

FILED

Jan 18, 2018

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 16F-07946

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 Leon
UNIT: 88113

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 6, 2017 at 3:06 p.m.

APPEARANCES

For the Petitioner: [REDACTED], counsel for the petitioner

For the Respondent: Camille Larson, Northwest Region counsel

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of August 23, 2016 and May 9, 2017 denying the petitioner's eligibility for Institutional Care Program (ICP) Medicaid.

The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

This matter was approved for multiple continuances requested by the petitioner due to his bankruptcy case. The hearing in this matter was scheduled for December 21,

2016, May 9, 2017, and September 19, 2017 with each date cancelled due to continuance. The matter was finally scheduled for hearing on December 6, 2017 and the petitioner's counsel again requested a continuance. The counsel for the petitioner requested the continuance citing he was new to the Medicaid appeal case. The undersigned notes counsel also represents the petitioner in his bankruptcy case and has been working with the petitioner's previous counsel for the Medicaid case. The Department's counsel was unwilling to continue the matter citing excessive continuances previously given. The Department also presented a Notice of Appearance as Additional Counsel filed with the Department, not the Office of Appeal Hearings, on September 15, 2017, in dispute of his claim. The undersigned found no valid basis for additional continuance and the hearing was held on December 6, 2017.

The petitioner submitted evidence on October 25, 2016 which was entered as Petitioner's Exhibit 1.

The Department submitted evidence on December 4, 2017 which was entered as Respondent's Exhibit 1.

The record was held open for Proposed Final Orders or Written Closing Arguments through January 3, 2018. The Department submitted a Proposed Final Order on January 3, 2018. The Respondent submitted a Written Closing Argument on January 3, 2018.

The record closed on January 3, 2018.

FINDINGS OF FACT

1. The petitioner filed an application for Institutional Care Program (ICP) Medicaid on July 21, 2016.
2. The Department issued a Notice of Case Action on August 23, 2016 denying the petitioner's application for ICP Medicaid as "We did not receive proof of the value of assets" and "We did not receive all the information requested to determine your eligibility". (Petitioner's Exhibit 1, pages 4 through 6)
3. The petitioner filed an application for ICP Medicaid on March 30, 2017.
4. The Department issued a Notice of Case Action on April 10, 2017 requesting verification of several assets, including promissory notes and various gifts he made between January 2013 and January 2015 while he was still healthy as well as proof the petitioner was healthy during that time period with no expectation of a need for Nursing Home and then suffered traumatic onset of illness. (Respondent Exhibit 1, pages 17 through 18)
5. The petitioner submitted a letter on April 20, 2017 requesting an additional 10 days to provide the remaining documentation requested. The letter also explained the liquidation of J.P. Morgan account [REDACTED] and that the proceeds from these funds were utilized to pay on his unpaid nursing home bill at [REDACTED] (Respondent Exhibit 1, pages 15 and 16).
6. The petitioner submitted the J.P. Morgan statement for March 2016 on account [REDACTED] (Respondent Exhibit 1, pages 19 through 30)
7. The petitioner submitted the April 2016 statement for Centennial Bank account [REDACTED] (Respondent Exhibit 1, pages 31 through 32) The petitioner noted

the balance liquidated from the J.P. Morgan account \$32,538.69 in the March statement was deposited in this account on March 31, 2016.

8. The petitioner submitted a statement from [REDACTED] showing payments on the petitioner's account. The statement shows a payment made on April 1, 2016 in the amount of \$36,790.12.

9. The Department issued a Notice of Case Action on May 9, 2017 denying the petitioner's application for ICP Medicaid as "We did not receive all information needed to determine eligibility". (Respondent Exhibit 1, pages 1 through 4)

10. The Department issued a manual Notice of Application Disposition on July 7, 2017 informing the petitioner that his application for Institutional Care Program Medicaid dated July 21, 2016 was denied in accordance with FAC 65A-1.712 and 65A-1.716. (Respondent Exhibit 1, page 9)

11. The petitioner voluntarily filed for bankruptcy May 27, 2016. In this process, the petitioner's bankruptcy estate was established. (Respondent's Exhibit 1, pages 36 through 87) Schedule C of the bankruptcy filing (pages 69 through 70) shows the petitioner had personal property in the amount of \$19,084, Life Insurance with a cash value of \$68,500 and a [REDACTED] Account with a balance of \$33,611.05 that was requested to be exempt from the bankruptcy estate.

12. The petitioner believed he had no assets to his name as all assets were assigned to the bankruptcy estate.

13. The petitioner believes that Federal Bankruptcy law supersedes state Medicaid rule.

14. The petitioner's son moved to [REDACTED] in August 2013 to assist with his father's declining health.

15. The petitioner's son became his power of attorney in May 2015 due to the petitioner's diminished mental capacity.

16. The petitioner's son stated he was party to the preparation of the case file for his father's bankruptcy case. He assisted with the preparation of reporting assets and meeting with creditors for the bankruptcy case.

17. The petitioner's son believes that the information should have been provided in a timely manner by the attorney representing the petitioner in this matter through September 2017 when she withdrew from this matter. He is unclear as to why that did not happen.

18. The petitioner's son does not believe it matters what assets his father had prior to the bankruptcy filing as they have all been turned over to the bankruptcy trustee.

19. The petitioner's son explained in testimony that the whole reason the family went through the whole process was their desire to get the petitioner Medicaid so that he could live the lifestyle at [REDACTED] best that he can and keep him safe. He went on to explain that the petitioner was a very controlling person and no one was aware of the financial debt he had incurred. It was the family's understanding that they had to liquidate all of his assets so that he could be eligible for Medicaid.

20. The petitioner has a bank account into which his Social Security check and MetLife annuity check are deposited into each month.

21. The petitioner has a Qualified Income Trust (QIT). All of his income, less the amount for his health insurance premiums, is transferred to the QIT each month. The funds in the QIT are then used to pay the facility in which the petitioner resides.

CONCLUSIONS OF LAW

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

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

24. Florida Admin. Code R. 65A-1.205, Eligibility Determination Process, 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.

...

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

25. The findings show the Department requested verification of all assets.

The above controlling authority requires the petitioner submit verification as requested.

The findings show the petitioner submitted verification in part, but requested additional time to submit the balance of the documentation. The findings show the partial verification, but a failure to provide all requested verification. The undersigned concludes the Department correctly denied the case based on the petitioner's failure to submit verification of assets.

26. 20 C.F.R. § 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.

(1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse).

...

(b) Liquid resources. Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit) and similar items. 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.)

(c) Nonliquid resources. (1) Nonliquid resources are property which is not cash and which cannot be converted to cash within 20 days excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily nonliquid are loan agreements, household goods, automobiles, trucks, tractors, boats, machinery, livestock, buildings and land. Nonliquid resources are evaluated according to their equity value except as otherwise provided. (See §416.1218 for treatment of automobiles.)

27. The findings show according to Schedule C of the petitioner's bankruptcy filing, there were personal property, life insurance cash value and a [REDACTED] account that were claimed as exempt from the bankruptcy. The above controlling authorities show that each of these types of resources are considered countable in determination of eligibility. The undersigned concludes verification of these items is a requirement for determination of eligibility for Medicaid.

28. 20 C.F.R. § 416.533, Transfer or assignment of benefits, states:

Except as provided in §416.525 and subpart S of this part, the Social Security Administration will not certify payment of supplemental security income benefits to a transferee or assignee of a person eligible for such benefits under the Act or of a person qualified for payment under §416.542. The Social Security Administration shall not certify payment of supplemental security income benefits to any person claiming such payment by virtue of an execution, levy, attachment, garnishment, or other legal process or by virtue of any bankruptcy or insolvency proceeding against or affecting the person eligible for benefits under the Act.

29. 42 U.S.C. § 1396a, State plans for medical assistance, states in relevant part:

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37),¹ 606(h),¹ or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6)¹ of this title),

...

(ii) at the option of the State, to 4 any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to 4 any reasonable

categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(l) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

...

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

30. 42 U.S.C. § 1382b, Resources, states in relevant part:

(b) Disposition of resources; grounds for exemption from disposition requirements

(1) The Commissioner of Social Security shall prescribe the period or periods of time within which, and the manner in which, various kinds of property must be disposed of in order not to be included in determining an individual's eligibility for benefits. Any portion of the individual's benefits paid for any such period shall be conditioned upon such disposal; and any benefits so paid shall (at the time of the disposal) be considered overpayments to the extent they would not have been paid had the disposal occurred at the beginning of the period for which such benefits were paid.

(2) Notwithstanding the provisions of paragraph (1), the Commissioner of Social Security shall not require the disposition of any real property for so long as it cannot be sold because (A) it is jointly owned (and its sale would cause undue hardship, due to loss of housing, for the other owner or owners), (B) its sale is barred by a legal impediment, or (C) as determined under regulations issued by the Commissioner of Social Security, the owner's reasonable efforts to sell it have been unsuccessful.

31. Florida Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource

Eligibility Criteria, states in relevant part:

(2) Exclusions. The Department follows SSI policy prescribed in 20 C.F.R. §416.1210 and 20 C.F.R. §416.1218 in determining resource exclusions, with the exceptions in paragraphs (a) through (g) below, in accordance with 42 U.S.C. §1396a(r)(2).

(a) Resources of a comatose applicant (or recipient) are excluded when there is no known legal guardian or other individual who can access and expend the resource(s).

...

(3) Transfer of Resources and Income. According to 42 U.S.C. §1396p(c), if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the Department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for ICP, Institutional Hospice or HCBS Waiver Programs....

(a) The Department follows the policy for transfer of resources in accordance with 42 U.S.C. §§1396p and 1396r-5. Transfer policies apply to the transfer of income and resources.

...

(d) Except for allowable transfers described in 42 U.S.C. §1396p(c)(2), in all other instances the Department must presume the transfer occurred to become Medicaid eligible unless the individual can prove otherwise.

...

(e) Each individual shall be given the opportunity to rebut the presumption that a resource or income was transferred for the purpose of qualifying for Medicaid. No period of ineligibility shall be imposed if the individual provides proof that they intended to dispose of the resource or income at fair market value or for other valuable consideration, or provides proof that the transfer occurred solely for a reason other than to become Medicaid eligible or if the individual's total countable resources (including the transferred resources) are below the program limits.

32. The findings show the petitioner filed for bankruptcy in May 2016. The findings further show the testimony of the petitioner's son that the reason they went through this process was to obtain Medicaid eligibility for the petitioner. The above controlling federal and state authorities are specific in the discussion of transferring of assets and transferring of assets for the purpose of qualifying for Medicaid. The undersigned concludes the Department must presume the petitioner transferred the assets in order to become Medicaid eligible UNLESS the petitioner provides proof that he intended to dispose of the resource at fair market value or for other valuable

consideration. The undersigned concludes the petitioner's filing of bankruptcy was done with the express purpose of making the petitioner eligible to receive Medicaid.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 18 day of January, 2018,
in Tallahassee, Florida.

Melissa D. Roedel

Melissa Roedel
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency
[REDACTED]
Camille Larson

FILED

Feb 15, 2018

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-03579

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 07ICP

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:07 a.m. on December 15, 2017.

APPEARANCES

For the Petitioner: [REDACTED] sq.
Elder Law Attorney

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

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on June 16, 2017. On May 18, 2017, [REDACTED] the petitioner's attorney, filed a "MOTION TO CONTINUE FAIR HEARING". The request was granted and the hearing was rescheduled for July 10, 2017. On May 23, 2017, [REDACTED] submitted a "NOTICE OF UNAVAILABILITY", stating he was unavailable on July 10, 2017. The hearing was rescheduled for August 16, 2017. On August 15, 2017, [REDACTED], filed another "MOTION TO CONTINUE FAIR HEARING". The request was granted and the hearing was rescheduled for September 13, 2017. On September 6, 2017, the undersigned cancelled the September 13, 2017 hearing, due to Hurricane Irma and rescheduled the hearing for September 21, 2017. On September 21, 2017, the hearing convened at 3:02 p.m. During the hearing, Brian Meola, Esq., the respondent's attorney, verbally requested a continuance, due to requiring the petitioner's medical records. The request was granted and the hearing was rescheduled for October 6, 2017. On September 28, 2017, Brian Meola, Esq., requested a hearing continuance. The request was granted and the hearing was rescheduled for October 10, 2017. On October 9, 2017 David Jacoby, Esq., filed a "MOTION TO CONTINUE FAIR HEARING". The request was granted, the hearing was not rescheduled until November 21, 2017, to convene on December 13, 2017. On December 12, 2017, Brian Meola, Esq., requested a hearing continuance. The request was granted, the hearing was rescheduled for and convened on December 15, 2017.

The following appeared at the September 21, 2017 hearing: The petitioner who did not testify. [REDACTED], witness for the petitioner. Stan Jones, ACCESS,

Economic Self-Sufficiency Specialist II, witness for the respondent. Witnesses for the respondent from the Department of Elder Affairs (DOEA) were Doris Hall, Field Assessor and Yvette Worlow, Program Operations Administrator. Appearing as observers from the DOEA were, Vicky Sexton, Government Analyst II, Francis Carbone, Deputy General Counsel and Melissa Vergeson, Bureau Chief.

The following appeared at the December 15, 2017 hearing: Witnesses for the respondent were Susan Martin, ACCESS Operations Management Consultant, and Yvette Worlow, DOEA Program Operations Administrator. Observers from DOEA were Melissa Vergeson, Bureau Chief, Doris Hall, Field Assessor and Karen Swindler, Regional Program Operations Administrator.

██████████ MD, was the only medical expert that appeared and testified. Ms. ██████████ is considered an expert in her field: however, does not have a medical education and is not considered a medical expert.

The Hearing Officer took administrative notice of, *Florida Administrative Code R. 59G-4.180, 59G-4.290 and Section 409.985 Florida Statutes*. The petitioner submitted one exhibit, entered as Petitioner Exhibit "1". The respondent submitted eight exhibits, entered as Respondent Exhibits "1" through "8". Proposed Orders were requested from both attorneys, due by January 3, 2018. The record was closed for other documents on December 15, 2017. Proposed Orders were timely received from both attorneys and considered in the Final Order.

FINDINGS OF FACT

Paragraphs "1" through "29" transpired during the September 21, 2017 hearing. Paragraphs "30" through "34" transpired during the December 15, 2017 hearing.

1. Prior to the action under appeal, the petitioner (age 56) received LTC, Institutional Care Program (ICP) benefits, due to suffering a [REDACTED] when she was age 53.
2. The petitioner transitioned from LTC ICP to LTC HCBS Waiver in April 2016. The petitioner currently resides alone, in her home. HCBS housekeeping and meals on wheels are the two services that were provided to the petitioner.
3. The Comprehensive Assessment and Review for Long-term Care Services (CARES) unit of the DOEA is mandated to complete Level of Care (LOC) assessments for individuals applying for or receiving LTC programs. The petitioner's initial LOC was completed and approved in 2014, when the petitioner was admitted to a nursing home facility.
4. HCBS participants must meet institutional LOC criteria. Although, HCBS allows the participants to live at home. The LOC criteria includes the "requirement for intermediate care services, including 24-hour observation and care and the constant availability of medical and nursing treatment and care".
5. United Healthcare is contracted to provide services to HCBS recipients. United Healthcare is responsible for submitting an annual 701B Comprehensive Assessment (701B) to CARES for HCBS recipients.
6. CARES is responsible for the approval and/or denial of the LOC for HCBS recipients. CARES is also responsible for submitting the completed LOC to the Department for approval and/or denial of HCBS.
7. A 701B was not completed by United Healthcare, for the petitioner, in 2016. The last 701B completed, by United Healthcare, was on August 20, 2015.

8. On March 1, 2017, CARES received a completed 701B (Respondent Exhibit 8) from United Healthcare. CARES determined that the 701B was not clear on whether the petitioner met the LOC and decided to complete their own 701B.

9. On March 8, 2017, Doris Hall, DOEA CARES Field Assessor, completed an in-person 701B (Respondent Exhibit 3) with the petitioner, at the petitioner's residence.

10. Ms. Hall testified that she asked the petitioner many questions during the March 8, 2017 assessment. The following are some questions Ms. Hall mentioned asking the petitioner. The petitioner's responses to the questions are in bold print.

Do you need outside assistance to evacuate? **NO**
Do you have a primary caregiver? **NO**
Do you have a power of attorney? **NO**
Do you have problems taking medication? **NO**
Can you call the doctor to make an appointment if needed? **YES**
Do you have adequate transportation to get to the doctor? **YES**
Are you able to move around the house? **YES**
Do you need help with bathing, eating, toileting, transferring or walking? **NO**
(The following were memory questions)
Do you suffer from memory loss or dementia? **NO**
I am going to say three words, "sock", "blue and "bed" for you to remember later.
The petitioner later remembered and repeated the three words.
Please tell me what year it is? **Correct answer**
Please tell me what month it is? **Correct answer**
Please tell me what month it is? **Correct answer**

11. Ms. Hall testified that the petitioner was not "wearing" oxygen during the assessment and the petitioner stated she uses oxygen on "as needed basis". Ms. Hall said that during the assessment the petitioner was able to sit, walk and stand without any issues.

12. Also on March 8, 2017, Ms. Hall completed a Case Recording Form (Respondent Exhibit 6, page 11). The form states in part:

Client DOES have limited ability reading, writing, speaking or understand English.

Client HAS become concerned about memory or had problems remembering important things.

Client has copd and is supposed to use O2 continuously, has concentrator as well as portable tanks but client only uses O2 prn [pro re nata, Latin for as necessary] basis, when/if sob [short of breath] client knows to use O2 and will take portable tank on outing in case of sob.

13. Ms. Hall asserted that the first sentence on the above Case Recording should read "Client DOES NOT have limited ability reading, writing, speaking or understand English."

14. Ms. Hall testified that following completion of the 701B, the petitioner's case (form 3008-medical record and 701B) was reviewed by an interdisciplinary staffing group. The group consisted of two registered nurses (RN), Yvette Worlow, DOEA Program Operations Administrator and other Field Assessors. And the group agreed that the petitioner did not meet the LOC, in accordance with Florida Administrative Code 59G-4.180 (2)(a).

15. Ms. Hall said that following review by the interdisciplinary staffing, the petitioner's case was sent to the Regional Program Operations Administrator and the DOEA physician to make the final decision.

16. The LOC (Respondent Exhibit 7), stating the petitioner "Does Not Meet LOC Criteria", was signed by DOEA physician Allen Castello, on March 17, 2017.

17. On April 10, 2017, the Department mailed the petitioner a Notice of Case Action, notifying her Medicaid (HCBS) would end on April 30, 2017 (Respondent Exhibit 4).

18. Following Ms. Hall's testimony, [REDACTED], testified that she did not attend the petitioner's interdisciplinary staffing meeting (as mentioned by Ms. Hall), because she

was not in the office that day. And Karen Swindler, Regional Program Operations Administrator was present at the meeting. [REDACTED] reviewed the petitioner's case prior to attending the hearing and agreed that the petitioner does not meet the LOC.

19. [REDACTED], internal medical physician, has been the petitioner's primary physician since March 2016. [REDACTED] testified that the petitioner's medical conditions include: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

20. [REDACTED] stated the number of medical conditions the petitioner has does not influence the decision on the LOC. It is the inability to manage her medical conditions independently that influence the LOC. [REDACTED] testified that the petitioner is capable of managing her medical conditions.

21. [REDACTED] testified that the petitioner requires assistance with daily living activities including: bathing, dressing, toileting, preparing meals and housework. And stated that the petitioner has poor balance and had fallen a few times in April 2017. [REDACTED] said that the petitioner burned herself a few times while cooking, due to not having mobility of her right hand.

22. [REDACTED] stated the petitioner burning herself, her inability to bathe, dress or complete housework are not medical issues and do not affect the decision on the LOC. [REDACTED] said only the inability to manage her medical conditions influence the LOC decision.

23. The petitioner's medical record, form 3008 (Respondent Exhibit 2), used to determine the LOC, was completed by the petitioner's physician [REDACTED] on February 23, 2017. The medical record states the petitioner requires oxygen, PRN at night.

24. Neither the petitioner's counsel nor the respondent's counsel questioned [REDACTED] as to the reason the medical record she completed on February 23, 2017 states the petitioner only requires oxygen at night. Or the reason [REDACTED] now is testifying the petitioner requires oxygen 24X7.

25. [REDACTED] asserted that she was unaware that the petitioner required oxygen 24X7 and had memory loss issues, until the day of the hearing when the petitioner's physician testified.

26. [REDACTED] testified that the petitioner's 24X7 oxygen requirement satisfies the LOC; due to her being "noncompliant in using oxygen 24X7" which requires outside supervision.

27. [REDACTED] alleged that if the petitioner does not believe she needs oxygen 24X7, "she should discuss it with her doctor". [REDACTED] said that the petitioner not using oxygen 24X7 could be a result of her memory loss.

28. [REDACTED] agreed with the petitioner's counsel that DOEA was incorrect in reporting that the petitioner did not meet the LOC. And agreed that the petitioner's HCBS should be reinstated. However, [REDACTED] said "I would like to get something in writing from her doctor, though."

29. The petitioner's counsel agreed to submit the requested medical records. [REDACTED] was no longer at the hearing when the medical records were requested. [REDACTED] was

the first individual to testify and then exited the hearing. This was at the request of the petitioner's counsel. The respondent's counsel had no objections and choose not to cross examine [REDACTED].

30. [REDACTED] stated "nursing home care is an entitlement care program and an individual is able to wave the right to nursing home care and receive services in the community, but still needs to meet the nursing home LOC."

31. The petitioner's counsel submitted a letter from [REDACTED] Independent Lung Associates, P.A. (Petitioner Exhibit 1). The letter in part states:

[REDACTED]

32. The petitioner's counsel stated that in addition to the above letter (#31) he submitted over 100 pages of medical records to the respondent. Said medical records were not submitted to the Hearing Officer by either party. The petitioner's counsel argued that although he submitted the medical records to the respondent, without a records custodian the medial records are of no value.

33. Ms. [REDACTED] testified that the medical records submitted after the September 21, 2017 hearing, do not indicate that the petitioner does not have the capacity to make a choice about her health care. And do no support that the petitioner has memory loss issues.

34. Ms. [REDACTED] stated that the medical records received after the September 21, 2017 hearing were not reviewed by DOEA physician [REDACTED]; because the physician is no longer employed by DOEA. [REDACTED] asserted that the new medical records were

reviewed by [REDACTED], DOEA RN, and herself. And they stand by the original decision that the petitioner does not meet the LOC.

CONCLUSIONS OF LAW

35. 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.

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

37. *Florida Administrative Code* R 59G-13.080, Home and Community-Based Services Waivers, in part states:

(1) Purpose. Under authority of Section 2176 of Public Law 97-35, Florida obtained waivers of federal Medicaid requirements to enable the provision of specified home and community-based (HCB) services to persons at risk of institutionalization. Through the administration of several different federal waivers, Medicaid reimburses enrolled providers for services that eligible recipients may need to avoid institutionalization. **Waiver program participants must meet institutional level of care requirements. The HCB waiver services are designed to allow the recipients to remain at home or in a home-like setting...** (emphasis added)

(3) Home and Community-Based (HCB) Waiver Services are those Medicaid services approved by the Centers for Medicare and Medicaid under the authority of Section 1915(c) of the Social Security Act. The definitions of the following services are provided in the respective HCB services waiver, as are specific provider qualifications...

(f) Chore Services and Housekeeping/Chore Services are provided to maintain the home in a clean, sanitary and safe environment. Chore services will be provided only in cases where neither the recipient, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency, or third party payor is capable of or responsible for their provision...

(n) Home Delivered Meals and Special Home Delivered Meals are designed to provide meals to persons who have difficulty shopping for or preparing food without assistance....

38. In accordance with the above authority, HCBS participants must meet the institutional LOC requirements and are allowed to live at home.
39. Pursuant to the above authority, the petitioner received HCBS house-keeping and meals on wheels.
40. Section 409.978, Florida Statutes, Long-term care managed care program, in part states:
- (1) Pursuant to s. 409.963, the agency shall administer the long-term care managed care program described in ss. 409.978-409.985, but may delegate specific duties and responsibilities for the program to the Department of Elderly Affairs and other state agencies...
 - (2) The agency shall make payments for long-term care, including home and community-based services, using a managed care model.
41. In accordance with the above authority, LOC determination was delegated to the DOEA CARES unit.
42. Section 409.979, Florida Statutes, Eligibility, in part states:
- (1) PREREQUISITE CRITERIA FOR ELIGIBILITY. Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the long-term care managed care program. The recipient must be:
 - (a) Sixty-five years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability.
 - (b) Determined by the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) preadmission screening program to require:
 - 1. Nursing facility care as defined in s. 409.985(3) ...
43. Section 409.985, Florida Statutes, Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program, in part states:

(3) The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4). When determining the need for nursing facility care, consideration shall be given to the nature of the services prescribed and which level of nursing or other health care personnel meets the qualifications necessary to provide such services and the availability to and access by the individual of community or alternative resources. **For the purposes of the long-term care managed care program, the term “nursing facility care” means the individual:**

(a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care professional and requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual; (emphasis added)

(b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual is incapacitated mentally or physically; or

(c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically...

44. Section 409.983, Florida Statutes, Long-term care managed care plan payment, in part states:

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

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

(b) Level of care 2 consists of recipients at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, and who require extensive health-related care and services because of mental or physical incapacitation.

(c) Level of care 3 consists of recipients at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, who have a limited need for health-related care and services and are mildly medically or physically incapacitated.

45. The above authorities explain that there are three different LOCs. Which correspond to the provisions of *Florida Administrative Code R. 59G-4.290* for “Skilled Services” (daily needs, medically complex, LOC one), 59G-4.180(4)(a) “Intermediate Care Services Level I” (daily or intermittent, extensive health needs due to physical incapacitation, LOC two), and 59G-4.180(4)(c) “Intermediate Care Services Level II” (limited needs, due to mild physical incapacitation, LOC three), respectively.

46. *Florida Administrative Code R. 59G-4.290*, Skilled Services, refers to LOC one and in part states:

(3) Skilled Services Criteria.

(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection. (emphasis added)

(b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:

1. Ordered by and remain under the supervision of a physician;
2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
4. Required on a daily basis;
5. Reasonable and necessary to the treatment of a specific documented illness or injury; and
6. Consistent with the nature and severity of the individual’s condition or the disease state or stage.

(c) Examples of services that qualify as skilled nursing services: (emphasis added)

3. Management and monitoring medication regime on a daily basis...

c. For residents with unstable conditions...

5. Administration of medical gases, aerosolized medication or oxygen which is started, monitored and regulated by professional staff... (emphasis added)

47. The above authority explains administration of oxygen, monitored and regulated by professional staff is a qualifying skilled nursing service.

48. The petitioner's physician testified that the petitioner requires oxygen 24X7.

49. ██████ testified that the petitioner uses oxygen on as need basis.

50. Evidence and testimony establish that the petitioner is not using oxygen 24X7 as required. Therefore, in accordance with the above authority, the petitioner's oxygen usage necessitates to be monitored by professional staff.

51. *Florida Administrative Code R. 59G-4.180, Intermediate Care Services*, refers to LOC two and three (Intermediate Care Services Level I or Level II) and in part states:

(1) Purpose. This rule establishes the level of care criteria that must be met in order for nursing and rehabilitation services to qualify as intermediate care services and clarifies the criteria that must be met in order for such services to qualify as an intermediate level I or intermediate level II service under Medicaid.

(2) Definitions as used in this section.

(a) Intermediate care nursing home resident. A Medicaid nursing home applicant or recipient who requires intermediate care services including 24-hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and treatment provided in a hospital or that which meets the criteria for skilled nursing services... (emphasis added)

(4)(a) Intermediate Care Service Level I is extensive health related care and service required by an individual who is incapacitated mentally or physically...

(c) Intermediate Care Services Level II is limited health related care and services required by an individual who is mildly incapacitated or ill to a degree to require medical supervision...

52. On September 21, 2017, ██████ testified that the petitioner did not meet the LOC in accordance with the above authority section (2)(a). However, in accordance with the

above (#46), *Florida Administrative Code R. 59G-4.290 (3)(c)5*, the petitioner meets skilled nursing services, due to not using oxygen 24X7, as required.

53. After [REDACTED] testimony (on September 21, 2017), [REDACTED] testified that the DOEA erred by stating the petitioner did not meet LOC criteria; because DOEA was unaware that the petitioner required oxygen 24X7 and had memory loss medical issues, until the day of the hearing, when the petitioner's physician testified. [REDACTED] requested the petitioner's medical records to confirm the oxygen requirement.

54. Both parties agreed that medical records were submitted to the respondent by the petitioner's attorney after the September 21, 2017 hearing. However, the medical records were not submitted to the Hearing Officer by either party.

55. At the December 15, 2017 hearing, [REDACTED] changed her testimony and said the petitioner did not meet the LOC because the medical records submitted (after the September 21, 2017 hearing) did not support that the petitioner requires oxygen 24X7 or has memory loss issues.

56. *Florida Administrative Code R. 28-106.213* addresses evidentiary standards for use at administrative hearings and in part states:

(3) Hearsay evidence, whether received in evidence over objection or not, may be used to supplement or explain other evidence, but shall not be sufficient in itself to support a finding unless the evidence falls within an exception to the hearsay rule as found in Sections 90.801-805, F.S.

57. Section 90.801, Florida Statutes, Hearsay; definitions; exceptions in part states:

(c) "Hearsay" is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.

(2) A statement is not hearsay if the declarant testifies at the trial or hearing and is subject to cross-examination concerning the statement...

58. The petitioner's physician testified that the petitioner's medical conditions include:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

59. Section 90.802, Florida Statutes, Hearsay rule, states "Except as provided by statute, hearsay evidence is inadmissible."

60. Section 90.803, Florida Statutes explains exceptions to the hearsay rule and in part states:

The provision of s. 90.802 to the contrary notwithstanding, the following are not inadmissible as evidence... (6)(a) A memorandum, report, record, or data compilation, in any form, of acts, events, conditions, opinion, or diagnosis, made at or near the time by, or from information transmitted by, a person with knowledge, if kept in the course of a regularly conducted business activity and if it was the regular practice of that business activity to make such memorandum, report, record, or data compilation, all as shown by the testimony of the custodian or other qualified witness, or as shown by a certification or declaration that complies with paragraph...

(c) A party intending to offer evidence under paragraph (a) by means of a certification or declaration shall serve reasonable written notice of that intention upon every other party and shall make the evidence available for inspection sufficiently in advance of its offer in evidence to provide to any other party a fair opportunity to challenge the admissibility of the evidence... (emphasis added)

61. Neither the physician that signed the LOC (stating that the petitioner did not meet LOC criteria); nor the RN that reviewed the petitioner's medical records and determined the petitioner did not meet the LOC criteria appeared/testified to support the respondent's argument that the petitioner did not meet the LOC.

62. Both parties agreed that the petitioner's counsel submitted medical records after the September 21, 2017 hearing. Said medical records with a "certification or declaration" were also not submitted by neither party.

63. *Florida Administrative Code R. 65-2.060*, Evidence, states:

(1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. **The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.** (emphasis added)

(2) When the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a Medical Review Team's decision, if the hearing officer considers it necessary, a medical assessment other than that of the person or persons involved in making the original decision shall be obtained at agency expense and made a part of the record.

64. Prior to the action under appeal, the petitioner received LTC HCBS. On April 10, 2017, the Department mailed the petitioner a NOCA, notifying her Medicaid (HCBS) would end on April, 30, 2017. Therefore, in accordance with the above authority the respondent carries the burden of proof by a preponderance of evidence.

65. In careful review of the cited authorities, evidence and testimonies, the undersigned concludes the respondent did not meet its burden of proof. Therefore, the respondent is hereby ORDERED to reinstate the petitioner's LTC HCBS benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted in accordance with the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15 day of February, 2018,

in Tallahassee, Florida.

Priscilla Peterson

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

Copies Furnished To:

[REDACTED]

Brian Meola, Esq.

Jan 18, 2018

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-04353

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 14, 2017 at 10:00 a.m.

APPEARANCES

For Petitioner: [REDACTED]

For Respondent: Joyce Miller, Esq.
Assistant Regional Counsel, Central Region
Department of Children and Families

STATEMENT OF ISSUE

Petitioner appeals Respondent's action denying her Institutional Care Program (ICP) Medicaid application dated August 17, 2015, for failure to provide information to determine eligibility, and bases her appeal on the following three arguments:

- 1) Petitioner's husband, John Clark (JC), abandoned her, and as such his assets should be excluded from her ICP eligibility determination.

2) JC's assets were unavailable to Petitioner due to circumstances beyond her control, and as such his assets should be excluded from her ICP eligibility determination.

3) Verification of JC's assets imposed an undue hardship on Petitioner, and as such his assets should be excluded from her ICP eligibility determination.

Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Pursuant to notice, the undersigned initially scheduled this appeal for a telephonic administrative hearing for June 27, 2017 at 2:00 p.m. On June 26, 2017, [REDACTED], Petitioner's designated representative, contacted the undersigned requesting a continuance as Petitioner had recently secured legal counsel, and needed time to prepare and discuss possible resolution. Pursuant to notice, the undersigned rescheduled the June 27, 2017 hearing for August 14, 2017 at 10:00 a.m.

On August 11, 2017, [REDACTED], contacted the undersigned requesting a continuance. The request indicated a continuance for no earlier than October 7, 2017, to allow additional time to prepare and discuss possible resolution. Respondent stated no objection. Pursuant to notice, the undersigned rescheduled the August 14, 2017 hearing for October 10, 2017 at 10:00 a.m.

On October 10, 2017, Respondent contacted the undersigned requesting a continuance to allow time to review Petitioner's memorandum of law filed and submitted on October 9, 2017. Petitioner stated no objection. Pursuant to notice, the undersigned rescheduled the October 10, 2017 hearing for November 14, 2017 at 10:00 a.m.

[REDACTED] appeared as Petitioner's witness without party objection. Respondent called no witnesses.

Petitioner submitted an evidence packet consisting of eleven exhibits, which were entered into evidence and marked as Petitioner's Exhibits "1" – "11." Respondent submitted an evidence packet consisting of seventeen exhibits, sixteen of which were entered into evidence and marked as Respondent's Exhibits "1" – 16." The undersigned did not enter Respondent's Exhibit, pages 8 – 9, Notice of Hearing, as these were notices created by the Office of Appeal Hearings and already included on the docket. The record closed on November 14, 2017.

FINDINGS OF FACT

1. As stipulated by the parties, the facts of this appeal are not in dispute, save but one (Petitioner and Respondent's Testimony) as stated in paragraphs 2 and 3. The remaining arguments are based on interpretation and application of law to the facts (Hearing Record).
2. Petitioner argued that she and JC held themselves out as separated at the time she signed the Assignment of Rights to Support on November 20, 2014 (Petitioner's Testimony).
3. Respondent argued that Petitioner and JC were living together up to the date she was admitted to [REDACTED] NH), and that they were holding themselves out as married until that point (Respondent's Testimony).
4. The following are the remaining undisputed facts as stipulated by the parties (Hearing Record):
5. On June 15, 2014, Petitioner was admitted to the NH (Respondent's Exhibit 6, Page 3).

6. On October 14, 2014, the [REDACTED] appointed [REDACTED] (PL) as Emergency Temporary Guardian for Petitioner (Petitioner's Exhibit 7, Page 2).
7. On, or about, November 20, 2014, PL applied for ICP benefits on behalf of Petitioner (Petitioner's Exhibit 9, Pages 3 – 17), by which she was subsequently approved for ICP benefits (Petitioner's Testimony).
8. On December 1, 2014, the [REDACTED] appointed PL as Plenary Guardian for Petitioner (Petitioner's Exhibit 7, Page 2).
9. On January 7, 2015, the [REDACTED] issued an Order authorizing PL to liquidate Petitioner's Individual Retirement Account (IRA) (Petitioner's Exhibit 7, Page 3).
10. On, or about, March 5, 2015, PL submitted a third notice (first notice was December, 2014) to Respondent notifying it to cancel Petitioner's ICP application as assets were discovered that should cover Petitioner's NH costs (Petitioner's Exhibit 9, Page 2).
11. On, or about, July, 2015, the funds in the IRA were depleted leaving no additional funds to cover Petitioner's NH costs (Petitioner's Testimony).
12. On August 17, 2015, PL submitted an ICP application on behalf of Petitioner, which is the subject application of this appeal (Respondent's Exhibit 6). This application indicated Petitioner was married (*Id.* at 2); received monthly income in the amount of \$692.00 in Social Security and \$91.24 in public retirement; that she holds an asset in the amount of \$87,000.00 for her home (*Id.* at 4); and that she incurs monthly expenses in the amount of \$227.45 for her Medicare Supplement, \$104.90 for her Medicare Part B, \$8,400.00 for her NH care, and \$157.00 for her dental care (*Id.* at 5 – 6).

13. On August 31, 2015, Respondent mailed a Notice of Case Action (NOCA) to Petitioner at her address of record requesting the following information:

We need the following information by September 10, 2015.

Please Complete and sign the "Financial Information Release" form
Other – please see comments below

Financial release form. Three months bank statements on bank letter head USB checking account [REDACTED] (all assets proof of gross retirement benefits (all income for 2015 level of care)

(Respondent's Exhibit 8, Page 1).

14. On, or about, September 8, 2015, PL submitted to Respondent Letters of Plenary Guardianship; Assignment of Rights to Support; Authorization to Disclose Information; Financial Information Release; Appointment of a Designated Representative; Informed Consent Form; Social Security Letter of Benefits; Canada Pension; October, 2014 USB checking account statement for account [REDACTED] (indicating it was closed by Petitioner's husband on October 15, 2014); and June, July, and August, 2015 USB guardianship account statements for account [REDACTED] (Petitioner's Exhibit 8). The Assignment of Rights to Support was dated November 20, 2014 (*Id.* at 3).

15. On September 17, 2015, Respondent mailed a NOCA to Petitioner at her address of record denying her August 17, 2015 ICP application as it did not receive all the information requested to determine eligibility (Respondent's Exhibit 5).

16. On October 13, 2015, [REDACTED], attorney for PL, contacted Respondent through mail regarding its September 17, 2015 NOCA (Petitioner's Exhibit 5, Pages 1 – 2). This letter informed Respondent that JC abandoned Petitioner at the NH when she became ill, transferred all accounts to his name, refused to pay any of her bills,

including her NH costs, and that she was ultimately denied ICP benefits due to his assets (*Id.*). This letter additionally indicated that it was not until after a deposition of JC¹ that assets were recovered to pay some of her expenses (*Id.*) Furthermore, that as JC swore under oath that he refused to pay for her care, that this case qualified as a Spousal Refusal case, that his assets should not be counted, and that to count them would cause an undue hardship to Petitioner as she lacks the ability to pay for her care and JC refuses to do so (*Id.*) This letter also indicated Respondent had initially approved Petitioner for ICP benefits based on an already executed Assignment of Rights to Support from the husband and in its possession. Lastly, this letter explicitly served as a request to appeal her ICP denial dated September 17, 2015 based on the Assignment of Rights to Support (*Id.*)

17. Though Respondent received the October 13, 2015 letter, it never took action on the appeal request as it did not forward the letter to the Office of Appeal Hearings (Respondent's Exhibit 14, Pages 1 – 2).

18. On November 18, 2015, [REDACTED] contacted JC through mail informing him that Petitioner was forced to apply for ICP benefits due to his refusal to support her, that he abandoned her at the NH when she became ill, and then transferred all assets to his name leaving her with no funds to pay for her care (Petitioner's Exhibit 5, Page 3). This letter also informed JC that Petitioner initially received ICP benefits due to his refusal to pay and her lack of assets; however, that Respondent refused to continue providing these benefits without financial documentation and written confirmation that

¹ Petitioner's Exhibit 10, Page 15, indicates this deposition occurred on, or about, January 31, 2015, at which point JC indicated his wish to terminate his joint tenant estate with Petitioner.

he refused to support Petitioner (*Id.*). This letter indicated that a Financial Information Release for JC's review and signature was enclosed, and that he was to return that form along with a handwritten statement confirming that he refused to pay for Petitioner's care (*Id.*). Lastly, this letter concluded informing JC that legal civil action may be filed against him for his failure to provide this information (*Id.*)

19. On March 15, 2016, the [REDACTED] issued a Summons requiring JC file written response to a civil lawsuit filed against him by PL, on Petitioner's behalf (Petitioner's Exhibit 10, Page 13).

20. On April 8, 2016, the [REDACTED] received JC's Response to the March 15, 2016 Summons, which included an insert from his January 31, 2015 deposition where he explicitly stated that he no longer wished to be in a joint tenant estate with Petitioner, and that a joint tenant estate had been terminated and continued to be terminated to that date (Petitioner's Exhibit 10, Pages 13 – 16).

21. On November 21, 2016, the [REDACTED] issued an Order on the civil lawsuit filed against JC, which directed him to sign the necessary Medicaid Waivers and to provide the necessary financial information, releases, and statements indicating that he was not willing to support Petitioner or pay for any of her NH expenses (Petitioner's Exhibit 10, Pages 4 – 6).

22. JC failed to comply with this Order and provide the required information as directed by the [REDACTED] (Petitioner's Exhibit 11, Page 3).

23. In February, 2017, Petitioner passed away and her civil lawsuit was not further pursued (Petitioner's Exhibit 11, Page 3).

24. The following are the parties' arguments of law as they apply to the facts of this appeal (Hearing Record):

25. Petitioner argued, under Department policy 2240.0604.14(2), that because JC abandoned her and held himself out as separated, Respondent could have approved her for ICP benefits, as separated spouses can be considered individuals under circumstances when the community spouse cannot be found or located (Petitioner's Testimony). The Assignment of Rights to Support dated November 20, 2014 along with JC's actions indicate they were separated at the time she began receiving ICP benefits (*Id.*).

26. Petitioner also argued, under Department policy 1640.0321, that because JC refused to cooperate in verifying his assets, even ignoring a court order to do so, along with the October 13 and November 18, 2015 letters from [REDACTED], convincing evidence was provided to Respondent indicating that JC's assets were unavailable to Petitioner due to circumstances beyond her control (*Id.*).

27. Petitioner lastly argued that because Florida law does not provide recourse for Petitioner's particular circumstances Federal law must be followed, which states that a State cannot deny eligibility based on a community spouse's resources if it would work an undue hardship on the institutionalized spouse (Petitioner's Exhibit 11).

28. Respondent argued that Florida law does not indicate that Petitioner cannot be denied ICP benefits due to JC's refusal to cooperate in verifying his assets, rather it is ultimately Petitioner's responsibility to provide information to Respondent required to establish eligibility (Respondent's Exhibit 16, Page 1).

29. Respondent also argued that though it agrees Florida law does not carve out an exception for Petitioner's particular circumstances, Federal law still presumes verification of the community spouse's resources prior to determining undue hardship, and in fact requires it (Respondent's Exhibit 16, Page 2).

30. Respondent lastly argued that if an exception is found for Petitioner under Federal law when Florida law does not provide for it, it would be a slippery slope in determining, on a case by case basis, the threshold requirement for what establishes undue hardship (Respondent's Testimony). Furthermore, Petitioner's estate could have pursued JC in civil court based on his failure to comply with the court order (*Id.*).

CONCLUSIONS OF LAW

31. 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.

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

33. Before addressing the merits of this appeal, the undersigned must determine if the Department of Children and Families, Office of Appeal Hearings, has jurisdiction over this appeal based on the timeliness of the request for hearing, pursuant to Florida Administrative Code Rule 65-2.046. This appeal addresses a NOCA issued by Respondent on August 17, 2015. Petitioner's prior counsel requested a hearing through a letter to Respondent dated October 13, 2015. Respondent acknowledged receipt of this request, but that it failed to take action on this request. Petitioner's designated

representative subsequently filed a new request for hearing on June 2, 2017, which is the basis for this current appeal. Though the current request for hearing is past the ninety (90) day time limit under the Florida rules, the undersigned concludes that Petitioner preserved her appeal rights through her timely request for hearing dated October 13, 2015. The undersigned concludes the Department of Children and Families, Office of Appeal Hearings, has jurisdiction over this appeal based on a timely request for hearing, pursuant to Florida Administrative Code Rule 65-2.046.

ABANDONMENT ISSUE

34. The Florida Administrative Code Rule 65A-1.701 defines a community spouse as “the non-institutionalized legal spouse of an institutionalized person” and spouse as “an institutionalized person’s non-institutionalized legal spouse whether they are living together or separated.”

35. The 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.

36. The Florida Administrative Code Rule 65A-1.712, SSI - Related Medicaid Resource Eligibility Criteria defines how resources are counted in ICP for a couple, and 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...

...

(4) 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...

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

...

(g) **The institutionalized spouse shall not be determined ineligible based on a community spouse's resources if all of the following conditions are found to exist:** (emphasis added)

1. The institutionalized individual is not eligible for Medicaid Institutional Care Program because of the community spouse's resources and the community spouse refuses to use the resources for the institutionalized spouse; and
2. The institutional spouse assigns to the state any rights to support from the community spouse by submitting the Assignment of Rights to Support, CF-ES 2504, 10/2005, incorporated by reference, signed by the institutionalized spouse or their representative; and
3. The institutionalized spouse would be eligible if only those resources to which they have access were counted; and
4. The institutionalized spouse has no other means to pay for the nursing home care.

...

37. The ACCESS Florida Program Manual sets forth the following:

1640.0314.01 ASSETS AVAILABLE TO SPOUSE (MSSI)

The following policy applies to Institutional Care Program (ICP), Institutional Hospice, and Home and Community Based Services (HCBS) Programs. This includes SSI recipients applying for institutional services.

Although the assets of a Medicaid recipient's spouse may not have been considered available to the individual in the community (e.g., when the couple is separated), when the individual applies for institutional services, the assets of both spouses must be considered in determining the individual's eligibility for institutional services. (emphasis added)

...

If after declaring and verifying his assets, the community spouse refuses to make them available to the institutionalized spouse, the institutionalized spouse may assign his rights of support to the state and obtain institutional care benefits (refer to passages 1640.0314.03 and 1640.0314.04 for policy) ... (emphasis added)

If the couple has been separated for a long time and the community spouse cannot be located, there is no "community spouse" and the applicant must be considered an individual when applying income and asset standards. (emphasis added)

...

38. The above cited authorities state that when an institutionalized applicant has a community spouse all countable resources owned solely or jointly by the husband and wife are considered in determining eligibility. Furthermore, the authorities state that under Spousal Impoverishment, the institutionalized spouse shall not be determined ineligible based on a community spouse's resources when all four of the conditions under the Florida Administrative Code Rule 65A-1.712(4)(g) have been met. These conditions are predicated on the verification of the community spouse's assets. In addition, the only time that an institutionalized spouse can be considered an individual, and the community spouse's income and assets can be excluded, is when the couple has been separated for a long time AND the community spouse cannot be located.

39. Petitioner also relied on the following ACCESS Florida Program Manual policy in its argument on this issue:

2240.0604.14 Changes in Marital Relationships (MSSI, SFP)

If there is a change in the marital relationship between two eligible individuals, that change will be treated as follows:

...

2. When a couple has been considered as an eligible individual and eligible spouse, and either the marital relationship terminates or the parties separate, each of the parties who still meets the requirements for

MSSI will be treated as an eligible individual beginning with the month following the month of separation. If both are residing in the same institution, they can choose whether to be considered as a couple or as individuals.

...

However, this policy applies to relationships between two eligible individuals. The undersigned concludes this policy does not apply to Petitioner as JC was never considered an eligible spouse. The evidence shows only Petitioner's eligibility for benefits was ever reviewed.

40. The undersigned concludes that, even though JC very clearly refused to make his assets available to Petitioner, and Petitioner did execute and submit an Assignment of Rights to Support to Respondent, due to the lack of verification of JC's assets Petitioner did not meet the predicate verification requirement for ICP eligibility under Spousal Impoverishment. Furthermore, the evidence shows that through the civil action against JC along with the November 18, 2015 letter sent to JC from [REDACTED], JC's location was never an issue. As JC's assets were never verified, allowing for an Assignment of Rights to Support under Spousal Impoverishment, and his location was always known, the actual date of the couple's separation or whether they ever were separated is moot, as any potential separation had no impact on the requirement to verify JC's assets in Petitioner's ICP eligibility determination.

ASSETS UNAVAILABLE ISSUE

41. The Florida Administrative Code Rule 65A-1.205 addresses the eligibility determination process, and states in relevant part:

- (1) The individual completes a Department application for assistance...
- (a) The Department must determine an applicant's eligibility initially at application...**It is the applicant's responsibility to keep appointments**

with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. (emphasis added) 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..., 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 interview, or 60 days from the date of application, whichever is later...If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension...**When the applicant provides all required information or verification, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.** (emphasis added)

...

42. The Florida Administrative Code Rule 65A-1.712(4)(a), SSI - Related Medicaid Resource Eligibility Criteria, as previously cited, also applies to this issue.

43. The ACCESS Florida Program Policy Manual sets forth the following:

1640.0314.01 ASSETS AVAILABLE TO SPOUSE (MSSI), as previously cited, also applies to this issue.

1640.0321 ASSETS UNAVAILABLE – CIRCUMSTANCES BEYOND CONTROL (MSSI, SFP)

Assets unavailable due to circumstances beyond the individual's control are not considered in the determination of eligibility.

The individual must present convincing evidence to prove the asset is unavailable to him due to circumstances beyond his control. The eligibility specialist will make an independent assessment of the availability based on the evidence presented...

44. The above cited authorities state that it is the applicant's responsibility to furnish information, documentation, and verification needed to establish eligibility. Once the applicant provides all information or verification then eligibility can be determined. When an institutionalized applicant has a community spouse all countable resources owned solely or jointly by the husband and wife must be considered in determining eligibility and must be verified. However, if assets or resources are unavailable due to circumstances beyond the applicant's control, these assets or resources are not considered in the determination of eligibility. The applicant must provide convincing evidence to prove the asset or resource is unavailable to him or her.

45. The undersigned concludes that, though Petitioner clearly provided convincing evidence that JC had no intention of supporting her, the evidence does not establish that his assets were unavailable to her. JC's assets, in fact, were unknown as verification was never provided by which an eligibility specialist could make an availability determination.

UNDUE HARDSHIP ISSUE

46. The United States Code Title 42, Section 1396R-5, Treatment of income and resources for certain institutionalized spouses addresses undue hardship, and states in relevant part:

...

(c) Rules for treatment of resources

...

(2) Attribution of resources at time of initial eligibility determination

In determining the resources of an institutionalized spouse at the time of application for benefits under this subchapter, regardless of any State laws relating to community property or the division of marital property—

(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse,

(emphasis added) and

(B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) of this section (as of the time of application for benefits).

(3) Assignment of support rights

The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse; (emphasis added)

(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

(C) the State determines that denial of eligibility would work an undue hardship. (emphasis added)

...

47. The Florida Administrative Code Rule 65A-1.712(4), SSI - Related Medicaid Resource Eligibility Criteria, as previously cited, also applies to this issue.

48. The above cited authorities state that for ICP eligibility all resources held by either the institutionalized spouse, community spouse, or both, shall be considered available to the institutionalized spouse and considered in the benefit eligibility determination. However, the institutionalized spouse shall not be determined ineligible by reason of resources where the institutionalized spouse has assigned to the State any rights to support from the community spouse, or the State determines that denial of eligibility would work an undue hardship.

49. The undersigned concludes that the state of Florida has determined not to provide an undue hardship option for applicants, under its discretion as provided by the United States Code Title 42, Section 1396R-5(c)(3)(C). Instead, the state has provided

an option in the Florida Administrative Code Rule 65A-1.712(4)(g), as required by the United States Code Title 42, Section 1396-5(c)(3)(A), for the Assignment of Rights to Support under Spousal Impoverishment when a community spouse refuses to support his or her institutionalized spouse. The undersigned acknowledges the rare and unique circumstances of Petitioner's appeal, and that federal and state law do not provide any recourse under her circumstances. However, the undersigned is bound by federal and state law.

50. In careful review of the cited authorities and evidence, the undersigned concludes Petitioner did not meet her burden of proof indicating Respondent incorrectly denied her ICP application dated August 17, 2015. Respondent did correctly deny Petitioner's ICP application dated August 17, 2015, as it determined she failed to provide required verification of JC's assets needed to determine her ICP eligibility.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED. Respondent's action is AFFIRMED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 18 day of January, 2018,

in Tallahassee, Florida.



Erik Swenk, Esq.
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To:



Jan 25, 2018

Office of Appeal Hearings
Dept. of Children and Families

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



APPEAL NO. 17F-05731

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88267

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 7, 2017 at approximately 1:18 p.m. CDT.

APPEARANCES

For the Petitioner:  designated representative

For the Respondent: Roneige Alnord, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of July 24, 2017 denying the petitioner's Medicaid application of July 20, 2017 due to a Child Support Enforcement (CSE) sanction. The petitioner specifically seeks Medicaid coverage for the month of March 2017. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "7" and "12".

The petitioner submitted a packet of information that was admitted into evidence and marked as Petitioner's Exhibit "1".

On September 7, 2017, [REDACTED], Outreach Patient Advocates office manager, appeared as a witness for the petitioner. Tessa Walker, revenue specialist II with the Department of Revenue (DOR) appeared as a witness for the respondent. The hearing was continued so that testimony could be heard from an unavailable witness and additional evidence submitted. The hearing was rescheduled for October 12, 2017 at 8:15 a.m. CDT.

On October 12, 2017, Roneige Alnord, respondent's representative, and Richard D'louhy, revenue administrator with DOR, respondent's witness, called in timely. We waited 15 minutes. The petitioner, nor her representative appeared. Within minutes of terminating the conference call, the petitioner called into the hearing. The hearing was continued and rescheduled for November 15, 2017.

On November 15, 2017 at approximately 8:14 a.m. CST, the hearing reconvened. Ken Denman, represented the petitioner. Roneige Alnord, represented the respondent. Theresa Bowman, revenue administrator II with DOR, appeared as a witness for the respondent.

The record remained open for further evidence due by close of business on November 22, 2017. Evidence was received from DOR on November 22, 2017 and

was marked as Respondent's Exhibits "8" through "11". The record was closed November 22, 2017.

FINDINGS OF FACT

1. On March 31, 2017, respondent's witness TC, appeared at the CareerSource office in [REDACTED] to complete the cooperation process for the petitioner so she could be Medicaid eligible for the month of March 2017. TC submitted a power of attorney (POA) and was prepared to offer all the information and to do anything necessary to get the CSE sanction in effect cured. The POA document was not accepted by CSE staffer, TB.
2. Petitioner's witness TB was working the desk March 31, 2017 and served TC. She explained as the case was closed since 2015 due to a sanction, that, TC was effectively requesting for the case to be reopened. To reopen a case, a service request would have to be created and the computer system would then go through the process of requesting, receiving and processing absent parent information which would take up to 15 days. TB explained that policy states a representative cannot apply for someone else. If the case had reopened based on TC's office visit, the would have been opened in April 2017 and the month of April 2017 would be the earliest possible effective date for the lifting of the sanction.
3. The petitioner asserts that CSE should have recognized the POA, allowed TC to represent the petitioner, cooperate, and have the sanction "cured" that day, which would make the petitioner Medicaid eligible based on the criteria of CSE effective the month of March 2017. The petitioner submitted a page from the Florida Department of Revenue

Child Support Program Procedures, Confidentiality – Disclosure of Information, page 25, concerning Power of Attorney to support their claim (Petitioner’s Exhibit 1).

4. On July 20, 2017, the petitioner, by way of her designated representative Ken Denman, applied for Medicaid. The household consisted of her son, PJ age 7, and herself (Respondent’s Exhibit 3).

5. At the time of the application, the petitioner was under a sanction for non-participation with CSE that had been in effect since April 1, 2015 (Respondent’s Exhibit 1).

6. By notice of case action (NOCA) dated July 25, 2017, the petitioner was informed that her Medicaid application had been denied because, “You or a member(s) of your household is not eligible due to failure to cooperate with child support enforcement” (Respondent’s Exhibit 5).

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

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

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

10. 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.

11. Cooperation with Child Support Enforcement is set forth in Section § 414.095, Florida Statutes, which states, “as a condition of eligibility for public assistance, the family must cooperate with the state agency responsible for administering the child support enforcement program.”

12. 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.

13. The respondent must follow the rules. The respondent asserts its action of not approving Medicaid was due to petitioner's ongoing failure to cooperate with CSE. In this instant case, CSE requested a sanction on the petitioner. The validity of the sanction is not in question. The above authority assigns the responsibility to determine non-cooperation to CSE. CSE determined that the efforts of TC were insufficient to lift

the sanction effective March 2017. Had TC been allowed to offer what information and authority she presumed by possession of a POA, if sufficient, the effective date of lifting the sanction would be no earlier than April 2017. Without good cause, the respondent's recourse is to place and remove sanction requests as informed of by CSE.

14. Whether CSE acted correctly by not allowing TC to complete cooperation for the petitioner on March 31, 2017 is not within this hearing officer's authority. The hearing officer's authority extends to the actions taken within the Department of Children and Families. CSE informed the respondent that the petitioner should be sanctioned for non-cooperation and the respondent applied the sanction penalty, as per the above cited authority.

15. Upon careful consideration of the testimony, evidence and authorities, the undersigned concludes that the petitioner has not met its burden. The respondent acted accordingly when denying Medicaid benefits to the petitioner for the month of March 2017 and ongoing because of her non-cooperation with CSE.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The

petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 25 day of January, 2018,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Jan 25, 2018

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-05859 17F-05860

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pasco
UNIT: 88267

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 20, 2017 at approximately 8:25 a.m. CST.

APPEARANCES

For the Petitioner: [REDACTED], *pro se*

For the Respondent: Roneige Alnord, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of August 7, 2017 approving her July 14, 2017 application for Supplemental Nutrition Assistance Program (SNAP) benefits in the amount of \$16 monthly, and enrolling her in the Medically Needy Program (MNP) with an estimated share of cost (SOC) of \$1,636. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "13".

The petitioner submitted a packet of information which consisted of a duplicate of one of the respondent's exhibits and was not admitted into evidence.

The hearing was originally scheduled for September 13, 2017. The hearing was continued at the petitioner's request and rescheduled for October 10, 2017.

The petitioner did not appear for the October 10, 2017 hearing. She telephoned the Office of Appeal Hearing to inquire as to the date for the rescheduled hearing on October 13, 2017. After being told the hearing date had passed, she stated that she had not received the appointment letter.

The hearing was rescheduled for November 8, 2017. This hearing was continued because of unavailability of the Department as a result of Disaster SNAP after hurricane Irma. The hearing was rescheduled for December 5, 2017.

On December 5, 2017, all parties met. After a pre-hearing conference, during which the merits of the case were not discussed before this hearing officer, both parties agreed to a continuance. The hearing was rescheduled for December 20, 2017.

The record was held open with a deadline date of January 5, 2018 for the petitioner to submit ongoing medical expenses, outstanding medical debt and a copy of her Social Security Administration (SSA) denial letter. As of January 16, 2018, nothing has been received from the petitioner. The record was closed January 16, 2018.

FINDINGS OF FACT

1. On July 14, 2017, the petitioner (52 years old) applied to the respondent for SNAP, Family and SSI-Related Medicaid (Respondent's Exhibits 3 and 4).
2. On July 24, 2017, a notice of case action (NOCA) was sent to the petitioner requesting the petitioner provide "verification of Sick and Disability" (Respondent's Exhibit 5)
3. On August 1, 2017, the petitioner replied. She submitted a statement concerning her health from [REDACTED] ate, DPM, Board Certified Podiatric Surgeon which states in part:

[REDACTED] was seen at our clinic today for f/u of right foot surgery (07-14-2017) and will require at 6 months [sic] to a year of recovery with at least 4 months of no weight bearing to her right foot. She will be on a wheelchair for the first 4 months and then transitioned to a walking boot for the next 2 months depending on how she heals. She will then have Physical therapy for 2 months as she transitions to a regular shoe. Her swelling will be the limiting factor to wear shoes and that may take also 6 months to a year to go down sufficiently to wear shoes. The surgical procedures are listed below:

1. [REDACTED]

[REDACTED] (Respondent's Exhibit 6)

4. The petitioner also included an explanation of benefit statement from Liberty Mutual showing a gross benefit claim payment to the petitioner of \$2,023.76 (Respondent's Exhibit 6).
5. The petitioner's 16-year old son, RH, receives \$405 monthly survivor's benefit from the Social Security Administration (Respondent's Exhibit 6). The petitioner did not answer the tax dependent questions on her application. She did answer "No" to the

“filing taxes” question. RH was included in the filing units for SNAP and Medicaid assistance groups (Respondent’s Exhibits 4 and 8).

6. On August 7, 2017, a NOCA was mailed to the petitioner informing her that her July 14, 2017 SNAP application was approved and she was eligible to receive an allotment of \$16 monthly. The NOCA also informed her that her MNP application dated August 4, 2017 was approved and that she was enrolled with an estimated SOC of \$1,636 monthly (Respondent’s Exhibit 7).

7. The Department’s SNAP budget for October 2017 and on-going is as follows;

\$2,428.76	(total gross income \$2,023.76 + \$405)
<u>0.00</u>	(earned income standard)
\$2,428.76	
- <u>160.00</u>	(standard disregard for assistance group (AG) of 2)
\$2,268.76	
- 0.00	(excess medical expenses disregard)
- 0.00	(dependent care disregard)
- 0.00	(child support deduction)
- <u>0.00</u>	(homeless income deduction)
\$2,268.76	(interim net adjusted income)
\$1,097.00	(shelter cost)
+ <u>347.00</u>	(standard utility allowance [SUA])
\$1,444.00	(total shelter costs)
- <u>1,134.38</u>	(50% of interim net adjusted income)
\$309.62	(excess shelter costs disregard)
\$1,238.76	(interim net adjusted income)
<u>309.62</u>	(excess shelter costs disregard)
\$1,959.14	(final net adjusted income)
X 30.0%	
<u>\$588.00</u>	(benefit reduction rounded up)
\$194.00	(maximum allotment for AG of 1)
- <u>588.00</u>	(benefit reduction)
\$0.00	(ongoing monthly allotment)
\$15.00	(recurring monthly allotment for HH of 2)

8. The respondent explained that the Cost of Living Adjustment effective October 1, 2017 changed the minimum allotment from \$16 to \$15 monthly and that otherwise the budgets for August and September are comparable to the October 2017 and on-going budget.

9. The Department's budget for October 2017 and on-going determining the petitioner's SOC is as follows:

\$2,023.76	(unearned income)
- 387.00	(MNIL, Medically Needy Income Limit)
\$1,636.00	(Share of Cost)

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

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

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

THE MNP ISSUE WILL BE DISCUSSED FIRST.

13. The Family-Related Medicaid income criteria is set forth in 42 C.F.R 435.603. It states:

- (a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.
- (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

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

14. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (f) defines a Household for Medicaid. It states:

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full-time students, age 21.

...

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

15. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at 2230.0400 Standard Filing Unit (MFAM) states:

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

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

16. In accordance with the above controlling authorities, the Medicaid household group is the petitioner and her 16-year-old child (two members). The findings show the Department determined the petitioner's eligibility with a household size of two to determine her eligibility for Medicaid.

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 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).

19. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit as \$241 and a Standard Disregard of \$146 for an adult with a child between 6-18 years old to be eligible for full Family-Related Medicaid Program. It also indicates the MNIL to be \$387.

20. 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 \$2,023.76 Step 2: There are no deductions provided as there was no tax return. Step 3: The total income of \$2,023.76 less the standard disregard of \$146 is \$1,877.76. Step 4: The balance of \$1,877.76 is greater than the income limit of \$241 for the mother with only a 6 through 18-year-old child to receive full Medicaid for herself. Step

5: With no MAGI disregard applied, the countable balance remains \$1,542.82. 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.

21. The Fla. Admin. Code R. 65A-1.707, Family-Related Medicaid Income and Resource Criteria, states in pertinent part, "For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C."

22. The Policy Manual at passage 2630.0502 Enrollment (MFAM) states:

If an individual meets the Medically Needy Program's technical eligibility criteria, he is enrolled into the program. There is no income limit for enrollment. The individual is only eligible (entitled to Medicaid) when he has allowable medical bills that exceed the SOC.

The income for an enrolled assistance group need not be verified. Instead, an estimated SOC is calculated for the assistance group. If after bill tracking, it appears the assistance group has met his "estimated" SOC, the unverified income must be verified before the Medicaid can be authorized. An individual is eligible from the day their SOC is met through the end of the month.

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

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

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

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

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

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

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

25. Effective April 2017, Appendix A-7 indicates that for the parent of a child between 6 and 18 years old the MNIL is \$387.

26. To determine petitioner's SOC the respondent determined the petitioner's household monthly to be \$2,023.76. The Medically Needy Income Level of \$387 for a standard filing unit size of two was subtracted resulting to the petitioner estimated SOC of \$1,636 effective August 20017.

27. The hearing officer found that no exception to these calculations. It is concluded that a more favorable share of cost could not be determined. Eligibility for full Medicaid was not found. The petitioner has failed to meet her burden that she is eligible for full Medicaid.

NOW THE SNAP ISSUE WILL BE DISCUSSED

26. Federal regulation C.F.R. § 273.9 addresses income/allowable deductions budgeting in the Food Assistance Program (FAP) in part and states as follows:

(a) Income eligibility standards...

(1) The gross income eligibility standards for the Food Stamp Program...

(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:

(i) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits; strike benefits; foster care payments for children or adults who are considered members of the household; gross income minus the cost of doing business derived from

rental property in which a household member is not actively engaged in the management of the property at least 20 hours a week. (d) Income deductions. Deductions shall be allowed only for the following household expenses:

- (1) Standard deduction—
- (2) Earned income deduction.
- (3) Excess medical deduction. That portion of medical expenses in excess of \$35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in §271.2. Spouses or other persons receiving benefits as a dependent of the SSI or disability and blindness recipient are not eligible to receive this deduction but persons receiving emergency SSI benefits based on presumptive eligibility are eligible for this deduction....
- (4) Dependent care.
- (5) Optional child support deduction.
- (6) Shelter costs—
 - (i) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d)(1) through (d)(5) of this section have been allowed
 - (ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d)(1) through (d)(5) of this section have been allowed. If the household does not contain an elderly or disabled member, as defined in § 271.2 of this chapter, the shelter deduction cannot exceed the maximum shelter deduction limit established for the area...
 - (A) Continuing charges for the shelter occupied by the household, including rent,
 - (iii) Standard utility allowances...
 - (A) With FNS approval, a State agency may develop the following standard utility allowances (standards) to be used in place of actual costs in determining a household's excess shelter deduction.

27. The respondent must follow these federal budgeting guidelines when determining eligibility. The regulation directs the Department to use gross income when determining eligibility. The FAP budgeting process also involves deducting a standard deduction as well as some of the recipient's actual expenses. Rent or mortgage is an allowable deduction as well as a standard deduction for utilities.

28. The federal regulation 7 C.F.R. § 273.10 (e) addresses "Calculating net income and benefit levels" as follows:

- (1) Net monthly income. (i) To determine a household's net monthly income, the State agency shall:
- (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income. Net losses from the self-employment income of a farmer shall be offset in accordance with Sec. 273.11(a)(2)(iii).
- (B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions.
- (C) Subtract the standard deduction.
- (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.
- 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.

29. The FAP standards for income and deductions appear in the Department's Policy Manual, CFOP 165-22 at Appendix A-1. Effective October 1, 2017, a two-person assistance group gross income limit is \$2,708, the net income limit is \$1,005, and the standard deduction is \$160. The maximum FAP benefit for a household size of two is \$352, the minimum allotment is \$15 and the Standard Utility Allowance is \$345. Effective October 1, 2016 the minimum allotment was \$16.

30. The above-cited regulation describes the eligibility process and defines deductions and shows the steps in determining net income. The petitioner was credited a standard deduction and an excess shelter deduction from her household's gross income to equal her net income.

31. The hearing officer found no exception to the calculations. It is concluded that a more favorable SNAP allotment could not be determined. An August and September 2017 allotment of \$16 and an October 2017 and on-going allotment of \$15 is correct. The petitioner has failed to meet her burden that she should receive more than the minimum SNAP allotment.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the SNAP and Medicaid appeals are denied. The respondent's action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 25 day of January, 2018,
in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
OFFICE OF ECONOMIC SELF SUFFICIENCY

Jan 10, 2018

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-06082

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88345

RESPONDENT.P

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on November 14, 2017 at approximately 3:30 p.m. CST.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Roneige Alnord, Economic Self-Sufficiency Specialist II
Deanne Fields, Esq. Assistant Suncoast Region Legal Counsel

STATEMENT OF ISSUE

At issue is whether the respondent properly denied the petitioner's application for Medicaid Institutional Care Program (ICP) benefits for the months of March 2016 through March 2017; and whether the petitioner's medical incapacity rendered her assets legally unavailable to her for the purpose of qualifying for Medicaid ICP benefits

for the months of March 2016 through March 2017. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner, represented by counsel, submitted a packet of information without objection.

The respondent, represented by counsel, submitted a packet of information without objection.

Both parties stipulated to the facts of the case.

The hearing record was left open until December 7, 2017 to allow for the submission of any additional evidence and for both parties to submit a proposed final order. A proposed final order and additional evidence was received from both parties. Petitioner's evidence was admitted and marked as Petitioner's Composite Exhibits "1" through "3". Respondent's evidence was admitted and marked as Respondent's Composite Exhibits "1" through "4". The record was closed December 7, 2017.

FINDINGS OF FACT

1. On June 22, 2016, [REDACTED] filed an application for Medicaid benefits on behalf of the petitioner. The application stated that the petitioner had no power of attorney, family or guardian available to complete the application and that an attorney is currently searching for a guardian. According to the application, the petitioner, a 99-year-old single female, was admitted to [REDACTED] [REDACTED]. Income and assets were each listed as \$1.00 (Respondent's Composite Exhibit 3, pages 55-58).

2. On February 16, 2016, [REDACTED] signed a determination of incapacity. The incapacitating condition cited was [REDACTED] of indefinite duration (Petitioner's Composite Exhibit 1, page 4).
3. The petitioner's first application was denied by Notice of Case Action (NOCA) dated June 22, 2016. The reason cited for denial was that the value of assets was too high and failure to provide proof of the value of assets (Respondent's Composite Exhibit 1, page 10).
4. MDR submitted five additional applications for Medicaid benefits on behalf of the petitioner. Those applications were dated September 7, 2016; November 3, 2016; December 22, 2016; February 22, 2017; and, April 20, 2017 (Respondent's Composite Exhibit 1, pages 60-81).
5. The applications dated September 7, 2016; November 3, 2016; December 22, 2016; and, February 22, 2017 were denied for either failing to submit requested information to determine eligibility or because the value of the petitioner's assets was too high for Medicaid (Respondent's Exhibit 1, pages 6-15). Although there was a NOCA issued on June 5, 2017 that approved the application for Medicaid dated June 3, 2017, the record does not show that the Department received an application dated June 3, 2017. It is presumed that the date listed on this NOCA was in error and the April 20, 2017 application was approved (Respondent's Composite Exhibit 1, pages 16-17).
6. On October 19, 2016, [REDACTED]
[REDACTED] as the guardian of the petitioner's person and property (Petitioner's Composite Exhibit 1, pages 5-6).

7. An order authorizing the petitioner's guardian to establish a pooled trust was entered on February 28, 2017 (Petitioner Composite Exhibit 1, page 7). Counsel for the petitioner submitted a copy of a Guardian Pooled Trust established pursuant to 42 U.S.C. § 1396p(d)(4)(C). Check images dated March 30, 2017 show that the pooled trust was funded with \$13,000. The petitioner's counsel also provided a copy of the trustee receipt and acknowledgement of trust funding (Petitioner's Composite Exhibit 3, pages 6-38).

8. On June 7, 2017, the Department received the petitioner's bank statements for the period of January 2016 through December 2016 (Respondent's Composite Exhibit 3, pages 85-104).

9. The petitioner's counsel concedes that the petitioner held more than \$2,000 in assets up until April 2017; however, disagrees as to whether those assets should have been considered available to the petitioner.

10. The petitioner's counsel believes that from March 2016 through March 2017, the assets should not be counted as they were unavailable to her due to circumstances beyond her control.

11. The petitioner died on or about June 25, 2017 (Respondent's Composite Exhibit 3, page 50).

12. In Florida's Second District Court of Appeal case [REDACTED], Final Order 16F-00593, the court affirmed a past Department decision to include the assets of a person with [REDACTED] (Respondent's Composite Exhibit 4, page 9).

CONCLUSIONS OF LAW

13. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.
14. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
15. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.
16. Fla. Admin. Code 65A-1.716, Income and Resource Criteria, states in pertinent part: “(5) SSI-Related Program Standards, (a) SSI (42 U.S.C. §§1382 – 1383c) Resource Limits: 1. \$2000 per individual.”
17. Fla. Admin. Code 65A-1.303, Assets, stated in pertinent 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. Accessibility depends on the legal structure of the account or property. **An asset is countable, if the asset is available to a representative possessing the *legal* ability to make the asset available for another’s support or maintenance**, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf. [Emphasis added.]
18. Federal regulation 20 C.F.R. § 416.1201(a)(1) states in part, “If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource.”

19. Federal regulation 20 C.F.R. § 416.1207, “Resources determinations” states in part:

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

(b) *Increase in value of resources*. If, during a month, a resource increases in value or an individual acquires an additional resource or replaces an excluded resource with one that is not excluded, the increase in the value of the resources is counted as of the first moment of the next month

(c) *Decrease in value of resources*. If, during a month, a resource decreases in value or an individual spends a resource or replaces a resource that is not excluded with one that is excluded, the decrease in the value of the resources is counted as of the first moment of the next month.

20. Federal regulation 20 C.F.R § 416.1208 “How funds held in financial institution accounts are counted” states in part:

(a) *General*. Funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can use the funds for his or her support and maintenance by looking at how the individual holds the account. This is reflected in the way the account is titled.

(b) *Individually-held account*. If an individual is designated as sole owner by the account title and can withdraw funds and use them for his or her support and maintenance, all of the funds, regardless of their source, are that individual's resource. For as long as these conditions are met, we presume that the individual owns 100 percent of the funds in the account. This presumption is non-rebuttable.

21. The Departments Policy Manual (Policy Manual), CFOP 165-22, section 1640.0320 states that:

Under the Florida Guardianship Law, only a guardian of the property is authorized to dispose of assets on behalf of a **legally** incompetent individual. Until a legal guardian is assigned, real property owned by a **legally incompetent individual** is not available.

Liquid assets (for example, patient fund accounts and checking accounts) are included as available if the individual has free access to the funds. If a legal guardian must petition the court in order to dispose of the individual's property, the asset is still included for the individual. The fact that the guardian must petition the court does not make the property an unavailable asset. [Emphasis added.]

22. According to Section 744.102, Florida Statutes, “(12) “Incapacitated person” means a person who has been judicially determined to lack the capacity to manage at least some of the property or to meet at least some of the essential health and safety requirements of the person.”

23. The Department’s Program Policy Manual (Policy Manual), CFOP 165-22, in chapter 4600, Glossary, defines Incompetent as, “A person’s inability to function normally (functional) or a person’s level of ability or condition as declared by a court (legal).”

24. The petitioner’s counsel presented a “determination of incapacity” that was signed by the petitioner’s treating physician. Incapacity is a term that describes an individual’s medical condition, but it does not meet the level of the legal term and definition of incompetency. Incapacity may be determined in a non-legal manner, that is, not by a court; however, an incompetent individual is legally determined as such by a court.

25. The petitioner was judicially determined to lack capacity on October 19, 2016. It was on this date, that the court declared [REDACTED] to act as a plenary guardian. Assets are countable if the asset is available to a representative with the legal ability to make the asset available for the individual’s support or maintenance. According to the Letters of Plenary Guardianship issued on October 19, 2016, the petitioner’s guardian

had the power and duty to exercise the following rights for the benefit of an in the best interest of the petitioner:

- To contact
- To sue and defend lawsuits
- To manage income, to manage tangible and intangible property, including bank accounts, investment accounts, and any other asset titled in the ward's name, and to make any gift or other disposition of such property
- To apply for government benefits
- To determine residence
- To consent to medical treatment
- To make decision about the ward's social environment or other social aspects of the ward's live

26. The petitioner's assets were legally in control of the plenary guardian in October 2016. The guardian did not obtain the court's permission to place the assets in a pooled trust until February 28, 2017 and did not fund the pooled trust until March 30, 2017. The fact that the guardian was required to petition the court to dispose of the asset does not make the property an unavailable asset. The undersigned therefore concludes that from October 19, 2016 through March 2017 the assets in question were available and should be considered in the petitioner's eligibility determination.

27. The petitioner's counsel argues that the assets should be considered unavailable due to the petitioner's diagnosis of [REDACTED] and cites this diagnosis as a circumstance beyond the petitioner's control. The question as to whether the assets of a person with [REDACTED] are considered available as been answered by Florida's Second District Court of Appeal when it issued an Order affirming the Department's decision to include the assets of a person with [REDACTED]. See Final Order Appeal No. 16F-00593, as affirmed by the Second District Court of Appeal in case 2D16-4592. The undersigned therefore concludes that from March 2016 through March 2017, the assets in question were

available and should be considered in the petitioner's eligibility determination. The petitioner has failed to meet its burden.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 10 day of January, 2018,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To:



FILED

Jan 25, 2018

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-06195

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

D - DDD - Disability

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 19, 2017 at 8:35 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Mary Triplett, supervisor

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

During the hearing, the petitioner did not submit any evidence for consideration. The respondent submitted seven exhibits, which were accepted into evidence and marked as Respondent's Exhibits 1 through 7.

The record was held open until January 2, 2018, for the petitioner to provide proof of her new condition, the letter of denial from Social Security Administration (SSA) and the medical conditions reviewed by SSA when it determined she was not disabled.

The respondent provided its DES6 screen print which was accepted into evidence and marked as Respondent's Exhibit 8. The petitioner did not provide any additional information, nor did she contact the hearing officer for additional time. The record was closed on January 2, 2018.

FINDINGS OF FACT

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

1. The petitioner [REDACTED] is 47 years old. She does not meet the aged criteria for SSI-Related Medicaid benefits. She has no minor children and does meet the technical requirement for the Family-Related Medicaid category. The petitioner did not allege blindness. Disability must be established to determine Medicaid eligibility.
2. The petitioner is not currently employed.
3. The petitioner alleges disability from the following conditions; [REDACTED]
[REDACTED].
4. On June 3, 2016, the petitioner applied for disability benefits with the SSA. SSA denied the petitioner's application citing she has the "capacity for substantial gainful activity-other work, no visual impairment" (N 32). The petitioner did not provide any evidence of what medical conditions were considered by SSA. On March 24, 2017, the petitioner requested an appeal challenging the SSA's decision (Respondent's Exhibit 8).

5. The Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid programs. To be eligible an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility.
6. On July 11, 2017, the petitioner applied for Medicaid benefits through the Department's SSI-Related Medicaid Program. On August 9, 2017, a disability package and Disability Determination and Transmittal was completed and forwarded to the DDD for a determination (Respondent's Exhibit 2).
7. On August 15, 2017, DDD returned a decision to the Department via Disability Determination and Transmittal. In box 25 Remarks was the comment, "Hank N32."
8. The Department explained that it adopted SSA's decision as it was rendered within 12 months of the latest Medicaid application. The respondent explained that SSA decision is binding and must be accepted by the Department (Respondent's Exhibit 4).
9. On August 22, 2017, the Department mailed the petitioner a Notice of Case Action denying her application for SSI-Related Medicaid benefits. The reason given for the denial was that she did not meet the disability requirement (Respondent's Exhibit 1).
10. On August 29, 2017, the petitioner requested a hearing to challenge the respondent's action.
11. At the hearing, the petitioner alleged new and disabling condition [REDACTED] [REDACTED] and [REDACTED] which began in October 2017. There is no evidence of what medical conditions SSA considered. The record was held open for the petitioner to

submit medical evidence of her new disabling conditions and the medical conditions SSA reviewed, and she did not.

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.
2.056.

14. Fla. Admin. Code R 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. Individuals less than 65 years of age must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states in relevant part:

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

15. The Code of Federal Regulations at 42 C.F.R. § 435.540(a) sets forth the definition and determination of disability and states, “the agency must use the same definition of disability as used under SSI...”

16. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations of disability states in part:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

- (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination;...
- (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
- (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
 - (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
 - (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility. (emphasis added)

17. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22 at passage 1440.1204 "Blindness/Disability Determinations (MSSI, SFP)" states:

...If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.

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

18. According to the above-cited authorities, an SSA decision made within 12 months of the Medicaid application that is under appeal is controlling and binding on the state agency unless the applicant reports a disabling condition not previously reviewed by SSA. The petitioner alleged a new disabling condition, [REDACTED]; however, she did not provide any medical evidence of such medical

conditions. She has not provided evidence of what conditions SSA reviewed when it denied her application.

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

20. The hearing officer explored all other Medicaid groups. The only other Medicaid group was Family-Related Medicaid Program benefits. The petitioner has no minor children residing with her. The Family-Related Medicaid Program benefit rules are set forth in the Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid Program, a dependent child must be living in the home. The petitioner does not meet the criteria for Family-Related Medicaid Program benefits. It is concluded, the respondent's action to deny the petitioner's application for Medicaid Program benefits was within the rules of the Program.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 25 day of January, 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

Jan 02, 2018

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-06266
17F-06284

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 December 4, 2017 at 3:54 p.m. All parties appeared at [REDACTED]

[REDACTED]

APPEARANCES

For the Petitioner: [REDACTED] pro se

For the Respondent: Pamela Wesley, supervisor

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for Medicare Savings Plan (MSP) and authorize \$15 in Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Assistance Program (FAP), benefits at application. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted a 10-page exhibit, which was marked and entered as Petitioner's Exhibits "1" and "2". The respondent submitted a 25-page evidence packet, which was marked and entered as Respondent's Exhibits "1" through "7".

The record was left open through December 20, 2017 for additional evidence including verification of additional reoccurring medical expenses, an updated SNAP budget, an updated Notice of Case Action, and the policy related to authorization of \$15 in SNAP benefits. No additional information was received. On December 20, 2017 the record was closed.

FINDINGS OF FACT

1. On August 17, 2017, the petitioner submitted a paper application to the respondent requesting SNAP benefits and Medicaid benefits for his household (Respondent's Exhibit 1).
2. The petitioner is the only household member. The petitioner has been determined disabled by the Social Security Administration (SSA) and receives \$1,794 (gross amount) in Social Security Disability Income (SSDI) per month. The petitioner also pays \$134 per month for his Medicare Part B premium (Respondent's Exhibit 4).
3. MSP is a Medicaid Buy-in Program in which the State of Florida pays the Medicare premiums. To be eligible for the MSP, an individual's income (minus any applicable income disregards) cannot exceed the following income standard for an individual: Qualifying Individual-1 (QI-1) \$1,357 (Respondent's Exhibit 7).
4. The petitioner pays a shelter cost of \$700, electric cost of \$125 per month, and a telephone expense of \$55 (Respondent's Exhibit 1).

5. The respondent determined the petitioner's SNAP budget effective October 2017 as follows (Respondent's Exhibit 2):

\$ 134	total medical costs
- 35	medical deduction
<hr/>	
\$ 99	excess medical expenses
\$1,794	gross unearned income
- 160	standard deduction
- 99	excess medical expenses
<hr/>	
\$1,535	adjusted income
\$ 700.00	shelter costs
+ 347.00	standard utility allowance (SUA)
<hr/>	
\$1,047.00	shelter/utility cost
- 767.50	shelter standard (50% of adjusted income)
<hr/>	
\$ 279.50	shelter deduction
\$1,535.00	adjusted income
- 279.50	shelter deduction
<hr/>	
\$1,255.00	food stamp adjusted income
\$ 192	thrifty food plan for household of one
- 377	benefit reduction (30% food stamp adjusted income)
<hr/>	
\$ 0	SNAP monthly allotment

6. The petitioner is receiving the minimum benefit of \$15 as he meets the net income limits for SNAP benefits.

7. The respondent determined the petitioner's budget for the MSP benefit as follows (Respondent's Exhibit 3):

\$1,794	gross unearned income
- 20	unearned income disregard
<hr/>	
\$1,774	countable unearned income

8. The petitioner is over the income limit for MSP.

9. On September 1, 2017, the respondent mailed a NOCA to the petitioner informing him the request for SNAP benefits was approved. The petitioner was eligible for \$0.00

for August 2017, \$16 for September 2017, and \$15 effective October 2017 and ongoing.

The NOCA also informed the petitioner his request for QI-1 was denied: "Reason: Your household's income is too high to qualify for this program" (Respondent's Exhibit 5).

10. The petitioner timely requested the appeal.

11. The petitioner states he was advised to submit additional medical expenses to help him with his SNAP benefit allotment. He further states they have been sent but they must be lost.

12. The respondent states no additional reoccurring medical expenses have been received by the department.

13. During the hearing, the petitioner submitted additional medical expenses including a monthly doctor visit of \$140 and monthly, reoccurring pharmacy charges of \$20 (Petitioner's Exhibits 1 and 2).

14. The record was left open through December 20, 2017 to provide the respondent an opportunity to evaluate the petitioner's newly reported expenses and to provide the petitioner an opportunity to submit additional reoccurring medical expenses.

15. No additional information was provided by either party.

CONCLUSIONS OF LAW

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

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

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

The SNAP allotment will be addressed first:

19. Federal Regulations at 7 C.F.R. § 273.9 define income and allowable deductions in the SNAP and in part states:

- (a) Income eligibility standards...
 - (1) The gross income eligibility standards for SNAP ...
 - (b) Definition of income. Household income shall mean all income from whatever source excluding only items specified in paragraph (c) of this section.
 - (2) Unearned income shall include, but not be limited to:...
 - (ii) Annuities; pensions; retirement, veteran's, or disability benefits;... old-age, survivors, or **social security benefits** (*emphasis added*)
 - (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...incurred by any household member who is elderly or disabled as defined in §271.2...
 - (6) Shelter costs...
 - (ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions...
 - (C) The cost of fuel for heating; cooling (i.e., the operation of air conditioning systems or room air conditioners); electricity or fuel used for purposes other than heating or cooling; water; sewerage; well installation and maintenance; septic tank system installation and maintenance; garbage and trash collection; all service fees required to provide service for one telephone
 - (iii) Standard utility allowances....Only utility costs identified in paragraph (d)(6)(ii)(C) of this section must be used in developing standards.

20. The Department Program Policy Manual (The Policy Manual) CFOP 165-22,

Appendix A-1, effective October 2016, sets forth for a household of one the following:

- \$194 maximum SNAP allotment
- \$ 16 minimum SNAP allotment
- \$990 net income limit
- \$157 standard deduction
- \$338 SUA

21. The Policy Manual at Appendix A-1, effective October 2017, sets forth for a household of one the following:

- \$ 192 maximum SNAP allotment
- \$ 15 minimum SNAP allotment
- \$1,005 net income limit
- \$ 160 standard deduction
- \$ 347 SUA

22. Federal Regulations at 7 C.F.R. §273.10 Determining household eligibility and benefit levels, explains income and deduction calculations:

- (d) Determining deductions. Deductible expenses include only certain dependent care, shelter, medical and, at State agency option, child support costs as described in §273.9...
- (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...
 - (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 ... 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...
 - (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...
 - (C) Except during an initial month, all eligible one-person and two-person households shall receive minimum monthly allotments equal to the minimum benefit. The minimum benefit is 8 percent of the maximum allotment for a household of one

23. The above cited authorities and policy manual set forth income and allowable deductions in the SNAP benefit determination. In accordance with the above cited authorities, the petitioner's household income of \$1,794 was counted in the SNAP

determination. The respondent included the household's total income and allowable deductions (standard deduction, excess medical deduction, shelter expenses, and utilities) in all SNAP calculations.

24. The Policy Manual at 2610.0106.02 Minimum Benefit (FS) states in the pertinent Part: "Issue a minimum of eight percent of the maximum benefit for a one-person assistance group to one or two-person assistance groups who are eligible." The petitioner met the net eligibility test and was issued \$16, as this is the minimum benefit.

25. Further, the above cited authorities state no benefit will be issued during the initial month to those one and two person households eligible for the minimum benefit.

26. In careful review of the cited authorities and evidence, the undersigned concludes the respondent correctly authorized \$0 in SNAP benefits for the month of August 2017, \$16 in SNAP benefits for the month of September 2017, and \$15 in SNAP benefits effective October 2017.

27. Federal Regulations at 7 C.F.R. § 273.12 Reporting requirements, states in the pertinent 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...

(iii) Changes in residence and the resulting change in shelter costs.

(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... 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.

28. The Policy Manual at passage 0810.0504 Effective Date of Beneficial Change (FS), states:

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.
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.

29. In accordance with the above cited authorities, the undersigned reviewed the reoccurring medical expenses submitted during the hearing, including a monthly doctor copay of \$140 and monthly prescription costs of \$20. No additional expenses were submitted by the petitioner.

30. The undersigned reviewed the petitioner's additional medical expenses and the petitioner's SNAP budget calculations based on the cited authorities and budgeting methodology and could not find a more favorable outcome. Using the additional medical expenses did not change the amount of SNAP already approved.

31. Based on the evidence and cited authorities, the undersigned concludes the respondent's action to authorize \$0 in SNAP benefits for the month of August 2017, \$16 in SNAP benefits for the month of September 2017, and \$15 in SNAP benefits effective October 2017 was within the rules of the program.

The MSP denial will now be addressed:

32. 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. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application.

(c) Working Disabled (WD). Under WD coverage, individuals are only entitled to payment of their Medicare Part A premium.

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

33. Fla. Admin. Code R. 65A-1.713, SSI-Related 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...

(b) For QMB, income must be less than or equal to the federal poverty level...

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

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

34. The Policy Manual CF-OP 165-22, at Appendix A-9, identifies MSP income standards for an individual, effective July 1, 2017 as follows:

QMB
\$1,005

SLMB
\$1,206

QI1
\$1,357

35. 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 of any unearned income in a month..."

36. In accordance with the above-mentioned authorities and policy manual, the respondent deducted \$20 unearned income from the household's total unearned income of \$1,794 to arrive at \$1,774. The highest income for any MSP is \$1,357.

37. In careful review of the cited authorities and the budget calculations completed by the respondent, the undersigned could not find a more favorable outcome.

38. Based on the cited authorities and evidence, the undersigned concludes the respondent rule in denying the petitioner's request for MSP benefits due to exceeding the income standard set for an individual.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal related the Supplemental Nutrition Assistance Program allotment is hereby denied and the department's action is affirmed. The appeal related to the Medicare Savings Program is hereby denied and the department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
17F- 06266,06284
PAGE -11

DONE and ORDERED this 02 day of January, 2018,
in Tallahassee, Florida.

Pamela B Vance

Pamela B. Vance
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Office: 850-488-1429
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Feb 26, 2018

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-06285

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 Polk
UNIT: 88222

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 11, 2018 at 10:06 a.m. in [REDACTED].

APPEARANCES

For Petitioner: [REDACTED], the petitioner's representative

For Respondent: Cheryl Westmoreland, assistant general counsel with the Central Region

STATEMENT OF ISSUE

At issue is whether the respondent's denial of the petitioner's Institutional Care Program (ICP) Medicaid benefits for the months of March 2017 through May 2017 is correct. The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The undersigned set an administrative hearing in the above-referenced matter on October 27, 2017 at 10:00 a.m. in [REDACTED]. The respondent requested a continuance for the October 2017 hearing as the respondent required more time to prepare.

The petitioner was not present, but was represented by [REDACTED]. The petitioner presented three witnesses who testified: [REDACTED], executive director of Medicaid services with [REDACTED] (PBS); [REDACTED] President of PBS; and retired [REDACTED]. The petitioner submitted no exhibits the hearing. The respondent was represented by Cheryl Westmoreland, Esq. with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). The respondent present one witness who testified: Stan Jones, Economic Self Sufficiency Specialist II with DCF. The respondent submitted two exhibits, which were accepted into evidence and marked as Respondent's Exhibits "1" through "2".

The undersigned left the record opened until January 22, 2018 to allow both parties to submit additional information. On January 22, 2018, the respondent and the petitioner both submitted Proposed Orders. The record closed on January 22, 2018.

Administrative notice was taken of Sections 701.01 and 701.02, Florida Statutes; *Heiskell v. Morris*, 182 So. 3d 714 (2015); *HSBC Bank USA, N. A. v. Perez*, 165 So. 3d 696 (2015); and *Townsend v. Morton* 36 So. 3d 865 (2010).

FINDINGS OF FACT

1. On March 30, 2017, the petitioner, through her attorney, executed five separate Absolute Assignments of the petitioner's life insurance policies. The petitioner

transferred all five of her policies to her disabled son. The respondent explained the transfer to the petitioner's son is allowable as her son is disabled.

2. The face value of all five policies totaled \$11,843.56 and the cash surrender values of the policies total \$7,212.43.

3. On March 31, 2017 and on May 30, 2017, the petitioner, through her representative, submitted an application for ICP benefits.

4. On June 5, 2017, the petitioner submitted a letter from Transamerica indicating the new owner of the policies was the petitioner's son.

5. On August 7, 2017, the petitioner submitted a letter from Foresters Financial indicating the company received the petitioner's assignment form on July 4, 2017 that transferred the policy to the petitioner's son.

6. On August 8, 2017, the petitioner, through her representative, submitted an application for ICP benefits.

7. The respondent approved ICP benefits for the petitioner effective June 2017 and ongoing. The months of March 2017 through May 2017 are the only months under appeal.

8. The petitioner explained the effective date of the transfers is March 2017 as that is the date the Absolute Assignments were executed. The petitioner believed the five Absolute Assignments were legally binding and the petitioner had no ownership in the policies effective March 2017.

9. The respondent explained the effective date of the transfers was June 2017 for four of the policies and July for one of the policies as that is the date when the insurance companies recognized the transfer of ownership. The respondent further

explained the transfers do not become valid until the assignments are acknowledged by the insurance company.

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-1.712 and 65A-1.716 addresses SSI-Related Medicaid asset criteria and in part states:

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C...

(5) SSI-Related Program Standards.

(a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:

1. \$2000 per individual.

13. Pursuant to the above authority, an individual's total resources must be equal or below \$2,000 to be eligible for ICP Medicaid benefits. Until the life insurance policies were transferred to the petitioner's son, the petitioner owned five life insurance policies with face value totaling \$11,843.56 and the cash surrender totaling \$7,212.43.

14. Fla. Admin. Code R 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, defines when the transfer of resources shall not have a penalty period and states:

(3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the Department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for ICP...

(c) No penalty or period of ineligibility shall be imposed against an individual for transfers described in 42 U.S.C. § 1396p(c)(2).

1. In order for the transfer or trust to be considered to be for the sole benefit of the spouse, the individual's blind or disabled child, or a disabled individual under age 65, the instrument or document must provide that: (a) no individual or entity except the spouse, the individual's disabled child, or disabled individual under age 65 can benefit from the resources transferred in any way, either at the time of the transfer or at any time in the future; and (b) the individual must be able to receive fair compensation or return of the benefit of the trust or transfer during their lifetime.

2. If the instrument or document does not allow for fair compensation or return within the lifetime of the individual (using life expectancy tables noted in paragraph (b) above), it is not considered to be established for the sole benefit of the indicated individual and any potential exemption from penalty or consideration for eligibility purposes is void.

3. A transfer penalty shall not be imposed if the transfer is a result of a court entering an order against an institutional spouse for the support of the community spouse.

4. A transfer penalty shall not be imposed if the individual provides proof that they disposed of the resource or income solely for some purpose unrelated to establishing eligibility.

5. A transfer penalty shall not be imposed if the Department determines that the denial of eligibility due to transferred resources or income would work an undue hardship on the individual. Undue hardship exists when imposing a period of ineligibility would deprive an individual of medical care such that their life or health would be endangered. Undue hardship also exists when imposing a period of ineligibility would deprive the individual of food, clothing, shelter or other necessities of life. All efforts to access the resources or income must be exhausted before this exception applies. The facility in which the institutionalized individual is residing may request an undue hardship waiver on behalf of the individual with the consent of the individual or their designated representative.

15. Pursuant to the above authority, a penalty period shall not be imposed if the petitioner meets one of the aforementioned criteria. The findings show the petitioner meets one of the five aforementioned criteria; therefore, the transfer of the life insurance

policies shall not have any penalty period. The issue under appeal becomes when the transfers to the petitioner's son are effective.

16. Section 627.422, Florida Statutes defines the assignment of policies and states:

A policy may be assignable, or not assignable, as provided by its terms. Subject to its terms relating to assignability, any life or health insurance policy under the terms of which the beneficiary may be changed upon the sole request of the policyowner may be assigned either by pledge or transfer of title, by an assignment executed by the policyowner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

17. Pursuant to the above authority, in order for a life insurance policy to be properly transferred to another person, the owner of the policy can execute an assignment naming a new policy owner. Furthermore, the assignment must be "delivered to the insurer". Although the petitioner executed the Absolute Assignments in March 2017, the insurance companies did not recognize the transfers until June 2017 and July 2017. The owner of the five policies was the petitioner from March 2017 through May 2017.

18. Fla. Admin Code R. 65A-1.712 addresses SSI-Related Medicaid asset exclusions and in part states:

(2) Exclusions. The Department follows SSI policy prescribed in 20 C.F.R. §416.1210 and 20 C.F.R. §416.1218 in determining resource exclusions, with the exceptions in paragraphs (a) through (g) below, in accordance with 42 U.S.C. §1396a(r)(2). . .

(c) The cash surrender value of life insurance policies is excluded as resources if the combined face value of the policies is \$2,500 or less. . .

19. Pursuant to the above authorities if the combined cash surrender value of the life

insurance policies are less than \$2,500, then the policies are excluded as an asset for the ICP program. The cash surrender value of all five policies are \$7,212.43. Since the petitioner's five life insurance policies are valued above \$2,500 and since the petitioner is the owner of the policies until June 2017, the respondent was correct to deny the petitioner's request for ICP Medicaid from March 2017 through May 2017.

20. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner does not meet the burden of proof indicating the respondent incorrectly denied the petitioner's request for Institutional Care Program Medicaid benefits from March 2017 through May 2017.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 26 day of February, 2018,
in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
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Copies Furnished To:



Jan 25, 2018

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-06424 & 17F-06940

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88345

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on January 11, 2018 at approximately 2:31 p.m. CST.

APPEARANCES

For the Petitioner: [REDACTED], designated representative

For the Respondent: Ed Poutre, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of July 3, 2017 denying Institutional Care Program (ICP) Medicaid coverage for the petitioner from July 2016 through June 2017. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for October 19, 2017 at 4:00 p.m. EDT. Both parties agreed to a continuance. The hearing was rescheduled for November 15, 2017 at 10:30 EST. Both parties appeared, conferenced and agreed to a continuance. The hearing was rescheduled for December 13, 2017 at 4:30 p.m. EST. Both parties appeared, conferenced and requested a continuance. The hearing was rescheduled for January 5, 2018 at 4:30 p.m. EST. The petitioner's witness was not available for the January 5, 2018 hearing. The hearing was rescheduled for January 11, 2018.

The respondent's representative on December 13, 2017 was Teshia Green, economic self-sufficiency specialist II; otherwise, the respondent was represented by Mr. Poutre.

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "8". During the hearing, the respondent emailed additional information, two past hearing decisions, 15F-04216 and 13F-07860, and an email offering guidance from the respondent's regional program office. The petitioner objected to them being admitted into evidence as the hearing decisions were easily distinguishable and he disagreed with the facts as presented in the program office's advice. The objection was sustained and these three potential exhibits were not admitted.

The petitioner submitted four packets of information, two of them during the hearing as the hearing officer discovered they had been previously emailed to the Office of Appeal Hearing but not uploaded into the docket. The evidence was marked as Petitioner's Exhibits "1" through "26".

[REDACTED]

[REDACTED] appeared as a witness for the petitioner.

There are two hearing requests, one ICP-Related the other SSI-Related. Upon the establishment of the issue, it became clear that the concern was ICP-Related: therefore, hearing number 17F-06424, the SSI-Related hearing, is dismissed as an invalid appeal.

FINDINGS OF FACT

1. The petitioner is a single 77-year-old female, born [REDACTED]. She passed away on June 25, 2017.
2. On December 1, 2015, the petitioner was admitted to [REDACTED] for the first time. Upon completion of her recuperation, she was released (Petitioner's Exhibit 12 and DW testimony).
3. On July 25, 2016, the petitioner was again admitted to [REDACTED] (Petitioner's Exhibit 12).
4. DW testified that upon admission, the petitioner was in full-blown [REDACTED]; that the petitioner could not sign for herself. The petitioner's treating physician [REDACTED] D.O., reported in a certified statement that:

At the time of her admission to Sunset Point on July 25, 2016 and subsequent thereto, [REDACTED] was diagnosed as suffering from a variety of series conditions, including, but not limited to Unspecified

[REDACTED]

[REDACTED] without

[REDACTED]
...it is my medical opinion that due to the seriousness of her conditions, [REDACTED] did not have the cognitive ability to participate in her Medicaid application process including filing applications, accessing her financial information, obtaining verification items from financial and other institutions to corroborate her eligibility, spend down any excess resources or submit an appeal(s) from July 25, 2016 through the date of her death on June 25, 2017. (Petitioner's Exhibit 13).

5. On October 14, 2016, an application for ICP for the petitioner was submitted to the respondent. This application was denied by notice of case action (NOCA) dated November 14, 2016 which stated, "The value of your assets is too high for this program" (Petitioner's Exhibit 3).

6. On February 10, 2017, an application for ICP for the petitioner was submitted to the respondent. This application was denied by NOCA dated March 14, 2017 which stated, "The value of your assets is too high for this program" (Petitioner's Exhibit 4).

7. On March 31, 2017, an application for ICP for the petitioner was submitted to the respondent. This application was denied by NOCA dated May 5, 2017 which stated, "The value of your assets is too high for this program" (Petitioner's Exhibit 5).

8. On May 30, 2017, an application for ICP for the petitioner was submitted to the respondent. Comments after the E-Signature state "[REDACTED] is helping with the application. We are obtaining a court appointed guardian on 6/6/2017, at least this is the hearing date." The following information concerning the petitioner's assets was reported on the application: (1) the petitioner's SunTrust savings account [REDACTED] with a reported value of \$8,200, and (2) checking account 23910 with a reported value of \$5,400. This application was denied by NOCA dated July 3, 2017

which stated, "The value of your assets is too high for this program" (Petitioner's Exhibits 5).

9. On June 7, 2017, the petitioner was legally determined incapacitated and [REDACTED] was appointed Limited Guardian of the Person and Property of

[REDACTED] She was given responsibility:

- To contract
- To sue and defend lawsuits
- To manage income, to manage tangible and intangible property, including bank accounts, investment accounts, and any other asset titled in the ward's name, and to make any gift or other disposition of such property
- To apply for government benefits
- To determine residence
- To make decisions about the Ward's social environment or other social aspects of the Ward's life (Petitioner's Exhibit 9)

10. Verification of the balance of the SunTrust accounts was received on June 20, 2017 from the court ordered guardian that was appointed on June 7, 2017. This information resulted in the denial of the May 30, 2017 application (Respondent's Exhibits 5 and 6).

11. DW testified that [REDACTED] (SL), the petitioner's companion, visited often and assisted with her admission. He had possession of the petitioner's debit card and on two occasions made a \$750 payment to [REDACTED]. These payments went toward the balance from the petitioner's previous stay. SL unexplainably stopped visiting and assisting. SL died in hospital on Sept 27, 2017 (Petitioner's Exhibit 18). NP asserts that upon the death of SL any access to the petitioner's accounts ended.

12. DW testified that [REDACTED] was aware that the petitioner had resources, bank accounts. In an attempt to access the accounts, to get bank statements to submit to the respondent for application processing, DW physically took the petitioner to a [REDACTED]

office. The petitioner was unable to sufficiently identify herself for the bank to allow access to the accounts. As there was no Power of Attorney, agent or other entity with access to the accounts, the petitioner was unable to submit bank account statements that were requested by the respondent.

13. NP stated that he does not dispute the accounts or account balances. He asserts that per the Department's Policy Manual, paragraphs 1640.0320 and 1640.0321, the asset values should be excluded as the petitioner did not have legal access to the resources, and also 1640.0308, as the petitioner did not have "unrestricted access to the funds."

14. NP stated that he found no legal definition of comatose in the pertinent authorities and argued that the petitioner's mental incapacity was the equivalent of being comatose; thereby, making the resources unavailable to the petitioner.

CONCLUSIONS OF LAW

15. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

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

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

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

19. Fla. Admin. Code 65A-1.303, Assets, stated in pertinent 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. Accessibility depends on the legal structure of the account or property. **An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance**, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf. [Emphasis added.]

20. Federal regulation 20 C.F.R. § 416.1201(a)(1) states in part, "If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource."

21. Federal regulation 20 C.F.R. § 416.1207, Resources determinations" states in part:

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

(b) *Increase in value of resources*. If, during a month, a resource increases in value or an individual acquires an additional resource or replaces an excluded resource with one that is not excluded, the increase in the value of the resources is counted as of the first moment of the next month

(c) *Decrease in value of resources*. If, during a month, a resource decreases in value or an individual spends a resource or replaces a resource that is not excluded with one that is excluded, the decrease in the value of the resources is counted as of the first moment of the next month.

22. Federal regulation 20 C.F.R § 416.1208 “How funds held in financial institution accounts are counted” states in part:

(a) *General.* Funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can use the funds for his or her support and maintenance by looking at how the individual holds the account. This is reflected in the way the account is titled.

(b) *Individually-held account.* If an individual is designated as sole owner by the account title and can withdraw funds and use them for his or her support and maintenance, all of the funds, regardless of their source, are that individual's resource. For as long as these conditions are met, we presume that the individual owns 100 percent of the funds in the account. This presumption is non-rebuttable.

23. The Departments Policy Manual (Policy Manual), CFOP 165-22, section 1640.0320 states that:

Under the Florida Guardianship Law, only a guardian of the property is authorized to dispose of assets on behalf of a **legally** incompetent individual. Until a legal guardian is assigned, real property owned by a legally incompetent individual is not available. Liquid assets (for example, patient fund accounts and checking accounts) **are included as available** if the individual has free access to the funds. If a legal guardian must petition the court in order to dispose of the individual's property, the asset is still included for the individual. The fact that the guardian must petition the court does not make the property an unavailable asset. [Emphasis added.]

24. According to Section 744.102, Florida Statutes, “(12) “Incapacitated person” means a person who has been judicially determined to lack the capacity to manage at least some of the property or to meet at least some of the essential health and safety requirements of the person.”

25. The Department’s Program Policy Manual (Policy Manual), CFOP 165-22, in chapter 4600, Glossary, defines Incompetent as, “A person’s inability to function

normally (functional) or a person's level of ability or condition as declared by a court (legal)."

26. The petitioner was judicially determined to lack capacity on June 7, 2017. It was on this date, that the court appointed [REDACTED]

[REDACTED]. Assets are countable if the asset is available to a representative with the legal ability to make the asset available for the individual's support or maintenance. According to the Order Determining Incapacity and Appointing Limited Guardian, the petitioner's guardian had the power and duty to exercise the following rights for the benefit of an in the best interest of the petitioner:

- To contact
- To sue and defend lawsuits
- To manage income, to manage tangible and intangible property, including bank accounts, investment accounts, and any other asset titled in the ward's name, and to make any gift or other disposition of such property
- To apply for government benefits
- To determine residence
- To consent to medical treatment
- To make decision about the ward's social environment or other social aspects of the ward's live

27. The petitioner's assets were legally in control of the guardian in June 2017. In accordance with the above authorities, the undersigned concludes that for the month of June 2017, the assets would be considered available to the petitioner.

28. For the period of time prior to the appointment of the guardian, petitioner's counsel argues that the assets should be considered unavailable due to the petitioner not having legal access to the resources prior to the appointment of a guardian.

29. The petitioner was not found to be legally incapacitated until June 7, 2017. The only medical exception to availability in the above cited authorities is when the individual

is comatose. Evidence and testimony does not show that the petitioner was comatose; therefore, the undersigned concludes that the assets should be considered available to the petitioner from the date of her final admission to Sunset Point, July 25, 2016 until her death on June 25, 2017.

30. The undersigned therefore concludes that from July 2016 through June 2017, the assets in question were available and should be considered in the petitioner's eligibility determination. The petitioner has failed to meet its burden. The respondent's action of July 3, 2017 denying ICP-Related Medicaid coverage from July 2016 through June 2017 for being over the asset limit is correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 25 day of January, 2018,
in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], PETITIONER
OFFICE OF ECONOMIC SELF SUFFICIENCY
[REDACTED]

FILED

Jan 11, 2018

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-06564

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 Okaloosa
UNIT: 88146

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 13, 2017 at 2:57 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Woodrow Hinson, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of September 1, 2017 terminating his SSI-Related Medicaid eligibility effective September 30, 2017 due not meeting the citizenship requirement. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing in this matter was scheduled to convene on November 15, 2017. However, the petitioner requested a continuance so that a translator who spoke [REDACTED]

██████████ could be present for the hearing. The hearing was then convened on December 13, 2017.

██████████ with Interpreter Services, id number ██████████ appeared to provide translation.

The Department submitted evidence on December 8, 2017. The Department reported two pages were missing and submitted those post hearing. The petitioner reported he had not received the Department's evidence prior to hearing, but wished to proceed without the evidence during the hearing.

The record was held open through December 22, 2017 to allow the petitioner to receive the Department's evidence and to submit any objection or questions of the evidence in writing to the Office of Appeal Hearings. The petitioner was advised during hearing, should no written question be submitted timely, the Department's evidence would be entered into the record. No update was received from the petitioner. The Department's evidence was entered as Respondent's Exhibit 1.

The record closed on December 22, 2017.

FINDINGS OF FACT

1. The petitioner applied for SSI-Related Medicaid on June 26, 2017. The petitioner's household consists of himself (age 67) and his wife (age 61).
(Respondent's Exhibit 1, pages 25 through 32)

2. The Department issued a Notice of Case Action approving the petitioner for SSI-Related Medicaid on August 4, 2017. The effective begin month of the Medicaid eligibility was June 2017. (Respondent Exhibit 1, page 16)

3. The petitioner applied to add Food Assistance to his case on August 15, 2017. (Respondent's Exhibit 1, pages 1 and 2)

4. The Department requested the petitioner provide proof of his INS status for non-citizens. (Respondent's Exhibit 1, pages 3 and 4)

5. The petitioner submitted his Immigrant Visa and Permanent Resident card for proof of citizenship. The permanent resident card indicates the petitioner is a United States resident since August 17, 2016. His date of birth is [REDACTED] His country of birth is the [REDACTED] (Respondent's Exhibit 1, pages 20 and 22)

6. The Department issued a Notice of Case Action on September 1, 2017 which terminated the petitioner's SSI-Related Medicaid effective September 30, 2017 due to failure to meet the citizenship requirement. (Respondent's Exhibit 1, pages 18 and 19)

7. The Department explained that the SSI-Related Medicaid was opened in error originally. The worker processing the Food Assistance application discovered the error and terminated the SSI-Related Medicaid in accordance with policy.

8. The petitioner confirmed he had only been in the United States one year and four months. The petitioner stated his entry into the United States was sponsored by his son-in-law who is in the Air Force.

9. The petitioner believes because he is a senior citizen with [REDACTED] he should qualify for Medicaid. The petitioner based this belief on the fact he qualified for Medicaid (MediCal) in [REDACTED].

10. The Department advised the petitioner does not meet citizenship requirement as although he is a Lawful Permanent Resident, he does not meet the five-year residency requirement to be eligible for Medicaid.

11. The Department provided referral information for resources in the petitioner's area to assist him with his health concerns.

CONCLUSIONS OF LAW

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

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

14. 42 C.F.R. § 435.406, Citizenship and non-citizen eligibility, states in relevant 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)(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.

15. 8 U.S.C. § 1613, Five-year limited eligibility of qualified aliens for Federal means-tested public benefit, states in relevant part:

(a) In general

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

16. The findings show the petitioner became a lawful permanent resident August 17, 2016. The above controlling authorities explain that a lawful permanent resident is subject to a five-year ban from receiving SSI-Related Medicaid. The

undersigned concludes as the petitioner is a lawful permanent resident of the United States for less than five years, he is subject to the five-year ban from receiving SSI-Related Medicaid. The undersigned further concludes the Department took appropriate corrective action to terminate the petitioner's SSI-Related Medicaid due to ineligibility.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11 day of January, 2018,
in Tallahassee, Florida.



Melissa Roedel
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

Jan 04, 2018

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-06786

PETITIONER,

VS.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 12 SARASOTA
UNIT: 88345

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 11th, 2017, at 1:12 p.m.

APPEARANCES

For the Petitioner: Petitioner was not present, but was represented by 


For the Respondent: Alicia Gonzalez, Esq., Suncoast Region District Legal Counsel for the Department of Children and Families.

STATEMENT OF ISSUE

The petitioner is appealing the issue of the respondent failing to re-evaluate the termination of the Institutional Care Program (ICP) after the pending notice was not received. The respondent carries the burden of proving its position by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as a witness for the respondent was Teshia Green, Economic Self-Sufficiency Specialist II for the Department of Children and Families.

Petitioner's exhibit composite 1 was admitted into evidence.

Respondent's exhibit composite 1 was admitted into evidence.

By way of a Notice of Case Action (NOCA) allegedly dated September 19th, 2017, the respondent informed the petitioner that his ICP benefits would end on September 30th, 2017. On October 4th, 2017, the petitioner filed a request to challenge the respondent's action. Because a copy of the NOCA in question was not entered into evidence, the appeal is considered to have been requested timely, and the undersigned will retain jurisdiction.

FINDINGS OF FACT

1. The petitioner applied for ICP benefits on June 12th, 2017. The application for ICP benefits was authorized on August 2nd, 2017, with a certification period of April 2017 through September 2017 and ongoing. (See Respondent's Composite 1 pg. 16).
2. The ICP application dated June 12th, 2017 shows a designated representative of [REDACTED] (See Respondent's Composite 1 pg. 6).
3. The respondent received a new designated representative form on August 16th, 2017, appointing the petitioner's son and durable power of attorney as the self-designated representative. (See Respondent's Composite 1 pg. 27). The respondent asserts that it replaced the [REDACTED] with the petitioner's son as the designated representative. The respondent contends that it prefers to have a family

member listed as the representative as opposed to an outside entity. However, the respondent notes that it does not limit the number of designated representatives an applicant can add to an assistance case. No evidence was provided to indicate that the respondent contacted the petitioner or [REDACTED] in regards to the son being added as a self-appointed representative.

4. On August 23rd, 2017, the petitioner submitted a change report to inform the respondent of the sale of his homestead property. By way of a NOCA dated August 29th, 2017, the respondent informed the petitioner's son that it required additional information by September 8th, 2017. (See Respondent's Composite Exhibit 24). The respondent testified that it did not provide a copy of the pending notice to the

[REDACTED].

5. According to the respondent, the requested information was not received by the deadline of September 8th, 2017. The respondent did not receive a deadline extension request from the petitioner or the petitioner's representative. Therefore, the ICP coverage was terminated on September 18th, 2017.

6. The respondent contends that the missing documentation was received on October 3rd, 2017. However, since the documents were received after the due date, a new application is required to establish eligibility. The respondent asserts that a Medicaid reevaluation is not required because the designated representative's failure to receive the pending notice does not meet good cause. According to the respondent, the pending notice was not returned by the postal service.

CONCLUSIONS OF LAW

7. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.
8. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.
9. Fla. Admin Code 65-2.060, Evidence states:
 - (1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.
10. The Code of Federal Regulation 42 C.F.R. 435.923 Authorized representatives states in part:
 - (c) The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on his or her behalf, or the authorized representative informs the agency that he or she no longer is acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based...
11. As stated in the above-cited authority, the applicant can modify the designated representative authorization or the representative can inform the agency that is it no longer representing the applicant. Otherwise, the designated representation on file remains valid. In this instance, the petitioner's son was self-designated. There is no indication that the respondent made contact with the petitioner or the [REDACTED]

Firm prior to adding the family member to the assistance case. Additionally, there was no evidence provided to indicate that either the petitioner or the [REDACTED] was contacted to determine whether or not the law firm was still representing the petitioner.

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

(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. The above-cited authority states that the respondent may deny benefits if required information is not provided and eligibility cannot be established. As outlined in the Findings of Fact, the respondent terminated the petitioner's ICP coverage after it did not receive the required documents to determine eligibility based on newly reported information.

14. The ACCESS Florida Policy Manual at 0440.0610 Reevaluating Medicaid

Adverse Actions (MSSI, SFP) states:

The Department must reevaluate any Medicaid determination where there is evidence of good cause that the previous determination was incorrect. The request for reevaluation applies to the following situations:

1. benefits terminated or denied in error;
2. an overstated patient responsibility/share of cost; and
3. an error in the calculation of the level of benefits.

If a participant requests a reevaluation:

1. Within 90 days of the mailing date of the notice, follow hearing policy and continue to work on resolution.

2. After 90 days from the mailing date of the notice but no more than 12 months following the effective date of the adverse action, review the request to determine if good cause exists.
3. After 12 months from the effective date of the notice, deny the eligibility on FLORIDA and inform the individual of hearing rights on the electronic notice.

Good cause exists when:

1. The Department made mistakes in mathematical computations.
2. The Department made an error in the determination.
3. **The participant presents new information that was not considered when the previous determination was completed and it may result in a different conclusion. The information must have been unavailable due to circumstances beyond the participant's control. [Emphasis added.]**

Once good cause is established, determine eligibility, authorize benefits as appropriate and send a new notice of case action. Notify the participant of the decision for all months as required below.

For applications: Review eligibility each month and authorize as appropriate back to the month of application, including any requested retroactive months.

For active cases: Review eligibility each month and authorize as appropriate back to the effective date of the action under review.

When good cause does not exist: Notify the individual of the reevaluation denial and hearing rights. The determination that good cause does not exist cannot be reevaluated.

15. The above-cited guideline explains when it is appropriate for the respondent to complete a Medicaid reevaluation due to an adverse action. The guideline specifically states that a reevaluation should be completed when new information is presented that wasn't previously considered. The information must be information that was unavailable due to circumstances out of the applicant's control. As established in the Findings of

Fact, the respondent received the missing documentation on October 3rd, 2017, which was considered untimely because the petitioner's son did not receive the pending notice requesting the documentation. Furthermore, the respondent did not send a pending notice requesting the documents from the petitioner's other designated representative,

16. After review of the guidelines, evidence, and testimony the hearing officer finds that respondent erred in not reevaluating the petitioner's ICP coverage. The respondent incorrectly deleted the [REDACTED] as a designated representative from its system and subsequently failed to issue the pending notice to the correct mailing address. Prior to removing the law firm as a representative, the appropriate action would have been to contact the petitioner and/or the law firm for clarification. The respondent did issue the pending notice to the petitioner's son at the correct address as listed on the designated representative form. Unfortunately, the whereabouts of the notice are unknown. This is at no fault of the petitioner, the representative, or the respondent. These circumstances meet a good cause exception.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of

FINAL ORDER (Cont.)

17F-06786

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

DONE and ORDERED this 04 day of January, 2017,

in Tallahassee, Florida.



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

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

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

FILED

Jan 11, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-06847

PETITIONER,

VS.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 12 SARASOTA
UNIT: 88345

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 12th, 2017, at 10:16 a.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se.

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

STATEMENT OF ISSUE

The petitioner is appealing the issue of the respondent denying her application for the Medicare Savings Program (MSP). The petitioner carries the burden of proving her position by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for November 2nd, 2017, at 10:00 a.m. Prior to that date, the respondent requested a continuance citing unavailability due to ongoing

duties related to a recent natural disaster. The request was granted, and the hearing was rescheduled for December 4th, 2017.

On December 4th, 2017, all parties phoned in as scheduled. The petitioner and the respondent were conducting a pre-hearing conference, and due to technical issues, the parties could no longer hear one another. Therefore, the hearing officer ended the call. The hearing officer and the respondent phoned back in but the petitioner did not. The hearing officer and respondent waited for 15 minutes then the hearing officer dismissed the petitioner. The hearing was rescheduled as detailed above.

During the hearing on December 12th, 2017, it was brought to the hearing officer's attention that a designated representative submitted the request for assistance regarding the MSP and a subsequent hearing request. The petitioner was unaware that the designated representative was no longer representing her until she spoke with the respondent. According to the respondent, the designated representative withdrew representation. The hearing officer believes good cause exists to hear the merits and render a decision despite there being a previous hearing request over the issue.

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

Respondent's exhibits 1 through 10 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated August 22nd, 2017, the respondent informed the petitioner that her application for Special Low-Income Medicare Part B Medicaid application dated July 21st, 2017 was denied. The reason provided was "We did not receive proof of identity for you or a household member," and

“We did not receive all the information requested to determine eligibility.” On October 5th, 2017, the petitioner filed a timely request to challenge the respondent’s action.

FINDINGS OF FACT

1. Eligibility Coordinator, [JH], of [REDACTED] submitted an online application for MSP benefits on the petitioner’s behalf on July 21st, 2017. The application indicates that the petitioner’s identification was discovered through an online verification system. According to the respondent, a series of questions used to authentication the petitioner’s identity was either skipped or answered incorrectly. Therefore, customer authentication not was complete. (See Respondent’s Exhibit 2). As part of the application process, the respondent is required to explore and verify all factors of eligibility, which include but are not limited to all technical requirements.
2. On July 26th, 2017, the respondent requested additional information from the petitioner and mailed two separate notices. One notice was mailed to the designated representative, JH, and the other was mailed to the petitioner’s address. (See Respondent’s Exhibit 4). The notices requested the following information:

“Please complete and sign the Financial Information Release form.
Other – please see comments below
***Please contact the office at 866-762-2237 to authenticate your
identity***

The petitioner contends that her daughter faxed the requested Financial Information Release Form on August 4th, 2017. However, the petitioner asserts that she did not know that she was required to authenticate her identity or that it was important. The respondent acknowledges that the Financial Information Release Form was received. According to the respondent, since the application was completed by a designated

representative, the applicant is required to complete authentication. The respondent provided, as part of its evidence, transmittal number [REDACTED] which explains customer authentication requirements. (See Respondent's Exhibit 9).

3. The petitioner testified that she spoke with the designated representative and was under the impression that all the requested information had been provided.

According to the respondent, the designated representative withdrew herself from representing the petitioner and did not provide the requested information.

4. The respondent contends to date, the petitioner has not reapplied for MSP benefits and has not completed customer authentication.

CONCLUSIONS OF LAW

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

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

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

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

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

8. As stated in the above-cited authority, if additional information is needed to determine eligibility, the respondent must allow the petitioner 10 days to provide the information. As established in the Findings of Fact, the respondent requested additional information from the petitioner. The petitioner provided part of the information but did not realize she should follow through with the remaining information. The respondent denied the application because it did not receive all the necessary information to determine eligibility.

9. ACCESS Program TRANSMITTAL NO.: C-16-04-0005, Revised Customer Authentication Procedures for Applications and Additional Benefit Requirements states in relevant part:

For Medicaid, when completing verbal or manual authentication with the applicant, staff must discuss that any identified designated or self-designated representative is the appropriate person to act on his or her behalf. If not, the applicant must represent him or herself or designate another individual to be the representative.

There has been no change in the following:

Applicants and recipients must have their identity verified prior to authorization of benefits. *[Emphasis added.]*

10. The above-cited guideline states that the respondent must complete authentication with the applicant and discuss whether or not the designated representative is appropriate to act on his or her behalf. Furthermore, the authentication must take place prior to the authorization of benefits. As established in the Findings of

Fact, customer authentication failed during the application process. Therefore, the respondent requested that the petitioner call and complete the authentication telephonically.

11. After review of the evidence, testimony, and regulations, the hearing officer concludes that the respondent was correct to deny the petitioner's application. The hearing officer reviewed the evidence and found no indication that the petitioner attempted to complete the customer authentication process. To date, customer authentication has not been completed.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11 day of January, 2018,

in Tallahassee, Florida.



Kimberly Vargo
Hearing Officer
Building 5, Room 255

FINAL ORDER (Cont.)

17F-06847

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1317 Winewood Boulevard
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Jan 09, 2018

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-06857

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 Indian River
UNIT: 88701

RESPONDENT.

_____ /

FINAL ORDER

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

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Pamela Wesley, DCF economic self-sufficiency supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of enrolling her in the Medically Needy (MN) Program with a high estimated share of cost (SOC) and the failure to track her medical expenses for September 2017. Petitioner is seeking full Medicaid or a lower SOC. Petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

During the hearing, Petitioner submitted three (3) exhibits which were accepted into evidence and marked as Petitioner's Exhibits 1 through 3. Respondent submitted five (5) exhibits which were accepted and marked as Respondent's Exhibits 1 through 5. The record was left open through November 27, 2017 for both parties to submit additional information for consideration. Petitioner's information was timely received and marked as Petitioner's Exhibit 4. Respondent submitted additional exhibits which were accepted and marked as Respondent's Exhibits 6 through 9. The record was closed on November 27, 2017.

FINDINGS OF FACT

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

1. Prior to the action under appeal, Petitioner was enrolled in the Medically Needy (MN) Program with an estimated SOC. Petitioner stated that those enrolled in MN are not viewed as Medicaid eligible by any third party provider prior to having medical bills tracked.
2. Petitioner is disabled and receives \$1,359 in monthly Social Security (SS) income. She has been Medicare eligible since 2015 and her Part B premiums are currently being paid by the state under the Medicare Savings Program (MSP). She has been checking her eligibility for supplemental insurance at MyMedicare.gov website and got a response indicating she did not have any, see Petitioner's Exhibits 1 & 2.
3. Petitioner was enrolled in MN in September 2017 with an estimated share of cost of \$1,159. Petitioner has been submitting medical bills to the Department for tracking,

see Petitioner's Exhibit 3. Her bills were tracked and she did meet the respective SOC most of the time. Respondent determined she did not meet the SOC for September 2017.

4. On September 25, 2017, Respondent sent a Notice of Case Action to Petitioner informing her that she was eligible for continued Medicaid coverage under the MN Program, see Respondent's Exhibit 1. On October 6, 2017, Petitioner filed an appeal requesting full Medicaid and bill tracking for September 2017.

5. The Department's representative explained its action to enroll Petitioner in the Medically Needy Program with a share of cost. The share of cost amount is directly dependent on Petitioner's SS benefits minus allowable deductions.

6. Petitioner was seeking full Medicaid or a lower SOC for herself. To begin the budgeting process for Medically Needy Program, Petitioner's monthly SS income of \$1,359 was reduced by a \$20 standard income disregard, followed by a \$180 Medically Needy Income Level (MNIL) deduction for one person to arrive at the initial estimated share of cost of \$1,159. For May 2017, It was further reduced by \$140.90 (Petitioner's Part B premiums), resulting in the final estimated SOC to be \$1,018, see Respondent's Exhibit 3.

7. Petitioner's Part B premiums are currently paid by the state. Respondent's most recent MN budget shows this amount (\$140.90) was removed as a deduction resulting in the final estimated SOC to remain \$1,159, see Respondent's Exhibit 2.

8. The representative explained how the share of cost was determined and how it could be met. She explained that most bills submitted by the Petitioner were considered, but were not enough to meet the SOC for a particular month. Petitioner

was advised to submit all outstanding medical bills to the Department so that it can be determined when the share of cost is met and when Medicaid coverage could begin.

The representative explained that all unpaid medical bills not previously used can be considered to track any future months for which eligibility is needed.

9. Petitioner did not dispute the income amount used by the Department in the eligibility process, but asserted as follows: That she has serious health issues that require constant monitoring, resulting in recurring medical expenses. That most doctors do not accept MN as Medicaid. That her SOC is too high and that she cannot afford that much monthly expense on a fixed income. That her enrollment in the program cannot be verified by any medical providers, making it difficult for her to get the care she needs. Petitioner argued after paying for her household expenses, she has no money left and cannot afford any deductibles. She is seeking full Medicaid to cover all of her medical expenses or a lower SOC, so the balance owed on September 2017 can be paid by Respondent.

10. The record was left open for petitioner to submit all outstanding medical bills incurred during September 2017 to the Department for tracking.

11. Respondent reviewed the information and determined that Petitioner remained ineligible for Medicaid in September 2017, as she failed to meet her SOC for that month. On November 27, 2017, the undersigned received a response from Respondent indicating that the original decision stands. Respondent determined she did not meet the SOC for September 2017 based on the medical bills received, see Respondent's Exhibits 7 through 9.

CONCLUSIONS OF LAW

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

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

14. Federal Regulations at 42 C.F.R. §435.500 sets forth the regulations for requirements for determining the eligibility of both categorically and medically needy individuals.

15. In this instant case, Petitioner was considered for the SSI-Related Medicaid Programs for being disabled. Based on this regulation, the Department determined Medicaid eligibility for Petitioner and approved her for SSI-Related Medically Needy Program benefits.

16. Fla. Admin. Code R. 65A-1.701, Definitions, states:

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

17. The above authority explains that the MEDS-AD (full Medicaid for an aged or disabled person) has an income limit of 88% of the federal poverty level (\$885).

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

19. The above-cited rules explain the budgeting procedure to determine the share of cost. Petitioner’s SS income is reduced by a standard deduction (\$20) to arrive at \$1,339 as countable income.

20. The Eligibility Standards for SSI-Related Programs appear in the Department’s Program Policy Manual CFOP 165-22 (the Policy Manual), at Appendix A-9. Effective July 1 2017, the limit for one member household is \$885. The Department determined Petitioner’s countable income after all deductions to be \$1,339 during the application at issue. Petitioner’s countable income is over the \$885 income limit. Additionally, she is a Medicare recipient; therefore, not qualified for full Medicaid. She was then evaluated for the Medically Needy Program.

21. The Medically Needy Program provides coverage for individuals who meet the technical requirements for Medicaid but whose income or assets exceed the income limits.

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

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

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

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

23. The above authorities also define Medically Needy and Share of Cost (SOC). SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits. This program is available for aged or disabled individuals or eligible couples who do not qualify for the MEDS-AD Program.

24. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the MNIL for an individual at \$180.

25. Since Petitioner was not eligible for full Medicaid, the Department proceeded to explore further Medicaid eligibility by deducting the \$180 Medically Needy Income Level deduction for one from her resulting income. After these deductions, the share of cost was determined to be \$1,159.

26. Based on the evidence, testimony, and the controlling authorities, the undersigned concludes that the Department correctly determined that Petitioner is not eligible for full Medicaid benefits and should be enrolled in the Medically Needy Program. No errors were found in the calculation of the amount of the share of cost. Petitioner's estimated SOC in September 2017 was \$1,159. The undersigned reviewed the medical bills submitted, but could find enough bills for Petitioner to meet her share of cost for that month. Petitioner has failed to meet her burden that she was eligible for full Medicaid or a lower share of cost and that her September 2017 bills should be paid by Medicaid.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 09 day of January, 2018,

in Tallahassee, Florida.



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

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

FILED

Jan 04, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-06967
APPEAL NO. 17F-08842

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 administrative hearing in the above-referenced matter on December 11, 2017 at 4:26 p.m. in [REDACTED].

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Patricia Rodriguez, supervisor

STATEMENT OF ISSUE

1. At issue is the denial of full Medicaid and enrollment in the Medically Needy Program with an estimated share of cost (SOC) at recertification. The petitioner is seeking full Medicaid or a lower SOC. The petitioner carries the burden of proof by a preponderance of evidence.
2. The petitioner is also seeking payment of his medical bills for September 2017.

PRELIMINARY STATEMENT

The respondent presented five exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 5. The petitioner presented 2 exhibits which were entered into evidence and marked as Petitioner's Exhibit 2. The record was held open until December 18, 2017, for the Department to track the past medical bills the petitioner provided at the hearing and provide the outcome of the bill tracking. The respondent provided a written statement and a Notice of Case Action which were accepted into evidence and marked as Respondent's Exhibit 6. The record was closed on December 18, 2017.

Present as witnesses for the petitioner were [REDACTED], father and [REDACTED], sister.

FINDINGS OF FACT

1. On August 10, 2017, the petitioner submitted an application to recertify for the Medicaid Needy Program and to see if he was eligible for full Medicaid benefits. He receives Social Security disability (SSDI) benefits of \$818. He receives Medicare benefits and the state pays for his Part B premium.
2. The respondent updated the petitioner's case and found him ineligible for full Medicaid benefits as he was receiving Medicare benefits. The respondent enrolled him in the Medically Needy Program with the same SOC he was receiving prior to his recertification application (Respondent's Exhibits 1 and 4).
3. The petitioner's SOC was determined as follows. The respondent subtracted a \$20 unearned income disregard from his monthly gross income of \$818. The Medically

Needy Income Limit (MNIL) of \$180 for a household size of one was subtracted resulting in \$618 as the petitioner's SOC (Respondent's Exhibit 4).

4. On August 16, 2017, the respondent mailed the petitioner a Notice of Case Action informing him that his application was approved and that he was eligible for the Medically Needy Program.

5. On October 12, 2017, the petitioner requested a hearing to challenge the respondent's action.

6. At the hearing, the petitioner provided his past paid bills for service in August and September 2017. The respondent stated that some paid bills can be used to meet the SOC for a future month. The petitioner is requesting his bill for service on September 1, 2017 of \$477.22 to be paid. The bills provided are as follows:

BILL TRACKING FOR SEPTEMBER 2017		
8/1/2017	\$15.01	paid
8/7/2017	\$29.53	paid
8/17/2017	\$34.35	paid
8/29/2017	\$296.62	paid
9/1/2017	\$477.22	unpaid
9/13/2017	\$14.07	paid
Total	\$866.80	

7. The petitioner asserted he needs full Medicaid or a lower SOC as he is very ill and need medical treatments on a regular basis.

8. The respondent asserted that there are no changes to the petitioner's Medicaid budget as compared to the Medicaid budget prior to his application in August 2017. He continues to be enrolled in the Medically Needy Program with the same SOC of \$618.

The respondent explained that the petitioner's SOC will increase to \$635 in January 2018 based on the new cost of living adjustment.

9. After the hearing, the respondent provided a Notice of Case Action dated December 18, 2017, informing the petitioner that his SOC has been met for September 2017.

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.

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

13. 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** (emphasis added) **or** if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

14. The undersigned concludes the respondent's action to deny full Medicaid benefits is a correct action, as the petitioner is currently receiving Medicare benefits.

The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

The Medically Needy share of cost will now be addressed:

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

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

17. Fla. Admin. Code R. 65A-1.701 (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.”

18. 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.”

19. 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...”

20. 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.

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

22. 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.

23. 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 (\$818-\$20=798-\$180= \$618). The petitioner is not eligible for a lower SOC.

The petitioner's bill tracking for September 2018 will now be addressed.

24. The Policy Manual at passage 2640.0506.01 addresses Allowable Medical Expenses (MSSI) and states:

Allowable medical expenses are medical expenses that are:

1. unpaid and still owed, or
2. paid during the current month, or
3. incurred and paid during the three months before the tracking month but no earlier than the three retroactive application months, and
4. not subject to third party payment.

There are two types of allowable medical expenses:

1. recognized health insurance costs, and
2. recognized medical services.

Only allowable medical expenses can be used to meet Share of Cost

25. The Policy Manual at passage 2640.0507.01 addresses, When to Count

Allowable Medical Expenses (MSSI) and states:

Whether a bill is used in the share of cost determination depends on whether it is paid, unpaid, an allowable third party payment, or subject to third party payment.

An allowable medical expense cannot be counted toward the share of cost before the date of service. A hospital bill which is issued in advance of scheduled service cannot be counted toward the share of cost prior to actual receipt of the service. An exception to this policy is global prenatal bills (refer to passage 2640.0506.05). A bill that is Medicaid compensable cannot be prorated because once the individual becomes Medicaid eligible by meeting the share of cost, the bill will be paid by Medicaid. Count paid bills, payments on existing bills, and allowable third party payments during the month the payment was made. Count bills incurred and paid during the three months before the tracking month. Bills incurred and paid before the three retroactive months to an application cannot be used.

If the paid bill was used in a prior month as an unpaid bill and SOC was met in that month, it cannot be used again to meet the share of cost. This includes a medical insurance premium payment made in one month for several months' coverage. The paid premium may only be counted in the month in which the payment was made.

Count unpaid bills not subject to third party payment in the month incurred or a later month, provided the expense remains unpaid and was not used to meet share of cost in a prior month. An unpaid medical expense cannot be used again once it is counted in a month when share of cost is met.

Count bills that are subject to third party payment based on information from the provider or individual. Do not adjust any share of cost calculations if the anticipated third party payment amount was incorrect. When a revised bill is received after share of cost has been met, and retracking will make a provider who has been paid ineligible to be paid, do not retrack all of the expenses.

26. The Policy Manual 2640.0507.02 Tracking Medical Expenses (MSSI)

Allowable medical expenses must be tracked on a monthly basis for each individual/family with a different assistance group and share of cost.

Allowable medical expenses whether paid or unpaid must be tracked in chronological order by date incurred (date of service to the individual). Inpatient hospital medical expenses are to be tracked on a day-by-day basis. An itemized bill should be requested from the hospital. If the hospital cannot or will not provide an itemized bill, it is appropriate to divide the bill by the number of days of the hospital stay. The eligibility specialist would then track on a daily basis until the individual has met the individual's share of cost. At that point, only the non-Medicaid compensable services, if any, could be carried forward to meet a future month's share of cost. Allowable medical expenses being tracked for a specific day should be tracked using paid bills first. On the day on which an individual meets their share of cost, expenses are considered in the following order:

1. Medicare or other recognized health insurance cost;
2. bills of individuals who cannot be entitled to Medicaid, are considered next; and
3. paid bills are a final consideration.

27. After the hearing, the respondent tracked the medical bills provided by the petitioner at the hearing and his SOC was met for September 2017. The respondent issued a Notice of Case Action dated December 18, 2017, informing of such action.

28. After considering the above authority, testimony and evidence presented, the undersigned concludes the respondent correctly determined the petitioner's SOC and completed bill tracking for September 2017.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal for full Medicaid benefits is denied and enrollment in the Medically Needy Program with a \$618 SOC is correct. The respondent's action is upheld.

The issue regarding the bill tracking for September 2017 is moot as the medical bills for September 2017 was tracked and the SOC met.

NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
17F-06967, 08842
PAGE -10

DONE and ORDERED this 04 day of January, 2018,
in Tallahassee, Florida.



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

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

FILED

Jan 04, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-07167

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 Polk
UNIT: 09ICP

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 13, 2017 at 1:39 p.m.

APPEARANCES

For the Petitioner: [REDACTED], designated representative, Medicaid Specialist, Lakeland Nursing and Rehab

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

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of denying Institutional Care Program (ICP) Medicaid on November 9, 2017. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner presented evidence prior to the hearing which was entered as Petitioner's Exhibit 1.

The Department presented evidence prior to the hearing which was entered as Respondent's Exhibit 1.

The record closed on December 13, 2017.

FINDINGS OF FACT

1. The petitioner was admitted to this facility in October 2016.
2. The petitioner has an altered mental status due to [REDACTED]. The petitioner is non-verbal. The petitioner presently has no power of attorney or guardian.
3. The facility began applying for Institutional Care Program (ICP) Medicaid in February 2017. The petitioner's most recently denied application was filed October 9, 2017.
4. The Department issued a Notice of Case Action on October 12, 2017 requesting the petitioner's bank statements from [REDACTED] the life insurance face and cash values for both [REDACTED], and the 2017 award letter for her retirement benefits. The Notice was issued to the petitioner and her designated representative.
5. The Department issued a Notice of Case Action on November 9, 2017 denying the petitioner's application for Medicaid as "We did not receive all the information requested to determine eligibility". This Notice was also issued to the petitioner and her designated representative.

6. The Department noted in case notes on November 8, 2017 that the petitioner failed to provide verification on June and July 2017 bank statements for [REDACTED]s [REDACTED] account, face value and cash value of life insurance policies with [REDACTED] and Minnesota Life as well as the 2017 award letter for the pension with [REDACTED]

7. The petitioner has submitted verification of the face value of the life insurance policies with [REDACTED] (\$5,000) and [REDACTED] (\$13,000). The verification of the [REDACTED] policy indicates there is no cash value for this policy. The verification of the [REDACTED] policy does not provide verification of the cash value. It does reflect the beneficiary is the daughter of the petitioner.

8. The petitioner reported each application since February 2017 has been denied for the same reason as given on November 9, 2017 notice.

9. The petitioner's pension is paid monthly to her bank account. The amount listed on the application for pension was the same amount as listed on the petitioner's bank statement. (Respondent Exhibit 1, page 11)

10. The Department explained that the bank statement is not valid verification of income.

11. The petitioner's representative stated the petitioner's grandson, [REDACTED] [REDACTED] has been working with the facility to obtain as much information as possible for the determination of eligibility. However, he discovered that the cost of becoming his grandmother's guardian is something he cannot afford.

12. The petitioner's representative reported the grandson attempted telephonic contact with Prudential to verify the petitioner's life insurance cash value and

pension amounts. He related to the petitioner that he was advised he would need either power of attorney paperwork or her grandmother on the phone.

13. The petitioner's representative stated she spoke with the Department on September 19, 2017 and was told that the case worker could have submitted a verification request form.

14. The petitioner's representative requested a hearing as the facility and family have been unable to obtain the necessary information and requires the Department's assistance in obtaining the information.

15. The Department reported the form to request verification from [REDACTED] [REDACTED] has been submitted.

16. The Department explained that even though they can request the information, that does not guarantee a response from the company.

17. The petitioner is in hopes the Department could offer some leeway or alternative to verification from the uncooperative source in obtaining the verification.

18. The Department explained that all assets and all income must be verified.

19. The petitioner filed a new application on December 4, 2017. This application is presently pending for the same information as previously requested and the petitioner has been unable to obtain.

20. The Department suggested that while the income and asset is not verified, it is in the petitioner's best interest to continue to file applications to keep all months potentially eligible IF the verification is ever received.

21. The Department explained once original verification from the company with the pension is received, the petitioner could use a 1099 form ongoing. However,

as the current value is presently unverified, the 1099 form is insufficient to establish eligibility.

22. The petitioner's facility is concerned that as this case gets close to a year old with no approval of Medicaid there could be difficulty in getting the facility paid.

23. The petitioner is currently paying what is estimated to be the patient responsibility pending Medicaid approval.

CONCLUSIONS OF LAW

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

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

26. Section 90.801, Florida Statutes, Hearsay; definitions; exceptions, states:

(1) The following definitions apply under this chapter:

(a) A "statement" is:

1. An oral or written assertion; or
2. Nonverbal conduct of a person if it is intended by the person as an assertion.

(b) A "declarant" is a person who makes a statement.

(c) "Hearsay" is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted.

(2) A statement is not hearsay if the declarant testifies at the trial or hearing and is subject to cross-examination concerning the statement and the statement is:

(a) Inconsistent with the declarant's testimony and was given under oath subject to the penalty of perjury at a trial, hearing, or other proceeding or in a deposition;

- (b) Consistent with the declarant's testimony and is offered to rebut an express or implied charge against the declarant of improper influence, motive, or recent fabrication; or
- (c) One of identification of a person made after perceiving the person.

27. The above controlling authority defines hearsay within a legal proceeding.

In the instant case, the petitioner's representative provided statements of what she learned from the petitioner's grandson regarding the petitioner's income and assets. The petitioner's grandson was not present to explain what actions he had taken in attempts to obtain the necessary information. The undersigned concludes the statements are hearsay and cannot rely on these statements as factual in making a determination in this matter.

28. Florida Admin. Code R. 65A-1.205, Eligibility Determination Process, states in relevant 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. An applicant can withdraw the application at any time without affecting their right to reapply at any time.

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

29. The above controlling authority places the responsibility for obtaining verifications on the petitioner. The authority does require the Department to provide assistance in obtaining the information when the assistance is requested or it appears necessary. The petitioner's representative has made a request for the Department to assist with obtaining of verification of the petitioner's pension and the cash value of the Prudential Life insurance policy. The Department stated an attempt has been made. The undersigned concludes, in an effort to be transparent to the petitioner, if the attempt to assist the customer was made in writing, the Department should provide a copy of the attempt to the petitioner for their records.

ICP Income Eligibility Determination

30. 20 C.F.R. § 416.1121, Types of unearned income, states in relevant part:

Some types of unearned income are—

(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans

benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

31. 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:

...

(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.

32. The Department's Program Policy Manual, CFOP 165-22, section

1840.0123, Verification of Income (MSSI, SFP) states:

Income must be verified and documented by the source.

A verbal statement from a suitable source as to the amount of income, amount and types of any deductions, frequency of receipt, and date of anticipated increases can be accepted when documentation is not available. Examination of a check or bank deposit is not sufficient for verification, because these do not necessarily include deductions.

33. The Department's Policy Manual, section 1840.0900, Benefits (MSSI, SFP), states: "Section 1840.0900 (inclusive) discusses types of benefits payable to individuals and their treatment as unearned income, including benefits such as: 1. Social Security payments; 2. private benefit income such as annuities, pensions, retirement, or disability (other than SSA); ..."

34. The Department's Policy Manual, section 1840.0901, Verification of Unearned income (MSSI, SFP) states:

All non-exempt unearned income must be verified at application and review unless otherwise specified. The following sources may be used to verify unearned income:

1. BENDEX or SDX tapes,
2. SSA document (award letter TYQY),
3. VA award letter,
4. pension or award letter,
5. Unemployment Compensation award letter,
6. child support court statement and/or current statement from absent parent, and
7. bank account statements to verify monthly interest/dividend income of more than \$10.

Accept the individual's statement for monthly interest/dividend income of \$10 or less. Bank account interest is included income only in patient responsibility calculations.

35. The Department's Policy Manual, section 1840.0902, Verification of Unearned Income (MSSI, SFP) states:

All unearned income must be verified from the source. Bank statements are not acceptable verification for any unearned income except the interest on the bank account, as they reflect the amount of benefits received after deductions, not necessarily the amount of income which must be counted. (Data exchange is an acceptable source of unearned income verification.)

36. The findings show the petitioner has a pension with [REDACTED] A pension is considered unearned income by the above controlling authorities. The above controlling authorities do not allow a bank statement to be considered as verification of income due to potential for unknown deductions prior to the deposit into the bank account.

37. The findings show the Department issued a Notice of Case Action in this matter requesting verification of the pension amount and providing a deadline for when the verification was due. The findings also show the petitioner failed to provide the verification and the case was subsequently denied. The undersigned concludes the Department correctly denied the case as the verification requested was not provided.

38. The findings show the petitioner's representative requested assistance in obtaining verification of the pension. The findings show the Department reported an attempt to assist the customer in obtaining the verification. The undersigned concludes that the responsibility for providing the verification lies with the petitioner, the Department's attempts to assist as required in the above controlling authority are in compliance.

ICP Resource Eligibility Determination

39. 20 C.F.R. § 416.1207, Resources determinations, states in relevant part:

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

(b) Increase in value of resources. If, during a month, a resource increases in value or an individual acquires an additional resource or replaces an excluded resource with one that is not excluded, the increase in the value of the resources is counted as of the first moment of the next month

(c) Decrease in value of resources. If, during a month, a resource decreases in value or an individual spends a resource or replaces a resource that is not excluded with one that is excluded, the decrease in the value of the resources is counted as of the first moment of the next month.

40. Florida Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource

Eligibility Criteria, states in relevant part:

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C.,

...
(2) Exclusions. The Department follows SSI policy prescribed in 20 C.F.R. §416.1210 and 20 C.F.R. §416.1218 in determining resource exclusions,

with the exceptions in paragraphs (a) through (g) below, in accordance with 42 U.S.C. §1396a(r)(2).

(a) Resources of a comatose applicant (or recipient) are excluded when there is no known legal guardian or other individual who can access and expend the resource(s).

...

(c) The cash surrender value of life insurance policies is excluded as resources if the combined face value of the policies is \$2,500 or less.

41. The findings show the petitioner has a life insurance policy with [REDACTED] with a face value of \$5,000. The findings also show the petitioner has a life insurance policy with [REDACTED] with a face value of \$13,000. The undersigned concludes, in accordance with the above controlling authority, the face value of these policies is greater than \$2,500 and therefore the cash value must be verified.

42. The findings show the petitioner does not presently have a guardian or power of attorney. The findings also show the petitioner has a diminished capacity and cannot aid her representative in providing information to determine her eligibility. The findings show the Department issued a Notice of Case Action requesting the verification of the cash value of the petitioner's life insurance policy. The findings further show no verification of the cash value of the life insurance policy was received. The undersigned concludes with no verification received, the Department appropriately denied the petitioner's application for ICP Medicaid.

43. The findings show the petitioner's has requested the Department's assistance in verifying the life insurance information. The findings also show the petitioner's daughter is the beneficiary of the life insurance policy. The Department has taken appropriate action to submit the appropriate forms to request the information. The undersigned notes, these action may or may not result in verifications being

received from the source. The undersigned concludes the petitioner's representative has not exhausted all available resources for trying to obtain the verification of life insurance cash value.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The Department's denial of eligibility at the time the action was taken is appropriate.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 04 day of January, 2018,

in Tallahassee, Florida.

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

Jan 22, 2018

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-07239

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88592

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on November 28, 2017 at 3:22 p.m.

APPEARANCES

For the Petitioner: [REDACTED], mother

For the Respondent: Hillary Campbell, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Whether the petitioner is eligible for SSI-Related Medicaid. The petitioner holds the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

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

By notice dated September 14, 2017, the Department informed the petitioner his application for SSI-Related Medicaid was denied.

The petitioner timely requested a hearing to challenge the Department's decision.

The petitioner was present, but did not testify. The petitioner did not submit documentary evidence during the hearing.

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

The record was held open until close of business on December 5, 2017 for the submission of additional evidence. Both parties timely filed evidence which was admitted into the record as Petitioner's Exhibit 1 and Respondent's Exhibit 2.

The record was closed on December 5, 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 29) filed an application for SSI Related-Medicaid with the Department on August 14, 2017. The petitioner is a single adult. He has eight children, but none of them live with him. (Respondent's Exhibit 1 and [REDACTED] testimony)
2. The petitioner listed \$720 monthly Social Security Income (SSI) on his application. (Respondent's Exhibit 1)

3. A Department caseworker interviewed the petitioner on August 18, 2017 in response to the application filed on August 14, 2017. The petitioner reported household income consisted of \$720 monthly SSI. (Respondent's Exhibit 1)

4. The Department issued a pending notice to the petitioner on August 17, 2017 which informed him that "proof of \$720 monthly [SSI]" was required on or before August 25, 2017. (Respondent's Exhibit 2)

5. The Department denied the petitioner's application on September 14, 2017. The Department's denial notice reads in pertinent part: "no household members are eligible for this program." (Respondent's Exhibit 1)

6. The petitioner requested a hearing on October 24, 2017.

7. The petitioner's mother explained that he received SSI due to mental illness from approximately age 8 to age 17. SSI benefits were terminated because the petitioner dropped out of high school and began working. He worked for several years, until his mental health issues escalated and he was no longer able to keep a job. The petitioner does not work and does not receive SSI. He has no source of income. The petitioner's mother testified that he has not been able to get the treatment he needs because he is uninsured. He currently seeks medical services by visiting local emergency rooms. The petitioner is seeking Medicaid coverage so he can receive treatment necessary to address his mental health issues. (Testimony [REDACTED], petitioner's mother)

8. The petitioner has applied for SSI on multiple occasions over the past few years and has been denied each time. The most recent application was filed on August

3, 2017 and denied by Social Security on September 26, 2017. The petitioner filed a copy of the denial notice post hearing. The notice reads in pertinent part:

You state that you are disabled and unable to work because of mental illness. We realize you are concerned about your condition and how it affects your ability to complete tasks. However, based on our review of the information in your case file, we have determined that you are capable of understanding and carrying out instructions, meeting general production and quality standards, and reporting to work on a regular and continuing basis. Although you may need treatment for your condition, and it may limit your ability to perform your past work, disability cannot be established because you are still capable of performing work that requires less physical effort, and only a very short, on-the-job training period.

(Petitioner's Exhibit 1)

9. The petitioner filed an appeal with Social Security on October 3, 2017. The appeal was still pending on the day of the hearing. (Testimony of petitioner's mother)

10. The Department asserted during the hearing that it denied the petitioner's application for SSI-Related Medicaid because it is required to adopt Social Security denial decisions made within the last 12 months, unless the individual has a new condition not reviewed by Social Security. Social Security denied the petitioner's application on September 26, 2017 and the petitioner did not assert a new condition. (Testimony of ██████████)

11. When asked how the Department's September 14, 2017 denial decision could have been based on a September 26, 2017 Social Security denial decision (Social Security had not made a determination regarding the petitioner's disability when the Department denied his Medicaid application), the Department's representative could not answer the question. The representative asserted that she did not process the petitioner's application herself and that she was a last, minute substitute representative

for the Department because the intended representative was not available. She was repeating the information told to her by the intended representative. (Testimony of [REDACTED])

12. The record was held open for the Department to clarify the reason for its denial decision. The Department filed a Statement of Matters on December 1, 2017 which reads:

The customer's Medicaid application was pended for proof of SSI income reported on the application because the Department could not verify it on the DES0 system we can use. The customer failed to verify the SSI income and the Medicaid was denied as not eligible since verification was not returned. The case was not pended for disability packet either due to customer report of SSI income.

(Respondent's Exhibit 2)

13. Department case notes filed post hearing show the petitioner visited a local service center on September 18, 2017 and informed the Department that his initial report of SSI income was not correct; he does not receive SSI. The case notes read, "Client was seen in the NBRSC regarding case status. Client states that he is not getting an amount form [sic] Social Security...client submitted document on 8/30/17..."

(Respondent's Exhibit 2)

14. The evidence submitted by the Department post hearing included documents the petitioner filed with the Department on August 18, 2017 and August 30, 2017 from the Social Security Administration. The document filed on August 18, 2017 appears to be a section of the petitioner's most recent application for SSI. The document showed \$720 monthly wages from [REDACTED]; employment period listed as August 2017 and continuing. However, last date paid was listed as April 6, 2006. The

document filed on August 30, 2017 was Social Security printout for the petitioner which showed the petitioner applied for disability benefits on August 3, 2017. Payment status code was listed as: H80- development pending. (Respondent's Exhibit 2)

CONCLUSIONS OF LAW

15. Pursuant to Section 409.285, Florida Statutes, the Department of Children and Families' Office of Appeal Hearings has jurisdiction over this proceeding.

16. This order is the final administrative decision of the Department of Children and Families pursuant to Section 409.285(2), Florida Statutes.

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

18. The Department denied the petitioner's application for SSI-Related Medicaid. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner. The standard of proof to be met for fair hearings is by a preponderance of the evidence.

19. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. 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...

20. The cited authority explains that single adults who are not elderly or have minor children that live in the home must be disabled in order to receive Medicaid.

21. To qualify for SSI-Related Medicaid, an applicant's income must be less than the Federal Poverty Level. The petitioner reported \$720 monthly SSI on his August 14, 2017 Medicaid application and reported the same income to a Department caseworker during an eligibility interview held on August 18, 2017. The Department was unable to verify the petitioner's declared SSI via its data match system (DES0), so it pended the petitioner for the verification. The petitioner later contacted the Department and provided documentation which shows he was not receiving SSI; but was possibly employed with [REDACTED]. This information was provided to the Department before it denied the petitioner's Medicaid application on September 14, 2017 for failure to verify SSI amount.

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

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

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

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

...

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

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

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

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

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

The verification/information due date is 10 calendar days after the date of the interview or if there is no interview requirement, 10 days after the date the pending notice is generated. In cases where medical information is required, the return due date is 30 calendar days from date of request. If the due date falls on a holiday or weekend, the deadline for the requested information is the next business day. At the individual's request, extend the due date. Leave the case pending until the 30th day after the date of

application to allow the household a chance to provide verifications. Assist applicants with getting missing verifications when needed.

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

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

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

25. The cited authorities explain that when verification is required to determine an applicant's eligibility, the Department must give the applicant written notice and 10 calendar days to provide the verification.

26. The evidence proves that the Department's decision denying the petitioner's application for SSI-Related Medicaid for failure to provide verification of SSI was incorrect. The petitioner provided verification from Social Security which showed that he was not receiving SSI two weeks before the Department denied his application.

27. The petitioner provided documentation during the application process which showed possible employment with [REDACTED]. The evidence proves that the Department did not act on this information. Per rule, the correct course of action was for the Department to send the petitioner a written notice requesting verification of his current employment status with [REDACTED] and give him 10 days to provide the verification.

28. The conclusions cited above would warrant remand of this matter to the Department for further development were it not for the fact that the petitioner has been

determined to be ineligible for SSI-Related Medicaid for another reason, failure to meet the disability criteria. On September 26, 2017, Social Security determined that the petitioner does not meet the disability criteria necessary to receive SSI-Related Medicaid. Social Security reviewed all of the petitioner's reported disabling impairments and concluded that he was still capable of performing some work in the national economy.

29. 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.

...

30. The authority cited above explains that Social Security's decisions made within the last 12 months are binding on the Department, unless the applicant reports a new disabling condition not previously reviewed by Social Security. The petitioner reported no new disabling conditions to the Department during the application process nor during the hearing. The Department is bound by Social Security's denial decision.

31. In the final analysis, the undersigned concludes that the petitioner does not meet the eligibility criteria required to receive SSI-Related Medicaid. Remanding the appeal to the Department to correct its procedural errors would not alter this conclusion.

DECISION

Based on the above Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 22 day of January, 2018,

in Tallahassee, Florida.

L. Green

Leslie Green
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

Jan 22, 2018

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-07251

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88624

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 20, 2017 at 2:19 p.m.

APPEARANCES

For the Petitioner: [REDACTED] daughter

For the Respondent: Carole Chance, economic self-sufficiency supervisor

STATEMENT OF ISSUE

Whether the petitioner is eligible for Institutional Care Program (ICP) Medicaid.
The petitioner holds the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The Department of Children and Families (Department or respondent) determines eligibility for ICP Medicaid.

By notice dated November 27, 2017, the Department informed the petitioner her application for ICP Medicaid was denied due to assets in excess of program limitations.

The petitioner timely requested a hearing to challenge the Department's decision.

Present as a witness for the petitioner: [REDACTED], owner, [REDACTED] [REDACTED]. The petitioner did not submit documentary evidence during the hearing.

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

The record was held open until close of business on December 27, 2017 for the submission of additional evidence. The Department timely filed evidence which was admitted into the record as Respondent's Exhibit 2.

The record was closed on December 27, 2017.

FINDINGS OF FACT

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

1. The petitioner (age 90) has been a resident of [REDACTED] since August 2015. She received ICP Medicaid from late 2015 through March 2017 to help cover the nursing home charges. [REDACTED] (petitioner's daughter)

2. In February 2017, the Department received an asset verification computer data match which showed that the petitioner owned a checking account with Bank of America (account number [REDACTED]) which contained a balance of approximately \$7,000. The ICP Medicaid asset limit for an individual is \$2,000. The Department

terminated the petitioner's ICP Medicaid coverage effective March 31, 2017, due to assets in excess of program limits. (Testimony of [REDACTED])

3. The petitioner filed an application to reinstate ICP Medicaid with the Department on May 31, 2017. The Department did not interview the petitioner during the application process. The Department relied exclusively on the application and computer system information to determine the petitioner's eligibility. The Department issued a pending notice to the petitioner on June 2, 2017 directing her to provide copy of her Bank of America "bank statement under asset limit and spend down of how this money was spent." The information was due by June 12, 2017. (Respondent's Exhibit 2)

4. On June 27, 2017, the petitioner faxed a copy of the June 2, 2017 pending notice to the Department with a message written on the bottom of the notice which reads, "[t]he daughter...is a joint account holder and her SSI check is deposited to the same account." Also included with the June 27, 2017 fax was a letter written by the petitioner's daughter, [REDACTED]. The letter reads: "Joint account for [petitioner] and [daughter]. Monthly deposit of \$809.27 is daughter's direct deposit Social Security checks – deposited in the name of [daughter]. This explains the accumulation of funds. Should additional information be required, please contact me at [REDACTED]." The fax also included the first page of a bank statement for the Bank of America account in question, for the period March 22, 2017 to April 18, 2017. The account was listed as [petitioner's name] or [daughter's name]. The account balance was \$8,094.54. The deposit amount listed on the statement was \$809.87. This figure was circled and next to it was a written message which reads, "monthly direct deposit for daughter['s] Social

Security check. Total over 10 mos. deposit.” The Department filed the faxed documents in its electronic records system, but took no other action on the information.

(Respondent’s Exhibit 2)

5. The Department denied the ICP application on June 30, 2017 due to assets in excess of program limits. (Respondent’s Exhibit 2) The petitioner did not appeal the denial decision.

6. The petitioner filed another application for ICP Medicaid with the Department on October 24, 2017. The Notes section of the application (which allows applicants to explain or clarify household circumstances) reads, “[t]his a reapplication...[Petitioner] was denied because her daughter commenced having her on SSA monies deposited into the account she shared with her mother and allowing the balance to accrue....”

(Respondent’s Exhibit 2)

7. The Department did not interview the petitioner during the application process. The Department relied exclusively on the application and computer system information to determine the petitioner’s eligibility. The Department issued a pending notice to the petitioner on October 26, 2017 directing her to provide “current bank statements for 10/2017.” The information was due by November 6, 2017. On November 3, 2017, the petitioner submitted a bank statement which showed the account balance was \$6,918.16. The Department denied the ICP application on November 27, 2017 due to assets in excess of program limits. (Respondent’s Exhibits 1 and 2)

8. The petitioner requested a hearing to appeal the Department’s denial decision. (Testimony of [REDACTED] petitioner’s daughter)

9. The petitioner's daughter explained that her mother has been confined to a nursing home since 2015. Due to the petitioner's age and health, the daughter handles the petitioner's business affairs. She explained that the funds in the joint Bank of America account, which caused the account balance to exceed the \$2,000 ICP asset limit, did not belong to the petitioner; the funds belong exclusively to the daughter. All the petitioner's funds (her Social Security benefits) have gone directly to the nursing facility since late 2015 to cover her patient responsibility (the portion of nursing home charges the resident must private pay, Medicaid pays the remaining charges). The daughter further explained that the bank account has been active for more than 30 years. The account was owned jointly by her parents for many, many years. Her father died in early 1991. A few months after the father's death, the petitioner added the daughter (and only child) to the account so she could take care of financial matters on the petitioner's behalf when necessary. The daughter asserted that from 1991 to 2015, she never used the account for her own financial transactions; it was used for receipt of the petitioner's Social Security income (approximately \$1,553 monthly) and to pay her expenses. The petitioner's Social Security was redirected to the nursing home after her admission in late 2015, to cover her patient responsibility. The daughter reached aged 62 ([REDACTED]) in 2015 and became eligible for Social Security retirement (SSRE). She began receiving SSRE in late 2015. The daughter stated she did not have her own banking account at that time. She has always worked in the restaurant industry, where she was paid directly, by check. Social Security required a bank account number for her SSRE direct deposit. Having no other bank account, the daughter used the Bank of America account jointly owned by the petitioner. The daughter received approximately

\$800 to \$900 monthly SSRE from mid-2015 to early-2017. She continued to work at the restaurant part-time, so her entire SSRE was not necessary to pay her living expenses. Her unused SSRE accumulated in the bank account. The daughter explained that she was not aware that her SSRE could impact her mother's eligibility for ICP Medicaid. Had she known of this possibility, she would have immediately opened her own bank account in 2015, for deposit of her SSRE. The daughter asserted that she repeatedly communicated to the Department that the funds in the account did not belong to the petitioner, starting in May or June 2017, but the Department continued to deny the petitioner's ICP Medicaid applications. (Testimony of [REDACTED], petitioner's daughter)

10. During the October 2017 application process, the petitioner's daughter filed the most current three Bank of America account statements (for the account in question) with the Department. The first bank statement covers June 21, 2017 to July 19, 2017 and shows the only deposits into the account were the daughter's SSRE, deposited June 21, 2017 and July 19, 2017, both deposits in the amount of \$917. There were no other deposits into the account except earned interest. The second bank statement covers July 20, 2017 to August 21, 2017 and shows the only deposit into the account was the daughter's SSRE, deposited on August 16, 2017 in the amount of \$917. There were no other deposits in the account except earned interest. The third bank statement covers August 22, 2017 to September 19, 2017. The statements shows an unidentified deposit of \$3,500. The petitioner's daughter explained that she was sick with [REDACTED] during this time period an unable to work. A relative gave her \$3,500 to pay expenses that month. (Respondent's Exhibit 2)

11. The petitioner's nursing home, [REDACTED], provided a Statement Register for the petitioner for the period December 2016 – May 2017. The register shows the petitioner's Social Security income was received directly by the facility each month, in the amount of \$1553. (Respondent's Exhibit 2)

12. The Department's asset data verification match printout for the petitioner, dated December 14, 2017, shows the checking account balance did not exceed \$2,000 until late 2015, after the petitioner's daughter reached age 62 and began receiving SSRE. (Respondent's Exhibit 1)

13. The petitioner's daughter argued that her mother's countable asset value never exceed \$2,000. She is seeking approval of the October 2017 ICP application, including three months retroactive coverage, July 2017 – September 2017. (Testimony of [REDACTED], petitioner's daughter)

14. The Department argued that the petitioner's countable assets exceeded the ICP program and it correctly denied the petitioner's application. The Department asserted that the petitioner did not file a non-ownership of assets claim until November 2017, after the ICP application was denied. The Department stands by its denial decision. (Testimony of [REDACTED])

CONCLUSIONS OF LAW

15. Pursuant to Section 409.285, Florida Statutes, the Department of Children and Families' Office of Appeal Hearings has jurisdiction over this proceeding.

16. This order is the final administrative decision of the Department of Children and Families pursuant to Section 409.285(2), Florida Statutes.

17. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code

R. 65-2.056.

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

19. Fla. Admin. Code § 65A-1.710 “SSI-Related Medicaid Coverage Groups” states in relevant part:

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

...

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

20. Fla. Admin. Code § 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...

21. Fla. Admin. Code 65A-1.716 Income and Resource Criteria states:

(5) SSI-Related Program Standards.

(a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:

1. \$2000 per individual.
2. \$3000 per eligible couple or eligible individual with an ineligible spouse who are living together.

22. The ICP Medicaid Program covers the institutional provider payment for skilled nursing home care. The legal authorities cited above explain that an applicant’s resources (assets) must be equal to or below the resource limit at some point during each month that ICP Medicaid eligibility is sought. The petitioner is a single individual. Her ICP resource limit is \$2,000.

23. The Department denied the petitioner's October 24, 2017 ICP application because she owned a joint checking account with her adult daughter which had a balance of approximately \$7,000. The Department concluded that the petitioner's countable resources exceeded the ICP limit of \$2,000. The Department asserted that the petitioner did not file a non-ownership of assets claim until November 2017, after her ICP application was denied.

24. The petitioner argued that all her funds have gone directly to her nursing home to cover her private pay portion of the charges since late 2015. The petitioner argued that since late 2015, all the funds in the bank account in question have belonged to someone else, her 64 year old daughter. The petitioner argued that she repeatedly filed a non-ownership of assets claims with the Department, beginning in May or June 2017.

25. C.F.R. § 416.905 addresses funds in bank accounts are counted and the process of rebutting ownership of funds in jointly owned accounts:

a) *General*. Funds held in a financial institution account (including savings, checking, and time deposits, also known as certificates of deposit) are an individual's resource if the individual owns the account and can use the funds for his or her support and maintenance. We determine whether an individual owns the account and can use the funds for his or her support and maintenance by looking at how the individual holds the account. This is reflected in the way the account is titled....

c) *Jointly-held account*—(1) *Account holders include one or more SSI claimants or recipients*. If there is only one SSI claimant or recipient account holder on a jointly held account, we presume that all of the funds in the account belong to that individual. If there is more than one claimant or recipient account holder, we presume that all the funds in the account belong to those individuals in equal shares.

(2) *Account holders include one or more deemors*. If none of the account holders is a claimant or recipient, we presume that all of the funds in a jointly-held account belong to the deemor(s), in equal shares if there is more than one deemor. A deemor is a person whose income and resources are required to be

considered when determining eligibility and computing the SSI benefit for an eligible individual (see §§416.1160 and 416.1202).

(3) *Right to rebut presumption of ownership.* If the claimant, recipient, or deemor objects or disagrees with an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, we give the individual the opportunity to rebut the presumption. Rebuttal is a procedure as described in paragraph (c)(4) of this section, which permits an individual to furnish evidence and establish that some or all of the funds in a jointly-held account do not belong to him or her. Successful rebuttal establishes that the individual does not own some or all of the funds. The effect of successful rebuttal may be retroactive as well as prospective.

Example: The recipient's first month of eligibility is January 1993. In May 1993 the recipient successfully establishes that none of the funds in a 5-year-old jointly-held account belong to her. We do not count any of the funds as resources for the months of January 1993 and continuing.

(4) *Procedure for rebuttal.* To rebut an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, the individual must:

(i) Submit his/her statement, along with corroborating statements from other account holders, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;

(ii) Submit account records showing deposits, withdrawals, and interest (if any) in the months for which ownership of funds is at issue; and

(iii) Correct the account title to show that the individual is no longer a co-owner if the individual owns none of the funds; or, if the individual owns only a portion of the funds, separate the funds owned by the other account holder(s) from his/her own funds and correct the account title on the individual's own funds to show they are solely-owned by the individual.

26. The Department's Program Policy Manual (165-22) section 1640.0308

General Availability (MSSI, SFP) states in relevant part:

When an individual is a joint account holder who has unrestricted access to the funds in the account, you must presume all of the funds in the account are owned by the individual. This presumption is made regardless to the source of the funds.

If the individual alleges the funds in the account belong to someone else, you must allow the individual to submit evidence to challenge this presumption. If the challenge is successful, do not count the funds in the account as an asset to the individual for any month. If the challenge to the presumption of ownership is not successful, you must consider the funds

as an asset to the individual. This policy applies to checking accounts, savings accounts, certificated of deposit and other jointly owned financial accounts.

27. The Department's Program Policy Manual (165-22) section 1640.0302.04

Proof Needed to Rebut Ownership (MSSI, SFP) states in relevant part:

When an individual has unrestricted access to the funds in a joint account but does not consider himself an owner of part or all of the account funds, you must advise the individual that:

1. the funds are presumed to be his; and
2. he may rebut the presumption of ownership by presenting proof the funds belong to someone else.

To rebut the presumption of ownership, the individual must provide the following information:

First, the individual must provide a written statement and corroborating evidence from the financial institution(s) and other sources to substantiate:

1. any claims about ownership of the funds or interest from the funds;
2. the reasons for establishing the joint account;
3. whose funds were deposited into the account;
4. who made withdrawals from the account; and
5. information on how withdrawals were spent.

Second, the individual must provide a written statement from the joint owner(s) explaining their understanding of the ownership of the account(s); that is, claims of ownership, why the account was set up, who deposited funds, withdrew funds and used the account.

When an individual is a co-owner of an account with someone who is incompetent or a minor, the corroborating co-owner statement is not necessary. You must obtain a corroborating statement from a third party who has knowledge of the circumstances.

If there is no third party or the individual is unable to provide all bank verification, you must make a rebuttal determination based on the evidence submitted. Enter an explanation on CLRC why no written corroborating statement was obtained from the joint owner.

To successfully rebut ownership of a joint account, the evidence must clearly support that the individual is not a joint owner of the funds.

28. The Department's Program Policy Manual (165-22) section 1640.0302.05

Evaluating Evidence for Rebuttal (MSSI, SFP) states in relevant part:

When all proof (per 1640.0302.03) is received, you must evaluate the evidence to determine if it supports the individual's claim that someone other than the individual owns the asset. The evidence must clearly corroborate that the funds deposited to the account did not belong to the individual and were not used to meet his needs.

If the rebuttal evidence proves that the account funds (all or partially) were deposited, withdrawn and used by the other joint owner(s) only, the individual has successfully proven that he does not own (all or part of) the funds.

If the individual successfully rebuts ownership of all the funds in the joint account, the individual's name must be removed from the account, so he no longer has access to the funds in the account. (This is not considered a transfer of assets.) Do not consider the funds in the account as an asset to the individual for any month (even for months prior to the month the individual's access to the account is removed). The individual must submit documentation of the original and revised (if any) account records showing his name has been removed. Photocopies are necessary for the case file.

29. The authorities direct the Department to allow applicants who assert that funds in a bank account belong to someone else an opportunity to prove their claims and if proven, the funds do not count as an asset for any month.

30. The evidence proves that the petitioner communicated to the Department in June 2017 and October 2017 that the funds in her Bank of America account belonged to her daughter. The Department's assertion that the petitioner did not report this information until after her application was denied is contradicted by the Department's own case record which shows receipt of a non-ownership of asset letters from the petitioner and her daughter on June 27, 2017. In addition, the petitioner made a non-ownership of asset claim in the comments section of her October 24, 2017 ICP application.

31. The petitioner provided current bank statements which show only the daughter's SSRE is being deposited into the account. The petitioner provided her

nursing home registry statement which shows her Social Security income has been going directly to the facility since at least December 2016. The Department's own asset data verification match shows the petitioner's bank account balance did not exceed \$2,000 until after the daughter reached age 62 in 2015 and began receiving SSRE. The petitioner is 90 years old and has been confined in a skilled nursing facility since 2015. There is no evidence that she has access to the bank account in question. The undersigned concludes that the petitioner provided substantial and credible evidence that the funds in the Bank of America account in question belong to her daughter.

32. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the Department failed to consider the petitioner's claims that the funds in the joint Bank of America checking account, which caused her countable asset value to exceed the applicable ICP limit, belonged to someone else. The Department's actions violate its controlling legal authorities.

DECISION

Based on the above Findings of Fact and Conclusions of Law, the Department's decision in this matter is reversed and remanded for further development. The Department is ordered to evaluate the petitioner's allegations that the funds in the Bank of America account belong to someone else. The Department shall allow the petitioner to provide any rebuttal evidence needed to complete the review. The Department shall issue a written decision notice upon completion of the review. The notice shall include appeal rights.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the

FINAL ORDER (Cont.)

17F-07251

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

DONE and ORDERED this 22 day of January, 2018,

in Tallahassee, Florida.



Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Jan 19, 2018

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-07264

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 December 4, 2017 at 8:30 a.m.

APPEARANCES

For the petitioner: [REDACTED], the petitioner's brother and representative

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

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her application for Adult-Related (SSI) Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any exhibits. The respondent submitted three exhibits, which were accepted into evidence and entered as Respondent's Exhibits "1" through "3".

FINDINGS OF FACT

1. The petitioner (60) filed an application for Medicaid disability on September 19, 2017. On the application, she reported that she was disabled. The petitioner is not age 65 or older and does not have any minor children.
2. The petitioner applied for disability with Social Security Administration (SSA) on January 4, 2017. The petitioner reported her disabling conditions to SSA. The petitioner was denied disability benefits through SSA with a denial code N-31 on March 2, 2017. Code N-31 means "Non-Pay-Capacity for substantial gainful activity-customary past work, no visual impairment". The petitioner filed a reconsideration with SSA on April 26, 2017. That appeal remains pending.
3. The Division of Disability Determination (DDD) is responsible for making State disability determinations on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. The petitioner's application was not referred to DDD because the respondent denied the petitioner's disability claim by adopting the SSA's denial (March 2, 2017).
4. On September 25, 2017, the respondent mailed the petitioner a Notice of Case Action denying her Medicaid application due to not meeting the disability requirement.
5. The petitioner's brother alleged her condition has worsened. The petitioner's brother explained that she has a heart condition that may require surgery. The

petitioner has been told by physicians that she may need a pacemaker because her heart condition has worsened. There is no evidence that SSA has refused to consider her worsening conditions.

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. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905, "Basic definition of disability for adults". The regulation states, in part:
 - (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work or any other substantial gainful work that exists in the national economy...
9. The Code of Federal Regulations at 42 C.F.R. § 435.541 addresses determinations of disability and states in part:
 - (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
 - (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §

435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations.

(1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA. [emphasis added]

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section. [emphasis added]

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of following circumstances exist:

...

(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)

10. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid

disability application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner reported all her disabling conditions to SSA. SSA denied the petitioner's disability claim on March 2, 2017 because it determined she was not disabled under its rules.

11. During the hearing, the petitioner's brother explained the petitioner's condition has worsened. The petitioner may require heart surgery. However, there is no evidence that SSA has refused to consider any worsening conditions.

12. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in adopting the SSA disability denial from March 2, 2017. The respondent's action to deny the petitioner's September 19, 2017 Adult-Related (SSI) Medicaid application was correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19 day of January , 2018,

in Tallahassee, Florida.



Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Jan 12, 2018

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-07288

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 December 6, 2017 at 1:33 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Shalonda Hill, supervisor

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for full Medicaid and enroll the petitioner in Medically Needy (MN) with an \$812 Share of Cost (SOC) at application. At hearing, the burden of proof was assigned to the respondent

by a preponderance of evidence. After further review, the burden of proof is reassigned to the petitioner.

PRELIMINARY STATEMENT

██████████ appeared as a witness for the petitioner. At hearing, the petitioner submitted no exhibits. The respondent submitted a 10-page evidence packet, which was marked and entered as Respondent's Exhibits "1" through "6".

The record was left open through December 20, 2017, for additional information including the SSI-Related Medicaid policy, the running record comments (CLRC) for the case, policy related to SSI termination processing, and any letters from the Social Security Administration (SSA) related to termination of SSI benefits. On December 12, 2017, the petitioner submitted an 11-page packet including letters from the SSA, which was marked and entered into evidence as Petitioner's Exhibit "1" and "2". On December 20, 2017, the respondent submitted an additional 64-page packet which included additional Notice of Case Actions, an additional application submitted by the petitioner, CLRC, and policy related to SSI termination, which were marked and entered as Respondent's Exhibits "7" through "20". The record was closed the same day.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner (34 years old) was determined disabled by the Social Security Administration (SSA) and received \$735 in SSI through April 2017 (Petitioner's Exhibit 1).
2. The SSA determines eligibility for Supplemental Security Income (SSI). An application for SSI is an application for Medicaid and when a Florida resident qualifies for SSI, they automatically qualify for Florida Medicaid. When an individuals' SSI

terminates, responsibility for Medicaid eligibility transfers from the SSA to the respondent (Respondent's Exhibit 8).

3. As of April 28, 2017, the SSA found the petitioner eligible for Social Security Disability, increasing her income. The petitioner was determined over the income limit for SSI and SSI Medicaid. The petitioner's SSI was terminated effective April 2017 (Petitioner's Exhibit 1). The petitioner's SSI Medicaid terminated effective June 30, 2017.

4. On May 18, 2017, the petitioner submitted a web application requesting Temporary Cash Assistance (TCA), Supplemental Nutrition Assistance Program (SNAP), and Medicaid benefits for herself. Medicaid is the only issue (Respondent's Exhibit 15).

5. The petitioner lives with her mother but is only applying for herself. The petitioner receives \$1,012 in Social Security Disability Income (SSDI) (Respondent's Exhibit 5).

6. The petitioner is not entitled to Medicare until June 2018 (Petitioner's testimony).

7. On June 7, 2017, the respondent mailed the petitioner a Notice of Case Action (NOCA) informing her the request for SNAP benefits was approved. No information related to Medicaid was addressed (Respondent's Exhibit 8).

8. On July 10, 2017, the petitioner contacted the Customer Call Center (CCC) requesting information about losing her Medicaid. The CCC agent explained as an SSI recipient, her Medicaid would terminate when her SSI payment terminated. She was advised SSA should have sent her a letter to apply with the department for Medicaid (Respondent's Exhibit 19).

9. The petitioner claims she was never notified of the termination of her SSI Medicaid (Petitioner's Testimony).

10. On July 13, 2017, the respondent mailed the petitioner an additional NOCA informing her the SNAP benefits would increase. No information related to Medicaid was addressed (Respondent's Exhibit 9).

11. On July 25, 2017, the respondent completed a Medicaid ex-parte, enrolling the petitioner in Medically Needy (MN) with a Share of Cost (SOC) effective July 1, 2017 (Respondent's Exhibits 19 and 20).

12. For the petitioner to be eligible for full Medicaid, her income cannot exceed the income limit of \$885. The respondent states the petitioner's income \$1,012 SSDI exceeds the income limit of \$885 set for one person. The next available program is MN with a SOC (Respondent's Exhibit 4).

13. The respondent determined the petitioner's SOC as follows (Respondent's Exhibit 3):

\$1,012	gross unearned income
- 20	unearned income disregard
<hr/>	<hr/>
\$ 992	countable unearned income
\$ 992	total countable income
- 180	medically needy income limit (MNIL)
<hr/>	<hr/>
\$ 812	SOC

14. On August 30, 2017, the petitioner contacted the CCC concerning her Medicaid again. She was informed she is now enrolled in MN with a SOC (Respondent's Exhibit 19).

15. On October 25, 2017, the petitioner requested the hearing.

16. The petitioner insists she needs full Medicaid because her doctors do not take MN and her quality of life has changed since her full Medicaid has ended. She further states she received no notice of termination from SSA concerning the Medicaid.

17. The respondent states the petitioner is not eligible for full Medicaid based on her income; however, she has been enrolled in MN with a SOC, a different Medicaid coverage.

CONCLUSIONS OF LAW

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

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

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

The timeliness of the appeal will be addressed first:

21. Fla. Admin. Code R. 65-2.046 states in the pertinent part:

(1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs.

...

(2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.

22. The above cited authority explains an individual must exercise the right to hearing within 90 calendar days of the date of written notification of the decision in all programs. Further, the authority states the time limitation does not apply when the department fails to send a required notification or fails to take action of a specific request.

23. In this instant case, the petitioner applied for all benefits on May 18, 2017. A NOCA was issued on June 7, 2017 related to the SNAP benefits. However, the respondent

failed to issue a notice related to the request for TCA and Medicaid. On October 25, 2017, the Office of Appeal Hearings (OAH) received the petitioner's request for hearing. 24. After careful review of the evidence and cited authority, the undersigned concludes the respondent did not issue required notification and failed to take action on the petitioner's request for Medicaid. Therefore, the petitioner's request for hearing is considered a timely request.

The request for full Medicaid will now be addressed:

25. The respondent 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 the SSI-Related Medicaid. Medicaid eligibility is based on federal regulations.

The petitioner was evaluated under the SSI-Related Medicaid coverage.

26. The ACCESS Program Transmittal NO.: P-11-06-0007, Supplemental Security Income Termination Review Process, dated June 7, 2011 states in part:

When an individual's SSI terminates, responsibility for Medicaid eligibility transfers from the SSA to the Department of Children and Families (DCF). There is no requirement for the individual to contact DCF or file an application to initiate the redetermination of Medicaid eligibility. ACCESS Florida staff must determine if the individual continues to be Medicaid eligible under any other category without contacting the individual unless eligibility cannot be determined otherwise.

Revised Instructions SSI Termination Review Process
The Agency for Health Care Administration (AHCA):

• **Extends Medicaid for adults on FLMMIS for at least two months beyond the SSI end date.** (*emphasis added*)

27. The above cited authority explains when an individual's SSI is terminated, the responsibility for Medicaid eligibility transfers from the SSA to the respondent. Further, the individual's Medicaid should be extended at least two months beyond the termination date. In this instant case, the petitioner's SSI was terminated in April 2017. The petitioner continued to receive full Medicaid through June 2017, giving two months of Medicaid beyond the termination date.

28. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI-Related Medicaid programs. It 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.

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

29. The Department's Policy Manual (The Policy Manual), CFOP 165-022, at Appendix A-9, sets forth 88% of the federal poverty level (FPL) for a household size of one as \$885.

30. In accordance with the above authority, the petitioner's income cannot exceed 88% of the FPL to be eligible for full Medicaid. In this instant case, the petitioner's \$1,012 SSDI exceeds the \$885 FPL for a household size of one. Therefore, the petitioner is not eligible for full Medicaid. MN must be explored for the petitioner.

Enrollment in Medically Needy with a Share of Cost will now be addressed:

31. 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.”

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

33. Fla. Admin. Code R. 65A-1.701 (30) states: “(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.”

34. 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.

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

36. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at \$180 for a family size of one.

37. In accordance with the authorities, the respondent deducted \$20 unearned income and \$180 MNIL from the petitioner's \$1,012 SSDI to arrive at \$812 SOC.

38. 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.

39. Based on the evidence and cited authorities, the undersigned concludes the respondent's action to deny the petitioner's request for full Medicaid and enroll the petitioner in MN with an \$812 SOC was within rule of the program.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
17F- 07288
PAGE -10

DONE and ORDERED this 12 day of January, 2017,
in Tallahassee, Florida.

Pamela B Vance

Pamela B. Vance
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

Feb 05, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-07356

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 CLAY
UNIT: 88367

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 18, 2017 at 3:05 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Sheron Mickens, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of October 12, 2017 denying her application for Adult-Related Medicaid as she does not meet the disability requirement.

The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Rebecca Sills, Program Office Administrator, Division of Disability Determinations, appeared as a witness for the Department.

The Department submitted evidence on November 20, 2017, which was entered as Respondent's Exhibit 1.

The record was held open for additional information from both parties through January 5, 2018. The Department submitted additional evidence on December 28, 2017, which was entered as Respondent's Exhibit 2. The petitioner did not submit additional information.

The record closed on January 5, 2018.

The undersigned reconvened the hearing on January 30, 2018 due to an update from the Department. The petitioner was present. Stephanie Ross, Economic Self-Sufficiency Specialist II appeared to represent the Department.

The record was closed again on January 30, 2018 following the reconvened hearing.

FINDINGS OF FACT

1. The petitioner filed an application for SSI-Related Medicaid on July 28, 2017. The household consisted of the petitioner, age 38. There are no minor children in the home. (Respondent's Exhibit 1, pages 6 through 11)
2. The petitioner also applied for Social Security Disability on July 28, 2017. (Respondent's Exhibit 2, page 6)
3. The Department submitted the disability determination packet to the Division of Disability Determinations (DDD) on August 28, 2017. (Respondent's Exhibit 1, page 14)
4. DDD established the primary diagnosis as [REDACTED] with a secondary diagnosis as [REDACTED]. DDD determined the petitioner did not meet the criteria

for disability and denied the disability with reason code N32. (Respondent's Exhibit 2, page 52)

5. The Department provided the DDD Medical Evaluation summary and Physical Residual Functional Capacity (RFC) which were completed during the determination of disability for the petitioner. (Respondent's Exhibit 2, pages 54 through 63)

6. The DDD witness explained the disability determination process. The petitioner is a 38-year-old female with no prior relevant work. DDD found she is unable to do self-care and currently wears a back brace. DDD used the five-step sequential evaluation process to determine the petitioner did not meet the disability criteria.

7. DDD determined the petitioner passes step one as she is not currently working.

8. DDD determined that the petitioner does have a severe impairment, meaning it is anticipated to last more than 12 months. The petitioner passed the second step.

9. DDD explained the petitioner's condition must meet or equal a listing in order to grant disability at step three. DDD determined that the petitioner's condition does not meet or equal a listing.

10. DDD explained in step four the petitioner's residual functional capacity or RFC must be determined. The maximum capacity for the petitioner was established as sedentary work. DDD had no report of past relevant work during the determination.

11. DDD reviewed step 5 and found the petitioner could perform other sedentary work. As DDD determined she could do other sedentary work, the disability was denied.

12. DDD explained this was an independent decision as the Social Security claim was still pending.

13. The Department issued a Notice of Case Action on October 12, 2017 regarding the petitioner's application for SSI-Related Medicaid. The Notice denied the petitioner eligibility for Medicaid with the reason of "You or a member of your household do not meet the disability requirement". (Respondent's Exhibit 1, page 1 through 3)

14. The petitioner reported her conditions to Social Security as [REDACTED]

[REDACTED]

[REDACTED] (Respondent's Exhibit 2, page 11)

15. The petitioner reported her conditions during the hearing as [REDACTED]

[REDACTED]

16. The petitioner testified she was admitted to the hospital with a severe [REDACTED] on July 18, 2017. The petitioner explained she was in the hospital for seven weeks and all of her conditions were diagnosed during this hospital stay.

17. The petitioner further reported she now has a [REDACTED] which came about after her denial by the Department.

18. The petitioner stated she has not had a mental diagnosis or exam completed as she has not been able to go see a mental health care provider.

19. The petitioner stated she was scheduled for a mental evaluation by Social Security for January 10, 2018. The petitioner stated she is also scheduled for a physical evaluation with Social Security on January 8, 2018.

20. The petitioner stated she has no insurance for follow-up treatments. She states she needs physical therapy and pain management but is unable to afford these treatments.

21. The petitioner stated she did work for a catering company as a chef, but can no longer do the work. She stated she cannot lift 10 pounds. She thinks she may be able to lift two pounds, but would still be in severe pain. She stated she cannot sit for two hours at a time due to the pain. The petitioner stated she was a housewife for a long time and previously worked for [REDACTED], but that was years ago.

22. DDD reported the petitioner has a new application pending with Social Security with an application date of October 13, 2017.

23. The Department reported the receipt of an update from the Social Security Administration. A determination of not disabled due to reason code N32 was issued on January 18, 2018.

24. The Department explained that a decision on disability by Social Security must be honored by the Department for 12 months, unless the petitioner has a new or worsened condition that has not been considered by Social Security.

25. The petitioner stated that she was examined by Social Security for both her physical diagnosis and her mental health diagnosis prior to the Social Security decision.

26. The petitioner stated she has no new diagnosis or evidence of worsened condition since the Social Security decision.

27. The petitioner stated she is appealing the decision made by Social Security, but has not filed the appeal at this time as she was trying to gather more medical evidence.

CONCLUSIONS OF LAW

28. 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.

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

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

31. 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.

32. 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).

33. 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.)

34. 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)

35. The undersigned explored potential eligibility for SSI-Related Medicaid for the petitioner. The findings show the petitioner was 38 at time of her application. In accordance with the above controlling authorities, the undersigned concludes as the petitioner is under age 65, she must meet the disability requirement for eligibility for SSI-Related Medicaid.

36. The findings show the Department initially denied the petitioner's application for SSI-Related Medicaid due to disability based on the independent decision made by the Division of Disability Determinations (DDD). The undersigned concludes at the time of the decision, the Department correctly requested the disability determination from DDD as no decision had been rendered by the Social Security Administration (SSA). The findings show the SSA issued a decision on the petitioner's disability on January 18, 2018. In accordance with the above controlling authorities, the undersigned further concludes now that a decision has been made by SSA, that decision supersedes any decision rendered by DDD.

37. The findings show the petitioner applied for Social Security disability. The findings further show the petitioner was denied for Social Security disability on January 18, 2018. 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 claims her condition is worsening daily, but she has not filed her appeal with SSA regarding her disability denial.

38. Based on the evidence and testimony presented as well as the above cited authorities, the undersigned concludes the SSA decision is binding on the Department. The undersigned 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 Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 05 day of February, 2018,

in Tallahassee, Florida.



Melissa Roedel
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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FINAL ORDER (Cont.)

17F-07356

PAGE - 11

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

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

FILED

Jan 12, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-07444

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Flagler
UNIT: 88882

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on December 12, 2017 at 9:35 a.m.

APPEARANCES

For the Petitioner: The petitioner was present and represented himself.

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

ISSUE

At issue is the respondent's action on October 27, 2017 to deny his application for SSI-Related Medicaid on its contention that he did not meet the disability requirement.

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

PRELIMINARY STATEMENT

Appearing as a witness for the petitioner was his aunt and caregiver, [REDACTED]

Evidence was received and entered as the Respondent's Exhibits 1 through 2.

The record was held open until 5:00 p.m. on December 12, 2017 to allow the petitioner and the respondent to submit additional evidence. Evidence was received and entered as the Petitioner's Exhibit 1 and the Respondent's Exhibit 3.

The record was closed at 5:00 p.m. on December 12, 2017.

FINDINGS OF FACT

1. The petitioner (date of birth [REDACTED]) applied for SSI-Related Medicaid on August 24, 2017 for himself only. The petitioner has no children.

2. The Department reviewed the petitioner's application for SSI-Related Medicaid and forwarded it to the Division of Disability Determination (DDD) for review.

3. The Respondent's Exhibit 2 includes the Disability Determination and Transmittal (Transmittal), which indicates that the DDD received the petitioner's disability claim on or around September 25, 2017. On October 24, 2017, the DDD completed the Transmittal with a decision to deny the petitioner's claim for disability. The DDD did not make an independent disability determination because the Social Security Administration (SSA) determined that the petitioner was not disabled and used the denial code of "N35" (*Respondent's Exhibit 2, page 11*). The Department explained that the denial code of "N35" is defined as "Non-pay-No Visual Impairment." The Department denied the petitioner's application for SSI-Related Medicaid.

4. The petitioner does not agree with the Department's denial. The petitioner argues that his right leg was amputated below the knee. The petitioner lists his other medical conditions as [REDACTED] and [REDACTED]. The petitioner believes his medical condition of a [REDACTED] were not reviewed by the SSA. The petitioner explained that this condition with his vision was not addressed with physicians because he does not have health insurance and is not under the care of a physician. The petitioner explained that he has always had issues with his vision and that his vision is getting worse. The petitioner contends that he has not been seen by an ophthalmologist; therefore, he believes he has no medical records to show evidence of this condition.

5. The petitioner's witness contends that the petitioner is not employed and is living with her in her home; she does not expect for him to pay any household expenses. The petitioner's witness argues that the petitioner needs a prosthetic leg but cannot afford to purchase one. The petitioner's witness contends that the petitioner has ordered glasses for his visual issues but cannot afford to pay for them. The petitioner's witness argues that the petitioner has medical bills for the months of July 2017 through October 2017, which total over \$263000. The petitioner's witness explained that the petitioner's medical conditions that were reviewed by the SSA were "... [REDACTED] [REDACTED], according to the disability denial letter dated October 24, 2017 from the SSA (*Petitioner's Exhibit 1*). The petitioner's witness contends that the petitioner has not filed an appeal with the SSA but will do so.

6. The Department contends that the petitioner's claim for disability was denied by the SSA; therefore, the Department adopted the SSA disability denial.

CONCLUSIONS OF LAW

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

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

9. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

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

10. Additionally, 42 C.F.R. § 435.541 Determination of Disability, states:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

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

§435.912 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)...

(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...21246000753867

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

State disability determinations for disability-related Medicaid applications must be done for all applicants with pending Title II or Title XVI claims unless SSA has denied their disability within the past year...

When the individual files an application within 12 months after the last unfavorable disability determination by SSA **and provides evidence of a new condition not previously considered by SSA**, the state must conduct an independent disability determination...(emphasis added)

12. The above authorities explain that a disability application must be sent to the Division of Disability Determination to be reviewed for applicants who are under the age of 65, who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien programs. However, if SSA has denied disability within the past year, the SSA decision is to be adopted. If the individual

applies for Medicaid within one year of an SSA denial and provides evidence of a new disabling condition that was not considered by SSA, the Department must make an independent disability decision. The petitioner provided no further evidence of a new disabling condition that was not considered by the SSA.

13. In this case, the petitioner is under age 65 and has medical conditions of an [REDACTED]. The findings show that the petitioner's medical conditions were reviewed by the SSA in its disability determination. The petitioner reports a [REDACTED] that he believes was not reviewed by the SSA. The petitioner reports that he has always had issues with his vision. There was no evidence submitted to indicate this as a disabling condition. The petitioner's concern and situation is recognized, however, the Department is required to follow the rules and regulations set forth by the governing authorities. The undersigned concludes that the petitioner did not meet his burden of proof to show that the Department's action was incorrect. The undersigned concludes that the Department was correct to adopt the SSA denial from October 24, 2017 (within 12 months of the Medicaid application with the Department) which resulted in the Medicaid denial.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the

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

DONE and ORDERED this 12 day of January, 2018,

in Tallahassee, Florida.



Paula Ali
Hearing Officer
Building 5, Room 255
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Jan 12, 2018

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-07456

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88582

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 7, 2017 at 1:00 p.m., at [REDACTED],

[REDACTED].

APPEARANCES

For the petitioner: [REDACTED] pro se

For the respondent: Marsha Shearer, ACCESS Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny his application for Medicaid disability benefits on the basis that he did not meet the disability Program requirement. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Donald Burdick, Unit Supervisor with the Division of Disability Determination (DDD), appeared telephonically, as a witness for the respondent.

The petitioner submitted one exhibit, which was accepted into evidence and entered as Petitioner's Exhibit "1". The respondent submitted seven exhibits, which were accepted into evidence and entered as Respondent's Exhibits "1" through "7".

FINDINGS OF FACT

1. On August 8, 2017, the petitioner (59) applied for Medicaid disability benefits for himself. The petitioner also applied for disability benefits through the Social Security Administration (SSA) on August 28, 2017. The petitioner is not over age 65 or blind and does not have any minor children.
2. The petitioner declared his disabling conditions to be [REDACTED]
[REDACTED]
[REDACTED]. His disabling conditions also include [REDACTED]
3. The petitioner graduated from high school. The petitioner was last employed as a real estate agent for a timeshare for the last eight years. The petitioner resigned his position on May 27, 2017.
4. The respondent reviewed the petitioner's eligibility for Medicaid for the blind, aged or disabled. The respondent sent the petitioner's medical information to DDD on September 7, 2017 for a disability determination.

5. The respondent's witness explained DDD completed an independent medical evaluation of disability and determined that the petitioner did not meet the criteria of aged, blind or disabled to be eligible for Medicaid disability benefits.

6. On October 2, 2017, DDD completed a disability review, which resulted in an unfavorable (N32) decision. DDD lists the petitioner's primary diagnosis as [REDACTED] and his secondary diagnosis as [REDACTED] (also known as [REDACTED]). The decision code N32 signifies "Impairment of insufficient severity to preclude individual's engaging in all SGA."

7. DDD Case Analysis Form, SSA-416, dated October 2, 2017, states in part:

1. Is claimant engaging in SGA? DDD did not address
2. Is impairment severe? YES
3. Does impairment meet or equal a Listing? NO
Listings considered- 5.05, 11.14, and 7.05
4. Can claimant perform PRW? YES

8. DDD determined the petitioner not disabled at step four. DDD determined that the petitioner's impairments did not meet or equal a listing according to the Social Security Act (Adult Listings-Part A). The petitioner was found not to be disabled and capable of returning to his previous employment.

9. On October 3, 2017, the respondent sent the petitioner a Notice of Case Action denying his August 8, 2017 application for Medicaid disability benefits. The reason stated was that he did not meet the disability requirement.

10. The petitioner explained he has [REDACTED] He is not able to work due to his illness. Additional medical documentation was sent to DDD to review prior to the hearing and given to the undersigned at the hearing. The petitioner

explained these medical documents indicate that he is enrolled on the donors list for a liver transplant.

11. The undersigned reviewed the medical documents that were sent to DDD to review; the documents indicate that the petitioner was referred to [REDACTED] and has an appointment scheduled for January 15, 2018. No evidentiary documents were submitted to support the petitioner's claim that he is enrolled on the list for a liver transplant.

12. The respondent's witness explained DDD reviewed the additional medical documents submitted by the petitioner and concluded the petitioner's impairments continue to not meet a relevant medical listing according to Social Security Act (Adult Listings-Part A). DDD affirmed its determination that the petitioner is not disabled and is capable of returning to his previous employment.

CONCLUSIONS OF LAW

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

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

15. The Code of Federal Regulations at 42 C.F.R. § 435.541 sets standards for when it is appropriate for the state Medicaid agency to make a determination of disability for individuals who apply for Medicaid. The regulation states in relevant 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...

(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.

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

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. The regulation states in part:

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

17. The Code of Federal Regulations at 42 C.F.R. § 435.541 indicates that a state Medicaid agency's determination of disability must be in accordance with the requirements for evaluating evidence under the SSI program specified in 20 C.F.R. §§ 416.901 through 416.998.

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

- (a) General—(1) Purpose of this section. This section explains the five step sequential evaluation process we use to decide whether you are disabled, as defined in § 416.905.
- (2) Applicability of these rules. These rules apply to you if you are age 18 or older and you file an application for Supplemental Security Income disability benefits.
- (3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled.
- (4) The five-step sequential evaluation process. The sequential evaluation process is a series of five “steps” that we follow in a set order. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and at step five when we evaluate your claim at these steps. These are the five steps we follow:
 - (i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)
 - (ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)
 - (iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment (s) that meets or equals one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)
 - (iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. (See paragraph (f) of this section and § 416.960(b).)
 - (v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an

adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. (See paragraph (g) of this section and § 416.960(c).

19. The Code of Federal Regulations at 20 C.F.R. § 404.1567 “Physical exertion requirements” states:

To determine the physical exertion requirements of work in the national economy, we classify jobs as sedentary, light, medium, heavy, and very heavy...In making disability determinations under this subpart, we use the following definitions:

(a) Sedentary work. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

(b) Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

20. In evaluating the first step, the petitioner is not engaging in substantial gainful activity. Therefore, the first step is met.

21. In evaluating the second step, the impairments must last or be expected to last for a continuous period of at least 12 months to meet durational requirements. The

petitioner has a diagnosis of [REDACTED] (non-bleeding grade 3) with [REDACTED]

[REDACTED],
which is considered severe. The second step is met.

22. In evaluating the third step, the impairment(s) would have to meet or equal one of the listings in Appendix 1 to Subpart P of Part 404 of the Social Security Act (Adult Listings-Part A) as it relates to listings 5.05, 11.14 and 7.05. The undersigned reviewed [REDACTED]. The listing indicates that the required level of severity demonstrates hemorrhaging from [REDACTED] or [REDACTED] or from [REDACTED]. The listing also indicates requiring hospitalization for transfusion of at least 2 units of blood or Beta thalassemia major requiring life-long RBC transfusions to maintain life. According to the evidence on the Physical Residual Functional Capacity Assessment (SSA-4734), the petitioner is able to perform his personal care independently, his household chores, prepares his own meals and is able to lift and carry about 20 pounds. According to the testimony and evidence, no records were presented to indicate the petitioner has had any hospitalizations or blood transfusions that were required due to esophageal varices. The petitioner was referred to see the [REDACTED]. There is no indication or evidence of hemorrhaging from esophageal or hemodynamic instability that requires hospitalization and interferes with the petitioner's daily activities. Based on a combination of the medical evidence submitted into the record and the petitioner's testimony, the undersigned concludes the petitioner does not meet or equal a relevant Social Security listing. The petitioner does not meet this step. The analysis continues on to step 4.

23. The fourth step is an assessment of the petitioner's residual functional capacity and past relevant work. The petitioner was employed for eight years as a real estate agent. DDD stopped on step four. Based on the petitioner's age, educational grade

level, employment history and his impairments, DDD determined the petitioner would be capable of light work. According to DDD's analysis and the objective medical evidence, the petitioner should be capable of performing his previous employment in real estate.

24. Based on the evidence submitted, the hearing officer must conclude that the petitioner does have the ability to perform work in the national economy. The petitioner does not meet the disability criteria and does not meet the definition of disability as set forth in the Social Security Act. It is concluded that the respondent's denial of the petitioner's Medicaid disability application is correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 12 day of January, 2018,

in Tallahassee, Florida.



Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
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

Jan 31, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-07542

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55207

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 5, 2017 at 1:15 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Jennie Rivera, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's 7-year-old child full Medicaid and enroll her in the Medically Needy Program with a share of cost ("SOC") is proper. The burden of proof was assigned to the respondent by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted no exhibits. The respondent submitted a 76-page packet which was marked and entered as Respondent's Exhibit "1" through "13." The record was left open through December 6, 2017, for the respondent to provide additional information including the Notice of Case Action ("NOCA") showing the SOC of \$1923. On December 5, 2017, the above-mentioned information was received, marked and entered as Respondent's Exhibit "14." The record was closed the same day.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner's 7-year-old child, LH, was certified for full coverage Medicaid from October 1, 2016 through September 30, 2017. The respondent explained that the petitioner's child received 12 months of full coverage Medicaid (Resp. Exh. 5).

2. On August 23, 2017, the petitioner recertified online for Family Medicaid (Resp. Exh. 3).

3. The household consists of the petitioner and her child, LH.

4. On the same date as the application, the petitioner provided paystubs from her current job at [REDACTED] dated July 28, 2017 and August 11, 2017. The respondent stated that these were not the most recent paystubs but were the paystubs that the department used in the determination (Resp. Exh. 4).

5. The respondent used the pay checks dated August 11, 2017 of \$1296.75 as representative and the pay check from August 25, 2017 of \$1618.88 as non-representative, due to an increase in the petitioner's hours.

6. On August 30, 2017, a NOCA was sent to the petitioner explaining the approval of medically needy Medicaid coverage for LH (Resp. Exh. 9).

7. On October 12, 2017, an online recertification for Family-Related Medicaid was received by the department. The household composition was still one adult and one child and the only income reported was from Office Depot (Resp. Exh. 3).

8. On October 16, 2017, the petitioner provided earned income with pay check dates of September 22, 2017 and October 6, 2017 to the respondent. The respondent did not use the pay from September 22, 2017 and deemed it as non-representative as the pay was less than the paychecks previously provided by the petitioner (Resp. Exh. 4).

9. The respondent only used the pay check dated October 6, 2017 for \$1155.48 and multiplied that by 2 to determine the monthly gross income of \$2310.96 (Resp. Exh. 7).

10. On October 27, 2017, a NOCA was mailed to the petitioner informing her that her estimated share of cost decreased from \$2128.00 to \$1956.00 per month effective December 1, 2017 (Resp. Exh. 9).

11. On November 2, 2017, the petitioner timely requested a hearing.

12. On November 27, 2017, the respondent reviewed the budgets and noticed that the incorrect paystubs were used in the determination of the share of cost amount and the respondent updated the share of cost amount to \$1923.00. The petitioner did not object to the paychecks used or the calculation the department explained.

13. On November 28, 2017, a NOCA was sent to the petitioner explaining that the share of cost decreased from \$1926.00 to \$1923.00 effective January 1, 2018 (Resp. Exh. 14).

14. The petitioner did not understand how her income has been consistent over the past year and a half and now her child is being moved into a share of cost. The petitioner explained the only change has been that her child is now one year older and she does not see how that change causes her to be in a share of cost Medicaid now. The petitioner wants full coverage Medicaid for her child.

15. The respondent stated that she is unaware of the actions the department took at the last application but was just able to review the recent actions made by the department. The respondent explained that the 7-year-old child is not eligible for full Medicaid because the household income exceeds the Family-Related Medicaid income limit for the household size. The child was enrolled in the Medically Needy Program because she failed to meet the income guideline for Family-Related Medicaid and the SOC was directly related to the household's gross income.

CONCLUSIONS OF LAW

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

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

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

FULL MEDICAID BENEFITS WILL NOW BE ADDRESSED:

19. Federal Regulation at 42 C.F.R. § 435.603(c) explains “the agency must determine financial eligibility for Medicaid based on **“household income”** as defined in paragraph (d) of this section [emphasis added].”

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

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

22. 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...”

23. The Department’s Program Policy Manual, CFOP 165-22 (“The Policy Manual”) at 2230.0400 Standard Filing Unit (MFAM) states:

The SFU is determined for each individual by following one of three rules based on intended tax filing status for the upcoming tax year as reported by the applicant/recipient. Individuals cannot receive Medicaid benefits under more than one assistance group, but can have their income included in more than one assistance group.

...

Tax Dependent Rule: If the individual being tested for eligibility expects to be claimed as a tax dependent for the tax year in which eligibility is being determined, the SFU includes the:

1. individual,
2. individual's spouse, even if the individual and the individual's spouse are living separately and filing a joint return,
3. tax filer,
4. tax filer's spouse, if any, even if the tax filer and tax filer's spouse are living separately and filing a joint return, and
5. all claimed tax dependents of the tax filer living inside or outside of the household.

24. In accordance with the above cited authority and The Policy Manual, the respondent correctly determined the petitioner's eligibility with a household size of two, including the petitioner and her one child.

25. Federal Regulation at 42 C.F.R. § 435.603, Application of modified adjusted gross income ("MAGI"), defines Household Income for Medicaid:

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

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

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

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

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based

methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

26. 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).

27. The Policy Manual at Appendix A-7, effective February 14,2017, lists the Family-Related Medicaid income limits for a household of two for children over age six and under age 19 as follows. It does not provide a standard disregard for this group:

\$1,800 income standard

\$ 387 MNIL (Medically Needy Income Limit)

\$ 68 MAGI

28. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner's child. Step 1: The total income counted in the budget is \$2,310.96. Step 2: There were no deductions provided. Step

3: There is no standard disregard provided for children six through 18. Step 4: The balance of \$2,310.96 is greater than the income limit of \$1,800 for a child six through 18 in a household of two. Step 5: The income of \$2,310.96 less the MAGI disregard of \$68 is \$2,242.96. The amount is greater than the income limit of \$1,800. The undersigned concludes that the petitioner is not eligible for full coverage Medicaid and Medically Needy eligibility must be explored.

MEDICALLY NEEDED WITH A SHARE OF COST WILL NOW BE ADDRESSED:

29. 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.

30. Fla. Admin. Code R. 65A-1.701, "Definitions" defines share of cost 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".

31. Fla. Admin. Code R. 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.

32. In accordance with the above cited authorities and The Policy Manual, the respondent determined the petitioner's countable household income to be \$2,310.96.

The MNIL of \$387 was subtracted from the income to determine the petitioner's SOC of \$1923.

33. The undersigned reviewed the SOC calculation completed by the Department and could not find a more favorable outcome.

34. Based on the evidence and a review of the respondent's budget calculations, the undersigned has concluded that the respondent used the best available information to terminate full Medicaid benefits and enroll the petitioner's child in the Medically Needy Program with a SOC.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is hereby denied. Eligibility for full Medicaid benefits is not found and enrollment in the Medically Needy Program is correct.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 31 day of January , 2018,

in Tallahassee, Florida.



Ashley Brunelle
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

Jan 25, 2018

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-07563

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 St. Johns
UNIT: 88366

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 7, 2017 at 2:36 p.m. in [REDACTED]

APPEARANCES

For the Petitioner: The petitioner was present and represented himself.

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

ISSUE

At issue is the respondent's action on August 7, 2017 to terminate the petitioner's son's full coverage under the Medicaid program and enroll him in the Medically Needy (MN) program with an estimated share of cost (SOC) in the amount of \$2534.

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

PRELIMINARY STATEMENT

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

The record was held open until 5:00 p.m. on December 21, 2017 to allow for the respondent to submit additional evidence. Evidence was submitted and entered as the Respondent's Exhibit 3.

The record was closed at 5:00 p.m. on December 21, 2017.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner's son (age 11) was receiving full-coverage Medicaid benefits until August 31, 2017. On July 27, 2017, the petitioner completed an application to recertify for Medicaid for himself (age 61) and his son. The petitioner is divorced from the non-custodial parent, who is the mother to his son. The petitioner listed his current wife, DW, (age 56) as an out-of-the household individual on the application. The petitioner listed on the application that he receives Social Security income in the amount of \$1220.60, that his son receives Social Security income in the amount of \$610.30, and that his current wife earns \$1800 each month.

2. The Department included in the petitioner's son's Medicaid budget, the petitioner's Social Security income in the amount of \$1220 and his wife's income in the amount of \$1800, for a total income of \$3020. The \$3020 income exceeded the income limit of \$2264 for three persons; therefore, the Department determined that the petitioner's son was no longer eligible for full-coverage Medicaid and enrolled him in the

MN Program. The income was reduced by the \$486 Medically Needy Income Level (MNIL) for three persons to result in a monthly share of cost in the amount of \$2534.

3. The Department terminated the full-coverage Medicaid for the petitioner's son and enrolled him in the MN program effective September 1, 2017. The Department mailed to the petitioner the Notice of Case Action on August 17, 2017 to inform him that his son was no longer eligible for Medicaid, effective August 31, 2017, and that he would be enrolled in the MN program with an estimated SOC in the amount of \$2534. The Department did not continue the full-coverage Medicaid pending the outcome of the hearing because the petitioner did not request a hearing until November 3, 2017, which was after August 31, 2017 when his Medicaid was terminated.

4. The petitioner challenges the Department's action and believes his son is still eligible for full-coverage Medicaid. The petitioner explained that he and his current wife were married at the end of 2016; however, they are not living together because the judge will not give him permission to relocate to live with his wife. The petitioner argues that his current wife's income should not be included in the budget, as she is not living in the home with him. The petitioner argues that his son should be eligible for full-coverage Medicaid because he was informed by Florida Healthy Kids that his current wife's income does not count in the Medicaid budget for his son. The petitioner argues that he was informed that his son's Medicaid would be restored. The petitioner contends that he took his son to the doctor on October 24, 2017 and was informed that his son was not receiving full-coverage Medicaid. The petitioner explained that he received a bill in the amount of \$165 and that he paid \$80 on the bill.

5. The Department explained that due to the Affordable Care Act federal law changes, the standard filing unit (SFU) was changed according to the petitioner's tax filing status. The Department contends that an interview that was conducted with the petitioner does not indicate that he was asked about his tax filing status. The Department explained that the prior Medicaid budgets did not include the petitioner's current wife's needs and income. The Department's evidence includes the "Out of the Household Individuals" screen, which shows that the petitioner's current wife is listed as an out of household tax dependent who has earnings in the amount of \$1800 each month (*Respondent's Exhibit 2, page 28*). The Department's Senior Human Services Program Specialist, Brenda Vrabel, sent an email dated December 7, 2017 in response to the email sent by the Department, to receive clarification as to whether or not the petitioner's current wife should be included in the Medicaid budget for the son's case. Brenda Vrabel wrote in the email: "If he is a tax filer and is claiming her as a tax dependent then yes, she will not be a recipient but her needs and income will need to be included" (*Respondent's Exhibit 3, page 1*).

6. The petitioner explained that the non-custodial parent claims their son on her tax return. The petitioner contends that he plans to file taxes this year but is not sure if he and his current wife will file together or separately. The petitioner pointed out that he and his wife may each file as head of household since they are living separately.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

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

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

9. The Family-Related Medicaid income criteria are set forth in Federal Regulations at 42 C.F.R § 435.603 and states:

(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.

Parent means a natural or biological, adopted or step parent.

Sibling means natural or biological, adopted, half, or step sibling.

Tax dependent has the meaning provided in §435.4 of this part.

(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....

(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.

(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, with the following exceptions—

(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—

(iii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed as a tax dependent by a non-custodial parent. For purposes of this section—

(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—(emphasis added)**

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's parents and siblings under the age specified in paragraph (f)(3)(iv) of this section.

10. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, 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.

Note: If one of the following exceptions apply, the individual's SFU will be determined based on non-filer rules:

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 a child...the SFU includes the:

1. individual,
2. individual's parents (biological, adopted and step) **living** in the household...(emphasis added)

11. The Respondent's Exhibit 2, page 27, includes the Office of Economic Self-Sufficiency's "How Standard Filing Units (SFUs) Are Determined in Family-Related Medicaid" is a chart that explains how the SFU is determined. The chart explains that if the individual is claimed as a tax dependent, the Department is to use the "Tax Filer" rule to determine the household's SFU. However, an exception to the rule includes children who are claimed as tax dependents by non-custodial parents. If the child meets this exception, the Department is to apply the "Non-Tax Filer" rule, which states that in this situation, the SFU includes: "The child + siblings (biological, adopted, step, half) and parents (including step-parents) **living** with the child" (emphasis added). The chart further explains that the child must be under the age of 19.

12. The Policy Manual, 165-22, Appendix A-7, indicates the Family-Related Medicaid income limit for Children ages 6 through 18 is \$2264 for a family size of three. The Medically Needy Income Limit (MNIL) is \$486 for a family size of three. The

income limit for Children ages 6 through 18 is \$1800 for a family size of two. The MNIL is \$387 for a family size of two.

13. The Department's 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).

14. The above authorities explain that household income is the sum of the MAGI-based income of every individual included in the individual's household. The Department should not include in the Medicaid budget, the income of a child and a tax dependent who is not expected to be required to file a tax return. The above authorities also explain that an individual who is a child under 19 and is expected to be claimed as a tax dependent by a non-custodial parent, the Department is to use the "non-tax filer"

rule to determine the SFU for the household. The “non-tax filer” rule according to the above authorities, instructs the Department to include in the SFU, the individual (under 19) and, if living together, the individual’s parents and stepparents. The above authorities also establishes that the income standard for a child aged 6 through 18 in a family size of three is \$2264 and \$1800 for a family size of two.

15. In this case, the Department terminated the Medicaid coverage for the petitioner’s son on its contention that the household income exceeded the income standard for a family size of three. According to the above authorities, the undersigned concludes that the Department is required to use the “non-tax filer” rule and exclude the needs and the income of petitioner’s current wife from the Medicaid SFU for the petitioner’s son’s case, as she is not living in the home. Therefore, the petitioner’s son’s Medicaid SFU should consist of the petitioner and his son. In this case, it is the petitioner’s 11 year old child seeking Medicaid; therefore, the SFU for the purpose of determining his son’s Medicaid eligibility is two. The undersigned concludes that the Department incorrectly determined the household size as three for Medicaid for the petitioner’s child. Therefore, the income standard of \$1800 for a family size of two should have been used in the petitioner’s Medicaid case for his child.

16. Based on the above findings and governing authorities, the undersigned concludes that the Department’s action to terminate the Medicaid coverage for the petitioner’s son and enroll him in the MN program was incorrect. The Department is remanded with instructions to re-determine eligibility for the petitioner’s son by including the petitioner’s income and by NOT including the needs of the petitioner’s current wife

from the date of the application on July 27, 2017. The Department is to issue a notice, to include appeal rights, upon completion of the re-determination.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 25 day of January, 2018,

in Tallahassee, Florida.



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FINAL ORDER (Cont.)

17F-07563

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

Jan 29, 2018

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-07765

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 St. Lucie
UNIT: 88510

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 4, 2018, at 1:37 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Patricia Roy, DCF supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action of denying him Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that he does not meet the disability criteria. The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

By a Notice of Case Action dated September 29, 2017, the respondent informed the petitioner that his SSI-Related Medicaid Program benefits were being denied because he did not meet the disability requirement of the Program. On November 9, 2017, the petitioner timely requested a hearing challenging the respondent's action.

The petitioner submitted an evidence packet which was accepted and marked as Petitioner's Exhibit 1. The respondent's evidence was accepted and marked as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

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

1. The petitioner [REDACTED] is 45. He does not meet the aged criteria for SSI-Related Medicaid benefits. He has no minor children and does meet the technical requirement for Family-Related Medicaid. The petitioner did not allege blindness. Disability must be established to determine Medicaid eligibility.
2. Petitioner is not currently employed and has not been since being involved in a car accident on April 21, 2017. The petitioner sustained multiple injuries, including [REDACTED]. He has incurred some significant medical expenses.
3. The petitioner's medical record, see Petitioner's Exhibit 1, indicates he suffered from a variety of medical ailments, including nerve damage. Notes from a June 1, 2017 examination by [REDACTED], indicate that the petitioner has a condition that manifests itself

...by acute symptoms of sufficient severity, which may include severe pain, such as the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, and/or serious impairment to bodily functions, and/or serious dysfunction of any bodily organ or part.

4. The petitioner has been receiving care from the [REDACTED] clinic that provides free services to those with no insurance. A statement from [REDACTED], ARNP, indicates that the petitioner has medical conditions that require Neurosurgery and/or Orthopedic surgery, see Petitioner's Exhibit, page 6.
5. On July 11, 2017, the petitioner applied for disability with the Social Security Administration (SSA). His application was initially denied on August 11, 2017 for being over the asset limit (N-04), see Respondent's Composite Exhibit, page 19. In September 2017, the petitioner requested an appeal to challenge the SSA's decision and has retained legal counsel. Petitioner's disability claim was reconsidered.
6. After review, SSA denied the petitioner's application with reason code N 36 (NONPAY Insufficient or no medical data furnished, no visual impairment.). That decision is under appeal.
7. The Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid programs. To be eligible an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility for individuals applying for disability benefits under the state Medically Needy Program. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and effectuation of any benefits due.

8. On July 5, 2017, the petitioner applied for Medicaid benefits through the Department's SSI-Related Medicaid Program. Information obtained from the petitioner was forwarded to DDD for review on July 20, 2017.

9. On September 25, 2017, DDD denied the petitioner's claim of disability by adopting SSA denial (N36), citing a Hankerson adoption as its authority, see Respondent's Composite Exhibit 1, page 20). DDD did not make an independent determination.

10. On September 29, 2017, the Department mailed the petitioner a Notice of Case Action denying his July 5, 2017 application for SSI-Related Medicaid due to not meeting the disability criteria, see Respondent's Composite Exhibit 1, page 22.

11. The respondent explained that it denied the petitioner's SSI Related Medicaid application because SSA has determined that the medical information he submitted was not sufficient enough for them to determine whether or not he was disabled and DDD has adopted the decision. The respondent explained that SSA decision is binding and must be accepted by the Department as final.

12. The petitioner did not dispute the facts presented; however, he asserted as follows: That he was just a passenger in a DUI accident. That he had suffered serious injuries that require additional care. That his medical conditions are getting worse. Petitioner explained that his he is in need of medical insurance so he can get the medical care he needs to get back on his feet and return to work. He did not claim any new conditions. He was not aware of the most recent SSA decision related to insufficient medical information. The undersigned offered to keep the record open for

the petitioner so he could provide additional information related to the most recent SSA decision, but he declined.

13. The petitioner's appeal before the Social Security Administration is still pending. He has been to medical appointments on December 26, 2017 and December 29, 2017 and is awaiting a final decision. The petitioner is seeking Medicaid coverage to continue with his recovery.

CONCLUSIONS OF LAW

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

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

16. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. Individuals less than 65 years of age must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states in relevant part:

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

17. The Code of Federal Regulations at 42 C.F.R. § 435.540(a) sets forth the definition and determination of disability and states, “the agency must use the same definition of disability as used under SSI...”

18. Federal Regulations at 42 C.F.R. § 435.541 “Determination of Disability,” states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-

- (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
- (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

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

...If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.

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

20. The Policy Manual at passage 1440.1205 Exceptions to State Determination of Disability (MSSI, SFP) states:

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

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization.
5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).
- 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)

The eligibility specialist must explore eligibility for Medicaid for the individual based on other coverage criteria, e.g., family-related coverage prior to exploring eligibility for disability-related Medicaid.

21. According to the above-cited authorities, an SSA decision made within 12 months of the Medicaid application that is under appeal is controlling and binding on the State Agency unless the applicant reports a disabling condition not previously reviewed by SSA. Additionally, they direct worsening and deteriorating of conditions to the SSA. In this instant case, SSA has determined that the petitioner's medical information was insufficient to determine whether or not he was disabled, and that decision is under appeal.
22. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's action to deny the petitioner Medicaid under the SSI-Related Medicaid coverage group is correct.
23. The hearing officer explored all other Medicaid groups. The only other Medicaid group was Family-Related Medicaid Program benefits. The petitioner has no minor children residing with him. The Family-Related Medicaid Program benefit rules are set forth in the Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid Program, a dependent child must be living in the home. The petitioner does not meet the criteria for Family-Related Medicaid Program benefits. It is concluded, the respondent's action to deny the petitioner's application for Medicaid Program benefits was within the rules of the

Program. The petitioner has failed to meet his burden that he is eligible for any Medicaid benefits.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 29 day of January, 2018,
in Tallahassee, Florida.



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

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

FILED

Jan 11, 2018

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-07796
17F-08400

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 December 4, 2017 at 10:45 a.m. and reconvened on December 12, 2017 at 9:45 a.m.

APPEARANCES

For the petitioner: [REDACTED], pro se

For the respondent: Sylma Dekony, ACCESS Economic Self-Sufficiency Specialist II (ESS II), appeared on December 4, 2017 and Marsha Shearer, ESS II, appeared on December 12, 2017

STATEMENT OF ISSUE

The petitioner is appealing the following:

I. The respondent's action to deny her application for Supplemental Nutrition Assistance Program (SNAP), also known as Food Assistance, benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

II. The respondent's action to enroll the petitioner in the Medically Needy (MN) Program with a share of cost (SOC) amount of \$1,132.00. The petitioner is seeking full Medicaid benefits for herself. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for December 4, 2017 at 10:45 a.m. The parties conducted a pre-hearing conference outside of the undersigned's presence. After the pre-hearing conference, the parties requested the hearing be rescheduled as the respondent was not aware the petitioner had also requested to appeal the Medicaid benefits. The parties agreed to reconvene the hearing. The hearing was reset for December 12, 2017 and appeal 17F-08400 was implemented to challenge the issue for the Medicaid Program.

On record and as the hearing began on December 12, 2017, the petitioner indicated she last received full Medicaid on May 31, 2017. The respondent issued a Notice of Case Action (NOCA) to the petitioner on May 20, 2017 informing her that her 12 months of Transitional Medicaid benefits would expire on May 2017. The petitioner requested the undersigned review the respondent's action to terminate her full Medicaid effective May 31, 2017. The NOCA which notified the petitioner of this action was issued on May 20, 2017, the petitioner did not request a hearing regarding the termination of her full Medicaid until December 4, 2017, which is over 90 calendar days from the date the NOCA was issued. Therefore, pursuant to Florida Administrative Code R. 65-2.046, the undersigned lacks jurisdiction to review the matter as the request

was made outside of the time allowed for a timely hearing request. The undersigned will only review the respondent's action to enroll the petitioner in the MN Program with a SOC.

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".

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was receiving Family Related-Medicaid for her daughter (age 15) and MN with a SOC of \$1,400.00 for herself. Medicaid for the petitioner's daughter is not an issue. On October 30, 2017, the petitioner submitted an on-line application to add on SNAP benefits for herself and her daughter.
2. On the application, the petitioner reported her source of income was her employment with [REDACTED]. The petitioner listed her monthly expenses as rent of \$1,405.00, electricity of \$80.00, water/sewer of \$120 and telephone of \$195.00. The petitioner submitted her paystubs dated September 27, 2017 gross pay \$759.60 and October 11, 2017 gross pay \$759.60. 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 \$1,633.14 ($\759.60×2.15).
3. The respondent imposed a 12-month Intentional Program Violation (IPV) disqualification penalty in the SNAP benefits beginning June 1, 2017. The petitioner

was not included in the SNAP benefits due to the IPV penalty imposed effective June 1, 2017.

4. The respondent compared the petitioner's monthly gross income to the SNAP monthly gross income limit. It was determined that the household's gross income of \$1,633.14 exceeded the gross income limit of \$1,307.00 for a household size of one.
5. On November 6, 2017, the respondent mailed the petitioner a NOCA informing her that her application was denied citing that her household's income was too high to qualify for this Program.
6. The respondent explained that according to the Department's policy, a disqualified individual's needs are not included in the SNAP eligibility determination; however, his/her income counts entirely.
7. In determining Medicaid eligibility for the petitioner, the respondent used the two paystubs provided by the petitioner. The countable household income of \$1,519.20 was determined by adding the petitioner's two paystubs ($\$759.60 + \$759.60 = \$1,519.20$). The countable household income of \$1,519.20 was compared to the Family-Related Medicaid income limit for a parent in a household size of two (\$241.00), the respondent determined the petitioner was not eligible for full Medicaid benefits as the household income exceeded the Medicaid income limits.
8. The petitioner did not dispute the SOC amount because she is seeking full Medicaid benefits. The petitioner explained her income has remained the same since 2016 and does not understand why she no longer qualifies for full Medicaid. Additionally, the

petitioner explained that her income is not enough to cover her household expenses and does not agree that she was excluded from the SNAP benefits.

9. 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 respondent testified that the petitioner's household received twelve (12) months of Transitional (full) Medicaid benefits from June 2016 through May 31, 2017.

10. The petitioner's SOC has gone down from \$1,400.00 to \$1,132.00 per month effective December 1, 2017.

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.

SNAP DENIAL ISSUE

13. The Code of Federal Regulations 7 C.F.R. § 273.9 defines "Income" and "Deductions" in the SNAP. 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)).

(1) The gross income eligibility standards for SNAP shall be as follows:

(i) The income eligibility standards for the 48 contiguous States and the District of Columbia, Guam and the Virgin Islands shall be 130 percent of the Federal income poverty levels for the 48 contiguous States and the District of Columbia.

...

(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...

...

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

(1) Standard deduction...

(2) Earned income deduction...

...

(6) Shelter costs...

14. The Code of Federal Regulations 7 C.F.R. § 273.10, Determining household eligibility and benefit levels, 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... 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...

(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.

(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.

...

15. The Code of Federal Regulations 7 C.F.R. §273.11, Action on households with special circumstances, states in part:

...

(c) Treatment of income and resources of certain nonhousehold members. During the period of time that a household member cannot participate for the reasons addressed in this section, the eligibility and benefit level of any remaining household members shall be determined in accordance with the procedures outlined in this section.

(1) Intentional Program violation, felony drug conviction, or fleeing felon disqualifications, and workfare or work requirement sanctions. The eligibility and benefit level of any remaining household members of a household containing individuals determined ineligible because of a disqualification for an intentional Program violation, a felony drug conviction, their fleeing felon status, noncompliance with a work requirement of §273.7, or imposition of a sanction while they were participating in a household disqualified because of failure to comply with workfare requirements shall be determined as follows:

(i) Income, resources, and deductible expenses. **The income and resources of the ineligible household member(s) shall continue to count in their entirety**, (emphasis added) and the entire household's allowable earned income, standard, medical, dependent care, child support, and excess shelter deductions shall continue to apply to the remaining household members.

(ii) **Eligibility and benefit level. The ineligible member shall not be included when determining the household's size for the purposes of:**

(A) Assigning a benefit level to the household;

(B) Assigning a standard deduction to the household;

(C) Comparing the household's monthly income with the income eligibility standards... (emphasis added)

16. The Department's Program Policy Manual (Policy Manual), Appendix A-1, sets forth the monthly gross income limit for a household of one as \$1,307.00.

17. The above-cited regulations explain that participants in the SNAP are required to meet income standards. The above regulations also set forth income which must be included, deductions which are allowed in the SNAP benefit determination and the budgeting process on how the gross and net income is determined in the SNAP budget. In this case, the respondent calculated the petitioner's earned income as \$1,633.14 by multiplying her bi-weekly paystubs by a conversion factor of 2.15, the undersigned concludes this calculation is correct.

18. The petitioner did not agree that she was excluded from the SNAP benefits. According to the above-cited regulations, an IPV ineligible member is not included when determining the household's size for the purpose of assigning a benefit level to the household, assigning a standard deduction to the household, and comparing the household's monthly income with the income eligibility standards during the disqualification period; however, his/her income continues to count in its entirety. The undersigned concludes the respondent was correct in excluding the petitioner's needs and counting all of her gross income in the SNAP eligibility determination.

19. In careful review of the evidence and cited authorities, the undersigned concludes that the respondent's action to deny the petitioner's SNAP application due to exceeding the gross income limit was correct.

FULL MEDICAID BENEFITS FOR THE PETITIONER ISSUE

20. Fla. Admin. Code R. 65A-1.707, Family-Related Medicaid Income and Resource

Criteria, states in part:

(1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows.

(a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages, self-employment, benefits, contributions, rental property, etc. Cash is money or its equivalent, such as a check, money order or other negotiable instrument. Total gross income includes earned and non-earned income from all sources...For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C. For the CNS criteria, refer to subsection 65A-1.716(1), F.A.C. For the payment standard income levels, refer to subsection 65A-1.716(2), F.A.C.

...

(2) The department considers income in excess of the medically needy income level available to pay for medical care and services. Available income from a one month period is used to determine the amount of excess countable income available to meet medical care and services. To be allowable, a paid expense may not have been previously deducted from countable income during a period of eligibility...

21. The Code of Federal Regulations at 42 C.F.R. § 435.110 sets forth the Medicaid

budgeting criteria for parents and states:

(a) Basis. This section implements sections 1931(b) and (d) of the Act.

(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.

(c) Income standard. The agency must establish in its State plan the income standard as follows:

(1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

(2) The maximum income standard is the higher of—

- (i) The effective income level in effect for section 1931 low-income families under the Medicaid State plan or waiver of the State plan as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or
- (ii) A State's AFDC income standard in effect as of July 16, 1996 for the applicable family size, increased by no more than the percentage increase in the Consumer Price Index for all urban consumers between July 16, 1996 and the effective date of such increase.

22. 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:

<u>Family Size</u>	<u>Income Level</u>
1	\$180
2	\$241

23. Pursuant to the above authority, the petitioner's \$1,519.20 ($\$759.60 + \$759.60 = \$1,519.20$) countable household income is more than the \$241.00 income limit; therefore, she is not eligible for full Medicaid benefits.

24. In careful review of the evidence and cited authorities, the undersigned concludes the respondent was correct to enroll the petitioner in the MN Program with a SOC as she is over income for full Medicaid benefits.

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

DONE and ORDERED this 11 day of January, 2018,

in Tallahassee, Florida.



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

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

Jan 23, 2018

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-07802

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 St. Lucie
UNIT: 88510

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 4, 2018, at 3:10 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Eric Eckhardt, DCF supervisor.

STATEMENT OF ISSUE

At issue is the respondent's action to terminate the petitioner's full Medicaid and enroll the two adults in Medically Needy (MN) with a Share of Cost (SOC) at recertification is correct. The burden of proof was assigned to the respondent by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted no exhibits. The Department submitted a 33-page evidence packet which was marked and entered as Respondent's Composite Exhibit "1".

FINDINGS OF FACT

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

1. Prior to the action under appeal, the petitioner's household has been receiving transitional Medicaid benefits under the Family-Related Medicaid coverage group. The household has been receiving this benefit since December 1, 2016.
2. Transitional Medicaid provides up to 12 months of Medicaid coverage to recipients are no longer eligible for full Medicaid due to income. This coverage was to expire on November 30, 2017.
3. On October 16, 2017, the respondent sent a Notice of Case Action (NOCA) to the petitioner informing her that it is time to review her case to find out if she is still eligible.
4. On October 21, 2017, the respondent sent a Notice of Case Action to the petitioner informing her that Medicaid benefit would end in October 2017 after a 12-month of eligibility, see Respondent's Composite Exhibit 1, pages 5 & 6.
5. On October 23, 2017, the petitioner submitted a recertification application requesting Medicaid for her household. The petitioner's household includes the petitioner, her husband and their mutual child, see Respondent's Composite Exhibit 1, pages

6. The petitioner is not employed. Her husband is employed earning \$500 a week. They file taxes jointly with the child as their dependent, see Respondent's Composite Exhibit 1, pages 33 & 34. The husband's income is not in dispute.

7. Based on the income information, petitioner was approved for the Medically Needy benefits for herself and her husband. The child was approved for full Medicaid.

8. On October 31, 2017, the respondent sent the petitioner a Notice of Case Action informing her she was approved for the Medically Needy Medicaid with a \$1,514 SOC, see Respondent's Composite Exhibit 1, pages 9-14.

9. The 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 the husband's \$500 weekly salary was multiplied by 4 to arrive \$2,000 modified adjusted gross income (MAGI). The 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.

10. As the 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 (\$2,000), resulting in an estimated SOC of \$1,514, see Respondent's Composite Exhibit 1, pages 35 & 36.

11. On November 1, 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.

12. After a case review, full Medicaid coverage was approved for the petitioner's household for November 2017 to complete the 12-month period for the transitional Medicaid coverage. A notice was sent to her on November 14, 2017 informing her of the action. A separate notice was sent on November 16, informing her that her 12 months of eligibility period would now expire in November 2017, see Respondent's Composite Exhibit 1, pages 16 & 17.

13. The respondent explained that the household has been receiving this coverage since December 1, 2016 and that the 12-month period ends on November 30, 2017. He further 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. He explained that petitioner's SOC amount is directly dependent on the household income.

14. The petitioner did not dispute any facts presented by the respondent. During the hearing, the petitioner asserted as follows: That her husband has been making the same money while she received this coverage. That she has medical issues that require medical attention. That once she received the notice that her coverage would be terminated on October 31, 2017 she cancelled all her medical appointments, because she could not afford to pay out-of-pocket. She explained that by the time the respondent discovered coverage was missing for November 2017 and reinstated the benefit, she did not have much of a chance to reschedule any of her appointments. She

did not incur any unpaid medical expenses during the month of November 2017. She maintains that she would not have cancelled her medical appointments has she known she would have coverage in November. The respondent explained that the same money now has a different effect on the household, after a year of transitional Medicaid coverage. He further 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

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.

Termination of the Transitional 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.

18. 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.

19. 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.

20. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at 2030.0203 Transitional Coverage (MFAM) defines transitional coverage:

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...

21. In accordance with the above cited authority and policy, the petitioner's income caused the petitioner and her husband 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 December 1, 2016 through November 30, 2017. The respondent is required to provide transitional Medicaid for up to 12 months to all household members once the Medicaid has been lost due to income, based on the policy.

22. Based on the testimony provided, the respondent provided the transitional Medicaid effective from December 1, 2016 to November 30, 2017. The undersigned concludes the transitional Medicaid was correctly terminated. The respondent has met

the burden of proof to show that transitional Medicaid for the petitioner's household was timely terminated.

Full Medicaid will now be addressed

23. 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..."

24. 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 husband's wages must be included in the Medicaid budget calculations.

25. 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..." The Family-Related Medicaid income limit for a three-member household is \$303.

26. 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.

27. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income (MAGI) (f) defines a Household for Medicaid:

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

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual—

(i) The individual's spouse;

(ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section.

(iv) The age specified in this paragraph is either of the following, as elected by the agency in the State plan—

(A) Age 19; or

(B) Age 19 or, in the case of full-time students, age 21.

...

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

28. 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.

29. In accordance with the above controlling authorities, the Medicaid household group is the petitioner, her husband and their mutual child (three members). The findings show the Department determined the petitioner's eligibility with a household size of three for Medicaid. The undersigned concludes the Department correctly determined the petitioner's household size for Medicaid.

30. 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.

31. The Policy Manual at passage 1830.0200 addresses Earned Income (MFAM)

states:

Earned income includes all gross (before taxes or other deductions) wages and salaries including income derived from the sale of blood or plasma, tips from performance of work, wages deferred that are beyond the individual's control, Federal Work Study and National and Community Services Trust Act living allowances through the Peace Corp, VISTA, Americorps, Foster Grandparent Program, Service Corps of Retired Executives and other volunteer programs. Wages are included as income at the time they are received rather than when earned.

Wages are considered earned income even when withheld at the request of the employee or provided as an income advance on income expected to be earned at a future date.

32. 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.

33. The above allow 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.

34. The Department's Policy Manual section 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).

35. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for petitioner. The undersigned concludes that the petitioner's household is not eligible for full Medicaid under the Family-Related Medicaid Program. The respondent proceeded to explore the Medically Needy Program. The undersigned recognizes the petitioner's concerns about her medical needs. However, the controlling legal authorities do not allow for any more favorable outcome.

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

36. 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.

37. 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".

38. 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.

39. 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.

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

41. The Family-Related Medicaid income standard appears in the Policy Manual at Appendix A-7. Effective April 2017, the MNIL for a household of three is \$486.

42. In accordance with the above controlling authorities, the respondent determined the petitioner's countable household income to be \$2,000. The MNIL of \$486 was subtracted from the income to arrive at a \$1,514 SOC. The undersigned found no exception to these calculation. The hearing officer reviewed the respondent's SOC calculation and could not find a more favorable outcome.

43. 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 \$1,514 is correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the

FINAL ORDER (Cont.)

17F-07802

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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 January, 2018,

in Tallahassee, Florida.



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

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

FILED

Jan 31, 2018

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-07829
APPEAL NO. 17F-07830

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned reconvened a telephonic administrative hearing in the above-referenced matter on January 17, 2018 at 11:47 a.m.

APPEARANCES

For the Petitioner: Petitioner was present and represented herself.

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

ISSUE

At issue is the respondent's action on November 6, 2017 to deny the petitioner's application for Supplemental Nutrition Assistance Program (SNAP) benefits for the months of September 2017 and October 2017 on its contention that she did not provide the requested verifications needed to determine her eligibility for the program.

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

PRELIMINARY STATEMENT

The hearing originally convened on December 18, 2017 at 9:39 a.m. The respondent requested a continuance to allow for a review of information submitted by the petitioner. The petitioner did not object. The respondent's request was granted and the hearing was scheduled to reconvene on January 17, 2018 at 11:45 a.m.

The hearing reconvened as scheduled. The petitioner stated on the record that her issue has been resolved for the Medicaid program and no longer needs a hearing for Appeal Number 17F-07830. Therefore, Appeal Number 17F-07830 is closed as withdrawn.

Evidence was submitted and entered as the Respondent's Exhibits 1 through 4.

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. On September 29, 2017, the petitioner completed an application for SNAP benefits for herself, age 46. The petitioner included a note on the application stating: "As of 9/28/2017, I am no longer working. I am blind and previously received both SSI and SSDI" (Respondent's Exhibit 2, page 24).

2. On October 11, 2017, the Department issued to the petitioner the Notice of Case Action (NOCA) requesting the following: "Proof of loss of income, last pay date and all income received in the month of 10/2017 using the "Verification of loss of income" form or provide a letter from other job" (Respondent's Exhibit 4). The NOCA

also requested for the petitioner to contact the Department for an interview by telephone by October 20, 2017.

3. On November 6, 2017, the Department mailed to the petitioner the NOCA to inform her that her application for SNAP benefits was denied on its contention that she failed to provide the necessary verifications to determine her eligibility for the program.

4. The petitioner requested a hearing on November 7, 2017 to challenge the Department's action.

5. The petitioner argues that she is legally blind and did not have access to the NOCAs informing her of the requested documentation. The petitioner explained during the hearing that she has a tool on her computer that allows her to read documents that are sent to her email. The petitioner explained that since she is not able to read documents that are mailed to her, she contacted the Customer Call Center by telephone after completing the application. The petitioner contends that she contacted the Customer Call Center up until October 20, 2017, when she provided the verification of terminated employment.

6. The petitioner contends that she completed the interview with DCF on October 24, 2017. The petitioner contends that she informed the interviewer that she is visually impaired and does not have access to the notices that are mailed to her. The petitioner contends that she asked the interviewer if there were any other verifications needed to process her case. The petitioner contends that the interviewer informed her of the date of the interview for the Medicaid portion of her case. The petitioner contends

that she was also informed that the verification of terminated employment that she provided was sufficient and that no other verifications were needed.

7. The petitioner argues that when she did not receive the status of her application, she contacted the Customer Call Center on November 5, 2017. The petitioner contends that she was informed that her case was denied, but did not receive any details as to the reason her application for SNAP benefits was denied. The petitioner argues that the Department did not properly communicate with her; therefore, she was not aware of the required verifications.

8. The Department is unaware if the petitioner was informed of missing verifications during the interview that took place on October 24, 2017. The Department's Running Records Comments (CLRC) dated October 19, 2017 states: "Rescheduled DDD interview to 11/1 for client and sent notice." The CLRC dated October 24, 2017 notes at the interview as follows: A ID verified via SSN and DOB called for phone int. Intake Completed..." The CLRC notes are signed by employee [REDACTED]. The CLRC dated October 27, 2017 includes notes stating: "Updated info from FS Interview. Client provided termination letter from [REDACTED] job, however, no paystubs were provided...client has 10 days from date of FS interview (10/24/17) to provide appropriate LOI." This CLRC entry was signed by employee [REDACTED] (Respondent's Exhibit 2, pages 32 to 34). The Department's evidence does not include verification that a NOCA was submitted to the petitioner to inform her of the missing verifications and to allow her additional time to submit the verifications. It is the

Department's contention that the petitioner was informed of the requested verifications on the NOCA that was mailed to her on October 11, 2017.

9. The Department explained that it was not aware of the petitioner's inability to access the NOCA informing her of the requested verifications and was under the impression that she received assistance when completing the application. The Department explained that she spoke with the petitioner after the case was denied and was informed of the petitioner's inability to review documents mailed to her. The Department also explained that the petitioner informed her that she is able to review documents that are sent to her by email. The Department explained that the petitioner is set up to receive NOCAs by regular mail but may change her preferences by going to her MyAccess account. The Department pointed out that the NOCA informs applicants and recipients of the ability to access MyAccess to set up preferences (Respondent's Exhibit 2, page 2).

10. The Department contends that she explained to the petitioner during the supervisory review on November 14, 2017, that the reason for the denial of her application dated September 29, 2017 was due to her not providing her final pay. The Department explained that she also spoke with the petitioner on November 29, 2017 and informed her that she would need to reapply for SNAP benefits. The Department received the petitioner's final pay stub, dated September 29, 2017, on November 30, 2017. The Department contends that since the petitioner notated on the application completed on November 30, 2017 that she required assistance, the caseworker was able to approve her for SNAP 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. 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 § 65A-1.205 Eligibility Determination Process states:

(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.

(2) In accordance with 7 C.F.R. § 273.14, 45 C.F.R. § 206.10(a)(9)(iii), 42 C.F.R. § 435.916, and Section 414.095, F.S., the Department must determine eligibility at periodic intervals.

(a) A complete eligibility review is the process of reviewing all factors related to continued eligibility of the assistance group.

(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.

(5) The Department can substantiate, verify or document information provided by the applicant/recipient as part of each determination of eligibility. For any program, when there is a question about the validity of the information provided, the Department will ask for additional documentation or verification as required. The term verification is used

generically to represent this process.

(a) Substantiation establishes accuracy of information by obtaining consistent, supporting information from the individual.

(b) Verification confirms the accuracy of information through a source(s) other than the individual. The Department can secure verification electronically, telephonically, in writing, or by personal contact.

14. Federal Regulations at 7 C.F.R. § 273.2 Office operations and application processing states in part:

...
(5) Notice of Required Verification. The State agency shall provide each household at the time of application for certification and recertification with a notice that informs the household of the verification requirements the household must meet as part of the application process. The notice shall also inform the household of the State agency's responsibility to assist the household in obtaining required verification provided the household is cooperating with the State agency as specified in (d)(1) of this section. The notice shall be written in clear and simple language and shall meet the bilingual requirements designated in §272.4(b) of this chapter. At a minimum, the notice shall contain examples of the types of documents the household should provide and explain the period of time the documents should cover.

(e) Interviews...

...The interviewer must not simply review the information that appears on the application, but must explore and resolve with the household unclear and incomplete information.

(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...

(5) Responsibility of obtaining verification. (i) The household has primary responsibility for providing documentary evidence to support statements on the application and to resolve any questionable information. **The State agency must assist the household in obtaining this verification provided the household is cooperating with the State agency** as specified under paragraph (d)(1) of this section...(emphasis added)

(g) Normal processing standard—(1) Thirty-day processing...

...
(3) Denying the application. Households that are found to be ineligible shall be sent a notice of denial as soon as possible but not later than 30 days following the date the application was filed. If the household has failed to appear for a scheduled interview and has made no subsequent

contact with the State agency to express interest in pursuing the application, the State agency shall send the household a notice of denial on the 30th day following the date of application. The household must file a new application if it wishes to participate in the program. In cases where the State agency was able to conduct an interview and request all of the necessary verification on the same day the application was filed, and no subsequent requests for verification have been made, the State agency may also deny the application on the 30th day if the State agency provided assistance to the household in obtaining verification as specified in paragraph (f)(5) of this section, but the household failed to provide the requested verification.

(h) *Delays in processing.* If the State agency does not determine a household's eligibility and provide an opportunity to participate within 30 days following the date the application was filed, the State agency shall take the following action:

(1) *Determining cause.* The State agency shall first determine the cause of the delay using the following criteria:

(i) A delay shall be considered the fault of the household if the household has failed to complete the application process even though the State agency has taken all the action it is required to take to assist the household. The State agency must have taken the following actions before a delay can be considered the fault of the household:

...

(C) In cases where verification is incomplete, the State agency must have provided the household with a statement of required verification and offered to assist the household in obtaining required verification and allowed the household sufficient time to provide the missing verification. Sufficient time shall be at least 10 days from the date of the State agency's initial request for the particular verification that was missing (**emphasis added**).

15. The above authorities explain that the Department is responsible for determining an individual's eligibility at application. The individual is responsible for providing the verifications needed. The Department must be available at the appointed time to conduct the telephone interview, if scheduled, and is to provide assistance in obtaining verifications when it appears to be necessary. The Department is to explore and resolve unclear and incomplete information with the applicant. The Department is to allow the applicant at least 10 days to provide requested verifications. The

Department is to process the application within 30 days. When verifications are incomplete, the Department must provide the household with a statement of the required verifications and offer to assist. The Department is to allow the household sufficient time (at least 10 days) to provide the missing verifications.

16. The findings show that the petitioner was mailed the NOCA informing her to provide verification of terminated employment and pay for the month of October 2017. The findings show that the petitioner provided verification of terminated employment on October 20, 2017. The findings also show that the petitioner completed an interview with the Department on October 24, 2017 but was not informed of any missing verifications during this interview. There was no evidence provided by the Department to show that the petitioner was informed of the missing verification to allow her the opportunity to provide the missing verifications. Therefore, based on the above authorities, evidence, and findings of fact, the undersigned concludes that the Department's denial of the petitioner's SNAP application was incorrect. Therefore, the FAP denial is reversed. The case is remanded with instructions for the Department to determine eligibility from the Sept 29, 2017 date of application, not duplicating any SNAP benefits already issued. A new notice with appeal rights is to be issued upon completion of the new determination.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is granted and remanded for corrective action. The Department's denial action is

reversed. The Department is to determine eligibility for SNAP benefits as explained in the above conclusions and issue written notice to include appeal rights.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 31 day of January, 2018,

in Tallahassee, Florida.



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

FINAL ORDER (Cont.)
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Feb 05, 2018

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

Office of Appeal Hearings
Dept. of Children and Families



PETITIONER,

APPEAL NO. 17F-07842
17F-08737

Vs.

CASE NO. 

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 December 19, 2017 at 8:30 a.m.

APPEARANCES

For the petitioner: , pro se

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

STATEMENT OF ISSUE

The petitioner is appealing the following:

I. The respondent's action to terminate his Adult-Related (SSI) Medicaid benefits and enroll him in the Medically Needy (MN) Program with a share of cost (SOC) amount of \$1,073.00 beginning January 2018. The petitioner is seeking full Medicaid benefits for himself. The respondent carries the burden of proof by a preponderance of the evidence.

II. The respondent's action to terminate his Supplemental Nutrition Assistance Program (SNAP) benefits on November 30, 2017. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner presented one exhibit, which was entered into evidence as Petitioner's Exhibit "1". The respondent submitted four exhibits, which were entered into evidence as Respondent's Exhibits "1" through "4". The record was held open until close of business on December 29, 2017 for submission of additional evidence from the respondent. On December 20, 2017, the respondent submitted an additional exhibit, which was accepted into evidence and entered as Respondent's Exhibit "5". The record closed on December 29, 2017.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner (58) was receiving Supplemental Security Income (SSI) of \$733 and was a recipient of Adult-Related (SSI) Medicaid benefits for himself. The petitioner was also receiving SNAP benefits for himself, his wife and their mutual child (16) since his application dated June 12, 2017. The SNAP benefits certification period was from June 2017 through December 2017.
2. The petitioner received the maximum SNAP allotment of \$511.00 for a household size of three. The income calculated in the SNAP budget was the petitioner's SSI of \$733.00. The petitioner's adult daughter, who lives outside of the home, paid the petitioner's rent of \$860.00 and his heating/cooling expenses directly to the vendors. Therefore, no utility allowance or shelter deduction were credited in the SNAP budget.

3. The Department's system generates a Notice of Expiration (NOE) one month prior to the end of the SNAP certification period. The NOE would have notified the petitioner that his SNAP benefits would end on December 31, 2017, unless he reapplied by December 15, 2017. A NOE was not issued to the petitioner.
4. On October 30, 2017, the Department notated on the running record comments that it received information from the State Data Exchange¹ on October 18, 2017, indicating the petitioner's SSI ended and that he was approved for Social Security Disability (SSDI) of \$1,249.00 and that his child was approved for Social Security Benefits of \$637.00. The respondent processed the information and determined the petitioner was not eligible for full Medicaid benefits because his SSDI of \$1,249.00 exceeded the \$885.00 Medicaid income limit.
5. On October 31, 2017, the respondent mailed the petitioner a Notice of Case Action (NOCA) indicating his Adult-Related (SSI) Medicaid benefits would end on November 30, 2017. The respondent attempted to determine protected Medicaid coverage for the petitioner; however, the petitioner's income exceeded the income limit. Therefore, the respondent ended the petitioner's Adult-Related (SSI) Medicaid benefits on December 31, 2017 and enrolled him in the MN Program with a SOC of \$1,073.00 beginning January 2018. As of January 2018, the petitioner's SSDI increased to \$1,274.00. The respondent used \$1,273.00, instead of \$1,274.00, to calculate the petitioner's SOC as follows:

¹ The State Data Exchange Screen (DESD) displays SSI information for a specific individual.



TOTAL UNEARNED INCOME:	1273.00	COUNTABLE EARNED INCOME:	.00
PARENT'S DEEMED INCOME: +	.00	COUNTABLE UNEARNED INCOME: +	1253.00
MISC. INCOME DISREGARDS: -	.00	MEDICALLY NEEDY DISREGARD: -	.00
UNEARNED INCOME DISREGARD: -	20.00	TOTAL COUNTABLE INCOME: =	1253.00
COUNTABLE UNEARNED INCOME: =	1253.00		
		INCOME STANDARD:	.00
SELF-EMP. ADJ. GROSS EARN.:	.00		
ADDITIONAL EARNED INCOME: +	.00		
MISC. INCOME DISREGARDS: -	.00	TOTAL COUNTABLE INCOME:	1253.00
REM. UNEARNED INC. DISREGARD: -	.00	MNIL: -	180.00
EARNED INCOME DISREGARD: -	.00	SHARE OF COST: =	1073.00
1/2 REMAINING DISREGARD: -	.00		
BLIND WORK EXPENSES: -	.00	MED. INSURANCE PREMIUM: -	.00
COUNTABLE EARNED INCOME: =	.00	RECURRING MED. EXPENSES: -	.00
		REMAINING SOC: =	1073.00

AG HAS PASSED THE SSI-RELATED MEDICAID ELIGIBILITY DETERMINATION BUDGET

6. The respondent explained the same notice issued on October 31, 2017 notified the petitioner that his SNAP benefits would end on November 30, 2017. The respondent testified that the ineligibility language on the notice was incorrect. The correct reason for the denial was due to the SNAP certification period ending. However; according to the Department's running record comments on October 30, 2017, the petitioner's total household income (the petitioner's SSDI of \$1,249.00 and his child's Social Security Benefits of \$637.00) exceeded the income standard.

7. The respondent determined the household's combined income was \$1,886.00 (\$1,249.00 and \$637.00). This amount was calculated in the SNAP budget. No shelter or utility expenses were credited in the SNAP budget. The respondent terminated the petitioner's SNAP benefits due to being over income for the program and shorten his certification through November 2017.

8. On October 31, 2017, the petitioner contacted the Department and reported his adult daughter was no longer paying for his shelter and utility expenses. This information should have been considered as a change in the SNAP budget. However,

the Department did not take any action because it had already ended the petitioner's SNAP benefits effective November 30, 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 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.

ADULT-RELATED (SSI) MEDICAID ISSUE

11. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2040.0802.01, Protected Medicaid(MSSI), states in pertinent part:

Protected Medicaid is a categorical Medicaid coverage group that is extended to certain eligible individuals. There are five Protected Medicaid coverage groups.

Passages 2040.0802.02 through 2040.0802.05 give the technical criteria for Protected Medicaid eligibility.

Passages 2040.0804.01 through 2040.0809 describe Protected Medicaid coverage groups and give the special eligibility criteria for each group.

...

2040.0802.07, Income (MSSI)

The individual's countable income, after disregard of SSA cost of living adjustments received since the individual was last eligible for (and received concurrently) SSA and SSI benefits, must not exceed the current SSI FBR². The policy in Chapters 1800 and 2400 is to be used in determining what income is and how it is counted.

² The Federal Benefit Rate (FBR) is \$750.00 for an individual. The petitioner's income of \$1,274.00 exceeds the FBR income limit.

12. The respondent testified that the petitioner is not entitled to Protected Medicaid.

The petitioner's \$1,274.00 monthly SSDI income exceeds the FBR of \$750.00.

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).

15. The Policy Manual, CFOP 165-22, Appendix A-9, identifies \$885.00 as 88 percent of the FPL for an individual. The petitioner's \$1,274.00 SSDI exceeds the \$885.00 income limit for full Medicaid. Therefore, the petitioner is not eligible for full Medicaid.

16. In accordance with the above authority, the Department correctly used the petitioner's gross income in determining his Adult-Related (SSI) Medicaid eligibility.

17. 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...”

18. The Florida Administrative Code R. 65A-1.716 sets forth the MNIL at \$180 for an individual.

19. In accordance with the above authorities, the Department deducted \$20 and \$180 from the petitioner’s \$1,273.00 SSDI to arrive at a \$1,073.00 SOC.

20. 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 terminate the petitioner’s Adult-Related (SSI) Medicaid benefits and enroll him in the MN Program with a \$1,073.00 SOC, was proper.

SNAP ISSUE

21. The Code of Federal Regulations at 7 C.F.R. § 273.14, Recertification, states in part:

(a) General. No household may participate beyond the expiration of the certification period assigned in accordance with §273.10(f) without a determination of eligibility for a new period. The State agency must establish procedures for notifying households of expiration dates, providing application forms, scheduling interviews, and recertifying eligible households prior to the expiration of certification periods. Households must apply for recertification and comply with interview and verification requirements.

(b) Recertification process—(1) Notice of expiration. (i) The State agency shall provide households certified for one month or certified in the second month of a two-month certification period a notice of expiration (NOE) at the time of certification. The State agency shall provide other households the NOE before the first day of the last month of the certification period, but not before the first day of the next-to-the-last month. Jointly processed PA and GA households need not receive a separate SNAP notice if they are recertified for SNAP benefits at the same time as their PA or GA redetermination.

- (ii) Each State agency shall develop a NOE. The NOE must contain the following:
 - (A) The date the certification period expires;
 - (B) The date by which a household must submit an application for recertification in order to receive uninterrupted benefits; ...
 - (G) The household's right to request a fair hearing if the recertification is denied or if the household objects to the benefit issuance;

22. 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...
 - ...
 - (iii) Changes in residence and the resulting change in shelter costs.
 - ...
- (b) Report forms.
 - ...
 - (3) Changes reported over the telephone or in person by the household shall be acted on in the same manner as those reported on the change report form...
- (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... The State agency shall document the date a change is reported, which shall be the date the State agency receives a report form or is advised of the change over the telephone or by a personal visit. **Restoration of lost benefits shall be provided to any household if the State agency fails to take action on a change which increases benefits within the time limits specified in paragraph (c)(1) of this section.** (emphasis added)
 - (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...
 - (iii) The State agency may elect to verify changes which result in an increase in a household's benefits in accordance with the verification requirements of §273.2(f)(8)(ii), prior to taking action on these changes. If the State agency elects this option, **it must allow the household 10 days from the date the change is reported to provide verification required**

by §273.2(f)(8)(ii). (emphasis added) If the household provides verification within this period, the State shall take action on the changes within the timeframes specified in paragraphs (c)(1) (i) and (ii) of this section. The timeframes shall run from the date the change was reported, not from the date of verification. If, however, the household fails to provide the required verification within 10 days after the change is reported but does provide the verification at a later date, then the timeframes specified in paragraphs (c)(1) (i) and (ii) of this section for taking action on changes shall run from the date verification is provided rather than from the date the change is reported. If the State agency does not elect this option, verification required by §273.2(f)(8)(ii) must be obtained prior to the issuance of the second normal monthly allotment after the change is reported. If in these circumstances the household does not provide verification, the household's benefits will revert to the original benefit level. Whenever a State agency increases a household's benefits to reflect a reported change and subsequent verification shows that the household was actually eligible for fewer benefits, the State agency shall establish a claim for the overissuance in accordance with §273.18. In cases where the State agency has determined that a household has refused to cooperate as defined in §273.2(d), the State agency shall terminate the household's eligibility following the notice of adverse action....

(4) State agency option for processing changes in deductible expenses. (i) If the household reports a change to an established deduction amount during the first six months of the certification period, other than a change in earnings or residence, that would affect the household's eligibility for, or amount of, the deduction under §273.9(d), the State agency may at its option disregard the change and continue to provide the household the deduction amount that was established at certification until the household's next recertification or after the sixth month for households certified for 12 months. When a household reports a change in residence, the State agency must investigate and take action on potential changes in shelter costs arising from this reported change. However, if a household fails to provide information regarding the associated changes in shelter costs within 10 days of the report, the State agency should send a notice to the household that their allotment will be recalculated without the deduction. The notice will make it clear that the household does not need to await its first regular utility or rental payments to contact the SNAP office. Alternative forms of verification can be accepted, if necessary.

23. The 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.
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.

24. On October 31, 2017, and after the respondent terminated the petitioner's SNAP benefits due to being over income for the program, the petitioner reported to the respondent that his adult daughter was no longer paying his shelter or utility expenses.

25. Pursuant to the above authorities, beneficial changes to SNAP 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's availability date is the twenty fourth day of each month.

26. 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. Note: When information received via Data Exchange conflicts with the information provided on the application, resolve the discrepancy per the instructions in manual passage 3010.0100. This may require

contact with the individual, collection of additional verifications, correction of the information entered in the system...

27. According to the above transmittal, the respondent is required to process beneficial changes, when taking any action on a case. The undersigned concludes the respondent should have mailed a pending notice allowing the petitioner ten (10) days to provide verification of his shelter and utility obligation, if questionable.

28. After careful review of the evidence and controlling legal authorities, the undersigned concludes the respondent erred in terminating the petitioner's SNAP benefits before December 31, 2017, the end of his certification period. Therefore, this matter is remanded back to the Department to allow the petitioner to submit verification of his shelter and utility costs regarding the change he reported to the respondent on October 31, 2017. **If needed**, the respondent is to send a notice to the petitioner allowing him ten (10) days from the date of the notice to provide any required information. The respondent is then ordered to determine the petitioner's SNAP eligibility for November 2017 and December 2017, utilizing all allowable deductions and without duplicating SNAP benefits already issued. Once an eligibility determination is made, the respondent is to issue a new NOCA to the petitioner notifying him of the outcome.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's Adult-Related (SSI) Medicaid appeal, 17F-07842, is denied and the respondent's action is affirmed.

The petitioner's SNAP appeal, 17F-08737, is granted and remanded back to the respondent to take corrective action as specified in the Conclusions of Law.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WIL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 05 day of February, 2018,

in Tallahassee, Florida.



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

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

Feb 23, 2018

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGSOffice of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 17F-07846

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Nassau
UNIT: 88211RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 3, 2018 at 10:50 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 and Families (DCF).

ISSUE

The petitioner is appealing the Department's action on August 2, 2017 to enroll her in the Medically Needy (MN) program with an estimated monthly share of cost in the amount of \$668.

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

PRELIMINARY STATEMENT

The petitioner was mailed the Notice of Case Action on August 2, 2017. The hearing was requested on November 9, 2017, which exceeds the time limit to request a hearing. The petitioner contends that she requested a hearing prior to November 9, 2017. The petitioner argues that she contacted DCF on September 7, 2017 to request a hearing. The petitioner contends that she may not have specifically stated that she wanted a hearing, but she did ask to speak with a higher authority to inquire why she was not covered under the Medicaid program. The Department's evidence includes the Running Records Comments (CLRC) dated September 7, 2017 which indicate that the petitioner contacted DCF to inquire as to the reason she was enrolled in the MN program. Based on the evidence and testimony, the undersigned ruled to take jurisdiction over this appeal. The petitioner stated on the record that she does not wish to address the Supplemental Nutrition Assistance Program (SNAP) benefits.

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

The record was held open until 5:00 p.m. on January 3, 2018 to allow the respondent to submit additional evidence. Evidence was submitted and entered as the Respondent's Exhibit 3.

The record was closed at 5:00 p.m. on January 3, 2018.

FINDINGS OF FACT

1. On July 27, 2017, the petitioner completed an application to recertify for SNAP and Medicaid benefits. The household consists of the petitioner (age 52) and her grandchild (age 13). The petitioner was receiving full-coverage Medicaid in previous

months. The Department discovered at the time of her application that the petitioner was recently approved for Social Security income in the amount of \$957. The petitioner is not yet receiving Medicare (Respondent's Exhibit 2, page 17).

2. The Department included the petitioner's Social Security income in the Medicaid budget and determined that she was not eligible for full-coverage Medicaid, as the income exceeded the limit for the program. The Department determined that the petitioner was eligible for the MN program with a SOC in the amount of \$668.

3. The Department included the petitioner's Social Security income in the amount of \$957 in the MN budget. The Medically Needy Income Limit in the amount of \$289 was deducted from the petitioner's Social Security income to calculate the remaining SOC in the amount of \$668.

4. The petitioner argues that she needs full-coverage Medicaid in order to be treated for her health condition. The petitioner argues that she has custody of her grandchild and does not know who will take care of him if she cannot get the medical attention that she needs.

5. The petitioner explained that she does not file taxes and that no one claims her or her grandson as a dependent on their taxes.

6. The Department explained that the petitioner is no longer eligible for Medicaid due to the receipt of Social Security income for which she was recently approved. The Department explained that due to the Affordable Care Act (ACA) federal law changes, the petitioner was the only one included in the standard filing unit (SFU) based on her tax filing status.

CONCLUSIONS OF LAW

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

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

9. The 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.

(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...

(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 children under the ages specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's parents and siblings under the age specified in paragraph (f)(3)(iv) of this section.

10. 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. The above also explains that the household includes the individual, individual's spouse, and the individual's natural or adopted children if the individual is not expected to be required to file a tax return and is not going to be claimed as a tax dependent by another tax filer. In this case, the findings show that the petitioner lives in the home with her grandchild and is not going to file taxes, nor is she claimed as a dependent on anyone else's tax return. Therefore, the undersigned concludes that the Department was correct to include the petitioner and her income in its calculations.

11. 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.

12. The Department's Program Policy Manual, CFOP 165-22, Appendix A-7, indicates the Family-Related Medicaid income limit for Caretakers is \$180 for a family size of one and the standard disregard is \$109. The Medically Needy Income Limit (MNIL) is \$289 for a family size of one and the MAGI disregard is \$50.

13. 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).

14. In this case, the Department considered the petitioner's Social Security income in the amount of \$957 to determine her eligibility for Medicaid. The Department compared the household income to the Family-Related Income Limit in the amount of

\$180 for a family size of one 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 enroll the petitioner in the Medically Needy program was correct. The income exceeds the limit for the caretaker to receive full coverage Medicaid.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)

17F-07846

PAGE - 8

DONE and ORDERED this 23 day of February, 2018,

in Tallahassee, Florida.



Paula Ali
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Email: Appeal.Hearings@myflfamilies.com

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

FILED

Jan 22, 2018

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-07926
17F-07928
17F-07929
17F-07930

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 Santa Rosa
UNIT: 88630

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on December 14, 2017 at 1:37 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Natarsha Peacock, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's actions of October 30, 2017 denying the petitioner's application for Food Assistance, Adult-Related Medically Needy and the Medicare Savings Program. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted information prior to hearing which was entered as Respondent's Exhibit 1.

The record was held open for additional information from both parties through December 28, 2017. The Department submitted additional information on December 22, 2017. This information was entered as Respondent's Exhibit 2. The petitioner did not submit any additional information.

The record closed on December 28, 2017.

FINDINGS OF FACT

1. The petitioner submitted an application for Food Assistance and Medicare Savings Plan on September 27, 2017 for herself and her husband. According to the application, the petitioner's husband is a non-citizen who arrived in the United States September 25, 2008. The petitioner's application indicates the petitioner receives Social Security benefits of \$492. (Respondent's Exhibit 1, pages 3 through 10)

2. The Department issued a Notice of Case Action on September 29, 2017 informing the petitioner of the need for a telephonic interview on October 9, 2017. The Notice also informed the petitioner of the need for verification of loss of earned income and all income for September 2017, the need to complete the authentication process at the local storefront and verification of [REDACTED] retirement income. (Respondent's Exhibit 1, pages 35 and 36)

3. The Department issued a Notice of Case Action on September 29, 2017 regarding the petitioner's application for Qualifying Individual 1 (QI 1). This notice

informed the petitioner that the application was denied as “No household members are eligible for this program”. (Respondent Exhibit 1, page 37 through 39)

4. The Department issued a Notice of Case Action on October 5, 2017 informing the petitioner of the need to complete and return the Financial Information Release form by both the petitioner and her husband, current verification regarding the pension income as the information provided was not acceptable. The information was due to be returned to the Department no later than October 16, 2017. (Respondent’s Exhibit 1, page 34)

5. The Department issued a Notice of Case Action on October 30, 2017 denying the petitioner’s Food Assistance and Medically Needy application dated September 27, 2017 due to not receiving proof of unearned income necessary to determine eligibility. (Respondent’s Exhibit 1, pages 27 through 33)

6. The petitioner submitted documents on November 13, 2017 regarding income documentation for the petitioner’s husband. (Respondent’s Exhibit 1, pages 40 through 49)

7. The Department converted the petitioner’s husband pension income from British pounds to US dollars. The income includes pension amounts of \$292.63, \$779.98 and ██████████ pension of \$145.46 (all US dollar amounts). The total income for the petitioner’s husband is \$1,218.07 ($\$292.63 + \$779.98 + \$145.46 = \$1,218.07$).

8. The petitioner confirmed the Department’s conversion of her husband’s income is accurate.

9. The petitioner confirmed her Social Security benefits were \$492 per month in 2017. Her Social Security benefits increase to \$502 effective January 2018.

10. The petitioner has a mortgage of \$550 in 2017 that will increase to \$616.22 effective 2018. The mortgage includes the homeowner's insurance and property tax. The petitioner stated she heats and cools her home with electricity.

11. The Department issued a Notice of Case Action on November 16, 2016 approving the household for Food Assistance in the amount of \$15 effective October 2017. This notice also denied the petitioner's application for Qualifying Individuals 1 (QI 1) as the household's income was too high to qualify for the program.

12. The petitioner reported in hearing that she incurs \$45 in medical expenses.

13. The Department provided a copy of the petitioner's January 2018 Food Assistance budget. The Department included gross unearned income in the amount of \$1,720.07 which is the petitioner's Social Security of \$502 and the petitioner's husband total pension amount of \$1,218.07. The Department allowed a Standard deduction of \$160. The Department allowed the petitioner's medical expenses of \$45 less the \$35 medical deduction to give an excess medical expense of \$10 in the budget. The gross unearned income of \$1,720.07 less the standard deduction of \$160 and excess medical expense of \$10 leaves an adjusted net income of \$1,550.07 ($\$1,720.07 - \$160 - \$10 = \$1,550.07$). The Department multiplied the adjusted net income of \$1,550.07 by 50 percent to reach a shelter standard for the petitioner's household of \$775.03 ($\$1,550.07 \times 50\% = \775.03). The Department allowed the petitioner the Standard Utility Allowance (SUA) of \$347 due to the petitioner's ability to incur a heating or cooling expense. The Department totaled the petitioner's mortgage of \$616.22 and the SUA of \$347 to reach a total shelter cost of \$963.22. The Department subtracted the shelter

standard of \$775.03 from the petitioner's total shelter cost of \$963.22 to reach an excess shelter expense of \$188.19 ($\$963.22 - \$775.03 = \188.19). The Department subtracted the excess shelter expense of \$188.19 from the adjusted net income of \$1,550.07 to reach a Food Assistance Adjusted income of \$1,361.88 ($\$1550.07 - \$188.19 = \$1,361.88$). The Department then multiplied the Food Assistance Adjusted income of \$1,361.88 by 30 percent to reach a benefit reduction amount of \$409 ($\$1,361.88 \times 30\% = \409). The Department compared the Thrifty Food Plan amount for a two-person household of \$352 to the benefit reduction amount of \$409 and determined the benefit reduction amount is greater than the maximum allotment for this household size. The Department then approved the minimum benefit allotment of \$15 for the household.

14. The petitioner reported she is on Medicare Part A but does not presently receive Medicare Part B.

15. The petitioner expressed her concern that the \$15 was so low that it really did not assist them that much.

16. The petitioner expressed concern that with the Medically Needy Share of Cost being \$1,600 per month, they will have nothing left to live on.

CONCLUSIONS OF LAW

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

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

FOOD ASSISTANCE

19. 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;

20. The findings show the Department included the petitioner's Social Security and the pensions for the petitioner's husband as unearned income. The undersigned concludes the Department correctly determined the petitioner's income as unearned income.

21. 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.... Allowable medical costs are:

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

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

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

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

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

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

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

(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.

...

(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.

22. 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. Net losses from the self-employment income of a farmer shall be offset in accordance with §273.11(a)(2)(iii).

...

(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.

- (ii) In calculating net monthly income, the State agency shall use one of the following two procedures:
- (A) Round down each income and allotment calculation that ends in 1 through 49 cents and round up each calculation that ends in 50 through 99 cents; or
 - (B) Apply the rounding procedure that is currently in effect for the State's Temporary Assistance for Needy Families (TANF) program. If the State TANF program includes the cents in income calculations, the State agency may use the same procedures for SNAP income calculations.

...

(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; 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.
- (B) If the calculation of benefits in accordance with paragraph (e)(2)(ii)(A) of this section for an initial month would yield an allotment of less than \$10 for the household, no benefits shall be issued to the household for the initial month.
- (C) Except during an initial month, all eligible one-person and two-person households shall receive minimum monthly allotments equal to the minimum benefit. The minimum benefit is 8 percent of the maximum allotment for a household of one, rounded to the nearest whole dollar.

23. The Department's Policy Manual, Appendix A-1, Food Assistance Income Eligibility Standards and Deductions, lists the following standards effective October 1, 2017: The Standard Deduction for a one to three-person household is \$160. The

Standard Utility Allowance is \$347. The appendix also lists the maximum allotment for a two-person household as \$352. The minimum allotment for a one or two-member household is \$15.

24. As the Department failed to provide the Food Assistance budget calculations for October through December 2017, the undersigned calculated the benefit allotment as follows to determine accuracy. The findings show the household income for this period includes the petitioner's Social Security of \$492 and the petitioner's husband total pension amount of \$1,218.07. The total gross household income is \$1710.07. The standard deduction for a household of two is \$160. The undersigned included the petitioner's medical expenses of \$45 less the \$35 medical deduction to give an excess medical expense of \$10 in the budget. The gross unearned income of \$1,710.07 less the standard deduction of \$160 and excess medical expense of \$10 leaves an adjusted net income of \$1,540.07 ($\$1,710.07 - \$160 - \$10 = \$1,540.07$). The adjusted net income of \$1,540.07 multiplied by 50 percent gives a shelter standard for the petitioner's household of \$770.03 ($\$1,540.07 \times 50\% = \770.03). The petitioner qualifies for the Standard Utility Allowance (SUA) of \$347 due to the petitioner's ability to incur a heating or cooling expense. The petitioner's mortgage of \$550 and the SUA of \$347 equals a total shelter cost of \$897 ($\$550 + \$347 = \897). The petitioner's total shelter cost of \$897 less the shelter standard of \$770.03 equals an excess shelter expense of \$146.97 ($\$897 - \$770.03 = \146.97). The adjusted net income of \$1,540.07 less the excess shelter expense of \$146.97 equals a Food Assistance Adjusted income of \$1,393.10 ($\$1,540.07 - \$146.97 = \$1,393.10$). The Food Assistance Adjusted income of \$1,393.10 multiplied by 30 percent equals a benefit

reduction amount of \$418 ($\$1,346.88 \times 30\% = \418). The Thrifty Food Plan amount for a two-person household is \$352. The benefit reduction amount of \$418 greater than the maximum allotment for this household size. The undersigned concludes the petitioner's household is eligible for the minimum benefit allotment of \$15.

25. The undersigned reviewed the Department's calculations for Food Assistance eligibility effective January 2018. The undersigned can find no more favorable outcome.

ADULT-RELATED MEDICALLY NEEDY

26. 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.

27. The findings show the petitioner is a recipient of Medicare. The undersigned concludes she cannot receive Medicaid under the MEDS-AD program. The undersigned concludes the Department correctly proceeded to determine the petitioner's eligibility under the Medically Needy Program.

28. 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.

29. 20 C.F.R. § 416.1124, Unearned income we do not count, states in relevant part:

(a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount.

...

(c) Other unearned income we do not count. We do not count as unearned income—

(12) The first \$20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need.

30. The Department's Program Policy Manual (165-22), Appendix A-9, SSI-Related Programs, effective July 2017 lists the income limit for a couple to receive MEDS-AD is \$1,191. The Appendix is updated effective January 2018. The income limit for a couple to receive MEDS-AD remained \$1,191.

31. The petitioner's husband's unearned income of \$1,218.07 + the petitioner's Social Security benefits at time of application of \$492 equals \$1,710.07. The total income less the \$20 disregard as allowed in the above controlling authorities leaves countable income of \$1,690.07 ($\$1,710.07 - \$20 = \$1,690.07$). The countable income of \$1,690.07 exceeds the couple income limit of \$1,191 for the petitioner's husband to receive full Medicaid. The undersigned concludes the Department correctly proceeded to determine eligibility under the Medically Needy Program for the petitioner's husband.

32. Florida Admin. Code R. 65A-1.702, Special Provisions, states in relevant part:

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

...

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

33. Florida Admin. Code R. 65A-1.713, SSI-Related Medicaid Income

Eligibility Criteria, states in relevant part:

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. §1396 (2000 Ed., Sup. IV) (incorporated by reference), or another less restrictive option is elected by the state under 42 U.S.C. §1396a(r)(2) (2000 Ed., Sup. IV) (incorporated by reference).

...

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

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

34. 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 two as \$241.

35. The findings show the household’s total unearned income in 2017 is \$1,710 (petitioner’s Social Security of \$492 + husband’s pensions of \$1,218 = \$1,710). The above controlling authorities require the Department to disregard \$20 of the income leaving \$1,690 ($\$1,710 - \$20 = \$1,690$). The authorities also require the Department to deduct the Medically Needy income level for the household size to reach the share of cost. The countable income of \$1,690 less \$241 leaves a share of cost of \$1,449 ($\$1,690 - \$241 = \$1,449$). The undersigned concludes the share of cost for each should be \$1,449 for November 2017 through December 2017.

36. The findings show the household’s total unearned income in 2018 is \$1,720 (petitioner’s Social Security of \$502 + husband’s pensions of \$1,218 = \$1,720). The above controlling authorities require the Department to disregard \$20 of the income leaving \$1,700 ($\$1,720 - \$20 = \$1,700$). The authorities also require the Department to deduct the Medically Needy income level for the household size to reach the share of cost. The countable income of \$1,700 less \$241 leaves a share of cost of \$1,459 ($\$1,700 - \$241 = \$1,459$). The undersigned concludes the share of cost for each should be \$1,459 for January 2018 and ongoing.

37. The undersigned notes the Notice of Case Action dated December 5, 2017 does state the share of cost is ‘estimated’. The Department is to review the Medically Needy and ensure the share of cost no longer appears as estimated.

MEDICARE SAVINGS PROGRAM

38. 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.

...

(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.)

39. The Department's Policy Manual, section 1440.1400, Receipt or Entitlement to Medicare Part A (MSSI) states in relevant part:

Individuals must be enrolled in Medicare Part A as a condition of eligibility for Qualified Medicare Beneficiary (QMB).

...

Individuals must be enrolled in Medicare Part A as a condition of eligibility for Special Low-Income Medicare Beneficiary (SLMB) and Qualifying Individuals 1 (QI1).

40. The findings show the petitioner is enrolled in Medicare Part A. The undersigned concludes the petitioner meets the criteria of applying for Medicare to receive the Medicaid Savings Program.

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:

...

(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.

42. 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.

...

(5) To be eligible as a QMB or for the SLMB coverage the individual must be entitled to Medicare.

43. The Department's Policy Manual, Appendix A-9, SSI-Related Programs, effective July 2017 shows the income limit for a couple to receive Qualifying Individuals 1 (QI 1) is \$1,827. The Appendix was updated effective January 1, 2018. The income limit for QI 1 remained the same.

44. The Court held in Winick v Dep't of Children and Family Services, 161 So.3d 464 (Fla. 2d DCA 2014), where an individual who receives Medicare Part A is applying for the Medicare Buy-In Program and lives with his/her spouse, the Department must determine eligibility using the family size of two.

45. The facts show the petitioner is married and living with her husband. She is the only one in the household receiving Medicare and she is requesting assistance with the payment of her Medicare Part B premium. Therefore, the undersigned applies the Winick decision to this appeal. It is concluded that the respondent erred in applying the individual income standard to the petitioner.

46. According to the above controlling authorities, the income standard to receive QI 1 effective July 1, 2017 was \$1,827. The petitioner's total household income of \$1,710 less the \$20 unearned income deduction leaves a countable income of \$1,690. The petitioner's countable household income of \$1,690 is less than the standard for a couple. The undersigned concludes the petitioner is eligible for QI 1 beginning October 2017. The petitioner's total household income beginning January 2018 is \$1,720. The total household income of \$1,720 less the \$20 unearned income deduction leaves countable income of \$1,700 which is less than the income standard of \$1,827 effective January 2018. The undersigned concludes the petitioner remains eligible for QI 1. The Department is to establish the petitioner's eligibility for QI 1 beginning October 2017.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied in part and granted in part. The Food Assistance appeal is denied as the undersigned can find no more favorable outcome. The Medically Needy is granted in that the Department is to ensure the petitioner's share of cost is correct and no longer shows estimated if the income has been verified. The Qualified Individuals 1 is granted and the Department is to establish eligibility and issue appropriate notices to include appeal rights.

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 22 day of January, 2018,

in Tallahassee, Florida.

M. Roedel

Melissa Roedel
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

Feb 19, 2018

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-08000
17F-08001

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 17, 2018 at 8:30 a.m.

APPEARANCES

For Petitioner: [REDACTED], pro se

For Respondent: Sylma Dekony, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner appeals Respondent's action reducing his Supplemental Nutrition Assistance Program (SNAP), also known as Food Assistance, benefits from \$16.00 to \$15.00 effective October 1, 2017. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

Petitioner also appeals Respondent's action terminating his for full Medicaid (MMS) benefits. Respondent carries the burden of proof by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Pursuant to notice, the undersigned initially scheduled this appeal for a telephonic administrative hearing on December 13, 2017 at 1:00 p.m. On December 11, 2017, Respondent requested a continuance to allow the parties time to prepare for the hearing and discuss possible resolution. Pursuant to notice, the undersigned rescheduled the December 13, 2017 hearing for January 11, 2018 at 2:30 p.m.

On January 11, 2018, Respondent and the undersigned called in to the hearing and waited fifteen minutes. Petitioner did not dial in.

On January 12, 2018, Petitioner contacted the Office of Appeal Hearings notifying that he had missed his hearing and would like to reschedule. Pursuant to notice, the undersigned rescheduled the January 11, 2018 hearing for January 17, 2018 at 8:30 a.m.

Initially, the undersigned assigned the burden of proof to Petitioner for his second issue on appeal. However, upon further review, the undersigned concluded that the burden of proof for Petitioner's Medicaid appeal should have been assigned to Respondent, as it approved him for full Medicaid and subsequently terminated his full Medicaid benefits on its own accord. The undersigned now assigned Respondent the burden of proof for Petitioner's second appeal.

Petitioner did not submit any exhibits. Respondent submitted an evidence packet consisting of eleven exhibits, which were admitted into evidence and marked as Respondent's Exhibits "1" – "11." The record closed on January 17, 2018.

FINDINGS OF FACT

1. Prior to the action under appeal, Petitioner was receiving \$16.00 in SNAP benefits (Respondent's Exhibit 7), and was certified for those benefits through August 31, 2017 (Respondent's Exhibit 2, Page 16).
2. Also, prior to the action under appeal, Petitioner was receiving MMS benefits through August 31, 2017 (Respondent's Exhibit 9, Page 1). Petitioner does not dispute his enrollment in the Medically Needy Program (MNP) or the amount of his Share of Cost (SOC) (Petitioner's Testimony). Petitioner only disputes his ineligibility determination for MMS (*Id.*).
3. On July 17, 2017, Respondent sent a Notice of Eligibility Review to Petitioner at his current residence notifying him that the last month he would receive SNAP benefits would be August, 2017, unless he reapplied by August 15, 2017 (Respondent's Exhibit 2, Page 16).
4. On August 14, 2017, Petitioner timely submitted a paper SNAP and Medicaid redetermination application for himself (Respondent's Exhibit 3).
5. Petitioner indicated on his August 14, 2017 SNAP and Medicaid application that he was not currently employed, nor did he receive income from any other source (*Id.* at 8).
6. Petitioner also indicated on his August 14, 2017 SNAP and Medicaid application that his household incurred monthly expenses in the amount of \$128.00 for rent, \$130.00 for electricity, \$40.00 for water/sewer, \$160.00 for cable, and \$100.00 for medical (*Id.* at 9).

7. In addition, Petitioner indicated on his August 14, 2017 SNAP and Medicaid application that he was currently enrolled in Medicaid, Medicare, and Qualified Medicare Beneficiary (QMB) (*Id.*).

8. An interview was not required for Petitioner's August 14, 2017 SNAP and Medicaid application (Respondent's Exhibit 10, Page 4).

9. On August 18, 2017, Respondent verified that Petitioner currently received Social Security Disability Income (SSDI) (Respondent's Exhibit 10, Page 5) in the monthly amount of \$873.00 (Respondent's Exhibit 5).

10. Respondent calculated Petitioner's SNAP budget as follows:

Unearned Income	\$ 873.00
Total Household Gross Income	\$ 873.00
Standard Deduction for a Household of 1	-\$ 157.00
Adjusted Income After Deductions	\$ 716.00
Shelter Costs	\$ 132.00
Standard Utility Allowance	+\$ 338.00
Total Shelter Costs	\$ 470.00
Shelter Standard (50% adjusted income)	-\$ 358.00
Excess Shelter Deduction	\$ 112.00
Adjusted Income	\$ 716.00
Excess Shelter Deduction	-\$ 112.00
Adjusted Net Income After Shelter Deduction	\$ 604.00

(Respondent's Exhibit 6, Page 1).

11. Respondent deducted 30% of \$604.00 to calculate the benefit reduction of \$182.00 (*Id.* at 2).

12. Effective October 1, 2016, the maximum SNAP benefit amount for a household size of one was \$194.00 (Respondent's Exhibit 11, Page 19).

13. Also, effective October 1, 2016, the minimum allotment for a one or two-member household was \$16.00 (*Id.*).
14. Respondent subtracted \$182.00 from \$194.00 to arrive at \$12.00 in SNAP benefits (Respondent's Exhibit 6, Page 2). Respondent subsequently approved Petitioner for the minimum SNAP allotment of \$16 (*Id.*).
15. On August 21, 2017, Respondent sent a Notice of Case Action (NOCA) to Petitioner at his current residence notifying him that his SNAP benefits would stay the same (Respondent's Exhibit 2, Page 13).
16. On August 31, 2017, Respondent closed Petitioner's MMS benefits (Respondent's Exhibit 9, Page 1).
17. Effective October 1, 2017, the SNAP standards, income limits, allowances, and deductions were set to change from those effective October 1, 2016 (Respondent's Exhibit 11, Pages 18 – 19).
18. Based on this change, Respondent recalculated Petitioner's SNAP budget effective October 1, 2017 as follows:

Unearned Income	\$ 873.00
Total Household Gross Income	\$ 873.00
Standard Deduction for a Household of 1	-\$ 160.00
Adjusted Income After Deductions	\$ 713.00
Shelter Costs	\$ 132.00
Standard Utility Allowance	+\$ 347.00
Total Shelter Costs	\$ 479.00
Shelter Standard (50% adjusted income)	-\$ 356.50
Excess Shelter Deduction	\$ 122.50
Adjusted Income	\$ 713.00
Excess Shelter Deduction	-\$ 122.50
Adjusted Net Income After Shelter Deduction	\$ 590.50

(Respondent's Exhibit 6, Page 3).

19. Respondent deducted 30% of \$590.50 to calculate the benefit reduction of \$178.00 (*Id.* at 4).

20. Effective October 1, 2017, the maximum SNAP benefit amount for a household size of one is \$192.00 (Respondent's Exhibit 11, Page 18).

21. Also, effective October 1, 2017, the minimum allotment for a one or two-member household is \$15.00 (*Id.*).

22. Respondent subtracted \$178.00 from \$192.00 to arrive at \$14.00 in SNAP benefits (Respondent's Exhibit 6, Page 4). Respondent subsequently approved Petitioner for the minimum SNAP benefit allotment of \$15.00 (*Id.*).

23. On September 5, 2017, Respondent sent a NOCA to Petitioner at his current residence notifying him that his SNAP benefits would decrease from \$16.00 to \$15.00 effective October 1, 2017 due to a law or policy change (Respondent's Exhibit 2, Page 9).

24. On September 15, 2017, Respondent sent a NOCA to Petitioner at his current residence notifying him that his August 14, 2017 Medicaid application was approved for MNP with a monthly SOC amount of \$673.00 effective September 2017, and ongoing (Respondent's Exhibit 2, Page 6).

25. On December 11, 2017, Respondent sent a NOCA to Petitioner at his current residence requesting proof of his out-of-pocket medical expenses (Respondent's Exhibit 2, Page 1), as it failed to request verification of those expenses in its determination of his August 14, 2017 SNAP benefit eligibility (Respondent's Exhibit 1, Page 2).

26. As of the date of hearing, Petitioner had not provided verification of his out-of-pocket medical expenses for consideration in his SNAP benefit amount (Respondent's Testimony), nor did document imaging indicate that he had provided verification of these expenses during his prior certification (Respondent's Exhibit 4).

27. Petitioner argued that other tenants in his housing unit receive more in SNAP benefits than him, and that his residence manager also informed him that he should be receiving more in SNAP benefits than he currently receives (Petitioner's Testimony).

28. Respondent argued that every individual's circumstances are different, which is the reason that other tenants could be receiving more in SNAP benefits than Petitioner currently receives (Respondent's Testimony).

29. Petitioner also argued that he received an increase in SNAP benefits for a month in 2017, and that those SNAP benefits then again decreased (Petitioner's Testimony).

30. Respondent argued that Petitioner's SNAP benefits did increase in September 2017 by \$6.00 and again in October 2017 by \$355.00 due to Hurricane Irma, as households were entitled to SNAP supplemental and replacement benefits for the disaster period (Respondent's Exhibit 7).

31. Petitioner further argued that he is entitled to full Medicaid, and that he knows this because a supervisor in Jacksonville explained this to him and subsequently approved him for full Medicaid (Petitioner's Testimony).

32. Respondent argued that on July 13, 2017, Petitioner called its Customer Call Center (CCC) to inquire about his medical coverage, and that a case worker mistakenly approved Petitioner for MMS benefits (Respondent's Exhibit 10, Page 7). Respondent further argued that this mistake was a result of the case worker failing to consider that

Petitioner was receiving Medicare, as individuals receiving Medicare are ineligible for MMS benefits unless also receiving institutional, hospice, or home and community based services (Respondent's Exhibit 11, Page 26).

33. Petitioner testified that he receives Medicare and did not claim to receive institutional, hospice, or home and community based services (Petitioner's Testimony).

34. Petitioner asked Respondent if transportation is provided in his MNP coverage (Petitioner's Testimony).

35. Respondent informed Petitioner that it is only responsible for determining Medicaid eligibility and not Medicaid management (Respondent's Testimony).

Respondent provided 1-877-254-1055 as the phone number for the Agency for Health Care Administration (ACHA) who is responsible for the management of the Medicaid program and the services provided (*Id.*).

CONCLUSIONS OF LAW

36. 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.

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

SNAP BENEFIT REDUCTION ISSUE

38. The Code of Federal Regulations Title 7, section 273.9 defines income and allowable deductions in the SNAP eligibility determination as follows:

(a) *Income eligibility standards.* Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet...

...

(b) *Definition of income.* Household income shall mean all income from whatever source...

...

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

(ii) Annuities; pensions; retirement, veteran's, or disability benefits... old-age, survivors, or social security benefits...

...

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

(1) *Standard deduction.*

...

(3) *Excess medical deduction.* That portion of medical expenses in excess of \$35 per month...incurred by any household member who is elderly or disabled as defined in §271.2...

(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.*

39. The Code of Federal Regulations Title 7, section 273.2 defines information that must be verified in the SNAP eligibility determination, and 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.

...

40. The ACCESS Florida Program Policy Manual sets forth the following:

Appendix A-1	\$192.00 Maximum Benefit for a household of one
	\$347.00 Standard Utility Allowance
	\$160.00 Standard Deduction for a household size of one
	Uncapped maximum shelter deduction for AGs with an elderly or disabled member
	\$15.00 Minimum Allotment for 1 or 2 member Household

41. The Code of Federal Regulations Title 7, Section 273.10 sets forth the rules for determining household eligibility and benefit levels, and states in relevant part:

...

(d) *Determining deductions.* Deductible expenses include only certain dependent care, shelter, medical and, at State agency option, child support costs as described in §273.9.

...

(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... 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 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 ... 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) 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...

...
(C) Except during an initial month, all eligible one-person and two-person households shall receive minimum monthly allotments equal to the minimum benefit. The minimum benefit is 8 percent of the maximum allotment for a household of one, rounded to the nearest whole dollar.

...

42. The above cited authorities set forth the definition of income; what income, deductions, and standards must be included in the SNAP budget; what expenses must be verified; as well as calculations used in determining SNAP eligibility and benefits.

The undersigned concludes that though individuals' circumstances vary, which does affect the benefit amounts those individuals are eligible to receive, Respondent properly calculated Petitioner's SNAP benefits based on his particular circumstances.

Respondent properly calculated Petitioner's gross income, as verified through the Social Security Administration, and subtracted the appropriate standard deduction to determine his adjusted income. Respondent then properly calculated Petitioner's excess shelter cost by subtracting fifty percent of his adjusted income from his monthly rent and utilities. Respondent then properly calculated Petitioner's remaining SNAP budget by subtracting his excess shelter expense from his adjusted income to determine his net adjusted income, of which it then multiplied by thirty percent to

determine his SNAP benefit reduction. Respondent then properly subtracted Petitioner's SNAP benefit reduction from the maximum SNAP benefit amount to determine his monthly recurring SNAP benefit amount. As this amount resulted in an amount less than the minimum SNAP benefit amount, Respondent approved Petitioner for the minimum SNAP benefit amount of \$15.00.

43. The undersigned does note that if Petitioner incurs out-of-pocket medical expenses as reported on his August 14, 2017 SNAP and Medicaid application, and provides Respondent verification of these expenses pursuant to the December 11, 2017 NOCA, he MAY be eligible for additional SNAP benefits. However, the undersigned concludes that Respondent properly excluded Petitioner's out-of-pocket medical expenses in his SNAP budget as he failed to verify these expenses. Petitioner is encouraged to provide verification of his out-of-pocket medical expenses to Respondent.

44. The ACCESS Program Transmittal NO.: I-17-09-0014, Food Assistance Supplements for the Disaster Supplemental Nutrition Assistance Program (DSNAP) due to Hurricane Irma, dated September 26, 2017, states in relevant part:

The purpose of this memorandum is to provide information on automatic supplements for current food assistance households living in a designated Disaster Supplemental Nutrition Assistance Program (DSNAP) county.

Current food assistance households receive additional benefits through supplements and new households (non-recipients) will receive benefits through the DSNAP process. Since current food assistance households are not eligible to participate in a DSNAP, their regular monthly allotment will automatically be increased to the maximum amount based on household size.

Procedures:

Current food assistance households, not receiving the maximum allotment, will receive an increase for September and October 2017 benefits to the maximum amount based on household size...

45. The ACCESS Program Transmittal NO.: I-17-09-0019, Food Assistance

Replacements due to Hurricane Irma, dated September 18, 2017, states in relevant part:

Policy

The purpose of this memorandum is to provide information on automatic mass replacements and individual replacements for food assistance benefits lost due to Hurricane Irma. Families and individuals who experience food loss due to spoilage because of damage or power outage caused by Hurricane Irma may receive replacement of food assistance benefits for the value of the food loss, up to the allotment amount received in September 2017.

Automatic Mass Replacements

Current food assistance households in the following counties lost power for four or more hours: Alachua, Baker, Bradford, Brevard, Broward, Charlotte, Citrus, Clay, Collier, Columbia, Desoto, Dixie, Duval, Flagler, Franklin, Gilchrist, Glades, Hamilton, Hardee, Hendry, Hernando, Highlands, Hillsborough, Indian River, Jefferson, Lafayette, Lake, Lee, Levy, Madison, Manatee, Marion, Martin, Miami-Dade, Monroe, Nassau, Okeechobee, Orange, Palm Beach, Pasco, Pinellas, Polk, Putnam, Sarasota, Seminole, St. Johns, St. Lucie, Suwanee, Taylor, Union, Volusia, and Wakulla. Households in these counties will automatically receive 40% of their food assistance allotment for September 2017, to replace food loss caused by Hurricane Irma.

The automatic replacement will be available on September 19, 2017, to households who were receiving food assistance benefits as of September 7, 2017, in the identified counties.

46. The above cited authorities set forth that households that were receiving SNAP benefits during Hurricane Irma were issued supplemental and replacement benefits, which gave households the maximum amount of SNAP benefits allowed for September and October, 2017, based on household size, and provided a forty percent replacement

of September, 2017, SNAP benefits lost due to the disaster. The undersigned concludes that the increase in Petitioner's SNAP benefits in the month of October, 2017 was a result of disaster relief for Hurricane Irma.

FULL MEDICAID TERMINATION ISSUE

47. Florida Administrative Code Rule 65A-1.701, Definitions, in part states:

...

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

48. Florida Statutes, Section 409.904, Optional payments for eligible persons, in part states:

(1) Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, **and who is not eligible for Medicare** (emphasis added) or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage.

49. The above cited authorities set forth that full Medicaid eligibility requires an individual to not receive Medicare, or if receiving Medicare, also receive institutional care, hospice, or home and community-based Medicaid services. The undersigned concludes that Petitioner is not eligible for full Medicaid because he receives Medicare, and is not receiving institutional care, hospice, or home and community-based Medicaid services. Furthermore, the evidence submitted establishes that Respondent erred by

previously approving Petitioner for full Medicaid (MMS) for the months of July and August 2017.

50. In careful review of the cited authorities and evidence, the undersigned concludes Petitioner did not meet the burden of proof to indicate Respondent incorrectly reduced his SNAP benefits from \$16.00 to \$15.00 effective October 1, 2017.

Respondent correctly reduced Petitioner's SNAP benefits as a result of a change to law or policy effective October 1, 2017. Furthermore, the undersigned concludes Respondent did meet the burden of proof to indicate it correctly terminated Petitioner's full Medicaid benefits. Respondent correctly terminated Petitioner's full Medicaid and enrolled him in the Medically Needy program with a SOC, as he is receiving Medicare and is not eligible for full Medicaid.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, these appeals are DENIED. Respondent'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 Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 19 day of February , 2018,

in Tallahassee, Florida.



Erik Swenk, Esq.
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

Feb 15, 2018

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-08015

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66032

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 8, 2018 at 9:45 a.m.

APPEARANCES

For the petitioner: , pro se

For the respondent: Marsha Shearer, ACCESS, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her application for Adult-Related (SSI) Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any exhibits. The respondent submitted five exhibits, which were entered into evidence as Respondent's Exhibits "1" through "5".

FINDINGS OF FACT

1. The petitioner (55) filed an application for disability Medicaid on August 21, 2017. On her application, she reported that she was disabled. The petitioner is not age 65 or older and does not have any minor children.
2. The petitioner applied for disability with the Social Security Administration (SSA) on July 17, 2017. The petitioner reported all her disabling conditions to SSA. At the time of the petitioner's disability Medicaid application, SSA had not yet render its decision.
3. The Division of Disability Determination (DDD) is responsible for making State disability determinations on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. The petitioner's application was referred to DDD on September 7, 2017.
4. On September 27, 2017, the respondent received a data report through the State of Florida On-Line Query. The State On-Line Recipient Query (SOLQ)¹ indicated SSA denied the petitioner's disability application with a denial code N-31. Code N-31 means "Non-Pay-Capacity for substantial gainful activity-customary past work, no visual impairment".
5. On September 28, 2017, the respondent mailed the petitioner a Notice of Case Action denying her Medicaid application due to not meeting the disability requirement.
6. DDD did not conduct an independent review; instead, it denied the petitioner's disability claim by adopting the SSA denial decision and forwarded its decision to the respondent on October 2, 2017. DDD has access to SSA information.

¹ The Social Security Administration (SSA) provides real time access to SSA's enumeration verification service and Title II and Title XVI benefit data using the State On-Line Recipient Query.

7. The petitioner understands the reason for the denial, but does not agree with the respondent's decision. She argued she needs Medicaid benefits to get the necessary treatments to help with her medical conditions. The petitioner filed a reconsideration of her SSA denial with SSA on December 8, 2017 and that appeal remains pending.

CONCLUSIONS OF LAW

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

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

10. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905, "Basic definition of disability for adults". The regulation states, in part:

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

11. The Code of Federal Regulations at 42 C.F.R. § 435.541 addresses determinations of disability and states in part:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations.

(1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) **An SSA disability determination is binding on an agency until the determination is changed by SSA.** [emphasis added]

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) **The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.** [emphasis added]

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of following circumstances exist:

...

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid...

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) **Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations;** [emphasis added] and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

12. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid disability application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner reported all her disabling conditions to SSA. SSA denied the petitioner's disability claim on September 27, 2017 because it determined she was not disabled under its rules. The petitioner appealed SSA's decision on December 8, 2017 and that appeal remains pending. The petitioner did not testify to any new or worsening condition that SSA has refused to review.

13. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in adopting the SSA disability denial from September 27, 2017. The respondent's action to deny the petitioner's August 21, 2017 Adult-Related (SSI) Medicaid application was correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15 day of February, 2018,

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

Feb 05, 2018

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

APPEAL NO. 17F-08037

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88651

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 28, 2017 at 10:50 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: , Patient Advocate
with Cleveland Clinic

For the Respondent: Cori Driscoll,
Economic Self-Sufficiency Supervisor

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for Emergency Medicaid for Aliens (EMA) at application. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted a 23-page evidence packet, which was marked and entered as Petitioner's Exhibits "1" through "9". The respondent submitted a 17-page evidence packet, which was marked and entered as Respondent's Exhibits "1" through "6". The record was left open through January 4, 2018 for additional information including verification of what was faxed to the respondent, 60-day rule policy, retroactive Medicaid policy related to denials, and a copy of the document image entry screen.

On December 28, 2018, the petitioner submitted a fax cover sheet, which was marked and entered as Petitioner's Exhibit "10". On January 5, 2018, the respondent submitted additional policy related to retroactive Medicaid, policy related to the 60-day reuse, and the document imaging entry screen, which were marked and entered as Respondent's Exhibits "7" through "9". The record was closed the same day.

FINDINGS OF FACT

1. The Department of Children and Families (DCF, respondent) determines eligibility for SSI-Related Medicaid programs. To be eligible, an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility for individuals applying for disability benefits under the state Medically Needy Program. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and approval of any benefits due.
2. On August 16, 2017, the petitioner submitted a web application requesting SSI-Related Medicaid. The alerts "ID Not Discovered" and "Not Authenticated" appeared on the application (Respondent's Exhibit 2 and 3).

3. The petitioner (73 years old) is the only household member. She has no income and no expenses (Respondent's Exhibit 3).
4. On August 21, 2017, the respondent mailed the petitioner a Notice of Case Action (NOCA) to [REDACTED] the address of record, requesting a telephone interview with the petitioner to authenticate her identity. The date it was due was August 29, 2017 (Respondent's Exhibit 6).
5. On September 5, 2017, the petitioner submitted a copy of her identity and medical records, including Medical Assistance Referral and Alien Emergency Medicaid Statement requesting Emergency Medicaid for Aliens (EMA) (Petitioner's Exhibit 6 -8, Respondent's Exhibit 9).
6. On September 6, 2017, the respondent mailed the petitioner an additional NOCA (shown below) to the address of record, requesting verification of her immigration status, her identity, and complete customer authentication with a due date of September 18, 2017 (Respondent's Exhibit 6)
7. On September 26, 2017, the respondent mailed the petitioner a NOCA denying the request for Medicaid because information requested was not received (Respondent's Exhibit 1).
8. The authorized representative timely requested the appeal.
9. The authorized representative contends the customer authentication questions did not appear at the time of application so she was not aware authentication was required. She further states the notices should have been sent to her, as the authorized representative.

10. The respondent states customer authentication is required when an application is submitted for any program and must be completed. She further states the notices were all mailed to the petitioner with no returned mail and the authorized representative was not listed on the application as such. The respondent claims she did not receive the authorized representative form until December 21, 2017, after the representative requested the hearing.

CONCLUSIONS OF LAW

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

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

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

14. The Fla. Admin. Code R. 65A-1.203(9) defines representative:

“Authorized/Designated Representative: An individual who has knowledge of the assistance group’s circumstances and is authorized to act responsibly on their behalf.”

15. The Department’s Program Policy Manual (The Policy Manual), CFOP 165-22 at Passage 0640.0109 addresses Designated Representatives (MSSI) and states: “A designated representative may be appointed or self-designated to act on behalf of the household. If the individual does not select a specific person as designated representative, determine if the self-designated representative is the most appropriate person to fulfill this responsibility.”

16. The Policy Manual at Passage 0640.0111 Medical Provider Referrals (MSSI) states: "Hospitals and other Medicaid providers refer individuals who are potentially eligible for Medicaid. **Upon receipt of a referral, contact the individual, determine eligibility status and notify the provider of the disposition**" (*emphasis added*).

17. The above cited authority and policy manual explain the petitioner's representative may act on her behalf for the application, including interviews. The representative assumes the same rights and responsibilities as the applicant, including the responsibility of furnishing information, documentation, and verification needed. Further, once a medical referral is received, the department should contact the representative to determine eligibility.

18. In this instant case, the respondent mailed a NOCA on August 21, 2017 to the petitioner requesting customer authentication be completed. On September 5, 2017, the authorized representative submitted a referral for EMA, with her contact information including address listed on the referral. On September 6, 2017, the respondent mailed a second pending NOCA requesting customer authentication for the petitioner. No notice was sent to the authorized representative.

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

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

20. The Fla. Admin. Code R 65A-1.205, Eligibility Determination Process, sets forth the time frame for an applicant to provide additional information:

(1)(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later...

21. The above cited authorities state during the eligibility process the department must provide written notice to the client requesting verification, including what is required and the time limit for verification to be provided. In this instant case, the respondent pended the petitioner for customer authentication. Once the authorized representative submitted the medical referral, the respondent sent a second notice to the petitioner only.

22. After careful review of the evidence and testimony, the undersigned has concluded the respondent erred in denying the petitioner's request for EMA. The petitioner's authorized representative was not properly notified of the required verification to make an eligibility determination. The case is remanded to the respondent to send the authorized representative notice of all information, including customer authentication requirements, required to make an eligibility determination, and give ten (10) days to provide the required verification, including completion of the customer authentication, preserving the original date of application August 16, 2017.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is hereby granted. The respondent is hereby ordered to take corrective action as stated in the above Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 05 day of February, 2018,

in Tallahassee, Florida.



Pamela B. Vance
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

Feb 05, 2018

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

APPEAL NO. 17F-08079

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88249RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on January 11, 2018 at approximately 10:48 a.m. CST.

APPEARANCESFor the Petitioner: , *pro se*, Gary Malone, her husband

For the Respondent: Belinda Lindsey, economic self-sufficiency specialist supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of bill tracking medical expenses incurred for April 2017 and determining that the petitioner's expenses did not meet the Share of Cost (SOC); thereby, determining the petitioner not eligible for Medicaid payment for April 2017. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted a packet of information that was admitted into evidence and marked as Petitioner's Exhibits "1" through 5".

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "9".

An additional packet of information was submitted by the respondent. It was admitted into evidence and marked as Respondent's Exhibits "10" and "11".

The record remained open for the respondent to submit additional evidence. This evidence was received January 12, 2018. It was admitted into evidence and marked as Respondent's Exhibit 12. The record was closed the same day.

FINDINGS OF FACT

1. On August 19, 2016, the petitioner submitted a web-based change report. In the comments after E-Signature, the petitioner stated, "I have resumed my job and now have earned more than the " allowable" [sic] amount as listed on my letter. We have to review my case and determine whether I still qualify which I may not. Also, please determine what is going on with [REDACTED] case, she is dissolved and no longer on my access account..." (Respondent's Exhibit 4). The filing unit size of 5 was not an issue in dispute. Tax filing status was not discussed.
2. On August 15, 2016, the petitioner was informed by notice of case action (NOCA) that her Medically Needy Program (MNP) application of August 10, 2016 was approved and that the petitioner and GM were enrolled with an estimated SOC of \$2,415 (Petitioner's Exhibit 2).

Fair Hearings and Administrative Disqualification Hearings” as grounds to accept the income verification (Respondent’s Exhibits 1, 6, 8, 9 and 12).

5. As the actual SOC for April 2017 is greater than the amount of medical expenses submitted by the petitioner (\$6,381 > \$3,450.95), Medicaid eligibility to pay these medical expenses was not found.

6. The petitioner believes that the SOC for April was \$2,415 and therefore her SOC should have been met by the bills that she provided which totaled \$3,450.95.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

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

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

10. The Family-Related Medicaid income criteria is set forth in 42 C.F.R 435.603. It states:

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

of this section, of every individual included in the individual's household.

11. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income

(MAGI) (f) defines a Household for Medicaid. It states:

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, the household consists of the individual and, if living with the individual— (i) The individual's spouse; (ii) The individual's natural, adopted and step children under the age specified in paragraph (f)(3)(iv) of this section; and (iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's natural, adopted and step parents and natural, adoptive and step siblings under the age specified in paragraph (f)(3)(iv) of this section. (iv)The age specified in this paragraph is either of the following, as elected by the agency in the State plan— (A) Age 19; or (B) Age 19 or, in the case of full-time students, age 21.

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

13. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit as \$426 and the Medically Needy Income Level (MNIL) to be \$684 for a household size of five. The MNIL includes the Standard Deduction for the household.
14. The Fla. Admin. Code R. 65A-1.708 Family-Related Medicaid Budgeting Criteria states in part:
 - (1) The department uses a prospective budgeting system. In a prospective budgeting system, eligibility is based on the department's best estimate of the coverage group's income and circumstances. This estimate shall be based on the department's reasonable expectation and knowledge of current or future circumstances. **When eligibility is being determined for a month which has passed, the actual income and circumstances for that month shall be used.** [Emphasis added.]
15. The Policy Manual, Passage 2430.0700, Income Conversion (MFAM), states in part that "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" [Emphasis added.]
16. The Policy Manual, Passage 2430.0206, Budgeting Methods (MFAM) 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. [Emphasis added.]

17. The Policy Manual, 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. [Emphasis added.]

18. The respondent testified that the pay dates used to determine the SOC for April 2017 were March 21, 2017 and April 4, 2017. Pursuant to the above cited authority, the pay dates that should have been used were April 4, 2017 and April 18, 2017 as they are the actual income received in April 2017.

19. The undersigned's recalculation of the SOC per the above cited authorities is as follows:

April 4 Gross Pay:	\$3,174.45
April 18 Gross Pay:	<u>\$3,416.90</u>
Total Gross Pay:	\$6,591.34
Gross Pay divided by 2	\$3,295.68 average bi-weekly pay rounded up
Factored by 2	\$6,591.34 monthly averaged gross income
	\$6,591.34
	- <u>\$684.00</u> MNIL
	\$5,907.34 SOC rounded down to \$5,907.

20. The petitioner's estimated SOC was \$2,415; however, after verifying the income for the month of April 2017, the actual SOC was more. Although the undersigned found errors in the computation of the petitioner's actual SOC, the result is the same. The amount of the medical expenses submitted to the respondent for April 2017 still do not

meet the actual SOC based on certified verification of income for April 2017 (\$5,907 > \$3,450.95). The petitioner has not met the burden of proof.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 05 day of February, 2018,
in Tallahassee, Florida.



Gregory Watson
Hearing Officer
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Copies Furnished To: [REDACTED] PETITIONER
OFFICE OF ECONOMIC SELF SUFFICIENCY

FILED

Feb 02, 2018

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-08090

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 02 JEFFERSON
UNIT: 88313

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on January 17, 2018 at 3:06 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Sheila Rushing, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of November 3, 2017 denying his application for SSI-Related Medicaid due to not meeting the disability requirement. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence on December 15, 2017 which was entered as Respondent's Exhibit 1.

The petitioner did not submit any evidence to be considered in this matter.

The record closed on January 17, 2018.

FINDINGS OF FACT

1. The petitioner submitted an application to add SSI-Related Medicaid to his case on October 24, 2017. The petitioner was 48 years old at the time of his application. The petitioner indicated on his application that he had not been established as disabled previously. He indicated he had appealed a disability denial and that his health condition has changed since he was denied. (Respondent's Exhibit 1, pages 1 through 6.)

2. The petitioner explained he had Medicaid until his daughter turned 18 years old and then it ended.

3. The petitioner stated his conditions include [REDACTED], a [REDACTED], [REDACTED], [REDACTED]), [REDACTED], [REDACTED], [REDACTED], [REDACTED]. The petitioner stated all of his conditions began prior to his denial for disability in October 2017.

4. The petitioner stated he believes he is getting worse, but cannot work as the health problems cumulatively affect his ability to work/hold a job. The inability to work negatively affects his ability to obtain health insurance. He further stated he cannot see doctors for follow up/treatment due to no insurance.

5. The Department referred the petitioner's claim for disability to the Division of Disability Determinations (DDD) on October 30, 2017. (Respondent's Exhibit 1, page 34)

6. DDD returned the file electronically to the Department on November 2, 2017 informing the Department that the disability was denied with reason code N35. (Respondent's Exhibit 1, page 9)

7. The Department issued a Notice of Case Action on November 3, 2017 informing the petitioner his Medicaid application dated October 24, 2017 was denied as "You or a member of your household do not meet the disability requirement". (Respondent's Exhibit 1, pages 10 through 14)

8. DDD returned the Disability Determination and Transmittal to the Department on November 7, 2017. On this transmittal, DDD noted the denial code was N35. DDD also noted this was a "Hankerson" decision and the petitioner was denied in October 2017 with related conditions.

9. The Department explained that a "Hankerson decision" means that the decision was made by Social Security and not an independent decision by the Division of Disability Determinations.

10. The Department explained that a Social Security (or federal) decision overrides a state decision. The Department referred to the policy on page 97 of Respondent's Exhibit 1 to support the explanation.

11. The Department explained the reason code N35 means that the Impairment was severe at the time of adjudication but not expected to last 12 months, no visual impairments.

12. The Department explained that for the petitioner to receive Medicaid under age 65 he must either be disabled by Social Security or DDD or he must have a dependent child under 18 residing in the home.

13. The Department advised there is no other option for Medicaid in Florida at this time. There is no “general assistance” program that will cover single adults under age 65.

14. The petitioner’s application for Social Security disability was filed on October 6, 2015. The petitioner’s most recent denial was in October 2017.

15. The petitioner appealed the Social Security denial on November 20, 2017.

16. The petitioner stated that all of his conditions were reported to Social Security Administration by his representative at Capital Regional Medical Center. He now has a paralegal with legal aid assisting him with the appeal process for Social Security.

CONCLUSIONS OF LAW

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

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

19. The undersigned explored eligibility 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.

20. 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.

21. 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).

22. 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.)

23. 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)

24. The undersigned explored potential eligibility for SSI-Related Medicaid for the petitioner. The findings show the petitioner was 48 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.

25. The findings show the petitioner applied for Social Security disability and was denied in October 2017. The findings show the petitioner appealed the denial of Social Security disability on November 20, 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 October 2017 denial that SSA has refused to consider.

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

DONE and ORDERED this 02 day of February, 2018,
in Tallahassee, Florida.

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

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

FILED

Jan 26, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-08164
17F-08399

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 88879

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at 9:00 a.m. on December 28, 2017, in [REDACTED]

APPEARANCES

For the Petitioner: [REDACTED] petitioner's wife

For the Respondent: Sheron Mickens, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) actions to: (1) terminate the petitioner's Supplemental Nutrition Assistance Program (SNAP) benefits, also known as Food Assistance, and (2) deny the petitioner Medicaid benefits, are proper. The respondent carries the burden of proof by a preponderance of the evidence for the SNAP issue. The petitioner carries the burden of proof by a preponderance of the evidence for the Medicaid issue.

PRELIMINARY STATEMENT

The petitioner was present and provided testimony. Appearing as an interpreter for the [REDACTED] language from Language Line Solutions was translator ID number [REDACTED]. The petitioner submitted one exhibit, entered as Petitioner Exhibit "1". The respondent submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The record remained open until January 5, 2018, for the respondent's representative to submit additional exhibits. The exhibits were received timely and entered as Respondent Exhibits "8" through "11". The record was closed on January 5, 2018.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner and his wife received SNAP benefits (Respondent Exhibit 10).
2. On July 5, 2015, the petitioner and his wife entered the U.S., from Egypt, after winning the Green Card Lottery.
3. The Department of Homeland Security, SAVE Program, identifies the petitioner and his wife as Lawful Permanent Residents (LPRs) and lists the petitioner's class of admission (COA) into the U.S. as DV1 (diversity immigrant) and his wife as DV2 (spouse of an alien as DV1) (Respondent Exhibit 2).
4. To be eligible for SNAP benefits, the petitioner and his wife must have a qualified alien status and meet one of two alien criteria: (1) have 40 qualifying quarters of work in the U.S. or (2) have resided in the U.S. with a qualified alien status for five years.
5. The petitioner and his wife meet the LPR alien status; however, they do not meet

one of the two alien criteria. They do not have 40 qualifying quarters of work in the U.S. and have not resided in the U.S. with a qualified alien status for five years. Therefore, they are not eligible for SNAP benefits.

6. In October 2017, the petitioner became ill and was hospitalized.

7. The petitioner is also not eligible for Medicaid, due to not meeting alien status requirements. However, the petitioner is eligible for Emergency Medicaid for Aliens (EMA) for his hospital stay in October 2017.

8. On October 16, 2017, the Department received two Medicaid applications for the petitioner (Respondent Exhibit 8). The designated/authorized representative listed on both applications is "Change Healthcare" and lists "applying for another individual".

9. The petitioner's wife asserted the October 16, 2017 applications were not submitted by her or the petitioner. And said someone at the hospital was assisting them in attempting to get the hospital bill payed.

10. On October 30, 2017, the Department received a hospital bill from [REDACTED] for the petitioner; no action was taken by the Department (Respondent Exhibit 4).

11. On November 20, 2017, the Department processed the petitioner's October 16, 2017 application and discovered it had erred previously by authorizing the petitioner SNAP benefits.

12. On November 21, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA) denying SNAP and Medicaid benefits (Respondent Exhibit 9).

13. On November 28, 2017, the Department reused the petitioner's October 16, 2017 application for EMA (Respondent Exhibit 1).

14. On December 6, 2017, the Department mailed the petitioner a NOCA approving EMA from October 13, 2017 to October 21, 2017 (Respondent Exhibit 3).

15. The petitioner received a NOCA, from the Department, dated December 22, 2017, approving SNAP benefits, effective December 2017 through May 2018 (Petitioner Exhibit 1).

16. The respondent's representative asserted that the Department again erred by approving the petitioner SNAP benefits and mailing the December 22, 2017 NOCA.

17. On December 28, 2017, the Department mailed the petitioner another NOCA, ending the petitioner's SNAP benefits (Respondent Exhibit 9).

CONCLUSIONS OF LAW

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

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

20. The Findings establish that the petitioner and his wife entered the U.S. on July 5, 2015, from Egypt, due to winning the Green Card Lottery.

SNAP ISSUE

21. Title 7 of the Code of Federal Regulations § 273.4 explains SNAP Citizenship and alien status and in part states:

- (a) Household members meeting citizenship or alien status requirements.
No person is eligible to participate in the Program unless that person is:

(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...

(3) An individual who is:

(i) An American Indian born in Canada...

(4) An individual who is:

(i) Lawfully residing in the U.S. and was a member of a Hmong or Highland Laotian tribe...

(5) An individual who is:

(i) An alien who has been subjected to a severe form of trafficking in persons...

(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...

(H) An alien who is a Cuban or Haitian entrant...

(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...** (emphasis added)

(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...

- (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...
- (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. (emphasis added)** The 5 years in qualified status may be either consecutive or nonconsecutive...
- (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...
- (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...

22. In accordance with the above authority, noncitizens must meet qualified alien status and at least one alien criteria to be eligible for SNAP benefits.

23. The evidence submitted establishes that the petitioner and his wife meet the LPR alien status; however, they do not meet one of two alien criteria: (1) have 40 qualifying quarters of work in the U.S. or (2) have resided in the U.S. with a qualified alien status for five years.

MEDICAID ISSUE

24. Title 42 of the Code of Federal Regulations § 435.406 explains Medicaid

Citizenship and non-citizen eligibility and in part states:

- (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...

(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...

25. 8 U.S.C. § 1613, Five-year limited eligibility of qualified aliens for Federal means-tested public benefit, in part states:

(a) In general

Notwithstanding any other provision of law and except as provided in subsections (b), (c), and (d) of this section, an alien who is a qualified alien (as defined in section 1641 of this title) and who **enters the United States on or after August 22, 1996, is not eligible for any Federal**

means-tested public benefit for a period of 5 years beginning on the date of the alien's entry into the United States (emphasis added) with a status within the meaning of the term "qualified alien"...

26. 8 U.S.C. § 1641, Definitions, in part states:

b) Qualified alien. For purposes of this title, the term "qualified alien" means an alien who, at the time the alien applies for, receives, or attempts to receive a Federal public benefit, is--

(1) an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act,

(2) an alien who is granted asylum under section 208 of such Act [8 USCS § 1158],

(3) a refugee who is admitted to the United States under section 207 of such Act [8 USCS § 1157],

(4) an alien who is paroled into the United States under section 212(d)(5) of such Act [8 USCS § 1182(d)(5)] for a period of at least 1 year,

(5) an alien whose deportation is being withheld under section 243(h) of such Act [8 USCS § 1253(h)] (as in effect immediately before the effective date of section 307 of division C of Public Law 104-208) or section 241(b)(3) of such Act [8 USCS § 1251(b)(3)] (as amended by section 305(a) of division C of Public Law 104-208),

(6) an alien who is granted conditional entry pursuant to section 203(a)(7) of such Act [8 USCS § 1153(a)(7)] as in effect prior to April 1, 1980; or

(7) an alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980 [8 USCS § 1522 nt.]).

(c) Treatment of certain battered aliens as qualified aliens...

27. Title 42 of the Code of Federal Regulations § 435.956, Verification of other non-financial information, in part states "(a) Citizenship and immigration status. (1)(i) The agency must—(A) Verify citizenship status through the electronic service established in accordance with §435.949 or alternative mechanism authorized in accordance with § 435.945(k), if available..."

28. In accordance with the above authorities, the Department verified the petitioner and his wife's immigration status electronically, through the Department of Homeland

Security, SAVE Program. The SAVE Program identifies the petitioner and his wife as LPRs and lists the petitioner's COA into the U.S. as DV1 (diversity immigrant) and his wife as DV2 (spouse of an alien as DV1).

29. The above authorities explain the petitioner and his wife must have a qualified alien status and must have resided in the U.S. for five years to be eligible for Medicaid.

30. The evidence submitted establishes that the petitioner and his wife have LPR qualified alien status; however, they have not resided in the U.S for five years.

31. In accordance with the above authorities, the petitioner and his wife are subject to a five-year ban, from the date of entry to the U.S., to be eligible for Medicaid benefits.

32. 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).

33. In accordance with the above authority, the Department approved the petitioner EMA for his medical services in October 2017.

HEARING OFFICER CONCLUSIONS

34. In careful review of the evidence and cited authorities, the undersigned concludes:
- A. The respondent met its burden of proof for the SNAP issue.
 - B. The petitioner did not meet the burden of proof for the Medicaid issue.
 - C. The petitioner and his wife do not meet alien status requirements to be eligible for SNAP and Medicaid benefits.
 - D. The Department's actions to terminate the petitioner's SNAP benefits and deny the petitioner Medicaid benefits, are proper.
 - E. The Department's action to approve the petitioner EMA, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the respondent'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 Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 26 day of January, 2018,

in Tallahassee, Florida.



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

FILED

Feb 13, 2018

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-08185

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66032

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 9, 2018 at 1:00 p.m.

APPEARANCES

For the petitioner: [REDACTED] pro se

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

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her application for Medicaid benefits for herself. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Glovana Amaro, Administrative Specialist II with the Department of Revenue (Child Support Enforcement), appeared telephonically as a witness for the respondent.

The petitioner did not submit any exhibits. The respondent submitted two exhibits, which were accepted into evidence and entered as Respondent's Exhibits "1" and "2".

FINDINGS OF FACT

1. The Department of Revenue (DOR) is the agency responsible for establishing and enforcing child support obligations and for requesting the imposition and removal of Child Support Enforcement (CSE) sanctions. As a condition of eligibility, recipients of public assistance benefits must cooperate with CSE.
2. On May 25, 2016, DOR mailed the petitioner an Acknowledge Request for Services letter to open a child support case. CSE also sent a Paternity Declaration form to the petitioner to be completed and returned. On June 24, 2016, a Follow Up Appointment Notice was sent to the petitioner requesting she report to the CSE office no later than July 5, 2016; the petitioner failed to attend. As a result, A Notice of Noncooperation was mailed to the petitioner on July 9, 2016. The petitioner's case file with CSE was closed.
3. Prior to the action under appeal, the petitioner was sanctioned with CSE since September 2016. The petitioner was only receiving benefits for her two children (ages 2 and 6). The petitioner was not included in the Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits.

4. On September 18, 2017, the petitioner submitted an application to recertify for SNAP benefits and to add Medicaid benefits for herself. Medicaid benefits for the children and SNAP benefits are not the issue.
5. On September 26, 2017, the Department sent the petitioner a pending notice requesting additional information. The notice also indicated the child support sanction needed to be lifted by the child support office with a contact number of 1-800-622-5437, the petitioner needed to cooperate no later than October 5, 2017.
6. The respondent reviewed the petitioner's application and determined eligibility for the petitioner's children. The petitioner was not included in the benefits. On October 9, 2017, the respondent mailed the petitioner a Notice of Case Action notifying the petitioner that her September 18, 2017 application for Medicaid benefits for herself was denied. The petitioner was found ineligible as she did not cooperate with CSE in order to lift her CSE sanction.
7. The petitioner explained that she did not want to cooperate with CSE because she and the children's father have an agreement for him to provide direct financial support to the children. The petitioner further explained that she does not want to risk losing the financial support from the children's father; therefore, she is not cooperating with CSE. However, the petitioner is requesting to be included in the Medicaid Program because she has health issues.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

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

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

10. Florida Statutes Section 409.2572 shows that good faith cooperation with child support enforcement is a requirement for public benefits eligibility. Paragraph (1) of this statute sets forth cooperation requirements as follows:

(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:

(a) Identifying and helping to locate the alleged parent or obligor.

(b) Assisting in establishing the paternity of a child born out of wedlock.

(c) Assisting in obtaining support payments from the obligor.

(d) Assisting in obtaining any other payments or property due from the obligor.

(e) Identifying another putative father when an earlier named putative father has been excluded by DNA, Human Leukocyte Antigen, or other scientific test.

(f) Appearing at an office of the department, or another designated office, as necessary to provide verbal or written information, or documentary or physical evidence, known to, possessed by, or reasonably obtainable by the applicant or recipient.

(g) Appearing as a witness at judicial or other hearings or proceedings.

(h) Providing information under oath regarding the identity or location of the alleged father of the child or attesting to the lack of information.

(i) Paying to the department any support received from the obligor after the assignment is effective.

(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.

...

(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...

(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.

11. The Department's Program Policy TRANSMITTAL NO.: P – 12-02-0007, dated February 22, 2012, addresses CSE Re-Referrals on Prior Non-Cooperative Individuals and states in relevant part:

NEW POLICY

Individuals reapplying or requesting to be added to an existing **benefit who have not cooperated with CSE either due to failure to demonstrate up-front cooperation or sanctioned for non-cooperation, must be referred to CSE to cure the sanction prior to receiving benefits.** (emphasis added) DCF must be notified by CSE of their cooperation before their eligibility for benefits can be restored (except for pregnant women applying for Medicaid who are not required to cooperate with CSE in order to be eligible).

Until programming can be completed to initiate an electronic re-referral to CSE, staff must advise the individual of the need to cooperate with CSE using the Automated Management System (AMS) notice. Provide this notice and take action to process the application or review. Do not hold an application or review pending for a sanctioned individual to cooperate with CSE.

12. According to the above rules, the Department of Children and Families is responsible for complying with DOR in imposing and removing CSE sanctions. The petitioner failed to cooperate with CSE since September 2016 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.

13. Fla. Admin. Code R. 12E-1.008, Determination of Cooperation; Determination of Noncooperation; Determination of Good Cause, states in part:

(1) Definitions...

...

4. "Good cause" means a legally and factually sufficient reason to excuse the applicant or recipient from cooperation requirements as determined by the department, after evaluating the applicant or recipient's written good cause claim, and other evidence available to the department, in accordance with subsection (5) of this rule.

...

(2) Cooperation Requirements for Applicants or Recipients of Public Assistance. As a condition of eligibility for public assistance, an applicant or a recipient must cooperate in good faith with the child support enforcement program.

(a) Cooperation Requirement for Applicants for Public Assistance...

(b) Continuous Cooperation Requirement...

1. A recipient of public assistance must continue to make a good faith effort to cooperate with the department in accordance with Section 409.2572, F.S., to assist the department in its efforts to identify and locate the noncustodial parent, establish paternity, establish, modify, and enforce medical and financial support, and collect support or other payments or property due from the noncustodial parent.

...

(c) Good cause shall be determined when the recipient provides sufficient documentation, based upon the unique circumstances of the good cause claim, to justify the existence of one or more of the following circumstances.

1. A reasonable certainty that physical or emotional harm would come to the child or recipient, if they cooperated with the department.

2. The child was born as a result of rape or incest.

3. Legal proceedings for the adoption of the child are pending before a court.

4. The parent or caretaker relative is being assisted by a public or licensed private social agency to determine whether to place the child for adoption.

14. 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.

15. 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.

16. The hearing officer could not find any exception that could be determined as good cause for the petitioner not to cooperate with CSE.

17. After careful review of all facts, 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 within the rules and regulations of the Program.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 13 day of February, 2018,

in Tallahassee, Florida.



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

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

FILED

Feb 26, 2018

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-08198

PETITIONER,

VS.

CASE NO. 

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 January 16, 2018, at 4:01 a.m.

APPEARANCES

For the Petitioner:  grandmother

For the Respondent: Marilyn Newton, operations management consultant I

STATEMENT OF ISSUE

At issue is the respondent's action to end the petitioner's grandson's Medicaid benefits effective November 30, 2017. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

At the hearing, the respondent presented one exhibit which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not present any exhibits. The record was held open until January 26, 2017, for the Notice of Case Action. The petitioner submitted the Notice of Case Action which was accepted into evidence and marked as Petitioner's Exhibit 1. The petitioner submitted one additional exhibit after the record was closed which was not accepted into evidence. The record was closed on January 26, 2017.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner's grandson was receiving Family-Related Medicaid benefits.
2. On September 18, 2017, the petitioner submitted an application for Supplemental Nutrition Assistance Program (SNAP) benefits. The Department reviewed the application and approved SNAP benefits. Additionally, the Department ended the grandson's Medicaid benefits, as her grandson was 21 years of age. His date of birth is [REDACTED] (Respondent's Composite Exhibit 1).
3. On November 17, 2017, the respondent mailed a Notice of Case Action to the petitioner informing her that her grandson's Medicaid benefits will end on November 30, 2017 (Petitioner's Exhibit 1).
4. On November 21, 2017, the petitioner requested a hearing to challenge the respondent's action.
5. At the hearing, the petitioner stated that her grandson was very ill and needed Medicaid as he was suffering with traumatic brain injuries which occurred during the

year. The respondent informed the petitioner that it did not receive a disability application for her grandson. The respondent explained that her grandson can apply for disability Medicaid. The petitioner agreed to complete a disability-related Medicaid application.

CONCLUSION 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. The petitioner's grandson's Medicaid eligibility was determined under the Family Related Medicaid Program as there was no disability application on file.

9. 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....

10. 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.

11. The above authorities explain the respondent must provide Medicaid benefits for children under the age of 21. The findings show the petitioner's son was 21 years old; therefore, the undersigned concludes the petitioner's grandson is no longer considered a minor child and does not meet the age requirement to be eligible for Family Related Medicaid benefits.

12. In careful review of the evidence and cited authorities, the undersigned concludes the respondent followed the rule in terminating the grandson's Medicaid benefits on November 30, 2017.

13. The petitioner is encouraged to apply for disability-related Medicaid benefits for her grandson.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is 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 Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 26 day of February, 2018,

in Tallahassee, Florida.



Christiana Gopaul-Narine
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Office of Economic Self Sufficiency

FILED

Feb 28, 2018

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-08199

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Flagler
UNIT: 88369

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned reconvened a telephonic administrative hearing in the above-referenced matter on February 12, 2018 at 10:49 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 November 14, 2017 to enroll the petitioner in the Medically Needy (MN) program with a share of cost in the amount of \$796.

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

PRELIMINARY STATEMENT

The hearing originally convened on January 17, 2018 at 9:38 a.m. The respondent requested a continuance to allow additional time to prepare for the hearing. The petitioner did not object. The respondent's request was granted. The hearing was scheduled to reconvene on February 12, 2018 at 10:45 a.m.

The hearing convened as scheduled. Evidence was received and entered as the Petitioner's Exhibit 1 and the Respondent's Exhibits 1 through 3.

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. On October 23, 2017, the petitioner (age 42) applied for SSI-Related Medicaid. The petitioner received Social Security income in the amount of \$996 at the time of its action. The petitioner was previously covered under the Medicaid program for pregnant women (MMP) but subsequently miscarried the pregnancy in March 2017. The petitioner's coverage under MMP was terminated in October 2017. The petitioner does not have any children.

2. The Department determined that the petitioner was not eligible for full-coverage Medicaid, as her income exceeded the Medicaid for Aged and Disabled (MEDS-AD) income limit in the amount of \$885 for an individual. The Department calculated the MN budget by including the petitioner's total gross monthly Social Security income in the amount of \$996. The total gross income was subtracted by the unearned income disregard in the amount of \$20 to result in \$976 total countable

income. The total countable income was subtracted by the Medically Needy income limit (MNIL) in the amount of \$180 to result in a monthly SOC in the amount of \$796.

3. The petitioner does not agree with her enrollment in the MN program. The petitioner argues that she was initially unable to get approved for chemotherapy, as she was unable to get her medical bills tracked. The petitioner argues that she now receives Social Security income in the amount of \$1015 and only has \$200 left after paying bills (*Petitioner's Exhibit 1*). The petitioner does not receive Medicare A and Medicare B.

4. The Department explained that there was a delay in terminating the petitioner's coverage under MMP. The Department explained that the petitioner's MMP coverage ended on October 31, 2017 and that she was automatically enrolled in the Family Planning (FP) program. The Department explained that the FP coverage lasts for at least one year, so her coverage under this program will end in October 2018. The Department contends that the petitioner's coverage under the FP program caused a technical issue with the MN program that would not allow the petitioner's medical bills to be tracked (*Respondent's Exhibit 2, pages 2 through 5*). The Department contends that a request to correct the technical issue was submitted to the Agency for Health Care Administration (AHCA). The Department contends that AHCA made a correction to the petitioner's file in order to allow for her medical bills to be tracked. The Department explained that the petitioner was advised to have the provider re-submit the bill for the medication for which she is seeking to get approval.

5. The petitioner stated on the record that she was eventually able to get the approval for her chemotherapy. The petitioner argues that her monthly SOC has now increased to \$815.

6. The Department explained that the SOC amount increased due to the increase in the petitioner's Social Security income from \$996 to \$1015 (*Respondent's Exhibit 3, page 4*).

CONCLUSIONS OF LAW

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

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

9. Federal Regulations at 20 CFR § 416.1121 Types of unearned income states:

Some types of unearned income are—

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

10. The above authority explains that unearned income, such as Social Security income, is included as income in determining eligibility for the Medicaid programs. The findings show that the petitioner is receiving Social Security income. Therefore, the undersigned concludes that the Department was correct to include the petitioner's Social Security income in its calculations.

11. Federal Regulations at 20 C.F.R. § 416.1124 “Unearned income we do not count” states:

(a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the \$20 general exclusion described in paragraph (c)(12) of this section.

(c) *Other unearned income we do not count.* We do not count as unearned income—

...

(12) The first \$20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility. The \$20 exclusion does not apply to a benefit based on need that is totally or partially funded by the Federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions is excluded totally from income as described in §416.1124(c)(2). If you have less than \$20 of unearned income in a month and you have earned income in that month, we will use the rest of the \$20 exclusion to reduce the amount of your countable earned income;

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

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

13. 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.

14. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the income standards for MEDS-AD for an individual, effective January 2017, as \$885.

15. The above controlling authorities explain that the full coverage Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-Related program is for individuals who are not receiving Medicare and whose income does not exceed 88% of the poverty level. The above authorities also explain that the Medically Needy program is for aged, blind or disabled individuals who do not qualify for full Medicaid due to their income. The income standard for the MEDS-AD program is set at \$885 for an individual. The findings show that the petitioner is not receiving Medicare but her income of \$996 (at the time of the Department's action on November 14, 2017) exceeds the guidelines set for the program. Therefore, the undersigned concludes that the petitioner does not qualify for full-coverage Medicaid.

16. Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility

Criteria states in part:

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

(h) For Medically Needy, income must be less than or equal to the

Medically Needy income standard after deduction of allowable medical expenses.

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

17. The Medically Needy income levels are set forth in the Fla. Admin. Code R.

65A-1.716 :

(1) The monthly federal poverty level figures based on the size of the filing unit...

(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows...

Size...1 Level \$180...

18. According to the above authorities, the Department was correct to enroll petitioner in the MN Program and deduct \$180 from petitioner's countable income before determining the share of cost.

19. A review of the rules did not find any exceptions to the income limits. The petitioner was enrolled in a Medicaid Medically Needy Program with a share of cost. The share of cost is gross monthly income less the Medically Needy Income Level (MNIL) for one. The gross monthly household unearned income of \$996, less the unearned income disregard of \$20 and MNIL of \$180, equals a share of cost of \$796. The hearing officer found no exception to this calculation. The undersigned concludes that the respondent's actions to enroll the petitioner in the Medically Needy Program and to determine the amount of the monthly share of cost as \$796, was a correct action.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 28 day of February, 2018,

in Tallahassee, Florida.



Paula Ali
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

Feb 27, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-08474

PETITIONER,
Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 20 LEE
UNIT: 88281

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 25, 2018, at 8:15 a.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Ed Poutre, Senior Program Specialist

STATEMENT OF ISSUE

The petitioner requested an appeal hearing due to unpaid dental claims. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not directly submit any documents as evidence for the hearing, although he had previously submitted copies of dental claims which were included in the Department's evidence packet.

The respondent submitted a 62-page packet of documents pertaining to the petitioner's Medicaid benefits, which was marked as Respondent's Exhibit 1.

FINDINGS OF FACT

1. The petitioner was approved for Medicaid coverage on or about November 1, 2015. He had regular Medicaid coverage from November, 2015 through April, 2016. The petitioner became covered by Medicare upon reaching his 65th birthday in [REDACTED], [REDACTED]. From April, 2016 through December, 2017, the petitioner had Share-of-Cost Medicaid as a Qualified Medicaid Beneficiary (QMB). Under the QMB program, Medicaid pays the premium for the beneficiary's Medicare coverage.

2. The petitioner was covered in 2016 for dental services by the managed care plan Molina Healthcare. He had difficulty obtaining needed dental services through Molina. He subsequently needed oral surgery services but could not find a dental provider that accepted Medicaid. He paid out-of-pocket and also incurred a loan to pay for the dental services himself. His dental coverage changed in 2017 to United Healthcare-Medicare and he had more dental work performed by a different dental provider in 2017. The petitioner is seeking coverage and/or reimbursement for the dental services performed in 2016 and 2017. He stated he was led to believe the Department would process his bills for payment and/or reimbursement.

3. The Department representative explained that if the Medicaid program has not paid some of the petitioner's dental claims, that is an issue which should be addressed with the state agency which administers the Medicaid program – the Agency for Health Care Administration (AHCA). The representative also stated the Medicaid program will only pay the provider and will not reimburse a beneficiary for out-of-pocket payments.

CONCLUSIONS OF LAW

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

5. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

6. After considering the testimony and evidence presented, the undersigned concludes there is no relief which can be afforded to the petitioner in this case. The Department of Children and Families determines issues related to Medicaid eligibility. The petitioner was determined to be eligible for Medicaid by the Department, first for regular Medicaid and then Share-of-Cost and QMB Medicaid after he became covered by Medicare. Any issues related to coverage for Medicaid benefits should be addressed with the Agency for Health Care Administration (AHCA) or with the managed care plans which provided the dental coverage – Molina and United Healthcare.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 27 day of February, 2018,

in Tallahassee, Florida.



Rafael Centurion
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Copies Furnished to: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Feb 23, 2018

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-08527

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Seminole
UNIT: 66292

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:26 p.m. on January 10, 2018.

APPEARANCES

For the Petitioner: [REDACTED], pro se

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

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to deny the petitioner Medicaid disability, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appearing as an interpreter for the [REDACTED] language from Language Line Solutions was translator ID number [REDACTED]. The petitioner submitted one exhibit,

entered as Petitioner Exhibit "1". The respondent submitted eight exhibits, entered as Respondent Exhibits "1" through "8". The record was closed on January 10, 2018.

FINDINGS OF FACT

1. On October 19, 2017, the petitioner (age 50) submitted a SSI-Related Medicaid disability and Supplemental Nutrition Assistance Program, also known as Food Assistance, application for herself (Respondent Exhibit 3). Medicaid is the only issue.
2. The petitioner described her disability as having [REDACTED] which cause her [REDACTED].
3. To be eligible for SSI-Related Medicaid, the petitioner must be age 65 or older; or considered blind/disabled by the Social Security Administration (SSA) and/or the Division of Disability Determination (DDD).
4. The DDD determines Medicaid disability eligibility on behalf of the Department.
5. On April 17, 2017, the petitioner applied for disability through the SSA. The SSA denied the petitioner disability on August 14, 2017 (Respondent Exhibit 6). And on December 1, 2017, the petitioner, through her attorney, appealed the SSA denial decision. A hearing date for that appeal has not been set.
6. The SSA denial determination of the petitioner's disability is binding on the Department.
7. On November 15, 2017, the Department forwarded the petitioner's medical documents to the DDD for a disability review (Respondent Exhibit 5).
8. On November 17, 2017, the DDD denied the petitioner disability, due to adopting the SSA denial decision (Respondent Exhibit 5).

9. On November 20, 2017, the Department mailed the petitioner a Notice of Case Action, denying Medicaid, due to not meeting the disability requirement (Respondent Exhibit 2).

10. The petitioner has had two surgeries to remove the [REDACTED]; however, the [REDACTED] [REDACTED]. The last surgery was in October 2017.

11. The petitioner's attorney will inform the SSA of the petitioner's October 2017 surgery and the return of the [REDACTED] at the SSA appeal hearing.

CONCLUSIONS OF LAW

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

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

14. *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..."

15. Title 20 of the Code of Federal Regulations Section 416.905, Basic definition of disability for adults, in part states:

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

your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.) ...

16. In accordance with the above authorities, the petitioner must be age 65 or older or considered disabled to be eligible for SSI-Related Medicaid.

17. Title 42 of the Code of Federal Regulations § 435.541, Determinations of disability, in part states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and—

- (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
- (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
- (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and—
 - (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
 - (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility...

18. The above authority explains that the SSA determination is binding on the Department.

19. The evidence submitted establishes that the SSA denied the petitioner disability on August 14, 2017. And the petitioner is currently appealing the SSA denial decision; a hearing date for that appeal has not been set.

20. In accordance with the above authority (#17), the Department adopted the SSA August 14, 2017 denial decision and also denied the petitioner's Medicaid disability.

21. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes the Department's action to deny the petitioner Medicaid disability, is proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 23 day of February , 2018,

in Tallahassee, Florida.

Priscilla Peterson

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

FILED

Feb 28, 2018

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-08579

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 14 Jackson
UNIT: 88146

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on February 1, 2018 at 1:07 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Sheila Rushing, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of September 14, 2017 terminating his Medicare Savings Program eligibility under the Special Low Income Beneficiary (SLMB) program. The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department provided evidence prior to the hearing. This evidence was entered as Respondent's Exhibit 1.

The petitioner did not provide any evidence.

The record closed on February 1, 2018.

FINDINGS OF FACT

1. The petitioner filed an application to recertify his Medicare Savings Program eligibility on September 6, 2017. The household consists of the petitioner only. His income consists of Social Security income of \$1,160 per month and his earnings from [REDACTED]. (Respondent's Exhibit 1, pages 1 through 4)

2. The petitioner provided his paystubs for August 4, 2017, August 18, 2017, and September 1, 2017 as verification of his earnings with [REDACTED]. The petitioner's paystub for August 4, 2017 reflects 28.75 hours worked with a gross pay of \$232.88. The petitioner's paystub for August 18, 2017 reflects 20.00 hours worked with a gross pay of \$162.00. The petitioner's paystub for September 1, 2017 reflects 61.50 hours worked with a gross pay of \$498.15. (Respondent's Exhibit 1, pages 5 through 7)

3. The Department verified through a data match with Social Security, the petitioner's Social Security disability (SS DI) income amount was \$1,164 per month effective January 2017.

4. The Department explained that the petitioner's earned income was not included in the benefit calculations for the Medicare Savings Program prior to this recertification. The Department explained that due to this error, only his Social Security income of \$1,164 less \$20 unearned income disregard ($\$1,164 - \$20 = \$1,144$) was compared to the income standard (\$1,206) when determining that he was eligible to

receive Medicare Savings Program benefits under the Special Low Income Beneficiary (SLMB) program.

5. The Department explained they used the last two pays as representative of what he may earn during the coming year.

6. The Department calculated the petitioner's potential eligibility under the Qualifying Individuals 1 (QI 1) program as the income limit is higher under this program. The income standard for QI 1 is \$1,357. The petitioner's SS DI income of \$1,164 less the \$20 standard unearned income disregard left a countable unearned income of \$1,144. The petitioner's gross earned income was calculated as \$660.16. ($\$498.15 + \$162.00 = \$660.15 / 2 = \$330.08 \times 2 = \660.16) The Department explained that \$65 is deducted from his earned income and then one half of the balance is deducted to reach the countable earned income of \$297.58 ($\$660.16 - \$65 = \$595.16 / 2 = \297.58) ($\$595.16 - \$297.58 = \297.58) The countable unearned income of \$1,144 added to the countable earned income of \$297.58 equals a total countable income of \$1,441.58. ($\$1,144 + \$297.58 = \$1,441.58$) The Department compared the total countable income of \$1,441.58 to the income standard for the QI 1 program of \$1,357 to determine the petitioner's total income exceeds the income standard for the QI 1 program.

7. The Department explained that with his earned income included in the calculations, the petitioner now exceeds the income limit for both the SLMB and QI 1.

8. The Department issued a Notice of Case Action on September 14, 2017 denying the petitioner's eligibility for Qualifying Individuals 1 as income is too high to qualify for this program. The notice also informed the petitioner that his Special Low Income Beneficiary (SLMB) was terminated effective September 30, 2017.

9. The petitioner maintains that the total gross income included is too high. His pay for September 1, 2017 is not representative of what he normally receives in earnings. He worked additional hours during this time to fill in for others who were out.

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. 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. 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.)

13. 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:

...

(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.

...

(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.**

...

1. When income is received monthly or more often than once per month the monthly income from that source shall be computed by first determining the weekly income amount and then multiplying that amount by 4. A five-week month shall not be treated any differently than a four-week month.

...

3. When earned income is received less often than monthly, the department counts the total amount in the month received and does not prorate.
(emphasis added)

14. 20 C.F.R. § 416.1110, What is earned income, states in relevant part:

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

(a) Wages—(1) Wages paid in cash—general. Wages are what you receive (before any deductions) for working as someone else's employee. Wages are the same for SSI purposes as for the social security retirement program's earnings test. (See §404.429(c) of this chapter.) Wages include salaries, commissions, bonuses, severance pay, and any other special payments received because of your employment.

15. 20 C.F.R. § 416.1112, Earned income we do not count, states in relevant part:

(a) General. While we must know the source and amount of all of your earned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your income in the month.

...

(c) Other earned income we do not count. We do not count as earned income—

...

(4) Any portion of the \$20 monthly exclusion in §416.1124(c)(10) which has not been excluded from your unearned income in that same month;

(5) \$65 of earned income in a month;

...

(7) One-half of remaining earned income in a month;

16. 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.

17. 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. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility. The \$20 exclusion does not apply to a benefit based on need that is totally or partially funded by the Federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions is excluded totally from income as described in §416.1124(c)(2). If you have less than \$20 of unearned income in a month and you have earned income in that month, we will use the rest of the \$20 exclusion to reduce the amount of your countable earned income;

18. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, Eligibility Standard for SSI-Related Programs, Financial Eligibility Standards: July 1, 2017 lists the income limits for individuals for SLMB as \$1,206 and for QI 1 as \$1,357.

19. The findings show the petitioner the petitioner's hours worked during each of the pay periods presented. The findings also show the petitioner's testimony that he worked additional hours on his pay received September 1, 2017 due to being short-staffed. The undersigned reviewed all three paystubs and the hours worked during each. The first was for 28.75 hours, the second for 20 hours and the third for 61.50 hours. The undersigned concludes under de novo review of the petitioner's pay information, the pay received on September 1, 2018 was not representative of what the petitioner normally earns and should not have been included in the calculation of earned income.

20. The undersigned reviewed the calculation of countable income as follows:

- a. The undersigned included the gross pay for August 4, 2017 of \$232.88 and the gross pay for August 18, 2017 of \$162.00 to reach a total

gross income of \$394.88 ($\$232.88 + \$162 = \394.88). The total gross income of \$394.88 less \$65 earned income disregard equals \$329.88 ($\$394.88 - \$65 = \329.88). One half of the \$329.88 is \$164.94 ($\$329.88 / 2 = \164.94). The countable earned income is \$164.94.

- b. The total unearned income for the petitioner is \$1,164. The unearned income less the \$20 unearned income disregard equals the countable unearned income of \$1,144 ($\$1,164 - \$20 = \$1,144$).
- c. The countable earned income of \$164.94 combined with the countable unearned income of \$1,144 equals a total countable income of \$1,308.94 ($\$164.94 + \$1,144 = \$1,308.94$).

21. The above controlling authorities show the income standard for SLMB effective July 1, 2017 was \$1,206. The undersigned concludes the petitioner's total countable income of \$1,308.94 exceeded the income standard for SLMB.

22. The above controlling authorities show the income standard for QI 1 effective July 1, 2017 was \$1,357. The undersigned concludes the petitioner's total countable income of \$1,308.94 is less than the income standard for QI 1. The undersigned concludes the Department should have opened the petitioner for QI 1 effective October 1, 2017.

23. The undersigned notes the petitioner's SSDI income as well as the income standards for the programs were adjusted effective January 1, 2018. The petitioner's eligibility for the program may differ effective January 2018 from the October 1, 2017 determination shown above due to this change.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The Department is to update the petitioner's earned income amount as outlined above and open the petitioner's Medicare Savings Program benefit effective October 1, 2017. The Department is to issue new Notices of Case Action to include appeal rights.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 28 day of February, 2018,
in Tallahassee, Florida.

Melissa 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

Feb 14, 2018

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-08976
17F-08977

PETITIONER,

Vs.

CASE NO. 

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 matters on January 18, 2018 at 2:13 p.m.

APPEARANCES

For the Petitioner:



For the Respondent:

Michael Dupe, ACCESS Supervisor
Micha L Morrison, Direct Reader

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of December 20, 2017. He is requesting additional Food Assistance benefits as well as full Medicaid for his daughter. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department administers the Supplemental Nutritional Assistance Program (SNAP) which is also known as Food Stamps and the Food Assistance Program.

The Department submitted evidence on January 10, 2017 which was entered as Respondent's Exhibit 1.

The petitioner submitted evidence on December 28 which was entered as Petitioner's Exhibit 1. The petitioner submitted additional information on January 18, 2018 which was entered as Petitioner's Exhibit 2.

The record closed on January 18, 2018.

FINDINGS OF FACT

1. The petitioner submitted an application on December 11, 2017 to add Food Assistance and Medicaid to his case. The household consists of the petitioner, his wife and their two children ages 6 and 3. The petitioner reported household income for himself and his wife from employment. The petitioner reported mortgage, utilities, and child care and child support expenses on the application. (Respondent's Exhibit 1, pages 2 through 11)

2. The Department issued a Notice of Case Action on December 22, 2017. The Notice denied the petitioner's application for Food Assistance citing the petitioner's household income was too high to qualify for this program. (Respondent's Exhibit 1, pages 20 and 21)

3. The Department reviewed the petitioner's case following the petitioner's filing of a hearing request. The Department discovered the petitioner's child care expense was not correctly budgeted in the Food Assistance. (Respondent's Exhibit 1, page 12)

4. The Department issued a Notice of Case Action dated December 29, 2017 approving the petitioner's household for \$80 in Food Assistance benefits beginning with December 2017. (Respondent's Exhibit 1, pages 22 and 23)

5. The Department used the petitioner's check stubs from December 8, 2017 and November 24, 2017 to calculate his average monthly income. The gross pay on December 8, 2017 was \$692.78. The gross pay received on November 24, 2017 was \$808.10. The Department determined that the gross pay from November 24, 2017 was not representative of his normal pay. The Department multiplied the gross pay of \$692.78 by 2.15 to reach an average monthly income of \$1,489.48 for the petitioner in the Food Assistance budget.

6. The Department included the monthly gross income of the petitioner's wife in the benefit calculation. Her gross income received November 30, 2017 was \$2,577.24.

7. The Department included the total gross income for the household of \$4,066.72 which is the sum of the petitioner's average monthly gross income of \$1,489.48 added to the petitioner's wife's gross monthly income of \$2,577.24 ($\$1,489.48 + \$2,577.24 = \$4,066.72$).

8. The Department determined the household gross income of \$4,066.72 was less than the gross monthly income standard for a household of four which is \$4,100. The Department continued the eligibility calculation.

9. The Department multiplied the household's gross income of \$4,066.72 by 20 percent to obtain the earned income disregard of \$813.34 ($\$4,066.72 \times 20\% = \813.34).

10. The Department allowed the standard deduction for a household of four of \$170.00.

11. During the recalculation of benefits, the Department determined the household was entitled to the Dependent Care disregard of \$666.50 per month. The child care for the petitioner's daughter is \$35 per week. The Department calculated this as \$35 multiplied by 4.3 weeks to get the monthly amount for her as \$150.50. The child care for the petitioner's son is \$240 biweekly. The Department calculated this as \$240 multiplied by 2.15 to get the monthly amount of \$516. The Department totaled \$150.50 and \$516 to get the total child care amount of \$666.50.

12. The Department allowed the child support payment for a child outside the home to be deducted. The Department found the amount of child support paid outside of the home is \$129.23 biweekly. This is shown on both the petitioner's paystubs as well as the corresponding child support payment inquiry. The Department calculated the monthly amount as \$129.23 multiplied by 2.15 to reach the monthly amount of \$277.84 to be allowed as a deduction.

13. The Department used the gross income of \$4,066.72 less the expenses named in paragraphs 9 through 12 to reach an adjusted income of \$2,139.04
($\$4,066.72 - \$813.34 - \$666.50 - \$277.84 = \$2,139.04$)

14. The Department multiplied the adjusted income of \$2,139.04 by 50 percent to get the shelter standard of \$1,069.52 ($\$2,139.04 \times 50\% = \$1,069.52$).

15. The Department determined the petitioner has a heating and cooling expense and allowed the petitioner's household to use the Standard Utility Allowance (SUA) of \$347. The petitioner's rental expense is \$996.62. The rental expense of

\$996.62 combined with the SUA of \$347 gives the petitioner's household a total shelter expense of \$1,343.62 ($\$996.62 + \$347 = \$1,343.62$).

16. The Department subtracted the shelter standard of \$1,062.52 from the total shelter expense of \$1,343.62 to reach the excess shelter deduction of \$274.10 ($\$1,343.62 - \$1,069.52 = \274.10).

17. The Department subtracted the excess shelter expense of \$274.10 from the adjusted income of \$2,139.04 to reach a net adjusted income of \$1,864.94 ($\$2,139.04 - \$274.10 = \$1,864.94$).

18. The Department determined that the net adjusted income of \$1,864.94 is less than the maximum net monthly income for a household of four which is \$2,050. The eligibility calculation for Food Assistance continues.

19. The Department multiplied the net adjusted income of \$1,864.94 by 30 percent to obtain the benefit reduction amount of \$560 ($\$1,864.94 \times 30\% = \560).

20. The Department found the Maximum Allotment for a household of four in the SNAP program is \$640. The maximum allotment of \$640 less the benefit reduction of \$560 leaves a monthly benefit amount of \$80 for the petitioner's household. ($\$640 - \$560 = \$80$)

21. The petitioner questioned the eligibility for Medicaid for his daughter ending. He is requesting full Medicaid for his daughter as he is unable to afford health insurance for her.

22. The Department explained the Medicaid calculations are different from the SNAP calculations.

23. The Department explained that the income is calculated differently for Medicaid than for SNAP.

24. The first difference comes with individuals who are paid more often than monthly. In Medicaid the income average biweekly income is multiplied by two. In this case, the petitioner's gross income of \$692.78 was multiplied by two is \$1,385.56.

25. The Department also noted there is a difference in how a school employee's income, such as the petitioner's wife, is counted in Medicaid as it can be the most recent consecutive four weeks income OR prorating the assistance groups annual income over a 12-month period based on the most recent tax return. The Department used the month recent consecutive four weeks of income that was submitted during review, \$2,577.24.

26. The Department totaled the petitioner's income of \$1,385.56 and wife's income of \$2,577.24 to reach a total gross income of \$3,962.80 ($\$1,385.56 + \$2,577.24 = \$3,962.80$).

27. The Department explained the Medicaid eligibility for each child is calculated separately and also factors in the child's age. The petitioner's daughter is age 6 and son is age 3.

28. The Department explained due to more deductions allowed for a child from birth through age 5, the petitioner's son remains eligible for full Medicaid.

29. The Department explained the gross income for the petitioner's household is \$3,962.80 exceeds the income standard for a child between the ages of 6 and 18 which is \$2,727.

30. The Department proceeded to determine the Medically Needy Share of Cost (SOC) for the petitioner's daughter. The total gross earned income of \$3962 less the Medically Needy Income Limit (MNIL) of \$585 leaves a SOC of \$3,377.

31. The petitioner provided updated paystubs for himself in hopes that these stubs would reflect a lower income being received and improve his benefits for both SNAP and Family Medicaid. The paystub dated January 5, 2018 reflects a gross pay of \$824.73. The paystub dated January 19, 2018 reflects a gross pay of \$733.48.

CONCLUSIONS OF LAW

32. 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.

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

FOOD ASSISTANCE

34. 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.

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

35. The findings show the petitioner and his wife are both working. The findings also show the Department coded the income as earned income and allowed the appropriate deduction.

36. 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

...

(2) Earned income deduction. Twenty percent of gross earned income as defined in paragraph (b)(1) of this section.

...

(4) Dependent care. Payments for dependent care when necessary for a household member to search for, accept or continue employment, comply with the employment and training requirements as specified under §273.7(e), or attend training or pursue education that is preparatory to employment, except as provided in §273.10(d)(1)(i).

...

(5) Optional child support deduction. At its option, the State agency may provide a deduction, rather than the income exclusion provided under paragraph (c)(17) of this section, for legally obligated child support payments paid by a household member to or for a nonhousehold member, including payments made to a third party on behalf of the nonhousehold member (vendor payments) and amounts paid toward child support arrearages.

...

(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.

...

(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.

(B) Property taxes, State and local assessments, and insurance on the structure itself, but not separate costs for insuring furniture or personal belongings.

...

(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);

37. 7 C.F.R. § 273.10, Determining household eligibility and benefit levels,

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.

...
(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.

38. The findings show the petitioner's gross income from December 8, 2017 was \$692.78. The undersigned concludes this paystub is the lowest of all paystubs provided and the one used in his eligibility determination in December 2017. The findings show the Department multiplied this pay amount of \$692.78 by 2.15 to reach a monthly gross income of amount of \$1,489.48. The undersigned concludes the petitioner's gross earned income was correctly calculated on this application. The undersigned can find no better outcome by using the updated pay amounts.

39. The findings also show the Department included the monthly income of the petitioner's wife which is \$2,577.24. The undersigned concludes this was correctly included as earned income.

40. The above analysis shows the petitioner's earned income as \$1,489.48 and the petitioner's wife's earned income as \$2,577.24. The undersigned concludes the household's total gross earned income is \$4,066.72 ($\$1,489.48 + \$2,577.24 = \$4,066.72$). The undersigned further concludes the Department correctly included all gross earned income in the eligibility determination.

41. 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....

(B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions....

(C) Subtract the standard deduction.

...

(E) Subtract allowable monthly dependent care expenses, if any, as specified under §273.9(d)(4) for each dependent.

(F) If the State agency has chosen to treat legally obligated child support payments as a deduction rather than an exclusion in accordance with §273.9(d)(5), subtract allowable monthly child support payments in accordance with §273.9(d)(5).

...

(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....

(ii) In calculating net monthly income, the State agency shall use one of the following two procedures:

(A) Round down each income and allotment calculation that ends in 1 through 49 cents and round up each calculation that ends in 50 through 99 cents; or

(B) Apply the rounding procedure that is currently in effect for the State's Temporary Assistance for Needy Families (TANF) program.

...

(2) Eligibility and benefits. (i)...

(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;

42. The Department's Program Policy Manual, CFOP 165-22, Appendix A-1,

Food Assistance Income Eligibility Standards and Deductions states in relevant part:

Assistance Group Size	165% Need Standards Effective October 1, 2017	Maximum Benefit Effective October 1, 2017	Gross and Net Income Limits Effective October 1, 2017		
			Monthly 200% Gross Income Limit	Monthly 130% Gross Income Limit	Monthly 100% Net Income Limit
1	\$1,659	\$192	\$2,010	\$1,307	\$1,005
2	\$2,233	\$352	\$2,708	\$1,760	\$1,354
3	\$2,808	\$504	\$3,404	\$2,213	\$1,702
4	\$3,383	\$640	\$4,100	\$2,665	\$2,050
Each Additional Member Add	+\$575	+\$144	+\$698	+\$453	+\$349
Food Assistance Deductions					
Standard Utility Allowance			\$347		
Basic Utility Allowance			\$280		
Telephone Standard			\$ 45		
Standard Deductions Effective October 1, 2017			1-3 Members \$160	4 Members \$170	5 Members \$199 6+ Members \$228
Homeless Income Deduction Effective October 1, 1995			\$143		
Maximum Deduction For Dependent Care Effective October 1, 2008			No Maximum		
<u>Maximum Shelter Deduction:</u>					
AG'S Without Elderly or Disabled Member Effective October 1, 2017			\$535		
AG'S With an Elderly or Disabled Member			UNCAPPED		

43. The above controlling authorities describe the eligibility process and defines deductions. The findings show the petitioner was credited with an earned income deduction, standard deduction, child care deduction, child support deduction and an excess shelter deduction. The undersigned reviewed the calculations made by the Department as described in the findings paragraphs five through 20. The

undersigned concludes the updated SNAP benefit calculations as calculated with the child care expense included in the budget are correct.

44. After considering the evidence, testimony and controlling authorities, the undersigned concludes there is no more favorable outcome based on reported income and expenses. The undersigned further concludes the petitioner's newly provided paystubs would not provide a more favorable outcome as his income on the new paystubs is higher than the paystub utilized during the determination of eligibility.

FAMILY RELATED MEDICAID

45. The findings show the petitioner is concerned that his daughter, age 6, is not eligible for full Medicaid. The Medicaid eligibility for the petitioner's daughter was determined under the Family-Related Medicaid Program.

46. 42 C.F.R. § 435.118, Infants and children under age 19, states in relevant part:

(b) Scope. The agency must provide Medicaid to children under age 19 whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

(c) Income standard. (1) The minimum income standard is the higher of—

(i) 133 percent FPL for the applicable family size; or

(ii) For infants under age 1, such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989 for determining eligibility for infants, or, as of July 1, 1989 had authorizing legislation to do so.

(2) The maximum income standard for each of the age groups of infants under age 1, children age 1 through age 5, and children age 6 through age 18 is the higher of—

(i) 133 percent FPL;

(ii) The highest effective income level for each age group in effect under the Medicaid State plan for coverage under the applicable sections of the Act listed at paragraph (a) of this section or waiver of the State plan covering such age group as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with

guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or

47. 42 C.F.R. § 435.218, Individuals with MAGI-based income above 133 percent FPL, states in relevant 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.

48. 42 C.F.R. § 435.603, Application of modified adjusted gross income (MAGI), 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....

Parent means a natural or biological, adopted or step parent.

Sibling means natural or biological, adopted, half, or step sibling.

Tax dependent has the meaning provided in §435.4 of this part.

(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.

49. In accordance with the above controlling authorities, the Medicaid

household group when looking at the petitioner's daughter is the petitioner, his wife and

both children. The findings show the Department determined the Medicaid eligibility for the petitioner's daughter using a household size of four.

50. The Department's Policy Manual, section 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).

*Note: Children aged 6-18 do not receive the standard disregard. They do receive the 5% MAGI disregard, if it's needed to determine the assistance group eligible.

51. The Department's Policy Manual, Appendix A-7, Family Related Medicaid Income Limits, lists the income standards for determination of eligibility effective April 2017. In relevant part, the standards for a household size four includes for children ages six through 18, 133 percent FPL of \$2,727, MNIL \$585, MAGI Disregard \$103. The Appendix notes the following: Children aged 6 through 18 **do not** receive the

standard disregard. They do get the 5% MAGI disregard, if needed. MNIL is the Medically Needy Income Limit, which includes the appropriate standard disregard. No additional disregards should be applied to establish a share of cost. The 5 percent MAGI disregard is used in a budget **only** if it makes a “failing” individual “pass” a full coverage Medicaid group.

52. The undersigned reviewed the calculation of Medicaid for the petitioner’s daughter. The petitioner’s income of \$1,385.56 ($\$692.78 \times 2 = \$1,385.56$) and wife’s income of \$2,577.24 are added together to reach a total gross income of \$3,962.80 ($\$1,385.56 + \$2,577.24 = \$3,962.80$). There are no allowable income tax deductions and so the MAGI income amount for the petitioner’s daughter is \$3,962.80. The MAGI income amount is greater than the 133 percent income standard for a household of four which is \$2,727. The undersigned concludes as the MAGI income exceeds the income standard, the determination must proceed to the next step. The MAGI income of \$3,962.80 less the MAGI deduction of \$103 is \$3,859.80 ($\$3,962.80 - \$103 = \$3,859.80$). The undersigned concludes the MAGI disregard will not make the countable income of \$3,859.80 less than the income standard of \$2,727 and therefore the petitioner’s daughter does not qualify for full Medicaid.

53. 42 C.F.R. § 435.308, Medically needy coverage of individuals under age 21, states in relevant part:

- (a) If the agency provides Medicaid to the medically needy, it may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18), as specified in paragraph (b) of this section:
 - (1) Who would not be covered under the mandatory medically needy group of individuals under 18 under §435.301(b)(1)(ii); and
 - (2) Who meet the income and resource requirements of subpart I of this part.

54. 42 C.F.R. § 435.831, Income Eligibility, states in relevant part:

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

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

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

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

...

(c) Eligibility based on countable income. If countable income determined under paragraph (b) of this section is equal to or less than that applicable income standard under §435.814, the individual is eligible for Medicaid.

(d) Deduction of incurred medical expenses. If countable income exceeds the income standard, the agency must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party. An expense is incurred on the date liability for the expense arises. The agency must determine deductible incurred expenses in accordance with paragraphs (e), (f), and (g) of this section and deduct those expenses in accordance with paragraph (h) of this section.

55. The Department's Policy Manual, section 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.

56. The undersigned concludes the Department correctly proceeded to the determination of eligibility under Medically Needy when the petitioner's daughter did not qualify for full Medicaid. The countable income of \$3,859 less the Medically Needy Income Level (MNIL) of \$585 leaves a share of cost of \$3,377. The petitioner did not supply any medical insurance premiums or recurring medical expenses by which the share of cost could be reduced. The undersigned concludes the Department correctly determined the share of cost for the petitioner's daughter.

57. The findings show the petitioner's gross income from December 8, 2017 was \$692.78. This is the lowest of all paystubs provided and the one used in his eligibility determination in December 2017. The undersigned concludes recalculating the Medicaid eligibility for the petitioner's daughter based on the updated paystubs would not result in a more favorable outcome.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of

the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 14 day of February, 2018,

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

Jan 08, 2018

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

APPEAL NO. 17F-09077

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Lee
UNIT: 88692RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on January 4, 2018 at approximately 8:16 a.m. CST.

APPEARANCESFor the Petitioner:  *pro se*

For the Respondent: Shakira Upshaw, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of December 21, 2017 denying his application for disability related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "10".

The petitioner submitted one document that was admitted into evidence and marked as Petitioner's Exhibit "1".

The petitioner was granted an expedited hearing.

FINDINGS OF FACT

1. The petitioner is a 49-year-old single man.
2. On November 16, 2017, the petitioner submitted an application requesting an independent determination of disability be made by the respondent (Respondent's Exhibit 2).
3. The petitioner testified that prior to the application with the respondent, he made an application for Social Security Administration (SSA) for Disability Insurance. The petitioner claimed that he was disabled and unable to work because of [REDACTED]

[REDACTED]. The petitioner did not report worsening of the condition. The petitioner completed an SSA medical examination December 14, 2017. The application was denied and is now under appeal. The SSA Explanation of Determination states in part:

...We realize that your condition will continue to affect you and may require ongoing medical care. However, based on your age, education and past work experience, we conclude that following your period of recover, you will be able to perform other work that requires less physical exertion. Therefore, because your condition is not expected to keep you from working for a period of at least 12 months in a row, your claim for disability benefits is denied. (Petitioner's Exhibit 1)

4. On December 08, 2017, the disability determination request was sent to the Division of Disability Determination (DDD). DDD received the request on December 14, 2017. The primary diagnosis was [REDACTED]. There was no secondary diagnosis. The petitioner was determined not to be disabled. The reason given was N-35, No pay-

impairment not 12 months. In the remarks section was the one-word explanation "Hankerson."

5. On December 21, 2017, the petitioner was notified by notice of case action (NOCA) that the November 16, 2017 Medicaid application was denied. The reason given was "You or a member(s) of your household do not meet the disability requirement. No household members are eligible for this program (Respondent's Exhibit 7).

6. The respondent explained that a medical decision on the issue of disability made by the SSA must be adopted by the Department within certain parameters. In this instant case, the respondent adopted the SSA's medical determination that the petitioner was not disabled.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

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

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

10. Fla. Admin. Code R 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. Individuals less than 65 years of age must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states in relevant part:

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

11. The Code of Federal Regulations at 42 C.F.R. § 435.540(a) sets forth the definition and determination of disability and states, “the agency must use the same definition of disability as used under SSI...”

12. Federal Medicaid Regulations at § 435.541 “Determinations of disability” states in part:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

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

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a

section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

(emphasis added)

13. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22 at passage 1440.1204 "Blindness/Disability Determinations (MSSI, SFP) states: "...**If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal**" (emphasis added).

14. The Policy Manual at passage 1440.1205 Exceptions to State Determination of Disability (MSSI, SFP) states:

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

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization.
5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).

The eligibility specialist must explore eligibility for Medicaid for the individual based on other coverage criteria, e.g., family-related coverage prior to exploring eligibility for disability-related Medicaid.

15. The findings show that the petitioner applied for disability benefits with the SSA and was denied as he was found not disabled. Although the petitioner could not remember the actual date of application or of denial of SSA benefits and the respondent testified that the SSA on-line query contained no information about the petitioner's SSA case, it can be deduced from the evidence and testimony that the SSA denial was made after the medical examination that took place on December 14, 2017, and before the DDD decision made on December 20, 2017 that referenced the SSA denial. The SSA's determination is less than 12 months old. The undersigned concludes that all of the petitioner's disabling conditions have been reviewed by the SSA. The undersigned concludes there are no new disabling conditions not known by the SSA.

16. According to the above-cited authorities, a SSA decision that is under appeal made within 12 months of the Medicaid application is controlling and binding on the State Agency unless the applicant reports a disabling condition not previously reviewed by SSA. Additionally, they direct worsening and deteriorating of conditions to the SSA. In this instant case, SSA has determined that the petitioner's conditions were not severe enough to prevent him from engaging in substantially gainful activities. DDD received the petitioner's disability packet and concluded that it contained the "same/related allegations" already considered by SSA. On December 20, 2017, DDD adopted the SSA decision and alerted the Department that the petitioner was not disabled.

17. The hearing officer explored all other Medicaid groups. The only other Medicaid group was Family-Related Medicaid Program benefits. Petitioner has no minor children residing with him. The Family-Related Medicaid Program benefit rules are set forth in the Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid Program, a dependent child must be living in the home. Petitioner does not meet the criteria for Family-Related Medicaid Program benefits. It is concluded, the respondent's action to deny the petitioner's application for Medicaid Program benefits was within the rules of the Program.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 08 day of January, 2018,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
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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

Feb 01, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17N-00096

PETITIONER,

VS.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 14, 2017 at 9:22 a.m., at [REDACTED]
[REDACTED].

APPEARANCES

For the Petitioner: [REDACTED] daughter

For the Respondent: [REDACTED], Nursing Home Administrator

STATEMENT OF ISSUE

At issue is the facility's intent to discharge the petitioner alleging that her needs cannot be met by the facility based on Federal Regulations found at 42 C.F.R. § 483.15. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

PRELIMINARY STATEMENT

Witnesses for the petitioner were [REDACTED] son, [REDACTED], granddaughter, [REDACTED], Sunshine case manager [REDACTED] [REDACTED] prior Sunshine case manager, [REDACTED], Sunshine health supervisor.

Witnesses for the respondent were [REDACTED], risk manager, [REDACTED] [REDACTED] clinical reimbursement manager and [REDACTED], director of rehabilitation.

The petitioner presented two exhibits which were entered into evidence and marked as Petitioner's Composite Exhibits 1 and 2. The respondent presented three exhibits which were entered into evidence and marked as Respondent's Exhibits 1, 2 and 3. The undersigned received a letter from the Agency of Health Care Administration stating that its representative completed an unannounced visit at the [REDACTED] on November 13 & 14, 2017 and found no violations. This letter was entered into evidence and marked as Hearing Officer's Exhibit 1.

FINDINGS OF FACT

1. The petitioner was admitted to the facility on October 16, 2016. Upon admission, she was diagnosed with [REDACTED], [REDACTED]
2. The respondent contends that it is unable to meet the petitioner's needs due to her family's insistence to have staff utilize unsafe methods to transfer the petitioner to a Sit to Stand Lift. Additionally, it requires three people to assist in ambulation.

3. On October 3 2017, the respondent issued a Nursing Home Transfer and Discharge Notice to the petitioner. A 30-day discharge letter was attached to the Notice. The reason cited on the Notice, "Your needs cannot be met in this facility".
4. The petitioner's daughter requested that the petitioner's toileting be done by using a Sit to Stand Lift rather than the Hoyer Lift, which is currently being used by the facility. The petitioner's daughter believes the Sit to Stand Lift will also serve as a form of therapy for the petitioner as she is [REDACTED] has [REDACTED] and is very weak.
5. The respondent's position is that the Sit to Stand Lift will not improve the petitioner's health or mobility.
6. The respondent held multiple care planning meetings with the petitioner's representative regarding use of the Sit to Stand Lift. The facility rented a Sit to Stand Lift and used it in order to facilitate the daughter's request; however, the facility determined the Sit to Stand Lift is not beneficial to the petitioner.
7. The respondent asserted that the petitioner's representative has filed 22 complaints regarding the care of her mother and they also lodged complaints with the Agency of Health Care Administration. The respondent stated that it has been cleared from all of these allegations.
8. The physician assigned to the petitioner, signed the Transfer and Discharge Notice, but no supporting documentation from the petitioner's medical records or testimony from the physician was offered to explain why the physician believes her needs cannot be met by the respondent.
9. The respondent's administrator testified that all of the petitioner's basic needs are being met except for having the Sit to Stand Lift.

10. The petitioner's daughter expressed satisfaction with the current quality of care her mother is receiving except for the use of a Sit to Stand Lift as requested. The daughter stated she prefers her mother stay at the facility rather than be discharged in order to get access to a Sit to Stand Lift. The daughter stated the petitioner is comfortable and familiar with the staff at the [REDACTED]. The daughter provided a letter from [REDACTED] (the petitioner's private doctor) stating that having the petitioner remain at respondent's facility is in her best interest, as a change of environment could cause confusion to a patient with [REDACTED] (Petitioner's Composite Exhibit 1).

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 400.0255(15), Florida Statutes.

12. 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.

(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.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

(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 (c)(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 resident's 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.

(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and...(emphasis added).

13. In this case, the petitioner was given a notice on October 3, 2017, indicating that she would be discharged from the facility citing, "your needs cannot be met in this facility". The above-cited authorities set forth the conditions which must exist for a nursing home to involuntarily discharge a resident. This is one of the reasons given in the above federal and state law to permit discharge from a facility. The above authority also states that the reasons for the transfer or discharge should be recorded in the resident's medical record. No testimony or evidence of such was presented.

14. Section 400.0255, Florida Statutes, Resident transfer or discharge; requirements and procedures; hearings, states in relevant part:

(3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer...

(7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstance, the facility shall give notice as soon as practicable before the transfer or discharge:

(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical records by the resident's physician; or

(b) The resident's health or safety or other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.

15. The respondent bears the burden of proof by clear and convincing evidence to show that the facility is unable to meet the petitioner's needs. The federal regulation is clear of the intent of a discharge. The transfer or discharge is necessary when the resident's welfare is at risk and the resident's needs cannot be met in the facility.

16. The facility's attending physician did sign the Nursing Home Transfer and Discharge Notice indicating the petitioner's needs cannot be met by the facility. The petitioner's medical record was *not* documented by the attending physician to reflect the doctor's agreement with the reason for discharge. The testimony provided by the respondent was based on the petitioner's representative actions, not that of the petitioner. The facility did not prove that the petitioner's needs cannot be met or that the discharge was necessary for the petitioner's welfare. This is both a federal and state requirement.

17. Based on documentation and testimony offered, the petitioner was admitted to the respondent's facility as a [REDACTED] patient who needs nursing care and a secure environment. There was no testimony or evidence presented to show that the respondent is unable to provide such care.

18. After considering the entire record, the undersigned concludes that the respondent has not met its burden to prove by clear and convincing evidence that petitioner's needs cannot be met. The respondent's intent to discharge the petitioner from its facility is not consistent with the above controlling authorities.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The facility has not established that this discharge is permissible under federal

or state regulations. Therefore, the facility may NOT proceed with the discharge at this time.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm.255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 01 day of February, 2017,

in Tallahassee, Florida.

Christiana Gopaul-Narine

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

Copies Furnished To:

[REDACTED]

Jan 17, 2018

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

[REDACTED]

APPEAL NO. 17N-00098

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on December 8, 2017 at 1:26 p.m. at the [REDACTED]

[REDACTED]

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Monika Peters, Executive Director

ISSUE

At issue is the facility's intent to discharge the petitioner due to non-payment of a bill for services and due to his health improving sufficiently so that he no longer needs the services provided by the facility. A Nursing Home Transfer and Discharge Notice was issued on October 13, 2017. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. § 483.15.

PRELIMINARY STATEMENT

The petitioner was present and testified. The petitioner submitted no exhibits at the hearings. The respondent was represented by Monika Peters, Executive Director with [REDACTED] (hereafter "facility" or "respondent"). The respondent presented four witnesses who testified: [REDACTED], Business Office Manager; [REDACTED], Director of Rehabilitation; [REDACTED] Director of Nursing; and [REDACTED], M.D., Medical Director. The respondent submitted four exhibits, which were accepted into evidence and entered as Respondent's Exhibits "1" – "4".

FINDINGS OF FACT

1. The petitioner entered the facility on July 25, 2017. When the petitioner entered the facility, he was placed on a "Medicare bed". On October 24, 2017, the petitioner moved to a "Medicaid bed".
2. On October 13, 2017, the facility issued the petitioner a Nursing Home Transfer and Discharge Notice. The reasons for the discharge were "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay"; and "Your health has improved sufficiently so that you no longer need the services provided by this facility".
3. The petitioner's monthly income was Social Security benefits of \$1,157 (gross) per month.
4. On September 1, 2017, Medicare part A no longer paid the facility. The petitioner converted to private pay rate for the months of September 2017 and October 2017 as he remained on a "Medicare bed". The private pay rate ended when the petitioner moved to a "Medicaid bed" on October 24, 2017.

5. The petitioner's patient liability for October 2017 was \$236.67 (prorated amount) and for November 2017 and ongoing was \$1,049.

6. As of October 2, 2017, the petitioner's outstanding balance to the facility was \$26,460. As of December 2017, the petitioner's outstanding balance to the facility was \$25,707.87.

7. The facility billed the petitioner the following private pay and patient liability amounts:

\$0 for July 2017 and August 2017; \$12,801.93 for September 2017;
\$236.87 and \$10,584 for October 2017; \$1,049 for November 2017; and
\$1,049 for December 2017.

8. The petitioner has not made any payments to the facility towards his outstanding balance and has not made any payment arrangements to pay his outstanding balance.

9. The petitioner entered the facility for physical therapy services and wound care. The respondent explained the petitioner is able to independently transfer from his bed to wheelchair; independently utilize his wheelchair for ambulation; and independently move about in the community. The facility also explained the petitioner no longer requires skilled nursing services and receives therapy services in the community.

10. The petitioner explained the facility has never provided the level of care he needs for his health to improve. He further explained the staff did not provide proper wound care and did not provide the necessary equipment for the treatment of his legs. The petitioner wishes to remain in the facility as he has access to his medications and to healthcare.

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 400.0255(15), Florida Statutes. In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.

12. The Code of Federal Regulations 42 C.F.R. § 483.15 limits the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that he would be discharged from the facility as he had not paid his bill for services to the facility and since his health has sufficiently improved, he no longer needs the services provided by the facility:

...

(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 respondent's reasons for the discharge were that the petitioner had not paid his bill for services to the facility and since his health has sufficiently improved, he no longer needs the services provided by the facility.

14. The facility billed the petitioner the following private pay and patient liability amounts \$0 for July 2017 and August 2017; \$12,801.93 for September 2017; \$236.87 and \$10,584 for October 2017; \$1,049 for November 2017; and \$1,049 for December 2017. The petitioner has not made any payments towards his outstanding balance and has not made any payment arrangements with facility.

15. The hearing officer concludes that although the facility had two reasons for discharging the petitioner, the facility has meet the burden of proof to establish that the petitioner has been given reasonable and appropriate notice of the need to pay for his stay at the facility. Furthermore, the petitioner has not made any payments towards his outstanding balance; and has not cooperated with the facility to create a payment plan to repay the facility for his outstanding balance. Based on the evidence presented, the nursing facility has established that the petitioner has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) his stay at the facility. This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident.

16. One step in the discharge process is establishing that the reason for a discharge is lawful. 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 only considered whether the discharge is for a lawful reason.

17. 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 petitioner's 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 action in accordance with the Agency for Health Care Administration's rules and guidelines.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm.255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 17 day of January, 2018,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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Copies Furnished To:

[REDACTED]

Jan 31, 2018

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-00102

PETITIONER,

Vs.

Administrator

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on January 2, 2018 at 11:00 a.m., at [REDACTED]

[REDACTED]

APPEARANCES

For Petitioner: [REDACTED]
Power of Attorney and Husband of Petitioner

For Respondent: [REDACTED]
Spectro, Gador, and Rosen, P.C.

STATEMENT OF ISSUE

Petitioner appeals Respondent's action discharging her from the Facility, due to non-payment of a bill for services. Respondent carries the burden of proof by clear and convincing evidence in this appeal.

PRELIMINARY STATEMENT

Petitioner did not have any witness appear on her behalf [REDACTED], Nursing Home Administrator; [REDACTED], Social Services Director; [REDACTED], Business Office Manager; and [REDACTED], Acting Director of Nursing; appeared as witnesses for Respondent.

Petitioner submitted two exhibits, which were not entered into evidence as they were irrelevant to the issue in dispute. Respondent submitted an evidence packet consisting of eight exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" – "8." The undersigned submitted one exhibit, which was entered into evidence and marked as Hearing Officer's Exhibit "1." The record closed on January 2, 2018.

FINDINGS OF FACT

1. On August 29, 2017, the Facility admitted Petitioner (Respondent's Exhibits 5 and 6) who was suffering from respiratory failure; severe [REDACTED] [REDACTED] to both [REDACTED]; [REDACTED]; need for assistance with personal care; [REDACTED]; [REDACTED] [REDACTED] (Respondent's Exhibit 6, Page 1).

Petitioner remained in the care of the Facility at the date of hearing (Testimony of Tammie Smith).

2. Tammie Smith (TS) testified to her role as Social Services Director indicating she is responsible for providing psychosocial and financial assessments for the Facility's patients and their families, and assists in discharge planning and ancillary specialized service referrals (*Id.*).

3. TS further testified that by assisting patients and their families in financial assessments she often makes referrals to community resources such as Veteran Administration, Medicare, Medicaid, private pay, and other financial advisors to aid patients and their families in providing payment for Facility costs of services (*Id.*).
4. On August 12, 2017, [REDACTED] (RB) executed a Health Care Proxy Designation and Acceptance Letter giving him authority to make health care decisions on behalf of Petitioner (Respondent's Exhibit 2).
5. On September 12, 2017, TS completed a psychosocial assessment with RB, which discussed Petitioner's history, indicated RB wished for Petitioner to remain in the Facility for long-term care, and that he maintained Power of Attorney for her (Respondent's Exhibit 5, Page 3).
6. RB's Durable Unlimited Power of Attorney was established on March 1, 2007, giving RB all rights to make medical decisions on Petitioner's behalf (Respondent's Exhibit 1).
7. On September 27, 2017, TS held a lengthy meeting with RB regarding the Medicaid process, Medicare coverage, Petitioner's progress, and RB's future plans for Petitioner (Respondent's Exhibit 5, Page 3). Though RB seemed to understand the information provided he was evasive when questioned about future plans and needs for Petitioner, and refused any need for assistance regarding alternative placement (*Id.*).
8. On October 4, 2017, TS held another lengthy meeting with RB regarding Petitioner's plan of care, the upcoming end to her Medicare coverage for Facility costs of service, and discharge plan as RB indicated his unwillingness to pay Facility costs of

service after Medicare coverage terminated or to apply for a third party payer to do so on her behalf (Testimony of TS).

9. On October 10, 2017, TS called the [REDACTED] to request a wellness check for RB as she had been unable to get in contact with him after numerous calls since October 4, 2017 (Respondent's Exhibit 5, Page 2). RB indicated to police that he was aware the Facility was trying to contact him (*Id.*)

10. On October 20, 2017, a Notice of Medicare Non-Coverage was mailed certified mail to RB at his address of record (Respondent's Exhibit 7, Page 7).

11. Medicare covered eighty percent of Petitioner's Facility costs of service for the first twenty days of her stay (Testimony of TS). At day twenty-one, Medicare coverage ceased and a co-payment was required for Petitioner's Facility costs of service from that date forward (*Id.*)

12. On October 26, 2017, Respondent provided a Nursing Home Transfer and Discharge Notice (DN) to Petitioner (Respondent's Exhibit 7), which was left at her bedside (Testimony of TS) and mailed to RB at his address of record by both regular and certified mail with confirmation of receipt (Respondent's Exhibit 7, Pages 9 – 11).

13. The DN indicated that a bill for services rendered had not been paid after reasonable and appropriate notice to pay as the reason for discharge, a discharge effective date of November 26, 2017, RB's home residence as Petitioner's discharge location, and that [REDACTED] signed the DN (*Id.* at 1).

14. [REDACTED] was the acting Nursing Home Administrator at the time the Facility issued the October 26, 2017 DN (Testimony of TS).

15. On November 6, 2017, TS contacted [REDACTED] with the Ombudsman's office regarding the October 26, 2017 DN (Respondent's Exhibit 5, Page 2).

16. RB testified that at no point did he attempt to provide payment for Petitioner's Facility costs of service, apply for Medicaid, or apply for any other third party payer on her behalf (Testimony of RB).

17. RB argued that Petitioner's admittance to the Facility was based on an unconscionable contract (*id.*).

18. Respondent argued Petitioner's admittance to the Facility is irrelevant in regards to the lawfulness of her discharge (Testimony of Respondent).

19. Respondent provided a balance statement, dated January 1, 2018, for dates of service from November 21, 2017 through November 30, 2017 in the amount of \$18,740.26 (Respondent's Exhibit 3). The total remaining balance due at the date of hearing was \$25,227.06 ([REDACTED]).

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 400.0255(15), Florida Statutes. In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.

21. The Code of Federal Regulations, Title 42, Section 483.15, Admission, transfer and discharge rights in relevant part states:

...
(c) *Transfer and discharge*—(1) *Facility requirements*—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
- (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
- (D) The health of individuals in the facility would otherwise be endangered;
- (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid (emphasis added); or**
- (F) The facility ceases to operate.

...

(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.

...

(3) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must—

(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and

(iii) Include in the notice the items described in paragraph (c)(5) of this section.

(4) *Timing of the notice.* (i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

...

(5) *Contents of the notice.* The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 *et seq.*); and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

...

22. On October 26, 2017, the Facility issued Petitioner's DN. The Facility's reason for discharging Petitioner is that a bill for services rendered had not been paid after reasonable and appropriate notice to pay. This is one reason permitted for discharge from a Facility in accordance with the above Federal Regulation.

23. RB argued that Petitioner's admittance to the Facility was based on an unconscionable contract. The undersigned does not have jurisdiction to consider the lawfulness of her admittance to the Facility. In addition, the undersigned concludes that even if the Office of Appeal Hearings had jurisdiction to hear that matter, her admittance to the Facility is irrelevant to the issue of the lawfulness of the discharge.

24. The Florida Statutes, Title 29, Section 400.0255, Resident transfer or discharge; requirements and procedures; hearings in part states:

...

(3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.

...

(7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:

...

(b) The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's

medical records by the resident's physician or the medical director if the resident's physician is not available.

...

(10)

...

(b) If a resident requests a hearing within 10 days after receiving the notice from the facility, the request shall stay the proposed transfer or discharge pending a hearing decision. The facility may not take action, and the resident may remain in the facility, until the outcome of the initial fair hearing, which must be completed within 90 days after receipt of a request for a fair hearing.

25. In accordance with the above Federal Regulation and State Statute, the DN was signed by the then acting Facility Administrator thirty days prior to the discharge date. The DN also indicated the reason and effective date of the discharge, the location to which Petitioner was to be discharged, and Petitioner's appeal rights along with other required assistance information.

26. The evidence submitted establishes that Petitioner's medical records were well documented with the Facility's attempts to assist RB with securing payment for the Facility costs of services, and that RB refused to pay for the Facility costs of services or apply for aid in paying for those services with Medicaid or any other third party payer. This is the basis for Petitioner's discharge.

27. Petitioner requested a hearing within ten days after receipt of the DN. Subsequently, the Facility stayed Petitioner's discharge pending the hearing decision.

28. Establishing that the reason(s) for a discharge is lawful is just one step in the discharge process. The Facility must also identify an appropriate transfer or discharge location and a safe and orderly transfer or discharge from the facility. The Hearing Officer cannot and has not considered either of these issues. The Hearing Officer only

considered whether the discharge was for a lawful reason(s) and that the requirements of the controlling authorities have been met.

29. Discharge by the Facility must comply with all applicable Federal Regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should Petitioner have concerns about the appropriateness of the discharge location or the discharge process, she may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

30. In accordance with the above authorities, the Facility seeks to involuntarily discharge Petitioner to her husband, RB for the reason that a bill for services rendered has not been paid after reasonable and appropriate notice to pay.

31. After careful review of the evidence and testimony, the undersigned concludes that Respondent met its burden of proof. The undersigned concludes that Respondent's discharge of Petitioner for non-payment of a bill for services is proper.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED. The Facility's action to discharge Petitioner is in accordance with Federal Regulations. The Facility may proceed with its proposed discharge action, as described in the Conclusions of Law and in accordance with all applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm.255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 31 day of January, 2018,

in Tallahassee, Florida.



Erik Swenk, Esq.
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
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Copies Furnished To:



Jan 16, 2018

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-00104

PETITIONER,

Vs.

Administrator

[REDACTED]

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on November 30, 2017 at 10:13 a.m. in [REDACTED], Florida.

APPEARANCES

For the Petitioner:

[REDACTED]

Power of Attorney

For the Respondent:

[REDACTED]

Executive Director

Wedgewood Healthcare Center

STATEMENT OF ISSUE

Petitioner is appealing Respondent's action to discharge her from the facility by Nursing Home Transfer and Discharge Notice issued on October 13, 2017.

Respondent carries the burden of proof by clear and convincing evidence.

PRELIMINARY STATEMENT

Petitioner informed the undersigned-hearing officer prior to proceeding on the Record that she will not appear at the hearing and her representative [REDACTED] will represent her at the hearing.

Petitioner submitted no exhibits into evidence. Respondent introduced Exhibits "1" through "2," which were accepted into evidence and marked accordingly.

[REDACTED] Regional Director of Business Office Services with Consulate Health Care, appeared as a witness for Respondent.

Mary Jane Stafford, Hearing Officer with the Office of Appeals Hearings, appeared as an observer.

FINDINGS OF FACT

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

1. Petitioner is a female who has resided at the Respondent's facility since March 3, 2017.
2. The Nursing Home Transfer and Discharge Notice dated October 13, 2017 indicates the reason for discharge or transfer as: "Your bill for services at this facility has not been paid after reasonable and appropriate notice to pay. Resident given 30 days discharge due to non-payment of services being rendered for her care."
3. The discharge notice contains the signature of the facility administrator. The discharge notice does not contain Petitioner's signature or her designee's signature on the notice. The notice does not provide a discharge or transfer location for Petitioner. Respondent stated they hand-delivered the discharge notice to Petitioner at the facility and mailed a copy to her last known address. (See Respondent's Exhibit 2).

Petitioner's representative indicated she did not receive a copy of the discharge notice, but her niece received the copy.

4. Respondent contends that it has not received a payment from Petitioner. The facility attempted several times to work with Petitioner to establish a payment plan in order to reduce the money owed to the facility. Petitioner currently owes \$40,204.29 at the time of this hearing. Petitioner owed \$25,259.29 at the time the facility provided her the Discharge Notice on October 13, 2017. Petitioner did not dispute money is owed to the facility.

5. Petitioner does not qualify for Medicaid because she is over assets and Medicare does not cover the cost of room and board.

6. Petitioner currently receives \$1,170.00 per month from social security and \$813.00 per month from her retirement fund. Petitioner has assets and investments that are currently being investigated by Petitioner's representative. The funds are currently unavailable due to inability to access the investment accounts.

7. The only available income Petitioner has is funds from her social security and retirement fund. There was no evidence provided that any of Petitioner's social security or retirement fund was provided to the facility to pay Petitioner's bill.

8. Petitioner's representative stated that one of Petitioner's investment funds was liquidated and a check for \$12,000.00 from [REDACTED] was sent to the facility. However, Respondent contends they did not receive the check for \$12,000.00. Petitioner received an additional check for \$8,000.00 from the [REDACTED] investment fund that was sent to Petitioner's Power of Attorney. However, Petitioner's Representative stated the money was used to pay for Petitioner's back taxes and other expenses.

CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15) of the Florida Statutes. In accordance with Section 400.0255(15) of the Florida Statutes, this Order is the final administrative decision of the Department of Children and Families. The standard of proof in this administrative hearing is clear and convincing evidence pursuant to Section 400.0255(15)(b) of the Florida Statutes.

10. Title 42 of the Code of Federal Regulations, Section 483.15, limits the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient and states the following:

....

- (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.

11. The October 13, 2017 Nursing Home Transfer and Discharge Notice indicates the reason for discharge as: "Your bill for services at this facility has not been paid after

reasonable and appropriate notice to pay. Resident given 30 day Discharge due to non-payment of services being rendered for her care.”

12. The above-cited authority sets forth conditions which must exist for a nursing home to involuntarily discharge a resident. The undersigned concludes the reason provided by Respondent in the discharge notice is included in the authority as a valid reason for involuntary discharge.

13. Section 400.0255(8) of the Florida Statutes- Resident transfer or discharge; requirements and procedures; hearings, states in relevant part:

The notice required by subsection (7) must be in writing and must contain all information required by state and federal law, rules, or regulations applicable to Medicaid or Medicare cases. The agency shall develop a standard document to be used by all facilities licensed under this part for purposes of notifying residents of a discharge or transfer. Such document must include a means for a resident to request the local long-term care ombudsman council to review the notice and request information about or assistance with initiating a fair hearing with the department’s Office of Appeals Hearings. In addition to any other pertinent information included, the form shall specify the reason allowed under federal or state law that the resident is being discharged or transferred, with an explanation to support this action. **Further, the form must state the effective date of the discharge or transfer and the location to which the resident is being discharged or transferred.** The form must clearly describe the resident’s appeal rights and the procedures for filing an appeal, including the right to request the local ombudsman council review the notice of discharge or transfer. **A copy of the notice must be placed in the resident’s clinical record, and a copy must be transmitted to the resident’s legal guardian or representative and to the local ombudsman council within 5 business days after signature by the resident or resident designee.** (Emphasis Added).

14. According to the controlling state law, the discharge notice requires a discharge or transfer location for the resident. In this case, the discharge notice did not provide a discharge or transfer location for the resident. The discharge notice also failed to have the resident’s signature or resident’s designee sign the discharge notice.

15. Based on the evidence presented, Respondent's proposed discharge action does not adhere to the controlling legal authorities.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The facility is not allowed to discharge the resident under the notice at issue.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm.255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 16 day of January, 2018, in
Tallahassee, Florida.



Allison Smith-Dossou
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
[Redacted], Respondent
Ms. [Redacted]
Agency for Health Care Administration
[Redacted]

Feb 13, 2018

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-00107

PETITIONER,

Vs.

Administrator

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on January 12, 2018 at 1:11 p.m. at the [REDACTED]

[REDACTED]

APPEARANCES

For the Petitioner: [REDACTED] the petitioner's daughter

For the Respondent: [REDACTED], the facility's representative

ISSUE

At issue is the facility's intent to discharge the petitioner due to non-payment of a bill for services. A Nursing Home Transfer and Discharge Notice was issued on November 14, 2017. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate under federal regulations found in 42 C.F.R. § 483.15.

PRELIMINARY STATEMENT

The petitioner was present, but did not testify as he was represented by his daughter, [REDACTED], who testified. The petitioner submitted no exhibits at the hearing. The respondent was represented by [REDACTED], the facility's representative with [REDACTED] (hereafter "facility" or "respondent"). The respondent presented four witnesses who testified: [REDACTED] Administrator; [REDACTED], Business Office Manager; [REDACTED], Administrator in Training; and [REDACTED], Central Office Administrator. [REDACTED], Paralegal, observed the proceedings. The respondent submitted five exhibits, which were accepted into evidence and entered as Respondent's Exhibits "1" – "5".

FINDINGS OF FACT

1. The petitioner entered the facility on May 8, 2017. Medicare paid the facility from May 9, 2017 through July 18, 2017. Medicare will also pay the facility in full from December 26, 2017 through January 13, 2018.
2. On November 14, 2017, the facility issued the petitioner a Nursing Home Transfer and Discharge Notice. The reason for the discharge was "your bill for services at this facility has not been paid after reasonable and appropriate notice to pay".
3. The petitioner's monthly income was Social Security benefits of \$1,330 (gross). The facility is the petitioner's payee for his Social Security benefits. The petitioner did not indicate he would remove the facility as the payee of his Social Security benefits.
4. The petitioner's Medicaid closed effective May 31, 2017 and his patient liability was \$1,334 per month.

5. When the petitioner's Medicaid closed and when his Medicare no longer paid for his bill for services, the facility began to charge him the private pay rate of \$220 per day.
6. On August 31, 2017, the Department of Children and Families (hereafter DCF) mailed a Notice of Case Action informing the petitioner his Medicaid application dated July 12, 2017 was denied as "We did not receive all of the information requested to determine your eligibility."
7. On October 31, 2017, DCF mailed a Notice of Case Action informing the petitioner his Medicaid application dated September 28, 2017 was denied as "We did not receive all of the information requested to determine your eligibility."
8. On December 26, 2017, DCF mailed a Notice of Case Action informing the petitioner his Medicaid application dated November 22, 2017 was denied as "We did not receive all of the information requested to determine your eligibility."
9. On January 2, 2018, DCF mailed a Notice of Case Action informing the petitioner he was required to submit verification by January 12, 2018. The petitioner has a pending Medicaid application when the hearing occurred on January 12, 2018.
10. The respondent explained the petitioner was given monthly notices that indicated the amount the petitioner owed to the facility. The petitioner had made the following payments to the facility: \$1,080.50 for the months of July 2017 through November 2017; and \$1,147.22 for December 2017. These payments were towards his outstanding balance.
11. As of January 11, 2018, the petitioner's outstanding balance to the facility was \$33,754.76.

12. The facility billed the petitioner the following private pay amounts: \$3,080 for July 2017; \$6,820 per month for August 2017 and October 2017; \$6,600 for September 2017 and November 2017; and \$2,640 for December 2017.

CONCLUSIONS OF LAW

13. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes. In accordance with that section, this Order is the final administrative decision of the Department of Children and Families.

14. The Code of Federal Regulations 42 C.F.R. § 483.15 limits the reasons for which a Medicaid or Medicare certified nursing facility may discharge a patient. In this case, the petitioner was sent notice indicating that he would be discharged from the facility as he had not fully paid his bill for services to the facility:

- ...
- (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.

15. The respondent's sole reason for the discharge was that the petitioner had not paid his bill for services to the facility. The facility billed the petitioner the private pay amounts of \$3,080 for July 2017; \$6,820 per month for August 2017 and October 2017; \$6,600 for September 2017 and November 2017; and \$2,640 for December 2017.

16. The petitioner has made two payments to the facility for the months of July 2017 through December 2017. His two payments totaled \$2,227.72.

17. It is not known if the petitioner's Institutionalized Care Program (ICP) Medicaid benefits will be approved or the effective date of his ICP Medicaid benefits. As a result it is unknown if the petitioner would still owe payments to the facility. Furthermore, the facility is the petitioner's payee for his Social Security benefits and he has made payments every month from July 2017 through December 2017. The petitioner did not indicate he would remove the facility as a payee to his Social Security benefits so the facility will continue to receive the petitioner's Social Security benefits.

18. The Department of Health and Human Services, Centers for Medicaid and Medicare Services, State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities states in part:

A resident cannot be transferred for non-payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay.

19. Pursuant to the above authority, the aforementioned guidance to the Agency for Health Care Administration surveyors allows the reviewing of a discharge notice due to non-payment to be considered in this appeal. In this instance, the petitioner has a

pending ICP application with the Department of Children and Families to determine if he is eligible for ICP Medicaid benefits. The respondent must wait until the Department of Children and Families provides it a denial notice for the petitioner's ICP Medicaid benefits for the months of July 2017 and ongoing before proceeding with this discharge action.

20. 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 convincing¹. The undersigned concludes the respondent's evidence does not rise to the level of clear and convincing and the evidence submitted does not indicate the petitioner has failed, after reasonable and appropriate notice, to pay for his stay at the facility.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED. The facility has not established that this discharge is permissible under federal or state regulations; therefore, the facility may not proceed with the discharge at this time.

¹ State v. Graham, 240 So.2d 486 (1974), states, "Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established. (Id. quoting Slomowitz v. Walker, 429 So.2d 797, 800 (Fla. 4th DCA 1983))."

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm.255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 13 day of February , 2018,

in Tallahassee, Florida.

Mary Jane Stafford

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

Copies Furnished To: [REDACTED] Petitioner
[REDACTED], Respondent
Agency for Health Care Administration
[REDACTED]

Jan 24, 2018

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

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 18F-00397

PETITIONER,

Vs.

CASE NO. 

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on January 22, 2018 at 8:30 a.m.

APPEARANCES

For the petitioner:  pro se

For the respondent: Susan Martin, ACCESS Operations & Management
Consultant I

STATEMENT OF ISSUE

The petitioner is appealing the following:

I. The respondent's action to deny the petitioner's wife's application for Adult-Related Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

II. The respondent's action to enroll the petitioner in the Medically Needy (MN) Program with a share of cost (SOC). The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Pursuant to 42 C.F.R. § 431.224(a)(1), "the agency must establish and maintain an expedited fair hearing process for individuals to request an expedited fair hearing, if the agency determines that the time otherwise permitted for a hearing under § 431.244(f)(1) could jeopardize the individual's life, health or ability to attain, maintain, or regain maximum function." On January 12, 2018, the petitioner requested an expedited fair hearing. On January 17, 2018, the petitioner submitted documentation to support his expedited request. On January 18, 2018, a determination was made that the petitioner met the criteria for an expedited fair hearing pursuant to 42 C.F.R. § 431.224(a)(1). A telephonic expedited fair hearing was scheduled for January 22, 2018 at 8:30 a.m. The parties were notified of the hearing date, time and dialing instructions by electronic mail.

Dawn Murray, ACCESS Operations Manager, appeared as an observer.

The petitioner submitted one exhibit, which was entered into evidence as Petitioner's Exhibit "1". The respondent submitted four exhibits, which were entered into evidence as Respondent's Exhibits "1" through "4". The record was held open until 12:00 p.m. on January 22, 2018 for submission of additional evidence from the respondent. On January 22, 2018, additional evidence was received from the respondent, which was entered into evidence as Respondent's Exhibit "5". The record closed on January 22, 2018.

FINDINGS OF FACT

1. On November 20, 2017, the petitioner (56) filed an application through the Federally Facilitated Marketplace¹. The application was for Medicaid benefits for himself and his wife (50). On the application, the petitioner reported that he and his wife are not age 65 or older and do not have any minor children. He also indicated he and his wife are disabled and that he receives Social Security benefits for himself. The petitioner reported his address as [REDACTED]
2. On November 22, 2017, the respondent mailed the petitioner a pending notice giving him a deadline of November 28, 2017 to contact the office to complete a telephone interview and to provide the following information:
[REDACTED]

Dear [REDACTED]

The following is information about your eligibility.

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

We need to have a phone interview with you to determine your eligibility or to continue your benefits. Please call (407) 317 - 7408 on or before November 28, 2017 between the hours of 8:00 A.M and 5:00 P.M for your phone interview.

To finish your application we need the following information no later than ten days from the date of your interview.

Please read the disability pamphlet
Please complete and sign the Authorization To Disclose Information Form
Please complete and sign the Informed Consent Form
Please complete and sign the Affidavit for Designated Representative Form

2Call for your interview, address, and phone number of your medical providers (doctors and hospitals), including name and any treatments and procedures received and a list of your current medications. You will need to sign and date the Authorization to Disclose (ES 2514). The Financial Information Release (ES 2613) mailed with this notice must be signed by you and your spouse if married, your designated representative, or POA/Legal Guardian. A copy of the POA or guardianship document is needed, as verification. Note: You must apply for benefits with the SSA and provide proof of application before Medicaid can be approved and diligently pursue to conclusion any benefit you may be entitled to receive. Please return signed forms to ACCESS PO Box 1770. Ocala. FL. 34478

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

3. On November 29, 2017, the respondent received the above pending notice as returned mail indicating “return to sender, no such number.”
4. On December 11, 2017, the respondent submitted another on-line application for Medicaid. On this application, the petitioner reported his address as [REDACTED]. The respondent closed this application as a duplicate because the case was pending for the November 20, 2017 application. The respondent did not review the December 11, 2017 application which showed the petitioner’s correct address.
5. On December 19, 2017, the respondent attempted to contact the petitioner at the number listed on the November 20, 2017 application but was unsuccessful in reaching anyone to complete the interview. According to the Department’s policy, the respondent must attempt to contact the applicant for an interview within three working days from the date of the application. It is unknown why the respondent contacted the petitioner twenty-nine (29) days after the application date (November 20, 2017).
6. On December 21, 2017, the respondent mailed the petitioner a Notice of Case Action (NOCA) denying his Medicaid application dated November 20, 2017 due to “you failed to complete an interview necessary for us to determine your eligibility for this program”. The NOCA was mailed to [REDACTED].
7. On January 8, 2018, the petitioner submitted another application for Medicaid and requested retroactive Medicaid coverage for the month of December 2017. On this application, the petitioner reported his address as [REDACTED]. On January 10, 2018, the respondent mailed the petitioner a

pending notice giving him a deadline of January 22, 2018 to submit some additional forms.

8. The Division of Disability Determinations (DDD) is responsible for making State disability determinations on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. The respondent explained the case can be forwarded to DDD once it receives the signed Authorization to Disclose Information form from the petitioner's wife. As of the date of the hearing, the petitioner's wife's January 8, 2018 Medicaid application remained pending. The respondent has not made a final determination of eligibility as it still waiting on additional verification.

9. The respondent reviewed the State of Florida SSA State On-Line Query (SOLQ) which indicates the petitioner receives Social Security Disability Income (SSDI) of \$2,011.00 and pays \$134.00 for his Medicare part B premium. The respondent determined Medicaid eligibility for the petitioner based on the January 8, 2018 application. The respondent enrolled the petitioner in the MN SOC. The respondent determined the petitioner's \$1,616.00 SOC as follows:

ABSB		SSI-RELATED MA ELIGIBILITY DETERMINATION	
TOTAL UNEARNED INCOME:	2011.00	COUNTABLE EARNED INCOME:	.00
PARENT'S DEEMED INCOME: +	.00	COUNTABLE UNEARNED INCOME: +	1991.00
MISC. INCOME DISREGARDS: -	.00	MEDICALLY NEEDY DISREGARD: -	.00
UNEARNED INCOME DISREGARD: -	20.00	TOTAL COUNTABLE INCOME: =	1991.00
COUNTABLE UNEARNED INCOME: =	1991.00		
		INCOME STANDARD:	.00
SELF-EMP. ADJ. GROSS EARN.:	.00		
ADDITIONAL EARNED INCOME: +	.00	TOTAL COUNTABLE INCOME:	1991.00
MISC. INCOME DISREGARDS: -	.00	MNIL: -	241.00
REM. UNEARNED INC. DISREGARD: -	.00	SHARE OF COST: =	1750.00
EARNED INCOME DISREGARD: -	.00		
1/2 REMAINING DISREGARD: -	.00	MED. INSURANCE PREMIUM: -	134.00
BLIND WORK EXPENSES: -	.00	RECURRING MED. EXPENSES: -	.00
COUNTABLE EARNED INCOME: =	.00	REMAINING SOC: =	1616.00
AG HAS PASSED THE SSI-RELATED MEDICAID ELIGIBILITY DETERMINATION BUDGET			

10. The petitioner's total countable income was determined as \$1,991.00 by subtracting a \$20.00 unearned income disregard from his SSDI of \$2,011.00. The petitioner's total countable income of \$1,991.00 was then compared to the Medicaid income limit for a household size of one (\$885.00) or a married couple (\$1,191.00). The respondent determined the petitioner was ineligible for full Medicaid benefits as his income exceeded the Medicaid income limits.

11. The petitioner is disputing the December 11, 2017 and January 8, 2018 applications. On these applications, the petitioner reported SSDI between \$1,800.00 to \$1,911.00. The petitioner was not aware of being enrolled in the MN SOC. The record was left open for the respondent to submit the MN Medicaid budget. On January 22, 2018, the respondent submitted additional evidence, including the State of Florida SSA State On-Line Query. According to the State of Florida SSA State On-line Query, the petitioner was receiving SSDI of \$2,011.00. However; as of January 2018, the current amount is \$1,816.00.

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.

ADULT-RELATED MEDICAID DENIAL FOR THE PETITIONER'S WIFE ISSUE

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

Screen applications for disability related Medicaid to see if an expedited interview is necessary. Provide eligible AGs expedited services regardless of whether or not they are requested.

Individuals or families are entitled to expedited services if an AG member is:

1. under age 65 and claiming a disability; and
2. not currently receiving SSI or SSDI benefits from the Social Security Administration (SSA); ...

...

Provide the individual a copy of the Screening for Expedited Medicaid Appointments form. Inform the individual that the Department uses all recorded information to determine eligibility for an expedited interview. Provide individuals eligible for expedited services with a notice of the time and date of the scheduled interview.

Schedule an interview for an expedited applicant within three working days; conduct an interview and complete the disability packet within seven calendar days of the date of application. If the application is dropped off or mailed, contact the household by phone to tell them of the scheduled appointment, and mail a follow-up appointment notice. **If unable to reach the applicant by phone, schedule the appointment five to seven calendar days from the application date.** (emphasis added)

Provide individuals with a brochure titled Notice of Disability Information and Request Form. The brochure includes a list of the information the individual will need to bring to the interview to complete the disability forms used by the Division of Disability Determinations to determine whether the applicant is disabled. The date of the scheduled interview is the verification due date for these households. The notice/brochure will also advise the individual that failure to show for the interview or to bring the requested information to the interview may delay application processing.

15. The Policy Manual at passage 0640.0400, APPLICATION TIME STANDARDS (MSSI, SFP), explains in relevant part:

The time standard begins upon receipt of a signed application.

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

Disability/Blindness Decision:

1. Conduct an interview and complete a disability/blindness packet within seven calendar days from the application date.
2. Request a disability/blindness decision within two calendar days of receipt of appropriate information.
3. Submit the packet no more than nine calendar days following the date of application.

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

(1)(b) Time standards for processing applications vary by public assistance program in accordance with 7 C.F.R. § 273.2(g), 45 C.F.R. § 206.10(a) (3) (i) and 42 C.F.R. § 435.911. For Food Assistance and Cash Assistance Programs, time standards begin the date following the date the application was filed and end on the date the Department makes benefits available or mails a notice concerning eligibility. For the Medicaid Program, the time standard ends on the date the Department mails an eligibility notice. The Department must process and determine eligibility within the following time frames:

	Application Processing	
<u>Program:</u>		<u>Time Standards</u>
Medical Assistance and State Funded Programs for individuals who apply on the basis of disability		90 days

The Department uses information provided on the Screening for Expedited Medicaid Appointments form, CF-ES 2930, 04/2007, incorporated by reference, to expedite processing of Medicaid disability-related applications.

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later.

17. Based on the policies and authority cited above, the petitioner's application for disability related Medicaid should have been screened for an expedited interview. In this case, the respondent received an application for the petitioner through the Federally Facilitated Marketplace on November 20, 2017. According to the parties' testimony, the petitioner's address listed on this application was incorrect. On December 11, 2017, the petitioner submitted another on-line application that showed his correct address. The respondent attempted to contact the petitioner to complete the interview on December 19, 2017; after the December 11, 2017 application. The respondent caused a delay in the application process when it closed the December 11, 2017 application as a "duplicate" without reviewing the information reported on the application.

18. The petitioner submitted another application on January 8, 2018 and requested retroactive Medicaid coverage for the month of December 2017. The respondent has not completed the eligibility determination process for the January 8, 2018 application as the case is pending for the Authorization to Disclose Information form signed by the petitioner's wife. Once this information is provided by the petitioner, the respondent can forward the case to DDD to make a disability determination for the petitioner's wife.

19. After careful review of the evidence and controlling legal authorities, the undersigned concludes the respondent erred in not properly screening and reviewing the petitioner's December 11, 2017 disability related Medicaid application for expedited services. Furthermore, the undersigned concludes the respondent incorrectly disposed of the petitioner's December 11, 2017 application as a duplicate, which caused further delay in the petitioner's wife's Medicaid eligibility determination. However, since the petitioner submitted a new application on January 8, 2018, which is still being

processed, there is no better outcome the undersigned can provide to the petitioner regarding his wife's Medicaid eligibility. The respondent has not issued a notice to the petitioner regarding his January 8, 2018 application and his request for retroactive Medicaid coverage for the month of December 2017. The respondent will issue a written NOCA to the petitioner which will include appeal rights, upon completion his wife's Adult-Related Medicaid eligibility determination.

PETITIONER'S ENROLLMENT IN THE MN PROGRAM WITH A SOC ISSUE

20. Fla. Admin. Code R. 65A-1.711(1), SSI-Related Medicaid Non-Financial Eligibility Criteria, states "for MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. §416.905..."

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

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

(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...

22. The above authority explains that to be eligible for full Medicaid, income cannot exceed 88 percent of the federal poverty level for an individual (\$885.00) or a couple (\$1,191.00). The Medically Needy Program provides coverage for individuals who do not qualify for full Medicaid due to income.

23. The Code of Federal Regulations 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...”

24. 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.”

25. Fla. Admin. Code R. 65A-1.716(2), Income and Resource Criteria, states in relevant part:

Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

<u>Family Size</u>	<u>Income Level</u>
1	\$180
2	\$241

26. Pursuant to the above authority, the petitioner’s total countable income of \$1,991.00 is more than the Medicaid income limits; therefore, he is not eligible for full Medicaid.

27. The Policy Manual, Appendix A-9, SSI-Related Programs – Financial Eligibility Standards, sets forth the MEDS-AD income limits (88% FPL) as \$885.00 for an individual and \$1,191.00 for a couple. It further indicates the Medically Needy Income Level (MNIL) for a couple is \$241.00. The respondent determined the petitioner’s SOC

by using his monthly SSDI (\$2,011.00) minus the \$20.00 unearned income disregard to calculate his total countable income of \$1,991.00. The respondent then subtracted the \$241.00 MNIL and his \$134.00 Medicare premium from his \$1,991.00 total countable income, which resulted in his SOC of \$1,616.00. However, according to the State of Florida SSA State On-line Query, the petitioner's current SSDI is \$1,816.00.

28. The undersigned recalculated the petitioner's MN Medicaid budget for January 2018 and ongoing by using the petitioner's current SSDI of \$1,816.00 minus the \$20.00 unearned income disregard to calculate his total countable income of \$1,796.00 (\$1,816.00 – \$20.00). The undersigned then subtracted the \$241.00 MNIL and the \$134.00 Medicare premium from his \$1,796.00 total countable income, which resulted in a SOC of \$1,421.00.

29. The undersigned concludes the respondent erred in not utilizing the petitioner's current SSDI in the determination of his MN SOC amount. Therefore, the undersigned hereby remands this matter back to the Department to correct the petitioner's SOC from \$1,616.00 to \$1,421.00 beginning January 2018. The respondent is to issue the petitioner a new NOCA with appeal rights upon completion of the recalculation.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is partially denied and partially granted as follows:

The appeal concerning the respondent's action to deny the petitioner's wife's application for Adult-Related Medicaid benefits is dismissed as not ripe for review. The petitioner's January 8, 2018 application is pending.

The appeal concerning the petitioner's MN SOC is granted. The respondent is ordered to take corrective action and revise the petitioner's MN SOC amount as specified in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 24 day of January , 2018,

in Tallahassee, Florida.



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

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

Feb 22, 2018

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-01243

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 08 Alachua
UNIT: 88778

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on February 20, 2018 at 10:54 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Shirley-Ann Rhule, economic self-sufficiency supervisor

STATEMENT OF ISSUE

At issue is the respondent's decision denying the petitioner's application for SSI-Related Medicaid due to assets in excess of program limitations. The petitioner holds the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

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

By notice dated February 9, 2018, the Department informed the petitioner his application for SSI-Related Medicaid was denied due to assets in excess of program limitations.

Pursuant to 42 C.F.R. § 431.224(a)(1), “the agency must establish and maintain an expedited fair hearing process for individuals to request an expedited fair hearing, if the agency determines that the time otherwise permitted for a hearing under § 431.244(f)(1) could jeopardize the individual’s life, health or ability to attain, maintain, or regain maximum function.” The petitioner filed an expedited Medicaid hearing request on February 14, 2018. The petitioner’s expedited hearing request was granted on February 16, 2018 and pursuant to notice by telephone and e-mail, the hearing convened February 20, 2018 at approximately 10:54 a.m.

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

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

The record was held open until the morning of February 21, 2018 for the submission of additional evidence from the Department. Evidence was received and admitted as Respondent’s Exhibit 2. The record was closed on February 21, 2018.

FINDINGS OF FACT

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

1. Prior to the action under appeal, the petitioner (age 55) was a self-employed [REDACTED]. The petitioner earned \$600 - \$800 monthly. Through the Affordable Care Act, the petitioner had third party health insurance coverage with [REDACTED] Company; the petitioner received an employment tax credit which resulted in him paying a monthly health insurance premium of \$37. The petitioner's assets included a checking and savings account with Bank of America, combined balances totaled approximately \$8,000. He also owned a certificate of deposit (CD) valued at approximately \$5,000. (Testimony of [REDACTED])

2. The petitioner became seriously ill in July 2017 and was no longer able to work. In August 2017, he was diagnosed with [REDACTED] and began [REDACTED] treatment. Throughout the remainder of 2017, unable to work, the petitioner cashed in his CD and began using the funds in his banking accounts to pay his monthly expenses (rent, utilities, child support, IRS debt, etc.) (Testimony of [REDACTED])

3. The employment tax credit the petitioner received for his health insurance was terminated in December 2017 because he was no longer working. His monthly premium increased from \$37 to approximately \$600. The petitioner could not afford the premium and stopped making payment in December 2017. At the time of the hearing, the petitioner was not sure if the policy with [REDACTED] had expired. (Testimony of [REDACTED])

4. The petitioner was determined disabled by the Social Security Administration (SSA) in late 2017 and began receiving SSDI in November 2017. Child support and other expenses are deducted from the benefit amount prior to receipt of income by the

petitioner. The petitioner receives approximately \$300 monthly net SSDI. (Testimony of [REDACTED])

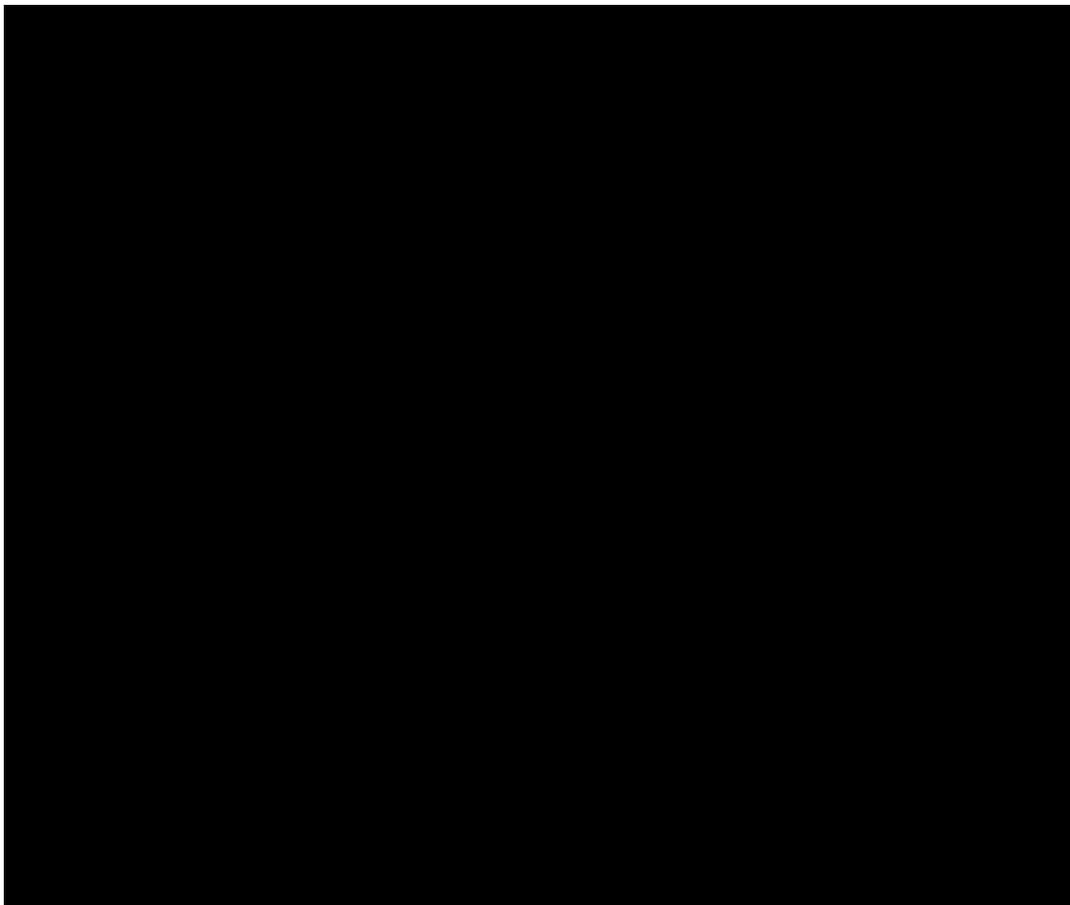
5. The petitioner, a single adult, filed an application for SSI-Related Medicaid with the Department on February 8, 2018 in order to continue his [REDACTED] treatments. (Testimony of [REDACTED])

6. The Department accessed an asset verification system which showed the petitioner had multiple bank accounts with Bank of America. The Department determined that the petitioner had three active accounts, two checking and one savings, which contained a combined balance of \$5,375.31. The SSI-Related Medicaid asset limit for an individual is \$5000. The Department concluded that the petitioner's countable asset value exceed program limitations and denied his application in a notice dated February 8, 2018. (Respondent Exhibit 1 and Shirley-Ann Rhule testimony)

7. The petitioner filed an expedited Medicaid hearing request on February 14, 2018 which asserted he required a decision in this matter immediately in order to resume [REDACTED] treatment. Without treatment, his life was in jeopardy. (Respondent's Exhibit 1)

8. The petitioner's son asserted that he has one checking and one savings account with Bank of America, not three accounts, and at the time of application, the combined balance of the accounts was below \$5,000 because the petitioner had been using those funds to pay his living expenses since he stopped working in July 2017. (Testimony of [REDACTED])

9. Upon re-review of the documentation it obtained from the asset verification system, the Department asserted that it had mistakenly counted one of the petitioner's banking accounts twice, in error. After correcting its error, the Department asserted that the petitioner's countable assets at the time of application did not exceed \$5000. The Department reversed its denial decision on the record. After the hearing, the Department provided an e-mail and screen shots from its Medicaid eligibility system which showed that it had approved SSI-Related Medicaid benefits for the petitioner effective February 1, 2018. The Department's e-mail reads: "After further review [petitioner] will full [sic] Medicaid, will be effective 02/201/2018 [sic]." The Medicaid eligibility screen prints show SSI-Related Medicaid benefits have been approved for the petitioner effective February 1, 2018:



CONCLUSIONS OF LAW

10. Pursuant to Section 409.285, Florida Statutes, the Department of Children and Families' Office of Appeal Hearings has jurisdiction over this proceeding.

11. This order is the final administrative decision of the Department of Children and Families pursuant to Section 409.285(2), Florida Statutes.

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

13. The Department denied the petitioner's application for SSI-Related Medicaid due to assets in excess of program limitations. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner. The standard of proof to be met for fair hearings is by a preponderance of the evidence.

14. Upon reconsideration, the Department reversed its denial decision and approved full coverage SSI-Related Medicaid benefits for the petitioner back to the date of the adverse action. The undersigned could order no more advantageous outcome in this matter. Therefore, the appeal is dismissed as moot.

DECISION

The appeal is dismissed as explained in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

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

funds to assist in this review.

DONE and ORDERED this 22 day of February, 2018,
in Tallahassee, Florida.



Leslie Green
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