1 beneficiary, an individual must meet all the following eligibility criteria:

1. Be enrolled in Medicare Part A;
2. **Have income greater than 120% of the federal poverty level but equal to or less than 135% of the federal poverty level; (emphasis mine)**

3. Have assets not exceeding three times the SSI resource limit with annual increases based on the yearly Consumer Price Index (refer to Appendix A-9);
  4. Be a U.S. citizen or qualified noncitizen;
  5. Take necessary steps to access any other benefits to which they may be entitled; and
  6. Does not qualify for Medicaid under any other Medicaid coverage group, except Medically Needy.
17. The above policy states that an individual must meet all of the eligibility criteria to be approved for QI1 program benefits.
18. 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.
19. The Code of Federal Regulations, 20 C.F.R. § 416.1123, How we count unearned income, states in relevant part:
- (b) Amount considered as income. We may include more or less of your unearned income than you actually receive.
    - (1) We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see §416.1121) has been reduced to recover a previous overpayment. You are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of the debt reduction is also part of your unearned income. Exception: We do not include more than you actually receive if you received both SSI benefits and the other benefit at the time the overpayment of the other benefit occurred and the overpaid amount was included in figuring your SSI benefit at that time.  
...
    - (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. (Emphasis mine)**

20. 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. 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.

21. The findings show the petitioner receives Social Security benefits. The above controlling authorities describe these benefits as unearned income. The undersigned concludes that the Department correctly included the income as unearned income.

22. The findings show the petitioner's Social Security check was reduced to (1) repay overpayment of previous Social Security benefits and (2) to pay her monthly Medicare Part B premium of \$134. In accordance with the above controlling authorities, the undersigned concludes the gross amount of the Social Security benefits is the correct amount to include in the benefit calculation.

23. The findings show the petitioner's sole income is Social Security Retirement benefits in the amount of \$1,410. The controlling authorities allow for \$20 of the total income of \$1,410 to be disregarded which leaves a countable income of \$1,390.

24. The undersigned reviewed the case using the January 1, 2017 income standard for QI 1, as this was the standard in effect when the petitioner's application was

processed in February 2017. The undersigned concludes the total countable income of \$1,390 exceeds the income limit for Q11 of \$1,341, which is the highest income level for a Medicare Savings Program. The undersigned concludes the Department correctly terminated the Q11 effective March 1, 2017.

25. The undersigned reviewed the case using the April 1, 2017 income standard for Q11 as this standard was in effect at the time of the first hearing. The above controlling authority shows the income standard for Q11 was \$1,357. The undersigned concludes countable income for the household of \$1,390 exceeded the income limit for Q11. The undersigned concludes the household remained ineligible for Q11 based on income.

26. The undersigned reviewed the case using the July 1, 2017 income standard for Q11 as this standard was in effect at the time of the reconvened hearing. The above controlling authority shows the income standard for Q11 was \$1,357. The undersigned concludes countable income for the household of \$1,390 exceeded the income limit for Q11. The undersigned concludes the household remained ineligible for Q11 based on income.

27. The undersigned reviewed all applicable rules and regulations to determine if there were any rule which allowed an exception to counting the income reported by the petitioner. The undersigned found no rule allowing an exception when the household exceeds the income standard by even a small amount. The undersigned can find no more favorable outcome for the petitioner.

28. Determined on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's action to deny the petitioner Q11 benefits is correct.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED and the Department's actions are upheld.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 31 day of July, 2017,

in Tallahassee, Florida.



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Ursula Lett-Robinson  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
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Email: Appeal.Hearings@myflfamilies.com

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

Jul 03, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

PETITIONER,

APPEAL NO. 17F-03640  
17F-04394

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 6, 2017 at 2:15 p.m.

**APPEARANCES**

For the petitioner: [REDACTED], pro se

For the respondent: Jennie Rivera, ACCESS Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

The petitioner is appealing the following:

I. The respondent's action to approve the petitioner's Food Assistance Program (FAP) benefits in the amounts of \$10.00 for April 2017 and \$16.00 per month for May 2017 and ongoing. The petitioner is seeking a higher amount. The petitioner carries the burden of proof by a preponderance of the evidence.

II. The respondent's action to exclude the petitioner's son from the FAP assistance group and approve FAP benefits for a household size of two instead of three members. The petitioner carries the burden of proof by a preponderance of the evidence.

III. The respondent's action to terminate the petitioner's son's Medicaid benefits effective April 30, 2017. The respondent carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

At the outset of the hearing, the petitioner argued she had also requested a hearing to challenge the respondent's action to terminate her son's Medicaid benefits. The respondent was able to address the issue regarding the Medicaid benefits; therefore, the hearing was conducted and the merits were developed. An appeal was implemented for the Medicaid Program, appeal 17F-04394.

During a supervisory review, the respondent recalculated the petitioner's FAP benefits effective April 2017. The respondent determined there were errors made on the case and that the petitioner was eligible for \$177.00 FAP benefits for April 2017 and \$120.00 per month for May 2017 and ongoing. The petitioner already received \$10 FAP benefits for April 2017; therefore, the respondent issued \$167.00 additional FAP benefits to the petitioner for April 2017. The petitioner already received \$16 FAP benefits for May 2017; therefore, the respondent issued \$104.00 additional FAP benefits to the petitioner for May 2017. The issue remained challenged as the petitioner is requesting to include her son in her FAP benefits and a higher amount.

The respondent submitted six exhibits, which were entered as Respondent's Exhibits "1" through "6". The record was held open until the end of business on June 13, 2017 for submission of additional evidence from the respondent. The respondent was instructed to submit the following:

Department's Policy on the Medicaid Program.  
Department's Policy on change reports and date of applications.  
Correct FAP budget calculation for April 2017.

Additional evidence was received from the respondent on June 7, 2017; however; the respondent did not submit the FAP budget for April 2017. The additional evidence was entered as Respondent's Exhibit "7". The record closed on June 13, 2017.

#### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner was receiving Family-Related Medicaid benefits for herself and her two children (ages 13 and 21) since January 2015. On April 7, 2017, the petitioner submitted a change report to inform the respondent that her employment with Fortira, Inc. had ended on March 10, 2017. No action was taken on the reported change.
2. On April 12, 2017, the petitioner submitted an application to add FAP benefits. She listed herself and her two children on the application. She listed her sources of income as her employment with [REDACTED], which ended on March 10, 2017, and child support of \$282.08 received weekly. However, the petitioner has not received child support income since 2016. Her monthly expenses were listed as rent of \$750.00 which included heating/cooling cost.

3. The petitioner indicated on the application that her son (21) is a full-time college student and not employed.
4. The petitioner completed a phone interview on April 19, 2017 and reported that she applied for unemployment compensation (UC). As part of the application process, the respondent verified UC for the petitioner. The respondent explained the Department used the following UC income in the FAP budgets: April 4, 2017 for \$275.00, April 19, 2017 for \$550.00, and May 5, 2017 for \$550.00 and ongoing paid bi-weekly.
5. The respondent utilized the petitioner's actual UC income received on April 2017, which was \$825.00 ( $\$275 + \$550$ ). The respondent calculated the petitioner's UC monthly gross income for May 2017 and ongoing as \$1,182.50 by multiplying her \$550.00 bi-weekly UC income by a conversion factor of 2.15 ( $\$550.00 \times 2.15$ ).
6. The petitioner's son was not eligible for FAP benefits as he was determined to be an ineligible student. To be eligible for FAP benefits as a school participant in an institution of higher education, ages 18 to 49, a student must meet one of nine student exemptions. The petitioner's son did not meet any of the exemptions; therefore, the respondent excluded the petitioner's son from the FAP benefits.
7. The respondent calculated the petitioner's FAP benefits for a household size of two as follows:

FINAL ORDER (Cont.)

17F-03640

17F-04394

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ABFN	FOOD STAMP NET INCOME BUDGET	05/18/2017 12:54
		Z17062 J RIVERA
CASE: [REDACTED]	CAT: FS SEQ: 01	AG NAME: [REDACTED] WORKER: TG4029
BEGIN: 05/01/2017	END: 05/31/2017 STATUS:	PEND, PASS, HEAR
	TOTAL GROSS INCOME:	1182.50
	EARNED INCOME DEDUCTION:	- .00
	STANDARD DEDUCTION:	- 157.00
TOTAL MEDICAL COSTS:	.00	
MEDICAL DEDUCTION:	- .00	
EXCESS MEDICAL EXPENSES:	= .00	EXCESS MEDICAL EXPENSES: - .00
		DEPENDENT CARE DEDUCTION: - .00
SHELTER COSTS:	750.00	CHILD SUP PAYMENT DEDUCT: - .00
UTILITY STD. ( SUA/ BUA/ PH) :	+ .00	HOMELESS INCM DEDUCTION: - .00
SHELTER/UTILITY COSTS:	= 750.00	ADJUSTED INCOME: = 1025.50
SHELTER STD(50% ADJ NET INC):	- 512.75	
EXCESS SHELTER/DEDUCTION:	= 237.25	SHELTER DEDUCTION: - 237.25
		FOOD STAMP ADJ INCOME: = 788.25
ASSISTANCE GROUP SIZE:	2	MAX NET MONTHLY INCOME: 1335.00

8. The maximum monthly allotment of FAP benefits for a household size of two is \$357.00. To determine the petitioner's FAP benefit amount, the Department took 30% of \$788.25 (Adjusted income after deductions) to calculate the benefit reduction of \$237.00. The respondent subtracted the \$237.00 benefit reduction from \$357.00 to arrive at \$120.00 FAP benefits for May 2017 and ongoing. The respondent determined the petitioner was eligible for \$177.00 FAP benefits for April 2017 (prorated from the April 12, 2017 application).

9. The petitioner's adult son was receiving Medicaid benefits in the category of Medicaid for Children 18 to 21 years old; the respondent terminated these benefits on April 30, 2017. The respondent determined that the petitioner's son was no longer eligible for any Family-Related Medicaid category due to his age. According to the application he is not disabled; therefore, he was not eligible for any SSI-Related Medicaid category.

10. On May 8, 2017, the respondent mailed the petitioner a Notice of Case Action notifying her son's full Medicaid benefits would end effective May 31, 2017. However, the parties testified that the petitioner's son's full Medicaid benefits ended on April 30, 2017.

11. The petitioner does not dispute the proration of her FAP benefits for April 2017; however, she disputes the date the respondent prorated her benefits from. Since the petitioner submitted a change report on April 7, 2017, she believes the Department should honor the April 7, 2017 date instead of the April 12, 2017 application date because she intended to apply for FAP benefits on April 7, 2017. Additionally, the petitioner explained she is financially responsible for her son's food and medical expenses; therefore, he should be included in the FAP and Medicaid benefits.

#### **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 party with the burden of proof shall establish his/her position, by a preponderance of the evidence, to the satisfaction of the hearing officer.

#### **FOOD ASSISTANCE ISSUES**

14. The Code of Federal Regulations at 7 C.F.R. § 273.2 addresses operation of food stamp offices and processing of applications and states in relevant part:

(a) Operation of food stamp offices and processing of applications—(1) Office operations. State agencies must establish procedures governing the operation of food stamp offices that the State agency determines best serve households in the State... **The State agency must provide timely, accurate, and fair service to applicants for, and participants in, the Food Stamp Program...** [emphasis added]

(2) **Application processing. The application process includes filing and completing an application form, being interviewed, and having certain information verified. The State agency must act promptly on all applications and provide food stamp benefits retroactive to the month of application to those households that have completed the application process and have been determined eligible...** [emphasis added]

...  
(c) Filing an application—(1) Household's right to file. **Households must file food stamp applications by submitting the forms to the food stamp office either in person, through an authorized representative, by fax or other electronic transmission, by mail, or by completing an on-line electronic application.** [emphasis added]

...  
(3) Availability of the application form. The State agency shall make application forms readily accessible to potentially eligible households. The State agency shall also provide an application form to anyone who requests the form. If the State agency maintains a Web page, it must make the application available on the Web page...

(d) Household cooperation. **(1) To determine eligibility, the application form must be completed and signed** [emphasis added], the household or its authorized representative must be interviewed, and certain information on the application must be verified...

15. The Florida Administrative Code R. 65A-1.205, addresses the Eligibility

Determination Process and states in part:

(1) The individual completes a Department application for assistance to the best of the individual's ability using either the ACCESS Florida Application, CF-ES 2337, 11/2011, <https://www.flrules.org/gateway/reference.asp?NO=Ref-00981>, incorporated by reference, or an ACCESS Florida Web Application (only accepted electronically), CF-ES 2353, 09/2011 <https://www.flrules.org/gateway/reference.asp?NO=Ref-00982> incorporated by reference, and submits it. An application must include at least the individual's name, address and signature to initiate the

application process. An eligibility specialist determines the eligibility of each household member for public assistance...

(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...

16. The petitioner argued that when she submitted the change report, she intended to apply for the FAP benefits.

17. The Florida Administrative Code R. 65A-1.203 defines the date of application as "the date the Department receives an application. If a web or facsimile application is received after business hours, the next business day following receipt is the date of application. Applications may be submitted in person, by the postal system, facsimile or electronically."

18. The above-cited regulations set the rules for the processing of FAP applications and explain that in order to have an eligibility determination for FAP benefits made, an individual must file an application by submitting the application form to the State agency. Without an application, the application process is incomplete and the respondent cannot make an eligibility determination. The findings show prior to submitting the April 12, 2017 application; the last application for FAP benefits submitted by the petitioner was on January 7, 2015. The evidence indicates the petitioner submitted a change report on April 7, 2017 not an application; therefore, the respondent was correct to use April 12, 2017 as her date of application for FAP benefits.

19. The Code of Federal Regulations at 7 C.F.R. § 273.9 defines "Income" in the Food Assistance Program. The passage reads in relevant part:

(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....

(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...

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

(1) Standard 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...

(iii) Standard utility allowances...

20. The above-cited legal authority sets forth income, allowable standards and expenses to be included in the FAP budget.

21. The Code of Federal Regulations at 7 C.F.R. § 273.10, Determining household eligibility and benefit levels states in relevant part:

(a) Month of application—(1) Determination of eligibility and benefit levels...

**(ii) A household's benefit level for the initial months of certification shall be based on the day of the month it applies for benefits and the household shall receive benefits from the date of application to the end of the month... [emphasis added]**

(B) The State agency shall prorate benefits over the exact length of a particular calendar or fiscal month.

(iii) To determine the amount of the prorated allotment, the State agency provided by FNS or whichever of the following formulae is appropriate:

(A) For State agencies which use a standard 30-day calendar or fiscal month the formula is as follows, keeping in mind that the date of application for someone applying on the 31st of a month is the 30th:

$$X = \frac{a \times b}{c}$$

$$\text{full month's benefits} \times \frac{(31 - \text{date of application})}{30} = \text{allotment}$$

...

(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....

(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.

...

(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.

(B) In addition to meeting the net income eligibility standards, households which do not contain an elderly or disabled member shall have their gross income, as calculated in accordance with paragraph (e)(1)(i)(A) of this section, compared to the gross monthly income standards defined in §273.9(a)(1) 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 to the nearest higher dollar...

22. The above regulation states that a household's benefit level for the initial month of certification shall be based on the day of the month it applies for benefits. Therefore, the undersigned concludes that the Department was correct to determine the petitioner's FAP eligibility from her April 12, 2017 application and authorize prorated FAP benefits from that date.

23. The Code of Federal Regulations at 7 C.F.R. § 273.5 defines student eligibility for Food Assistance benefits and in part states:

(a) **Applicability.** An individual who is enrolled at least half-time in an institution of higher education shall be ineligible to participate in the Food Stamp Program unless the individual qualifies for one of the exemptions contained in paragraph (b) of this section. An individual is considered to be enrolled in an institution of higher education if the individual is enrolled in a business, technical, trade, or vocational school that normally requires a high school diploma or equivalency certificate for enrollment in the curriculum or if the individual is enrolled in a regular curriculum at a college or university that offers degree programs regardless of whether a high school diploma is required.

**(b) Student Exemptions. To be eligible for the program, a student as defined in paragraph (a) of the section must meet at least one of the following criteria.** (emphasis added)

- (1) Be age 17 or younger or age 50 or older;
- (2) Be physically or mentally unfit;
- (3) Be receiving Temporary Assistance for Needy Families under Title IV of the Social Security Act;
- (4) Be enrolled as a result of participation in the Job Opportunities and Basic Skills program under Title IV of the Social Security Act or its successor program;
- (5) Be employed for a minimum of 20 hours per week...
- (6) Be participating in a State or federally financed work study program during the regular school year...
- (7) Be participating in an on-the-job training program. A person is considered to be participating in an on-the-job training program only during the period of time the person is being trained by the employer;
- (8) Be responsible for the care of a dependent household member under the age of 6;
- (9) Be responsible for the care of a dependent household member...
- (c) The enrollment status of a student shall begin on the first day of the school term of the institution of higher education. Such enrollment shall be deemed to continue through normal periods of class attendance, vacation and recess, unless the student graduates, is suspended or expelled, drops out, or does not intend to register for the next normal school term (excluding summer school).

24. The above authority explains that an individual who is enrolled at least half-time in an institution of higher education shall be ineligible for FAP unless the individual qualifies for one of the exemptions listed.

25. The cumulative evidence and testimony show the petitioner's son is a full-time college student who does not meet any of the listed exemptions in order to participate in the FAP benefits. Therefore, the undersigned concludes the petitioner's son is ineligible for FAP benefits.

26. The Department failed to provide the FAP budget to indicate how it determined the petitioner was eligible for \$177.00 FAP benefits effective April 2017. However; the respondent testified that it recalculated the petitioner's April 2017 FAP budget using actual income received in April 2017.

27. The Department's Field Guide Handouts/Proration Factors for Food Assistance, lists 0.633 as the proration factor that corresponds to the 12th day of the month. The respondent determined the petitioner's FAP benefits for the full month of April 2017 would have been \$279.00. As the petitioner applied on April 12, 2017, her full month \$279.00 FAP benefits were multiplied by above proration factor to determine \$177.00 FAP benefits ( $\$279.00 \times 0.633$ ), as the prorated amount for April 2017. The undersigned concludes the respondent's action to approve the petitioner for \$177.00 in FAP benefits for April 2017 was correct.

28. The respondent recalculated the petitioner's FAP budgets beginning May 2017 and determined the petitioner was eligible for \$120 FAP benefits per month for May 2017 and ongoing. The undersigned could not find a more favorable outcome for the petitioner in regards to the May 2017 and ongoing FAP benefit amount.

29. In careful review of the evidence and controlling legal authorities, the undersigned concludes the petitioner did not meet her burden of proof to indicate the respondent incorrectly approved her for FAP benefits in the amounts of \$177.00 for April 2017 and \$120.00 per month for May 2017 and ongoing. Furthermore, the undersigned concludes the respondent's action to exclude the petitioner's son from the FAP assistance group, due to being an ineligible student, and approve FAP benefits for a household size of two instead of three members, was correct.

**MEDICAID ISSUE FOR THE PETITIONER'S SON (21)**

30. Fla. Admin. 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.

(a) Children under the age of 21 living with a specified relative who meet the eligibility criteria of Title XIX of the Social Security Act. Included in this coverage group are children who are under age 21 in intact families, provided that the children are living with both parents, unless a parent is temporarily absent from the home....

31. The Code of Federal Regulations at 42 C.F.R. § 435.222, Optional eligibility for reasonable classifications of individuals under age 21, states in part:

(a) Basis. This section implements sections 1902(a)(10)(A)(ii)(I) and (IV) of the Act for optional eligibility of individuals under age 21.

(b) Eligibility. The agency may provide Medicaid to all—or to one or more reasonable classifications, as defined in the State plan, of—individuals under age 21 (or, at State option, under age 20, 19 or 18) who have household income at or below the income standard established by the agency in its State plan in accordance with paragraph (c) of this section.

32. The above authorities explain the respondent must provide Medicaid benefits for children under the age of 21. The findings show the petitioner's son is twenty-one years old; therefore, the undersigned concludes the petitioner's son is no longer considered a minor child and does not meet the age requirement to be eligible for Medicaid benefits.

33. In careful review of the evidence and cited authorities, the undersigned concludes the respondent followed rule in terminating the petitioner's son's Medicaid benefits on April 30, 2017.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the Department's actions are affirmed.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 03 day of July, 2017,

in Tallahassee, Florida.



---

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

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

**FILED**

Jul 31, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-03691

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 15 PALM BEACH  
UNIT: 88506

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on June 7, 2017, at 10:04 a.m.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:

Corinne Driscoll, supervisor

**STATEMENT OF ISSUE**

At issue was whether the respondent correctly denied the petitioner's request for Medicaid benefits (at recertification of other household members) due to her noncompliance with Child Support Enforcement (CSE) requirements. The petitioner carries the burden of proof by a preponderance of the evidence

**PRELIMINARY STATEMENT**

The respondent presented one exhibit which was entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not present any

exhibits. The record was held open until June 17, 2017, for the respondent to provide its policy on child support cooperation. The evidence was received, entered into evidence and marked as Respondent's Composite Exhibit 2. The record was closed on June 17, 2017.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner had a prior CSE sanction effective December 1, 2014. The petitioner was excluded from all benefits. She was aware of the CSE sanction imposed in October 2014.
2. The Department of Revenue (DOR) is the agency responsible for establishing and enforcing child support obligations and is responsible for requesting the imposition and removal of CSE sanctions.
3. On April 24, 2017, the petitioner submitted an online application requesting Medicaid benefits and Food Assistance (FA) benefits for herself and her four children (Respondent's Composite Exhibit 1).
4. The respondent reviewed the petitioner's application and determined eligibility for the petitioner and her children. She was found ineligible as she did not cooperate with CSE in December 2014.
5. The respondent mailed a Notice of Case Action to the petitioner, informing her that she was ineligible for Medicaid benefits. The notice also informed her that her four children were eligible for Medicaid (Respondent's Composite Exhibit 2).
6. On May 8, 2017, the petitioner requested a hearing to challenge the respondent action to deny her Medicaid benefits. She is not appealing Food Assistance benefits.

7. At the hearing, the petitioner stated she needed Medicaid benefits because she has serious health problems and she is unable to pay for private insurance. The petitioner was informed that she must first comply with CSE before Medicaid can be approved for her, as compliance with CSE is a requirement for Medicaid benefits (Respondent's Composite Exhibit 2).

8. At the hearing, the petitioner stated she was not going to cooperate with CSE, as her child's father was providing direct financial support to his child.

### **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. Cooperation as a condition of eligibility for Medicaid Program benefits is set forth in the Code of Federal Regulations at 42 C.F.R. § 435.610. It states:

(a) As a condition of eligibility, the agency must require legally able applicants and beneficiaries to:

(1) Assign rights to the Medicaid agency to medical support and to payment for medical care from any third party;

(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

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for

care and services under the plan, unless the individual establishes good cause for not cooperating.

(b) The requirements for assignment of rights must be applied uniformly for all groups covered under the plan.

(c) The requirements of paragraph (a) of this section for the assignment of rights to medical support and other payments and cooperation in obtaining medical support and payments are effective for medical assistance furnished on or after October 1, 1984. The requirement for cooperation in identifying and providing information for pursuing liable third parties is effective for medical assistance furnished on or after July 1, 1988.

12. Section 414.095, Florida Statutes child support enforcement 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.

13. According to the rules above, the Department of Children and Families is responsible for imposing and removing sanctions. The petitioner failed to cooperate with CSE in 2014 and expressed no desire to cooperate now. She explained she did not want to cooperate with CSE, as she receives direct financial support from the non-custodial parent. Therefore, the petitioner's sanction remained imposed and she was excluded from the Medicaid benefits.

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

(1) An applicant for, or recipient of, public assistance for a dependent child shall cooperate in good faith with the department or a program attorney...

(2) Noncooperation, or failure to cooperate in good faith...

(3) The Title IV-D staff of the department shall be responsible for determining and reporting to the staff of the Department of Children and Family Services acts of noncooperation by applicants or recipients of public assistance. Any person who applies for or is receiving public assistance for, or who has the care, custody, or control of, a dependent child and who without good cause fails or refuses to cooperate with the department, a program attorney, or a prosecuting attorney in the course of administering this chapter shall be sanctioned by the Department of Children and Family Services pursuant to chapter 414 and is ineligible to receive public assistance until such time as the department determines cooperation has been satisfactory.

15. The above statute establishes the general requirement to pursue parental support as related to authorizing Medicaid. Under statute, pursuit of parental support is important and the pursuer of support must comply with federal and state requirements.

16. The above authorities provide that applicants or recipients of public assistance for a dependent child shall cooperate in good faith with the Department.

17. The petitioner is required to comply with CSE cooperation standards unless there is good cause for noncompliance. Compliance must be achieved for purposes of enforcing and/or collecting support as related to receipt of public assistance.

18. The Policy Manual, passages 1430.1708 addresses Reasons for Good Cause (MFAM).

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).

19. The Policy Manual, consistent with rule and statute, sets forth "good cause" reasons for noncooperation as listed above. Good cause reasons involve such things as emotional and physical harm, and legal proceedings for adoption. Lack of desire to cooperate as the child father is providing direct financial support is not identifiable as good cause, even if the arrangement is satisfactory to the individuals involved.
20. The hearing officer could not find any exception that could be determined as good cause for the petitioner not cooperating with CSE.
21. After careful review of all factors, statutes, regulations and evidence, the undersigned concludes that the respondent's action to exclude the petitioner from the Medicaid benefits due to non-cooperation of CSE was justified and was within the rules and regulations.

### **DECISION**

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

FINAL ORDER (Cont.)  
17F-03691  
PAGE -7

DONE and ORDERED this 31 day of July, 2017,  
in Tallahassee, Florida.

*A. T. G. Narine*

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Christiana Gopaul-Narine  
Hearing Officer  
Building 5, Room 255  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

**FILED**

Aug 04, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 17F-03721

PETITIONER,

Vs.

CASE NO. 

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 6, 2017 at 1:30 p.m.

**APPEARANCES**

For Petitioner: 

For Respondent: Sylma Dekony, Economic Self Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner appeals Respondent's action denying her Medicaid Disability application dated April 17, 2017. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

Petitioner submitted two exhibits, which were entered into evidence as Petitioner's Exhibits "1" and "2.". Respondent submitted an evidence packet consisting of eleven exhibits, nine of which were entered into evidence and marked as

Respondent's Exhibits "1" – "9." After further review and subsequent to the record closing, the undersigned realized two exhibits were marked together as Respondent's Exhibit "3." These two exhibits were separated, marked as Respondent's Exhibits "3" and "4," and the subsequent exhibits were re-marked as Respondent's Exhibits "5" through "10." The undersigned did not enter Respondent's exhibit pages 2 – 4 into evidence as it consisted of notices created by the Office of Appeal Hearings and already included on the docket. The record remained open until 5:00 p.m. on June 13, 2017 to allow Petitioner time to submit additional evidence supporting her case. Petitioner timely submitted additional evidence which was marked as Petitioner's Exhibit "3." Petitioner untimely submitted additional evidence on June 14, 2017. As this evidence was relevant and necessary to the undersigned's decision, the undersigned re-opened the record and admitted this evidence marked as Petitioner's Exhibit "4". The record closed on June 14, 2017.

### **FINDINGS OF FACT**

1. On April 17, 2017, Petitioner, age 33, submitted a paper application for Food Assistance and Medicaid Disability for herself, indicating that she was disabled (Respondent's Exhibit 3). Medicaid is the only issue.
2. Petitioner described her disabling conditions as [REDACTED]  
[REDACTED]  
[REDACTED] (Petitioner's Exhibit 2, Page 2).
3. On June 29, 2016, Petitioner applied for disability through the Social Security Administration (SSA) (Respondent's Exhibit 7).

4. On February 13, 2017, the SSA denied Petitioner's disability application (Respondent's Exhibit 7).
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. On May 5, 2017, Respondent mailed Petitioner a Notice of Case Action notifying that her April 17, 2017 Medicaid Disability application was denied, due to not meeting the disability requirements (Respondent's Exhibit 2).
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.
8. Petitioner claimed to have new or worsened medical conditions that the SSA was unaware of (Petitioner's Testimony). The undersigned left the record open for Petitioner to provide the February 13, 2017 SSA denial letter indicating what conditions it considered during its review of her application. Petitioner provided an incomplete copy of the denial letter that did not include the conditions the SSA considered for her June 29, 2016 disability application.

#### **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 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.

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

11. 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...

12. 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.

...

13. 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 within the time limits set for in section 435.912 on the same issues presented in the Medicaid application. Respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA.

14. In accordance with the above authority, Respondent denied Petitioner's April 17, 2017 Medicaid Disability application, due to adopting the SSA denial decision.

15. Petitioner is appealing the February 13, 2017 SSA denial through an attorney. Furthermore, Petitioner provided no evidence that she has new or worsened medical conditions that the SSA is unaware of.

16. 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 April 17, 2017 Medicaid Disability application. The undersigned concludes Respondent's action denying Petitioner's April 17, 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 Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 04 day of August, 2017,  
in Tallahassee, Florida.



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Erik Swenk, Esq.  
Hearing Officer  
Building 5, Room 255  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Jul 25, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-03794

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 June 19, 2017 at 11:21 a.m.

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: Julie Schell, supervisor

**STATEMENT OF ISSUE**

The petitioner is appealing full Medicaid benefits or a lower share of cost (SOC) in the Medically Needy Program for his wife. The burden of proof is assigned to the petitioner by a preponderance of evidence.

### **PRELIMINARY STATEMENT**

The respondent provided seven exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 6 and Respondent's Composite Exhibit 7. The petitioner did not present any exhibits. The record was held open for the respondent to include the petitioner's dental expense and provide a new budget. The evidence was received, entered into evidence and marked as Respondent's Composite Exhibit 8. The record was closed on June 20, 2017.

### **FINDINGS OF FACT**

1. On April 19, 2017, the petitioner submitted a recertification application for himself and his family for Family-Related Medicaid benefits. The petitioner's household consists of himself, his wife and their two children. The petitioner and his wife file their taxes jointly with their children as their tax dependents. The petitioner is employed with [REDACTED] [REDACTED] and is paid \$2,000.27 twice per month. His paystub was provided as verification of his income (Respondent's Exhibit 2).
2. The respondent initially determined Medicaid eligibility for the petitioner's wife using State Wage Information Collection Agency (SWICA). She was found ineligible for full Medicaid as the household income was over the income limit for a household of four of \$815. The respondent proceeded to enroll the petitioner's wife in the Medically Needy program with an estimated SOC (Respondent's Exhibit 2).
3. On April 24, 2017, the petitioner requested a hearing to challenge the Respondent's action (Respondent's Exhibit 5).

4. Prior to the hearing, the respondent contacted the petitioner to do a supervisory review. After the supervisor's review, the petitioner provided his paystub to the respondent as verification of his income.

5. The respondent calculated the petitioner's monthly income by multiplying his gross semimonthly pay of \$2,000.27 by a conversion factor of 2 resulting in \$4,000.54. The respondent denied full Medicaid as the household's monthly gross income was over the income limit for full Medicaid. The respondent proceeded to determine eligibility in the Medically Needy Program. The medically needy income level (MNIL) of \$585 was subtracted from the household's monthly gross income resulting in \$3,415. A deduction for medical insurance of \$788.44 was subtracted which resulted in the wife's SOC of \$2,626.

6. At the hearing, the respondent discovered that the petitioner pays for dental insurance in addition to medical insurance. The respondent agreed to include the dental insurance as an expense in the Medicaid budget/SOC budget and to provide updated budgets to the petitioner and the undersigned.

7. On June 19, 2017, the respondent provided the updated budget which allowed the medical insurance and the dental insurance of \$820.31. The medical expenses and the MNIL were subtracted from the gross income resulting in the petitioner's wife SOC of \$2,594.

8. The petitioner's wife asserted she cannot afford medical insurance because it is very expensive for her husband to add her to his work insurance.

**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.

**The full Family-Related Medicaid benefits will be addressed first:**

11. The Family-Related Medicaid income criteria are 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.
- (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. . .
- (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
- (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.

12. Federal Medicaid Regulations 42 C.F.R. § 435.218 Individuals with MAGI-based income above 133 percent FPL (Federal Poverty Level) states in part:

(a) *Basis*. This section implements section 1902(a) (10) (A) (ii) (XX) of the Act.

(b) *Eligibility*—(1) *Criteria*. The agency may provide Medicaid to individuals who:

- (i) Are under age 65;
- (ii) Are not eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part;
- (iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and
- (iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.

(2) *Limitations*. (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.

(ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

13. 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 full-time.

14. In accordance with the above controlling authorities, the Medicaid household group is the petitioner, his wife and their two children. The findings show the Department determined the petitioner's eligibility with a household size of four for Medicaid. The undersigned concludes the Department correctly determined the petitioner's household size.

15. 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.

16. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for a parent is \$364 for the household size of four, the Modified Adjusted Gross Income (MAGI) disregard is \$103, the Standard Disregard is \$221 and the Medically Needy Income Limit (MNIL) is \$585.

17. The Department's Policy Manual section 2630.0108 Budget Computation (MFAM):

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

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

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

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

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

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

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

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

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

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

18. The Policy Manual at passage 2430.0700 Income Conversion (MFAM) states:

Most income is received more often than monthly; that is; it is received weekly, biweekly, or semimonthly. Since eligibility and benefit amounts are issued based on a calendar month, income received other than monthly is to be converted to a monthly amount.

The following conversion factors based on the frequency of pay are used:  
Semimonthly income (twice a month): Multiply by 2.

19. The above allows for the use of the conversion factor of 2 if income is received semimonthly, for Medicaid eligibility determination. The undersigned could not find a better outcome in determining the household income.

20. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for petitioner's wife. The undersigned concludes that the petitioner's wife is not eligible for full Medicaid under the Family-Related Medicaid Program as the household's modified adjusted gross income was more than the income limit of \$364 for a household size of four people. Step 1: The undersigned used the petitioner's modified adjusted gross income of \$4,000.54. Step 2: There were no deductions provided, as there was no tax return. Step 3: A standard disregard of \$221 was subtracted. The total income remained \$3,779.54. Step 4: The total countable net income of \$3,779.54 was compared with the income standard for four people. Step 5: Since it was greater than the income standard, the modified adjusted gross income disregard of \$103 was subtracted, resulting to \$3,676.54. This was compared to the income limit of \$364 for full Medicaid. The household's income was greater than the income limit for full Medicaid. The undersigned concludes the petitioner's wife is ineligible for full Medicaid. The undersigned recognizes the petitioner's wife concerns about her medical needs. However, the controlling legal authorities do not allow for a

more favorable outcome. The undersigned proceeded to explore the Medically Needy Program.

**The Medically Needy share of cost will now be addressed:**

21. Fla. Admin. Code 65A-1.701 "Definitions" define 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".

22. 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.

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, the respondent determined the petitioner's standard filing unit (SFU based on his tax filing status.

25. Effective April 2017, the Family-Related Medicaid income standard appears in the Policy Manual at Appendix A-7. It indicates that the MNIL for a household of four is \$585.

26. The undersigned reviewed the respondent's budget calculations and determined the petitioner was given all of the allowable deductions from the earned income that were allowed by the controlling authorities. A more favorable outcome other than the SOC assigned by the respondent.

27. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner's wife in the Medically Needy Program with an estimated SOC 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 Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)  
17F-03794  
PAGE -11

DONE and ORDERED this 25 day of July, 2017,  
in Tallahassee, Florida.



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

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

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

**FILED**

Jul 17, 2017

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-03797

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 12 MANATEE  
UNIT: 88326

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 10<sup>th</sup>, 2017, at 11:30 a.m.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se.

For the Respondent: Ed Poutre, Senior Worker for the Department of Children and Families.

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to deny her SSI-Related Medicaid application. The petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

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

Respondent's exhibits 1 through 8 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated April 20<sup>th</sup>, 2017, the respondent informed the petitioner that her Medicaid application dated March 20<sup>th</sup>, 2017, was denied because a member of the household did not meet a disability requirement, and no household members were eligible for the program. On May 11<sup>th</sup>, 2017, the petitioner filed a timely request to challenge the respondent's action.

### **FINDINGS OF FACT**

1. The petitioner submitted a paper application for Food Assistance (FA), Temporary Cash Assistance, SSI-Related Medicaid, and Home and Community Based Services (HCBS) on March 20<sup>th</sup>, 2017. (See Respondent's Exhibit 2). SSI-Related Medicaid is the only program at issue for this appeal. As part of the application process, the respondent is required to explore and verify all technical factors of eligibility.
2. The petitioner's household includes herself, 56 years of age, and her husband. There are no children under the age of 18 living in the petitioner's household. The petitioner considers herself disabled.
3. The petitioner applied for Social Security Disability (SSD) and Supplemental Security Income (SSI) from the Social Security Administration (SSA) on January 4<sup>th</sup>, 2017. The application was denied on February 10<sup>th</sup>, 2017. (See Respondent's Exhibit 6). The petitioner contends that the SSD was denied because she does not have enough quarters of work, and the SSI was denied because her husband's income is too high. The petitioner appealed the denial on March 8<sup>th</sup>, 2017, and believes that the appeal was also denied. (See Respondent's Exhibit 6).
4. The petitioner described her medical conditions as [REDACTED], [REDACTED]. The petitioner also listed

multiple surgeries and accompanying medical complications that have occurred over the last eight years.

5. The respondent provided, as part of its evidence, screen prints from the SSA State Data Exchange. (See Respondent's Exhibits 4 and 5). The screen prints include two separate denial codes for the petitioner's SSA claims. The first code is N31 which, according to the State Online Query (SOLQ) User Guide, means "Non-pay – Capacity for substantial gainful activity –customary past work, no visual impairment." The second code is N01 which, according to the SOLQ User Guide, means "Non-pay – Countable Income exceeds Title XVI federal benefit rate." The screen prints also show two separate disability pay codes of "R" and "F." (See Respondent's Exhibit 4 and 5). According to the SOLQ User Guide, a disability pay code of "R" means "Referred to State agency," while a disability pay code of "F" means "Final determination – allowance."

6. The respondent testified that it never requested a disability interview from the petitioner. Additionally, the respondent did not submit any information to the Department of Disability Determination (DDD) on the petitioner's behalf. An entry in the department's business notes (CLRC) indicates that an interview was completed for the FA portion of the application, and the respondent made mention of the need to request a disability Medicaid interview. There is no indication from CLRC that the respondent asked the petitioner any questions from the disability screening tool or sent any information to DDD. (See Respondent's Exhibit 7).

7. The petitioner asserts that she was never asked to complete a disability interview. However, the petitioner does contend that she received a letter from the

Department of Children and Families (DCF) office in ██████████ hat stated she was 100 percent disabled. However, no evidence was provided to support the claim.

### CONCLUSIONS OF LAW

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

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

10. The Code of Federal Regulations at 42 C.F.R. Section 435.541 Determinations of disability states, in part:

(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.** [*Emphasis added.*]

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination [emphasis added], alleges a new period of disability which meets the durational requirements of the Act, and—

11. As stated in the above-cited authority, the respondent is required to complete a disability determination if one of the criteria listed in the authority applies. According to the criteria listed under number one, if the petitioner applied for SSI and SSA and was denied for SSI for a reason other than disability then the respondent must complete a disability determination. As established in the Findings of Fact, the petitioner testified that she was denied SSI due to her husband's income. This also corresponds to the code N01 which means "Non-pay – Countable Income exceeds Title XVI federal benefit rate." The respondent testified that a disability interview was not requested. After review of the evidence, testimony, and guidelines, the hearing officer does not affirm the respondent's action to deny the petitioner's application for SSI-Related Medicaid without first completing a disability determination. Therefore, the respondent will, within ten days from the date of this order, initiate a disability determination. The petitioner will need to cooperate in this process. Once the process is complete, the respondent will provide written notice informing the petitioner of the outcome, and the notice will include appeal

rights which the petitioner may exercise in the event that the petitioner disagrees with the outcome.

**DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 17 day of July, 2017,

in Tallahassee, Florida.



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

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

**FILED**

Aug 07, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-03800

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 01 Escambia  
UNIT: 88630

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 4, 2017 at 8:36 a.m.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:

Delecia Greene, ACCESS Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of denying his application for Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

**PRELIMINARY STATEMENT**

This matter was originally scheduled for appeal on July 6, 2017. The petitioner requested the hearing be rescheduled so that he could gather and provide information. The hearing was rescheduled for August 4, 2017.

The petitioner presented evidence, which was entered as Petitioner's Exhibit 1.  
The Department presented evidence, which was entered as Respondent's Exhibit 1.

The record closed on August 4, 2017.

### **FINDINGS OF FACT**

1. The petitioner filed an application for Family-Related Medicaid on April 10, 2017. The petitioner is 60 years old and has no minor dependent children in his household. The petitioner did not report himself as disabled on his application. (Respondent Exhibit 1, pages 3 through 6)

2. The petitioner reported he is in good health, including riding a bicycle 13 miles to work prior to getting a car.

3. The petitioner reported he has not applied for disability with the Social Security Administration.

4. The Department issued a Notice of Case Action on April 17, 2017 denying the petitioner's April 10, 2017 application for Medicaid citing the reason for denial as: "You or a member of your household do not meet the disability requirement." (Respondent Exhibit 1, pages 35 through 38).

5. The petitioner argues that he did not receive the April 17, 2017 Notice of Case Action until he received the evidence packet. The petitioner reports no problem with receiving his mail at his home. The petitioner confirmed the address on the Notice is the address where he receives his mail.

6. The Department does not have any record of returned mail. The Department explained that all documents received by the Department are recorded in the Document Imaging System. The Department included a copy of the Document

Imaging System printout for the petitioner's case showing no returned mail received.

(Respondent Exhibit 1, page 39)

7. Due to the discrepancy of whether or not the petitioner the petitioner received the Notice, the undersigned must make a finding. The Department mailed the Notice to the address of the petitioner. The petitioner confirmed the address on the Notice is his mailing address. The Department reported and provided evidence that no mail has been received as returned mail for the petitioner. In addition, the undersigned relied on the presumption that correspondence properly mailed and not returned with no rebuttal evidence (*Brown v. Giffen Industries, Inc.*, Fla. 1973, 281 So.2d 897, 1973, Fla. SCt 997) to make the finding that the petitioner did receive the Notice of Case Action dated April 17, 2017.

8. The petitioner believes he financially qualifies to receive Medicaid.

9. The Department explained the petitioner does not meet the technical criteria of having a minor child in the home to qualify for Family-Related Medicaid.

10. The Department explained the petitioner does not meet the aged or disabled technical requirement to qualify for SSI-Related Medicaid.

### **CONCLUSIONS OF LAW**

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

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

13. The 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 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.

14. 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.

15. 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).**  
(emphasis added)

16. 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.

17. The findings show the petitioner is 60 years old. The findings also show the petitioner is not established as disabled. The above controlling authorities require that an individual be age 65 or disabled in order to qualify for SSI-Related Medicaid. In the instant case, the petitioner is under age 65 and does not claim to be disabled.

18. Based on the evidence and testimony presented as well as the above cited rules and regulations, the undersigned concludes the petitioner does not meet the technical requirements of age 65 or disabled to qualify for SSI-Related Medicaid. The undersigned further concludes the denial of SSI-Related Medicaid is appropriate.

### **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 Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 07 day of August, 2017,

in Tallahassee, Florida.

*M. Roedel*

---

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

**FILED**

Aug 07, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-03817

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 7, 2017 at 1:30 p.m.

**APPEARANCES**

For Petitioner: [REDACTED]

For Respondent: Sylma Dekony, Economic Self Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner appeals Respondent's action denying his Medicaid Disability application dated April 20, 2017. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

Priscilla Peterson, Hearing Officer, Department of Children and Families, Office of Appeal Hearings, appeared as an observer without party objection. [REDACTED]

██████████, Petitioner's wife, appeared as a witness for Petitioner, without party objection.

Petitioner did not submit any exhibits. Respondent submitted an evidence packet consisting of nine exhibits, eight of which were entered into evidence and marked as Respondent's Exhibits "1" – "8." The undersigned did not enter Respondent's exhibit pages 2 – 4 into evidence as it consisted of notices created by the Office of Appeal Hearings and already included on the docket. The record closed on June 7, 2017.

### **FINDINGS OF FACT**

1. On April 20, 2017, Petitioner, age 57, submitted an on-line application for Medicaid and Medicaid Disability for himself and his wife. (Respondent's Exhibit 3). Petitioner's Medicaid Disability denial is the only issue.
2. Petitioner described his disabling conditions as ██████████  
██████████  
██████████ (Petitioner's Testimony).
3. On February 13, 2017, Petitioner applied for disability through the Social Security Administration (SSA) (Respondent's Exhibit 4).
4. On March 22, 2017, the SSA denied Petitioner's disability application (Respondent's Exhibit 4).
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. On April 28, 2017, the Department electronically sent to the Division of Disability Determination (DDD) Petitioner's medical documents for review (Respondent's Exhibit

6, Page 1). DDD is responsible for making Medicaid Disability determinations for the Department.

7. On May 9, 2017, DDD denied Petitioner's disability application with denial code N31, which means "capacity for substantial gainful activity, customary past work, no visual impairment" (Respondent's Exhibit 8, Page 1). 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.

8. On May 10, 2017, Respondent mailed Petitioner a Notice of Case Action notifying that his April 20, 2017 Medicaid Disability application was denied, with the reason that no household members are eligible for this program (Respondent's Exhibit 2).

9. Petitioner did not claim to have new or worsened medical conditions that the SSA was unaware of (Petitioner's Testimony).

#### **CONCLUSIONS OF LAW**

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

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

12. Florida Administrative Code, Section 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty

Level. For an individual to receive Medicaid who are less than 65 years of age, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

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

13. The Code of Federal Regulations Title 42, Section 435.541, Determinations of Disability, states in relevant part:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c) (3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and—

- (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
- (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
- (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
  - (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
  - (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

...

14. The above authority explains that the SSA determination is binding on the Department. Federal regulation prohibits Respondent from making an independent determination of disability if SSA has already made a disability determination within the time limits set for in section 435.912 on the same issues presented in the Medicaid application. Respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA.

15. In accordance with the above authority, Respondent denied Petitioner's April 20, 2017 Medicaid Disability application, due to adopting the SSA denial decision.

16. Petitioner is appealing the March 22, 2017 SSA denial through an attorney and has no new or worsened medical conditions that the SSA is unaware of.

17. 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 April 20, 2017 Medicaid Disability application. The undersigned concludes

Respondent's action denying Petitioner's April 20, 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 Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 07 day of August, 2017,  
in Tallahassee, Florida.



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Erik Swenk, Esq.  
Hearing Officer  
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Copies Furnished [REDACTED] Petitioner  
Office of Economic Self Sufficiency

Aug 11, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-03916

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 15 PALM BEACH  
UNIT: 88998

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 10, 2017 at 10:02 a.m.

**APPEARANCES**

For the Petitioner

[REDACTED]

For the Respondent:

Mary Triplet, supervisor

**STATEMENT OF ISSUE**

The petitioner is appealing the denial of her SSI-Related Medicaid application. The petitioner carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The Department of Children and Families (Department or DCF or respondent) determines eligibility for participation in the Florida Medicaid Program.

The respondent presented six exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 6. The petitioner did not present any exhibits at the hearing on May 8, 2017.

Lauren Miller, program operations administrator with the Division of Disability Determination (DDD) was present as a witness for the Department.

The petitioner was not present at the hearing.

Appeal number 17F-03961 will be closed as a duplicate request.

### **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 February 28, 2017, the petitioner (age 55) filed an application for SSI-Related Medicaid with the Department. She last worked in December 2016 (Respondent's Exhibit 2).
2. The petitioner is single; she does not have minor children who live in the home. Single adults without minor children are not eligible to participate in the Medicaid Program unless they are elderly (age 65 or older) or have been determined disabled by the Social Security Administration (SSA) or the Department. The petitioner has not applied for Social Security benefits.
3. The petitioner's representative alleges that the petitioner is disabled due to mental health issues such as bipolar disorder and related disorders. Additionally, she asserted that the petitioner's illness is the cause of the petitioner not being able to work, cook, clean and take care of herself.

4. DDD performs disability determinations for the Department. The respondent forwarded the petitioner's disability package/application to DDD on March 21, 2017, for review.

5. DDD received the petitioner's disability package on March 27, 2017 and completed a five-step sequential analysis to determine if the petitioner is disabled using the following: (1) The individual cannot be engaging in substantial gainful activity (working and earning income that meets or exceeds set limits);(2) the alleged impairment must be severe and intended to last 12 continuous months; (3) impairment(s) meets a disability listing set forth in federal regulations; (4) individual incapable of returning to previous work; (5) individual incapable of performing any work in the national economy.

6. DDD relied on the Department's determination that the petitioner is not engaged in substantial gainful activity to determine the petitioner meets step one.

7. DDD determined the petitioner's medical conditions are severe and met the criteria for step two of the determination.

8. DDD proceeded to step three of the evaluation process. DDD used the Psychiatric Review Technique (PRT) to evaluate the petitioner's mental impairments. The evaluation was based on category 12.04, depressive, bipolar and related disorders. She was evaluated for areas of mental functioning such as, 1. understand, remember or apply information, 2. Interact with others, 3. Concentrate, persist or maintain pace. Her degree of limitation was mild. Additionally, her mental functioning to adapt or manage oneself was moderate. The petitioner was determined to have excellent control of her bipolar impairment. The medical records indicate that her bipolar symptoms were

benign. She has acute distress but with mild severity at her baseline. She was able to function independently (Respondent's Exhibit 5).

9. DDD also used the Mental Residual Functional Capacity Assessment (MRFC) to determine the petitioner's mental impairments. She was evaluated for areas of mental functioning such as understanding and memory, sustained concentration and persistence and social interaction. Her degree of limitation was not significantly limited. Additionally, her mental functioning to adapt or manage oneself was mostly mild except for her ability to respond appropriately to changes in the work setting which was found to be moderately limited (Respondent's Exhibit 5).

10. The Functional Capacity Assessment (FCA) concluded that the claimant/petitioner can understand, retain, and carry out complex instructions. She can consistently and usefully perform familiar tasks on a sustained basis with minimal supervision and can cooperate effectively with the public and co-workers in completing simple tasks and transactions. "Claimant can adjust to the mental demands of most new task settings" (Respondents' Exhibit 5, page 46).

11. DDD reviewed the petitioner's medical records from [REDACTED] and [REDACTED] [REDACTED], and explained its decisions as follows.

55 year old female Allegation of [REDACTED] and d [REDACTED]  
Education: high school. Language English. Past relevant work (PRW) in the last 15 years: medical assistance, and pharmacy tech.  
MER (Medical Evidence of Record) summary shows treatment for bi polar disorder.  
ADL's (Activity Daily Living)  
Self-reported ADLs per telephone call on April 13, 2017. She can do her personal care and household chores. She can walk and loft normally. She cannot drive due to limits on concentration.

She can shop but has difficulty focusing. She does not take care of any other persons or any pets. On a typical day she exercises and make her own meals and watch TV.

MENTAL

A mental [REDACTED], [REDACTED] dated April 13, 2017, found remarkably mental status is consistently benign, with not more than moderate severity of signs/symptoms when most acutely distressed and mild severity at her baseline.

A [REDACTED] dated April 13, 2017 found, claimant can understand, retain and carry out simple instructions. Claimant can consistently and usefully perform routine task on sustained d basis with minimal supervision and can cooperate effectively with public and co-workers in completing simple task and transactions. Claimant can adjust to the mental demands of most new task settings.

SUMMARY

The claimant is a 55 year old female with a diagnosis of [REDACTED]. She is able to perform the task required in a work setting. She makes no physical allegations and the MER reflects no serious physical conditions. She can perform PRW as medical assistance or pharmacy tech.

DECISION

N31 Denial. Capacity for substantial gainful activity (SGA), customary past work, no visual impairment (Respondent's Exhibit 5, pages 26, 27, 28).

12. DDD determined that the petitioner did not meet or equal a listing for step three of the disability criterion based on the MRFC.

13. DDD proceeded to step four to determine if the petitioner is capable of performing her past relevant work as a pharmacy technician or medical assistant. It was determined that she was capable of performing her past relevant work. DDD denied the petitioner's claim on April 20, 2017, with an N31 reason code. N31 means capacity for substantial gainful activity (SGA) customary past work, no visual impairment (Respondent's Exhibits 4 and 6).

14. On April 21, 2017, the Department issued a Notice of Case Action informing the petitioner that her Medicaid application was denied. The reason given for the denial was that she did not meet the disability requirement (Respondent's Exhibit 1)

15. On May 16, 2017, the petitioner requested a hearing to challenge the respondent's decision.

16. At the hearing, the petitioner's representative asserted that her Medicaid application should have been approved because of the severity of her mental health, which impacts her level of functioning. Her impairment has prevented her from performing her basic chores and her ability to work.

17. DDD acknowledged that the petitioner's mental health issues are serious; however, the DDD representative argued that the petitioner's acute behaviors are not so severe and not expected to last twelve months or prevent her from performing her past relevant work.

#### **CONCLUSIONS OF LAW**

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

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

20. The Fla. Admin. Code R. 65A-1.710, 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.

21. The petitioner is not 65 years old and has not been determined disabled by SSA. The cited authority explains that 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. On behalf of the Department, DDD makes the disability determination when an individual has not been determined disabled by the SSA.

22. 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.) ...

23. Federal Regulations at 20 C.F.R. § 404.1520 (4) addresses the disability evaluation and states:

*The five-step sequential evaluation process.* The sequential evaluation process is a series of five “steps” that we follow in a set order. See paragraph (h) of this section for an exception to this rule. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and step five when we evaluate your claim at these steps. These are the five steps we follow: (i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in §404.1509, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 of this subpart and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. See paragraphs (f) and (h) of this section and §404.1560(b).

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. See paragraphs (g) and (h) of this section and §404.1560(c).

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

25. Step one of the evaluation process determines if the petitioner is engaging in substantial gainful activity (SGA)/working, (20 C.F.R. § 404.1520(b) and 416.920(b)).

The findings show that the petitioner has not been employed December 2016. The petitioner meets step one.

26. Step two of the sequential analysis for disability is to determine if the individual has an impairment that is "severe" or a combination of impairments that are "severe" (20 C.F.R § 404.1520(c) and 416.920(c)). The petitioner's medical evaluation indicated that her mental disorders are severe. The undersigned, in review of the medical evidence submitted concurs with DDD decision and the analysis continues to step three.

27. Step three of the sequential analysis for disability is to determine whether or not the individual's impairment meets or equals a listed impairment in Title 20 of the Code of Federal Regulations, Appendix 1 of the Social Security Act.

28. To meet the disability criterion under listing 12.00 Mental Disorders, specifically 12.04 bi-polar the petitioner must present with:

A .Medical documentation of the requirements of paragraph 1 or 2:

1. Depressive disorder, characterized by five or more of the following:

- a. Depressed mood;
- b. Diminished interest in almost all activities;
- c. Appetite disturbance with change in weight;
- d. Sleep disturbance;
- e. Observable psychomotor agitation or retardation;
- f. Decreased energy;
- g. Feelings of guilt or worthlessness;
- h. Difficulty concentrating or thinking; or
- i. Thoughts of death or suicide.

2. Bipolar disorder, characterized by three or more of the following:

- a. Pressured speech;
- b. Flight of ideas;
- c. Inflated self-esteem;
- d. Decreased need for sleep;
- e. Distractibility;
- f. Involvement in activities that have a high probability of painful consequences that are not recognized; or
- g. Increase in goal-directed activity or psychomotor agitation.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).
3. Concentrate, persist, or maintain pace (see 12.00E3).
4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder 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 mental disorder (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)

29. The petitioner's medical evidence for her mental impairment falls under section 12.04 [REDACTED] did not show 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 objective medical evidence 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.

30. At step four, the undersigned must determine whether the petitioner has the residual functional capacity to perform the requirements of her past relevant work. Based on the evidence presented, the petitioner's past relevant work includes that of a pharmacy technician. The Dictionary of Occupational Titles (DOT) describes this job (pharmacy technician-DOT 074.382-010) as filling bottles with prescribed tablets and capsules, labeling bottles, and assisting pharmacist to prepare and dispense medication. The petitioner's Mental Residual Functional Capacity Assessment, dated April 13, 2017, by [REDACTED] shows petitioner can understand, retain, and carry out complex instructions. She 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. Furthermore, she can adjust to the mental demands of most new task settings. While the petitioner

may have some medically determinable impairments, these impairments should not preclude her from performing her past work as a pharmacy technician, as generally performed in the national economy. Based on the totality of the evidence presented, the undersigned finds DDD's denial at step-four was correct. After careful review of the evidence submitted and the relevant authorities set forth above, the undersigned finds the petitioner failed to meet her burden and respondent's action was proper.

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

DONE and ORDERED this 11 day of August, 2017,  
in Tallahassee, Florida.



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Christiana Gopaul-Narine  
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Copies Furnished To: [REDACTED] Petitioner  
Office of Economic Self Sufficiency

Jul 07, 2017

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGSAPPEAL NO. 17F-03950  
APPEAL NO. 17F-04546

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 15 Palm Beach  
UNIT: 88701RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 13, 2017 at 8:34 a.m.

**APPEARANCES**For the Petitioner: 

For the Respondent: Ronda Lanum, supervisor

**STATEMENT OF ISSUE**

1. At issue is the amount of Food Assistance Program (FAP) benefits approved at recertification.
2. Also at issue is the denial of full Medicaid for the petitioner's daughter and her enrollment in the Medically Needy Program with an estimated share of cost (SOC). She is seeking full Medicaid benefits for her daughter. The petitioner carries the burden of proof by a preponderance of evidence on both issues.

### **PRELIMINARY STATEMENT**

The respondent provided nine exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 9. The petitioner did not present any exhibits.

### **FINDINGS OF FACT**

1. On April 3, 2017, the petitioner submitted an application for Food Assistance Program (FAP) benefits for herself (age 46) and her daughter (19) and Medicaid benefits for her daughter. The petitioner is employed and is paid weekly. Her monthly expenses are rent of \$950, electricity of \$150, telephone \$80 and water \$50. The petitioner is a tax filer with her daughter as her tax dependent. The respondent determined eligibility and found the petitioner was eligible for \$14 in FAP benefits for April 2017 which was prorated based on the date of her application and \$16 FAP benefits ongoing (Respondent's Exhibits 1 and 7).
2. On April 14, 2017, the respondent mailed the petitioner a Notice of Case Action, informing that her application was approved from April 2017 through September 2017. By same notice, the respondent notified the petitioner that her daughter was eligible for the Medically Needy Program with a SOC of \$1,707 (Respondent's Exhibit 2).
3. On May 17, 2017, the petitioner requested a hearing to challenge the respondent's action.
4. The respondent used the petitioner's paychecks dated March 17, 2017 of \$548.67, March 24, 2017 for \$492.05, March 31, 2017 for \$520 and April 07, 2017 for \$533.65. The weekly average was found and multiplied by a weekly conversion factor for FAP of 4.3 resulting to \$2,251.44 as the household's gross monthly income.

5. The respondent applied the following deductions to the household's monthly income.

Earned Income \$2,251.44	\$2,251.44
Total household income	\$2,251.44
Earned Income Deduction	(\$450.28)
Standard deduction for a household of 2	(\$157)
Adjusted income after deductions	\$1,644.16
Shelter costs	\$950
Standard utility Allowance	\$338
Total rent/utility cost	\$1,288
Shelter standard (50% adjusted income)	\$822.08
Excess shelter deduction	\$465.92
Adjusted income	\$1,644.16
Excess Shelter Deduction	(\$465)
FA Adjusted income after shelter deduction	\$1,178.24
Maximum net monthly income for HH of 2	\$1,335
Thrifty Food Plan for a Household of 2	\$357
Benefit reduction (30% of \$1,178.24	\$354
Recurring FA monthly allotment/minimum allotment	\$16
Prorated Benefit for April 2017	\$14

### **Medicaid Issue**

6. The petitioner's household monthly income was determined according to the Medicaid guidelines by converting the petitioner's weekly income to monthly by using the Medicaid conversion factor of 4 resulting to \$2,251.44. It was then compared to the maximum income for full Medicaid for a child 19 of a household size two, which is \$1,354.

7. The respondent determined the petitioner's household monthly income of \$2,251.44 exceeded the maximum income limit of \$1,354 for full Medicaid benefits. The petitioner's daughter has been enrolled in the SOC program since July 2016.

8. The Medically Needy Income Limit of \$387 for a household size of two was subtracted from the countable net income of \$2,094 resulting in \$1,707 as the petitioner's daughter SOC.

9. At the hearing, the petitioner reported monthly medical expenses for prescriptions for her daughter in excess of \$200, dental insurance of \$31.76 and vision of \$3.09. In addition she has medical insurance of \$53.34 and medical GAP insurance of \$15.03 for herself. She also pays for car insurance.

### **CONCLUSION 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.

### **The FAP benefits issue will be addressed first.**

12. Federal regulation C.F.R. § 273.9 addresses income/allowable deductions budgeting in the FAP in part and 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...
  - (1) Earned income shall include:
    - (i) All wages and salaries of an employee...
    - (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.

(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...

(4) *Dependent care*. Payments for the actual costs for the care of children or other dependents when necessary for a household member to accept or continue employment, comply with the employment and training requirements as specified under §273.7(e), or attend training or pursue education which is preparatory to employment, except as provided in §273.10(d)(1)(i)...

(5)(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...

(D) The shelter costs for the home if temporarily not occupied by the household because of employment or training away from home, illness, or abandonment caused by a natural disaster or casualty loss. For costs of a home vacated by the household to be included in the household's shelter costs, the household must intend to return to the home; the current occupants of the home, if any, must not be claiming the shelter costs for food stamp purposes; and the home must not be leased or rented during the absence of the household...

(iii) *Standard utility allowances*...

13. The respondent must follow these federal budgeting guidelines when determining eligibility. It directs the respondent to consider income from wages as earned income that must be included in the eligibility determination.

14. Federal Regulations 7 C.F.R. § 273.10 addresses income and calculating net income and benefit levels:

(c)(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...

15. The weekly factor was used to convert the petitioner's earned income to monthly income. No mathematical errors were found in the conversion to monthly income.

16. The Food Assistance standards for income and deductions appear in the Department's Program Policy Manual (Policy Manual), CFOP 165-22, at Appendix A-1. The 200% Federal Poverty level (FPL) for a household size of two effective October 2016 is \$2,670. A two-person assistance group's net income limit is \$1,335, the standard deduction is \$157, the Standard Utility Allowance is \$338 and the minimum allotment is \$16.

17. 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...

(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

(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, 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...

(ii)(A)...the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30% of the household's net monthly income...

(iii) To determine the amount of the prorated allotment, the State agency shall use either the appropriate Food Stamp Allotment Proration Table provided by FNS...

(vi) (B) Except as provided in paragraphs (a)(1), (e)(2)(ii)(B), and (e)(2)(vi)(C) of this section, one- and two-person households shall be provided with at least the minimum benefit.

18. The Department's Field Guide Handouts/Proration Factors Chart, Cash & FS, 06/18/2012, lists the proration factor of 0.933 as the factor that corresponds to day 3. As the petitioner applied on April 3, 2017, the Department issued FAP benefits of \$14 for April 2017 ( $0.933 \times \$16$ ), a prorated amount.

19. The above-cited regulation describes the eligibility process and defines deductions. The petitioner was credited with an earned income deduction, an excess shelter deduction and a standard deduction. There is no indication the petitioner was eligible for any other deductions. The petitioner is not eligible for an excess medical deduction as no household members are aged or disabled.

20. After considering the evidence, the testimony and the appropriate authorities cited above, the hearing officer could not find the petitioner eligible for any additional FAP benefits based on her reported income and expenses.

**Medicaid Benefits will now be addressed**

21. The petitioner's daughter Medicaid eligibility was determined under the Family-Related Medicaid Program.

22. Federal Medicaid Regulations 42 C.F.R. § 435.218 Individuals with MAGI-based income above 133 percent of the FPL (Federal Poverty Level) states in part:

(a) *Basis*. This section implements section 1902(a) (10) (A) (ii) (XX) of the Act.

(b) *Eligibility*—(1) *Criteria*. The agency may provide Medicaid to individuals who:

(i) Are under age 65;

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

(iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and

(iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.

(2) *Limitations*. (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.

(ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

23. Family-Related Medicaid income criteria is set forth in 42 C.F.R. 435.603 and states:

(a) (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.

(3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section

will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under §435.916 of this part, whichever is later.

(b) *Definitions.* For purposes of this section—

*Child* means a natural or biological, adopted or step child.

*Code* means the Internal Revenue Code.

*Family size* means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver....

(c) *Basic rule.* Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on “household income” as defined in paragraph (d) 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.

(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.

24. 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 full-time.

25. In accordance with the above controlling authorities, the Medicaid household group is the petitioner and her daughter. The findings show the respondent determined the petitioner's eligibility with a household size of two for Medicaid. The undersigned concludes the Department correctly determined the petitioner's household size as two for Medicaid.

26. The Policy Manual at passage 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 Kid Care and/or the Federally Facilitated Marketplace (FFM).

27. The Policy Manual at section 2430.0204 addresses Determining Monthly Income (MFAM), and states:

The process of computing the amount of income to be considered in determining financial eligibility and the coverage group(s) is called "budgeting". When determining financial eligibility, one or more budget calculations will be completed. The best estimate of the standard filing unit's income and circumstances is used to determine eligibility. When determining eligibility benefits for a past month, the SFU's actual income and circumstances are used. The income is compared to the appropriate income limit to determine the coverage group.

28. The Policy Manual at section 2430.0509, Income More Often than Monthly (MFAM), states:

The following procedure to calculate the average of earned or unearned income received in varying amounts more frequently than monthly is the same for all programs:

1. Add the gross income amounts for the past four weeks to get the total.
2. If income is received weekly, add four pay periods and divide by four to get the weekly average.
3. If income is received biweekly, add two pay periods and divide by two to get the biweekly average.
4. If income is received semimonthly, add two pay periods and divide by two to get the semimonthly average.
5. If income is received monthly, use the most recent month if representative.

The result of the above is called the averaged amount. With the exception of monthly amounts, the averaged amount described above must be converted to a monthly amount.

29. The above instructs the Department to add the weekly pay periods and divide by four to determine the weekly average.

30. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for a child 19 years of age for a household size two as \$1,354. The Modified Adjusted Gross Income (MAGI) disregard of \$68 and the Medically Needy Income Limit (MNIL) of \$387.

31. In accordance with the above controlling authorities, the undersigned reviewed eligibility for full Medicaid benefits for the petitioner and did not find her eligible, as the modified adjusted gross income was more than the income limit of \$1,354 for a household size of two for a child 19 years of age. Step 1: The undersigned used the petitioner's monthly earned income of \$2,094.36. Step 2: MAGI was determined by deducting allowable income tax deductions. No income tax deduction was allowed as there was no tax return provided. The MAGI was determined to be \$2,094.36. Step 3: A standard disregard of \$146 was allowed resulting to \$1,945.36 as the countable net income. Step 4: The countable net income of \$1,948.36 was compared to the income limit of \$1,354, which exceeded the income limit. Step 5: A MAGI disregard of \$68 was allowed resulting to \$1,880.36 as the total monthly income. It was compared with the income limit for a parent of a household size of two of \$1,354 for full Medicaid for a child age 19. The petitioner's income was greater than the income limit for full Medicaid for a 19 year old. The undersigned concludes the petitioner's daughter is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

**The Medically Needy share of cost will now be addressed**

32. Fla. Admin. Code R. 65A-1.701 (30) 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.”

33. 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.

34. 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.

35. In accordance with the above controlling authorities, the respondent determined the petitioner’s SFU as a household of two, based on her tax filing status.

36. Fla. Admin. Code R. 65A-1.707 sets forth the income and resource criteria for Medically Needy coverage. “For Medically Needy coverage groups, the amount by

which the gross income exceeds the applicable payment standard income level is a share of cost...”

37. The Medically Needy Income Level (MNIL) appears in The Policy Manual at Appendix A-7. Effective April 2017, the MNIL for a household size of two is \$387.

38. The above cited authorities and policies address income standards and limits, calculating countable income, and income budgeting in the Family-Related Medically Needy Program.

39. The undersigned carefully reviewed the respondent’s determination of the petitioner’s daughter’s SOC of \$1,707 and could not find a more favorable outcome. The undersigned concluded that the respondent’s action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program was correct.

### **DECISION**

1. Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner’s appeal for FAP benefits is denied and the respondent’s action is upheld.
2. The petitioner’s appeal for full Medicaid and the Medically Needy Program is denied and the respondent’s action is upheld.

### **NOTICE OF RIGHT TO APPEAL**

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

FINAL ORDER (Cont.)  
17F-03950, 04546  
PAGE- 15

DONE and ORDERED this 07 day of July, 2017,  
in Tallahassee, Florida.



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

**FILED**

Aug 17, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-03983

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 18 Seminole  
UNIT: 07ICP

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 2:19 p.m. on July 12, 2017.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:  
Department

Brian Meola, Esq.  
of Children and Families (DCF)

**STATEMENT OF ISSUE**

At issue is whether the respondent's (or the Department) action to deny the petitioner Institutional Care Program (ICP) Medicaid benefits, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

[REDACTED], the petitioner's daughter, appeared as a witness for the petitioner. Stan Jones, ACCESS Economic Self-Sufficiency Specialist II, appeared as a witness for the respondent.

The petitioner submitted one exhibit, entered as Petitioner Exhibit "1". The respondent submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record remained open through end of business day on July 12, 2017, for the respondent's witness to submit the Notice of Case Action (NOCA). The NOCA was received timely and entered as Respondent Exhibit "5". The record was closed on July 12, 2017.

### **FINDINGS OF FACT**

1. The petitioner (age 99) was admitted to [REDACTED] in November 2016.
2. On March 28, 2017, an ICP application was submitted for the petitioner. The application lists \$1,050.80 Social Security, \$1,564.90 and \$1,193 Veterans benefits as the petitioner's income (Respondent Exhibit 1).
3. The petitioner was over the \$2,205 ICP income limit to be eligible for ICP Medicaid.
4. A Qualified Income Trust (QIT) was opened for the petitioner in December 2016 in anticipation of applying for Medicaid.
5. On April 26, 2017, the Department received the petitioner's QIT. The QIT was approved by DCF legal on May 12, 2017 (Respondent Exhibit 2). However, the QIT was not funded until June 2017.
6. On May 13, 2017, the petitioner passed away.

7. The petitioner's representative and the petitioner's daughter agreed that the QIT was not funded until June 2017, due to a misunderstanding. The petitioner's daughter said she "thought" that the QIT was not to be funded until the petitioner was "qualified".
8. On June 7, 2017, the Department mailed the petitioner's daughter a NOCA, notifying the petitioner's March 28, 2017 application was denied (Respondent Exhibit 5).
9. The petitioner's representative requested consideration to the petitioner's ICP denial, due to an honest mistake in not funding the QIT until June 2017.

### **CONCLUSIONS OF LAW**

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
11. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.
12. *Florida Administrative Code* R. 65A-1.713, "SSI-Related Medicaid Income Eligibility Criteria" in part states:
  - (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows...
    - (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C...
  - (2) (d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS...
  - (4) (b) For institutional care, hospice, and HCBS waiver programs the department applies the following methodology in determining eligibility:

1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month...

13. The above authority explains that gross income cannot exceed 300% of the SSI federal benefit rate to be eligible for ICP benefits. And an income trust may be established for those that exceed the income standard.

14. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-10 sets the federal benefit rate for an individual at \$735 (300% of \$735 = \$2,205).

15. Policy Manual, Appendix A-9, sets \$2,205 as the ICP income standard for an individual.

16. The Findings establish that the petitioner's income exceeded the \$2,205 ICP income limit. And the petitioner's QIT was not funded until June 2017. Therefore, the petitioner was over the \$2,205 ICP income limit.

17. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes that the respondent's action to deny the petitioner ICP Medicaid benefits, is proper.

### **DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 17 day of August, 2017,

in Tallahassee, Florida.

*D. Peterson*

---

Priscilla Peterson  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency  
Brian Meola, Esq.  
Tom Willoughby, JD

**FILED**

Aug 16, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 17F-03987

PETITIONER,

Vs.

CASE NO. 

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 12, 2017 at 1:30 p.m.

**APPEARANCES**

For Petitioner: 

For Respondent: Stan Jones, Economic Self Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner appeals Respondent's action denying her Institutional Care Program (ICP) Medicaid application. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

 appeared as an observer, on behalf of Petitioner, without party objection.

Petitioner did not submit any exhibits on the record. Respondent submitted an evidence packet, which was not entered on the record. After the hearing, Respondent's evidence was entered into the record and marked as Respondent's Exhibits "1" – "7." The undersigned did not enter Respondent's exhibit pages 3 – 6 into evidence as it consisted of notices created by the Office of Appeal Hearings and already included on the docket. The record was left open until 5:00 p.m. on June 14, 2017 for Petitioner to submit a copy of the signed Financial Information Release (FIR). Petitioner timely submitted the FIR, which was accepted into evidence and marked as Petitioner's Exhibit "1." Respondent also timely submitted an additional exhibit, which was accepted into evidence and marked as Respondent's Exhibit "8." The record closed on June 14, 2017.

#### **FINDINGS OF FACT**

1. Petitioner was admitted to [REDACTED] on January 23, 2017 and was still residing there at the time of hearing (Respondent's Exhibit 4).
2. On March 13, 2017, the staff at CCCC submitted an application for ICP Medicaid benefits on Petitioner's behalf (Respondent's Exhibit 2).
3. The March 13, 2017 ICP application indicated Petitioner had no assets and received Social Security Disability Income (SSDI) monthly (Respondent's Exhibit 2, Page 3).
4. The comments on the March 13, 2017 ICP application indicated CCCC was seeking ICP Medicaid for Petitioner based on hardship, as her family brought her to the facility and refused to provide any assistance regarding her financial information (Respondent's Exhibit 2, Page 2).

5. When Respondent electronically verified Petitioner's Social Security Administration (SSA) benefits, it was discovered she had a bank checking account, in which her SSA benefits were deposited (Respondent's Exhibit 5). There was no indication with which bank the checking account was opened.

6. On March 14, 2017, Respondent mailed a Notice of Case Action (NOCA) to Petitioner at CCCC's address of record requesting the following information by March 24, 2017:

Please Complete and sign the "Financial Information Release" form.  
Other – please see comments below:

The following information is need to complete this application: signed financial release/ bank statements begin date 11/2016 to current (with bank name on all pages) for all bank accounts / verification of all income and all assets which include life insurance/face/cash value {copies of check, direct deposit on bank statements and year-end tax statements 1099-R forms are not proof} / proof of any medical or RX premiums / completed 3008 pg 1 & 2, signed informed consent, h&p and medical packet to be forwarded to cares.

Please return or fax the information to the return address or fax number listed above. If you need help getting the information, let us know right away.

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.

(Respondent's Exhibit 3, Page 1)

7. On March 28, 2017, Petitioner faxed a signed FIR to Respondent as requested in the March 14, 2017 NOCA (Petitioner's Exhibit 1).

8. Petitioner contacted Respondent twice to express difficulty in obtaining the required bank statements and requested assistance from Respondent (Petitioner's Testimony).

9. On April 13, 2017, Respondent mailed a NOCA to Petitioner at CCCC's address of record denying her March 13, 2017 ICP application for March, April, and May, 2017 as it "did not receive all the information requested to determine eligibility" (Respondent's Exhibit 3, Page 2).

10. Petitioner's representative argued that she submitted a signed FIR, which should allow Respondent to request the required bank statements for verification (Petitioner's Testimony).

11. Respondent argued that without knowing which bank the checking account was opened with, it cannot use the FIR to request the bank statements as it does not know with which bank to make the request (Respondent's Testimony).

### **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 Rule 65A-1.710 defines SSI-Related Medicaid Coverage Groups and 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.

15. The Code of Federal Regulations Title 20, Section 416.1201, Resources;

general, states in relevant part:

(a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

...

(b) Liquid resources. Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit) and similar items. Liquid resources, other than cash, are evaluated according to the individual's equity in the resources. (See §416.1208 for the treatment of funds held in individual and joint financial institution accounts.)

16. Florida Administrative Code Rule 65A-1.716, Income and Resource Criteria, establishes the resource limits for SSI-Related Programs as \$2,000 per individual.

17. The above cited authorities state that bank accounts are considered countable assets for the SSI-Related Medicaid Programs, including ICP, and that resources cannot exceed \$2,000 for an individual. Therefore, Respondent was correct to request verification of Petitioner's checking account as it must determine if she meets the established asset limits.

18. Florida Administrative Code Rule 65A-1.205 addresses the eligibility determination process and states in relevant part:

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

appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time. If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.

...

(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. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension...

19. The above cited authority states that it is Petitioner's responsibility to furnish information needed to establish eligibility. If Respondent determines that additional information is required to establish eligibility, it must notify Petitioner so that he, or she, can provide the requested information. Though Respondent is directed to provide assistance in obtaining verification when requested, the ultimate responsibility for providing this verification rests with Petitioner. If Petitioner does not provide required verifications or information the application will be denied.

20. As required, on March 14, 2017, Respondent notified Petitioner that it required verification of her bank account in order to establish eligibility. Though Petitioner requested assistance in obtaining this information, Respondent was not able to provide the assistance as it was not informed from which bank to request the verification.

Petitioner's representative requested approval for ICP Medicaid based on hardship, however, neither the Code of Federal Regulations nor the Florida Administrative Code Rules provide for hardship approval. Ultimately, Petitioner failed to provide the required verification of her bank account as requested.

21. In careful review of the cited authorities and evidence, the undersigned concludes Petitioner did not meet her burden of proof that Respondent's action denying her March 13, 2017 ICP application was incorrect. The undersigned concludes Respondent's action denying Petitioner's March 13, 2017 ICP application, due to failing to provide verification of her bank account, was 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 Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 16 day of August, 2017,

in Tallahassee, Florida.



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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

**FILED**

Jul 27, 2017

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-04033

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 01 Okaloosa  
UNIT: 88630

RESPONDENT.

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 20, 2017 at 11:08 a.m.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:

Pat Hernandez, ACCESS Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of May 9, 2017 denying his application for SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

**PRELIMINARY STATEMENT**

The Department submitted evidence prior to the hearing. The evidence was entered as Respondent's Exhibit 1.

The record closed on July 20, 2017.

**FINDINGS OF FACT**

1. The petitioner filed an application for SSI-Related Medicaid on January 30, 2017. The petitioner is 54 years old and has no minor dependent children in the household. (Respondent Exhibit 1, page 3 through 8)

2. The petitioner reported his diagnosis including [REDACTED]  
[REDACTED] The petitioner reports all of these conditions were existing prior to his application for Social Security.

3. The petitioner filed for disability through the Social Security Administration (SSA) on January 25, 2017. The petitioner notified SSA of all of his conditions at that time. (Respondent Exhibit 1, pages 41 through 49)

4. The Department testified that the petitioner was denied disability by SSA on May 5, 2017.

5. The Department reported that petitioner filed an appeal of the SSA decision on May 17, 2017.

6. The petitioner confirmed the date of SSA denial and appeal as listed in paragraphs 4 and 5 are accurate.

7. The petitioner reported he has been in the hospital in January 2016, September and October 2016 as well as January 2017 with the same conditions. He believes his condition is worse than when he first applied.

8. The petitioner reported he is unable to work due to his conditions, which leave him very tired, experiencing shortness of breath, unable to walk more than 20 feet or so at a time. He reports his medications assist, but he still has problems.

9. The Department submitted the petitioner's case to the Division of Disability Determinations (DDD) on February 8, 2017. (Respondent's Exhibit 1, pages 35)

10. DDD returned the Disability Determination and Transmittal to the Department on May 8, 2017. The disability was denied with reason N32. The primary diagnosis was [REDACTED]. The secondary diagnosis is [REDACTED]. The transmittal indicated this was a "Hankerson" case. (Respondent's Exhibit 1, pages 35)

11. The Department explained that "Hankerson" meant that a decision had been made by Social Security and the DDD adopted that decision.

12. The Department explained the reason code N32 means: non-pay – capacity for substantial gainful activity – other work, no visual impairment.

13. The Department issued a Notice of Case Action on May 9, 2017 denying the petitioner's January 30, 2017 application for SSI-Related Medicaid citing the reason for denial as: "You or a member of your household do not meet the disability requirement". (Respondent Exhibit 1, pages 27 through 30)

14. There was no evidence presented to show that Social Security has refused to consider any worsening condition.

#### **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. 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 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.

18. 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.

19. 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).

20. 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.)

21. 42 C.F.R. § 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.

(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section—

**(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.**

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

**(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.**

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

...

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

**(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—**

**(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or**

**(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility. (emphasis added)**

22. The undersigned explored potential eligibility for SSI-Related Medicaid for the petitioner. The findings show the petitioner was 54 years old at the time of application. In accordance with the above controlling authorities, the undersigned concludes as the petitioner is under the age of 65, he must meet the disability requirement for eligibility for SSI-Related Medicaid.

23. The findings show the petitioner applied for Social Security disability and was denied on May 5, 2017. The findings show the petitioner appealed the denial of

Social Security disability on May 17, 2017. According to the above controlling authorities, a decision made by SSA within 12 months of the application is controlling and binding on the state agency **unless** the applicant reports a new or worsened condition that SSA has refused to consider. In the instant case, the petitioner did not report a new or worsened condition since the May 2017 denial.

24. Based on the evidence and testimony presented as well as the above cited rules and regulations, the undersigned concludes the SSA decision is binding on the Department. The undersigned further concludes the denial of SSI-Related Medicaid remains appropriate.

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

FINAL ORDER (Cont.)  
17F-04033  
PAGE - 8

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

*M. Roedel*

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Melissa Roedel  
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

**FILED**

Jul 12, 2017

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-04057  
APPEAL NO. 17F-05110

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 June 26, 2017 at 11:36 a.m.

**APPEARANCES**

For the Petitioner: The petitioner was present and represented herself.

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

**ISSUE**

At issue is the Department's action on May 19, 2017 to reduce the petitioner's Food Assistance Program (FAP) benefits due to the imposition of a Child Support Enforcement (CSE) sanction against herself and her daughter for the FAP, effective

June 1, 2017. It is the respondent's contention that the petitioner and her daughter failed to cooperate with CSE.

Also at issue is the Department's action on May 19, 2017 to terminate Medicaid benefits for the petitioner and her daughter due to the imposition of a CSE sanction against her Medicaid benefits, effective June 1, 2017. It is the respondent's contention that the petitioner and her daughter failed to cooperate with CSE.

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

### **PRELIMINARY STATEMENT**

Evidence was submitted and admitted as the Respondent's Exhibits 1 through 2.

The record was closed at the conclusion of the hearing.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner, her two children, and her two grandchildren were receiving FAP and Medicaid benefits.

2. On, or around, April 28, 2017, the Department received a data exchange alert on its Data Exchange Inquiry Child Support Sanction screen (DECS), which requests sanctions to be imposed due to failure to cooperate with CSE. The Department imposed a child support sanction against the petitioner and the petitioner's daughter, JG. The Department terminated FAP and Medicaid benefits for the petitioner and JG, for failure to cooperate with CSE.

3. On, or around, May 19, 2017, the Department terminated the FAP and Medicaid benefits for the petitioner and JG for failure to cooperate with CSE, effective June 1, 2017.

4. The petitioner acknowledges that she received an appointment letter from CSE to attend an appointment in April 2017 but was unable to attend the appointment due to her work schedule. The petitioner argues that she visited the CSE office on May 8, 2017 and was informed that she could not speak with an employee because she did not have an appointment. The petitioner contends that she completed another referral in order to get another appointment. The petitioner contends that after she completed the second referral, another employee with CSE informed her that she was permitted to come in to the local office without an appointment, which was contradictory to what she was told during the first visit on May 8, 2017. The petitioner argues that CSE was not able to accommodate her and that she was given incorrect information, which prevented her from being in compliance with the CSE requirements.

5. The respondent contends that CSE informed the Department by email, that the petitioner and JG did not attend an appointment for an office visit. The respondent attempted to contact a representative with CSE to attend the hearing to provide testimony but was not able to obtain a witness.

#### **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.

8. 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.

9. 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.

10. The Fla. Admin. Code R. 65-2.060, Evidence, states in part:

(1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

11. The above authority sets forth the rules for assigning the burden of proof in an administrative hearing. The Department held the burden of proof, as it terminated the petitioner’s and her daughter’s Medicaid benefits and reduced the petitioner’s FAP benefits. The Department asserts its action of reducing FAP and terminating Medicaid was due to the petitioner’s and her daughter’s failure to cooperate with CSE. The Department contends that the CSE employee reported by email that the petitioner and her daughter did not keep the appointment to meet with an employee with CSE. The

petitioner acknowledges that she and her daughter did not keep the appointment. The petitioner puts forth her reasons for non-compliance as not being able to keep the appointment due to her work schedule and not being able to get into contact with an employee with CSE to reschedule the appointments for herself and her daughter. There was no evidence or testimony from a representative from CSE that can be relied on to prove the correctness of the CSE sanction for non-cooperation. Therefore, the Department failed to meet its burden of proof regarding the correctness of the CSE sanction; there was no representative from Child Support Enforcement to testify or present evidence to support the sanction action.

12. After carefully reviewing the evidence and controlling legal authorities, the undersigned cannot conclude that the imposition of the child support sanction against the petitioner was correct. Therefore, the respondent's action to reduce the petitioner's FAP and terminate the petitioner's and her daughter's Medicaid benefits effective June 1, 2017 is reversed. The Department is remanded with instructions to reinstate the petitioner's and her daughter's Medicaid benefits beginning June 2017 and restore FAP benefits at the previous level beginning June 2017, not duplicating any benefits already received.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The Department's action to impose a child support sanction against the petitioner and the petitioner's daughter in the Food Assistance Program and Medicaid Program is reversed. The Department is to take corrective action and reinstate the

Food Assistance Program, and Medicaid benefits to the levels received prior to the sanction action under appeal beginning June 1, 2017.

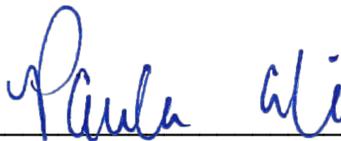
**ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.**

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

DONE and ORDERED this 12 day of July, 2017,

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](mailto:Appeal.Hearings@myflfamilies.com)

FINAL ORDER (Cont.)

17F-04057

PAGE -8

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

Jul 31, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 17F-04077

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 18 Seminole  
UNIT: 66032

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:35 a.m. on June 23, 2017.

**APPEARANCES**

For the Petitioner: , 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 Medicaid is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner did not submit exhibits. The respondent's representative submitted eight exhibits entered as Respondent Exhibits "1" through "8". The record was closed on June 23, 2017.

### **FINDINGS OF FACT**

1. On February 28, 2017, the petitioner (age 63) submitted a Food Assistance and Medicaid application for herself (Respondent Exhibit 2). Medicaid is the only issue.
2. To be eligible for Family-Related Medicaid, the petitioner must have minor children living at home or be pregnant. To be eligible for SSI-Related Medicaid, the petitioner must be age 65 or older or considered blind/disabled.
3. The petitioner does not have minor children, is not pregnant, is not age 65 or older, and has not been considered blind/disabled. Therefore, she is not eligible for Family-related or SSI-Related Medicaid.
4. On March 8, 2017, the Department mailed the petitioner a Notice of Case Action, notifying she is ineligible for Medicaid (Respondent Exhibit 3).
5. The petitioner said that although she is not disabled, she has medical conditions that require medical treatment.
6. The respondent's representative offered to mail the petitioner a list of medical facilities that might be able to assist her in receiving medical assistance.

### **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 *Florida Administrative Code R. 65-2.056*.

9. Medicaid eligibility is based on Federal Regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents and children, and pregnant women, and (2) SSI-Related Medicaid) for disabled individuals and adults 65 or older.

10. *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...

11. *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..."

12. Title 20 of the Code of Federal Regulations, section 416.905, Basic definition of disability for adults, in part states:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

13. Title 20 of the Code of Federal Regulations, section 416.903 addresses disability and blindness determinations and in part states, “(b) Social Security Administration. The Social Security Administration will make disability and blindness determinations...”

14. In accordance with the above authorities, to be eligible for Medicaid petitioner must have minor children, be pregnant, age 65 or older or be considered disabled/blind.

15. The evidence submitted establishes that the petitioner has no minor children, is not pregnant, is not age 65 or older and has not been determined disabled/blind. Therefore, the petitioner is not eligible for Medicaid.

16. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof. The undersigned concludes the Department’s action to deny the petitioner Medicaid, is proper.

**DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 31 day of July, 2017,

in Tallahassee, Florida.



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Priscilla Peterson  
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

Aug 16, 2017

Office of Appeal Hearings  
Dept. of Children and FamiliesSTATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

APPEAL NO. 17F-04084

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 10 Polk  
UNIT: 88582RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on June 19, 2017 at 12:03 p.m. All parties appeared by telephone from different locations.

**APPEARANCES**For the Petitioner: 

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

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of, May 15, 2017, enrolling her in the Medically Needy Program (MN) with a Share of Cost (SOC). Petitioner asserts that she was not notified of her ineligibility for full Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The Department of Children and Families (Department or respondent) administers eligibility for the Medicaid Program for the state of Florida. The Department presented evidence which was marked and accepted as Respondent's Exhibits "1" through "11" respectively. The record was closed on June 19, 2017.

### **FINDINGS OF FACT**

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

1. On March 20, 2017 the Department mailed a Notice of Eligibility Review to the petitioner notifying her that that it was time for a review of her Medicaid benefits and to submit an application for continued benefits, see Respondent's Exhibit 2.
2. On April 3, 2017, the petitioner submitted an application for Temporary Cash Assistance, Food Assistance and Medicaid. The petitioner, age 27, is married and lives with her husband and two minor children ages 4 years old and 6 months. The petitioner and her spouse are not tax dependents and will be filing taxes jointly. The household's sole source of income is the husband's job at [REDACTED], see Respondent's Exhibit 4.
3. On April 5, 2017, the Department mailed a Notice of Case Action informing the petitioner that her Medicaid would be ending on April 30, 2017. She had received full Medicaid through the Medicaid for Pregnant Women (MMP) category. MMP provides Medicaid for eligible pregnant women. Expectant mothers approved for MMP may receive Medicaid coverage through the month of birth of their child plus two months

post-partum coverage. Her baby was born [REDACTED] and she received Medicaid through April 30, 2017, see Respondent's Exhibit 2.

4. On April 14, 2017, the Department mailed a Notice of Case Action informing the petitioner that the household was not eligible for Temporary Cash Assistance as the household's income was too high. This notice also informed the household of their ongoing eligibility for Food Assistance benefits and the monthly amount. This notice did not address Medicaid eligibility, see Respondent's Exhibit 2.

5. On May 5, 2017, the petitioner contacted the agency inquiring about Medicaid coverage for herself. According to the case notes, the Department explained to the petitioner what a Share of Cost was, see Respondent's Exhibit 9.

6. On May 12, 2017, the petitioner contacted the agency inquiring as to why she had not received a notice about the household's eligibility for Medicaid, see Respondent's Exhibit 9.

7. On May 15, 2017, the Department mailed a Notice of Case Action to the petitioner. The petitioner was determined ineligible for full Medicaid based on her husband's earnings from [REDACTED], see Respondent's Exhibit 9. The petitioner was notified of enrollment into the Medically Needy Program for both the petitioner and her husband. No estimated Share of Cost was given on this notice.

8. On May 23, 2017, the petitioner timely appealed her enrollment into the Medically Needy program and the denial of full Medicaid coverage for herself.

9. On June 14, 2017, the Department mailed a Notice of Case Action to the petitioner that stated that her application for Medically Needy was approved with an

estimated Share of Cost of \$1280 for both she and her husband, see Respondent's Exhibit 2.

10. The Department determined that the petitioner's Medicaid Standard Filing Unit (SFU) size is two (2) and consists of the petitioner and her spouse. The petitioner's countable monthly gross income of \$1,787.48 consists of her husband's wages from [REDACTED] see Respondent's Exhibit 6. The petitioner did not dispute the amount of income used in the budget.

11. The Medically Needy Income Level (MNIL) is \$387 for a SFU size of two. The MNIL includes the appropriate standard disregard. In this instant case, the MNIL used is  $\$241 + \$146 = \$387$ , see Respondent's Exhibit 10.

12. The Department's calculation of the Medically Needy benefit is as follows: The gross earned income of the petitioner's husband is \$1,787.48. The modified adjusted gross income (MAGI) is \$1,787.48. The Department deducted the MNIL of \$387 from the MAGI of \$1,787.48 leaving a balance of \$1,400 ( $\$1,787.48 - \$387 = \$1,400$ ). The Department deducted \$120 in Medical Insurance Premium from the balance of \$1,400. The \$120 is the amount that her spouse pays for his employer provided medical insurance. The balance of \$1,280 is the estimated Share of Cost ( $\$1,400 - \$120 = \$1,280$ ).

13. The MAGI Disregard of \$68 for a household of two (5% of 100% of the Federal Poverty Level) was not applied to the budget as households are only eligible if the deduction would make a household failing for Medicaid eligible once applied. The MAGI Disregard is not used in Medically Needy budgets.

14. The petitioner felt that she did not receive adequate adverse action notice and because of that, she missed the open enrollment deadline for inclusion on her husband's medical insurance. If she had known and/or understood that she was no longer eligible for full Medicaid, the petitioner asserted that her husband would have added her to ensure that she continued receiving medical coverage as she has critical health issues that must be addressed. She stated that she and her husband are unable to afford the out-of-pocket expenses required for her care, Petitioner'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 409.285 Florida Statutes. This Order is the final administrative decision of the Department of Children and Families under 409.285, Florida Statutes.

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

17. Federal regulations at 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (d) defines family size and provides guidance for budgeting income. It states:

b) *Definitions*. For purposes of this section—

...

*Family size* means the number of persons counted as members of an individual's household. ...

(c) *Basic rule*. Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on "household income" as defined in paragraph (d) 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.

...

(e) *MAGI-based income*. For the purposes of this section, MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code, ...

...

(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.

...

(4) *Married couples*. In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under section 6013 of the Code or whether one spouse expects to be claimed as a tax dependent by the other spouse.

...

h) *Budget period*—(1) *Applicants and new enrollees*. Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

(2) *Current beneficiaries*. For individuals who have been determined financially-eligible for Medicaid using the MAGI-based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remainder of the current calendar year.

(3) In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors, in accordance with the income and eligibility verification requirements at §435.940 through §435.965, including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections.

18. In accordance with the above controlling authorities, the Medicaid Standard Filing Unit is the petitioner, her spouse and two children equaling a household size of four (4). The findings show the Department determined the petitioner's eligibility for Medicaid using a household size of two.

19. The Department's Program Policy Manual, CFOP 165-22, passage 2630.0108 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). (emphasis added)

20. The Department's Program Policy Manual, CFOP 165-22, Appendix A-7 (Effective April 1, 2017) indicates the Family-Related Medicaid Income Limit as \$241 and a Standard Disregard of \$146 for a two-person filing unit. The Medicaid Income Limit for a household of four is \$364 with a Standard Disregard of \$221 totaling \$585 as the MNIL. The 5% MAGI Disregard for a household of four is \$103.

21. 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 \$1,787.48. Step 2: The total income of \$1,787.48 less the standard disregard of \$146 is \$1,641.48. Step 3: The balance of \$1,641.48 is greater than the income limit of \$241 for a SFU of two. Step 4: Apply the MAGI disregard if the disregard would make the household eligible for Medicaid. The household would not be eligible if the \$68 disregard is applied. With no MAGI disregard applied, the countable balance remains \$1,641.48. This amount was greater than the income limit of \$241. The undersigned concludes that the petitioner is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored.

In reviewing the budget, the undersigned noted that the Standard Filing Unit should be for a household of four (4) not two (2) and that the Medical Deduction should be slightly higher. The calculations for this finding will be addressed below.

22. The Department's Program Policy Manual, CFOP 165-22, passage 2630.0502 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 Department's Program Policy Manual, CFOP 165-22, passage 2630.0500 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. (emphasis added)

24. The Department's Program Policy Manual, CFOP 165-22, Appendix A-7 indicates that the MNIL is \$387 for a standard filing unit of 2. To determine petitioner's SOC the respondent determined the petitioner's household monthly income to be \$1,787.48. The Medically Needy Income Level of \$387 for a standard filing unit size of two was subtracted resulting in a SOC of \$1400. The husband's medical insurance premium of \$120 was deducted from the SOC of \$1400 resulting in a remaining estimated SOC of \$1,280.

Using the Medically Needy Income Level of \$585 for a standard filing unit size of four, subtract the MNIL from \$1,787.48. This results in a SOC of \$1,202.48. The paystubs used in determining the monthly gross earned income also show that the spouse pays \$34.30 weekly for Medical and Dental coverage ( $\$34.30 \times 4 = \$137.20$ ). Deducting the husband's medical insurance premium of \$137.20 results in a remaining estimated SOC of \$1,065.28.

25. After carefully considering the testimony and evidence presented, along with the pertinent rules and regulations stated above, the undersigned determines that the petitioner is ineligible for Medicaid and was correctly enrolled into the Medically Needy Program with an estimated Share of Cost. The undersigned further determined that the

petitioner was notified via the Notice of Case Action on April 5, 2017 that “the Medicaid coverage for your pregnancy has ended” and the Notice of Case Action dated May 15, 2017 notified the petitioner of enrollment into the Medically Needy Program with a Share of Cost. The undersigned finds that the petitioner is not eligible for Medicaid due to the household’s income being over the income limit for a four person household. According to policy, the petitioner was eligible for and enrolled in the Medically Needy program with an estimated Share of Cost.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the Department’s action to enroll the petitioner in the Medically Needy Program is affirmed. This case is REMANDED to the Department to correct the household size and the Medical deductions and notify the petitioner of the lower estimated SOC.

### **NOTICE OF RIGHT TO APPEAL**

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

FINAL ORDER (Cont.)  
17F-04084  
PAGE -11

DONE and ORDERED this 16 day of August, 2017,  
in Tallahassee, Florida.



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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

Jul 31, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-04199

PETITIONER,

Vs.

CASE NO. 1 [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 18 Brevard  
UNIT: 55207

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:17 a.m. on July 3, 2017.

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: Stan Jones, ACCESS  
Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

At issue is whether the respondent's (Department) action to increase the petitioner's Medically Needy (MN), Share of Cost (SOC), is proper. The respondent carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The petitioner was present and did not provide testimony. The petitioner did not submit exhibits. The respondent submitted six exhibits, entered as Respondent Exhibits “1” through “6”. The record was closed on July 3, 2017.

**FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner received MN with a \$736 SOC.
2. On March 2, 2017, the petitioner submitted a Food Assistance and Medicaid application (Respondent Exhibit 1). Only Medicaid for the petitioner is at issue.
3. The petitioner receives \$937 Social Security Disability Income (SSDI) (Respondent Exhibit 5).
4. The following is the Department’s calculation of the petitioner’s SOC (Respondent Exhibit 3):

\$937	SSDI	
-\$ 20		unearned income disregard
-\$180		MN income limit (MNIL)
<hr/>		
\$737	SOC	

5. On March 6, 2017, the Department mailed the petitioner a Notice of Case Action, notifying her SOC would increase from \$736 to \$737, effective April 1, 2017 (Respondent Exhibit 2).
6. The petitioner’s mother argued that after the petitioner pays the monthly \$737 SOC, it only leaves the petitioner \$200 to live on.
7. The respondent’s representative explained that the petitioner does not pay \$737 SOC every month. That the petitioner needs to incur \$737 medical expenses monthly for Medicaid to cover the medical expenses.

8. The petitioner's mother said one of the petitioner's prescriptions is \$1,000 monthly.
9. The respondent's representative explained the \$1,000 medical expense exceeds the \$737 SOC, which will be covered by Medicaid. And the petitioner will have full Medicaid for the duration of the month, once the \$737 SOC is met. However, the petitioner must submit the bill to the Department for "bill tracking".

### **CONCLUSIONS OF LAW**

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
11. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.
12. The *Florida Administrative Code* R.65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in part:

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

(4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service... To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months...

13. The above authority explains MN SOC is determined by the individual's income amount (minus deductions) over the MN income limit. And unpaid medical expenses must be submitted to meet the SOC (bill tracking). It also explains the criteria for paid medical expenses.

14. Title 20 of the Code of Federal Regulations Section 416.1124 explains unearned income not counted and states in part "(c) Other unearned income we do not count... (12) The first \$20.00 of any unearned income in a month..."

15. The *Florida Administrative Code* R. 65A-1.716 sets forth the MNIL at \$180 for a family size of one.

16. In accordance with the above authorities, the Department deducted \$20 and \$180 from the petitioner's \$937 SSDI to arrive at \$737 SOC.

17. In careful review of the cited authorities and evidence, the undersigned concludes that the respondent met its burden of proof. The undersigned concludes the respondent's action to increase the petitioner's SOC from \$736 to \$737, is proper.

### **DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 31 day of July, 2017,

in Tallahassee, Florida.

*D. M. D.*

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

**FILED**

Aug 04, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-04265

PETITIONER,

Vs.

CASE NO [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 12 MANATEE  
UNIT: 88326

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 10<sup>th</sup>, 2017, at 10:26 a.m.

**APPEARANCES**

For the Petitioner: The petitioner was not present but was represented by [REDACTED], Disability Representative.

For the Respondent: Ed Poutre, Senior Worker for the Department of Children and Families.

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to deny her SSI-Related Medicaid application. The petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

Petitioner's composite 1 was admitted into evidence.

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

By way of a Notice of Case Action (NOCA) dated May 3<sup>rd</sup>, 2017, the respondent informed the petitioner that her application for Medicaid dated March 27<sup>th</sup>, 2017, was denied because she did not meet the disability requirement. On May 31<sup>st</sup>, 2017, the designated representative filed a timely request to challenge the respondent's action on the petitioner's behalf.

### **FINDINGS OF FACT**

1. [REDACTED] submitted an online application for SSI-Related Medicaid on the petitioner's behalf on March 27<sup>th</sup>, 2017. (See Respondent's Exhibit 2).
2. The petitioner is a single-person household and was age 54 at the time of the application. There are no children under the age of 18 living in the petitioner's household. [REDACTED] contends that the petitioner is unable to work and is disabled.
3. [REDACTED] asserts that the petitioner applied for through the Social Security Administration (SSA). However, SSA denied the application. [REDACTED] believes the denial to be based on a technical reason but was unable to provide evidence at the time of the hearing. The respondent provided, as part of its evidence, a screen shot of the State Online Query (SOLQ) system. The SOLQ screen shot shows that the petitioner applied for benefits through SSA on February 7<sup>th</sup>, 2017. SOLQ also shows a denial date of April 19<sup>th</sup>, 2017, and has an accompanying denial code of N32. (See Respondent's Exhibit 4). According to the SOLQ user guide, the denial code of N32 means "Non-pay – Capacity for substantial gainful activity – other work, no visual impairment." The screen shot does not indicate that the denial has been appealed.
4. [REDACTED] described the petitioner's conditions as [REDACTED], [REDACTED] diagnosis in 2016, and [REDACTED]

██████████ (COPD). ██████████ is unsure of what conditions were listed on the SSA application.

5. The respondent provided, as part of its evidence, a copy of its business notes (CLRC). A CLRC entry indicates that the respondent completed a disability Medicaid interview with on April 26<sup>th</sup>, 2017. However, the notes do not indicate who was interviewed. (See Respondent's Exhibit 7). The respondent asserts that it is possible that medical records were reviewed in lieu of a disability interview. CLRC also makes mention that the petitioner's medical records were sent to the Department of Disability Determination (DDD) for review the same day. The respondent testified that DDD returned an unfavorable decision on May 4<sup>th</sup>, 2017. The conditions reviewed by DDD are listed as COPD and affective disorder. According to the respondent, DDD denied the disability Medicaid because it adopted the previous decision made by SSA in April 2017. (See Respondent's Exhibit 5).

#### **CONCLUSIONS OF LAW**

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

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

8. The Code of Federal Regulations at 42 C.F.R. Section 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 Section 435.911 on the same issue presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility... (b) Effect of SSA determinations. **(1)(i) An SSA disability determination is binding on an agency until the determination is changed by SSA...** *[Emphasis added]* (c) Determination 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 disability condition different from, or in addition to, that considered by SSA in making its determination...

9. The above federal regulation indicates that the Department may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in Section 435.911 on the same issues presented in the Medicaid application. The regulation also states that the Department must make a determination of disability if the individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA and alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination or alleges more than 12 months after the most recent SSA determination. The Department is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA.

10. The hearing officer must consider whether or not the respondent took the correct action on the petitioner's Medicaid application. As established in the Findings of Fact, the petitioner conditions are described as, [REDACTED]

[REDACTED] According to the authorized representative,

she is unsure what conditions were listed on the SSA application. The findings show that the petitioner did not appeal the SSA denial. Therefore, the hearing officer concludes that the respondent's action to deny the petitioner's SSI-Related Medicaid application was correct. The petitioner must exercise appeal rights through the SSA in the event that she disagrees with that decision.

**DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 04 day of August, 2017,

in Tallahassee, Florida.



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

**FILED**

Aug 21, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

PETITIONER,

Vs.

APPEAL NO. 17F-04169  
17F-04296

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 09 Orange  
UNIT: 55207

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on June 22, 2017 at 9:45 a.m. and reconvened on July 25, 2017 at 8:30 a.m.

**APPEARANCES**

For the petitioner: [REDACTED]

For the respondent: Marsha Shearer, ACCESS Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to terminate the household's Food Assistance Program (FAP) and Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence on the FAP issue and the respondent carries the burden of proof by a preponderance of the evidence on the Medicaid issue.

**PRELIMINARY STATEMENT**

Serving as translator telephonically on June 22, 2017 from Language Line was employee number 254547 and on July 25, 2017 from Language Line was employee number 259592.

At the outset of the hearing on June 22, 2017, the petitioner explained the issue was the FAP amount of \$73.00 beginning July 2017. The petitioner was seeking the maximum FAP allotment of \$194.00 (one household member was eligible). The petitioner also had an issue with the respondent's action to terminate his and his wife's Medicaid benefits; and to terminate his child's full Medicaid benefits and enroll her in the Medically Needy (MN) Program with a share of cost (SOC).

A pre-hearing conference was completed with the petitioner on June 13, 2017. During the pre-hearing conference, the respondent realized it had caused an error. Based on the findings, the respondent terminated the household's FAP and Medicaid benefits beginning July 1, 2017. The petitioner was challenging the respondent's action to terminate his household's FAP and Medicaid benefits.

The record was fully developed on June 22, 2017; however; the petitioner believed he was not given enough time to testify regarding his expenses. The undersigned reset the hearing to allow the petitioner an opportunity to testify regarding his expenses. The hearing was reset for July 17, 2017 at 2:15 p.m.

On July 17, 2017, the respondent and the undersigned dialed in at the scheduled time and waited fifteen minutes for the petitioner to dial in. The petitioner did not appear. After the scheduled hearing, the petitioner contacted the office requesting to reschedule the hearing. The petitioner explained since the notices are written in English

he did not understand the language and instructions to dial in to the hearing. The undersigned granted the petitioner's continuance request and reset the hearing for July 25, 2017. As the notices are written in English, on July 25, 2017, the respondent accommodated the petitioner by dialing him into the conference call.

The petitioner did not submit any exhibits. The respondent submitted five exhibits, which were accepted into evidence and entered as Respondent's Exhibits "1" through "5". On June 22, 2017, the record was held open until close of business on June 30, 2017 for submission of additional evidence from the respondent. On June 22, 2017, additional evidence was received from the respondent, which was accepted into evidence and entered as Respondent's Exhibit "6". The record originally closed on June 30, 2017; however, the hearing reconvened on July 25, 2017. Therefore, the record closed on July 25, 2017.

### **FINDINGS OF FACT**

1. The petitioner's household consists of himself, his wife and their mutual child (age 9). Prior to the action under appeal, all three household members received Medicaid benefits. The household received \$54.00 in FAP benefits for one (child) household member instead of three members. The household's benefits were certified through June 30, 2017.
2. On May 18, 2017, the petitioner submitted an application to recertify for FAP and Medicaid benefits. On the application, the petitioner reported his and his wife's country of birth as "other". The petitioner reported his daughter was born in the United States.
3. On May 25, 2017, the respondent notified the petitioner that his household was approved for \$73.00 in FAP benefits beginning July 1, 2017 and that Medicaid benefits

would end on June 30, 2017. The household was enrolled in the MN Program with a SOC. The petitioner did not agree with the FAP amount. On May 25, 2017, the petitioner requested a hearing as he was seeking an increase in the FAP benefits.

4. On June 13, 2017, the respondent conducted a pre-hearing conference with the petitioner. As part of the eligibility and review process, the respondent verified the petitioner's household's citizenship. The respondent used the Department of Homeland Security's SAVE Program. Based on the data, the respondent verified that all three household members were born in Egypt and had obtained Temporary Employment Authorization status on March 5, 2015, which will expire on October 26, 2018.

5. Upon reviewing the case, the respondent realized the household was not eligible for FAP and Medicaid benefits based on the citizenship status. The petitioner's household had been approved for these benefits in error. On June 14, 2017, the respondent issued the petitioner a Notice of Case Action notifying him that the household's FAP and Medicaid benefits would end effective June 30, 2017.

6. The respondent explained to be potentially eligible for FAP and Medicaid benefits, the petitioner and his household must have resided in the U.S. as Lawful Permanent Residents (LPRs) for a period of five years or have another qualified alien status. The petitioner and his household have not obtained LPR status or any other qualified alien status. Therefore, his household is not eligible for FAP and Medicaid benefits.

7. After further review, the respondent determined the petitioner's child continued to be eligible for Medicaid benefits due to a July 2016 House Bill which provides eligibility for lawfully residing noncitizen children with a valid Visa. However, the petitioner's child was not eligible for full Medicaid benefits due to the household's income of \$3,332.50.

On June 14, 2017, the respondent notified the petitioner that his child was enrolled in the MN Program with an SOC of \$2,776.00 beginning July 2017.

8. The petitioner did not dispute the income or the MN SOC amount because he was seeking full Medicaid benefits for his household. During the hearing, the petitioner reported his wife's income has changed. Additionally, the petitioner explained he submitted an application for asylum (form I-797C) for his family to the Department of Homeland Security on April 22, 2015, which still remains pending.

### **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. 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...

12. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1430.0100, addresses Citizenship/Noncitizen Status (MFAM). It states, "The eligibility determination must include an evaluation of the citizenship/noncitizen status for each individual who applies for Medicaid."

13. The Code of Federal Regulations at 7 C.F.R. § 273.4, Citizenship and alien status stats 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.

(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):

(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. 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).

14. 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 a 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.

15. The Policy Manual, CFOP 165-22, passage 1410.0107, Asylees (FS) sets forth the following:

Noncitizens granted asylum under Section 208 received permission to remain in the U.S. based on a "well-founded fear of persecution" should the individual return to the individual's native land may be considered for asylum. A prospective asylee applies for asylum after entering the U.S., a U.S. territory or a U.S. embassy.

Proof of this status includes:

1. USCIS Form I-94 showing grant of asylum under Section 208,
2. USCIS Form I-688B (Employment Authorization Card) annotated 274a.12(a)(5),
3. USCIS Form I-766 (Employment Authorization Card) annotated A5,
4. grant of asylum letter from the Asylum Office of the USCIS,
5. order of an immigration judge granting asylum, or

6. other conclusive documentation of this status.

Note: Individuals granted asylum are not subject to the five-year ban.

16. According to the above-cited rules, a non-citizen must have a qualified alien status to be eligible for FAP and Medicaid benefits. The findings show that although the petitioner applied for asylum for himself, his wife and his child on April 22, 2015, they have not been granted asylum. Therefore, the undersigned concludes the petitioner, his wife and his child are not eligible for FAP benefits as they do not have a qualified alien status. Additionally, the petitioner and his wife are not eligible for Medicaid benefits as they do not have a qualifying alien status.

17. The Department of Children and Families published Transmittal No.: P-16-06-0005 on June 14, 2016, regarding "Medicaid Eligibility for Lawfully Residing Noncitizen Children up to age 19," it states in part:

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.

18. Pursuant to the above transmittal, the petitioner's child continues to be eligible for Medicaid benefits as she is considered a lawfully residing noncitizen child with a valid Visa.

19. The Policy Manual, Appendix A-7, Family-Related Medicaid Income Limits, sets the income limit for a child age 6 through 18, in a household size of three, as \$2,264.00, which is 133% of the Federal Poverty Level (FPL). The household's income of \$3,332.50 exceeds the income limit for the petitioner's child to be eligible for full Medicaid benefits.

20. On June 14, 2017, the respondent enrolled the petitioner's child in the MN Program with a SOC. Although the petitioner's child continues to meet a qualified alien status for Medicaid eligibility, she is not eligible for full Medicaid benefits due to the household's income. The undersigned is unable to find a better outcome for the petitioner than the respondent's action to enroll the petitioner's child in the MN Program with a SOC effective July 2017.

21. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes the respondent's action to terminate the household's FAP and the petitioner and his wife's Medicaid benefits was correct. The undersigned also concludes the respondent's action to terminate the petitioner's child's full Medicaid benefits and enroll her in the MN Program with a SOC effective July 2017 was correct.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the Department's actions are affirmed.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 21 day of August, 2017,

in Tallahassee, Florida.



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

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

Aug 21, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-04378

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 15 Palm Beach  
UNIT: 88701

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 17, 2017 at 11:38 a.m.

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: Eric Eckhardt, supervisor

**STATEMENT OF ISSUE**

The petitioner is appealing the termination of her son's (CH) Medicaid benefits. Only CH's Medicaid is at issue. The respondent carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The petitioner presented one exhibit which was accepted into evidence and marked as Petitioner's Composite Exhibit 1. The respondent presented five exhibits, which were accepted into evidence and marked as Respondent Exhibits 1 through 5.

### **FINDINGS OF FACT**

1. The petitioner and her three children were receiving Medicaid benefits from a prior certification.
2. On May 1, 2017, the petitioner submitted a recertification application for Food Assistance benefits and Medicaid benefits for herself (age 41) and her three children (CD age 20), (CH age 18) and (MB age 12). The application indicated that CH's date of birth and citizenship were verified.
3. On May 5, 2017, the respondent mailed a Notice of Case Action informing the petitioner that she needed to provide proof of identification for all household members who were age 16 and older. The notice specifically requested photo identification for CH. The requested information was due by May 15, 2017.
4. The respondent reviewed the case for processing and found the petitioner did not provide the requested photo identification for CH by the due date. The respondent updated the case and terminated CH's Medicaid benefits.
5. By notice dated June 1, 2017, the respondent informed the petitioner that Medicaid benefits for CH would end on June 30, 2017. The reason given for the termination was that proof of his identity was not received.
6. On June 6, 2017, the petitioner requested a hearing to challenge the respondent's action.
7. The petitioner argued that it was unnecessary for the Department to request proof of identification for CH, as he received Food Assistance benefits, Florida KidCare and Medicaid benefits for many years. She also asserted that her son does not have a

photo identification, as he lost his school identification and he does not have a driver's license or state identification.

8. The respondent asserted that even though CH was receiving Food Assistance, Florida KidCare and Medicaid benefits previously, he was still required to provide verification of identification when he turned age 16. The Department failed to request verification of his identity when he turned age 16, but it is still a requirement in order to receive Medicaid benefits. As of the date of this hearing, proof of CH's identity has not been provided to the respondent.

#### **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-1.705(8)(c)1 addresses identity and states, "prior to approval for Medicaid, children who are U.S. citizens must have their citizenship and identity verified unless they are exempt from the requirement as specified in 42 C.F.R. 435.406 (2007)."

12. Fla. Admin. Code R. 65A-1.704(2)(c)4 states, "U.S. citizens must provide proof of their U.S. citizenship and identity..."

13. The Department's Program Policy Manual CFOP 165-22 at passage 1430.0400 addresses Identity (MFAM) and further explains the required documentation for identity.

The identity of each U.S. citizen applying for, or receiving Medicaid must be documented...

The following documents are acceptable as proof of identity:

1. State driver's license with photo or other identifying information;
2. State ID card with photo or other identifying information;
3. School ID card with photo (for children under 16, includes nursery, daycare records, or school records, including school conference records and no photo is required);
4. Clinic, doctor, or hospital record for children under 16 (except for voided Puerto Rican birth certificates after September 30, 2010);
5. U.S. military card or draft record;
6. A military dependent's ID card;
7. Federal, state, or local government ID card with photo;
8. A certificate of Indian blood;
9. Native American tribal document;
10. Three or more of the following documents unless a fourth tier verification of citizenship was used:
  - a. Marriage license,
  - b. Divorce decree,
  - c. High school diploma,
  - d. Employer ID card, or
  - e. Any other document from a similar source...

Do not accept a Social Security card, birth certificate, voter's registration card or Canadian driver's license for identity verification.

14. The Department's Transmittal Number C-08-03-0005, U.S. Citizenship and

Identity Verification for Medicaid, dated March 6, 2008, states:

This memorandum provides policy clarification and an expanded list of allowable verifications of citizenship and identity for U.S. citizens applying for or receiving Medicaid...

The federal Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) requires states to verify citizenship and identity for Medicaid applicants and recipients who declare they are U.S. citizens...

Expanded List of Identity for Adults:

Staff may use a combination of at least three of the following documents to verify identity...

- marriage license,
- divorce decree,
- high school diploma,
- employer ID cards, or
- any other document from a similar source.

15. Fla. Admin. Code R. 65A-1.205, Eligibility Determination Process states:

(a)...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...

16. The above authority states that it is the petitioner's responsibility to provide the requested information to the Department within 10 days of the written notice. In this case, the petitioner was pended to provide verification of CH's identity and she failed to do it by the deadline date.

17. The petitioner did not provide the above documentation as verification of CH's identity. The respondent sent a Notice of Case Action dated May 5, 2017, advising the petitioner that she needed to provide verification of identity for her son CH. As of the date of this hearing, identity of CH has not been verified. There was no evidence presented to prove that the petitioner attempted to get the requested verification of identity for CH.

18. After carefully reviewing the governing authorities, evidence and testimony, the hearing officer concludes that the respondent followed procedure based on the above authority when it terminated Medicaid benefits for CH. It is a requirement for identity to be verified for all individuals 16 years and older. The respondent correctly followed the rules when it terminated the petitioner's son's Medicaid benefits.

**DECISION**

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

DONE and ORDERED this 21 day of August, 2017,

in Tallahassee, Florida.



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Christiana Gopaul-Narine  
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

**FILED**

Aug 07, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17F-04519  
APPEAL NO. 17F-05473

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 04 Duval  
UNIT: 88642

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned reconvened a telephonic administrative hearing in the above-referenced matter on July 25, 2017 at 11:40 a.m.

**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 Department's action on June 2, 2017 to deny the petitioner's application for Food Assistance Program (FAP) benefits on its contention that she was ineligible due to her income exceeding the FAP income guidelines.

Also at issue is the Department's determination to continue her enrollment in the Medically Needy program with an estimated share of cost in the amount of \$575.

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

### **PRELIMINARY STATEMENT**

The hearing originally convened on July 10, 2017 at 9:22 a.m.

Appearing as a translator for interpreter services was Rafael, identification number 250221.

The hearing required scheduling to reconvene for a later date due to the hearing exceeding the allotted time. The hearing was scheduled to reconvene on July 25, 2017 at 11:30 a.m.

The hearing convened as scheduled. Appearing as a translator for interpreter services was Leif Trueba.

Evidence was received and entered as the Respondent's Exhibits 1 through 3.

The record was held open until 5:00 p.m. on July 25, 2017 to allow the respondent to submit additional evidence. Evidence was received and entered as the Respondent's Exhibit 4.

The record was closed at 5:00 p.m. on July 25, 2017.

### **FINDINGS OF FACT**

1. On May 2, 2017, the petitioner, age 50, applied for FAP benefits for herself and her son, age 13 (*Respondent's Exhibit 2*). The petitioner listed on her application that she files taxes and that her son is her tax dependent. There was no evidence to show that the petitioner's son is included as a tax dependent on another individual's tax

return. The petitioner listed on her application that she is disabled and is receiving Social Security income in the amount of \$962. The Respondent's Exhibit 3, page 6, includes the SSA State On-line Inquiry Screen (DEB4), which shows that the petitioner's gross Social Security income is \$1087 and her net payments are \$962. The application also listed worker's compensation in the amount of \$2006.42. The petitioner's son is listed on the application as receiving Social Security income in the amount of \$223.

2. On May 5, 2017, the Department mailed to the petitioner the Notice of Case Action (NOCA) to inform her of the verifications needed to determine her eligibility for FAP benefits. The NOCA was written in Spanish; however, the NOCA included this statement: "Also, please provide proof of your worker's compensation income and how often you receive it by 05/15/2017." The NOCA included the fax number, [REDACTED] where verifications were to be submitted (*Respondent's Exhibit 2, page 1*).

3. The Department included in the FAP budget the petitioner's son's Social Security income in the amount of \$299, the petitioner's Social Security income in the amount of \$1087, and worker's compensation in the amount of \$2006.42, for a total gross income of \$3392.42. The petitioner was allowed the standard deduction of \$157. The petitioner was also allowed an out-of-pocket medical expense in the amount of \$125; the \$125 was reduced by the \$35 medical standard to result in an excess medical expense of \$90. The total unearned income in the amount of \$3392.42 was reduced by the \$157 standard deduction and the excess medical expense in the amount of \$90 to result in an adjusted net income of \$3145.42. The adjusted net income was multiplied by 50% to result in a \$1572.71 shelter standard. The petitioner was allowed a shelter

cost in the amount of \$1050 for rent and the standard utility allowance (SUA) in the amount of \$338, for a total shelter cost in the amount of \$1388. The Department subtracted the shelter standard in the amount of \$1572.71 from the \$1388 total shelter to equal to a \$0 excess shelter deduction. The excess shelter deduction was subtracted from the adjusted net income which resulted in \$3145.42 net income. The petitioner's \$3145.42 exceeded the net income standard of \$1335 for a household size of two; therefore, she was ineligible for FAP benefits (*Respondent's Exhibit 3, pages 4 through 5*).

4. The Respondent's Exhibit 3, page 5, includes the Family-Related Medicaid/Medically Needy Benefit Determination Budget (ABMG). The Department included the petitioner's gross monthly Social Security income in the amount of \$1087. The Medically Needy Income Limit for a household size of two, in the amount of \$387, was subtracted from the gross monthly income, to result in a share of cost in the amount of \$700. The Department further reduced the share of cost by subtracting the petitioner's Medicare Part B premium in the amount of \$125, for a remaining share of cost in the amount of \$575.

5. On June 2, 2017, the Department denied the petitioner's application for FAP benefits on its contention that the petitioner was ineligible for FAP benefits based on the \$2006.42 in worker's compensation, in addition to the Social Security income received by the petitioner and her son. The Department contends that the \$2006.42 figure was used in its calculations since the petitioner did not provide verifications of the worker's compensation. The Department continued the petitioner's enrollment in the MN

program with an estimated share of cost in the amount of \$575 (*Respondent's Exhibit 1*).

6. The petitioner disputes the Department's denial of her application for FAP benefits. The petitioner argues that her son is disabled and pays \$200 in out-of-pocket medical expenses. The petitioner argues that she has to purchase a uniform for her son, who will be attending a military school. The petitioner contends that she does not have enough money to pay all of her living expenses. The petitioner argues that her worker's compensation decreased to \$400 biweekly on May 15, 2017 or May 16, 2017. The petitioner contends that her son's Social Security income decreased to \$223 to repay an overpayment. The petitioner contends that her rent increased to \$1200 beginning May 2017. The petitioner was to submit, post-hearing, verification of the reduced payments in worker's compensation income and proof of the \$200 out-of-pocket medical expenses. The verifications were not received. The petitioner acknowledges receiving the NOCA requesting verifications but explained that she did not know where to submit the verifications.

7. The Department believes that the petitioner is aware of the fax number to use to provide verifications, as she has previously submitted verifications by fax. The Respondent's Exhibit 4 includes a fax that was received by the Department on February 1, 2017, indicating that the petitioner's worker's compensation equated to \$466.61 each week, paid biweekly in the amount of \$933.22 ( $\$933.22 \times 2.15 = \$2006.42$ ). The Department contends that the petitioner failed to provide proof of the current worker's compensation; therefore, it used the amount listed on the petitioner's application. The

Department contends that the petitioner previously informed the caseworker that her worker's compensation ended, and later explained that it decreased. The Department explained that the petitioner was asked to provide verification but never received the verification.

8. The Department's records show that the petitioner's son's Social Security income decreased to \$225 beginning July 1, 2017 and that it will use this amount for future budgets (*Respondent's Exhibit 3, page 6*). The Department explained that the petitioner would not be eligible for FAP benefits with the \$1200 rental obligation being included in the budget. The Respondent's Exhibit 4 includes a copy of a manual FAP budget to show that the petitioner would not be eligible for FAP benefits with the monthly rental obligation in the amount of \$1200.

9. The respondent contends that the petitioner has been enrolled in the Medically Needy since November 2016. The respondent contends that the petitioner has been paying her Medicare Part B premium (\$125) since July 2016.

#### **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.

The Food Assistance Program denial will be addressed:

12. 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...

(3) The Department conducts phone or face-to-face interviews with applicants/recipients or their authorized/designated representatives when required for the application or complete eligibility review process. The applicant/recipient or their authorized/designated representative must keep the interview appointment or reschedule the missed appointment. The Department mails a notice of missed interview to food assistance households who miss an interview.

(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.

13. Federal Regulations at 7 CFR § 273.2 Office operations and application processing.

(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.

(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.

14. Federal Regulations at 7 CFR § 273.9 Income and deductions 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. Households which contain an elderly or disabled member shall meet the net income eligibility standards for the Food Stamp Program. 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 the Food Stamp Program.

...

(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; oldage, survivors, or social security benefits; strike 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.

...

(ii) Excess shelter deduction.

(A) Continuing charges for the shelter occupied by the household, including rent...

(C) The cost of fuel for heating; cooling; electricity or fuel used for purposes other than heating or cooling;

(iii) Standard utility allowances.

15. The above authority explains that households including an elderly or disabled member need only pass the net income standard. Based on the above authority, the undersigned concludes that the petitioner is only required to meet the net

income standard as she is disabled. The above authority also explains that unearned income includes Social Security income and worker's compensation. The petitioner receives Social Security income and worker's compensation. Therefore, the undersigned concludes that the Department was correct to include the petitioner's Social Security income and worker's compensation as income. According to the above authority, households are entitled to receive a deduction to income, such as the standard deduction, medical expenses excluding the \$25 medical standard (if elderly or disabled), excess shelter, rental obligation, and the standard utility allowance. The petitioner was allowed a deduction for in the amount of \$1050 for her rent, heating and cooling costs and \$125 for her Medicare premium. The findings show that the petitioner's rent increased to \$1200, however, the increase would not result in a favorable outcome in her FAP benefits. The petitioner reported during the hearing that she also has \$200 in out-of-pocket medical expenses. The petitioner was given the opportunity to provide verification of the additional medical expenses but none were provided, post-hearing.

16. Federal Regulation at 7 CFR § 273.10 Determining household eligibility and benefit levels states:

*(a) Month of application—(1) Determination of eligibility and benefit levels.*

*(i) A household's eligibility shall be determined for the month of application by considering the household's circumstances for the entire month of application...*

...

*(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...

(ii) Income received during the past 30 days shall be used as an indicator of the income that is and will be available to the household during 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.

(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.

17. In this case, the Department contends that the petitioner's net income exceeded the established income limit for a household size of two. The petitioner argues that her worker's compensation decreased on May 15, 2017 or May 16, 2017. The petitioner was given the opportunity to provide verification of the decrease in worker's compensation but did not provide, post-hearing. The Department's records show that, previously, the petitioner was receiving \$933.22 bi-weekly payments in worker's compensation, to result in a monthly figure of \$2006.42, using the monthly conversion factor of 2.15. The petitioner's income also included Social Security income in the amount of \$1087 and the petitioner's son's Social Security income in the amount of \$299 at the time of the Department's denial, for a total income of \$3392.42.

18. The Department's Program Policy Manual, CFOP 165-22, Appendix A-1, shows the gross income limit for a household size of two as \$2670 and the net income limit as \$1335. The findings show that the petitioner's income included in the Department's calculations was \$3392.42 at the time of the denial action. Therefore, the undersigned concludes that the petitioner's income exceeded the FAP net income limit of \$1335. The petitioner argues that her worker's compensation is no longer \$2006.42, as it has decreased. The petitioner acknowledges not providing the requested verifications. The petitioner argues that she did not know where to fax the requested verifications. The undersigned does not find the petitioner's arguments persuasive, as the NOCA dated May 5, 2017 included the Department's fax number. The petitioner was also provided an opportunity to provide the requested verification of the decreased worker's compensation, post-hearing, but did not provide. Therefore, the undersigned concludes that the Department was correct to use the best available information at the time of its denial action.

19. After carefully reviewing the governing authorities and evidence presented, the undersigned concludes that the Department's action to deny the petitioner's application for FAP benefits due to exceeding the net income limit was correct.

The petitioner's enrollment in the Medically Needy Program will now be addressed:

20. The Family-Related Medicaid income criteria are set forth in Federal Regulations at 42 C.F.R § 435.603 and 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.

(b) Definitions. For purposes of this section—

Child means a natural or biological, adopted or step child...

...

Parent means a natural or biological, adopted or step parent.

...

(c) Basic rule. Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid base on "household income" as defined in paragraph (d) 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.

(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.

21. The above authority explains that the income of every individual in the household is to be included as household income when determining eligibility for Medicaid. However, the income belonging to natural children is excluded as long as the child is included in the household and is not expected to be required to file a tax return. In this case, the findings show that the petitioner's child is claimed as a dependent and is not claimed on anyone else's tax return. The petitioner files a joint tax return. Therefore, the undersigned concludes that the Department was correct to include as income the petitioner's income and exclude the petitioner's son's income in its calculations.

22. The 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:

1. Mother;
2. Father, legal or biological

(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.

23. The Department's Program Policy Manual, CFOP 165-22, Appendix A-7, indicates the Family-Related Medicaid income limit for Parents is \$241 for a family size of two and the standard disregard is \$146. The Medically Needy Income Limit (MNIL) is \$387 for a family size of two and the MAGI disregard is \$68.

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

25. In this case, the Department considered only the petitioner's Social Security income in the amount of \$1087 to determine her eligibility for Medicaid. The Department compared the household income to the Family-Related Income Limit in the amount of \$241 for a family size of two and determined that the petitioner was ineligible for full-coverage Medicaid as the household income exceeded the income limit. According to the above controlling regulations, the undersigned concludes that the Department's action to continue the petitioner's enrollment in the Medically Needy program was correct. The income exceeds the limit for the parent to receive full coverage Medicaid.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the above-mentioned appeals are denied.

### **NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 07 day of August, 2017,  
in Tallahassee, Florida.



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Paula Ali  
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

Aug 15, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

PETITIONER,

Vs.

APPEAL NO. 17F-04662  
17F-04869

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 17, 2017 at 9:45 a.m.

**APPEARANCES**

For the petitioner: [REDACTED]

For the respondent: Jennie Rivera, ACCESS Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

The petitioner is appealing the following:

I. The respondent's action to terminate her Food Assistance Program (FAP) benefits as of June 30, 2017. The petitioner carries the burden of proof by a preponderance of the evidence.

II. The respondent's action to terminate the household's full Medicaid Program benefits effective June 30, 2017 and to enroll the petitioner and her two children in the

Medically Needy (MN) Program with a share of cost (SOC) amount of \$2,649.00 beginning July 1, 2017. The petitioner is seeking full Medicaid benefits for her household. The respondent carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner did not submit any exhibits at the hearing. The respondent submitted five exhibits, which were entered as Respondent's Exhibits "1" through "5". During the hearing, the respondent submitted another exhibit, which was entered as Respondent's Exhibit "6". The record was held open until the end of business on July 31, 2017 for submission of additional evidence from the parties. The respondent was instructed to submit the FAP budget calculation for July 2017.

Evidence was received from the petitioner on July 24, 2017, which was entered as Petitioner's Exhibit "1". The FAP budget calculation for July 2017 was received from the respondent on July 18, 2017, which was entered as Respondent's Exhibit "7". On July 26, 2017, the respondent submitted additional documents regarding state data wages for the petitioner in the 4<sup>th</sup> quarter of 2016 and paystubs from a previous certification. The undersigned did not address this additional information as it is not relevant to the current issue. Therefore, the respondent's document's regarding the state data wages for the 4<sup>th</sup> quarter of 2016 and paystubs from a previous certification were not accepted into evidence.

On July 27, 2017, the undersigned received an email from the respondent objecting to the petitioner's evidence received on July 24, 2017, as the respondent did

not agree that the “overtime hours are not on a regular basis” and the child support court order record showing the payment frequency is monthly.

Fla. Admin. Code R. 65-2.057(12) states “the hearing officer shall request, receive and make part of the record information determined necessary to decide the issues being raised.” The undersigned concludes the additional information requested from the petitioner was necessary to make a decision on the issues raised on July 17, 2017. Therefore, pursuant to the above authority, the petitioner’s objection is overruled. The record closed on July 31, 2017.

#### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner (39) was receiving full Medicaid Program and FAP benefits for herself and her two children (ages 15 and 18). On February 14, 2017, the petitioner’s daughter turned 18. The FAP benefits were due to expire on June 30, 2017 and the Medicaid Program benefits were certified from August 1, 2016 through August 31, 2017.
2. On May 18, 2017, the petitioner submitted an application to recertify the FAP benefits. On the application, the petitioner reported her sources of income were her daughter’s (age 18) income from [REDACTED] and child support of \$307.62 bi-weekly. The petitioner listed her monthly expenses as rent of \$1,200.00, water of \$75.00, telephone of \$200.00 and electricity of \$190.00.
3. The respondent obtained verification of the child support income through the Child Support Inquiry Details report. Based on the report, the petitioner received child support payments on May 3, 2017 for \$143.08 and on May 17, 2017 for \$143.08, which totaled

\$286.16. The respondent determined the petitioner received \$205.12 on May 3, 2017 and \$104.88 on May 17, 2017, which totaled \$310.00. These two amounts were averaged then converted to monthly income using a conversion factor of 2.15. The monthly amount totaled \$333.25. However; it is unknown how the respondent arrived at these figures.

4. On May 23, 2017, the respondent pended the petitioner for her daughter's (18) paystubs and a written explanation of how the household was meeting its expenses. Based on the application, the petitioner's expenses exceeded the household income. The petitioner submitted her daughter's paystubs dated May 11, 2017 gross pay \$286.00 and May 25, 2017 gross pay \$297.00. These two paystubs were averaged then converted to monthly income using a conversion factor of 2.15. The petitioner's daughter's total monthly gross income was calculated as \$626.73.

5. The petitioner also submitted her paystubs from [REDACTED] dated April 28, 2017 gross pay \$1,223.25 and May 12, 2017 gross pay \$1,328.93. These two paystubs were averaged then converted to monthly income using a conversion factor of 2.15. The petitioner's total monthly gross income was calculated as \$2,743.59. The household's total gross earned income was calculated as \$3,370.32 by adding the petitioner's and her daughter's monthly gross income (\$2,743.59 + \$626.73). The child support income was then added to the total earned income to calculate the household's total gross income of \$3,703.57.

6. It was determined that the household's total gross income exceeded the gross income standard of \$3,360.00 for a household size of three.

7. The respondent explained it had caused an error in removing the petitioner's earned income in the previous certification budgets (January 2017 through June 2017). The respondent explained the petitioner was not eligible for FAP benefits in the previous certification.

8. The respondent testified that the household received eight (8) months of Transitional (full) Medicaid Program benefits from August 2016 through March 31, 2017; once the respondent included the petitioner's earned income, the petitioner was no longer eligible for full Medicaid benefits. Additionally, the petitioner's daughter turned 18 years old on February 2017, once she turned 18 years of age, the respondent determined Family-Related Medicaid coverage for the appropriate age group (18 to 21). This change affected the benefits for continued coverage in the Transitional Medicaid Program.

9. The petitioner and her children continued to receive full Medicaid benefits under a different category from April 1, 2017 through June 30, 2017.

10. The respondent excluded the child support income from the Medicaid budget. The countable household income of \$3,135.18 was determined by adding the petitioner's two paystubs ( $\$1,328.93 + \$1,223.25 = \$2,552.18$ ) and her daughter's two paystubs ( $\$286.00 + \$297.00 = \$583.00$ ); the countable household income was compared to the Family-Related Medicaid income limit for a child between the ages of 6 through 18 in a household size of three ( $\$2,264.00$ ), the respondent determined the petitioner's children were not eligible for full Medicaid benefits because the household income exceeded the Medicaid income limits for the children's age group.

11. The respondent then determined Medicaid eligibility for the petitioner. The countable household income of \$3,135.18 was compared to the Family-Related Medicaid income limit for a parent in a household size of three (\$303.00), the respondent determined the petitioner was not eligible for full Medicaid benefits as the household income exceeded the Medicaid income limits.

12. The petitioner is not disputing the SOC amount because she is seeking full Medicaid benefits. The petitioner disputed the paystubs the respondent used to calculate her income in the FAP and Medicaid budgets, the petitioner explained overtime is not guaranteed. The petitioner did not understand why the household's full Medicaid was terminated when her income has not changed. Additionally, the petitioner argued the court order child support payments are received monthly, not bi-weekly. The petitioner's youngest child has out-of-pocket medical expenses of \$3,000.00 a month due to his medical conditions; however, he has not been declared to be disabled.

13. On June 14, 2017, the respondent sent the petitioner a Notice of Case Action terminating the full Medicaid Program benefits effective June 30, 2017. The notice also indicated that the petitioner's FAP benefits would end on June 30, 2017 due to "your income is too high to qualify for this program".

14. The record was left open to allow the petitioner an opportunity to provide documents regarding the child support payments and overtime pay from her employer.

15. The petitioner provided a certification from the "Gobierno De Puerto Rico Departamento de la Familia" (Governor of Puerto Rico Department of Family), that indicates child support monthly payments of \$310.00. The petitioner also submitted a

statement from [REDACTED] indicating overtime pay is not anticipated or provided on a regular basis.

### **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.

### **FOOD ASSISTANCE ISSUE**

18. The Code of Federal Regulations 7 C.F.R. § 273.9 defines "Income" and "Deductions" in the Food Assistance Program. The passage reads in relevant part:

(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 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)).

...

(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...

...

Unearned income shall include, but not limited to:

(iii) Support or alimony payments made directly to the household from nonhousehold members.

...

(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.

...

(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...

19. The Code of Federal Regulations 7 C.F.R. § 273.10 addresses budgeting in the

FAP and states in relevant part:

...

(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. If the amount of income that will be received, or when it will be received, is uncertain, that portion of the household's income that is uncertain shall not be counted by the State agency... In cases where the receipt of income is reasonably certain but the monthly amount may fluctuate, the household may elect to income average. Households shall be advised to report all changes in gross monthly income as required by §273.12....

(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.

...

(e) Calculating net income and benefits levels—(1) Net monthly income.

(i) To determine a household's net monthly income, the State agency shall

(A) Add the gross monthly 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 costs... 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...

(I) Subtract the excess shelter cost...

(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.

**(B) In addition to meeting the net income eligibility standards, households which do not contain an elderly or disabled member shall have their gross income, as calculated in accordance with paragraph (e)(1)(i)(A) of this section, compared to the gross monthly income standards defined in §273.9(a)(1) for the appropriate household size to determine eligibility for the month.** (emphasis added)

(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.

20. The Department's Program Policy Manual (Policy Manual) sets forth the following income limits and maximum FAP benefit for a household size of three:

Appendix A-1	\$3,360.00 Gross Income Limit
	\$1,680.00 Net Income Limit
	\$ 511.00 maximum FAP benefit

21. The above authorities explain that households without an elderly or disabled member must meet both the gross income (200% of the federal poverty level) and the net income (100% of the federal poverty level) limits. The petitioner explained her child has medical conditions and requires medical care with expenses averaging to \$3,000.00 a month. However, no evidence was presented that verified the petitioner's child has been declared disabled. This household does not contain a disabled member; therefore, the medical expenses were not credited in the FAP budget.

22. The petitioner argued the respondent included overtime pay, which is not available on a regular basis, to calculate her gross monthly earned income. The petitioner also argued the child support income is received monthly, not bi-weekly.

23. The undersigned recalculated the petitioner's gross earned income in the FAP budget using her bi-weekly earnings of \$1,200.00 (\$15.00 an hour x 80 hours) times a conversion factor of 2.15, this resulted in \$2,580.00. The undersigned also recalculated the child support income from \$333.25 to \$310.00 as follows:



### FOOD ASSISTANCE BUDGET WORKSHEET

1. Name: \_\_\_\_\_ Case #: \_\_\_\_\_ Seq.: FS/01 Month(s): July 2017

<p><b>2a. Gross Monthly Earned Income</b> \$ 2,580.00          If needed, specify source(s) of earned income. Daughter's earned income + \$ 626.73  <b>b. Total Earned Income</b> = \$ 3,206.73</p>	<p><b>3a. Gross Monthly Unearned Income</b> \$ 310.00          If needed, specify source(s) of unearned income. UNREPORTED INCOME + \$ _____  <b>b. Total Unearned Income</b> = \$ 310.00</p>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**4. Total Monthly Gross Income:** Tot. Earned(2b) \$ 3,206.73 + Tot. Unearned(3b) \$ 310.00 = \$ 3,516.73  
 (Compare to) **Maximum Gross Income Standard:** \$ 3,360.00 (for HH Size of) 3  
**Result:** The Assistance Group has  Passed  Failed the Food Assistance **Gross** Income Test

5. a. <b>Total Earned Income</b> (2b)	\$ 3,206.73
b. 20% Exclusion	- 641.35
c. Subtotal	= 2,565.38
d. <b>Total Unearned Income</b> (3b)	+ 310.00
e. Total Income	= 2,875.38
f. Standard Deduction	- 157.00
g. <b>Total income</b>	= 2,718.38
h. Homeless Income Deduction	-
i. <b>Total Net Income</b>	= 2,718.38
7. a. <b>Excess Medical Expenses</b> (6c)	- 0.00
b. <b>Total</b>	= 2,718.38
c. Dependent Care	-
d. Net Income	= 2,718.38
e. Child Support Paid	- 567.24
f. <b>Adjusted Net Income</b>	= 2,151.14

<b>8. Adjusted Net Income</b> (7f)	\$ 2,151.14
<b>X .50 = Shelter Standard</b>	\$ 1,075.57

10. a. Adjusted Net Income (7f)	\$ 2,151.14
b. <b>Excess Shelter Deduction</b> (9g)	- 462.43
c. <b>FA Adjusted Net Income</b>	= 1,688.72

**6. Medical Expenses:** (qualified recipients only)

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
<b>a. Total Medical</b>	\$ 0.00
b. Minus Medical Standard	-
c. <b>Excess Medical Expenses</b>	= 0.00

**Explanation of "capped/uncapped" excess shelter deduction**

**9. Shelter Expenses:**

a. Mortgage/Rent	\$ 1,200.00
b. Insurance/Taxes	+ _____
c. Utilities (SUA/BUA/Phone)	+ 338.00
d. Other: _____	+ _____
e. <b>Total Shelter</b>	= 1,538.00
f. Shelter Standard (from 8)	- 1,075.57
g. <b>Excess Shelter Deduction</b>	= 462.43

**Calculate allowable excess shelter deduction**

**11. Compare FA Adj. Net Income** (10c) \$ 1,688.72 to **Maximum Net Income Std.** \$ 1,680.00 for HH Size 3  
**Result:** The Assistance Group has  Passed  Failed the Food Assistance **Net** Income Test

24. The undersigned reviewed the calculations and determined that even with the petitioner's gross earned income being calculated without the overtime pay and the child support calculated as \$310.00, the household remains ineligible for FAP benefits as its total monthly gross income still exceeds the applicable gross income limit. The household's recalculated total monthly gross income is \$3,516.73 which exceeds the \$3,360.00 gross income limit for a household size of three. Therefore, according to the

evidence, testimony and authorities cited above, the undersigned concludes that the respondent's action to end the petitioner's FAP benefits as of June 30, 2017 for exceeding the gross income limit was correct.

### **FULL MEDICAID BENEFITS ISSUE**

25. Section 445.029, Florida Statutes, Transitional medical benefits, sets forth, "(1) A family that loses its temporary cash assistance due to earnings shall remain eligible for Medicaid without reapplication during the immediately succeeding 12-month period..."

26. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2030.0203, Transitional Coverage (MFAM), states:

**Transitional coverage provides extended coverage for up to 12 months, beginning with the month of ineligibility. Changes during this period, other than the child turning 18 or loss of state residence, do not affect the transitional Medicaid period.** (emphasis added) An ex parte determination must be completed prior to cancellation and a notice sent when the parents and other caretaker relatives and/or children included in the assistance group becomes ineligible due to the following reasons:

1. initial receipt of earned income of the parent or caretaker relative, or
- 2. receipt of increased earned income of the parent or caretaker relative.** (Emphasis added)

Conditions that must be met:

1. The parents and other caretaker relatives' assistance group must be ineligible for Medicaid as parents and other caretaker relatives based on initial receipt of earned income or receipt of increased earned income by the parent or caretaker relative. If more than one budget change is being acted on at the same time, a test budget(s) will be necessary to determine if the change in earned income is the sole cause of ineligibility.

2. At least one assistance group in the household was eligible for and received Medicaid with income below the parent/other caretaker relative income limit (MA R- previously referred to as 1931 Medicaid) in at least three of the preceding six months. The three months can include a month in which Medicaid was received in another state, or a retroactive month. All assistance groups (except individuals previously requesting not to receive Medicaid and children ages 18 to 21) in which the parent or other caretaker relative with new or increased earned income is a counted or

eligible member are eligible for transitional coverage, provided all requirements are met.

Note: It is not necessary to change a child's coverage group to Transitional Medicaid if they remain eligible for Medicaid as a child. If the initial receipt or increase in earned income does not cause ineligibility for other SFU members, do not change those individuals' Medicaid coverage.

Example: A parent reports increased income over the Parent and Other Caretaker Relative income limit (19% federal poverty level(FPL)), **but the increased earned income does not go over the income limit for Children Under Age 19 (133% FPL).** (emphasis added)

27. According to testimony from the respondent, it had caused an error by removing the petitioner's earned income in the previous certification. The respondent corrected this error by including the petitioner's earned income in the budget.

28. According to the above-cited rules, the household's income must not exceed 133% of the Federal Poverty Level (FPL) to be eligible for full Medicaid. The Policy Manual, Appendix A-7, Family-Related Medicaid Income Limits, sets the income limit for a child age 6 through 18, in a household size of three, as \$2,264.00 and the income limit for a parent, in a household size of three, as \$303.00. The petitioner lost the Transitional Medicaid Program benefits coverage because her household's income exceeds program income limitations.

29. Fla. Admin. Code R. 65A-1.702, Special Provisions, states in 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.

30. In accordance with the above authority, after the petitioner lost the Transitional Medicaid Program benefits coverage, the respondent determined the petitioner and her children were eligible for full Medicaid under another coverage group through June 30, 2017. Once the petitioner's earned income was included, the respondent determined the petitioner and her children were not eligible for full Medicaid benefits effective July 1, 2017.

31. The undersigned recalculated the petitioner's gross earned income in the Medicaid budget as \$2,400.00 (\$1,200.00 x2) and the petitioner's daughter's gross earned income as \$583.00 (\$286.00+\$297.00) which resulted in a total countable income of \$2,983.00. Even with this recalculation the household's countable income exceeds the \$2,264.00 income limit for full Medicaid Program benefits.

32. 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 as follows:

Family Size	Income Level
1	\$180
2	\$241
3	\$303

33. Pursuant to the above authority, the household's recalculated countable income (\$2,400.00) exceeds the \$303.00 income limit; therefore, the petitioner is not eligible for full Medicaid benefits.

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34. In careful review of the evidence and cited authorities, the undersigned concludes the respondent's action to terminate the household's full Medicaid Program benefits effective June 30, 2017 was within the rules and regulations of the Program.

Furthermore, the respondent was correct to enroll the household in the MN Program with a SOC beginning July 1, 2017.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the Department's actions are affirmed.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 15 day of August, 2017,

in Tallahassee, Florida.



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

Aug 23, 2017

STATE OF FLORIDA  
DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGSOffice of Appeal Hearings  
Dept. of Children and Families

PETITIONER,

APPEAL NO. 17F-04776  
17F-05399

Vs.

CASE NO. FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 20 COLLIER  
UNIT: 88287RESPONDENT.  

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**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 27<sup>th</sup>, 2017, at 8:17 a.m.

**APPEARANCES**For the Petitioner: .

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

**STATEMENT OF ISSUE**

The petitioner is appealing the Food Assistance (FA) benefit level authorized by the respondent. On the record, the petitioner brought forth the issue of her daughter, MH, having Share of Cost (SOC) as opposed to full Medicaid. Therefore, a second appeal number (17F-05399) was added. The respondent holds the burden of proof in both appeals and must meet its burden by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

During the hearing, the petitioner did not present any documents for the hearing officer's consideration.

Respondent's exhibits 1 through 11 were admitted into evidence.

The hearing officer allowed until the close of business, August 3<sup>rd</sup>, 2017 for the petitioner to provide information and for the respondent to provide additional information. The petitioner provided the documents timely, and they were marked into evidence as Petitioner's exhibits 1 through 23. The respondent also provided documents timely, and they were entered as Respondent's exhibits 12 through 14. The hearing officer then allowed until the close of business August 14<sup>th</sup>, 2017, for either party to respond to the opposing party's evidence if it chose to do so. Neither party responded. Therefore, the record was closed.

By way of a Notice of Case Action (NOCA) dated June 1<sup>st</sup>, 2017, the respondent informed the petitioner that her FA benefits would increase due to a change in household circumstances. The increase would begin July 2017 and the household would receive a total FA amount of \$207 monthly. The respondent also informed the petitioner that the application for Medically Needy (MN) coverage dated May 31<sup>st</sup>, 2017, for MH was approved for July 2017 and ongoing. By way of a separate NOCA dated June 19<sup>th</sup>, 2017, the respondent informed the petitioner that the FA benefits would decrease from \$207 to \$44 effective July 1<sup>st</sup>, 2017. The reasons listed are, "A household member has left the home and can no longer be included in this program. No household members are eligible for this program. Individual is an ineligible student." On June 23<sup>rd</sup>, 2017, the petitioner filed a timely request to challenge the respondent's action.

### **FINDINGS OF FACT**

1. The petitioner submitted an online change report for FA and Family Medicaid on June 7<sup>th</sup>, 2017. (See Respondent's Exhibit 2). Both FA and Family Medicaid are issues in this appeal. According to the petitioner, the issues with the FA and Medicaid began prior to the June 7<sup>th</sup>, 2017, change.
2. The petitioner's household includes herself, 48 years of age, and two adult daughters, BH and MH, 22 years of age and 19 years of age respectively.
3. The petitioner is disabled and receives \$987 monthly in Social Security Disability (SSD) payments. (See Respondent's Exhibit pg. 48). This is the amount that the respondent used when determining eligibility. The petitioner contends that both of her daughters are also disabled. The petitioner provided documentation from Lee Memorial Health System that outlines some of the medical and cognitive difficulties that MH faces. (See Petitioner's Exhibit 2). The respondent provided, as part of its evidence, a screen print from the State On-Line Query (SOLQ). (See Respondent's Exhibit 6 pg. 24). The SOLQ screen print shows that MH applied for Social Security (SS) benefits on September 26<sup>th</sup>, 2016, and the application was denied on December 22<sup>nd</sup>, 2016. The denial code listed is "N32." According to the SOLQ user guide, denial code "N32" means, "Non-pay – Capacity for substantial gainful activity – other work, no visual impairment." SOLQ also shows that the denial was appealed on June 7<sup>th</sup>, 2017, and has an accompanying appeal code of "H." The SOLQ user guide explains an appeal code of "H" as, "Hearing." In regards to disability for BH, the petitioner provided a statement explaining that BH has not applied for SS benefits. The petitioner listed BH's conditions

as Attention Deficit Hyperactivity Disorder and Panic Disorder. (See Petitioner's Exhibit 7).

4. Both of the petitioner's daughters are college students. MH was attending [REDACTED] during the spring 2017 semester. The respondent provided, as part of its evidence, documents from [REDACTED] that were originally submitted by the petitioner. (See Respondent's Exhibit 6 pgs. 21 through 22). The printouts show a date of April 30<sup>th</sup>, 2017, and list the class schedules for MH totaling 13 credit hours. The classes are as follows:

[REDACTED] [REDACTED] [REDACTED]

The petitioner asserts that MH was unable to maintain full-time student status due to her disability. Therefore, seven of the credit hours were withdrawn during the spring 2017 semester which placed MH in a part-time status. (See Respondent's Exhibit 6 pg. 23). No evidence of student status was provided for BH.

5. In addition to receiving SSD payments, the petitioner owns rental property located at [REDACTED]. The respondent provided, as part of its evidence, tax documents from the year 2016 originally submitted by the petitioner. (See Respondent's Exhibit 4 pgs. 11 through 16). The gross income and deductions are as follows:

Rents received:	\$21,200
Insurance:	\$858
Legal/professional fees:	\$450

FINAL ORDER (Cont.)

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Supplies:	\$3,000
Taxes:	\$1,425
Maintenance yearly:	\$3,500
Management yearly:	\$6,000
Property preservation:	\$1,000
Repair water system:	\$325
Repair flooring:	\$225
Repair baseboards, trim, & walls:	\$725
Removal of trees & branches:	\$1,500

The respondent determined that rental property produced \$400 a month in self-employment income. The respondent used this amount when determining eligibility. However, the respondent asserts that it is unable to provide a detailed breakdown of how the \$400 amount was calculated. The petitioner testified that the amount of \$6,000 annually for management was the amount she was paying herself until the SSD was approved. After the SSD was approved, the petitioner began using the \$6,000 annually to hire other people to manage the property. Therefore, she no longer pays herself that money. The petitioner asserts that she has not gathered income and expense records for the rental property for the year 2017 but will have them prepared for the upcoming tax season. According to the petitioner, the 2017 tax return will differ from the 2016 tax return in that she is no longer being paid the \$6,000. The petitioner further testified that she claims both of her daughters as dependents on her yearly taxes.

6. The petitioner contends that the residence where she lives is paid off. Therefore, she is not responsible for a mortgage or rental payment. However, the respondent allowed a shelter expense of \$478 monthly. The petitioner was unable to recall what the expense would have been and did not provide proof of the expense. The petitioner pays electricity which includes the cost of heating and cooling her home. Accordingly, the

respondent afforded the petitioner the Standard Utility Allowance (SUA). In addition, the petitioner pays out of pocket for medical costs, including the cost of medical marijuana. The respondent testified that the cost of medical marijuana was not an allowable medical deduction, but did consider \$67.58 in total medical expenses when determining eligibility. The petitioner disputes this amount and contends that her out of pocket medical costs are higher. The petitioner provided, as part of her evidence, receipts from Integrated Healthcare Solutions, two Florida Turnpike toll receipts, two Dispensary 1 medical cannabis receipts, two Trulieve Online Store and Delivery receipts, a Tom Thumb receipt, and a [REDACTED] receipt. (See Petitioner's Exhibits 7 and 8). The petitioner testified that the receipts from Trulieve Online Store and Delivery are receipts for medical marijuana.

7. The petitioner contends that both of her daughters should be eligible for FA since they both meet the student eligibility test for disabled students. The petitioner further testified that MH should have full Medicaid coverage as opposed to SOC. In addition, the petitioner noted several occasions when she had difficulties communicating and relaying information to department personnel and does not understand why information was requested that was already on file from a previous certification.

8. The respondent reduced the household's FA benefits from \$207 to \$44 effective July 1<sup>st</sup>, 2017 when the change report dated June 7<sup>th</sup>, 2017, was authorized. In addition, full Medicaid coverage for MH was terminated on June 30<sup>th</sup>, 2017. The reason provided on the NOCA was, "You are receiving the same type of assistance from another program." The same NOCA shows that MH was enrolled in the MN program beginning

July 2017 with a SOC of \$901 per month. (See Petitioner's Exhibit 53). According to documentation provided by the respondent, the SOC for MH was determined using a household size of three. (See Respondent's Exhibit 13 pgs. 21 through 23). The respondent testified that the current certification periods for FA and Medicaid began in April 2017.

### **CONCLUSIONS OF LAW**

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

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

*The hearing officer will first address the issue of the respondent terminating full Medicaid for MH.*

11. The Family-Related Medicaid income criteria set forth in 42 C.F.R. Section 435.603 states:

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.

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.

12. Federal regulation 42 C.F.R. Section 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—

(ii) The individual's natural, adopted and step 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.

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with Section 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.

13. In accordance with the above-cited authorities, the Medicaid assistance group is the petitioner and her 19-year-old daughter, MH. The Findings of Fact show that the respondent determined the petitioner's eligibility with a household size of three. The hearing officer does not affirm the respondent's use of a household size of three. The petitioner's 22-year-old daughter should not be included in the Medicaid determination, as she has not been determined to be disabled either by the Social Security Administration or the Disability Determination Division.

14. The Department's Policy Manual Chapter 1830.0122 Verification of Income (MFAM) states:

To determine eligibility for Medicaid, verification of income will be performed by data exchange when available. An applicant's or recipient's self-attestation of income is accepted if the amount stated on the application or renewal is reasonably compatible with information obtained by the Department through electronic sources. Reasonably compatible means both self-attestation and electronic sources are below the applicable income standard or when the difference between both amounts is ten percent (10%) or less without regard to the income standard. If the difference is more than 10%, first ask for a reasonable explanation and, if necessary, paper documentation from the individual. **When income cannot be verified by data exchange, such as for individuals with no SSN or who have self-employment income, income must be verified by other acceptable means [emphasis added]** such as pay stubs, CF-ES 2620, etc.

15. As stated in the above-cited guideline, the respondent uses reasonable compatibility to determine income when both the self-attested income and electronic source of income are within 10% below the income standard. If the difference is more than 10%, then the respondent must ask for a reasonable explanation and possibly paper documentation. However, in some instances such as for individuals with no Social Security Number or with earnings from self-employment, the income must be verified. The hearing officer affirms the respondent's action to request verification of the petitioner's income and/or management despite the petitioner's claim that the documentation was previously on file. The respondent must verify the information at every certification.

16. The Department's Policy Manual Chapter 1830.0300 Self-Employment (MFAM) states:

An individual who owns a business or otherwise engages in a private enterprise is considered self-employed. Income derived from self-employment is considered earned income.

This includes but is not limited to:

1. childcare;
2. sales from a franchise company;
3. picking up and selling cans;
4. farming and fishing self-employment;
5. selling newspapers;
6. income from an S corporation (The income, losses deductions, or credits are based on a partnership agreement and passed on to shareholders based on a pro rata share.); or
7. **income from rental property.** *[Emphasis added.]*

17. The Department's Policy Manual Chapter Costs of Self-Employment Income

(MFAM) states:

Net earned income from self-employment is the total gross income derived from all trades and businesses as computed under the Internal Revenue Code, less deductions allowable under the Code, attributable to such trades or businesses. It includes the individual's share of ordinary net income (or loss) from partnerships even though the partnership profits have not been distributed yet. The assistance group is required to keep a record of business expenses incurred. Allowable costs of producing self-employment income include, but are not limited to, the following expenses:

1. identifiable costs of labor (salaries, employer's share of Social Security, group medical insurance, employee reimbursements, etc.);
2. stock, raw materials, seed and fertilizer, and feed for livestock;
3. rent and cost of normal building maintenance;
4. business telephone costs and utility expenses;
5. costs of operating a motor vehicle when required in connection with the operation of the business;
6. interest paid on debts related to the business property;
7. insurance premiums related to the business;
8. depreciation costs for owned property used in business or held to produce income;
9. travel meals, lodging and entertainment expenses away from home;
10. legal and professional fees; or
11. pension plans.

18. The Department's Policy Manual Chapter 1830.0316 Rental Income (MFAM)

states:

Rental income is any payment for using real estate or personal property less allowable expenses.

Examples of rental income include payments for the use of:

1. land;
2. buildings;
3. an apartment, room, or house; or
4. machinery or equipment.

Income received from the rental of real estate is considered earned income from self-employment.

19. As stated in the Findings of Fact, the respondent considered the petitioner's SSD monthly payments of \$987 and income from the rental property of \$400 monthly. The above-cited authority clearly states that self-employment is considered income and provides a list of allowable deductions. However, the respondent was unable to provide a detailed summary of how it determined \$400 was the correct amount of self-employment income.

20. The Department's Policy Manual Chapter 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).

21. The Department's Policy Manual Chapter 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.

22. The hearing officer utilized the self-employment figures as follows:

Rents received:	\$21,200 (\$1,766.67 monthly)
-Insurance:	\$858
-Legal/professional fees:	\$450
-Supplies:	\$3,000
-Taxes:	\$1,425
-Maintenance yearly:	\$3,500
-Management yearly:	\$6,000
-Property preservation:	\$1,000
-Repair water system:	\$325
-Repair flooring:	\$225
-Repair baseboards, trim, & walls:	\$725
<u>-Removal of trees &amp; branches:</u>	<u>\$1,500</u>

Total: \$2,192 (\$182.67 monthly)

The hearing officer allowed all expenses listed on the petitioner's 2016 tax return including the \$6,000 in yearly management costs. As stated in the Findings of Fact, the petitioner is no longer receiving that income since she now receives SSD. The petitioner has hired others to maintain the property, and the \$6,000 is now being paid to them. The total rental property income of \$21,200 minus \$19,008 rental expenses equals \$2,192 in net annual income. The net income of \$2,192 divided by 12 months equals \$182.67 in monthly self-employment income. The hearing officer does not affirm the respondent's determination of \$400 a month in self-employment income. The petitioner also receives \$987 in SSD payments, and the respondent considered the same amount. Therefore, the hearing officer will consider \$987 in SSD payments when reviewing Medicaid eligibility for MH.

23. The hearing officer reviewed the petitioner's Medicaid eligibility using the guidelines set forth in the above-cited authorities.

- Step 1: The total income beginning in April 2017 is \$987 plus \$1,766.67 (gross self-employment monthly) to derive a sum of \$2,753.67.
- Step 2: The total monthly deductions from the self-employment rental property are \$1,584. The monthly gross income of \$2,753.67 minus monthly deductions of \$1,584 equals \$1,169.67 in countable net income.
- Step 3: The MNIL of \$387 for a household of two, as found in the Department's policy manual Appendix A-7, is deducted from the countable net income of \$1,169.67 for a total of \$782.67 rounded down to \$782.
- Step 4: The total countable net income of \$1,167.67 is more than the income limit for a household of two which is \$387.

Step 5: Applying the 5% Modified Adjusted Gross Income (MAGI) deduction does not make MH eligible for full Medicaid. Therefore, the MAGI cannot be applied. The hearing officer determined a SOC amount of \$782 is appropriate. MH is not eligible for full Medicaid.

24. In review of the evidence presented and the applicable regulations and guidelines, the hearing officer does not affirm the SOC amount authorized by the respondent. Therefore, this portion of the appeal is hereby denied in that the hearing officer concludes that the petitioner is ineligible for full Medicaid benefits, but granted in that the hearing officer concludes that the petitioner is eligible for a lower share of cost that determined by the respondent.

*The hearing officer will now address the issue of the amount of FA authorized by the respondent.*

25. The Code of Federal Regulations appearing in 7 C.F.R. 273.9, income and deductions states in part:

(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 standards for the Food Stamp Program...

(b) Definition of income...

(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.** *[Emphasis added.]*

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

(ii) Annuities; pensions; retirement, veteran's, or disability benefits...

26. The Code of Federal Regulations appearing in 7 C.F.R. 273.9, income and deductions addresses the following in regards to medical deductions in FA:

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

(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. [Emphasis added.]**

(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;

(vi) Dentures, hearing aids, and prosthetics;

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

(viii) Eye glasses prescribed by a physician skilled in eye disease or by an optometrist;

(ix) Reasonable cost of transportation and lodging to obtain medical treatment or services;

(x) Maintaining an attendant, homemaker, home health aide, or child care services, housekeeper, necessary due to age, infirmity, or illness. In addition, an amount equal to the one person benefit allotment shall be deducted if the household furnishes the majority of the attendant's meals. The allotment for this meal related deduction shall be that in effect at the time of initial certification. The State agency is only required to update the allotment amount at the next scheduled recertification; however, at their option, the State agency may do so earlier. If a household incurs attendant care costs that could qualify under both the medical deduction of §273.9(d)(3)(x) and the dependent care deduction of §273.9(d)(4), the costs may be deducted as a medical expense or a dependent care expense, but not both.

27. 7 C.F.R. 273.10 Determining household eligibility and benefit levels explains how to average medical deductions and states in part:

(3) *Averaging expenses.* Households may elect to have fluctuating expenses averaged. Households may also elect to have expenses which are billed less often than monthly averaged forward over the interval between scheduled billings, or, if there is no scheduled interval, averaged forward over the period the expense is intended to cover...The household may elect to have one-time only expenses averaged over the entire certification period in which they are billed. Households reporting one-time only medical expenses during their certification period may elect to have a

one-time deduction or to have the expense averaged over the remaining months of their certification period. Averaging would begin the month the change would become effective...

28. The Code of Federal Regulations appearing in 7 C.F.R. 273.5 Students states in relevant part:

(a) Applicability. An individual who is enrolled at least half-time in an institution of higher education shall be ineligible to participate in SNAP unless the individual qualifies for one of the exemptions contained in paragraph (b) of this section. An individual is considered to be enrolled in an institution of higher education if the individual is enrolled in a business, technical, trade, or vocational school that normally requires a high school diploma or equivalency certificate for enrollment in the curriculum or if the individual is enrolled in a regular curriculum at a college or university that offers degree programs regardless of whether a high school diploma is required.

(b) Student Exemptions. To be eligible for the program, a student as defined in paragraph (a) of the section must meet at least one of the following criteria.

(1) Be age 17 or younger or age 50 or older;

(2) Be physically or mentally unfit;

29. The department's Program Policy Manual, CFOP 165-22, passage 2210.0320.02, addresses the student eligibility test in relevant part:

Complete the student eligibility test for students in institutions of higher education to determine if they meet a student exemption. Testing for student eligibility does not apply to individuals attending high school, individuals not attending school at least half-time, or individuals enrolled full-time in schools and training programs that are not institutions of higher education. Individuals pass the student eligibility test and are eligible to participate in the Food Stamp Program if they are:

1. age 17 or under or 50 or older. Or

2. physically or mentally unfit. Individuals are physically or mentally unfit if they are receiving temporary or permanent disability benefits from government or private sources or are obviously physically or mentally unfit. Individuals meet the obviously unfit criteria if the impairment is so severe that they are not only unable to do their previous work but cannot, considering their education and experience, hold any other kind of job in the national, state, or local economy. If the unfitness is not obvious, get written or verbal verification from a physician, physician's assistant, nurse, nurse practitioner, designated representative of the physician's office, licensed or certified psychologist, social worker, or other medical personnel. Assist the individual in providing the verification.

30. As stated in the above-cited authority and guideline, a student enrolled in an institution of higher education must meet certain criteria on the student eligibility test to be considered eligible for FA benefits. As mentioned in the Findings of Fact, the petitioner and the respondent have differing opinions on whether MH is eligible for FA benefits based specifically on criterion number two which states, "Be physically or mentally unfit..." The Findings of Fact also make note that the petitioner provided medical documentation for MH from [REDACTED]. Two out of twenty-two pages of a pediatric psychology report were provided for the hearing officer's consideration. A third document dated October 31<sup>st</sup>, 2016, from a licensed psychologist was also provided. The psychology report lists the results of past psychology testing. The letter from the psychologist makes mention of the past medical issues and treatment for MH. The letter also notes the dates of the most recent psychological testing completed on MH. In addition, the document lists several educational setting accommodations that may be helpful. However, none of the documents make mention of MH being disabled. They only list how she performed on certain cognitive tests and

provided recommendations. Therefore, the hearing officer affirms the respondent's determination to exclude MH from the FA benefits as an ineligible student.

31. In regards to the petitioner's daughter, BH, there was no evidence provided to indicate that she is physically or mentally unfit. Therefore, the hearing officer affirms the respondent's action to exclude BH from the FA benefits as an ineligible student.

32. The Code of Federal Regulations appearing at 7 C.F.R. 273.11 Action on households with special circumstances outlines how to calculate self-employment income and states in relevant part:

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

(1) Averaging self-employment income. (i) Self-employment income must be averaged over the period the income is intended to cover, even if the household receives income from other sources. If the averaged amount does not accurately reflect the household's actual circumstances because the household has experienced a substantial increase or decrease in business, the State agency must calculate the self-employment income on the basis of anticipated, not prior, earnings.

(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.

33. 7 C.F.R. 273.10 (e) covers calculating net income and benefit levels in the Food Assistance Program 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.

34. The calculation for Food Assistance benefits continues under 7 C.F.R. 273.10 as follows:

(e) Calculating net income and benefit levels-- (1) Net monthly income.  
(i) To determine a household's net monthly income, the State agency shall ...  
(C) Subtract the standard deduction. ...  
(2) Eligibility and benefits...  
(ii)(A) ... 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...

35. The hearing officer will use the guidelines outlined above to review the petitioner's eligibility. As established in the Findings of Fact, the petitioner receives SSD payments of \$987 monthly. This is the amount the respondent used when determining eligibility. The hearing officer will also use this amount. In addition to the SSD payments, the petitioner receives income from a rental property. As stated in the Findings of Fact, the respondent considered \$400 monthly in rental income. However, the respondent was unable to provide a detailed breakdown of how it determined that amount. According to the Findings of Fact, the respondent provided a copy of the petitioner's partial 2016 tax return which include the income and expenses for the rental property. The income and expense are as follows:

Rents received:	\$21,200
-Insurance:	\$858
-Legal/professional fees:	\$450
-Supplies:	\$3,000
-Taxes:	\$1,425
-Maintenance yearly:	\$3,500
-Management yearly:	\$6,000
-Property preservation:	\$1,000
-Repair water system:	\$325
-Repair flooring:	\$225
-Repair baseboards, trim, & walls:	\$725
<u>-Removal of trees &amp; branches:</u>	<u>\$1,500</u>
Total:	\$2,192 (\$182.67 monthly)

The hearing officer reviewed the above-cited authority and will allow all rental expense.

Therefore, the total annual income on the rental property is \$21,200 minus the total annual expenses of \$19,008 for a total net profit of \$2,192 yearly. The hearing officer recognizes that the petitioner was paying herself \$6,000 annually for property

management. However, according to the petitioner's testimony, after receiving SSD payments she has stopped paying herself and has hired other people to manage the property. Therefore, the \$6,000 is now a deductible expense. Furthermore, since the petitioner is no longer managing the property, the \$2,192 in annual income changes from earned income to unearned income and is not eligible for the 20% earned income disregard. The total annual unearned income of \$2,192 divided by 12 months equals \$182.67 in monthly rental property income. The amount of \$987 in SSD payments plus \$182.67 in rental income derives a sum of \$1,169.67 in monthly unearned income for the petitioner household. This is the amount the hearing officer will use when reviewing eligibility.

36. Following the above-cited guidelines, the hearing officer will deduct the Standard Deduction of \$157 (as found in the Department's policy manual, appendix A-1) for an adjusted income of \$1,012.67.

37. The hearing officer reviewed the receipts provided by the petitioner. The receipts from Dispensary 1 dated April 28<sup>th</sup>, 2017, and March 26<sup>th</sup>, 2017, from Trulieve cannot be considered. The hearing officer reviewed the regulations and according to the above-cited authority, cannabis (medical marijuana), is classified as a Schedule I controlled substance under The Controlled Substances Act, 21 U.S.C. 801. Therefore, it is not an allowable expense. The toll plaza receipts from the same date are also not allowable as there were no other receipts for allowable medical deductions located in the evidence with a corresponding date. The receipts from Tom Thumb and [REDACTED] [REDACTED] are not allowable as they do not contain any medical expenses. The two

receipts from Integrated Healthcare Solutions dated March 2<sup>nd</sup>, 2017, and April 1<sup>st</sup>, 2017, for \$250 each are allowable deductions. As stated in the above-cited authority, the bills may be used as a one-time deduction or have the bills averaged over the certification period beginning the month the change would go into effect. Using the bills as a one-time deduction is the better scenario for the petitioner. The hearing officer will review the FA eligibility using \$250 as a medical deduction for April 2017 and \$250 as a medical deduction for May 2017. Those are the months the changes would have gone into effect. The hearing officer will apply the \$35 medical deduction to each month yielding \$215 for April 2017 and \$215 for May 2017 to be considered in medical expenses. The amount of \$67.58 that the respondent previously considered will no longer be allowed as a deduction since the petitioner disagreed with the amount. The hearing officer will subtract \$215 from the adjusted gross income of \$1,012.67 for an adjusted gross income of \$797.67 for the months of April 2017 and May 2017. The adjusted gross income for the remaining months of the certification will remain at \$1,012.67.

38. Fifty percent of the adjusted gross income of \$797.67 for April 2017 and May 2017 is \$398.84 which becomes the Shelter Standard for those months. The Shelter Standard for the remaining months of the certification is \$506.34. As established in the Findings of Fact, the respondent considered \$478 monthly in rent during the entire certification. Also, in consideration are the petitioner's utility expenses, the hearing officer will consider the Standard Utility Allowance of \$338 (Ibid.) for a total shelter expense of \$816.

39. From the total shelter expenses of \$816, the hearing officer will subtract the Shelter Standard of \$398.84 to derive \$417.16 for April 2017 and May 2017 and \$309.66 for June 2017 and ongoing as an excess shelter deduction. Since the household includes an elderly or disabled individual, it is entitled to the uncapped excess shelter deduction.

40. The excess shelter deductions of \$417.16 is subtracted from the adjusted gross income of \$797.67 yielding \$380.51 for April 2017 and May 2017. The excess shelter deduction of \$309.66 is subtracted from the adjusted gross income of \$1,012.67 for a total of \$703.01 for June 2017 and ongoing in net income.

41. The net income amounts of \$380.51 and \$703.01 are multiplied by 30% for benefit reductions of \$114.15 (April 2017 and May 2017) and \$210.90 (ongoing). These amounts are rounded up to equal \$115 and \$211. The maximum FA allotment for a household of one is \$194. The maximum FA allotment of \$194 minus the benefit reduction of \$115 equals \$79. The hearing officer concludes that this amount is the amount of FA benefits for which the petitioner is eligible for the months of April 2017 and May 2017. In regards to the FA benefits for June 2017 and ongoing, the maximum FA allotment of \$194 minus the benefit reduction of \$211 equals a negative number. Since the household contains an elderly or disabled member, it is eligible for the minimum FA allotment of \$16. The hearing officer concludes that this is the amount of FA benefits for which the petitioner's household is eligible for June 2017 through the remainder of the certification. The hearing officer does not affirm the respondent's

authorization of \$16 for April 2017, \$16 for May 2017, \$207 for June 2017, and \$44 for July and ongoing.

42. In conclusion, the hearing officer recognizes the petitioner's claim that both of her daughters are disabled and should be counted in the FA benefits. If the Social Security Administration overturns the denial for MH, the petitioner may submit a change to add her to the FA benefits. If at any time, either daughter graduates or drops out of college, is recognized disabled through a government agency, or meets any other student criteria, her eligibility for FA benefits may be revisited. In terms of the petitioner's concern regarding her phone calls not returned by supervisors and employees within the Department of Children and Families, she may contact the Client Relations Coordinator at [REDACTED] or toll-free at (877) 595-0384.

### **DECISION**

Based on the foregoing Findings of Fact and Conclusions of Law, the Medicaid portion of the appeal (17F-05399) is granted in part because the hearing officer does not affirm the amount of the SOC that the respondent authorized. The Medicaid appeal is also denied in part because the hearing officer cannot grant MH full Medicaid. In regards to the FA portion of the appeal (17F-04776), this appeal is granted in part because the hearing officer does not affirm the amount of FA benefits authorized by the respondent for the months of April 2017 and May 2017. However, the appeal is also denied in part because the hearing officer cannot grant a higher FA allotment for the remaining months as requested by the petitioner.

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

DONE and ORDERED this 23 day of August, 2017,

in Tallahassee, Florida.



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Kimberly Vargo  
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

Aug 29, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

PETITIONER,

APPEAL NO. 17F-05053  
17F-05650

Vs.

[REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 15, 2017 at 9:45 a.m.

**APPEARANCES**

For the petitioner: [REDACTED]

For the respondent: Jennie Rivera, ACCESS Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

The petitioner is appealing the following:

- I. The respondent's decision not to issue supplemental Food Assistance Program (FAP) benefits for the months of June 2017 and July 2017 based on a change that was reported. The petitioner carries the burden of proof by a preponderance of the evidence.

II. The respondent's action to approve full Medicaid benefits effective August 2017, instead of July 2017, based on a change that was reported. The respondent carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The hearing was originally scheduled to convene at 9:45 a.m. on August 8, 2017. The undersigned and the respondent's representative appeared and waited 15 minutes for the petitioner. The petitioner did not dial in. Later in the day, on August 8, 2017, the petitioner called and requested the hearing be rescheduled due to her fiancé was in the hospital. The request was granted and the hearing was reset for August 15, 2017.

On August 15, 2017 and on record, the petitioner explained a fair hearing convened on June 6, 2017 to address her FAP benefit amounts for April 2017 and ongoing. On July 3, 2017, a Final Order was issued, for appeal 17F-03640, regarding her FAP benefit amounts for that previous appeal. The petitioner wanted to address the respondent's testimony from the previous hearing. Florida Administrative Code R. 65-2.057(10) states "a hearings officer shall not grant a motion for rehearing or reconsideration." The undersigned cannot, by rule, address issues from the petitioner's previous appeal, as that matter was already adjudicated in appeal 17F-03640.

At the outset of the hearing, the respondent informed the undersigned and the petitioner that it had authorized full Medicaid benefits for the petitioner's household beginning July 2017. On record, the petitioner explained she was satisfied with the respondent approving full Medicaid benefits for her household beginning July 2017.

Therefore, the Medicaid appeal, 17F-05650, will be dismissed as moot. The FAP benefits remained challenged.

The petitioner did not submit any exhibits at the hearing. On August 2, 2017, the respondent submitted five exhibits, which were accepted into evidence and entered as Respondent's Exhibits "1" through "5". On August 8, 2017, the respondent submitted documents regarding the petitioner's Medicaid benefits. On record, the petitioner indicated she did not wish to proceed with the Medicaid appeal; therefore, the documents were not accepted into evidence. The record was held open until close of business on August 23, 2017 for submission of additional evidence from the respondent. On August 18, 2017, additional evidence was received from the respondent, which was accepted into evidence and entered as Respondent's Exhibit "6". The record closed on August 23, 2017.

#### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner received \$120.00 FAP benefits for June 2017 and \$16.00 for July 2017. She was certified from April 2017 through September 2017.
2. On May 5, 2017, the respondent received information from the Department of Economic Opportunity indicating the petitioner received Unemployment Compensation Benefits (UCB) in the amount of \$275.00 and her first pay was on April 4, 2017. Her ongoing payment was anticipated to be \$550.00 bi-weekly.
3. On July 5, 2017, the petitioner went to the Department's storefront and reported a change indicating her UCB ended as of June 29, 2017. The petitioner submitted

documents to the respondent verifying she received her last UCB payment on July 1, 2017.

4. On July 7, 2017, the respondent mailed the petitioner a Notice of Case Action indicating her FAP benefits were increasing to \$357 per month effective August 2017.

5. The petitioner does not agree with the respondent's decision not to issue supplemental FAP benefits for June 2017 and July 2017. The petitioner argued the respondent was aware that her UCB would be ending. The petitioner expressed concern that she only received a \$275.00 UCB payment on July 1, 2017, before the funds ran out. Additionally, the petitioner explained the final UCB payment she received on July 1, 2017 was for weeks claimed for June 2017 and should not be counted in the July 2017 FAP budget.

6. The respondent explained that the petitioner was advised to report when her UCB ended so that it could take action to increase her FAP benefits. The Department explained that if the petitioner expected her UCB to end on July 2017, she should have reported the change in June 2017. If the petitioner would have reported her loss of UCB in June 2017, the change could have been made effective with her July 2017 benefit amount. The respondent further explained the petitioner's FAP benefits are posted on the first day of every month and she did not report her UCB ended until July 5, 2017.

7. The respondent explained that, according to the Department's policy, income received must be calculated in the month received.

### **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.

### **FULL MEDICAID BENEFITS ISSUE**

10. The petitioner's appeal regarding full Medicaid benefits for the household is no longer an issue as the respondent approved full Medicaid benefits for the petitioner's household beginning July 2017 and ongoing. Since the respondent already approved the household's full Medicaid benefits effective July 2017 and ongoing, there is no better outcome the undersigned can provide to the petitioner. Therefore, the petitioner's Medicaid appeal, 17F-05650, is dismissed as moot as the respondent has resolved the petitioner's Medicaid benefits issue.

### **FAP BENEFITS FOR JUNE 2017 AND JULY 2017 ISSUE**

11. The Code of Federal Regulations at 7 C.F.R. § 273.12, Reporting requirements, states in part:

(a) Household responsibility to report. (1) Monthly reporting households are required to report as provided in §273.21...

...

(c) State agency action on changes. The State agency shall take prompt action on all changes to determine if the change affects the household's eligibility or allotment...

(1) Increase in benefits. (i) For changes which result in an increase in a household's benefits, other than changes described in paragraph (c)(1)(ii) of this section, the State agency shall make the change effective no later than the first allotment issued 10 days after the date the change was

reported to the State agency. For example, a \$30 decrease in income reported on the 15th of May would increase the household's June allotment. If the same decrease were reported on May 28, and the household's normal issuance cycle was on June 1, the household's allotment would have to be increased by July...

12. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 0810.0504, Effective Date of Beneficial Change (FS), states in part:

When a recipient provides verification with a reported beneficial change or within 10 days of the beneficial change, make the increased allotment available:

**1. No later than the month following the date the SFU reports a substantial change. Authorize a supplement as appropriate.**

(emphasis added)

2. No later than the first allotment posted 10 days after the SFU reports a non-substantial change.

Request verification if it is not provided with the reported beneficial change. If a simplified reporting SFU does not provide verification, leave benefits unchanged and document the case. Process the change if simplified reporting SFUs provide verification later.

13. The Policy Manual, CFOP 165-22, passage 1810.0108, Available Income (FS), states in part "Income must be available to meet the SFU's needs to be included.

Generally, income is considered available when it is actually received and/or when the individual has the legal ability to access the monies."

14. Pursuant to the above authorities, it is the household's responsibility to report changes. Furthermore, beneficial changes to FA benefit amounts are effective the month following the date the change is reported unless the change is reported prior to the benefit availability date. The evidence indicates the petitioner reported her UCB ended on July 5, 2017. Her benefit availability date is the first day of each month.

15. The Department of Children and Families published Transmittal No.: P-16-09-0007 on September 13, 2016, regarding "FLORIDA Data Exchange Enhancement," which states in part:

This memorandum is to notify staff about changes to the FLORIDA Data Exchange (DE) process.

Requirement to Review Data Exchange Responses Prior to Authorizing Benefits:

Effective 9/26/16, staff will no longer be able to authorize or deny benefits at application, renewal or when processing a change when there are unreviewed/unworked or pending data exchange responses. There are some exceptions to this process and are described in the System Procedures below. Time standards for processing data exchanges are not changing...

System Procedures:

There are four major data exchange enhancement changes.

1. Data exchanges must be completed prior to authorization

Prior to authorizing a case on AWAA staff must review and update all unreviewed/unworked or pending data exchanges for any individuals included in any SFU. Staff will not be able to approve, deny, or close any assistance group (AG) until all data exchanges are worked. This will have an impact on Customer Call Center staff when processing changes, Case Maintenance Unit staff when completing bill tracking, as well as staff processing applications, renewals, additional benefits, closures, and changes.

16. The petitioner argued that the Department was aware that her UCB would be ending. According to the above transmittal, the respondent is required to process beneficial changes, sanction actions, and pending data exchange responses, which include UCB notifications, when taking any action on a case. However; the Department's data exchange response list shows the only data exchange response regarding the petitioner's UCB was received on May 5, 2017, when the respondent was notified that the petitioner had begun receiving UCB. No data exchange response was received to notify the respondent that the petitioner's UCB ended. The undersigned

could not find any rule, law, or policy to support the petitioner's position. Therefore, the undersigned concludes the respondent was correct to increase the petitioner's FA benefits effective August 2017.

17. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof in establishing the respondent's decision not to issue supplemental FAP benefits for June 2017 and July 2017 was incorrect. The undersigned concludes the respondent's action to increase the petitioner's Food Assistance benefits effective August 2017, instead of June 2017 and July 2017, was correct as the petitioner reported her change on July 5, 2017.

#### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's FAP appeal, 17F-05053, is DENIED and the respondent's action is AFFIRMED.

The petitioner's Medicaid appeal, 17F-05650, is DISMISSED as MOOT.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 29 day of August, 2017,

in Tallahassee, Florida.



---

Cassandra Perez  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
Fax: 850-487-0662  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Jul 05, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17N-00018

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, an administrative hearing in the above-referenced matter convened before the undersigned on March 24, 2017 at 9:15 a.m. and reconvened on May 26, 2017 at 9:15 a.m. at [REDACTED].

**APPEARANCES**

For the Petitioner: The petitioner and [REDACTED], the petitioner's mother, appeared for the March 24, 2017 hearing. The petitioner also appeared for the May 26, 2017 hearing and she was represented by her daughter, [REDACTED]

For the Respondent: [REDACTED], Director of Nursing

**STATEMENT OF ISSUE**

At issue is whether the respondent's intent to discharge the petitioner from the facility because her health has improved sufficiently so that she no longer needs the services provided by the nursing facility is correct. The facility (respondent) has the

burden of proof to establish by clear and convincing evidence that the discharge is appropriate under Federal Regulations found at 42 C.F.R. § 483.15.

### **PRELIMINARY STATEMENT**

At the outset of the hearing on March 24, 2017, the facility objected to the petitioner's mother, [REDACTED], representing the petitioner. The respondent requested the petitioner's daughter and power of attorney, [REDACTED], appear on behalf of the petitioner. The respondent requested a continuance to allow the facility's attending physician, [REDACTED], MD, to appear as a witness. The undersigned granted the continuance request. The hearing was reset for April 24, 2017 at 1:00 p.m. On April 21, 2017, the facility contacted the undersigned and requested a continuance due to illness of one of its witnesses. The undersigned granted the continuance request and the hearing was reset for May 26, 2017 at 9:15 a.m.

At the May 26, 2017 hearing, [REDACTED] the petitioner's mother, [REDACTED], the petitioner's brother and [REDACTED], the petitioner's daughter and power of attorney, appeared as witnesses for the petitioner. [REDACTED], Nursing Home Administrator and [REDACTED], Social Services Director appeared as witnesses for the respondent. The facility's attending physician [REDACTED], MD, did not appear. The undersigned was informed that [REDACTED] no longer worked for the facility.

At the request of the undersigned, the Agency for Health Care Administration (AHCA) conducted an on-site inspection of the facility and found no violations. A copy of the AHCA survey was given to the petitioner's daughter.

The petitioner presented one exhibit which was accepted into evidence and marked as Petitioner's Exhibit 1. The respondent presented one exhibit, which was accepted into evidence and marked as Respondent's Exhibit 1. The AHCA survey letter was entered as Hearing Officer's Exhibit 1. The record was held open until close of business on June 8, 2017 for submission of additional evidence from the respondent. On June 6, 2017, the respondent submitted additional information, which was accepted into evidence and marked as Respondent's Exhibit "2". The record closed on June 8, 2017.

#### **FINDINGS OF FACT**

1. The petitioner (44) entered the nursing facility on October 26, 2016. She entered the facility as a short-term skilled care resident. On February 2017, the petitioner was approved for Institutional Care Program (ICP) Medicaid benefits.
2. On January 4, 2017, the petitioner was seen by [REDACTED], her attending physician. After visiting, the physician updated the resident's physician order sheet and notated the following: "May discharge home with family, instructions; therapeutic range."
3. On January 25, 2017, the respondent issued a Nursing Home Transfer and Discharge Notice to the petitioner informing her that she was to be discharged from the nursing facility effective February 23, 2017. This action was being taken because her health had improved sufficiently that she no longer needed the services of the facility. In the support notes section of the Nursing Home Transfer and Discharge Notice was the comment "significant improvement: ambulates/transfers/ADL's are independent."

4. Although the petitioner's physician signed the Nursing Home Transfer and Discharge Notice, there was no testimony from the attending physician and no medical records were submitted into evidence to support the respondent's contention that the petitioner's health had improved sufficiently so that she no longer need skilled services.
5. The petitioner's daughter expressed concern for her mother being discharged to an Assisted Living Facility (ALF) or to her home. The petitioner's daughter cannot care for her mother because she is caring for her young children; therefore, she will not be able to meet the petitioner's needs. The petitioner's daughter explained her mother requires 24-hour care as well as someone who must administer her medications.
6. The petitioner's daughter presented a copy of a Speech Therapy Assessment, dated February 6, 2017 at 11:40 a.m. (EST). The document indicated the following "Justification for Discharge of Services":

D/C ST skilled services at this time as pt has met maximum rehab potential for ST. During tx, pt demonstrated improvements in attention, orientation, and auditory comprehension and processing. Cognitive linguistic persist in the areas of visual processing, problem solving/executive functioning, short term memory, and safety awareness. Pt requires 24 hr supervision for safety and assist with high level ADL's including meds, meals and finances.
7. The respondent explained the petitioner's medication must continue to be administered and 24-hour supervision is required in an ALF setting or at home.
8. The respondent presented its clinical notes report, dated December 7, 2016 through May 2, 2017. The notes were entered by the facility's social services department and document discharge planning efforts and the petitioner requesting to go home.
9. No testimony was given by the attending physician to explain the Speech Therapy Assessment notes. The record was held open to allow the respondent an opportunity to

submit doctor notes or medical records to support the respondent's contention that the petitioner's health had improved sufficiently to be discharged. The respondent submitted a copy of the Nursing Home Transfer and Discharge Notice dated January 25, 2017 and the resident's physician order sheet dated January 4, 2017 which indicates "May discharge home with family, instructions; therapeutic range."

### **CONCLUSIONS OF LAW**

10. The jurisdiction to conduct this hearing is conveyed to the Department of Children and Families by Federal Regulations appearing at 42 C.F.R. § 431.200. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to section 400.0255(15), Florida Statutes. In accordance with that section, this order is the final administrative decision of the Department of Children and Families.

11. The Code of Federal Regulation at 42 C.F.R. § 483.15 limits the reasons a nursing facility may discharge a Medicaid or Medicare patient and states in part:

...

(c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
- (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
- (D) The health of individuals in the facility would otherwise be endangered;
- (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for

his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

...

(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider....

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—

(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and

(B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident

(B) Resident representative information including contact information.

(C) Advance Directive information.

(D) All special instructions or precautions for ongoing care, as appropriate.

(E) Comprehensive care plan goals,

(F) All other necessary information, including a copy of the residents discharge summary, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

12. The above-cited authority sets forth the conditions which must exist for a nursing home to involuntarily discharge a resident.

13. In this case, the petitioner was given a Nursing Home Transfer and Discharge Notice on January 25, 2017, indicating that her health had improved sufficiently that she

no longer needed the services provided by the facility and she would be discharged on February 23, 2017.

14. The above regulations stipulate that before the facility discharges a resident under any of the circumstances referenced above, the resident's medical records must be documented by the resident's physician showing the reason for the discharge/transfer. The Nursing Home Transfer and Discharge Notice was issued to the petitioner on January 25, 2017 with the discharge to be effective February 23, 2017; however, the only documentation pertaining to the petitioner's readiness for discharge was the January 2017 Physician Order Sheet, dated January 4, 2017, which was inputted by her attending physician. The notes state "May discharge home with family, instructions; therapeutic range" but these did not address the petitioner's readiness to be discharged from a medical standpoint. No medical records were submitted to support the decision to discharge the petitioner, nor was any testimony from the physician given at the hearing. The respondent testified that the petitioner's medications must continue to be administered and 24-hour supervision is required but in an ALF setting or at home. The respondent did not present medical evidence to demonstrate that the petitioner's health had improved sufficiently so that she no longer required the services of a long-term skilled facility. The physician's order to support the discharge was inconclusive.

15. The hearing officer concludes that the reason for the discharge was provided in Federal Regulation (42 C.F.R. § 483.15); however, the facility failed to provide adequate documentation to support the discharge in the medical records by the physician, as required by the regulations.

16. 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<sup>1</sup>. The undersigned concludes the respondent's evidence does not rise to the level of clear and convincing.

17. After careful review of the evidence and cited controlling authorities, the undersigned concludes the facility has not met its burden to prove, by clear and convincing evidence, that the petitioner's health has improved sufficiently so that she no longer needs the services provided by the facility. The facility's intent to discharge the petitioner is not upheld at this time.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusion of Law, the petitioner's appeal is GRANTED. The facility may not proceed with the discharge of the petitioner at this time.

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<sup>1</sup> 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 Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 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 Julv, 2017,

in Tallahassee, Florida.



\_\_\_\_\_  
Cassandra Perez  
Hearing Officer  
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DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF APPEAL HEARINGS

**FILED**

Jul 14, 2017

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17N-00034

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 9, 2017 at 2:26 p.m. in [REDACTED]

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: [REDACTED]

**ISSUE**

Petitioner is appealing Respondent's action to proceed with discharging him from the facility by Nursing Home Transfer and Discharge Notice issued on April 6, 2017.

The respondent carries the burden of proof by clear and convincing evidence.

**PRELIMINARY STATEMENT**

[REDACTED], Business Office Manager, and [REDACTED], Social Services Director, were also present as witnesses for the facility.

[REDACTED], Registered Nurse Consultant, represented the Agency for Health Care Administration.

Ursula Lett-Robinson, Hearing Officer was present as an observer with no objection from the petitioner.

The respondent submitted evidence prior to hearing which was entered as Respondent's Exhibit 1.

The record was held open through June 23, 2017 to allow the petitioner opportunity to resolve the matter with the facility. The facility submitted an update on June 23, 2017. This was entered as Respondent's Exhibit 2.

#### **FINDINGS OF FACT**

1. The petitioner has been a resident of [REDACTED] [REDACTED] for approximately two years.
2. The petitioner received a Notice of Case Action from the Department of Children and Families dated February 24, 2017 stating that his Medicaid benefits would end on March 31, 2017. The reason for given for the termination of Medicaid benefits was listed as "we did not receive proof of the value of assets" and "you failed to complete or follow through with your Medicaid renewal".
3. The petitioner refused to provide verification to assist in the renewal process.
4. The petitioner was scheduled for an administrative hearing regarding his Medicaid termination, but failed to attend that hearing.
5. The respondent attempted discharge planning with the petitioner without success.

6. The respondent issued a billing statement on April 1, 2017. The bill was for room and board charges April 1 through April 30, 2017. The statement listed the payment due date as April 3, 2017. The total bill amount for the period in question was \$6,150.

7. The respondent issued the petitioner a Nursing Home Transfer and Discharge Notice on April 6, 2017. The resident refused to sign the notice. The reason cited for the discharge or transfer was "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay."

8. The petitioner made a partial private payment of \$1,435 on April 6, 2017.

9. The petitioner made a second partial private payment of \$1,435 on April 26, 2017.

10. The respondent reported the daily private pay rate is \$205.

11. The respondent agreed to a 14-day continuance. The purpose of the continuance was for the facility to assist the petitioner in obtaining the necessary documentation to file a new application for Medicaid, assisting the petitioner with going to the bank to move funds so that he could pay his unpaid private pay balance which was \$9,835 as of May 23, 2017. The respondent agreed if the resident was fully compliant with the actions necessary to help him with reducing his assets and paying the balances due, the Discharge and Transfer Notice would be rescinded.

12. The petitioner agreed during the course of the hearing that he would work with the facility toward paying the unpaid balance and getting his assets reduced and reapplying for Medicaid.

13. The respondent provided outstanding account notes on June 23, 2017. The notes reflect the respondent's attempts to assist the petitioner with obtaining bank statements and completing a spend down plan as discussed during the hearing. The notes reflect the resident's refusal to assist in progressing toward resolution. The balance on the outstanding account shows as \$22,140.

### **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 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

15. Federal Regulations appearing 42 C.F.R. § 483.15 sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

(c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary

paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

16. Based on the evidence presented, the nursing facility has established that the reason for discharge is non-payment of the petitioner's private pay bill. This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident.

17. 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.

18. 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.

19. The undersigned concludes the facility has given the petitioner reasonable and appropriate notice to pay for the petitioner's stay at the facility. Based on the

findings and the cited authorities, the undersigned concludes that the facility's action to discharge the petitioner is in accordance with federal regulations.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusion of Law, the petitioner's appeal is denied. The facility's action to discharge the petitioner is in accordance with federal regulations. The respondent may proceed with the discharge as described in the Conclusions of Law and in accordance with applicable Agency for Health Care Administration requirements.

**NOTICE OF RIGHT TO APPEAL**

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 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   14   day of   July  , 2017,

in Tallahassee, Florida.



---

Melissa Roedel  
Hearing Officer  
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FINAL ORDER (Cont.)

17N-00034

PAGE - 7

Copies Furnished To:



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

**FILED**

Jul 17, 2017

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17N-00038

PETITIONER,

Vs.  
ADMINISTRATOR

[REDACTED]

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on June 22, 2017 at 2:01 p.m., at [REDACTED]

[REDACTED]

[REDACTED]

For the petitioner: [REDACTED]

For the respondent: Gary Kurlewitz East Regional Executive Director

**STATEMENT OF ISSUE**

At issue is whether the facility's intent to discharge the petitioner due to non-payment of a bill for services based on federal regulations found at 42 C.F.R. § 483.15 is correct. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

**PRELIMINARY STATEMENT**

Present as witnesses for the respondent were [REDACTED], business office manager and [REDACTED], social service director.

The petitioner presented one exhibit which was accepted, entered into evidence and marked as Petitioner's Exhibit 1. The respondent presented three exhibits, which were accepted into evidence and marked as Respondent's Exhibits 1 through 3.

**FINDINGS OF FACT**

1. The petitioner entered the nursing facility on September 15, 2016. He came into the nursing facility from a hospital. He applied for Medicaid on November 7, 2017 and was approved on November 16, 2016. Medicaid determined the petitioner was responsible to pay \$979.48 monthly to the nursing facility effective October 2017 (Respondent's Exhibit 2).
2. The nursing facility mailed the petitioner's representative monthly statements of the patient's responsibility and the accruing balances beginning in October 2016. The petitioner's representative did not make any payments for October 2016, November 2016, and December 2016. The nursing facility wrote off those months (Respondent's Exhibit 3).
3. In January 2017, the petitioner's patient responsibility increased from \$978.48 to \$988.48.
4. The facility billed the petitioner \$988.48 per month for January 2017 through April 2017. No payments were received.

5. On April 21, 2017, the respondent issued a Discharge Notice to the petitioner's representative, informing her that the petitioner was to be discharged from the nursing facility effective May 25, 2017, due to non-payment of his bill for services.
6. On April 24, 2017, the petitioner's representative requested a hearing to challenge the facility's action.
7. On June 13, 2017, the petitioner's wife made three payments totaling \$2,000. The payments were applied to the outstanding balance reducing it to \$3,930.88 as of June 2017.
8. The nursing facility provided the monthly statements to the petitioner's representative with the balance owed each month. The facility mailed monthly statements and spoke with the petitioner's wife in person and on the telephone regarding the petitioner's outstanding balance. The facility was willing to rescind the discharge notice if the petitioner's representative make the nursing facility the petitioner's payee and work out a payment plan towards the outstanding balance. The petitioner's representative did not agree to make the nursing facility the petitioner's payee.
9. The petitioner's representative argued that she cannot pay the patient responsibility as she also has to live, maintain her home and pay for her own expenses.
10. The petitioner's representative did not dispute receiving monthly statements from the nursing facility. The representative spoke with the facility's director regarding the outstanding balances. The nursing facility is requesting that the petitioner's representative pay the current balance of \$3,930.88.

**CONCLUSIONS OF LAW**

11. The jurisdiction to conduct this hearing is conveyed to the Department of Children and Families by Federal Regulations appearing at 42 C.F.R. § 431.200. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes.

12. Federal Regulations appearing at 42 C.F.R. § 483.15, Admission, transfer and discharge rights, sets forth the limited reasons a Medicaid or Medicare certified nursing facility may involuntarily discharge a resident and states in part:

(c) *Transfer and discharge*—(1) *Facility requirements*—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.

Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

13. The undersigned's jurisdiction is limited to the above six reasons and will only consider if the discharge is for a legal reason based on any of the six allowable reasons listed above.

14. The petitioner was admitted to the nursing facility on September 15, 2016 and was approved for Medicaid on November 7, 2016, with a patient responsibility of \$979.48. The petitioner's representative acknowledged that she received monthly statements for her husband's stay at the nursing facility but is unable to pay as she has to pay her own living expenses. The undersigned reviewed the bill and finds that the petitioner has an outstanding bill for his care at the nursing facility.

15. According to the above authority, the facility may not discharge except for certain reasons, one of which is when the resident has failed, after reasonable and appropriate notice, to pay for the stay at the facility. The petitioner has an unpaid bill for care at the respondent's facility.

16. The hearing officer concludes that the facility has given the petitioner's representative reasonable and appropriate notice to pay for her husband's stay at the facility. Based on the evidence presented, the nursing facility has met its burden to prove that the petitioner's representative failed, after reasonable and appropriate notice, to pay for her husband's stay at the facility.

17. Establishing the reason for a discharge is lawful is just one-step in the discharge process. The nursing facility 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.

18. 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 denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The facility may proceed with the discharge, in accordance with all applicable Federal Regulations, Florida Statutes, and 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 Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 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 17 day of July, 2017,  
in Tallahassee, Florida.

*Christiana Gopaul Narine*

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Christiana Gopaul-Narine  
Hearing Officer  
Building 5, Room 255  
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Copies Furnished To:



Jul 25, 2017

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17N-00044

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, a hearing in the above-referenced matter convened on June 29, 2017 at 10:47 a.m. at the [REDACTED] [REDACTED]

[REDACTED]

**APPEARANCES**

For the Petitioner: The petitioner was present and represented himself.

For the Respondent: [REDACTED]

**ISSUE**

At issue is the facility's intent to discharge petitioner due to non-payment of a bill for services; a Nursing Home Transfer and Discharge Notice was issued on May 8, 2017 with an effective date of June 7, 2017.

The facility has the burden of proof to establish by clear and convincing evidence that the petitioner's discharge is in accordance with the requirements of the Code of

Federal Regulations at 42 C.F.R. § 483.15 and Section 400.0255, Florida Statutes (2009).

### **PRELIMINARY STATEMENT**

By notice dated May 8, 2017, the respondent informed the petitioner that the facility was seeking to discharge/transfer him due to nonpayment. On May 15, 2017, the petitioner timely requested a hearing to challenge the discharge/transfer.

Appearing as an observer for the petitioner was the Local Ombudsman, Don Hankey.

Appearing as witnesses for the respondent were [REDACTED], Registered Nurse Unit Manager, [REDACTED] Medicaid Pending Representative, [REDACTED], Business Office Manager, and [REDACTED], Respiratory.

Evidence was received and entered as the Petitioner's Exhibit 1 and the Respondent's Exhibits 1 through 4.

A letter dated June 5, 2017 from the Agency for Health Care Administration (AHCA) was sent to the undersigned, stating that the representative did not find the facility in violation of any laws or rules. This was entered as Hearing Officer Exhibit 1.

The record was closed at the conclusion of the hearing.

### **FINDINGS OF FACT**

1. The petitioner (age 58) was admitted into the facility on December 8, 2016 as a private pay patient.

2. The Respondent's Exhibit 2, page 10, includes an email dated May 23, 2017, sent from the facility's Medicaid Pending Representative to the facility's Executive

Director. The email includes a copy of the facility's collection notes in the petitioner's records. The notes dated December 9, 2016 states:

...Met with (Mr. P) on Fri 12/9. The resident is here recovering from an accident...He has Commercial FL. Blue Insurance Policy but we don't know his co-pay...Looks like I will be unable to submit a MCD appl for him due to amt of assets...He did say his co-pays will be a hardship for him, so we talked about a referral to SPS and he agreed as long as they waited a couple of days to let him settle in. Will send the referral on Mon. 12/12."

3. The respondent explained that an SPS is an outside source that assists with the application for Medicaid. The respondent contends that there was constant communication with the petitioner regarding his application for Medicaid, as notated in the Collection Notes included in the Respondent's Exhibit 3, pages 10 through 11. The respondent contends that the petitioner's assets are too high to qualify for Medicaid and that his application was denied.

4. The Respondent's Exhibit 2, page 13, includes the Notice of Case Action, dated March 31, 2017, which states: "No household members are eligible for this program. We did not receive all the information requested to determine eligibility."

5. The respondent explained that the petitioner is a private pay patient and is billed once a month. The respondent contends that the monthly billing statements are mailed to the home address provided by the petitioner. The respondent contends that if payment is not received, a phone call or a face-to-face visit is made to the resident to inform of the balance owed to the facility. The current business office manager began working at the facility in March 2017 and recalls providing a billing statement to the petitioner on April 25, 2017.

6. The Respondent's Exhibit 3 includes the billing statements, dated March 1, 2017 through July 1, 2017, that were mailed to the petitioner's father's address. The billing statement for the month of February 1, 2017 was mailed to the petitioner's address at [REDACTED]. The balance currently owed to the facility is \$47737.82, according to the billing statement dated July 1, 2017 (*Respondent's Exhibit 3*).

7. The respondent believes that the petitioner is aware of his financial obligation to pay the facility for his care, as this was discussed upon his admission. The Respondent's Exhibit 4 includes the "Private Pay Financial Expectations Worksheet" that was reviewed and signed by the petitioner on December 9, 2016. The respondent pointed out that the petitioner signed an "Authorization Agreement for Pre-Authorized Payments" on January 19, 2017.

8. The respondent's records under "Transaction History by Effective Date", show that the petitioner made payments to his account on the following dates: January 18, 2017 in the amount of \$25; February 13, 2017 in the amount of \$5000; February 23, 2017 in the amount of \$1116; and March 7, 2017 in the amount of \$941 (*Respondent's Exhibit 3*). The respondent has not received any payments from the petitioner since March 7, 2017.

9. The respondent contends that it discovered that the petitioner has an Individual Retirement Account (IRA) with Edward Jones that has a balance of \$98732.56 that can be used to pay the facility for his care (*Respondent's Exhibit 3*).

10. The petitioner argues that he did not receive anything in writing to inform him of his balance owed to the facility. The petitioner acknowledges that he received a billing statement on April 25, 2017, which was at the same time he received the discharge notice. The petitioner contends that the monthly billing statements are mailed to his father, who does not inform him when the statements are received. The petitioner explained that he provided his address at [REDACTED] that is included on the billing statement for February 1, 2017, because he knew that his mail would be forwarded to his father's address; he provided a forwarding address to the post office.

11. The petitioner contends that he was not aware of any of his assets that needed to be closed or transferred to qualify for Medicaid. The petitioner argues that he does not have access to the IRA because the account is not located in Ocala, Florida.

12. The respondent explained that the petitioner was given local addresses in Ocala, where he could transfer the account in order to gain access to the funds in the account (*Respondent's Exhibit 3*).

13. The petitioner contends that his father made the payments to his account in January 2017 through March 7, 2017 because he cannot write checks; therefore, he is not the one who made the payments. The petitioner argues that he cannot be discharged to his father's home because no one is home for the majority of the day. The petitioner is concerned that his parents' home does not have the equipment needed for his care. The petitioner believes he has not received the proper training needed to operate the equipment he needs to use on a daily basis. The petitioner believes that

other facilities were not contacted to explore as potential discharge locations

*(Petitioner's Exhibit 1).*

### **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 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

15. Federal Regulations appearing 42 C.F.R. § 483.15, sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

(c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(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;

16. Based on the testimony and evidence presented, the undersigned concludes that the nursing facility has established that the petitioner has failed, after reasonable and appropriate notice to pay for a stay at the facility. This is one of the six reasons

provided in 42 C.F.R. § 483.15 for which a nursing facility may involuntarily discharge a resident.

17. 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.

18. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

### **DECISION**

This appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The respondent may proceed with the discharge, as describe in the Conclusions of Law and in accordance with applicable Agency for Health Care Administration requirements.

**NOTICE OF RIGHT TO APPEAL**

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 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   25   day of   July  , 2017,

in Tallahassee, Florida.



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Paula Ali  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
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Copies Furnished To:



Aug 21, 2017

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 17N-00051

PETITIONER,

Vs.

[REDACTED]  
[REDACTED] BLVD.,  
ORANGE PARK, FL 32003

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, a hearing in the above-referenced matter convened on July 19, 2017 at 2:18 p.m. at the [REDACTED] [REDACTED]

[REDACTED]

**APPEARANCES**

For the Petitioner: The petitioner was present and represented herself.

For the Respondent: [REDACTED], Executive Director for the facility.

**ISSUE**

At issue is the facility's intent to discharge petitioner due to non-payment of a bill for services; a Nursing Home Transfer and Discharge Notice was issued on June 1, 2017 with an effective date of July 1, 2017.

The facility has the burden of proof to establish by clear and convincing evidence that the petitioner's discharge is in accordance with the requirements of the Code of Federal Regulations at 42 C.F.R. § 483.15 and Section 400.0255, Florida Statutes.

**PRELIMINARY STATEMENT**

By notice dated June 1, 2017, the respondent informed the petitioner that the facility was seeking to discharge/transfer her due to nonpayment. On June 8, 2017, the petitioner timely requested a hearing to challenge the discharge/transfer.

Appearing as witnesses for the petitioner were her husband, [REDACTED], and a family friend, [REDACTED].

Appearing as a witness for the respondent was [REDACTED] Business Office Manager for the facility.

Evidence was received and entered as the Respondent's Exhibits 1 through 2.

The record was closed at the conclusion of the hearing.

**FINDINGS OF FACT**

1. The petitioner (age 68) was admitted into the facility on May 6, 2016. The petitioner receives Social Security income and federal retirement benefits, for a total income in the amount of \$944. The Department of Children and Families determined that the petitioner has a patient responsibility of \$839, effective January 2017. The patient responsibility was \$836 prior to January 2017.

2. The respondent contends that the petitioner's patient responsibility has not been paid since the petitioner was admitted into the facility. The respondent contends

that the facility has been in contact with the petitioner's husband since the petitioner's admission to discuss payment of the patient responsibility.

3. The respondent contends that the petitioner reapplied for Medicaid and it was determined that the amount of the patient responsibility remained the same. The respondent contends that on April 4, 2017, the facility met with the petitioner's husband to inform him that the amount of the patient responsibility was not reduced based on information provided to the Department of Children and Families. The respondent contends that it attempted to work with the petitioner's family in order to get paid for the petitioner's care.

4. The Respondent's Exhibit 2 includes billing statements dated from June 1, 2016 through July 1, 2017. The balance owed to the facility, as of July 1, 2017, is \$12399.20.

5. The petitioner's husband does not dispute that the petitioner has a balance owed to the facility. The petitioner's husband argues that he does not agree with the amount of the patient responsibility that was determined by the Department of Children and Families. The petitioner's husband argues that the Department of Children and Families did not address his issues with its calculation of the amount of the patient responsibility whenever he contacted the agency. The petitioner's husband believes the patient responsibility should be lower.

#### **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 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

7. Federal Regulations appearing 42 C.F.R. § 483.15, sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

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8. Based on the testimony and evidence presented, the undersigned concludes that the nursing facility has established that the petitioner has failed, after reasonable and appropriate notice to pay for a stay at the facility. This is one of the six reasons provided in 42 C.F.R. § 483.15 for which a nursing facility may involuntarily discharge a resident.

9. Establishing that the reason for a discharge is lawful is just one step in the discharge process. The nursing home must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these

issues. The hearing officer has considered only whether the discharge is for a lawful reason.

10. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

### **DECISION**

This appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The respondent may proceed with the discharge, as describe in the Conclusions of Law and in accordance with applicable Agency for Health Care Administration requirements.

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FINAL ORDER (Cont.)

17N-00051

PAGE - 6

DONE and ORDERED this 21 day of August, 2017,  
in Tallahassee, Florida.



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Paula Ali  
Hearing Officer  
Building 5, Room 255  
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