

Jun 04, 2018

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

APPEAL NO. 18F-02044

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 in the above-referenced matter on April 25, 2018 at 11:34 a.m. All parties appeared telephonically from different locations.

APPEARANCESFor the Petitioner: , pro seFor 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 full Medicaid and enroll him in the Medically Needy (MN) program with an \$818 Share of Cost (SOC). The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted no exhibits. The respondent submitted a 23-page evidence packet, which was marked and entered as Respondent's Exhibits "1" through "8". The record was closed the same day.

On May 1, 2018, the undersigned issued an "Order Requesting Information" with a due date of May 10, 2018, requesting additional information including all Medicaid applications for the petitioner between December 1, 2017 and March 13, 2018, all Notices of Case Action (NOCA) related to the applications, and the Running Record Comments (CLRC) for the period of November 1, 2017 through March 30, 2018.

On May 11, 2018, the respondent submitted an additional 19-page evidence packet, including the application dated December 29, 2017 and the CLRC. The NOCAs provided were previously entered into evidence. The new information was marked and entered as Respondent's Exhibits "9" and "10". The record was closed the same day.

FINDINGS OF FACT

1. On November 22, 2017, prior to the action under appeal, the respondent mailed the petitioner a Notice of Case Action (NOCA) informing him his MN SOC would increase from \$818 to \$838 effective January 1, 2018 (Respondent's Exhibit 4).
2. On December 29, 2018, the petitioner submitted a web application requesting Supplemental Nutrition Assistance Program (SNAP) benefits and Medicaid. Medicaid is the only benefit at issue (Respondent's Exhibit 9).
3. Effective January 1, 2018, the petitioner's Social Security Retirement (SSRE) income increased from \$1,018 per month to \$1,038 per month (Respondent's Exhibit 5).

4. On January 19, 2018, the respondent mailed the petitioner a NOCA informing the petitioner he was enrolled in the MN program effective with an estimated SOC of \$818 for the month of December 2017 (Respondent's Exhibit 3).
5. On March 13, 2018, the petitioner contacted the Customer Call Center (CCC) to inquire about his Medicaid. The agent explained he was over the income limit for full Medicaid, providing the income limits (Respondent's Exhibit 10).
6. The petitioner timely requested the appeal.
7. On March 14, 2018, the petitioner ([REDACTED]) submitted an electronic web application to the respondent requesting SNAP benefits and SSI-Related Medicaid for himself, the only household member (Respondent's Exhibit 1).
8. The petitioner does not receive Medicare Part A and B (Respondent's Exhibit 5).
9. The petitioner's income of \$1,038 SSRE is over the income limit for full Medicaid of \$891 (Respondent's Exhibit 7).
10. The respondent evaluated the petitioner for MN with a SOC. The respondent determined the petitioner's SOC budget as follows (Respondent's Exhibit 6):

\$1,038	unearned income
- 20	unearned income disregard
<hr/>	<hr/>
\$1,018	countable unearned income
- 180	Medically Needy Income Limit for household of one
<hr/>	<hr/>
\$ 838	SOC

11. On March 15, 2018, the respondent mailed the petitioner a NOCA informing the petitioner his MN has been reviewed and he was eligible for continued Medicaid coverage (Respondent's Exhibit 2).

12. The petitioner believes he should be eligible for full Medicaid based on information shared with him at the Social Security Administration (SSA) office. He claims he was informed because he was fully disabled, he would still be eligible for full Medicaid after switching from Supplemental Security Income (SSI) to SSRE income.

13. The respondent states all Medicaid coverage is based on income limits.

14. During the hearing, the petitioner reported that he has a prescription that costs him approximately \$16 per day.

15. The respondent states only insurance premiums paid can be used to lessen the SOC amount.

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.

Full Medicaid will be address

19. The department determines Medicaid eligibility based on the household circumstances. When the household consists of parents and children, Medicaid eligibility is determined under Family-Related Medicaid policy. When the household consists of an elderly or disabled individual or couple, Medicaid eligibility is determined under Adult-Related Medicaid policy (also referred to as SSI-Related Medicaid or

Medically Needy). Medicaid eligibility is based on federal regulations. The petitioner was evaluated under the SSI-Related Medicaid coverage group.

20. Fla. Admin. Code R. 65A-1.701 Definitions, states in the pertinent 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.

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

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

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

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

(3) When Income Is Considered Available for Budgeting. The department counts income when it is received, when it is credited to the individual's account...

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied... When averaging income, all income from the most recent consecutive four weeks shall be used if it is representative of future earnings. A longer period of past time may be used if necessary to provide a more accurate indication of anticipated fluctuations in future income.

22. Effective January 1, 2018, the Department's Policy Manual (The Policy Manual), CFOP 165-22 at Appendix A-9, sets forth 88% of the federal poverty level (FPL) for a household of one as \$885.

23. Effective April 1, 2018, the Policy Manual at Appendix A-9, shows 88% of the FPL for a household of one as \$891.

24. In accordance with the above authority and the Policy Manual, the respondent included the petitioner's SSRE income to determine the total household income. The be eligible for full Medicaid, the petitioner's income cannot exceed 88% of the FPL and the petitioner cannot be receiving Medicare.

25. In this instant case, the petitioner is not receiving Medicare Part A & B, however, the petitioner's total countable income of \$1,038 exceeds the \$885 FPL for a household of one effective January 1, 2018; therefore, he is not eligible for full Medicaid.

26. Effective April 1, 2018, the petitioner's total countable income of \$1,038 exceeds the \$891 FPL for a household of one. Therefore, he is not eligible for full Medicaid.

27. The undersigned concludes Medically Needy must be explored.

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

28. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage group 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."

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

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

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

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

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

32. 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..."

33. Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at \$180 for a family size of one.

34. In accordance with the authorities cited above, the respondent deducted \$20 unearned income and \$180 MNIL from the petitioner's \$1,038 total countable income to arrive at \$838 SOC.

35. 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.

36. 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 the MN program with a \$838 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 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 04 day of June, 2018,

in Tallahassee, Florida.



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

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

FILED

May 14, 2018

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

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NOs 18F-02117
18F-02720

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11, Dade
UNIT: 88674

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 4th, 2018 at 11:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Joseph Austrie, Operational Management Consultant for the Economic Self-Sufficiency (ESS) program

STATEMENT OF ISSUE

The petitioner is appealing the benefit level in the Supplemental Nutrition Assistance Program (SNAP) (Appeal number 18F-02117). The petitioner carries the burden of proof by a preponderance of the evidence.

The petitioner is also appealing the respondent's action to terminate her Medicaid coverage and assign a share of cost (appeal number 18F-02720). The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents for the hearing.

Respondents exhibits 1 through 6 were admitted into evidence.

The record was held open until the close of business April 11th, 2018 to allow both parties to submit additional documents. One document was received from the petitioner and admitted into evidence as Petitioner's exhibit 1. Three documents were received from the respondent and admitted into evidence as Respondent's exhibit 7 through 8. All documents were received within the allotted time frame, and the record was then closed.

By way of Notice of Case Action (NOCA) dated February 20th, 2018, the respondent informed the petitioner that her application for Food Assistance dated February 19th, 2018 was approved in the monthly amount of \$13 effective March 2018. The same notice informs the petitioner that her husband, [REDACTED], would continue to be enrolled in the Medically Needy program, and that his share of cost (SOC) would increase from \$766 to \$1,445 effective April 1st, 2018.

By way of a separate NOCA, also dated February 20th, 2018, the respondent informed the petitioner that her application for Medically Needy dated February 19th, 2018 was approved with an assigned SOC of \$1,445 effective April 1st, 2018.

6. To determine the amount of SNAP benefits for March 2018, the respondent used the petitioner's gross Social Security Income of \$667 and added her husband's gross SSDI of \$1,039 resulting in \$1,706 as the household's total gross income. The petitioner agreed that these figures were correct. The respondent determined the petitioner's eligibility for SNAP follows:

\$1,1706.00	(total gross income)
<u>0.00</u>	(earned income standard)
\$1,706.00	
- <u>160.00</u>	(standard disregard for assistance group (AG) of 2)
\$1,546.00	
- 0.00	(excess medical expenses disregard)
- 0.00	(dependent care disregard)
- 0.00	(child support deduction)
- <u>0.00</u>	(homeless income deduction)
\$1,546.00	(interim net adjusted income)
\$850.00	(shelter cost)
+ <u>347.00</u>	(standard utility allowance [SUA])
\$1197.00	(total shelter costs)
- <u>773.00</u>	(50% of interim net adjusted income)
\$424.00	(excess shelter costs disregard)
\$1,546.00	(interim net adjusted income)
- <u>424.00</u>	(excess shelter costs disregard)
\$1122.00	(final net adjusted income)
X <u>30.0%</u>	
\$337.00	(benefit reduction rounded up)
\$352.00	(maximum allotment for AG of 2)
- <u>337.00</u>	(benefit reduction)
\$15.00	(ongoing monthly allotment)

7. Notably, the NOCA issued on February 20th, 2018, informed the petitioner that she would be eligible for \$13. However, the undisputed testimony is that the petitioner

received \$15. The respondent did not submit its SNAP budget for March 2018 into evidence. Therefore, the reason for the discrepancy is unclear.

8. The respondent asserted that the petitioner's FA benefits decreased as a result of her Social Security income of \$667 now being counted in the FA budget & that the \$5 effective April were due to a recoupment by the respondent's Benefit Recovery program. The respondent explained that other expenses the petitioner had mentioned were not expenses considered in the SNAP budgeting determination.

9. The petitioner did not dispute the income and expenses. She asserts as follows: that both she and her husband are disabled; that she has no money left for food after paying all her bills; that she has to pay for her son's eye drops due to a medical condition; that she was trying to see if she could get more Food Assistance so that she doesn't have to go to different food places to try to get food or get assistance from family members.

10. Prior to enrollment in the Medically Needy program, the petitioner had full Medicaid. At recertification, she reported receipt of \$667 per month from Social Security and was enrolled in the Medically Needy (MN) Program with an estimated SOC of \$1,445 effective April 2018.

11. The petitioner is seeking full Medicaid. She states that those enrolled in Medically Needy are not viewed as Medicaid eligible by any third party provider prior to having medical bills tracked.

12. The respondent explained that she was not eligible for Medicaid because of her income. The budget for SSI full Medicaid is as follows: \$1,706 (combined income of

the petitioner & spouse) was reduced by a \$20 standard income disregard which gave her \$1,686 total countable unearned income. This was compared to \$1,208 maximum income for two persons, which exceeded the income limit and made her ineligible for full Medicaid and enrolled her in MN.

13. The budget for Medically Needy Program: \$1,706 (combined income of the petitioner & spouse) was reduced by a \$20 standard income disregard, followed by a \$241 Medically Needy Income Level (MNIL) deduction for two persons resulting in the final estimated SOC to be \$1,445. No Medicare premiums nor medical expenses for petitioner or spouse were considered. The petitioner's son's medical expenses were not allowed.

14. The respondent explained how the share of cost was determined and how it could be met.

15. The petitioner did not dispute the income amount used by the respondent in the eligibility process. The petitioner however, stated that she has serious health issues that require constant monitoring, and she needs transportation to receive her medical care. The petitioner also stated that her doctors don't accept SOC as Medicaid, and that her SOC is too high. The petitioner also contends that she cannot afford that much monthly expense on a fixed income. The petitioner argued after paying for her household expenses, she has no money left and cannot afford any deductibles. She is seeking full Medicaid so that she can get the medical care she needs.

16. The petitioner also argued that she had received a letter from the respondent telling her that she was eligible for Medicaid, which she provided. See Petitioner's'

Exhibit 1 which states “The application you filed for SSI is also an application for Medicaid...Although you were denied SSI payments, you may still be eligible for Medicaid. Call the ACCESS Florida Customer Call Center toll free at 1-866-762-2237 within 30 days if you would like us to determine eligibility for Medicaid.”

CONCLUSIONS OF LAW

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

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

The undersigned will first address the SNAP issue (appeal number 18F-2117.)

18. Federal regulation 7 C.F.R. § 273.9 addresses income/allowable deductions budgeting in the SNAP in part and states as follows:

(a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet. Households which contain an elderly or disabled member shall meet the net income eligibility standards for the Food Stamp Program. Households which do not contain an elderly or disabled member shall meet both the net income eligibility standards and the gross income eligibility standards for the Food Stamp Program. Households which are categorically eligible as defined in §273.2(j)(2) or 273.2(j)(4) do not have to meet either the gross or net income eligibility standards. The net and gross income eligibility standards shall be based on the Federal income

poverty levels established as provided in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)).

(b) Definition of income. Household income shall mean all income from whatever source 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; strike benefits;...

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

(1) Standard deduction—

(2) Earned income deduction.

(3) Excess medical deduction. That portion of medical expenses in excess of \$35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in §271.2...

(4) Dependent care.

(5) Optional child support deduction.

(6) Shelter costs—

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

(A) Continuing charges for the shelter occupied by the household, including rent,

(iii) Standard utility allowances...

(A) With FNS approval, a State agency may develop the following standard utility allowances (standards) to be used in place of actual costs in determining a household's excess shelter deduction.

19. The respondent must follow these federal budgeting guidelines when determining eligibility. The SNAP budgeting process involved deducting a standard deduction as well as an excess medical expenses disregard. Rent or mortgage is an allowable deduction as well as a standard deduction for utilities.

20. 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).

...

(C) Subtract the standard deduction.

(D) If the household is entitled to an excess medical deduction as provided in Sec. 273.9(d)(3), determine if total medical expenses exceed \$35. If so, subtract that portion which exceeds \$35.

...

(H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.

(I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net income subtracted. The household's net monthly income has been determined.

21. The SNAP standards for income and deductions appear in the respondent'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 \$1,354, and the standard deduction is \$160. The maximum SNAP benefit for a household size of two is \$352 and the Standard Utility Allowance is \$347.

22. The above-cited regulation describes the eligibility process and defines deductions and shows the steps in determining net income. The petitioner was credited with a standard deduction, had no medical deduction and excess shelter deduction from her household's gross income to determine her net income. The undersigned reviewed the respondent's calculations established in the Findings of Fact and found no errors.

23. After considering the evidence, testimony, and the appropriate authorities cited above, the hearing officer concludes that the petitioner is entitled to \$15 monthly, which neither party disputes is the amount that the petitioner has received.

The undersigned will now address the Medically Needy issue (appeal number 18F-2720.)

24. 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.

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

26. 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...

27. 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 (\$1208 for couple).

28. 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..."

29. The above-cited rules explain the budgeting procedure to determine the share of cost. The petitioner's SS income and her spouse's SSDI of \$1,706 is reduced by a standard deduction (\$20) to arrive at \$1,686 as countable income.

30. 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 April 1 2018, the limit for a couple is \$1,208. The Department determined Petitioner's countable income after all deductions to be \$1,686 during the application at issue. Petitioner's countable income is over the \$1,208 income limit. She was then evaluated for the Medically Needy Program.

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

32. 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.

33. 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.

34. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the MNIL for a couple at \$241.

35. Since Petitioner was not eligible for full Medicaid, the department proceeded to explore further Medicaid eligibility by deducting the \$241 Medically Needy Income Level deduction for two from her resulting income. After these deductions, the share of cost was determined to be \$1,686.

36. 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. Therefore, the undersigned concludes that the petitioner has failed to meet her burden that she was eligible for full Medicaid or a lower share of cost.

DECISION

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

DONE and ORDERED this 14 day of May , 2016,

in Tallahassee, Florida.



Alma Patino
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

Jun 05, 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-02130

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pasco
UNIT: 88326

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 11, 2018 at 3:06 p.m.

APPEARANCES

For the Petitioner: [REDACTED], mother

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

STATEMENT OF ISSUE

The petitioner is appealing the denial of his application for SSI-Related Medicaid. The petitioner holds the burden of proof at the level of preponderance of the evidence.

PRELIMINARY STATEMENT

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

By notice dated March 14, 2018, the Department informed the petitioner that his application for SSI-Related Medicaid was denied. The notice reads in relevant part, “[y]ou...do not meet the disability requirement.”

On March 14, 2018, the petitioner timely requested a hearing to challenge the Department’s decision.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

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

The hearing record was closed on May 11, 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 and his mother were eligible for full coverage Family-Related Medicaid. The petitioner’s mother began working early 2017; her income exceeded the \$241 income limit for full coverage Family-Related Medicaid for a household size 2. The household was converted from full coverage Medicaid to transitional Medicaid. Transitional Medicaid allows a household 12 additional months of Medicaid after it loses eligibility due to earned income in order to “transition” to another form of medical coverage. The petitioner and his mother received transitional Medicaid coverage April 2017 – March 2018. (Department testimony)

2. Nearing the end of his transitional Medicaid coverage, the petitioner (age 19) applied for SSI-Related Medicaid on February 23, 2018. The petitioner is single; he lives in the family home with his mother. The petitioner asserted that he is disabled due to [REDACTED]

[REDACTED] (Testimony of petitioner's mother)

3. To be eligible for SSI-Related Medicaid, an applicant must be age 65 or older or be determined disabled by the Social Security Administration or the Department. The Department contracts with the Division of Disability Determination (DDD) to make disability determinations for its SSI-Related Medicaid applicants under age 65. The Department referred the petitioner's case to DDD in March 2018 for a disability review. DDD issued a denial decision on March 15, 2018; DDD informed the Department that it did not make an independent disability determination in the instant case because the Social Security Administration concluded in April 2017 that the petitioner's impairments were not severe enough to prevent him from engaging in some type of work in the national economy. (Department testimony)

4. On March 15, 2018, the Department denied the petitioner's Medicaid SSI-Related Medicaid application due to not meeting the disability requirement. The Department explained that it is required to adopt SSA disability decisions made within the last 12 months, unless there is a new disabling condition not reviewed by SSA. The Department was required to adopt SSA's decision regarding the petitioner's disability status through March 31, 2018. The petitioner did not allege a new disabling condition. (Department testimony)

5. The Department explored the petitioner’s eligibility for Medicaid under other categories. The Department’s Family-Related Medicaid Program includes coverage for young adults ages 18 - 21 who live in the family home. The household’s monthly income (mother’s wages) of \$1,713.62 exceeded the \$241 income limit (for a household size 2) for full coverage Medicaid in the 18 - 21 year old category. The Department enrolled the petitioner in the program’s share of cost option. The Department’s budget computation was as follows:

CASE:	██████████	CAT: NO Y	SEQ: 1	████████████████████
BEGIN:	05/01/2018	END:	STAT	████████████████████
EARNED INCOME:+	1713.62	SFU SIZE:	2	
UNEARNED INCOME:+	.00	INCOME STANDARD:	.00	
TOTAL REPORTED INCOME:=	1713.62	MNIL:-	387.00	
ALLOWABLE TAX DEDUCTIONS:-	.00	SHARE OF COST:=	1326.00	
MODIFIED ADJUSTED GROSS INC:=	1713.62	MED INSURANCE PREMIUM:-	.00	
STANDARD DISREGARD:-	.00	RECURRING MED EXPENSE:-	.00	
MAGI DISREGARD(5% OF FPL):-	.00	REMAINING SOC:=	1326.00	
COUNTABLE NET INCOME:=	1713.62	COUNT OF OOTHs:	0	

Individuals enrolled in the Medically Needy program must meet a share of cost (a deductible which consists of allowable medical expenses incurred by the assistance group) each month in order to be eligible for Medicaid. The petitioner’s monthly share of cost is \$1,326. (Respondent Exhibit 1 and Department testimony)

6. The petitioner’s mother stipulated that SSA denied the petitioner’s disability application in April 2017. The household filed an appeal with SSA. The appeal was still pending at the time of the hearing. The petitioner’s mother argued that he has severe

developmental and behaviors issues which render him unable to engage in any type of work in the national economy. The petitioner's mother asserted that he spends most days "staring at a wall." She disagrees with SSA's decision that he is capable of working; however, she did not allege that the petitioner had a new disabling condition not reviewed by SSA. (Testimony of petitioner's mother)

7. The petitioner's mother noted that the household is only appealing the Department's decision that he is not eligible for SSI-Related Medicaid. She did not dispute the accuracy of the income and deduction figures used in the Department's Family-Related Medicaid budget computation. She noted that household expenses are such that she cannot afford to pay out of pocket for the medical care necessary to address the petitioner's several developmental and behavioral issues. She asserted that the share of cost option is not useful for their household. (Testimony of petitioner's mother)

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. The petitioner appealed the Department's decision that he is not eligible for SSI-Related Medicaid. Only that issue will be addressed in this final order.

11. Fla. Admin. Code R. 65A-1.711 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. For an individual less than 65 years of age to receive SSI-Related Medicaid benefits, he or she must meet the disability 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.

12. Federal Regulation at 42 C.F.R. § 435.541 provides standards for state disability determinations 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.

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

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the

determination, except in cases specified in paragraph (c) (4) of this section.

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

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

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and-

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

...

13. On March 15, 2018, the Department denied the petitioner's application for SSI-Related Medicaid. The Department adopted SSA's April 2017 decision which concluded that the petitioner was not disabled because his impairments were not severe enough to prevent him from engaging in some type of work in the national economy.

14. The controlling legal authorities prevent the Department from making an independent disability determination within 12 months of an adverse SSA decision

unless the applicant alleges a new disabling condition not reviewed by SSA. The petitioner did not argue, and there is no evidence of, a new disabling condition not reviewed by SSA. Therefore, the Department's decision in this matter was correct.

DECISION

Based on 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 05 day of June, 2018,

in Tallahassee, Florida.



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

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

FINAL ORDER (Cont.)

18F-02130

PAGE - 9

May 24, 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. 18F-02175

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 12DDD

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 17, 2018, at 9:02 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Ernestine Bethune, DCF Economic Self-sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether Respondent's action denying Petitioner's Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that he does not meet the disability criteria is correct. Petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On March 16, 2018, Petitioner filed an appeal challenging the denial of his Medicaid application.

During the hearing, Petitioner did not submit any exhibits for the undersigned to consider. Respondent submitted seven (7) exhibits which were marked as Respondent's Exhibits "1" through "7" respectively.

The record was left open through end of business day for Respondent to provide additional information and extended through April 19, 2018 for Petitioner to provide information related to the Social Security Disability issue. Respondent's evidence was timely received and marked as Respondent's Exhibits 8 and 9. Petitioner's evidence was timely received and marked as Petitioner's Composite Exhibit 1. The record was closed on April 19, 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. On December 12, 2016, Petitioner was diagnosed with a [REDACTED]. On December 14, 2016, he applied for Social Security disability (SSD) with the Social Security Administration (SSA) alleging he is disabled.
2. On February 9, 2017, SSA denied Petitioner's application on the contention that the he has the "capacity for substantial gainful activity (SGA) -(customary past work, no visual impairment)" N 31.

3. On December 05, 2017, Petitioner requested an appeal challenging the SSA's decision, see Respondent's Exhibit 9. Petitioner has retained legal representation to assist with his appeal.
4. Petitioner [REDACTED] is [REDACTED]. He is not currently employed. He does not meet the aged criteria for SSI-Related Medicaid benefits. He has no minor children residing with him and does meet the technical requirement for the Family-Related Medicaid category. Petitioner is not blind. Disability must be established as part of his Medicaid eligibility determination.
5. The Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid programs. To be eligible, an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility. Once a disability review is completed, the case file is returned to DCF for a final determination of eligibility and effectuation of any benefits due.
6. On January 8, 2018, Petitioner applied for Medicaid benefits for himself through the Department's Family-Related and SSI-Related Medicaid Programs.
7. On February 5, 2018, Respondent sent Petitioner a Notice of Case Action informing him that his Medicaid benefits were denied because he did not meet the disability requirement, see Respondent's Exhibit 1. The Department did not initiate a disability review.
8. On February 26, 2018, information obtained from Petitioner was forwarded to DDD for review. On March 12, 2018, Respondent received an alert that the physical file was not received. The packet was sent to DDD that same day. DDD received

Petitioner's disability package from the Department for a disability review. The DDD has access to Social Security information. Case notes from the DDD Transmittal indicate Petitioner's medical condition to be [REDACTED] DDD determined this medical condition was already known and considered by SSA and will be addressed in the course of his appeal before an administrative law judge (ALJ).

9. On March 15, 2018, DDD denied Petitioner's claim of disability by adopting the 2017 SSA denial citing, "same/related allegations, hearing pending". The denial reason code was N 31. DDD did not make an independent determination, see Respondent's Exhibits 4 through 6 and 8.

10. Respondent explained that it denied Petitioner's SSI-Related Medicaid application because SSA has determined that he was not disabled and DDD has adopted the decision. She explained that the SSA decision is binding and must be accepted by the Department as final. She further explained that once DDD determined that Petitioner is not disabled, the Department has to deny his Medicaid for not meeting the technical requirement for the SSI-Related Medicaid Program for persons under age 65.

11. Petitioner's asserts as follows: (1) that he has a [REDACTED] and [REDACTED], (2) that his [REDACTED] has become cantaloupe size causing him to be grossly disfigured and cannot wear normal clothing, (3) that present medical conditions require multiple surgeries and extensive repair, (4) that the [REDACTED] would be a separate operation done by urologists and may require months of healing and recuperation, and (4) that he is bed ridden 99% of the time or in a recliner to keep gravity from affecting his condition.

12. Petitioner Composite Exhibit 1 indicates Petitioner received care at [REDACTED] on December 12, 2016. He was diagnosed with [REDACTED] and was advised by [REDACTED], to stay out of work. It also contains multiple medical opinions regarding Petitioner's present medical condition and his possible course of treatment.

13. As of the day of the hearing, Petitioner's hearing date with SSA is still pending. Petitioner is not claiming a new condition. He believes he should be found disabled based on his current medical status. He is seeking Medicaid coverage to get the necessary surgeries needed and the associated treatment to better his life.

CONCLUSIONS OF LAW

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

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

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

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s)

that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy.

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

18. Federal Regulations at 42 C.F.R. § 435.541 “Determination of Disability,” states:

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

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

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

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

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

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

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

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

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

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

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

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

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

19. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22

at passage 1440.1204 "Blindness/Disability Determinations (MSSI, SFP) states:

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

20. The Policy Manual at passage 1440.1205 Exceptions to State Determination of Disability (MSSI, SFP) states:

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

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization.
5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).
6. When the individual files an application within 12 months after the last unfavorable disability determination by SSA, and the individual alleges no new disabling condition or claims a deterioration of an existing condition previously considered by SSA. Refer the individual to SSA for disability reconsideration or appeal. Only request a disability decision from DDD if:
 - a. SSA refuses (or has already refused) to reconsider the unfavorable disability decision, or
 - b. the applicant no longer meets SSI non-disability criteria such as income or assets.

The eligibility specialist must explore eligibility for Medicaid for the individual based on other coverage criteria, e.g., family-related coverage prior to exploring eligibility for disability-related Medicaid.

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, a worsening and deteriorating of conditions is referred to the SSA. In this instant case, SSA has determined that Petitioner's conditions were not severe enough to prevent him from engaging in substantially gainful activities. DDD received Petitioner's disability packet and concluded that it contained the "same/related

allegations” already considered by SSA. On March 15, 2018, DDD adopted the SSA decision and alerted the Department that Petitioner was not disabled.

22. The evidence shows Petitioner was denied for SSA disability in February 2017. Petitioner did not claim any new condition not previously considered by SSA. The SSA case is presently under appeal at the ALJ level. Under these circumstances, the controlling authorities preclude the Department from rendering an independent disability determination.

23. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department’s action to deny Petitioner Medicaid under the SSI-Related Medicaid coverage group is correct.

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

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

May 14, 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-02181

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 10, 2018 at 9:38 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Sheila Rushing, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of February 23, 2018 denying her application for SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

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

The record was closed on May 10, 2018.

FINDINGS OF FACT

1. The petitioner filed an application for Medicaid on January 5, 2018. The petitioner indicated on her application that her date of birth is [REDACTED]. The application indicates this is a single person household with no minor children listed in the household. (Respondent's Exhibit 1, pages 3 through 6)
2. The Department determined as the petitioner had no minor children in her home and she was under age 65, her disability had to be established in order to receive Medicaid.
3. The Department submitted the petitioner's case to the Division of Disability Determinations (DDD) on January 19, 2018 for the determination of disability to be completed. (Respondent's Exhibit 1, page 16)
4. DDD responded to the Department's Disability Determination and Transmittal on February 22, 2018. DDD denied the petitioner's disability citing a previous disability denial of N32 by SSA, which is known as a "Hankerson" decision. (Respondent's Exhibit 1, page 120)
5. The petitioner reports that her conditions are [REDACTED], [REDACTED]. The petitioner reported all conditions have been reported to the Social Security Administration. The petitioner stated she has no new conditions since her application for SSI.
6. The Department issued a Notice of Case Action on February 23, 2018 informing the petitioner that her application for Medicaid was denied as "you or a member of your household do not meet the eligibility requirement". (Respondent Exhibit 1, pages 7 through 10)

7. The Department reviewed a data match with the Social Security administration which shows the petitioner was denied Supplemental Security Income (SSI) on March 8, 2018 with a reason code N32. The data match also reveals the petitioner appealed the SSI denial on March 13, 2018. (Respondent's Exhibit 1, page 17) The Department explained the reason code N32 means "non-pay; capacity for substantial gainful activity, no visual impairment".

8. The petitioner reported she received a letter dated April 30, 2018 showing her SSI appeal was denied. She has since retained an attorney to assist her with that appeal but could not identify the exact date of filing the appeal.

CONCLUSIONS OF LAW

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

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

11. 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.

12. 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.

13. 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).

14. 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.)

15. 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)

16. The undersigned explored potential eligibility for SSI-Related Medicaid for the petitioner. The findings show the petitioner was 37 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, she must meet the disability requirement for eligibility for SSI-Related Medicaid.

17. The findings show the petitioner applied for Social Security disability and was denied on March 8, 2018 and April 30, 2018. The findings show the petitioner has filed a new appeal of the second denial. 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 April 30, 2018 denial.

18. 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 14 day of May, 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

FILED

May 17, 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-02225

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 14 Bay
UNIT: 886DD

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 9, 2018 at 10:47 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Sheila Rushing, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of April 12, 2018 denying his application for SSI-Related Medicaid due to exceeding the asset limitation. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence on April 19, 2018. This was entered as Respondent's Exhibit 1.

The record closed on May 9, 2018.

FINDINGS OF FACT

1. The petitioner filed an application for SSI-Related Medicaid on March 12, 2018. The household consisted of the petitioner only. The petitioner was [REDACTED] years old at the time of application. The petitioner indicated on the application that he was not established as disabled. The petitioner acknowledged that the Social Security Administration denied his disability claim on November 20, 2017. The petitioner indicated he has appealed that decision. The petitioner reported no income in his home. The petitioner reported he had \$13,800 in a checking account and \$6,000 in a savings account. (Respondent's Exhibit 1, pages 3 through 7)

2. The Department issued a Notice of Case Action on March 13, 2018 to the petitioner requesting verification of his assets, specifically bank account balances. (Respondent's Exhibit 1, pages 12 through 14)

3. The Department issued a Notice of Case Action on April 12, 2018 informing the petitioner that his application for Medically Needy was denied as "the value of your assets is too high for this program". (Respondent's Exhibit 1, pages 8 through 11)

4. The Department recorded in the case notes on April 9, 2018 a conversation with the petitioner. The petitioner reported at that time he still had about \$10,000 in his checking account and \$6,000 in his savings account. (Respondent's Exhibit 1, page 15)

5. The Department explained the asset limit to receive SSI-Related Medicaid as an individual is \$5,000.

6. The Department did not submit the petitioner's application to the Division of Disability Determinations for a disability decision as the petitioner's assets exceeded the limitation.

7. The Department provided the Document Details screen for the petitioner's case. This screen indicates the petitioner has not submitted any verification of his bank account balances to the Department. (Respondent's Exhibit 11, page 23)

8. The petitioner explained he is presently using the money he has saved to live on right now. He explained his checking account balance is approximately \$9,800 and savings account balance is still \$6,000.

9. The petitioner explained he did apply for Social Security disability in August 2017. He has been denied twice since his original application. The petitioner has appealed the most recent denial and is awaiting a hearing date on that denial. The petitioner did not recall the reason that his Social Security disability application was denied.

10. The Department explained that a decision made by the Social Security office as relates to an individual's disability is binding on the Department for a year unless the petitioner reports a new or worsened condition that Social Security will not review.

11. The petitioner stated he has [REDACTED] [REDACTED]
The petitioner stated he cannot afford the cost of \$2,500 per eye to have the [REDACTED]
[REDACTED]

12. The petitioner stated he believes he may have [REDACTED]

[REDACTED] The petitioner stated he has not had a diagnosis from a physician on any of these conditions.

13. The petitioner does not believe the money he has worked for and saved should be counted against him when his eligibility for SSI-Related Medicaid is determined.

CONCLUSIONS OF LAW

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

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

16. The undersigned explored eligibility first under Family-Related Medicaid groups. The petitioner does not have a minor child in the home. The Family-Related Medicaid program benefit rules are set 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.

17. 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.

18. 20 C.F.R. § 416.1208, How funds held in financial institution accounts are counted, states in relevant part:

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

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

19. 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., with the following exceptions:

(a) For Medicaid for the Aged or Disabled Demonstration Waiver (MEDS-AD), an individual whose income is equal to or below 88 percent of the

federal poverty level must not have resources exceeding the current Medically Needy resource limit specified in Rule 65A-1.716, F.A.C.

...

(e) For Medically Needy, an individual or couple cannot have resources exceeding the applicable Medically Needy resource limit set forth in subsection 65A-1.716(3), F.A.C.

20.20 C.F.R. § 416.1210 "Exclusions from resources; general" states:

In determining the resources of an individual (and spouse, if any), the following items shall be excluded:

- (a) The home (including the land appertaining thereto) to the extent its value does not exceed the amount set forth in §416.1212;
- (b) Household goods and personal effects as defined in §416.1216;
- (c) An automobile, if used for transportation, as provided in §416.1218;
- (d) Property of a trade or business which is essential to the means of selfsupport as provided in §416.1222;
- (e) Nonbusiness property which is essential to the means of self-support as provided in §416.1224;
- (f) Resources of a blind or disabled individual which are necessary to fulfill an approved plan for achieving self-support as provided in §416.1226;
- (g) Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act (see §416.1228);
- (h) Life insurance owned by an individual (and spouse, if any) to the extent provided in §416.1230;
- (i) Restricted allotted Indian lands as provided in §416.1234;
- (j) Payments or benefits provided under a Federal statute other than title XVI of the Social Security Act where exclusion is required by such statute;
- (k) Disaster relief assistance as provided in §416.1237;
- (l) Burial spaces and certain funds up to \$1,500 for burial expenses as provided in §416.1231;
- (m) Title XVI or title II retroactive payments as provided in §416.1233;
- (n) Housing assistance as provided in §416.1238;
- (o) Refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit, as provided in §416.1235;
- (p) Payments received as compensation for expenses incurred or losses suffered as a result of a crime as provided in §416.1229;
- (q) Relocation assistance from a State or local government as provided in §416.1239;
- (r) Dedicated financial institution accounts as provided in §416.1247;
- (s) Gifts to children under age 18 with life-threatening conditions as provided in §416.1248;
- (t) Restitution of title II, title VIII or title XVI benefits because of misuse by

- certain representative payees as provided in §416.1249;
- (u) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses as provided in §416.1250;
- (v) Payment of a refundable child tax credit, as provided in §416.1235;
- and
- (w) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:
 - (1) A veteran (as defined in 38 U.S.C. 101); and
 - (2) Blind, disabled, or aged.

21. Florida Admin. Code R. 65A-1.716, Income and Resource Criteria, states in (3) "The resource limits for the Medically Needy program are as follows: Family Size of 1 the Monthly Asset Level is \$5,000."

22. The findings show the petitioner has reported his has a checking account which presently has an approximate balance of \$9,800. The findings also show the petitioner has a savings account with an approximate balance of \$6,000. The above controlling authorities outline the opportunity to exclude resources from counting in the determination of eligibility for Medicaid or Medically Needy. The undersigned concludes the petitioner's resources do not meet the criteria in the controlling authority to be excluded from the eligibility determination.

23. The above controlling authorities set the asset limit for SSI-Related Medicaid eligibility at \$5,000. The undersigned concludes the petitioner's assets total \$15,800 ($\$9,800 + \$6,000 = \$15,800$) which is greater than the asset limit. The undersigned concludes the Department correctly denied the petitioner's Medicaid application.

24. The undersigned concludes as the petitioner does not meet the resource requirement for the Medically Needy program, the factor of disability is not relevant at this time.

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 17 day of May, 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

FILED

May 18, 2018

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]

PETITIONER,

Vs.

APPEAL NO. 18F-02226
18F-02227

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 24, 2018 at 9:45 a.m.

APPEARANCES

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

For the respondent: Jackie Small, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny his application for Supplemental Nutrition Assistance Program (SNAP) and Medicaid Assistance benefits.

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

PRELIMINARY STATEMENT

[REDACTED], the petitioner's daughter, appeared telephonically and represented the petitioner.

The petitioner submitted one exhibit, which was entered into evidence as Petitioner's Exhibit "1". The respondent submitted five exhibits, which were entered into evidence as Respondent's Exhibits "1" through "5". The record was held open until close of business on May 7, 2018 for submission of additional evidence from the respondent. On April 26, 2018, the respondent submitted additional documents, which were entered into evidence as Respondent's Exhibit "6". The record closed on May 7, 2018.

FINDINGS OF FACT

1. On November 27, 2017, the petitioner (██████████) submitted an application for SNAP and Medicaid benefits for himself, his wife and their three children (ages ██████████).
2. On the application, he reported his country of birth as "Other", his wife's country of birth as ██████████ and the children's country of birth as ██████████. He listed the household sources of income were his wife's employment with ██████████ his 19-year-old daughter (██████████) employment with ██████████. and his 17-year-old daughter (██████████) employment with ██████████. (also known as ██████████).
3. As part of the application process, the respondent mailed the petitioner a Notice of Case Action (NOCA) on November 30, 2017, informing him a telephone interview was required to determine his eligibility and also requesting he provide additional information to complete his application (Respondent Exhibit 2). The NOCA indicated the following:

FINAL ORDER (Cont.)

18F-02226

18F-02227

PAGE - 3

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) 552-0456 on or before December 11, 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.

*Proof of INS status

*Proof of all gross income from the last 4 weeks using the "Verification Of Employment/Loss Of Income" form or you may send in your last 4 pay stubs

*Proof of your identification (example: driver's license)

*Proof of Florida residency

Proof of identification for members 16 or older (examples: driver's license, state id, military id)

Proof of citizenship for all household members applying for Medicaid. Please complete the 'Proof of U.S. Citizenship' forms to provide proof if other documentation is not available.

Other - please see comments below

Please call 407-552-0456 so we can complete authentication of your identity to make sure it is you applying for benefits, thank you.*INS status for ANASTASIA ZAKI is needed.

4. The petitioner completed the phone interview on December 11, 2017 and submitted the documentations requested by the respondent.
5. On December 29, 2017, the respondent mailed the petitioner a NOCA informing him that his application was denied due to "We did not receive all the information requested to determine eligibility." The respondent explained the paystubs submitted by the petitioner were blurred and unreadable.
6. The petitioner was not aware the paystubs submitted were unreadable. The petitioner also explained that he believes his youngest child should be eligible for SNAP and Medicaid Assistance benefits.
7. The respondent admitted they erred in not sending the petitioner a new notice to inform him that the documents submitted were unreadable. During the hearing and on record, the respondent explained it was willing to review the case.

8. The record was left open to allow the respondent an opportunity to review the case. Based on this review, the respondent processed and approved the petitioner's November 27, 2017 SNAP and Medicaid application. The petitioner was issued SNAP benefits in the amounts of \$18.00 for November 2017 (prorated from the date of application), and \$140.00 per month for December 2017 and ongoing. On April 25, 2018, the respondent mailed the petitioner a NOCA that indicates the respondent reviewed the case and approved \$686.00 in SNAP benefits for the period of November 1, 2017 through April 30, 2018. The respondent mailed another NOCA that indicates, the petitioner's minor children, [REDACTED] are enrolled in the Medically Needy Program with an estimated share of cost of \$2,512.00 effective November 2017 (Respondent Exhibit 6).

CONCLUSIONS OF LAW

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

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

11. The Code of Federal Regulations in 7 C.F.R. § 273.2, Office operations and application processing, states:

...
(f) Verification. Verification is the use of documentation or a contact with a third party to confirm the accuracy of statements or information. The State agency must give households at least 10 days to provide required

verification. Paragraph (i)(4) of this section contains verification procedures for expedited service cases.

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

(i) Gross nonexempt income. Gross nonexempt income shall be verified for all households prior to certification. However, where all attempts to verify the income have been unsuccessful because the person or organization providing the income has failed to cooperate with the household and the State agency, and all other sources of verification are unavailable, the eligibility worker shall determine an amount to be used for certification purposes based on the best available information.

...

(4) Sources of verification—(i) Documentary evidence. State agencies shall use documentary evidence as the primary source of verification for all items except residency and household size. These items may be verified either through readily available documentary evidence or through a collateral contact, without a requirement being imposed that documentary evidence must be the primary source of verification. Documentary evidence consists of a written confirmation of a household's circumstances. Examples of documentary evidence include wage stubs, rent receipts, and utility bills. Although documentary evidence shall be the primary source of verification, acceptable verification shall not be limited to any single type of document and may be obtained through the household or other source. Whenever documentary evidence cannot be obtained or is insufficient to make a firm determination of eligibility or benefit level, the eligibility worker may require collateral contacts...

(ii) Collateral contacts. A collateral contact is an oral confirmation of a household's circumstances by a person outside of the household. The collateral contact may be made either in person or over the telephone. The State agency may select a collateral contact if the household fails to designate one or designates one which is unacceptable to the State agency. Examples of acceptable collateral contacts may include employers, landlords, social service agencies, migrant service agencies, and neighbors of the household who can be expected to provide accurate third-party verification. When talking with collateral contacts, State agencies should disclose only the information that is absolutely necessary to get the information being sought. State agencies should avoid disclosing that the household has applied for food stamps, nor should they disclose any information supplied by the household, especially information that is protected by §273.1(c), or suggest that the household is suspected of any wrong doing.

...

(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) Households may supply documentary evidence in person, through the mail, by facsimile or other electronic device, or through an authorized representative. The State agency must not require the household to present verification in person at the SNAP office. The State agency must accept any reasonable documentary evidence provided by the household and must be primarily concerned with how adequately the verification proves the statements on the application. However, the State agency has primary responsibility for verifying fleeing felon and parole or probation violator status in accordance with §273.11(n).

(ii) Whenever documentary evidence is insufficient to make a firm determination of eligibility or benefit level, or cannot be obtained, the State agency may require a collateral contact or a home visit in accordance with paragraph (f)(4) of this section. The State agency, generally, shall rely on the household to provide the name of any collateral contact. The household may request assistance in designating a collateral contact. The State agency is not required to use a collateral contact designated by the household if the collateral contact cannot be expected to provide an accurate third-party verification. When the collateral contact designated by the household is unacceptable, the State agency shall either designate another collateral contact, ask the household to designate another collateral contact or to provide an alternative form of verification, or substitute a home visit. The State agency is responsible for obtaining verification from acceptable collateral contacts.

...

(h)(1)(c) In cases where verification is incomplete, the State agency must have provided the household with a statement of the 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)

12. The Department of Children and Families published Transmittal No.: I-12-05-0006, dated May 31, 2012, relating to "Automated 30th Day Re-Pend Notice for Applications,"

it states in part:

...

When the household completes a required interview by the 30th day or in circumstances where no interview is required, allow a 10-day pending period to return verifications. Assist households with getting missing verifications when needed.

...

If the household returned all verifications, process the case; ...

If the household has returned some but not all verification, set the courtesy notification using the region's procedure for tracking the 30/60 day cases. Staff will request the 30 day re-pend notice, which will be sent automatically to the applicant on the 30th day giving them until the 60th day to return all verification. (Refer to the Technology and Data section below, Staff Request Process, for an explanation about how it works.)

30th Day Re-Pend Notice – Staff Request Process

1. The 30th day re-pend notice can be requested by staff 25 to 30 days after the date of application...
4. Click the "Send 30 Day Notice" button located at the bottom of the page to pull up the 30th day re-pend notice Details page.
5. The 30th day re-pend notice Details page will show comments (if comments were entered on the most recently created letter) and the pending items selected from the previously generated information and appointment notices.
6. Modify any information on this page including the address, pending items, and comments, if needed. (Note: There has been an increase in the number of characters allowed in the comments section to 1000.) When all changes have been made, click "Save". The modified notice now appears on the Notice list page.

13. According to the above cited authorities, the Department must give the applicant/recipient ten (10) days to provide the required verification. In this case, the petitioner submitted the information requested by the Department before the 30th day of the application decision. The respondent testified the petitioner submitted paystubs that were blurred and unreadable. The respondent mailed the petitioner a NOCA denying the petitioner's application due to not receiving all the information requested; however, the respondent acknowledged it caused an error in not re-pending the case to inform the petitioner to resubmit clearer paystubs.

14. After further evaluation, the respondent approved SNAP benefits of \$18.00 for November 27, 2017 and \$140.00 for December 2017 and ongoing. The respondent enrolled the petitioner's children, [REDACTED] and EZ, in the Medically Needy Program with an estimate share of cost (SOC) of \$2,512.00 beginning November 2017. Since the respondent reviewed the case and approved SNAP and Medicaid benefits, there is no longer an issue to address.

15. In careful review of the cited authorities and evidence, the undersigned concludes the respondent erred in not properly notifying the petitioner that the verification he submitted was unreadable so that he could submit the proper documentation. However, since the respondent corrected the case and approved SNAP and Medicaid Assistance benefits from the petitioner's November 27, 2017 application, the undersigned is unable to conclude any better outcome for the petitioner.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are dismissed as MOOT.

NOTICE OF RIGHT TO APPEAL

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

FILED

May 14, 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-02314
APPEAL NO. 18F-02315

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 PASCO
UNIT: 88268

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 17, 2018 at 3:16 p.m., and reconvened on May 7, 2018 at 3:31 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Teshia Green, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

(A). At issue is the reduction of Supplemental Nutrition Assistance Program (SNAP) benefits.

(B). Also at issue is the termination of full Medicaid benefits for the petitioner and his wife and the enrollment in the Medically Needy Program with an estimated share of cost. He is seeking full Medicaid benefits. The petitioner is not appealing his

children's Medicaid benefits. The respondent carries the burden of proof by a preponderance of evidence on both issues.

PRELIMINARY STATEMENT

The respondent submitted seven exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 7. The petitioner submitted one exhibit which was accepted into evidence and marked as Petitioner's Exhibit 1. The undersigned found it necessary to further develop the record; therefore, the record was reopened and the hearing was reconvened on May 7, 2018 at 3:31 p.m. The record was held open until the close of business on May 7, 2018, for the Department to provide an updated SNAP budget. The budget was received, accepted into evidence and marked as Respondent's Exhibit 9. The record was closed on May 7, 2017.

FINDINGS OF FACT

1. On January 16, 2018, the petitioner submitted an application requesting Temporary Cash Assistance (TCA). The petitioner was already receiving SNAP benefits of \$760 from a prior application and full Medicaid benefits.
2. The petitioner's household consists of five members; himself, his wife and their three children. The only household's income was the petitioner's unemployment benefits of \$251 weekly (Respondent's Exhibit 2). The petitioner is a tax filer with his wife and his three children as dependents.
3. The Department approved SNAP benefits, full Medicaid benefits for the petitioner's three children and share of cost Medicaid benefits for the petitioner and his wife. TCA benefits were denied. The SNAP benefits were determined using the household income of \$1,079. The respondent determined the petitioner's monthly

household's income by multiplying his weekly unemployment benefits of \$251 by a conversion factor of 4.3, resulting to \$1,079. He pays rent of \$750 and utility expenses. He incurs cooling. The petitioner's household has no aged or disabled members. The respondent updated the case and determined SNAP eligibility. He was approved for SNAP benefits of \$656.

4. On March 14, 2018, the respondent mailed the petitioner a Notice of Case Action, informing him that his SNAP benefits would decrease from \$760 to \$656 effective April 1, 2018. By the same notice, the respondent notified the petitioner and his wife that they were eligible for the Medically Needy Program with an estimated share of cost of \$320 (Respondent's Exhibits 3 and 8).

5. On March 22, 2018, the petitioner requested a hearing to challenge the respondent's action.

6. The respondent's calculation of the petitioner's SNAP benefits after updating the SNAP budget with the unemployment income is as follows (Respondent's Exhibit 8).

Unemployment Income	\$1,079.30	\$1,079.30
Total household income		\$1,079.30
Standard deduction for a household of 5		(\$199)
Adjusted income after deductions		\$880.30
Shelter costs		\$750
Basic Utility Allowance		\$280
Total rent/utility cost		\$1,030
Shelter standard (50% adjusted income)		\$440.15
Excess shelter deduction		589.85
Adjusted income		\$880.30
Shelter Deduction(capped at \$535)		\$535
Adjusted income after shelter deduction		\$345.30
Maximum net monthly income for HH of 5		\$2,399
Thrifty Food Plan for a Household of 5		\$760
Benefit reduction (30% of \$345.30)		(\$104)

Recurring FA monthly allotment \$656

7. At the hearing on April 23, 2018, the petitioner informed the respondent that his household's monthly medical expenses exceed \$300 (Petitioner's Exhibits 1).

8. At the reconvened hearing on May 7, 2018, the Department agreed to update and provide the SNAP budget with the Standard Utility Allowance as the petitioner incurs cooling. The respondent also explained that the petitioner's shelter is capped as his household does not have an age or disabled member. Additionally, there were no excess medical deductions allowed as there were no aged or disabled members. After the update of the Standard Utility Allowance, there was no change in SNAP benefits (Respondent's Exhibits 8 and 9).

Medicaid issue

9. The respondent determined the petitioner's monthly household income according to the Medicaid guidelines by converting his weekly income of \$251 to monthly by using the Medicaid conversion factor of 4 resulting to \$1,004. It was then compared to the maximum income for a parent of a household size of five, which is \$426 (Respondent's Exhibit 4).

10. The respondent determined the petitioner's household monthly income of \$1,004 exceeded the maximum income limit of \$426 for full Medicaid benefits. The respondent explored transitional Medicaid benefits and found the petitioner and his wife already received transitional Medicaid benefits. The respondent proceeded to enroll the petitioner and his wife in the Medically Needy Program with an estimated share of cost (SOC).

11. The respondent determined their SOC by subtracting the Medically Needy Income Limit of \$684 for a household size of five from the countable net income of \$1,004 resulting to \$320 as the petitioner's SOC (Respondent's Exhibits 1 and 6).

CONCLUSION OF LAW

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

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

The FAP benefits issue will be addressed first.

14. Federal Regulation 7 C.F.R. § 273.9 addresses income/allowable deductions budgeting in the FAP in part and states:

(a) Income eligibility standards. Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet...

(b) Definition of income...

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

(ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation ...

(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...

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

this chapter, the shelter deduction cannot exceed the maximum shelter deduction limit established for the area...

(D) The shelter costs for the home if temporarily not occupied by the household because of employment or training away from home, illness, or abandonment caused by a natural disaster or casualty loss. For costs of a home vacated by the household to be included in the household's shelter costs, the household must intend to return to the home; the current occupants of the home, if any, must not be claiming the shelter costs for food stamp purposes; and the home must not be leased or rented during the absence of the household...

(iii) *Standard utility allowances.* (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); and, a limited utility allowance (LUA) that includes electricity and fuel for purposes other than heating or cooling...

15. The respondent must follow these federal budgeting guidelines when determining eligibility. It directs the respondent to consider income from unemployment compensation as unearned income that must be included in the eligibility determination.

16. Federal Regulations 7 C.F.R. § 273.10 addresses income and calculating net income and benefit levels:

(c)(2) *Income only in month received.* (i) Income anticipated during the certification period shall be counted as income only in the month it is expected to be received, unless the income is averaged. Whenever a full month's income is anticipated but is received on a weekly or biweekly basis, the State agency shall convert the income to a monthly amount by multiplying weekly amounts by 4.3 and biweekly amounts by 2.15, use the State Agency's PA conversion standard, or use the exact monthly figure if it can be anticipated for each month of the certification period...

17. The weekly factor was used to convert the petitioner's unemployment compensation income to monthly income resulting in the household's monthly income.

No mathematical errors were found in the conversion to monthly income.

18. The Food Assistance standards for income and deductions appear in the Department's Program Policy Manual (Policy Manual), CFOP 165-22, at Appendix A-1. The 200% Federal Poverty level (FPL) for a household size of five effective October 2017 is \$4,798. A five-person assistance group's net income limit is \$2,399, the standard deduction for five people is \$199 and the Standard Utility Allowance is \$347.

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

(1) Net monthly income

(i) To determine a household's net monthly income, the State agency shall:

(A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income...

(B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions. If the State agency has chosen to treat legally obligated child support payments as an income exclusion in accordance with §273.9(c)(17), multiply the excluded earnings used to pay child support by 20 percent and subtract that amount from the total gross monthly income.

(C) Subtract the standard deduction.

(D) If the household is entitled to an excess medical deduction as provided in §273.9(d)(3), determine if total medical expenses exceed \$35. If so, subtract that portion which exceeds \$35.

(E) Subtract allowable monthly dependent care expenses, if any, up to a maximum amount as specified under §273.9(d)(4) for each dependent

(H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.

(I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net

income subtracted. The household's net monthly income has been determined.

(2) Eligibility and benefits...

(ii)(A)...the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30% of the household's net monthly income...

(iii) To determine the amount of the prorated allotment, the State agency shall use either the appropriate Food Stamp Allotment Proration Table provided by FNS...

20. The above-cited regulation describes the eligibility process and defines deductions. The petitioner was credited with deductions for an excess shelter deduction, Standard Utility Allowance and a standard deduction. There is no indication the petitioner was eligible for any other deductions. There were no deduction allowed for a medical deduction as the petitioner or his wife is not aged or disabled.

21. After carefully reviewing the governing authorities cited above, the evidence and testimonies, the hearing officer could not find the petitioner eligible for any additional SNAP benefits based on his reported income and expenses. The undersigned concludes that the respondent's determination of the petitioner's SNAP benefits was correct.

Medicaid Benefits will now be addressed

22. The petitioner's Medicaid eligibility was determined under the Family Related Medicaid Program.

23. Federal Medicaid Regulations 42 C.F.R. § 435.218 Individuals with MAGI-based income above 133 percent of the FPL (Federal Poverty Level) states in part:

(a) *Basis*. This section implements section 1902(a) (10) (A) (ii) (XX) of the Act.

(b) *Eligibility*—(1) *Criteria*. The agency may provide Medicaid to individuals who:

(i) Are under age 65;

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

(iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and

(iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.

(2) *Limitations.* (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.

(ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

24. Family-Related Medicaid income criteria is set forth in 42 C.F.R. § 435.603 and

states:

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

(3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under §435.916 of this part, whichever is later.

(b) *Definitions.* For purposes of this section—

Child means a natural or biological, adopted or step child.

Code means the Internal Revenue Code.

Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver....

(c) *Basic rule.* Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on “household income” as defined in paragraph (d) of this section.

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

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

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

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

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

25. The Department’s Program Policy Manual CFOP 165-22 (the Policy Manual) at passage 2230.0400 Standard Filing Unit (MFAM), states:

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

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

26. In accordance with the above controlling authorities, the Medicaid household group is the petitioner, his wife and their three children. The findings show the respondent determined the petitioner's eligibility with a household size of five for Medicaid. The undersigned concludes the Department correctly determined the petitioner's household size as five for Medicaid.

27. The Policy Manual at passage 2630.0108 Budget Computation (MFAM) states:

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

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

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

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

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

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

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

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

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

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

28. The Policy Manual at section 2430.0204 addresses Determining Monthly Income (MFAM), and states:

The process of computing the amount of income to be considered in determining financial eligibility and the coverage group(s) is called "budgeting". When determining financial eligibility, one or more budget calculations will be completed. The best estimate of the standard filing

unit's income and circumstances is used to determine eligibility. When determining eligibility benefits for a past month, the SFU's actual income and circumstances are used. The income is compared to the appropriate income limit to determine the coverage group.

29. The Policy Manual at section 2430.0509, Income More Often than Monthly (MFAM), states:

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

1. Add the gross income amounts for the past four weeks to get the total.
2. If income is received weekly, add four pay periods and divide by four to get the weekly average.
3. If income is received biweekly, add two pay periods and divide by two to get the biweekly average.
4. If income is received semimonthly, add two pay periods and divide by two to get the semimonthly average.
5. If income is received monthly, use the most recent month if representative.

The result of the above is called the averaged amount. With the exception of monthly amounts, the averaged amount described above must be converted to a monthly amount.

30. The above instructs the Department to add the four weekly pay periods and divide by four to determine the weekly average.

31. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for a parent of household size five as \$426, the Modified Adjusted Gross Income (MAGI) of \$123 and the Medically Needy Income Limit (MNIL) of \$684.

32. In accordance with the above controlling authorities, the undersigned reviewed eligibility for full Medicaid benefits for the petitioner and his wife and did not find them eligible, as the modified adjusted gross income was more than the income limit of \$426 for a household size of five for a parent. Step 1: The undersigned used the petitioner's monthly unearned income of \$1,004. Step 2: MAGI was determined by deducting

allowable income tax deductions. No income tax deduction was allowed as there was no tax return provided. The MAGI was determined to be \$1,004. Step 3: A standard disregard of \$258 was allowed resulting to \$746 as the countable net income. Step 4: The countable net income of \$746 was compared to the income limit of \$426, which exceeded the income limit. Step 5: A MAGI disregard of \$123 was allowed resulting to \$623 as the total monthly income. It was compared with the income limit for a parent of a household size of five of \$426 for full Medicaid. The petitioner's income was greater than the income limit for full Medicaid. The undersigned concludes the petitioner is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

The Medically Needy share of cost will now be addressed

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

34 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.

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

36. Fla. Admin. Code R. 65A-1.707 sets forth the income and resource criteria for Medically Needy coverage. “For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost...”

37. The Medically Needy Income Level (MNIL) appears in The Policy Manual at Appendix A-7. Effective April 2017, the MNIL for a household size of five is \$684.

38. The above cited authorities and policies address income standards and limits, calculating countable income, and income budgeting in the Family-Related Medically Needy Program.

39. The undersigned carefully reviewed the respondent’s determination of the SOC of \$320 and could not find a more favorable outcome. The respondent subtracted the Medically Needy Income Limit of \$684 for a household size of five from the countable net income of \$1,004 resulting in \$320 as the petitioner’s SOC. The undersigned concludes that the respondent’s action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal for SNAP benefits is denied and the respondent’s action is upheld. The appeal for Medicaid and the Medically Needy Program is denied and the respondent’s action is upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the 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 May, 2018, 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

FILED

Jun 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. 18F-02374

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 12 Manatee
UNIT: 88326

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 20, 2018 at 10:26 a.m. All parties appeared by telephone from different locations.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Roneige Alnord, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the Department's action of March 19, 2018 denying her application for Supplemental Security Income-Related Medicaid (SSI-Related Medicaid). The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Florida Department of Children and Families (“Department” or “DCF”) determines eligibility for SSI-Related Medicaid programs. The respondent submitted written evidence which was admitted into the record and marked as Respondent’s Exhibits “1” through “9”. The record was held open seven (7) days to allow the respondent and/or the petitioner to submit the original Supplemental Security Income (SSI) denial notice from the Social Security Administration (SSA) and proof of a new medical condition. The respondent submitted additional evidence which was marked and entered into the record as Respondent’s Exhibit “10”. The petitioner did not submit any additional information. The record was closed on April 27, 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 submitted an application for disability with the SSA on April 2, 2016. SSA issued an unfavorable determination (N32) on September 1, 2016. Decision code N32 indicates the petitioner has the capacity for substantial gainful activity. The SSA determined that the petitioner’s impairment was not sufficient to preclude her from engaging in substantial gainful activity (SGA), see Respondent’s Exhibits 4 & 10.
2. The petitioner appealed the SSA denial On March 20, 2017. The petitioner alleges no new condition/s not previously considered by SSA, see Respondent’s Exhibit 4.
- 4.

3. The petitioner is a [REDACTED]-year-old single woman whose birthdate is [REDACTED].

The petitioner submitted a web application on March 9, 2018 for SSI-Related Medicaid for herself, see Respondent's Exhibits 3 & 4.

4. The respondent issued a Notice of Case Action (NOCA) dated March 19, 2018 denying the petitioner's application for Medicaid because the state adopted the Social Security Administration's (SSA) decision, see Respondent's Exhibit 6.

5. In the state of Florida, an individual must be disabled, blind, or aged (65 years or older) to be eligible for SSI- Related Medicaid, in addition to other technical requirements. When an individual applies for Medicaid who has not yet been determined disabled, blind or aged, DCF submits their application to the Department of Health's Division of Disability Determinations (DDD), see Respondent's Exhibit 8.

6. The petitioner previously received Medicaid in the state of Ohio and does not understand why she cannot receive "regular" Medicaid in Florida, Petitioner's testimony.

7. The respondent countered that an adult without children may be eligible for Florida Medicaid coverage only if the adult is aged (over 65), disabled, or pregnant. The petitioner is not over 65 years old nor is she pregnant. Therefore, her eligibility is limited to the disabled category if she meets criteria for disability, Respondent's testimony & see Respondent's Exhibit 8.

8. The respondent contends if SSA has denied disability within the past year and the decision is under appeal with SSA then the Department is bound by that federal decision, see Respondent's Exhibit 8.

9. The petitioner believes that she is disabled and that she should be eligible for Medicaid in Florida just like she was eligible in Ohio prior to her move to Florida. She

asserts that she cannot get her medication or the medical help she needs without Medicaid.

CONCLUSIONS OF LAW

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

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

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

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

14. 42 C.F.R. § 435.541 sets the standards for state disability determinations and 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 §435.911 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 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

....
(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.

15. The petitioner was denied Social Security benefits as she was determined not to be disabled. Petitioner did not claim any new conditions not reviewed by the Social

Security Administration in making the determination of the denial. The Department adopted the unfavorable disability decision made by the Social Security Administration rather than making an independent disability determination. According to the above regulations, the Social Security Administration's denial of the petitioner's disability is binding and must be relied upon by the Department. Therefore, the Department correctly denied the petitioner's application for SSI-Related Medicaid benefits as she was determined not disabled.

16. After careful review of the evidence submitted and the relevant laws set forth above, the undersigned concludes the Department's action was proper. The undersigned cannot find a more favorable outcome for the petitioner.

DECISION

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

FINAL ORDER (Cont.)
18F-02374
PAGE -7

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



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

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

Jun 15, 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. 18F-02426

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 Escambia
UNIT: 88630

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 14, 2018 at 12:45 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Sheila Rushing

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of May 3, 2018 denying SSI-Related Medicaid coverage for the months of October and November 2017. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department submitted evidence on May 7, 2018 which was entered as Respondent's Exhibit 1.

The record closed on May 14, 2018.

FINDINGS OF FACT

1. The petitioner, with the assistance of his medical representative, filed an application for SSI-Related Medicaid on January 26, 2018. The petitioner is ■ years old. The application shows there are no minor children in the petitioner's household.

(Respondent Exhibit 1, pages 56 through 59)

2. The Department issued a Notice of Case Action to the petitioner on January 30, 2018. This notice required the petitioner participate in a phone interview as well as submit some additional information. This notice was sent to the medical representative as well as the petitioner. (Respondent's Exhibit 1, pages 65 through 86)

3. The Department issued a Notice of Case Action dated March 15, 2018 denying the petitioner's application as "We did not receive all information needed to determine eligibility". (Respondent's Exhibit 1, pages 60 through 63)

4. The petitioner submitted the necessary verifications on April 14, 2018. (Respondent's Exhibit 1, pages 46 through 50)

5. The petitioner applied for Social Security disability benefits on January 18, 2018. (Respondent's Exhibit 1, page 47)

6. The Department utilized the 60-day rule to re-open the petitioner's case following receipt of all information necessary to submit the case for disability determination.

7. The Department submitted a Disability Determination and Transmittal to the Division of Disability Determinations (DDD) on March 6, 2018. The application date on this transmittal was March 2018. (Respondent's Exhibit 1, page 52)

8. DDD issued a response on March 14, 2018 approving the petitioner's disability application and allowing retroactive months of December 2017, January 2018, and February 2018.

9. The Department spoke with the medical representative on April 18, 2018. As a result of that conversation the Department agreed to resubmit the disability request to DDD with the correct application date and asking for retroactive Medicaid to begin October 2017.

10. The Department submitted a Disability Determination and Transmittal on April 24, 2018 to DDD. The application date on this transmittal was January 26, 2018. The transmittal also indicates the SSI application date of December 20, 2017. The transmittal indicates the petitioner is seeking retroactive Medicaid back to October 2017. (Respondent's Exhibit 1, page 27)

11. DDD issued a response on April 25, 2018 denying the petitioner's disability application with reason code N32. DDD noted on the transmittal that the decision is considered a "Hankerson" and adopted the decision issued by Social Security on March 28, 2018. (Respondent's Exhibit 1, page 11 and 27)

12. The Department explained that Social Security's reason code N32 means "non-pay – capacity for substantial gainful activity – other work, no visual impairment".

13. The Department issued a Notice of Case Action on May 4, 2018 denying the petitioner's application for Medicaid for the months of November 2017, May 2018 and June 2018. The Notice informed the petitioner they are not eligible as "You or a member of your household do not meet the disability requirement". (Respondent's Exhibit 1, page 3 through 5)

14. The Department issued a Notice of Case Action on May 3, 2018 denying the petitioner's application for Medicaid for the month of October 2017. The reason cited on the Notice is "You or a member of your household do not meet the disability requirement". (Respondent's Exhibit 1, pages 6 through 9)

15. The petitioner reported during hearing he had not filed an appeal of the Social Security decision.

16. The petitioner believes if the Department had correctly submitted the disability transmittal at the time of application, showing the correct date of application and request for retroactive Medicaid back to October 2017, then the months in question would have been approved.

17. The Department explained that due to the decision by the Social Security Administration denying the petitioner's disability, the Department is unable to overrule the Social Security decision.

CONCLUSIONS OF LAW

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

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

20. The 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.

21. 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.

22. 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).

23. 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.)

24. 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)

25. The undersigned explored potential eligibility for SSI-Related Medicaid for the petitioner. The findings show the petitioner was [REDACTED] 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.

26. The findings show the petitioner applied for Social Security disability and was denied on March 28, 2018. The findings show the petitioner has not appealed the Social Security denial. 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 March 2018 denial.

27. The findings show the petitioner was approved for disability beginning December 2017 through March 2018 prior to the SSA decision being made. The findings show the petitioner is requesting the disability approval (and Medicaid) for the months of October 2017 and November 2017. The request for this coverage was submitted after the SSA decision was made. The undersigned can find no rule or regulation which allows an exception for the state to review the petitioner's disability for these months after an SSA denial.

28. 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.

FINAL ORDER (Cont.)

18F-02426

PAGE - 9

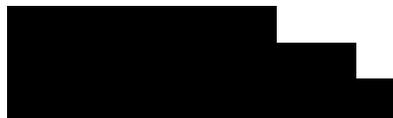
DONE and ORDERED this 15 day of June, 2018,
in Tallahassee, Florida.



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: , Petitioner
Office of Economic Self Sufficiency


Jun 29, 2018

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

APPEAL NO. 18F-02434

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Lee
UNIT: 88287RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on April 25, 2018 at 11:25 a.m. All parties appeared by telephone from different locations.

APPEARANCES

For the Petitioner:



For the Respondent:

Roneige Alnord,
Economic Self-Sufficiency Specialist II**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of March 21, 2018, enrolling her children into the Medically Needy Program (MN) with a Share of Cost (SOC) rather than approving them for full Medicaid coverage. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department of Children and Families (Department or respondent) administers the Medicaid Program for the state of Florida. The Department presented evidence which was marked and accepted as Respondent's Exhibits "1" through "10" respectively. The record was closed on April 25, 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. On March 19, 2018, the petitioner applied for Food Assistance and Medicaid benefits for a three-person household. Food Assistance is not an issue for this appeal, see Respondent's Exhibit 3.
2. The petitioner, age [REDACTED] is a single parent with two minor sons ages [REDACTED]. The petitioner is a tax filer, see Respondent's Exhibit 3.
3. On March 20, 2018, the Department determined that the household was eligible for Food Assistance benefits and Medically Needy Medicaid with a Share of Cost benefits for the petitioner and her minor children.
4. On March 21, 2018, the Department sent a Notice of Case Action (NOCA) to the petitioner informing her of its eligibility determination. The petitioner appealed this action on March 26, 2018, see Respondent's Exhibits 6 & 9.
5. The petitioner argued that her income has been constant for the last three years and her boys were eligible for full Medicaid before and she believes that they should still be eligible.

6. The respondent countered that the Department uses the current pay stubs to determine the budget and that a review of her paystubs reveals that her total monthly pay may fluctuate and that the petitioner sometimes receives commissions. ,

Respondent's testimony.

7. The petitioner's countable monthly gross income consists of wages from her employment with [REDACTED]. Based on the paystubs for February 2018, the petitioner works an average of 38.93 hours weekly and is paid \$17 an hour, see Respondent's Exhibit 5.

8. The gross pay for February 2018 used by the respondent for budget calculations is as follows:

2/2/18	\$693.28
2/9/18	\$637.50
2/16/18	\$674.90
2/23/18	<u>\$680.00</u>
	\$2,685.68

9. During the hearing, the respondent noted that the pay for February 2, 2018 included commission payments. Because the petitioner does not normally earn commissions, this pay should not have been used in the budget calculation. Per testimony, only three pays should have been used by adding the last three weeks together and dividing by three to get a weekly average and then multiplying that number by four to determine the monthly average to be used in estimating the SOC. This resulted in a slightly lower SOC, Respondent's testimony.

2/9/18	\$637.50	$\$1,992.40/3=\$664.13 \times 4=\$2,656.52$
2/16/18	\$674.90	
2/23/18	<u>\$680.00</u>	
	\$1,992.40	

10. The SOC was determined as follows:

Household Size 3

Income Standard \$2,264

Gross Earned Income	\$2,656.52
- MNIL	<u>\$ 486</u>
SOC	\$2,170
- Medical Ins Premium	<u>\$ 114.56</u>
Remaining SOC	\$2055

11. The petitioner felt that her Share of Cost was still too high. She argued that her income has not changed and that if they were eligible for full Medicaid before, they should be eligible for full Medicaid now, Petitioner's testimony.

12. The respondent countered that Medicaid eligibility for the above-mentioned months has been correctly calculated according to the household's size and income. He also explained the referral to Florida Healthy Kids and that their insurance premiums would be based on the household's income but are significantly less than the SOC, Respondent's testimony.

CONCLUSIONS OF LAW

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

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

15. Federal regulations at 42 C.F.R. § 435.603(f) Household- It states in pertinent parts:

(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 ...

16. In accordance with the above controlling authorities, the Medicaid household group is the petitioner, and her two sons (three members). The findings show the Department correctly determined the petitioner's eligibility for Medicaid using a household size of three.

17. In accordance with Florida Administrative Code R. 65A-1.707 Family-Related Medicaid Income and Resource Criteria income is defined in pertinent parts as:

(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....

18. The controlling authorities above instruct as to the type of income counted and how to calculate eligibility based on all countable income. In this instant case, the petitioner's earned income is countable income.

19. The Department's Program Policy Manual, CFOP 165-22 (The Policy Manual) at 2430.0204 Determining Monthly Income (MFAM) states:

Several factors are involved in determining a gross amount of monthly income to be budgeted. These are anticipating and projecting income, averaging income, and converting the income to a monthly amount.

When income is received more often than monthly, it will be converted to a monthly amount. When averaging income, use the most recent consecutive four weeks or the best available information when it is representative of the individual's future income

20. The Policy Manual at 2430.0505 Less than a Four Week Average (MFAM) states in pertinent part:

“When a shorter than four week average is to be computed, use the number of weeks available up to four at the new amount, to compute the revised average....”

21. The Policy Manual at 2430.0600 Rounding (MFAM) states:

When it is necessary to divide because of averaging or prorating, round the resulting amount to the nearest cent as follows:

Step 1 - Perform the division to three decimal positions; that is, to three positions after the decimal point.

Step 2 - If the third decimal position is five to nine, round the amount to the next higher cent.

Step 3 - If the third decimal position is four or less, round the amount to the next lower cent (that is, drop the third decimal position).

22. The Policy Manual at 2430.0700 Income Conversion (MFAM) describes how the income is converted into the budget. It 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.

23. The respondent followed the Department's policies regarding budgeting, averaging, converting and rounding the income used in the Medicaid budget. As the respondent has stated that the pay for February 2, 2018 is not representative pay, the revised calculations used to determine the countable monthly earned income are correct based on the controlling authorities cited above.

24. Federal regulations at 42 C.F.R. § 435.110 Parents and other caretaker relatives states in pertinent parts:

(b) Scope. The agency must provide Medicaid to parents and other caretaker relatives... 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.

25. 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
3	\$303

26. Federal regulations at 42 C.F.R. § 435.118 Infants and children under age 19 states in pertinent parts:

(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; ... (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;

27. The Policy Manual at Appendix A-7 Family Related Medicaid Income Limits

(Effective April 1, 2017) notes for a family of three the following income limits:

Parents, Caretakers, Children 19 & 20	\$303
Children 6 through 18 (133% of FPL)	\$2264

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

(MAGI) (d) defines Household Income and provides guidance for budgeting income of

individuals who are tax filers, and tax dependents. 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.

....

(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,

29. The Department's Program Policy Manual, CFOP 165-22 (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). [Emphasis mine]

***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. [Emphasis mine]**

30. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner and for the petitioner's children. The total countable income counted in the budget is \$2,656.52. As children over the age of 5 do not receive a standard disregard and the household does not qualify for the MAGI disregard, there are no deductions included in the calculations. The total countable income of \$2,656.52 less disregards of \$0 equals \$2,656.52, which is the amount used to compare to the Medicaid income limits. For the petitioner, the income limit for a parent is \$303. For the petitioner's children, the income limit for children ages six through eighteen is \$2264. The undersigned concludes that the countable income exceeds the income limits for the petitioner and the petitioner's children; therefore, the

undersigned concludes that the petitioner and the petitioner's children are ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored.

31. The Fla. Admin. Code R. 65A-1.707(1)(a), 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."

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

33. Appendix A-7 indicates that for a three-person household the Medically Needy Income Level (MNIL) is \$486.

34. To determine petitioner's SOC the respondent determined the petitioner's monthly countable income to be \$2,656.52. The MNIL of \$486 is subtracted resulting in the petitioner's SOC of \$2,170. The petitioner incurs medical insurance premiums for her coverage through her employer. The monthly amount of \$114.56 is subtracted from the SOC for an adjusted or remaining SOC of \$2,055.

35. After carefully considering the testimony and evidence presented, along with the pertinent rules and regulations stated above, the undersigned concludes the respondent was correct to enroll the petitioner's household in the MN Program with a SOC as all members of the household are over income for full Medicaid benefits. The undersigned also concludes that the estimated Share of Cost based on the representative pays is correct. The undersigned could not determine a more favorable outcome.

DECISION

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

DONE and ORDERED this 29 day of June, 2018,

in Tallahassee, Florida.



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

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

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

FILED

Jun 21, 2018

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 18F-02509

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88690

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 14th, 2018, at 8:30 a.m.

APPEARANCES

For the Petitioner: , pro se.

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

STATEMENT OF ISSUE

The petitioner is appealing the respondent not tracking her medical bills for April 2017. On the record, the undersigned assigned the burden of proof to the respondent. However, after further review, the undersigned has determined that the burden of proof must be assigned to the petitioner. The standard of proof at this hearing is a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents for the hearing.

The respondent's exhibits 1 through 3 were admitted into evidence.

On May 14th, 2018, the hearing proceeded and the respondent completed its oral arguments and submitted documentary evidence. The petitioner also completed her oral arguments; however, she did not present any documents. Before the hearing record could be closed, petitioner left the conference. No reason was provided by the petitioner before she exited the call. Since the presentation of evidence was completed by both parties, the undersigned dismissed the respondent, and ended the call.

On May 15th, 2018, the undersigned issued an Order for Parties to Respond due to the petitioner exiting the conference before the record was closed. The order allowed both parties ten (10) days the option of rescheduling the hearing, so that any additional evidence could be submitted. As of the close of business May 25th, 2018, neither party had responded to the order; therefore, the undersigned will make a ruling based on the evidence presented on the May 14th, 2018 hearing.

By way of a Notice of Case Action (NOCA) dated October 18th, 2017, the respondent notified the petitioner that she had met the Medically Needy share of cost, and is eligible for Medicaid for the period of 04/01/2017 to 04/30/2017. (Respondent's Exhibit 1.)

On March 28th, 2018, the petitioner requested an appeal stating that she was not informed of the bill tracking for her April 2017 medical bills.

FINDINGS OF FACT

1. The above-mentioned notice dated on October 18th, 2017, was issued to the mailing address reported by the petitioner on the application at: [REDACTED]

The petitioner confirmed the mailing address during the hearing, and stated that she receives all her mail at that address. The hearing notice was also issued to the same address and the petitioner did receive it. The respondent stated that the NOCA was not returned by the United States Post Office (USPS.)

2. The petitioner initially argued that her medical bills for April 2017 were not tracked by the respondent. When informed by the respondent that they had been tracked, and that she was eligible for full Medicaid for the month of April 2017, the petitioner argued that the respondent did not inform her of that; therefore, she was not aware that she was eligible for Medicaid. Additionally, the petitioner contends that it is the respondent's responsibility to notify her medical providers.

3. The respondent argued that the notice clearly states to the petitioner, "it is your responsibility to contact each provider and give them your Medicaid Identification Number." (Respondent's Exhibit 1.)

4. The respondent submitted into evidence the Temporary Emergency Medicaid Identification Card (MIC) indicating Medicaid coverage for the petitioner for the period of 04/01/2017-04/30/2017. (Respondent's Exhibit 2.)

5. Additionally, the respondent submitted document which shows the petitioner's Medicaid eligibility for April 2017 on the Florida Medicaid Management Information System

(FLMMIS) recipient file. The file is managed by the Agency for Health Care Administration (AHCA), which is responsible for administering the Medicaid Program. (Respondent's Exhibit 3.)

CONCLUSIONS OF LAW

6. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 120.80, Fla. Stat.
7. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.
8. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
9. Fla. Admin. Code R. 65-2.056 set forth the basis of hearings, and states:

The hearing shall include consideration of:

- (1) Any Department action, or failure to act with reasonable promptness, on a claim of financial assistance, social services, medical assistance, Temporary Assistance of Needy Families (TANF), or Supplemental Nutrition Assistance Program (SNAP) benefits, which includes delay in reaching a decision on eligibility in both initial and subsequent determination, or in making a payment, the amount of payment, change in payments, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.
- (2) The hearing officer must determine whether the Department's decision on eligibility or procedural compliance was correct at the time the decision was made. The hearings are de novo hearings, in that, either party may present new or additional evidence not previously considered by the Department in making its decision.

10. The above-cited authority grants a hearing officer jurisdiction on issues cited above as well as *de novo* evidence. The petitioner's appeal was based on the contention that her bills for April 2017 were not tracked by the respondent. Findings show that the bills were tracked by the respondent making the petitioner eligible for Medicaid for April 2017. The respondent also informed the petitioner of her Medicaid eligibility by issuing a NOCA to the address provided by the petitioner, and was not returned by the USPS. The notice also advise the petitioner that it is the petitioner's responsibility to inform each provider of her eligibility.

11. The Fla. Admin. Code 65-2.060, Evidence, states in part:

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

12. In this instance, since the petitioner stated that she had provided the medical bills, and the respondent acknowledged receiving them, the burden of proof was initially assigned to the respondent due to the delay in tracking. However, after reviewing the respondent's evidence, the undersigned concluded that the respondent tracked the petitioner's medical bills for the period of April 1st, 2017 through April 30th, 2017, making the petitioner eligible for Medicaid. There is nothing more for the undersigned to consider at this time.

13. Based on a review of the evidence presented, the undersigned concludes that the petitioner's issue at appeal has been resolved; therefore, the issue is moot.

DECISION

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

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 21 day of June, 2018,

in Tallahassee, Florida.



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

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

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

FILED

Jun 29, 2018

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 18F-02540

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 PINELLAS
UNIT: 88993

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 16, 2018 at 10:33 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:



For the Respondent:

Roneige Alnord
Economic Self-Sufficiency Specialist II
Department of Children and Families

STATEMENT OF ISSUE

At issue is whether the respondent's action in denying the petitioner's application for SSI-Related Medicaid benefits on the basis that he does not meet the citizenship

requirement is correct. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on April 24, 2018. On this date, the Department requested a continuance to review policy and documentation that the petitioner provided. There were no objections from the petitioner and the hearing was rescheduled for May 16, 2018.

Kate Sampson, Economic Self-Sufficiency Specialist II with the Department of Children and Families, was present as an observer without any objection.

The petitioner presented a packet of documents which were marked and entered as Petitioner's Exhibits "1" through "9." The respondent submitted nine exhibits which were marked and entered as Respondent's Exhibits "1" through "9."

FINDINGS OF FACT

1. On February 20, 2018, the authorized representative submitted an application for Medicaid on behalf of the petitioner from July 2017 through ongoing (Pet. Exh. 5). The authorized representative stated that previous applications were submitted to secure the retroactive Medicaid back to July 2017.

2. The application indicates that the petitioner is a 71-year-old male who lives alone and is a U.S. citizen that was born in Canada (Pet. Exh. 5). The petitioner is not receiving Supplemental Security Income ("SSI"), enrolled in Medicare or receiving disability insurance benefits.

3. On February 21, 2018, the petitioner was mailed a Notice of Case Action (“NOCA”) informing him that authentication was needed by March 5, 2018 (Resp. Exh. 5).

4. On March 22, 2018, the petitioner was mailed a NOCA stating that the Medicaid application was denied as the Department did not receive all information requested to determine eligibility (Resp. Exh. 6).

5. On March 25, 2018, the petitioner requested a hearing timely.

6. On April 10, 2018, the Department reviewed the case because of the hearing request and noticed that authentication was needed, and the Department did not send the necessary pending letter to the authorized representative. The Department was able to reach the authorized representative and complete the authentication on this date.

7. On April 17, 2018, the respondent noticed that they were not able to verify citizenship for the petitioner. The Department reviewed the Driver and Vehicle Information Database (“DAVID”) and it did not show that the petitioner is a citizen. The database indicates that he is a non-immigrant that was born in Canada (Resp. Exh. 3).

8. The Department then reviewed the State On-line Query which indicates that the petitioner applied for SSI on October 16, 2013 and was denied on that same date for the reason being that he is not a U.S. citizen (Resp. Exh. 4). The petitioner did not appeal this denial from Social Security Administration.

9. On April 17, 2018, the Department mailed a notice to the authorized representative requesting verification of citizenship status with the INS number. The notice also indicated that if the petitioner was not a citizen to submit an emergency

statement, bills and emergency referral for the Department to process Medicaid eligibility. This information was due to the Department by April 27, 2018 (Pet. Exh. 4).

10. On April 24, 2018, the authorized representative spoke to the respondent and was informed that the Department received the petitioner's Canadian birth certificate and the petitioner's mother's birth certificate, indicating that she was born in New York (Pet. Exh. 8 & 9).

11. On May 15, 2018, the Department emailed the authorized representative informing him, after contacting their Program Office, that for the petitioner to be considered a citizen there would need to be a declaration of citizenship or a determination done by United States Citizenship and Immigration Services ("USCIS") (Pet. Exh. 1).

12. The Department explained that they did not receive any proof that the petitioner declared his citizenship in front of the U.S. Counsel or verification of a determination completed by USCIS. The petitioner meets the Medicaid criteria as he is elderly but since citizenship was not verified the Department denied the Medicaid due to this reason only.

13. The authorized representative explained that the petitioner has dual citizenship but has no documentation showing citizenship in the United States. He also explained that the petitioner is mentally and physically disabled and is not able to represent himself.

14. The authorized representative reviewed DCF policy passage 1440.0101 that states the designated representative may sign the application declaring the citizenship status of all members and indicated that the petitioner appointed [REDACTED] as his

authorized representative on January 30, 2018 (Pet. Exh. 3). The authorized representative declared the petitioner was a citizen on the application that was submitted on February 20, 2018. The authorized representative stated this application he filled out stating the petitioner was a citizen and signed by himself should be enough verification of citizenship for the Department.

15. The Department explained that on the paper application the Statement of Understanding is included and explains that DCF may verify information given on the application and they have the right to ask for more information if necessary or deny the application. The Department stated that they cannot believe that all information on the application is automatically true.

16. The authorized representative stated that since the petitioner's mother was a U.S. citizen when the petitioner was born then the petitioner meets the citizenship criteria for Medicaid making him eligible for full coverage Medicaid.

17. The authorized representative also referenced the DCF policy passage 1440.0102 that states that a child born abroad to unmarried parents may acquire citizenship at birth if one of the parents is a U.S. citizen. He stated that he is not sure if the petitioner's parents were married at the time of the petitioner's birth but believes they were not based off the fact that they have different last names on the birth certificate.

18. The Department explained that without the declaration of citizenship or proof of citizenship from the petitioner they are unable to approve full coverage Medicaid for the petitioner. The Department explained that they are willing to explore Emergency Medicaid for Aliens ("EMA") if they receive an EMA statement, medical bills and an

emergency referral. At the time of the hearing, the Department did not have this information to process EMA for the petitioner as the authorized representative is seeking full coverage Medicaid.

19. The authorized representative stated that a declaration of citizenship has not been completed and explained how he interprets the policy is different than how the department is interpreting it.

CONCLUSIONS OF LAW

20. 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.

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

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

23. Fla. Admin. Code R. 65A-1.301 discusses the requirement to verify citizenship status and states in part:

(1) The individual whose needs are included must meet the citizenship and noncitizen status established in: P.L. 104-193, The Personal Responsibility and Work Opportunity Reconciliation Act of 1996; P.L. 105-33, the Balanced Budget Act of 1997; P.L. 105-185, the Agricultural Research, Extension, and Education Reform Act of 1998; P.L. 105-306, the Noncitizen Benefit Clarification and Other Technical Amendments Act of 1998; P.L. 109-171, the Deficit Reduction Act of 2005; and, the Immigration and Nationality Act.

(2) For Medicaid, an individual who indicates they are a U.S. citizen, and who is not subject to an exemption as specified in 42 C.F.R. 435.406(2007) (incorporated by reference). The Department will assist with obtaining documentation if the applicant or recipient indicates they are having a problem obtaining the documentation.

(3) The eligibility specialist must verify the immigration status of noncitizens through the United States Citizenship and Immigration Service

(USCIS), formerly the United States Bureau of Citizenship and Immigration Services. Verification will be requested electronically using the alien number, or based on a USCIS or prior Immigration and Naturalization Services (INS) document provided by the applicant. The system of verification is known as the Verification Information System-Customer Processing System (VIS-CPS), which is part of the Systematic Alien Verification for Entitlements (SAVE) Program.

24. 42 C.F.R. § 435.406, Citizenship and non-citizen eligibility, 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; 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.

(iii) The following groups of individuals are exempt from the requirement to provide documentation to verify citizenship in paragraph (c) of this section:

(A) Individuals receiving SSI benefits under title XVI of the Act.

(B) Individuals entitled to or enrolled in any part of Medicare.

(C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).

(D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are beneficiaries of foster care maintenance or adoption assistance payments under Title IV-E of the Act.

(E)(1) Individuals who are or were deemed eligible for Medicaid in the State under §435.117 or §457.360 of this chapter on or after July 1, 2006,

based on being born to a pregnant woman eligible under the State's Medicaid or CHIP state plan or waiver of such plan;

(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...

(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...

(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. 42 C.F.R. § 435.407, Types of acceptable documentary evidence of citizenship, states:

(a) Stand-alone evidence of citizenship. The following must be accepted as sufficient documentary evidence of citizenship:

(1) A U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or Card was issued without limitation.

(2) A Certificate of Naturalization.

(3) A Certificate of U.S. Citizenship.

(4) A valid State-issued driver's license if the State issuing the license requires proof of U.S. citizenship, or obtains and verifies a SSN from the applicant who is a citizen before issuing such license.

(5)(i) Documentary evidence issued by a Federally recognized Indian Tribe identified in the FEDERAL REGISTER by the Bureau of Indian Affairs within the U.S. Department of the Interior, and including Tribes located in a State that has an international border...

(6) A data match with the Social Security Administration.

(b) *Evidence of citizenship.* If an applicant does not provide documentary evidence from the list in paragraph (a) of this section, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in paragraph (c) of this section—

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Guam, American Samoa, Swain's Island, Puerto Rico (if born on or after January 13, 1941), the Virgin Islands of the U.S. or the CNMI (if born after November 4, 1986, (CNMI local time)). The birth record document may be issued by a State, Commonwealth, Territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico or the Northern Mariana Islands before the applicable date referenced in this paragraph, the individual may be a collectively naturalized citizen. The following will establish U.S. citizenship for collectively naturalized individuals:

(i) Puerto Rico ...

(ii) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI))...

(2) At State option, a cross match with a State vital statistics agency documenting a record of birth.

(3) A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.

(4) A Report of Birth Abroad of a U.S. Citizen.

(5) A Certification of birth in the United States.

(6) A U.S. Citizen I.D. card.

(7) A Northern Marianas Identification Card issued by the U.S. Department of Homeland Security (or predecessor agency).

(8) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a Statement from a State-approved adoption agency that shows the child's name and U.S. place of birth.

(9) Evidence of U.S. Civil Service employment before June 1, 1976.

(10) U.S. Military Record showing a U.S. place of birth.

- (11) A data match with the SAVE Program or any other process established by DHS to verify that an individual is a citizen.
- (12) Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000 as amended (8 U.S.C. 1431).
- (13) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.
- (14) Life, health, or other insurance record that indicates a U.S. place of birth.
- (15) Official religious record recorded in the U.S. showing that the birth occurred in the U.S.
- (16) School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth.
- (17) Federal or State census record showing U.S. citizenship or a U.S. place of birth.
- (18) If the applicant does not have one of the documents listed in paragraphs (a) or (b)(1) through (17) of this section, he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized...

26. The above cited regulations state that citizenship must be verified in order to determine Medicaid eligibility. The petitioner does not meet any of the exemptions stated in the federal regulation above that would exclude him from providing documentation to verify citizenship. The authorized representative claimed that the petitioner has dual citizenship for the United States and Canada, yet the Department is not in receipt of any of the documentary evidence of citizenship as stated above. The undersigned was not able to determine if the petitioner's parents were married at the time of his birth based off the evidence provided, so this was not taken into

consideration in determining the final decision of this appeal.

27. Fla. Admin. Code R. 65A-1.715, Emergency Medical Services for Aliens, sets forth:

(1) Aliens who would be eligible for Medicaid but for their immigration status are eligible only for emergency medical services. Section 409.901(10), F.S., defines emergency medical conditions.

(2) The Utilization Review Committee (URC) or medical provider will determine if the medical condition warrants emergency medical services and, if so, the projected duration of the emergency medical condition. The projected duration of the emergency medical condition will be the eligibility period provided that all other criteria are continuously satisfied.

(3) Emergency services are limited to 30 consecutive days without prior approval. For continued coverage beginning with the 31st day prior authorization must be obtained from the Agency for Health Care Administration (Medicaid Program Office).

28. The above regulation states that noncitizens who would otherwise be eligible for Medicaid except for their noncitizen status are eligible for emergency medical services. If the petitioner has to seek emergency medical services, he can submit an application for EMA and may apply for that benefit at any time.

29. The authorized representative was pended to provide the EMA information needed but did not provide it to the Department. As such, the respondent is unable to determine if the petitioner is eligible for EMA at this time.

30. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's action to deny the petitioner's Medicaid benefits was within the rules of the program.

DECISION

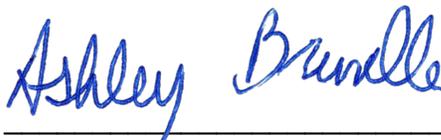
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is hereby denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 29 day of June, 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

Jun 15, 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. 18F-02554

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 8:21 a.m. on May 22, 2018.

APPEARANCES

For the Petitioner: [REDACTED], Authorized Representative (AR)

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

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to deny the petitioner retroactive Medicaid coverage for December 2017, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner resides in an institutional care facility and was not present. The petitioner's AR did not submit exhibits. The respondent's representative submitted four exhibits entered as Respondent Exhibits "1" through "4". The record was closed on May 22, 2018.

FINDINGS OF FACT

1. On January 5, 2018, a Medicaid application was submitted by [REDACTED] (JM), [REDACTED], on behalf of the petitioner. The application requested Medicaid coverage effective December 2017 (Respondent Exhibit 1).
2. On January 29, 2018, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying the January 5, 2018, application was approved for Medicaid, effective January 2018 (Petitioner Exhibit 2).
3. On March 26, 2018, the Department mailed the petitioner a NOCA, requesting the following information, due by April 5, 2018 (Respondent Exhibit 2):

Proof of income and assets for each month you are requesting retroactive Medicaid...
Also, pending all bank statements ([REDACTED]) from 12/2017 – current and Medicare Card.
4. On April 23, 2018, the petitioner's retroactive Medicaid request for December 2017 was denied; for not returning the above requested documents (Respondent Exhibit 4). However, the Department did not mail the petitioner a denial notice until May 22, 2018 (Respondent Exhibit 2).

5. The petitioner's AR said the respondent's representative called JM (the petitioner's AR's co-worker) and informed her the petitioner's December 2017 Medicaid was denied; due to not providing asset verification.
6. The respondent's representative agreed he informed JM during a pre-hearing call that the petitioner's December 2017 Medicaid was denied; due to not receiving asset verification.
7. The petitioner's AR did not dispute not providing the petitioner's asset documents for December 2017.
8. The petitioner's AR argued that the petitioner was approved for food assistance benefits without asset verification; and did not understand the reason the Department was requesting asset verification for the December 2017 Medicaid benefits.
9. The respondent's representative explained that the Department does not require asset verification for food assistance benefits; however, asset verification is required for retroactive Medicaid.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
11. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.
12. *Florida Administrative Code* R. 65A-1.702, Special Provisions, in part states:

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

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

13. In accordance with the above authority, Memorial Healthcare System requested December 2017 retroactive Medicaid coverage for the petitioner.

14. *Florida Administrative Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria*, in part states “**(1) Resource Limits. If an individual’s total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C...**” (emphasis added)

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

16. In accordance with the above authorities, an individual’s asset cannot exceed \$2,000 during the month of Medicaid eligibility. Therefore, the Department required verification that the petitioner’s assets did not exceed \$2,000 in December 2017.

17. *Florida Administrative Code R. 65A-1.205, Eligibility Determination Process*, in part states:

(1)(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for

employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request...

If the applicant does not provide required verifications or information by the deadline date the application will be denied...

18. In accordance with the above authority, the Department mailed the petitioner a NOCA on March 26, 2018, requesting verification of his assets for December 2017, due by April 5, 2018.

19. The evidence submitted establishes the petitioner did not submit the requested December 2017 asset verification required to determine his December 2017 Medicaid eligibility.

20. The petitioner's AR did not dispute not providing the petitioner's asset verification for December 2017.

21. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof. The Hearing Officer concludes the Department's action to deny the petitioner retroactive Medicaid coverage for December 2017, is proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 15 day of June , 2018,

in Tallahassee, Florida.



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

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

Jun 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. 18F-02636

PETITIONER,

Vs.

CASE NO. [Redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 88DR1

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 15, 2018 at 1:05 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [Redacted]

For the Respondent: Stephanie Ross, DCF Economic self-sufficiency Specialist II

STATEMENT OF ISSUE

At issue is the respondent's (or Department's) action to deny the petitioner's request for Family-Related Medicaid benefits at application. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted an evidence packet which was accepted and marked as Petitioner's Composite Exhibit 1. The respondent submitted seventeen (17) exhibits which were marked and entered as Respondent's Exhibits "1" through "17". The record was left open through May 29, 2018 for the respondent to further explore the authentication process with the DR and for the DR to respond with any objection.

On May 15, 2018, the respondent submitted a statement which was accepted into evidence and marked as Respondent's Exhibit 18. The petitioner's representative did not provide any additional information, nor did he contact the hearing officer for additional time. The record was closed on May 29, 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. From August 29, 2017 through September 11, 2017, the petitioner incurred some medical expenses at [REDACTED]. On August 31, 2017, the petitioner appointed [REDACTED], LLC as her designated representative, see Petitioner's Composite Exhibit 1.
2. On September 1, 2017, the DR submitted a web application requesting Family-Related Medicaid, see Respondent's Exhibit 10. The respondent's running record comments (CLRC) indicate that the petitioner's application was flagged as "No ID discovered", "Not Authenticated".

3. As part of the application process, the respondent is required to establish, explore, and verify all factors of eligibility. The applicant's cooperation in securing such verification(s) is requested if deemed necessary.
4. All applicants for benefits need to be authenticated and identified. Identification and authentication are two different things. The authentication process helps to ensure the person completing the application is the actual person by using a series of questions that only the applicant should know. Both factors must be met for the case to be approved.
5. On September 7, 2017, the respondent sent the petitioner a Notice of Case requesting informing her that she needed to report to [REDACTED] for a face-to-face interview on September 18, 2017 at 11:00 a.m. A separate notice was sent to the DR addressed to [REDACTED] : [REDACTED], [REDACTED] indicating the same, see Respondent's Exhibits 1 and 2. The petitioner did not report for the interview as requested.
6. On October 4, 2017, the respondent sent a Notice of Case Action to the petitioner informing her that her Medicaid application was denied citing, "No household members are eligible for this program", see Respondent's Exhibit 5. That notice was not sent to the DR.
7. On November 30, 2017, the petitioner submitted a web application requesting Family-Related Medicaid, see Respondent's Exhibit 11. The respondent's CLRC comments indicate that the petitioner's application was flagged as "No ID discovered ", "Not Authenticated".

8. On December 11, 2017, the petitioner reported to the local Daytona Beach DCF office to turn in pending information. The respondent testified that she did not tell the staff there that she needed to be authenticated.

9. On December 12, 2017, the respondent sent the petitioner a Notice of Case requesting verification of her household income by December 22, 2017. The notice also informed her that she needed to call to be authenticated and that she needed to answer questions to confirm her identity. A separate notice was sent to the DR at [REDACTED] [REDACTED] indicating the same, see Respondent's Exhibits 3 and 4.

10. On January 3, 2018, the respondent sent the petitioner a NOCA denying the request for Medicaid because information requested was not received, see Respondent's Exhibit 6.

11. On January 29, 2018, the representative sent an inquiry to the respondent requesting an update on the application. Respondent documented in its case record that the petitioner still needed to be authenticated.

12. On March 16, 2018, the petitioner submitted a new web application requesting Family-Related Medicaid. The alerts "ID Discovered" and "Not Authenticated" appeared on the application, see Respondent's Exhibit 12.

13. On March 21, 2018, the respondent mailed the petitioner a Notice of Case requesting verification of her household income by April 2, 2018, see Respondent's Exhibit 7.

14. On March 26, 2018, the DR requested the appeal challenging the respondent's action.

15. On April 17, 2018, the respondent sent a Notice of Case Action to the petitioner informing her that her March 16, 2018 Medicaid application was denied citing, “No household members are eligible for this program”, see Respondent’s Exhibit 9.

16. The respondent explained that customer authentication is required when an application is submitted for any program and must be completed. She asserts as follows: (1) that the petitioner was not authenticated by the system and that a manual authentication process was necessary; (2) that the petitioner was identified, but needed to be authenticated before her Medicaid could be approved and (3) that she did not receive the authorized representative form until after the representative requested the hearing; therefore, could not use the DR to authenticate the petitioner.

17. The DR argued that once the petitioner reported to the service center to be “identified”, she should have been determined to be “authenticated”. He agreed to undergo the authentication process on behalf of the petitioner. He is seeking Medicaid coverage for the petitioner effective August 2017.

18. During the hearing, the respondent recognized the designated representative as being qualified to act on the petitioner’s behalf and agreed to attempt the authentication process through him. The record was left open through May 29, 2018 for that purpose. On May 15, 2018, the undersigned received a statement from the respondent indicating that the DR was unable to answer a basic question about the petitioner; therefore, has failed the authentication test and that the case will remain denied, see Respondent’s Exhibit 18.

19. As of the day of this order, the DR did not submit any objection or rebuttal to the respondent’s statement regarding the authentication process.

CONCLUSIONS OF LAW

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

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

22. 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.

23. The Fla. Admin. Code R 65A-1.205, addresses Eligibility Determination Process and sets forth the time frame for an applicant to provide additional information:

(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.

(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...

24. Initially, the respondent did not use the DR as a source to authenticate the petitioner. During the hearing, the respondent acknowledged the DR as being qualified

to act on the petitioner's behalf and agreed to attempt the authentication process through him. The DR agreed.

25. 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.”

26. Federal Regulations at 42 C.F.R. § 435.923 define authorized representatives and state:

(a)(1) The agency must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency. Such a designation must be in accordance with paragraph (f) of this section, including the applicant's signature, and must be permitted at the time of application and at other times.

(2) Authority for an individual or entity to act on behalf of an applicant or beneficiary accorded under state law, including but not limited to, a court order establishing legal guardianship or a power of attorney, must be treated as a written designation by the applicant or beneficiary of authorized representation.

(b) Applicants and beneficiaries may authorize their representatives to—

(1) Sign an application on the applicant's behalf;

(2) Complete and submit a renewal form;

(3) Receive copies of the applicant or beneficiary's notices and other communications from the agency;

(4) Act on behalf of the applicant or beneficiary in all other matters with the agency.

(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. Such notice must be in accordance with paragraph (f) of this section and should include the applicant or authorized representative's signature as appropriate.

(d) The authorized representative—

(1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in paragraph (b)(2) of this section, to the same extent as the individual he or she represents; (emphasis added)

(2) Must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

(e) The agency must require that, as a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization must affirm that he or she will adhere to the regulations in part 431, subpart F of this chapter and at 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of this chapter (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

(f) For purposes of this section, the agency must accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission. Designations of authorized representatives must be accepted through all of the modalities described in §435.907(a).

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

passage:0640.0109 addresses Designated Representatives (MSSI) and states:

A designated representative may be appointed or self-designated to act on behalf of the household. If the individual does not select a specific person as designated representative, determine if the self-designated representative is the most appropriate person to fulfill this responsibility. An applicant must authorize a designated representative in writing prior to eligibility determination or anytime during the review period. The applicant does not have to be functionally or legally incompetent to have a designated representative...

28. Based on the above cited, the DR can act on behalf for the applicant. He assumes the same rights and responsibilities as the applicant, including the responsibility of furnishing information, documentation and verification needed.

29. In this instant case, the DR agreed to answer a series of questions about the petitioner for authentication purposes; however, he failed to provide the correct answers according the respondent. The designated representative assumes the obligation for fulfilling all responsibilities encompassed within the scope of the authorized representation, to the same extent as the individual he represents and he failed to do so.

30. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not met his burden of proof in establishing the respondent incorrectly denied his requests for Family-Related Medicaid benefits effective with the September 1, 2017.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 11 day of June, 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

Jun 07, 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-02666

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 08 Alachua
UNIT: 88882

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 14, 2018 at 1:08 p.m.

APPEARANCES

For the Petitioner: , aunt and authorized representative

For the Respondent: Sheila Hunt, economic self-sufficiency specialist II

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

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

By notice dated March 7, 2018, the Department informed the petitioner that her application for SSI-Related Medicaid was denied. The notice reads in relevant part, “[y]ou...do not meet the disability requirement.”

The petitioner timely requested a hearing to challenge the Department’s decision.

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

Rebecca Sills, program administrator, Division of Disability Determination, was present as a witness for the Department. The Department submitted documentary evidence which was admitted into the record as Respondent’s Exhibit 1.

The record was closed on May 14, 2018.

FINDINGS OF FACT

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

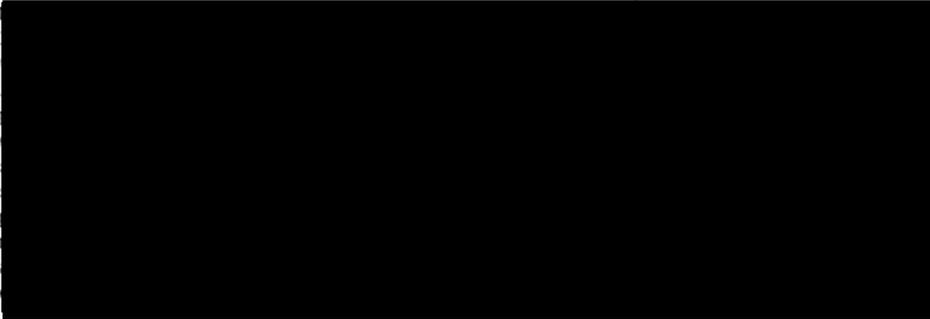
1. The petitioner (██████) filed an application for SSI Related-Medicaid with the Department on January 11, 2018. The petitioner is a single adult; she does not have minor children. The petitioner lives in the family home with her grandmother, mother and sibling (age 19). The petitioner asserted that she is disabled due to an ██████████ ██████████ (Respondent’s Exhibit 1 and Department testimony)

2. To be eligible for SSI-Related Medicaid, an applicant must be age 65 or older or be determined disabled by the Social Security Administration or the Department. The Department contracts with the Division of Disability Determination (DDD) to make disability determinations for its SSI-Related Medicaid applicants under age 65. The

Department referred the petitioner's case to DDD on February 9, 2018 2018 for a disability review.

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

4. DDD reviewed the petitioner's claim that she is disabled due to an [REDACTED] [REDACTED] and determined that the petitioner was not disabled at step five of the disability analysis. DDD determined that the petitioner's educational records (grade school records which show she was enrolled in special education classes exclusively and received a special education diploma) and psychological records (which show she has full scale IQ of 67, which is considered consistent with mild [REDACTED]) proved that she is [REDACTED]d, but that her disability is mild and does not prevent her from performing unskilled manual labor jobs which involve simple and repetitive tasks, such as sorter, key cutter, and paper cutter. DDD explains its decision in the Case Analysis section of the petitioner's Disability Assessment:

Assessment:	
Seq. Eval.2: Is the impairment severe?	Yes
Seq. Eval.3: Does the impairment meet or equal a listing?	██████████
Seq. Eval.4: Can the claimant perform past relevant work?	No
Seq. Eval.5: Can the claimant perform other work?	Yes
Data: Clmnt is a ██████ old female w/ an allegation of ██████ Her highest level of education is a special high school diploma.	
ADLs: She is able to do her own self care and can do hh chores w/ some difficulty cooking due to difficulty following directions. She does not have any difficulty walking and is able to L&C 30 pounds. She is unable to drive because she could never pass a driving test. She thinks she could do her own shopping, but she has difficulty making sense of money. She lives w/ family.	
	
Summary/Decision: No physical limitations have been established that would preclude the clmnt from any level of physical work. Based on the MRFC by Dr. Thomas Clark the clmnt is capable of performing SRTs. As a result the clmnt is determined to be not disabled. Case is denied N32. Possible jobs include:	

(Respondent Exhibit 1 and Rebecca Sills testimony)

5. DDD informed the Department that the petitioner did not meet the disability criteria via transmittal on March 6, 2018. The Department issued a denial notice to the petitioner on March 7, 2018. (Respondent's Exhibit 1 and Sheila Hunt testimony)

6. The petitioner requested a hearing on March 15, 2018. (Respondent's Exhibit 1)

7. In early 2018, the petitioner also applied for disability benefits with the Social Security Administration (SSA). Both her DCF Medicaid application and SSA disability application were pending at the same time. On May 4, 2018, after the Department's decision, but before the hearing convened, SSA also determined that the petitioner did

not meet the disability criteria because she was capable of performing some work in the national economy. The Department explained that SSA's decisions are binding on the Department and supersede independent disability decisions made by the Department, when the decisions differ, unless there is a disabling condition not reviewed by SSA. This means that if the Department determined in March 2018 that the petitioner met the intellectual disability criteria, it would have been required to adopt SSA's May 2018 adverse decision and deny or terminate the petitioner's Medicaid, unless the petitioner claimed a disabling condition not reviewed by SSA. The petitioner asserted no disabling condition other than [REDACTED]. SSA's decision is binding on the Department. (Testimony of Sheila Hunt and Rebecca Sills)

8. The petitioner's representative explained that after receiving a special education diploma, the petitioner attended a vocational rehabilitation program for a number of years, to develop job skills, but her efforts were not successful. The petitioner participated in several unpaid internships, but was never offered a paid position because she lacked the intellectual ability to perform the job duties. The petitioner has never worked outside the family home. She is given an occasional allowance for helping her elderly grandmother with errands within the family home, such as locating the grandmother's walker/stroller. (Testimony of [REDACTED])

9. The petitioner's representative argued that her [REDACTED] prevents her from being able to hold down a job is evidenced by the fact the another agency, the Agency for Persons with Disabilities (an agency which operates a Medicaid Waiver Program that provides support services for adults diagnosed with specific

developmental disabilities, including [REDACTED]), approved the petitioner's application for program participation under the category of [REDACTED], but due to limited funding, the petitioner was placed on a waiting list and is not currently receiving support services through the waiver. The representative summarized her position in a written statement:

The documents attached are provided as evidence and provide information that indicate that [REDACTED] was approved based on the documents provided as [REDACTED]. She has filed a disability claim with the Department of Children and Families as well as the Agency for Persons with Disabilities; this same documentation is attached. This evidence clearly shows that she has an [REDACTED]. The document established that her impairment has been since the age of 6 years old. The public-school education experts indicated her ability to function and impairment has been in effect since she first began attending public school. Special Education classes have been recommended by a school psychologist and from 1st grade until the age of 18 as she was granted graduation from public school in [REDACTED] county with special education criteria. (IEP's are attached for all grade levels)

After leaving public school [REDACTED] Community College provided her with ABE Literary class instruction to assist [REDACTED] in advancing further in her vocational goals. She also asked for assistance with work search through Vocational Rehabilitation services [REDACTED] followed all instructions and to the best that her impairment would allow, she has been trying to find and secure employment since the age of 18. Vocational Rehabilitation did provide, (copy is attached) a psychological evaluation at the age of 25 and this documentation is evidence that her impairment affects her ability to function the same as would all adults in her age level. It clearly reflects that because [REDACTED] is not able to find gainful employment and due to her disability, that her functional abilities may in fact be the reason. [REDACTED] is willing and is physically able; however, the existence of her intellectual impairment does not allow her to obtain a GED diploma, it does not allow her to apply for jobs that physically impaired individuals with IQ scores exceed hers are qualified for, it clearly leads to the fact that is why a working setting as an adult has not been found by the VR counselors that have attempted to assist [REDACTED]. Through their efforts the experts for individuals with a wide range of abilities, not even Vocational Resources have provided, employment opportunities that have resulted in gainful employment to support [REDACTED] to be an independent adult [REDACTED] is in desperate need to provide her own food, housing, and healthcare. The simple opportunity that any adult of her age is at a minimum offered in our prosperous community, should be available to her, at no fault of her own [REDACTED] has not been supported by our community at its best attempt in providing and the educational opportunities made available to her failed in this quest of her search to be as independent as possible.

(Petitioner's Exhibit 1 and [REDACTED] testimony)

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, 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-1.711 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. For an individual less than 65 years of age to receive SSI-Related Medicaid benefits, he or she must meet the disability 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.

13. Federal Regulation at 42 C.F.R. § 435.541 provides standards for state disability determinations 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.

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

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

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

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

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and-

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

...

14. On March 7, 2018, the Department denied the petitioner's application for SSI-Related Medicaid. The Department determined that the petitioner did not meet the disability criteria because she was capable of performing unskilled manual labor jobs which involve simple and repetitive tasks. On May 4, 2018, SSA also determined that the petitioner did not meet the disability criteria because she is capable of performing some work in the national economy.

15. The petitioner's representative argued that her [REDACTED] has prevented her from ever being able to find employment, even after numerous years of vocational rehabilitation training.

16. The controlling legal authorities explain that the Department is required to adopt unfavorable SSA decisions made within one year of the date of application for Medicaid and all disabling conditions have been reviewed. The petitioner applied for Medicaid on January 11, 2018. The petitioner asserted that she was disabled to [REDACTED]. SSA made an unfavorable disability decision based on the petitioner's assertion of [REDACTED] on May 5, 2018. The petitioner did not assert, and there is no evidence of, a disabling condition not reviewed by SSA. The Department is bound by SSA's decision in this matter.

The petitioner noted that she has been approved for APD waiver participation under the category of [REDACTED]. DCF and APD are different government agencies which are controlled by different legal authorities. The agencies have different eligibility criteria. The Department is not bound by APD eligibility determinations.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 07 day of June, 2018,

in Tallahassee, Florida.



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

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

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

FILED

Jun 19, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-02679

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Seminole
UNIT: 55207

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 2:24 p.m. on May 14, 2018.

APPEARANCES

For the Petitioner: [REDACTED], pro se

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

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to terminate the petitioner's Medicare Saving Program (MSP) Qualified Medicare Beneficiary (QMB) and instead authorize MSP Special Low-Income Medicare Beneficiary (SLMB), is proper.

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

PRELIMINARY STATEMENT

The petitioner did not submit exhibits. The respondent submitted seven exhibits, entered as Respondent Exhibits “1” through “7”. The record was closed on May 14, 2018.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received MSP QMB.
2. On December 26, 2017, the petitioner submitted a redetermination application for MSP (Respondent Exhibit 2).
3. In 2016, the petitioner received \$1,016 in Social Security (SS). In 2017, the petitioner received SS Cost of Living Adjustment (COLA), which increased his SS amount to \$1,037 (Respondent Exhibit 4, page 15).
4. The Department determined the petitioner’s MSP eligibility using \$1,036 SS instead of \$1,037 (Respondent Exhibit 6, page 20). The following is the Department’s budget calculation:

\$1,036	SS
<u>-\$ 20</u>	<u>unearned income disregard</u>
\$1,016	total countable income

5. The income limit for an individual to be eligible for QMB is \$1,005 monthly. The petitioner’s \$1,016 monthly income exceeds \$1,005.
6. The next available MSP is SLMB. The income limit for an individual to be eligible for SLMB is \$1,206 monthly. The petitioner’s \$1,016 monthly income does not exceed \$1,206; therefore, he was eligible for SLMB.

7. On January 3, 2018, the Department mailed the petitioner a Notice of Case Action, notifying his QMB would end on January 31, 2018, and he was approved for SLMB effective February 2018 (Respondent Exhibit 3).

8. The petitioner disagrees that the COLA increase caused him to lose QMB. The petitioner argued that his doctor co-pay visits are more than the COLA increase he received.

CONCLUSIONS OF LAW

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

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

11. *Florida Administrative Code* R. 65A-1.702, Special Provisions, explains MSP and in part states:

(12) Limits of Coverage.

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

(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application...

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

12. *Florida Administrative Code* R. 65A-1.713, SSI-Related Medicaid Income Eligibility

Criteria, in part states:

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

(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...

13. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9 (January 1, 2018), identifies the income standard for QMB as \$1,005 and SLMB as \$1,206.

14. Title 20 of the Code of Federal Regulations § 416.1121, Types of unearned income in part 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..."

15. Title 20 of the Code of Federal Regulations § 416.1124(c) (12) establishes a \$20 disregard for "the first \$20 of any unearned income in a month".

16. In accordance with the above authorities, the Department subtracted \$20 from the petitioner's \$1,036 SS income to arrive at \$1,016 monthly income.

17. The petitioner's correct SS income amount is \$1,037; subtracting \$20 from \$1,037 results in \$1,017.

18. Both amounts, \$1,016 and \$1,017, are over the \$1,005 QMB income limit and under the \$1,206 SLMB income limit.

19. In careful review of the cited authorities and evidence, the undersigned concludes the Department met the burden of proof. The Hearing Officer concludes the

Department's action to terminate the petitioner's MSP QMB and instead approve MSP SLMB, 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 19 day of June, 2018,

in Tallahassee, Florida.



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

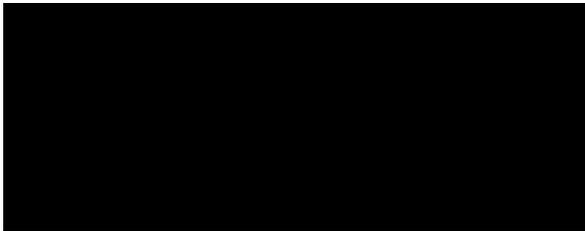
Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

FILED

Jun 28, 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-02695

PETITIONER,

Vs.

CASE NO. 

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 1, 2018 at 1:09 p.m.

APPEARANCES

For the Petitioner: , daughter

For the Respondent: Stanley Jones, economic self-sufficiency specialist II

STATEMENT OF ISSUE

The petitioner is appealing the amount of spousal allowance he is allowed to receive from his wife, who resides in a long term care facility (nursing home) with the assistance of Institutional Care Program (ICP) Medicaid. The petitioner seeks a higher

spousal allowance. The petitioner holds the burden of proof at the level of preponderance of the evidence.

PRELIMINARY STATEMENT

Florida Department of Children and Families (Department or respondent) determines eligibility for ICP Medicaid and the amount of spousal allowance the community spouse is eligible to receive.

By notice dated April 3, 2018, the Department informed the petitioner's wife that she was eligible for ICP Medicaid. The notice further informed her that she may give her community spouse, the petitioner, \$833.46 of her monthly income as a spousal allowance.

On the same day, April 3, 2018, the petitioner and his daughter/authorized representative requested a hearing. The petitioner is seeking a higher spousal allowance.

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

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

The hearing record was closed on June 1, 2018.

FINDINGS OF FACT

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

1. The petitioner's wife ([REDACTED]) suffered [REDACTED] in 2016; she was admitted into a nursing home because she required total care. In January 2018, a representative applied for ICP Medicaid to help cover the cost of her nursing home care. The Department approved her application on April 3, 2018. The notice reads in pertinent part:

Medicaid

Your application for Medicaid dated January 26, 2018 is **approved**. You are eligible for the months listed below:

Name	Apr, 2018
[REDACTED]	Eligible
[REDACTED]	Ineligible
Your gross countable income	\$4090.26
Amount you keep for personal needs	\$105.00
Amount you may give to your community spouse/dependents	\$833.46
Amount you are expected to pay the nursing facility or provider (1)	\$2915.00

(Respondent's Exhibit 1 and Testimony of [REDACTED])

2. The petitioner (age 85) filed a hearing request on April 3, 2018. He is seeking a higher spousal allowance (to keep more of his wife's income for his expenses in the community). The hearing request reads in pertinent part:

My ICP case has been approved but DCF is not allowing for proper diversion to community spouse in an ALF. Policy allows for rent as a deduction in the spousal budget. The issue here is that the ALF charges for room and board as a package deal and the board cannot be separated from the total. Verification of this was sent to the DCF caseworker but the room and board bill / verification was not considered in the budget. My income and assets are insufficient to pay the monthly room & board and this causing an extreme hardship.

(Respondent's Exhibit 1)

3. The petitioner and his daughter explained that he traveled daily from the family home in [REDACTED] to his wife's nursing home in [REDACTED] help care for

her, 100 miles round trip daily. During the commute, the petitioner had two car accidents within a short period of time. Concerned for his safety, the petitioner and his daughter decided he should live in [REDACTED] to be closer to his wife. The petitioner moved into [REDACTED] (ALF) in January 2018. The petitioner is verbal and ambulatory; he is no visual or hearing impairments. He is independent with all the activities of daily living (ADLs); however, the petitioner explained with age, it takes more to perform ADLs. The primary purpose of moving in the ALF was so the petitioner could be closer to his wife. The family was also concerned that he was only eating one meal a day and he occasionally forgets to take his medication on time. ALF staff ensure that he receives three meals daily and that he takes his medication as prescribed. (Testimony of petitioner and [REDACTED])

4. The petitioner's ALF monthly room and board charges are \$2,950. The petitioner's daughter has been using her retirement savings to pay the ALF charges. The charges are depleting her savings and causing financial hardship. The family would like to increase the monthly spousal allowance the petitioner receives from his wife from \$833.46 to \$2,950, to cover his ALF charges. (Testimony of petitioner and [REDACTED])

5. The petitioner's monthly income and expenses are as follows:

INCOME TYPE	AMOUNT	EXPENSE TYPE	AMOUNT
Social Security Retirement	\$1,189.00	Car Payment	\$ 349.12
Pension 1	\$ 126.00	Credit Cards (6 cards)	\$ 950.00
Pension 2	\$ 140.00	Property Tax and maintenance	\$ 100.00

		(unoccupied family home)	
Spousal Allowance From Wife	\$ 833.46	Electric Bill (unoccupied family home)	\$ 87.00
		Cell Phone	\$ 180.00
		Cell Phone Car Service	\$ 20.00
		Internet	\$ 25.00
		Health Insurance Premium	\$ 407.57
		Medications	\$ 30.00
Total	\$2,288.46		\$ 2,148.69

6. The wife's monthly income consists of \$2,592.50 Pension, \$148.76 Insurance Subsidy, and \$1,349 SSRE. The Department's calculation of her patient responsibility was as follows:

INCOME PROTECTED FIRST/LAST MONTH: N

TOTAL GROSS EARNED INCOME:	.00
TOTAL GROSS UNEARNED INCOME: +	4090.26
REPARATION PAYMENTS: +	.00
TOTAL INCOME: =	4090.26
PERSONAL NEED ALLOWANCE: -	105.00
MAINTENANCE NEED ALLOWANCE: -	833.46
1/2 THERAPEUTIC WAGES: -	.00
OTHER INCOME EXCLUDED FROM ELIGIBILITY DETERM.: +	.00
UNCOVERED MEDICAL EXPENSES: -	236.80
PATIENT RESPONSIBILITY: =	2915.00

(Respondent's Exhibit 1)

7. The Department's calculation of the petitioner's spousal allowance was as follows:

SPOUSE: [REDACTED]	SSN: [REDACTED]	DEPENDENTS:
	SHELTER COSTS: 699.59	
	30% OF MMMIA: - 609.00	
	EXCESS SHELTER COSTS: = 90.59	
	MMMIA: + 2030.00	
	TOTAL: = 2120.59	
	ALLOWABLE SHELTER DEDUCTION: = 2120.59	
	COMMUNITY SPOUSE GROSS INCOME: - 1287.13	
	COMMUNITY SPOUSE INCOME ALLOWANCE: = 833.46	
(IF COMMUNITY SPOUSE)	(IF NO COMMUNITY SPOUSE)	
MMMIA - INCOME = SUBTOTAL ALLOWANCE	TOTAL DEPENDENT CNS: .00	
	TOTAL DEPENDENT INCOME: - .00	
	DEPENDENT ALLOWANCE: = .00	

(Respondent's Exhibit 1)

8. The Department explained that the \$699.59 shelter costs included in the spousal allowance budget were for property taxes, maintenance, etc., for the unoccupied family home, which the petitioner and his wife own (they do not have a mortgage). The Department explained that its policies include an expense deduction for ALF room charges, if the charges can be distinguished from the board charges (meals, personal care, etc.). The petitioner's ALF could not or would not distinguish room and board charges; accordingly, the Department could not allow a room/shelter expense deduction in the petitioner's budget. (Department testimony)

9. The Department also noted that the income reported for the petitioner during the application process (\$1,189 SSRE + \$98.13 Pension = \$1,287.13) was less than what was reported during the hearing (\$1,189 SSRE + \$140 Pension 1 + \$126 Pension 2 = \$1,455). (Department testimony)

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, 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-1.713 "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). When averaging income, all income from the most recent consecutive four weeks shall be used if it is representative of future earnings. A longer period of past time may be used if necessary to provide a more accurate indication of anticipated fluctuations in future income.

...

(b) For institutional care, hospice, and HCBS waiver programs the department applies the following methodology in determining eligibility:

1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month.
2. If the individual's monthly income does not exceed the institutional care income standard in any month the department will prorate the income over the period it is intended to cover to compute patient responsibility, provided that it does not result in undue hardship to the client. If it causes undue hardship it will be counted for the anticipated month of receipt.

13. The Department's ACCESS Program Policy Manual, CFOP 165-22, section

1840.0101 "Earned and Unearned Income (MSSI, SFP)" states in relevant part:

Income is classified into two categories for budgeting purposes: earned income and unearned income. All non-exempt income must be verified at application and review unless otherwise specified.

Exempt income is income (earned or unearned) that is excluded from consideration when determining eligibility or patient responsibility. Accept the individual's statement for amount and type of exempt income, unless information is questionable or verification is required.

...

Unearned income is income for which there is no performance of work or services. Unearned income may include:

1. retirement, disability payments, unemployment/workers' compensation, etc.;
2. annuities, pensions, and other regular payments;
3. alimony and support payments;
4. dividends, interest, and royalties;
5. proceeds of life insurance policies;
6. prizes and awards;
7. gifts and inheritances; and
8. SSA, SSD, and SSI.

14. The Department's Policy Manual section 1840.0102 ""Deductions from Gross

Income (MSSI, SFP)" states in relevant part:

Some deductions withheld from gross income must be included as income. Examples of these deductions include:

1. premiums for Supplemental Medical Insurance (SMI/Medicare) from a Title II (Social Security) benefit,
2. premiums for health insurance or hospitalization,
3. premiums for life insurance,
4. federal and state income taxes,
5. Social Security taxes,
6. optional deductions,
7. a garnished or seized payment,
8. guardianship fees, and
9. child support if not redirected irrevocably from the source.

15. The authorities cited above set forth income, deductions, and budget calculations for ICP Medicaid. After careful review, the evidence proves that the petitioner's income was underreported during his wife's ICP application process (\$1,287.13 monthly income reported during application process versus \$1,455 actual monthly income) which resulted in him receiving a large spousal allowance from his wife than he was actually eligible to receive. In turn, his wife's patient responsibility (the amount she owes the nursing facility each month) was understated. However, the undersigned will not order a less advantageous outcome (smaller spousal allowance than the petitioner currently receives).

16. The petitioner would like to increase the monthly spousal allowance that he receives from his wife from \$833.46 to \$2,950, to cover his ALF charges.

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

(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. Spousal impoverishment policies are not applied to individuals applying for, or receiving services under, HCBS Waiver Programs, except for individuals in the Long-Term Care Community Diversion Program, the Assisted Living Facility Waiver or the Cystic Fibrosis Waiver.

(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.

(b) At the time of application only those countable resources which exceed the community spouse's resource allowance are considered available to the institutionalized spouse.

(c) The community spouse resource allowance is equal to the maximum resource allocation standard allowed under 42 U.S.C. § 1396r-5 or any court-ordered support, whichever is larger.

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

(e) If either spouse can verify that the community spouse resource allowance provides income that does not raise the community spouse's income to the state's minimum monthly maintenance income allowance (MMMIA), the resource allowance may be revised through the fair hearing process to an amount adequate to provide such additional income as determined by the hearing officer. Effective November 1, 2007 the hearing officers must consider all of the community spouse's income and all of the institutionalized spouse's income that could be made available to a community spouse. The hearing officers will base the revised community spouse resource allowance on the amount necessary to purchase a single premium lifetime annuity that would generate a monthly payment that would bring the spouse's income up to the MMMIA (adjusted to include any excess shelter costs). The community spouse does not have to actually purchase the annuity. The community spouse will have the opportunity to present convincing evidence to the hearing officer that a single premium lifetime annuity is not a viable method of protecting the necessary resources for the community spouse's income to be raised to the state's MMMIA. If the community spouse requests that the revised allowance not be based on the earnings of a single premium lifetime annuity, the community spouse must offer an alternative method for the hearing officer's consideration that will provide for protecting the minimum amount of assets required to raise the community spouse's income to the state's MMMIA during their lifetime.

(f) Either spouse may appeal the post-eligibility amount of the income allowance through the fair hearing process and the allowance may be adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the allowance to meet their needs exist. Exceptional circumstances that result in extreme financial duress include circumstances other than those taken into account in establishing maintenance standards for spouses. An example is when a community spouse incurs unavoidable expenses for medical, remedial and other support services which impact the community spouse's ability to maintain themselves in the community and in amounts that they could not be expected to be paid from amounts already recognized for maintenance and/or amounts held in resources. Effective November 1, 2007, the hearing officers must

consider all of the community spouse's income and all of the institutionalized spouse's income that could be made available to a community spouse. If the expense causing exceptional circumstances is a temporary expense, the increased income allowance must be adjusted to remove the expenses when no longer needed.

(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:

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.

(emphasis added)

18. A Department memorandum entitled "Excess Shelter Allowance for Community Spouse in ALF", dated August 18, 2003, explains that if an ALF is "unwilling or unable to identify the amount of the bill attributable to the room cost, no amount of the ALF bill can be used towards the community spouse shelter excess expense." The memorandum further explains that "[t]he only way the individual may be granted an increase in the community spouse income allowance is through a fair hearing."

19. The authorities cited above allow for an increase in the spousal allowance an ICP Medicaid recipient gives to their community spouse if the community spouse demonstrates exceptional circumstances. Examples of exceptional circumstances are

“unavoidable expenses for medical, remedial and other support services which impact the community spouse’s ability to main themselves in the community...”

20. After careful review, the undersigned concludes that the petitioner failed to demonstrate exceptional circumstances which necessitate an increase in the spousal allowance he receives from his wife. There is no evidence of unavoidable medical or remedial expenses. The petitioner has no debilitating or incapacitating illness which requires support services. He is verbal, ambulatory, and independent in all activities of daily living. He has no visual or hearing impairments. The petitioner’s primary reason for moving into an ALF was to be closer to his wife’s nursing facility. The petitioner’s secondary reasons for moving into an ALF were - 1) reminders to take his medication and 2) provision of three meals daily; both needs are routine in nature and can be met outside of an ALF setting. The petitioner did not provide evidence of exceptional circumstances. The undersigned concludes that the petitioner failed to meet his burden of proof in this matter.

DECISION

Based on 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 June, 2018,

in Tallahassee, Florida.



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

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

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

FILED

Jun 15, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 18F-02711

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88656

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 21, 2018 at 2:30 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Fredo Dutes, Operations and Management Consultant

ISSUE

At issue is the respondent's action of March 28, 2018 denying the petitioner's application for SSI-Related Medicaid based on its contention that she did not meet the disability requirement.

The petitioner has the burden of proving her case by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents as evidence for the hearing.

The respondent submitted a 37-page packet of documents as evidence for the hearing, which was marked as Respondent Exhibit 1. These documents included the petitioner's Medicaid application as well as documents pertaining to the denial of her application.

FINDINGS OF FACT

1. The petitioner, who is [REDACTED] years of age, applied for SSI-Related Medicaid on March 26, 2018 for herself only.
2. The petitioner's Medicaid application included information that she had been denied Social Security Administration (SSA) disability benefits on August 10, 2017.
3. The petitioner stated she believes her disability should be approved because she has had [REDACTED] in the past. She also stated she has a pending appeal for the denial of Social Security disability benefits.
4. The Department contends that the petitioner's claim for disability was denied by the SSA within the past year; therefore, the Department adopted the SSA disability denial.

CONCLUSIONS OF LAW

5. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

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

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

7. 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

8. 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)

9. 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.

10. In this case, the petitioner's medical conditions were reviewed by the SSA in its disability determination. The petitioner has not alleged any new disabling conditions which were not reviewed by the SSA. She has a pending appeal regarding the SSA disability denial. The undersigned concludes that the petitioner did not meet the burden of proof to show that the Department's action was incorrect. The undersigned also concludes that the Department was correct to adopt the SSA denial from August 10, 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 15 day of June, 2018,

in Tallahassee, Florida.

FINAL ORDER (Cont.)

18F-02711

PAGE - 6



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

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

FILED

Jun 07, 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-02722
18F-02723

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 01 Okaloosa
UNIT: 88630

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 2, 2018 at 11:37 p.m.

APPEARANCES

For the Petitioner: [REDACTED], wife of petitioner

For the Respondent: Cecilia Salter-Cassaberry, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of January 19, 2018 terminating Supplemental Nutritional Assistance Program (SNAP) benefits due to the certification period ending. The petitioner also appeals the November 13, 2017 action by the Department denying them (husband and wife) full Medicaid or Medicare Savings Program benefits and enrolling them in the Medically Needy program. The Department holds the burden of proof by the preponderance of the evidence as related to the SNAP

issue. The petitioner carries the burden of proof by the preponderance of evidence as related to the Medicaid issues.

PRELIMINARY STATEMENT

The Department administers the Supplemental Nutritional Assistance Program also known as SNAP. SNAP is previously known as Food Assistance or Food Stamps.

The Department submitted evidence on April 25, 2018 which was entered into the record as Respondent's Exhibit 1.

The record was held open through May 9, 2018 for additional information from both parties.

The Department submitted additional information on May 3, 2018 which was entered as Respondent's Exhibit 2.

The undersigned, in review of the additional information, determined that the information was insufficient. An Order to Reopen and Supplement the Record was issued on May 4, 2018. This Order specifically requested additional information from the Department which would connect the report provided in the additional information to the petitioner's case. The order allowed the petitioner to submit any evidence they wished to submit, including any rebuttal statements. The deadline for submitting additional information was extended to May 15, 2018.

The Department submitted additional information on May 9, 2018. This was entered as Respondent's Exhibit 3.

The petitioner submitted a written statement on May 8, 2018. This was entered as Petitioner's Exhibit 1. The petitioner also submitted evidence on May 14, 2018. This was entered as Petitioner's Exhibit 2.

The record closed on May 15, 2018.

Additional information was submitted by the petitioner May 21, 2018 and May 26, 2018. This information was not reviewed or considered in the processing of this order as it was untimely filed.

FINDINGS OF FACT

1. The petitioner filed an application on October 16, 2017 for SNAP, Family Medicaid and SSI-Related Medicaid. The application reflects the household composition of a husband and wife. Both household members are disabled and receive Social Security and Medicare. (Respondent's Exhibit 1, pages 3 through 11)

2. The Department issued a Notice of Case Action dated November 13, 2017. This Notice reflected the continuation of the petitioner's Food Assistance, approval of enrollment in the Medically Needy program, and denial of the Qualifying Individuals 1. The Notice also informs the petitioner of the right to request a fair hearing before a state hearings officer within 90 days from the mailing date at the top of the notice. The Notice also explains the methods in which a person may request a fair hearing. (Respondent's Exhibit 2, pages 3 through 8)

3. The Department issued a Notice of Eligibility Review on December 18, 2017. This Notice informed the petitioner that their SNAP (Food Assistance) benefit certification would end on January 31, 2018. The Notice also informed the petitioner that they must reapply no later than January 15, 2018 to continue receiving the SNAP benefit without a break. (Respondent's Exhibit 1, pages 22 through 25)

4. The petitioner filed an appeal of action taken on SNAP benefits on December 1, 2017 (Appeal 17F-08388). The Office of Appeal Hearings records indicate the petitioner did not appear for the scheduled hearing on December 28, 2017 and did not contact the Office of Appeal Hearings regarding rescheduling the hearing. This appeal was dismissed as abandoned January 4, 2018.

5. The petitioner filed an appeal of action taken on SNAP benefits on December 29, 2017 (Appeal 18F-00017). The Office of Appeal Hearing records indicate the petitioner did not appear for the scheduled hearing on January 25, 2018 and did not contact the Office of Appeal Hearings regarding rescheduling the hearing. This appeal was dismissed as abandoned on February 1, 2018.

6. The Department found the petitioner's January 2018 SNAP benefits did not post properly due to a previous hearing. The Department created a manual issuance of the petitioner's January 2018 SNAP benefits on January 9, 2018 to issue the petitioner's January 2018 benefits of \$352. (Respondent's Exhibit 1, pages 26 through 28)

7. The petitioner maintains they did not receive any SNAP benefits for the month of January 2018.

8. The Department advised there is a report from the Electronic Benefit Transfer system to confirm the posting of the petitioner's January 2018 SNAP benefits. The Department explained that should the report show these benefits did not post properly, corrective action will be taken to ensure the benefits are issued and the petitioner will be notified.

9. The Department provided a "Transaction Search Results" report from "Government Solutions Administrative Terminal". The report shows the petitioner's SNAP Case number and EBT card number. The transactions listed each show the petitioner's EBT card number as a reference. The report shows on January 8, 2018 at 20:53 a deposit was made to the account in the amount of \$352. The report also shows card usage between January 9, 2018 and February 1, 2018 spending down the balance to \$0.23. (Respondent's Exhibit 3, pages 3 through 5)

10. The Department explained that the petitioner's benefits did not continue after January 31, 2018 as the petitioner failed to complete an application to recertify SNAP benefits for February 2018 and ongoing.

11. The petitioner maintains they filed application in October 2017 and marked the application for Food Assistance, therefore this application should have been considered for recertification even though it was submitted early.

12. The Department explained the application was marked as an application for additional assistance. As such, only the benefits that the petitioner was not already receiving were reviewed. The Department further explained that as the petitioner was already receiving SNAP benefits, that benefit was not reviewed with the October 2017 application.

13. The Department issued a Notice of Case Action on January 26, 2018 informing the petitioner that Medically Needy Bill Tracking was completed and the household members were eligible for Medicaid for the period of October 13, 2017 through October 31, 2017. However, both the husband and wife were listed as "ineligible" household members.

14. The Department provided the Medicaid Recipient Information print for the petitioner. The print shows the petitioner's Medicaid open on the file for October 13, 2017 through October 31, 2017. The printout also reflects the petitioner's eligibility for December 1, 2017 through December 31, 2017. (Respondent's Exhibit 2, page 2)

15. The petitioner submitted unpaid medical expenses. Some of the records appear to be incomplete statements from Medicare regarding medical bills. Some of the bills are from medical billing companies and include dates of service which are several years old. The records provided do not indicate if the bills have been previously provided to the Department. The records do not indicate if the bills have previously been tracked or otherwise utilized in the determination of eligibility. (Petitioner's Exhibit 2)

16. The Department explained the Medicare Savings Program has three eligibility levels. The Qualified Medicare Beneficiaries (QMB) has an income limit for a couple of \$1,392 and will pay for the Medicare premium as well as copays and deductibles. This program will also qualify the individuals for "extra helps" toward the Medicare Part D prescription coverage. The Special Low Income Medicare Beneficiaries (SLMB) has an income limit for a couple of \$1,666 and will cover the Medicare premium. This program will also qualify the individuals for "extra helps" toward the Medicare Part D prescription coverage. The Qualifying Individuals 1 (QI 1) has an income limit for a couple of \$1,872. This program covers the Medicare premium only.

17. The petitioner reported the husband's gross Social Security benefit is \$1,175 per month. The petitioner wife's gross Social Security benefit is \$920 per month.

18. The petitioner confirmed they both have Medicare with the premium of approximately \$134 per month. Their Medicare with [REDACTED] which has co-pays. The primary care physician co-pay is \$15. The in-network specialist co-pay is \$50. The out-of-network co-pay is \$70.

19. The petitioner expressed concerns that due to their health problems they have many extremely high medical bills along with these co-pays. The petitioner also expressed concern that they are now in a foreclosure status.

20. The petitioner filed a new application for SNAP benefits on May 2, 2018.

21. The Department explained the begin date for eligibility for SNAP benefits is the date of application. The Department further explained there is no "retroactive" policy regarding SNAP eligibility.

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.

Food Assistance

24. 7 C.F.R. § 273.14, Recertification, states in relevant 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.

...

(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;

(C) The consequences of failure to apply for recertification in a timely manner;

25. The findings show the petitioner was issued a Notice of Eligibility Review on December 18, 2017. The findings show the Notice informed the petitioner when the certification period expired, when they must submit the application to continue receiving uninterrupted benefits and that SNAP benefits would end if they did not reapply. The undersigned concludes the Department complied with the above controlling authority in notifying the petitioner of the certification period ending. The undersigned further concludes the petitioner was not entitled to benefits after January 2018 as they failed to complete the recertification process.

26. The findings show the petitioner filed an application October 16, 2017. The findings show the Department considered this as an application for additional assistance as the petitioner's certification period was not due to expire for several months. The undersigned concludes when the October 16, 2017 application was filed, there were still three months remaining in the current certification period. The undersigned reviewed the applicable rules and regulations. The undersigned found no requirement for the Department to complete the recertification process early when an application to add benefits is submitted.

27. 7 C.F.R. § 273.15, Fair Hearings, (k) Continuation of benefits, states in relevant part:

(1) If a household requests a fair hearing within the period provided by the notice of adverse action, as set forth in §273.13, **and its certification period has not expired**, the household's participation in the program shall be continued on the basis authorized immediately prior to the notice of adverse action, unless the household specifically waives continuation of benefits.

...

(2) Once continued or reinstated, the State agency must not reduce or terminate benefits prior to the receipt of the official hearing decision unless:

(i) The certification period expires. The household may reapply and may be determined eligible for a new certification period with a benefit amount as determined by the State agency;
(emphasis added)

28. The findings show the petitioner's certification period was scheduled to end January 31, 2018. In accordance with the above controlling authority, the current appeal or previously dismissed appeals could not extend the petitioner's certification period for SNAP benefits beyond January 31, 2018.

29. The findings show the petitioner's SNAP benefits for the month of January 2018 were issued on January 8, 2018 in the amount of \$352. The undersigned concludes the petitioner received SNAP benefits for the month of January 2018.

30. The findings show the petitioner is requesting SNAP benefits be approved back to February 2018. The undersigned reviewed all controlling authorities and can find no controlling authority by which a petitioner's SNAP benefits can be determined for months prior to the filing of an application for SNAP.

SSI-Related Medicaid / Medicare Savings Program (MSP)

31. Florida Admin. Code 65-2.046, Time Limits in Which to Request a Hearing, states in relevant part:

(1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs except the Road to Independence (RTI) Program under Section 409.1451(4), F.S., and the Adoption Subsidy Program under Sections 120.569 and 120.57, F.S. ... The 90-day time period for all other programs begins with the date following:

- (a) The date on the written notification of the decision on an application.
- (b) The date on the written notification of reduction or termination of program benefits.
- (c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.

(2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.

32. The findings show the Department issued a Notice of Case Action regarding the Medically Needy enrollment and the Qualifying Individuals I (QI 1) denial on November 13, 2017. The undersigned calculated the 90 calendar day period following the mailing date of this Notice ended on February 11, 2018.

33. The findings show the petitioner requested appeals regarding her SNAP benefits during the 90 calendar days following the Notice of Case Action dated November 13, 2017, but did not file any appeal of the Medically Needy or QI 1 determination until April 4, 2018. The undersigned concludes this appeal is filed untimely. The undersigned therefore dismisses the appeal of the Medically Needy enrollment and denial of QI 1 as untimely filed.

34. The findings show a question regarding the petitioner's share of cost being met in October 2017. The findings also show the petitioner's Medicaid is open for October 13, 2017 through October 31, 2017 on the Medicaid file. The undersigned concludes the issue is moot.

35. The findings show the petitioner submitted several medical billing records. The undersigned concludes it is premature to determine how the bills may be utilized in the petitioner's eligibility as it is unknown if the Department has previously utilized these bills in either the SNAP benefit calculation or to meet the Medically Needy Share of Cost. The Department should review the documentation provided and discuss how these bills are used with the petitioner.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the Supplemental Nutritional Assistance Program appeal is denied and the Medically Needy / Medicare Savings Program (MSP) is dismissed due to untimely filing.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 07 day of June, 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

Jun 20, 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-02780

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88998

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 29, 2018 at approximately 1:20 p.m. CDT.

APPEARANCES

For the Petitioner: [REDACTED], attorney,
[REDACTED], attorney's assistant

For the Respondent: Marjorie Desporte, attorney

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of March 19, 2018 denying the petitioner's application for Medicaid nursing home benefits because the durable power of attorney (DPOA) does not give the petitioner's agent authority to create a pooled trust. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Elise Goodine, economic self-sufficiency specialist supervisor, appeared for the respondent as custodian of the record.

Arlene Shuford, senior human services program specialist, appeared as a witness for the respondent.

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

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "6".

The respondent's counsel objected to the admission of Respondent's Exhibit 2, CF-ES 2323, a pooled trust evaluation form used by the respondent as a communication form between eligibility determination staff and the regional counsel, because of attorney client privilege. The document was admitted into evidence over her objection.

FINDINGS OF FACT

1. On January 31, 2018, the petitioner applied to the respondent for Institutional Care Program (ICP) Medicaid benefits (Respondent's Exhibit 1).
2. On February 15, 2018 by notice of case action (NOCA), the respondent requested that the petitioner submit pool trust bank statements with a due date of February 26, 2018 (Respondent's Exhibit 4).
3. On February 20, 2018, the CF-ES 2323 was sent to regional counsel for evaluation of the pooled trust documents. On March 16, 2018, counsel responded that the pooled trust documents were not acceptable stating that Section 24(b) of the DPOA

does not grant power to the agent to execute a trust on behalf of the settlor/grantor (Respondent's Exhibit 1).

4. On March 16, 2018, the January 31, 2018 application was denied (Respondent's Exhibit 1).

5. On March 16, 2018, the petitioner applied to the respondent for Medicaid nursing home benefits (Respondent's Exhibit 3).

6. On March 19, 2018, by notice of case action (NOCA), the petitioner was informed that the March 16, 2018 application was denied. The reason given on the NOCA stated "We did not receive all the information requested to determine eligibility" (Respondent's Exhibit 3).

7. The petitioner's counsel questioned the reason for the case denial. The respondent explained that the application was denied because legal had decided that the DPOA submitted does not allow the setting up of a trust (Petitioner's Exhibit 1).

8. The petitioner's counsel asserts that the petitioner's agent under the DPOA did not and cannot create a pooled trust because pursuant to law, only a non-profit can create a pooled trust. Counsel contends that the agent entered into a joinder agreement which established a sub-account under the pooled trust which allowed her to fund said sub-account under the pooled trust. Rather than creating a trust, the petitioner's counsel asserts that the agent signed a contract to enter into a pooled trust that was already created.

9. The respondent's counsel contends that signing a joinder agreement creates a pooled trust and that paragraph 24b of the DPOA prohibits the petitioner's agent from creating a trust.

10. The DPOA authorizes the petitioner's agent to act with full power and authority to do everything necessary in exercising any of the powers herein granted (1), enter into contacts and agreements (5), deal with banks (6), arrange and pay the costs of medical care, explicitly mentioning nursing homes (8), make application for any governmental agency for any benefit (19) and make investments deemed proper and to add assets to said investments (23). The DPOA also restricts the agent from executing a trust on the petitioner's behalf (24b) (Petitioner's Exhibit 3).
11. The pooled trust is funded (Petitioner's Exhibit 4).

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.
13. 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. Pursuant to Section 709.2208(2)(a), Florida Statutes, "a power of attorney...grants general authority to...buy, sell, and exchange investment instruments."
16. Pursuant to Section 709.2208(2)(f), Florida Statutes, Banks and other financial institutions, "investment instruments" means "...a statutory or common law business trust, a statutory trust... common trust funds..." thereby granting the petitioner's agent authority to invest in an already-existing trust.

17. Section 709.2201(4), Florida Statutes, Authority of agent, states "...if the subjects over which authority is granted in a power of attorney are similar or overlap, the broadest authority controls."

18. Paragraph 8 of the DPOA gives the agent the power to handle the petitioner's medical care and explicitly lists nursing homes.

19. The general grant of power in paragraph one gives the agent the power to do any act as necessary to effectuate the agent's specifically enumerated powers.

20. Paragraph 19 of the DPOA states the agent can apply for government benefits. Receiving government benefits needed for the petitioner's medical care, as granted in paragraph eight, requires the agent to place the petitioner's assets into a pooled trust in order to be eligible.

21. Paragraph 24 states explicitly that the agent cannot create a trust; however, paragraph 23 gives the agent power to make investments. Indeed, any investment she deems proper, and to add assets to said instrument.

22. To the extent paragraph 24 is ambiguous as to whether or not creating a trust is the same as investing in an existing trust, 709.2201(4) says to construe the ambiguity as granting the broader authority, not the more restrictive.

23. The hearing officer concludes that the single statement in paragraph 24b prohibiting the creation of a trust the more restrictive power when considering that elsewhere in the DPOA the agent is authorized to handle the petitioner's healthcare, enter contracts and agreements, apply for government benefits and make investments deemed proper. Paragraph five, along with others previously discussed, gives the

agent the power to execute the contract to form the sub-account under the pooled trust which becomes the vehicle for funding the trust.

24. Considering the evidence, testimony and the above cited authorities, the hearing officer concludes that the petitioner's agent had the authority to establish and fund the sub-account incorporating the terms of the pooled trust by reference and has met the burden of proof by the preponderance of evidence.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is GRANTED. The respondent is ordered to accept the establishment and funding of the sub-account incorporating the terms of the pooled trust by reference and determine eligibility from the initial application date of January 31, 2018. Once a determination is completed, inform the petitioner by NOCA and include appeal rights.

NOTICE OF RIGHT TO APPEAL

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

FINAL ORDER (Cont.)
18F-02780
PAGE -7

DONE and ORDERED this 20 day of June, 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
Marjorie Desporte, Esq.

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

FILED

Jun 29, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-02864

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 3, 2018 at 1:00 p.m.

APPEARANCES

For Petitioner: [REDACTED], pro se

For Respondent: Jackie Smalls, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner appeals Respondent's action denying her Medicaid Disability application dated February 15, 2018. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

Petitioner submitted no exhibits. Respondent submitted an evidence packet consisting of twelve exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" – "12." The record closed on May 3, 2018.

FINDINGS OF FACT

1. On February 15, 2018, Petitioner, age 56, submitted an on-line application for Food Assistance and Medicaid Disability for herself (Respondent's Exhibit 2).

Petitioner's Medicaid Disability denial is the only issue.

2. Petitioner described her disabling conditions as [REDACTED]

[REDACTED] (Petitioner's Testimony).

3. On September 19, 2016, Petitioner applied for disability through the Social Security Administration (SSA) (Respondent's Exhibit 6, Page 1).

4. On February 15, 2017, the SSA denied Petitioner's disability application with denial code N31, which means "capacity for substantial gainful activity, customary past work, no visual impairment" (*Id.*).

5. Petitioner is appealing the SSA denial through an attorney; an appeal hearing has been set for June 1, 2018 (Petitioner's Testimony).

6. Respondent did not make an independent disability decision on Petitioner's Medicaid Disability application. Instead, it adopted the SSA decision and denied Petitioner's application based on that decision, as she did not meet the technical requirements of age (at least 65) or disability.

7. On February 17, 2018, Respondent mailed Petitioner a Notice of Case Action notifying that her February 15, 2018 Medicaid Disability application was denied, with the reason that no household members meet the disability requirement (Respondent's Exhibit 5, Page 2).

8. Petitioner claimed to have worsened medical conditions, but was not able to indicate whether the SSA was, or was not, aware of these worsening conditions (Petitioner's Testimony).

CONCLUSIONS OF LAW

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

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

11. Florida Administrative Code Rule 65A-1.711, sets forth the rules of eligibility for elderly and disabled individuals. For an individual to receive Medicaid who is less than 65 years of age, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in 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 or any other substantial gainful work that exists in the national economy...

12. The Code of Federal Regulations Title 42, Section 435.541, Determinations of Disability, states in relevant part:

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

...

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

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

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

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

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

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

...

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

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and-

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

...

13. The above authority explains that the SSA determination is binding on the Department. Federal regulation prohibits Respondent from making an independent determination of disability if the SSA has already made a disability determination.

Respondent is bound by the federal agency's decision until it changes its decision, there is evidence of a new disabling condition not reviewed by the SSA, or there is a deterioration of an existing condition that the SSA refuses to consider.

14. In accordance with the above authority, Respondent denied Petitioner's February 15, 2018 Medicaid Disability application, due to adopting the SSA denial decision.

15. Petitioner is appealing the February 15, 2017 SSA denial through an attorney. Furthermore, Petitioner provided no evidence that she has new or worsened medical conditions that the SSA is unaware of.

16. In careful review of the cited authority and evidence, the undersigned concludes that Petitioner did not meet the burden of proof to indicate Respondent incorrectly denied her February 15, 2018 Medicaid Disability application. The undersigned concludes Respondent's action denying Petitioner's February 15, 2018 Medicaid Disability application was proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the 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 June, 2018,

in Tallahassee, Florida.



Erik Swenk, Esq.
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

Jun 19, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-03026

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55207

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:19 a.m. on June 1, 2018.

APPEARANCES

For the Petitioner: [REDACTED], pro se

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

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to deny the petitioner Medicaid disability, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit exhibits. The respondent submitted nine exhibits, entered as Respondent Exhibits "1" through "9". The record was closed on June 1, 2018.

FINDINGS OF FACT

1. On November 17, 2017, the petitioner (age 48) submitted a SSI-Related Medicaid disability application for herself (Respondent Exhibit 3, page 15).
2. On December 19, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA) denying the petitioner's November 17, 2017 Medicaid application (Respondent Exhibit 2, page 8).
3. On February 8, 2018, the Department determined the petitioner's November 17, 2017 application was denied in error (Respondent Exhibit 8, page 32).
4. Also on February 8, 2018, the Department reused the petitioner's November 17, 2017 application (Respondent Exhibit 3). The Department forwarded the petitioner's documents to the Division of Disability Determination (DDD), for review.
5. The DDD determines Medicaid disability eligibility for the Department.
6. To be eligible for SSI-Related Medicaid, the petitioner must be age 65 or older or considered blind/disabled by the Social Security Administration (SSA) or the DDD.
7. The petitioner applied for disability through the SSA on June 2, 2015. The SSA denied the petitioner disability on October 14, 2015 (Respondent Exhibit 6).
8. The petitioner reapplied for disability with the SSA in 2017, the SSA again denied the petitioner (dates in 2017 are unknown). The petitioner, with an attorney, appealed the SSA denial; a hearing date has not been set.

9. The petitioner said her medical conditions have changed since 2015; and her attorney will ensure all her medical condition documents are provided to the SSA.

10. On February 14, 2018, the DDD denied the petitioner disability, due to adopting the SSA denial decision (Respondent Exhibit 5).

11. On February 16, 2018, the Department mailed the petitioner a NOCA denying the petitioner Medicaid (Respondent Exhibit 2).

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 § 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 petitioner applied for disability through the SSA on June 2, 2015, and SSA denied the petitioner disability on October 14, 2015.

20. The Findings establish the petitioner reapplied with the SSA in 2017 and the SSA again denied the petitioner (dates in 2017 are unknown). The petitioner, with an attorney, appealed the 2017 SSA denial; a hearing date has not been set.

21. The petitioner argued her medical conditions have changed since 2015; and her attorney will ensure all her medical condition documents are provided to the SSA.

22. In accordance with the above authority (#17), the Department adopted the 2017 SSA denial decision and also denied the petitioner's Medicaid disability.

23. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof. The Hearing Officer concludes the Department's action to deny the petitioner Medicaid disability, is proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19 day of June, 2018,

in Tallahassee, Florida.



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

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

16STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED

Jun 08, 2018

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 18F-03140

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88651

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 21, 2018 at 2:05 p.m.

APPEARANCES

For the Petitioner:



For the Respondent:

Cori Driscoll, Supervisor

STATEMENT OF ISSUE

At issue is the denial of the petitioner's January 9, 2018 application for Medicaid benefits. The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The respondent presented six exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 6. The petitioner presented one exhibit which was accepted into evidence and marked as Petitioner's Composite Exhibit 1. The

record was held open until May 23, 2018, for the petitioner to provide a copy of emails to the Department. An email was received, entered into evidence and marked as Petitioner's Exhibit 2. The Department's representative sent an electronic mail to the undersigned as a rebuttal to the petitioner's evidence without sending the petitioner's representative the same electronic mail. This was accepted into evidence and marked as Respondent's Exhibit 7. The undersigned sent an order sharing the respondent's electronic mail with the petitioner. The record was closed on May 25, 2018.

FINDINGS OF FACT

1. On January 9, 2018, the petitioner's representative submitted an application for Medicaid benefits for the petitioner (age 36), her husband (age 32) and child (age 11) (Respondent's Exhibit 1).
2. On January 22, 2018, the respondent mailed a Notice of Case Action to the petitioner's representative informing her that she needed to complete a telephone interview by January 31, 2018. The same notice informed her that she needed to provide proof of citizenship. She was to [REDACTED] at 8:00 a.m. (Respondent's Exhibit 2).
3. The case was reviewed and it was noted that the petitioner did not complete the required interview.
4. On February 9, 2018, the respondent mailed the petitioner a Notice of Case Action, informing her that her Medicaid application dated January 9, 2018, was denied. The reason given for the denial was that all of the information needed to determine eligibility was not received (Respondent's Exhibit 1).

5. On March 22, 2018, the petitioner sent an email to the Department's representative advising that MLA was needed for coverage for December 30, 2017. The petitioner's representative did not get a response from the Department. The representative checked the petitioner's ACCESS account and found out that the case was closed.
6. On April 19, 2018, the petitioner's representative requested a hearing to challenge the respondent's action to deny the January 09, 2018 application for Medicaid benefits.
7. At the hearing, the petitioner's representative asserted she did not get the pending notice or the denial notice. The representative stated she found out that the case was closed when she went to the petitioner's ACCESS account. The respondent followed normal business practice in the pending notice to the petitioner and her representative. The respondent did not have any return mail for the aforementioned notice. Additionally, the respondent asserted that pending notice was mailed through its normal business practices.
8. The respondent asserted it mailed a pending notice to both the petitioner and her representative requesting for an interview to be completed (Respondent's Exhibits 2 and 3). This was required because the Department was not able to complete the authentication process online. The Department needed to interview the petitioner or her representative and ask three questions that would verify the petitioner's identity. The interview/identity process was not completed.

CONCLUSION OF LAW

9. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
11. The petitioner's representative claimed that she did not get the pending notice sent by the Department. The Department received no returned mail. Where mail has been properly addressed, stamped, and mailed pursuant to normal office procedure, there is a presumption that the addressee received the mail. See (Brown v. Giffen Industries, Inc., 281 So. 2d 897 (Fla. 1973)). It is concluded that the petitioner received the notice in question.
12. Fla. Admin. Code R. 65A-1.205, Eligibility Determination Process, sets forth:

(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...**If the applicant does not provide required verifications or information by the deadline date, the application will be denied...**(emphasis added)
13. The above cited authorities explain that Department must issue a written notice to the applicant when additional information is needed to complete the eligibility process. The Department must allow 10 calendar days from the date of the pending notice for the applicant to provide the information. When not provided, the application will be denied.

14. The respondent mailed the petitioner's representative a Notice of Case Action informing her she needed to complete an interview/authentication. The respondent denied the case on February 9, 2018. The petitioner was given the opportunity to complete the interview but no interview was completed by the due date. No interview/authentication was completed by the due date of January 31, 2018. According to the above authority if the applicant does not provide required verifications or information by the deadline date, the application will be denied. In this instance a required interview/authentication was needed in order for Medicaid benefits to be approved. The petitioner has not completed the interview; therefore, she has not met her burden of proof.

15. After carefully reviewing the governing authorities and evidence presented, the undersigned concludes that the respondent's action to deny the January 9, 2018 Medicaid application is correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the 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 June, 2018,
in Tallahassee, Florida.



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

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

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

FILED

Jun 29, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-03618
18F-03620

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 13th, 2018, at 10:00 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Jackie Smalls, Economic Self-Sufficiency Specialist for the Economic Self Sufficiency Program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to terminate full Medicaid benefits and enroll her in the Medically Needy program with an assigned Share of Cost (SOC), instead of full Medicaid (appeal number 18F-3618). On the record, the hearing officer assigned the burden of proof to the petitioner. However, upon further review, the hearing officer must assign the burden of proof to the respondent.

The petitioner is also appealing the respondent's action to deny her application for Assistance for Families with Dependent Children (AFDC) Program, also known as Temporary Assistance for Needy Families (TANF), or simply as Temporary Cash Assistance (TCA.) (appeal number 18F-3620). The petitioner carries the burden of proof on this issue by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner's exhibit 1 was admitted into evidence.

The respondent's exhibits 1 through 12 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated April 27th, 2018, the respondent informed the petitioner that "your Medicaid benefits will end on May 31st, 2018." (Respondent's Exhibit 4.)

By way of a Notice of Case Action (NOCA) dated May 1st, 2018, the respondent notified the petitioner that "your application for Medically Needy dated April 26th, 2018 is approved. You are enrolled with an estimated share of cost for the months listed below: June 2018 and ongoing Share of Cost \$818.00." (Respondent's Exhibit 5.)

No NOCA was furnished indicating a denial of TCA. On May 1st, 2018, the petitioner filed an appeal to challenge the respondent's actions. The Medicaid appeal was filed timely. Absent evidence to the contrary, the TCA appeal is considered to have been filed timely.

FINDINGS OF FACT

1. Prior to the action under appeal, the respondent authorized the petitioner for full Medicaid from January through May of 2018. The petitioner was not receiving TCA.

2. On April 26th, 2018, the petitioner submitted an electronic application for continued benefits for a household size of one (1) listing just herself. For type of benefit selected, the petitioner selected: Food Assistance; Cash assistance for myself and my family; and SSI-Related Medicaid. The petitioner reported on the application that her only source of monthly income is \$1,018 from the Social Security Administration (SSA) based on her disability. The petitioner also reported monthly expense of \$736 for rent, and additional expenses for household utilities such as gas and electricity. (Respondent's Exhibit 1.)

3. Based on the information provided by the petitioner on her application dated April 26th, 2018, the respondent determined eligibility for the petitioner. The respondent determined that the petitioner did not qualify for the TCA program due to no deprived children living in the household. The respondent based its decision based on its policy which states: "TCA is to provide financial assistance to children deprived of the support or care of one of both parents." (Respondent's Exhibit 12, page 46.)

4. Using the program policy guidelines related to SSI-Related Medicaid, and the SSI-Related Programs Financial Eligibility Standards for April 2018, the respondent determined the petitioner's eligibility for SSI Medicaid. The chart shows that in order to meet the program's financial eligibility standard, the petitioner's monthly income must be at or below \$891. (Respondent's Exhibit 11.)

5. The petitioner's verified monthly income from SSA is \$1,018, which was confirmed by the petitioner during the hearing, exceeds the Medicaid income standard of \$891. Therefore, the respondent determined that the petitioner did not qualify for Medicaid. The respondent then determined the petitioner's eligibility for the Medically Needy program and completed a budget to calculate the assigned SOC. (Respondent's Exhibit 7.)

6. The petitioner's unearned income is \$1,018. The petitioner is entitled for a \$20 unearned income disregard; which, when deducted from \$1,018 left a countable unearned income of \$998. The Medically Needy Income Level (MNIL) for a one-person household is \$180, which was then deducted from \$998, resulted in an estimated SOC of \$818. (Respondent's Exhibit 8, page 39.)

7. On May 1st, 2018, the respondent issued a NOCA to the petitioner informing her that the application dated April 26th, 2018 was approved, and she is now enrolled in the medically needy program with an assigned SOC of \$818, effective June 2018 and ongoing months. (Respondent's Exhibit 5, page 30.)

8. The petitioner stated that she was receiving full Medicaid prior to her application on April 26th, 2018. The petitioner argued that the only change in her application was that she applied for TCA benefits. The petitioner believes the respondent penalized her for applying for TCA by denying her full Medicaid. The petitioner stated that she knew when applied that she might not qualify for the TCA program; however, she applied anyway, due to her financial circumstances. The petitioner understands that without children, she would not qualify for TCA, and does not contest the denial. The petitioner's main argument is for full Medicaid, stating that she could not afford to pay for her monthly medications.

9. The respondent stated that applying for one program does not disqualify the petitioner from receiving benefits in another program; and enrolling the petitioner in the medically needy program was strictly based on her income; which exceeded the Medicaid income standard. The respondent erroneously authorized Medicaid for the petitioner from January through May 2018 due to reporting no income. However, when the actual income was budgeted, the petitioner is only eligible to be enrolled in the medically needy program with a SOC. The respondent stated that it would track the petitioner's medical bills; however, the bills were not high enough to meet the monthly SOC.

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 § 409.285, Fla. Stats.

11. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stats.

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

13. Federal regulations 45 C.F.R. § 260.20 explains the purpose of the TANF program and states:

The TANF program has the following four purposes:

- (a) Provide assistance to needy families so that **children may be cared for in their own homes** [*emphasis added*] or in the homes of relatives;
- (b) End the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;

(c) Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and

(d) Encourage the formation and maintenance of two-parent families.

14. Florida Statutes Chapter 414 § 414.095 explains how eligibility for temporary cash assistance is determined and in part states:

(1) ELIGIBILITY. —An applicant must meet eligibility requirements of this section before receiving services or temporary cash assistance under this chapter ...,

... (2) ADDITIONAL ELIGIBILITY REQUIREMENTS. —

(a) To be eligible for services or temporary cash assistance ...

... 4. A minor child must reside with a parent or parents, with a relative caretaker who is within the specified degree of blood relationship as defined by 45 C.F.R. part 233, or, if the minor is a teen parent with a child, in a setting approved by the department as provided in subsection (14).

5. Each family must have a minor child *[emphasis added]* and meet the income and resource requirements of the program. All minor children who live in the family, as well as the parents of the minor children, shall be included in the eligibility determination unless specifically excluded.

(b) The following members of a family are eligible to participate in the program if all eligibility requirements are met:

1. A minor child who resides with a parent or other adult caretaker relative.
2. The parent of a minor child with whom the child resides.
3. The caretaker relative with whom the minor child resides who chooses to have her or his needs and income included in the family.
4. Unwed minor children and their children if the unwed minor child lives at home or in an adult-supervised setting and if temporary cash assistance is paid to an alternative payee.
5. A pregnant woman.

15. Pursuant to the above cited federal and state authorities, the intent of the Temporary Assistance for Needy Families (TANF) is to provide assistance to those families who have children. The state authority further explains the eligibility requirements and states that the families must have a minor child living in the household in order to qualify for the program. The petitioner's household does not contain a minor child; therefore, she failed to meet the eligibility requirement to qualify for the TCA program.

16. Fla. Admin. Code R.65A-1.710 and 65A-1.713 list the SSI-Related Medicaid categories and the income and resource criteria. These authorities set forth full Medicaid coverage groups available for the household member.

17. 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.

18. In this instance, the since the petitioner has no minor children in the household, she would not meet the requirement to qualify for the Family-Related Medicaid. The petitioner was considered for the SSI-Related Medicaid program for the disabled due to the petitioner meeting the definition of disability according the Social Security Administration.

19. 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...

20. The above-cited 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 (FPL). That figure effective April 2018 is \$891.

21. Fla. Admin. Code R. 65A-1.710 address SSI-Related Medicaid coverage groups:

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).
- (2) Institutional Care Program (ICP). A coverage group for institutionalized aged, blind or disabled individuals ...
- (3) Hospice Program. A coverage group for terminally ill individuals ...
- (4) Home and Community Based Services (HCBS). ...
- (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** *[emphasis added]* or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.
- (6) Traumatic Brain Injury and Spinal Cord Injury Waiver Program....

22. Fla. Admin. Code R. 65A-1.713 address SSI-Related Medicaid Income Eligibility

Criteria:

- (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
 - (a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

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

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

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

... (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.

23. 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 April 1st, 2018, the income limit for one member household is \$891. The respondent determined the petitioner's countable income after the \$20 deduction \$998, which is over the \$891 income limit.

24. The Fla. Admin. Code 65-2.060, Evidence, states in part:

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

25. The burden of proof for the termination of Medicaid was assigned to the respondent. The petitioner's income exceeded the income standard for Medicaid. Therefore, the respondent is correct to enroll her in the medically needy program with an assigned SOC. The undersigned reviewed the medically needy budget completed by the respondent, and found no errors in the SOC calculation. Based on the findings of fact, and the controlling legal authorities, the undersigned concludes that the respondent is correct to enroll the petitioner in the medically needy program. Therefore, the respondent met its burden of proof in this matter.

26. The petitioner failed to meet the basic criteria to qualify for TCA benefit, which provides temporary cash assistance for needy families with dependent children. The petitioner is a single person with no dependent children under eighteen (18) years of age living with her in the household. Therefore, the petitioner did not meet the TCA program requirement, and the

respondent is correct to deny the petitioner's request for TCA. The petitioner did not make a counter argument, instead stated that she understands that she is not eligible based on not having children, however, applied anyway. Based on the above finding, and the controlling legal authorities, the undersigned concludes the petitioner failed to meet her burden of proof in this matter.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, both 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 29 day of June, 2018,

in Tallahassee, Florida.



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

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

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

FILED

Jun 21, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-03674

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 5, 2018, at 1:42 p.m.

APPEARANCES

For Petitioner:

[REDACTED]

For Respondent:

Riphard Nicolas, supervisor

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's application for full Medicaid for her newborn son and enroll him in the Medically Needy Program with an estimated share of cost (SOC). She is seeking full Medicaid. The burden of proof was originally assigned to the petitioner.

PRELIMINARY STATEMENT

The respondent submitted one package of documents which was entered into evidence and marked as Respondent's Composite Exhibit 1. The petitioner did not

submit any exhibits. The record was held open until the end of business on June 5, 2018, for the respondent to provide the SOC budget. Additional time was allowed for the respondent to provide its SOC budget. The budget was received on June 8, 2018, entered into evidence and marked as Respondent's Exhibit 2. The record was closed on June 8, 2018.

FINDINGS OF FACT

1. On April 4, 2018, the petitioner submitted an application for family related Medicaid benefits. The household consists of three people, petitioner and her two children. She is applying for her newborn only. The petitioner is employed and paid \$3,750 gross twice per month. The petitioner is the tax filer with her two children as dependents.
2. The petitioner provided per paystubs as verification of her income. The Department updated her case with the income and did not find the petitioner's newborn eligible for full Medicaid benefits.
3. The Department calculated petitioner's gross monthly earned income to be \$7,500 by adding paystubs dated April 13, 2018 and April 30, 2018. The Department compared it to the gross income limit, for an infant under one with three members as the household size. The petitioner's monthly gross income exceeded the income limit of \$3,464 for full Medicaid. The respondent proceeded to enroll the newborn in the Medically Needy Program with an estimated (SOC).
4. The respondent performed the following budget calculations when it determined the petitioner's estimated SOC. The Medically Needy Income Limit of \$486 for a

household size of three was subtracted from the household's income of \$7,500, resulting in \$7,014 as the newborn's SOC.

5. On May 4, 2018, the respondent mailed the petitioner a Notice of Case Action informing her that her child was enrolled in a SOC of \$7,014 (Respondent's Composite Exhibit 1, page 14).

6. At the hearing, the petitioner explained that she does not take home \$7,500; therefore, the respondent should only count her take home income. Additionally, the petitioner explained she cannot get any insurance to cover her newborn and was applying to Medicaid as her last hope as she cannot leave her newborn without medical insurance coverage.

7. The respondent explained that it has to use gross income, not net income to determine Medicaid eligibility.

CONCLUSION OF LAW

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

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

10. Federal Medicaid Regulations 42 C.F.R. § 435.218 Individuals with MAGI-based income above 133 percent FPL (Federal Poverty Level) states in part:

(a) *Basis*. This section implements section 1902(a) (10) (A) (ii) (XX) of the Act.

(b) *Eligibility*—(1) *Criteria*. The agency may provide Medicaid to individuals who:

(i) Are under age 65;

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

(iii) Are not otherwise eligible for and enrolled for optional coverage under a State's Medicaid State plan in accordance with section 1902(a)(10)(A)(ii)(I) through (XIX) of the Act and subpart C of this part, based on information available to the State from the application filed by or on behalf of the individual; and

(iv) Have household income that exceeds 133 percent FPL but is at or below the income standard elected by the agency and approved in its Medicaid State plan, for the applicable family size.

(2) *Limitations*. (i) A State may not, except as permitted under an approved phase-in plan adopted in accordance with paragraph (b)(3) of this section, provide Medicaid to higher income individuals described in paragraph (b)(1) of this section without providing Medicaid to lower income individuals described in such paragraph.

(ii) The limitation on eligibility of parents and other caretaker relatives specified in § 435.119(c) of this section also applies to eligibility under this section.

11. Family-Related Medicaid income criteria is set forth in 42 C.F.R. 435.603 and

states:

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

(3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under §435.916 of this part, whichever is later.

(b) *Definitions*. For purposes of this section—

Child means a natural or biological, adopted or step child.

Code means the Internal Revenue Code.

Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2

person(s) or as herself plus the number of children she is expected to deliver....

(c) *Basic rule.* Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on “household income” as defined in paragraph (d) of this section.

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

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

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

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

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

12. The Department’s Program Policy Manual (Policy Manual), CFOP 165-22, at section 2430.0204, addresses Determining Monthly Income (MFAM), and states:

The process of computing the amount of income to be considered in determining financial eligibility and the coverage group(s) is called “budgeting”. When determining financial eligibility, one or more budget calculations will be completed. The best estimate of the standard filing unit’s income and circumstances is used to determine eligibility. When determining eligibility benefits for a past month, the SFU’s actual income and circumstances are used. The income is compared to the appropriate income limit to determine the coverage group.

13. The Policy Manual at section 2430.0509, Income More Often than Monthly (MFAM), states:

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

1. **Add the gross income amounts for the past four weeks to get the total**(emphasis added).
2. If income is received weekly, add four pay periods and divide by four to get the weekly average.
3. If income is received biweekly, add two pay periods and divide by two to get the biweekly average.
4. **If income is received semimonthly, add two pay periods and divide by two to get the semimonthly average** (emphasis added).
5. If income is received monthly, use the most recent month if representative.

The result of the above is called the averaged amount. With the exception of monthly amounts, the averaged amount described above must be converted to a monthly amount.

14. The above instructs the Department to add the two semimonthly pay periods and divide by two to determine the semimonthly and then convert to monthly income.

Additionally, the above directs the respondent to use the gross income for the past four weeks (month).

15. The Policy Manual at Appendix A-7 indicates the Family-Related Medicaid Income Limit for a child under one year with a household size of three is \$3,464, the Standard Disregard is \$104, and the Medically Needy Income Limit (MNIL) is \$486 and the MAGI Disregard is \$87.

16. The Policy Manual at passage 2630.0108 Budget Computation (MFAM) states:

Financial eligibility for Family-Related Medicaid is determined using the household's Modified Adjusted Gross income (MAGI). The MAGI is the household's adjusted gross income as calculated by the Internal Revenue

Service plus any foreign earned income and interest income exempt from tax.

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

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

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

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

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

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

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

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

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

17. In accordance with the above controlling authorities, the undersigned calculated eligibility for Medicaid for the petitioner's newborn child and did not find the newborn eligible for full Medicaid as the petitioner's modified adjusted gross income is more than the income limit of \$3,464, for a household of three. Step 1: The petitioner's two paychecks were added to get the modified adjusted gross income of \$7,500. Step 2: There are no deductions provided, as there was no tax return. Step: 3: The total income of \$7,500 less the standard disregard of \$104 is \$7,396. Step 4: The total countable net income of \$7396 was compared with the income standard for three of \$3,464. Step 5: Since it was greater than the income standard, the MAGI disregards of \$87 was subtracted, resulting in \$7,309. This was compared to the income limit of \$3,464 for full Medicaid for a child under one in a house size of three. The petitioner's household income was greater than the income limit for full Medicaid. The undersigned

concludes the petitioner's newborn was not eligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the newborn.

The Medically Needy share of cost will now be addressed

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

19. The methods of determining the share of cost for Medically Needy Program benefits is set forth in the Fla. Admin. Code R. 65A-1.713. It states:

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

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

20. The above cited authorities and policies address income standards and limits, calculating countable income and income budgeting in the Family-Related Medically Needy Program.

21. The undersigned carefully reviewed the respondent's determination of the newborn's SOC budget and did not find any errors with the Department's calculation. The household's modified adjusted gross income of \$7,500, less the MNIL of \$486 resulted in the newborn's SOC of \$7,014.

22. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program was correct.

23. In careful review of the cited authorities and evidence, the undersigned did not find the petitioner's newborn eligible for full Medicaid benefits or a lower share of cost.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the 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 21 day of June, 2018,

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

Jun 14, 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. 18F-03758

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on May 30, 2018 at approximately 2:38 p.m. CDT.

APPEARANCES

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

For the Respondent: Lorry Beauvais, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of February 27, 2018 denying his February 23, 2018 application SSI-Related Medicaid benefits. 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 "11".

The record was left open for the respondent to submit a budget. It was received later that same day. The budget was admitted into evidence and marked as Respondent's Exhibit "12". The record was closed the same day.

Kate Sampson, economic self-sufficiency specialist II, observed.

FINDINGS OF FACT

1. After having received Medicaid benefits, specifically the paying of the petitioner's Medicare Part-B premium via the Medicare Savings Programs (MSP), the ongoing case was closed at recertification.
2. On December 29, 2017, the petitioner submitted recertification documents to the respondent (Respondent's Exhibit 11).
3. On January 29, 2018, the recertification was denied for the reason of non-receipt of requested information (Respondent's Exhibit 11).
4. On February 8, 2018, the petitioner applied with the respondent to have his MSP benefits reinstated (Respondent's Exhibit 3).
5. On February 14, 2018, by notice of case action (NOCA), the petitioner was informed that his application was denied for the reasons: you are receiving the same type of assistance from another program; the value of your assets is too high for this program; and, no household members are eligible for this program (Respondent's Exhibit 5).

6. On February 23, 2018, the petitioner applied with the respondent to have his MSP benefits reinstated (Respondent's Exhibit 4).
7. On February 27, 2018, by notice of case action (NOCA), the petitioner was informed that his application was denied for the reasons: you are receiving the same type of assistance from another program; the value of your assets is too high for this program; and, no household members are eligible for this program (Respondent's Exhibit 4).
8. The petitioner's prior Medicaid eligibility was the result of an error made by the respondent. The petitioner reported unearned income of \$500 monthly from an account which the respondent erroneously took to be a retirement account. The respondent explained that with a retirement account from which monthly income is being paid out, the amount paid out is considered unearned income in the eligibility determination and the asset value is not included in the eligibility determination.
9. The unearned income of \$500 monthly was ultimately determined to be withdrawals from a mutual fund.
10. The value of a mutual fund is counted as a liquid asset in the eligibility determination (Respondent's Exhibit 10).
11. Both parties agree that the account in question is a mutual fund.
12. At the time of verification, the total value of the mutual fund portfolio was \$44,372.83 (Respondent's Exhibit 8).
13. The asset limit for the MSP for an individual is \$7,560 (Respondents Exhibit 8).

14. The respondent explained that unlike a retirement account, with a mutual fund, the value of the asset is considered in the eligibility determination. It was this difference that caused the Medicaid to fail.

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. Federal Regulations at 20 C.F.R. §416.1208, How funds held in financial institution accounts are counted, states in pertinent 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.

19. Fla. 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...

20. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, SSI-Related Programs – Financial Eligibility Standards: April 1, 2018, states that the asset limit for the MSP for an individual is \$7,560.

21. The above cited authorities state that applicants cannot exceed the monthly asset limits for SSI-Related Medicaid. The MSP asset limit for a household consisting of an individual cannot exceed \$7,560.

22. The undersigned concludes that the value of the petitioner's mutual fund, \$44,372.83 exceeds the asset limit for the MSP. As the value of the petitioner's assets exceeded the SSI-Related Medicaid MSP asset limit, the petitioner was ineligible for MSP benefits.

23. In careful review of the cited authorities, testimony and evidence, the undersigned concludes the petitioner did not meet his burden of proof indicating that his February 8, 2018 or February 23, 2018 applications should not have been denied for exceeding the SSI-Related Medicaid MSP asset limit. The undersigned concludes that the respondent properly denied the Petitioner's SSI-Medicaid applications for exceeding the asset limit.

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 14 day of June, 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

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

FILED

Jun 29, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-03860

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 88652

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 18th, 2018, at 11:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se.

For the Respondent: Fredo Dutes, Operations & Management Consultant
for the Economic Self-Sufficiency program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her application for Medicare Savings Program (MSP) coverage under the Qualifying Individual 1 (QI1) program based on her income exceeded the income eligibility standard.

The petitioner carries the burden of proof by a preponderance of the evidence on this issue.

PRELIMINARY STATEMENT

The petitioner did not submit any documents for the hearing.

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

By way of a Notice of Case Action (NOCA) dated March 26th, 2018, the respondent notified the petitioner that, "your Qualifying Individual 1 application/review dated March 16th, 2018 is denied for the following months: March 2018, April 2018, May 2018. Reason: Your household income is too high to qualify for this program." (Respondent's Exhibit 2.)

On May 10th, 2018, the petitioner filed a timely appeal to challenge the respondent's action.

FINDINGS OF FACT

1. On March 16th, 2018, the petitioner applied for Medicare Savings Plan (MSP) for a household size of one; listing just herself. For monthly income, the petitioner reported \$842 in disability benefits from the Social Security Administration (SSA.) Additionally, the petitioner listed expenses for Medicare premiums, rent and other household utilities such as water, telephone, and electricity. (Respondent's Exhibit 1.)

2. Using its Data Exchange System with the Social Security Administration, the respondent verified the petitioner's gross monthly income from SSA is \$968.00 (Respondent's Exhibit 6.)

3. The respondent obtained additional verification indicating that the petitioner also receives a monthly public retirement benefit in the amount of \$726.61 from the State of Florida. (Respondent's Exhibit 5.)

4. The respondent combined the petitioner's verified income from the two sources, and determined the petitioner's monthly gross income as \$1,694.61 (SSA \$968.00+PR \$726.61=\$1,694.61.) Based on the combined gross income, the respondent determined the petitioner's eligibility for the MSP utilizing the SSI-Related Programs -- Financial Eligibility Standards: April 1, 2018. (Respondent's Exhibit 8.)

5. The chart shows that for Programs for People with Medicare (Medicare Savings Programs/Buy-in) consists of three limited coverage Medicaid programs. Those are listed as: the Qualified Medicare Beneficiary (QMB), which pays for Medicare A&B premiums, co-insurance and deductibles; the Special Low-Income Medicare Beneficiary (SLMB), which pays for Medicare Part-B premiums only; and the Qualified Individual 1 (QI1), which pays for Medicare Part-B premiums only. The individual income limit to qualify for those programs are: for QMB, 100% of the Federal Poverty Level (FPL), currently \$1,012; for SLMB, 120% of the FPL, currently \$1,214; and for QI1, 135% of the FPL, currently \$1,366. (Respondent's Exhibit 8.)

6. When the respondent receives an application for MSP, it tests the applicant against the QMB income standard first, since that is the program which provides the most benefits, failing which, the applicant will be tested against the SLMB standard. If that also fails, a final test will be done to see if the applicant meets the QI1 standard.

7. In the petitioner's case, her verified gross income is \$1,694.61. The only deduction the petitioner is eligible to receive is a standard unearned income disregard of \$20,; which when deducted from \$1,694.61 left the petitioner with a total countable income of \$1,674.61. The respondent compared the petitioner's total countable income of \$1,674.61 to the QMB income standard of \$1,012 first, and the petitioner failed. It then compared the income standard to the SLMB standard of \$1,214, and lastly to the QI1 standard of \$1,366. Since the petitioner's countable income exceeded the income standard for all three, she failed to qualify for any one of the MSP. (Respondent's Exhibit 7.)

8. On March 26th, 2018, the respondent issued a NOCA notifying the petitioner that her application for Qualified Individual 1 dated March 16th, 2018 is denied due to her household's income being too high to qualify for the program. (Respondent's Exhibit 2.)

9. The petitioner believes that she should get credit for other expenses she incurs, and just a \$20 unearned income disregard is not proper. The petitioner sought clarification from the respondent as to the difference between QMB and QI1, and the respondent explained.

10. The respondent stated that according to its policy, the only allowable deduction is the \$20 from the unearned income. Since both the SSA and PR are considered as unearned income, the petitioner is only entitled to a maximum disregard of \$20.

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 § 409.285, Fla. Stat.

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

13. This hearing was held as a *de novo* proceeding pursuant to Florida Administrative Code R.65-2.056.

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

...

(12) Limits of Coverage.

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

(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application.

(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.)

...

15. Fla. Admin. Code R. 65A-1.713(1) further addresses the SSI-Related Medicaid Income Eligibility Criteria as follows:

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

...

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

...

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

...

(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**. *[emphasis added]* QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

16. The Department's Program Policy Manual at Appendix A-9, effective April 1st, 2018, sets forth the individual income limit for QMB benefits as \$1,012; SLMB benefits as \$1,214; and QI1 benefits as \$1,366.

17. The above-cited authority clearly sets forth the financial eligibility criteria to be met in order to qualify for one of the MSP. The respondent must follow these guidelines when determining eligibility for the petitioner. The findings established that the respondent did follow those guidelines. The petitioner's total countable income of \$1,674.61 exceeds the income standard of \$1,366 for the QI1 program; therefore, the petitioner is not eligible. There are no exceptions found in the regulations which would allow a different outcome for the petitioner. Therefore, the undersigned concludes that the respondent's action to deny the petitioner's request for the MSP based on income being too high is correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 29 day of June, 2018,

in Tallahassee, Florida.



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

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

FILED

Jun 13, 2018

Office of Appeal Hearings
Dept. of Children and Families

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

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 18N-00005

PETITIONER,

Vs.

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, a hearing in the above-referenced matter was convened on
May 18, 2018 at 9:30 a.m. at the [REDACTED]

[REDACTED].

APPEARANCES

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

For the Respondent: [REDACTED], Facility Administrator.

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
January 5, 2018 with an effective date of February 5, 2018.

The facility has the burden of proof to establish by clear and convincing evidence that the petitioner's discharge is in accordance with the requirements of the Code of Federal Regulations at 42 C.F.R. § 483.15 and Section 400.0255, Florida Statutes.

PRELIMINARY STATEMENT

By a notice dated January 5, 2018, the respondent informed the petitioner that the facility was seeking to discharge/transfer her due to non-payment. On January 11, 2018, the petitioner timely requested a hearing to challenge the discharge/transfer.

Appearing as an observer for the petitioner but not giving testimony was [REDACTED] from the Long Term Care Ombudsman Program.

Appearing as witnesses for the respondent were [REDACTED], Office Manager, and [REDACTED], Social Services Director.

The petitioner did not submit any documents as evidence for the hearing.

The respondent submitted the notice of discharge as evidence for the hearing, which was marked as Respondent Exhibit 1. The respondent also submitted a transaction history, billing report, and Medicaid eligibility history information. These documents were marked as Respondent Exhibit 2.

A letter dated March 2, 2018 from the Agency for Health Care Administration (AHCA) was sent to the undersigned, stating that the representative did not find the facility in violation of any laws or rules. This was entered as Hearing Officer Exhibit 1.

FINDINGS OF FACT

1. The petitioner has been residing in the facility since August of 2017.
2. The respondent's husband stated he was informed by the billing manager at the nursing facility on August 3, 2017 that there would be no cost to the patient for the nursing home services and that his wife could keep her monthly Social Security benefit. He stated everything was fine for the first few months until he was informed by the facility that a mistake had been made and there was actually a patient responsibility that had been due to the facility. He stated the facility agreed to waive the first two months' charges due to this mistake. He also stated he requested Medicaid reinstatement for his wife about a month prior to the hearing date.
3. The facility administrator stated the facility was informed on September 27, 2017 by the Medicaid Program that there was a monthly patient responsibility of \$995 in the petitioner's case.
4. The facility's office manager stated the patient responsibility was \$995 monthly upon admission and this increased to \$1,018 in February, 2018. He acknowledged the petitioner's husband may have been misinformed as to the patient responsibility at the time of his wife's admission to the facility. He also stated the petitioner was denied Medicaid coverage in February, 2018 due to being over the asset limit. Although the Medicaid coverage was canceled at that time, the petitioner's Medicaid HMO provider ([REDACTED]) paid the facility charges for February and March, 2018. There has been no payment since April 1, 2018. The total arrearages at the time of the hearing was \$9,047.

CONCLUSIONS OF LAW

5. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

6. Federal Regulations, appearing at 42 C.F.R. § 483.15, set forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

(c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

...

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;

7. The petitioner's husband contends he was given false information as to the patient responsibility payment when his wife was first admitted to the facility. He believes there should be no patient responsibility because of this.

8. However, the documents submitted by the facility establish that a patient responsibility payment was in fact required by the Medicaid Program. The documents also show the petitioner's Medicaid coverage was canceled effective February 1, 2018 and there has been no payment to the facility since April 1, 2018. Although the

petitioner's husband stated he requested reinstatement of his wife's Medicaid coverage, no document or other evidence was submitted to establish the Medicaid coverage was ever approved or reinstated after it was canceled on February 1, 2018. In any event, even if the Medicaid coverage had been subsequently approved, there would still have been past due charges for the patient responsibility portion of the payments.

9. Based on the evidence presented, the nursing facility has established that the petitioner has failed, after reasonable and appropriate notice, to pay for a stay at the facility. This is one of the six reasons provided in 42 C.F.R. § 483.15 for which a nursing facility may involuntarily discharge a resident.

10. Establishing that the reason for a discharge is lawful is just one step in the discharge process. The nursing home must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

11. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

DECISION

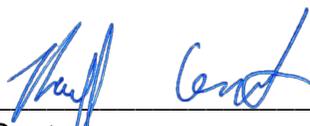
This appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The respondent may proceed with the discharge, as described in the Conclusions of Law and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm.255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 13 day of June, 2018,

in Tallahassee, Florida.



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

FINAL ORDER (Cont.)

18N-00005

PAGE -7

Copies Furnished To: [REDACTED] Petitioner

[REDACTED],
RESPONDENT

[REDACTED], RN

AGENCY FOR HEALTH CARE ADMINISTRATION

[REDACTED]

Jun 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.: 18N-00009

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on May 9, 2018 at 10:00 a.m.

APPEARANCES

For the Petitioner:

[REDACTED]
Petitioner's Daughter

For the Respondent:

[REDACTED]
Administrator

STATEMENT OF ISSUE

Petitioner is appealing the nursing home facility's decision to transfer and/or discharge her from the nursing home. The facility has the burden of proving by clear and convincing evidence that the transfer and/or discharge was appropriate under 42 C.F.R. § 483.15.

PRELIMINARY STATEMENT

A telephonic administrative hearing was held on March 19, 2018 at 2:30 p.m. and was continued, by agreement of the parties, to exchange and submit evidence for this appeal.

██████████, Petitioner's Son-In-Law, appeared as a witness for Petitioner. Petitioner introduced Composite Exhibit "1," which was accepted into evidence.

██████████ Director of Nursing with ██████████
██████████ appeared as a witness for Respondent. ██████████, Nursing Home Administrator with ██████████, appeared as a witness for Respondent.

Respondent introduced Composite Exhibits "1" and "2," which were accepted into evidence.

FINDINGS OF FACT

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

1. Petitioner is a 67-year-old male who is a Medicaid recipient that is eligible for Medicaid nursing facility services.
2. On October 26, 2017, the nursing home transferred Petitioner, who was ██████████ at the time, to ██████████ due to being unresponsive. The decision to transfer was made by the nursing home's Medical Doctor.
3. The ██████████ transferred Petitioner to ██████████ for further treatment on November 17, 2017.

4. On December 28, 2017, the nursing home facility refused to readmit Petitioner because the facility was no longer accepting [REDACTED] patients, and he was gone from the nursing home facility for ninety (90) days, which exceeded their bed hold policy.

5. Respondent's Bed Hold and In-House Transfer Policy dated October 26, 2017 states:

Medicaid Residents

A vacant bed may be held for you while you are in the hospital or on therapeutic leave, depending on your individual state's policy on payment for bed hold. Medicaid pays for the following in this state: Hospitalization Days eight (8) and Therapeutic Leave Days sixteen (16) During this time, you are permitted to return and resume residence in the facility.

If your hospitalization or therapeutic leave exceeds the number of days indicated above, you will be readmitted immediately upon the first availability of a vacant bed in a semiprivate room if: (1) You require the services provided by the facility, and (2) You are eligible for Medicaid nursing facility services. (See Respondent's Exhibit 2).

6. Respondent admitted the above notice was provided to Petitioner when he went to the hospital and a copy was mailed to Petitioner's daughter on October 26, 2017. The bed hold policy notice was not signed by Petitioner or Petitioner's daughter.

7. The nursing home administrator for [REDACTED] provided testimony, which is summarized as follows: He admitted that the nursing home did not provide a discharge notice to Respondent. The basis for discharging Petitioner was on their bed hold policy. The nursing home facility is under new management and they have decided to remove the [REDACTED] unit. The nursing home is currently discharging [REDACTED] patients to other nursing home. Petitioner is [REDACTED] and the nursing home will not have the capability to care for him.

The State has reviewed their discharge policy and bed hold policy and did not find any deficiencies in the nursing home's practice.

8. The nursing home administrator for [REDACTED], who at the time of Petitioner's transfer to the hospital was the administrator for [REDACTED] [REDACTED], provided testimony, which is summarized as follows: Petitioner was [REDACTED] at the time he was sent to the hospital via 911 and placed in the intensive care unit. He was not inappropriately discharged because the facility could not provide him the care he needed, which was the basis for sending him to the hospital. The nursing facility decided to close their [REDACTED] unit and no longer accept [REDACTED] [REDACTED] around November of 2017. The nursing home decided not to readmit Petitioner to the nursing home facility because their [REDACTED] unit was closing. The nursing facility would not accept Petitioner because he had the potential to become [REDACTED] and they will not have the facility or staff to care for him once the [REDACTED] unit is closed.

9. Petitioner's witness stated that she did not receive a discharge notice or a bed hold policy from the nursing facility. Petitioner witness indicated this is not the first time Petitioner has left the nursing facility to go to the hospital and has always returned to the nursing facility after his hospital stay.

10. Petitioner's witness indicated Petitioner is no longer [REDACTED] and is stable with his [REDACTED] and should be able to remain at the facility because he is no longer on a [REDACTED].

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

Section 400.0255(15), Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 400.0255(15), Florida Statutes.

12. Section 400.022(1), Florida Statutes, provides standards for residents' rights in nursing facilities as follows:

(i) The right to be fully informed, in writing and orally, prior to or at the time of admission and during his or her stay, of services available in the facility and of related charges for such services, including any charges for services not covered under Title XVIII or Title XIX of the Social Security Act or not covered by the basic per diem rates and of bed reservation and refund policies of the facility.

....

(u) The right to be informed of the bed reservation policy for a hospitalization. The nursing home shall inform a private-pay resident and his or her responsible party that his or her bed will be reserved for any single hospitalization for a period up to 30 days provided the nursing home receives reimbursement. Any resident who is a recipient of assistance under Title XIX of the Social Security Act, or the resident's designee or legal representative, shall be informed by the licensee that his or her bed will be reserved for any single hospitalization for the length of time for which Title XIX reimbursement is available, up to 15 days; but that the bed will not be reserved if it is medically determined by the agency that the resident will not need it or will not be able to return to the nursing home, or if the agency determines that the nursing home's occupancy rate ensures the availability of a bed for the resident. Notice shall be provided within 24 hours of the hospitalization.

13. 42 C.F.R. § 483.15 provides standards for notifying residents of bed-hold policies and allowing residents the right to return to a facility even though hospitalization or therapeutic leave has exceeded the bed-hold. In this case, Petitioner was provided a written notice of the bed-hold policy pursuant to 42 C.F.R. § 483.15(d). The regulation states in part:

(d) Notice of bed-hold policy and return---(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies—
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;

(ii) The reserve bed payment policy in the state plan, under §447.40 of this chapter, if any;

(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and

(iv) The information specified in paragraph (e)(1) of this section.

(2) **Bed-hold notice upon transfer.** At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.

(e)(1) **Permitting residents to return to facility.** A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.

(i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident

(A) Requires the services provided by the facility; and

(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.

(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. [Emphasis Added]

14. 42 C.F.R. § 483.15 limits the reasons a nursing facility may discharge a Medicaid

or Medicare patient and states in part:

(c) Transfer and discharge— (1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.

Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including

Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.

(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—

(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and

(B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident

(B) Resident representative information including contact information.

(C) Advance Directive information.

(D) All special instructions or precautions for ongoing care, as appropriate.

(E) Comprehensive care plan goals,

(F) All other necessary information, including a copy of the residents discharge summary, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

(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 (b)(5) of this section.

(4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(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.

(ii) Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

(5) Contents of the notice. The written notice specified in paragraph (b)(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.

(6) Changes to Notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients

of the notice as soon as practicable once the updated information becomes available.

15. The above-cited authority sets forth the conditions, which must exist for a nursing home to involuntarily discharge a resident. Petitioner is a Medicaid recipient who did not receive a proper discharge notice. Respondent effectively discharged Petitioner when it failed to readmit him upon his release from the hospital due to the closing of their [REDACTED] unit.

16. Respondent believed it did not have to provide a discharge notice to Petitioner because it provided Petitioner with a bed hold policy. The above authority clearly states, "If the facility that determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges."

17. Petitioner had an expectation of returning to the nursing home facility after his hospital stay, if not to his same bed because he exceeded his bed hold days, then to the next available bed. Respondent admitted that the nursing home would have accepted Petitioner back in December of 2017, but it was closing its [REDACTED] unit. The bed hold policy does not negate the fact that Respondent is required to provide a discharge notice once it has determined Petitioner is not allowed to return to the facility. Therefore, a discharge notice should have been provided according to 42 C.F.R. § 483.15(c).

18. Based on the totality of the evidence, Respondent has not met its burden of proving by clear and convincing evidence¹ that its action was proper. The undersigned Hearing Officer will not address the merits of this case because the nursing home facility did not comply with procedural requirements as outlined in the authority above. The facility failed to provide a discharge notice to Petitioner as required by the Code of Federal Regulations. Therefore, Petitioner must be allowed to return to his previous room if available; otherwise, he must be admitted to the next available bed in a semi-private room. If not, the facility must provide Petitioner with a proper discharge notice.

DECISION

Based upon the foregoing findings of fact and conclusions of law, Petitioner's appeal is GRANTED. Petitioner must be readmitted to the facility's first available bed.

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 25 day of June, 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
C/O [REDACTED] Respondent
[REDACTED]
Agency for Health Care Administration
[REDACTED]

FILED

May 24, 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.: 18N-00013

PETITIONER,

Vs.

Administrator

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on April 9, 2018 at 9:12 a.m. and on April 11, 2018 at 8:30 a.m.

APPEARANCES

For Petitioner:

[REDACTED]

Petitioner's Son

For Respondent:

[REDACTED]

STATEMENT OF ISSUE

Petitioner is appealing the nursing home facility's decision to transfer and/or discharge her from the nursing home. The facility has the burden of proving by clear and convincing evidence that the transfer and/or discharge was appropriate under 42 C.F.R. § 483.15.

PRELIMINARY STATEMENT

██████████, District Ombudsman Manager and ██████████, Certified Ombudsman, appeared as witnesses for Petitioner. Petitioner introduced Composite Exhibit "1," which was accepted into evidence.

At the request of Petitioner, the Hearing Officer took administrative notice of the following:

- Section 400.022, Florida Statutes
- 42 C.F.R. § 483.15

██████████ R.N., Care Manager and Discharge Planner with ██████████ ██████████, appeared as a witness for Respondent. Respondent introduced Composite Exhibit "1," which was accepted into evidence.

The record was held open until April 18, 2018 for Respondent to provide additional evidence regarding the physician's signature and for both parties to submit proposed orders or final statements.

Respondent submitted the additional evidence on April 11, 2018, which was entered into evidence as Composite Exhibit "2." Respondent filed a closing statement on April 17, 2018 and Petitioner filed a proposed order on April 18, 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. Petitioner entered the facility on November 14, 2017 and was discharged from the facility on December 6, 2017 due to ██████████ and a decline in her ██████████.

2. Respondent's witness [REDACTED] admitted that the facility failed to provide a thirty (30) days discharge notice to Petitioner. However, Respondent's witness [REDACTED]. [REDACTED] stated on December 1, 2017, the facility did discuss with Petitioner's son by phone about Petitioner's pending discharge from the facility.

3. The Notice of Resident Transfer or Discharge dated December 1, 2017 states:

As per the admission agreement, the facility must transfer/discharge a resident when the facility determines that such action is appropriate in order to meet the resident's needs for healthcare services. This correspondence is to inform you that [Petitioner] will be transferred/discharged to [REDACTED], Florida on December 6, 2017 for the following reason(s): The resident's health has improved sufficiently that the resident no longer needs the services provided by this facility. The notice further states: The resident's health has improved sufficiently so the resident no longer needs the services provided by the facility. (See Petitioner's Composite Exhibit 1)

4. Respondent's witness admitted that the reason provided in the discharge notice was incorrect. The correct reason is that the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility. The facility provided a care patrol to Petitioner. A care patrol is a person who locates appropriate nursing home facilities for patients. The care patrol helped Petitioner's son locate a secure and safe nursing home for Petitioner.

5. Respondent's witness [REDACTED] provided testimony, which is summarized as follows: Petitioner suffers from [REDACTED]. The facility is not secure enough to handle a [REDACTED] patient. Petitioner had instances where she could not remember how she reached a location within the facility. Petitioner would ambulate to the front hallway creating a potential for elopement. Petitioner would make statements like "it's her birthday" or "arriving from Germany."

6. The Nursing Home Discharge Summary plan indicated Petitioner's family initiated the discharge to [REDACTED] and that the family and patient was in agreement with the discharge plan. However, Petitioner's son stated that he did not request Petitioner to be discharged from the facility. He received a phone call from the facility about his mother being discharged and had to find a new nursing home.

7. Petitioner's witness [REDACTED] argued that the discharge notice was not valid because the wrong reason was provided on the notice for Petitioner's discharge.

8. Petitioner's witness [REDACTED] stated the medical certification form provided with the discharge notice did not provide sufficient evidence that Petitioner suffered from a decline in [REDACTED]. The [REDACTED] on the report provides that Petitioner is alert, disoriented, but can follow simple instructions. The report does not indicate elopement as a patient risk alert for Petitioner. (See Petitioner's Composite Exhibit 1).

9. Petitioner's witness [REDACTED] provided a letter from [REDACTED] indicated they do not have a [REDACTED] or secure unit, and Petitioner did not exhibit any behavior of elopement or wandering. (See Petitioner's Composite Exhibit 1).

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 400.0255(15), Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 400.0255(15), Florida Statutes.

11. 42 C.F.R. § 483.15 limits the reasons a nursing facility may discharge a Medicaid or Medicare patient and states in part:

- (c) Transfer and discharge— (1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—
- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
 - (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
 - (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
 - (D) The health of individuals in the facility would otherwise be endangered;
 - (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
 - (F) The facility ceases to operate.

(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

- (i) Documentation in the resident's medical record must include:
- (A) The basis for the transfer per paragraph (c)(1)(i) of this section.
 - (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
- (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—
- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
 - (B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section.
- (iii) Information provided to the receiving provider must include a minimum of the following:

- (A) Contact information of the practitioner responsible for the care of the resident
- (B) Resident representative information including contact information.
- (C) Advance Directive information.
- (D) All special instructions or precautions for ongoing care, as appropriate.
- (E) Comprehensive care plan goals,
- (F) All other necessary information, including a copy of the residents discharge summary, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

(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 (b)(5) of this section.

(4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(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.**

(ii) Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

(5) Contents of the notice. The **written notice specified in paragraph (b)(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.

(6) Changes to Notice. **If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.** (Emphasis Added).

12. The above-cited authority sets forth the conditions, which must exist for a nursing home to involuntarily discharge a resident. Respondent admitted that the facility initiated the discharge of Petitioner.

13. In the instant case, Petitioner was given a Nursing Home Transfer and Discharge Notice on December 1, 2017, which indicated that “the resident’s health has improved sufficiently that the resident no longer needs the services provided by this facility” and she would be discharged on December 6, 2017. The reason provided on the discharge notice is a lawful reason. However, Respondent’s witness admitted the reason provided on the discharge notice is incorrect. The correct reason is “the transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in this facility.” Respondent failed to provide the changes in writing and in a timely manner to

all relevant parties. Therefore, Petitioner's discharge notice is defective because it lacks the correct reason for the discharge.

14. Petitioner signed the discharge notice on December 1, 2017 and she was discharged on December 6, 2017. However, Respondent admitted they did not provide a thirty ("30") day notice of the discharge to Petitioner; and did not send a copy of the discharge notice to Petitioner's representative, instead they informed him by phone about the discharge on December 1, 2017. The authority above states:

"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...and 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."

15. Based on the totality of the evidence, Respondent has not met its burden of proving by clear and convincing¹ evidence. The Notice of Transfer and Discharge Notice dated December 1, 2017, signed by Petitioner, is defective because it provided the incorrect reason for her discharge and does not comply with the procedural requirements of the above cited authority.

16. Respondent reported a change for the discharge reason on the day of Petitioner's appeal hearing, which is not timely, and it does not negate the requirement that the changes needs to be in writing. Petitioner's representative testimony is found to be credible that he did not receive the discharge notice in writing. Respondent admitted

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))."

to not providing Petitioner with sufficient notice of the discharge. The undersigned Hearing Officer will not address the merits of this case because the Discharge Notice is defective and does not comply with procedural requirements as outlined in the authority above. The facility has failed to provide a proper discharge notice to Petitioner as required by the Code of Federal Regulations.

DECISION

Based upon the foregoing findings of fact and conclusions of law, Petitioner's appeal is GRANTED. The resident must be readmitted to the facility's first available bed.

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 24 day of May, 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] E, Petitioner
[REDACTED], Respondent
Agency for Health Care Administration
[REDACTED]

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

FILED

May 21, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18N-00016

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on April 26, 2018 at 2:00 p.m., at [REDACTED]

[REDACTED]

APPEARANCES

For Petitioner: [REDACTED], Petitioner's Daughter

For Respondent: [REDACTED], Director of Nursing

STATEMENT OF ISSUE

Petitioner appeals Respondent's action discharging her from the Facility. Respondent carries the burden of proof by clear and convincing evidence in this appeal.

PRELIMINARY STATEMENT

Pursuant to notice, this hearing was initially scheduled with Hearing Officer Rick Zimmer. On March 20, 2018, this appeal was reassigned to the undersigned as Hearing Officer Zimmer would not be available for the scheduled hearing. On March 21, 2018,

the parties were notified of this reassignment through an Order Transferring Hearing Officer.

Petitioner called no witnesses. [REDACTED], Social Services Director and Abuse Coordinator, and [REDACTED], Licensed Practical Nurse, appeared as witnesses for Respondent.

On March 19, 2018, the Agency for Health Care Administration submitted a survey, based on an on-site visit of the Facility, indicating that it determined the Facility committed a violation of the Code of Federal Regulation, Section 483.12, regarding its action to discharge a resident (Hearing Officer's Exhibit 1). The undersigned did not take this survey into consideration regarding the final decision.

Petitioner submitted no evidence. Respondent submitted an evidence packet consisting of six exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" – "5." Subsequent to hearing, the undersigned discovered that two exhibits were marked as Respondent's Exhibits "4" and re-marked the last two exhibits as Respondent's Exhibits "5" and "6." The undersigned submitted one exhibit, which was entered into evidence and marked as Hearing Officer's Exhibit "1." The record closed on April 26, 2018.

FINDINGS OF FACT

1. On December 8, 2017, Facility admitted Petitioner, now age 57, to the [REDACTED] Unit suffering from [REDACTED], and [REDACTED] (Respondent's Exhibit 3, Page 27). Petitioner currently resides at [REDACTED] in [REDACTED] (Testimony of [REDACTED])

2. Respondent alleges that Petitioner's needs could not be met in its Facility as a result of Petitioner's behavior, which involved unpredictable and unprovoked incidents on two dates resulting in physical altercations between Petitioner and five individuals in the Facility (Testimony of [REDACTED]). Because of Petitioner's behavior, Respondent is unable to provide the necessary level of care to meet her needs (*Id.*).

3. From December 8, 2017 through January 9, 2018, there were no indications of any physical altercations between Petitioner and any other resident or staff at the Facility (Respondent's Exhibit 4, Pages 9 – 17).

4. Up to January 8, 2018, Petitioner's medications consisted of 625 mg of [REDACTED], 10 mg of [REDACTED], and .5 mg of [REDACTED] (Respondent's Exhibit 3, Page 10). [REDACTED] was administered as Petitioner's [REDACTED] (Testimony of [REDACTED]).

5. On January 8, 2018, Dr. [REDACTED], Facility's psychiatrist, decreased Petitioner's [REDACTED] from 10 mg to 5 mg as a trial dose reduction due to her positive reaction to the current dose (Respondent's Exhibit 3, Page 11).

6. On January 19, 2018, Petitioner was involved in an incident that involved her swinging at other residents and being uncooperative with staff and care (Respondent's Exhibit 4, Page 8). There is no indication that any resident or staff member was actually struck (*Id.*).

7. On January 20, 2018, Petitioner was involved in multiple incidents that involved her striking three residents and a staff member (*Id.*). [REDACTED] appeared and authenticated her witness statement dated January 20, 2017 (Respondent's Exhibit 3, Page 24), stating that the year 2017 indicated in her statement was a clerical error and

that the correct year was 2018, and also indicated these incidents occurred over a time span of approximately 10 – 15 minutes (Testimony of [REDACTED]).

8. On January 22, 2018, [REDACTED] increased Petitioner's [REDACTED] from 5 mg back to 10 mg (Respondent's Exhibit 3, Page 13), noting a failed attempt to reduce her [REDACTED] dose (*Id.*).

9. Petitioner remained on 1:1 observation from January 20 – 26, 2018 (*Id.* at 17).

10. On January 29, 2018, Petitioner was involved in another incident that involved her striking a resident twice in the back of the head, causing a laceration above the right eye when the resident fell hitting her face on the floor (Respondent's Exhibit 4, Page 1).

11. As a result of this incident, and in conjunction with the past incidents, Dr. [REDACTED] o [REDACTED] Petitioner (*Id.*) due to the safety of her well-being as well as others as a result of her [REDACTED] (Respondent's Exhibit 1, Pages 12 – 13).

12. On January 30, 2018, Respondent provided a Nursing Home Transfer and Discharge Notice (DN) to Petitioner, effective the same date, transferring her to [REDACTED] [REDACTED] (*Id.* at 5 – 11). The DN was signed by [REDACTED], Facility Administrator, and [REDACTED] Tolentino, Facility psychiatrist, and delivered to [REDACTED] [REDACTED] by certified mail (*Id.*).

13. Respondent provided its bed-hold policy to Petitioner's representative at the time of admission (Respondent's Exhibit 5), but stated that it failed to provide its bed-hold policy at the time of discharge (Testimony of [REDACTED]). However, Respondent did state that it was below 95% capacity at the time of Petitioner's discharge (*Id.*).

14. Also, on January 30, 2018, [REDACTED] transferred Petitioner to [REDACTED], a sister hospital, as it had no beds available (Testimony of [REDACTED]).

15. On January 31, 2018, a social worker with [REDACTED] contacted Respondent to inquire whether it intended to readmit Petitioner (*Id.*).

16. Respondent argued that the social worker confirmed that Petitioner was still acting unpredictably and, as such, refused to readmit Petitioner (Testimony of [REDACTED]).

17. Ms. [REDACTED] argued that Petitioner's behavior was based on the dosage alterations to her medications, and that prior to the decrease in her [REDACTED] her behavior was predictable and without threat to the safety of herself or others (Testimony of [REDACTED]). [REDACTED] further argued, that since Petitioner's admittance to [REDACTED]s, and subsequently to [REDACTED], as well as being on stabilized doses of her medications subsequent to that admittance, she has remained predictable and without threat to the safety of herself or others (*Id.*).

18. [REDACTED] argued that it is her wish for Respondent to readmit Petitioner to the Facility (*Id.*).

CONCLUSIONS OF LAW

19. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes. In accordance with that section this order is the final administrative decision of the Department of Children and Families.

20. 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 (emphasis added);

(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 (emphasis added):

(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 (emphasis added)...

...

(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.

(ii) Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

(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.

21. On January 30, 2018, the Facility issued Petitioner's DN. The Facility's reason for discharging Petitioner was that her needs could not be met at the Facility. This is one reason permitted for discharge from a facility in accordance with the above Federal Regulation.

22. 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.

...
(c) If the hearing decision is favorable to the resident who has been transferred or discharged, the resident must be readmitted to the facility's first available bed....

...
(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:

(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...

...

23. In accordance with the above Federal Regulation and State Statute, the DN was signed by the Facility Administrator and the Facility Physician (Psychiatrist) and a copy provided to Petitioner's representative by certified mail. 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.

24. However, the evidence submitted does not establish that Petitioner's medical records were well documented with the reasons by which her medical needs could not be met. The evidence indicates that, though Petitioner instigated a number of physical altercations on two separate dates, those altercations were likely a result of the decreased dosage of her [REDACTED] medication on January 8, 2018, one and a half weeks prior to the first altercation. Petitioner's [REDACTED] medication was then increased on January 22, 2018 back to the original dosage. However, this increase may not have had time to take effect to prevent the January 29, 2018 altercation.

25. Prior to the decrease in Petitioner's [REDACTED] medication, the evidence indicates that the Facility had no issues meeting her needs. Furthermore, there is no evidence indicating the Facility implemented any behavior or treatment plans to reasonably attempt to meet Petitioner's needs, without success, after the physical altercations began. Though Petitioner's welfare may have been in question at the time of her

discharge on January 30, 2018, the undersigned concludes that Respondent failed to prove that it could not meet her needs. If the hearing decision is favorable to the resident who has been transferred or discharged, the resident must be readmitted to the Facility's first available bed.

26. In accordance with the above authorities, the Facility sought to involuntarily discharge Petitioner to [REDACTED] for the reason that "[her] needs cannot be met in this facility."

27. 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.

28. After careful review of the cited authorities and evidence, the undersigned concludes that Respondent did not meet its burden of proof by clear and convincing evidence indicating that it could not meet Petitioner's needs. The undersigned concludes that Respondent's discharge of Petitioner was improper, as it failed to indicate the Facility could not meet her needs. As such, the Facility must readmit Petitioner to the first available bed.

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))."

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is GRANTED. The Facility is ORDERED to immediately readmit Petitioner to the Facility. If a bed is not currently open to readmit Petitioner, the Facility must readmit Petitioner as soon as a bed becomes available.

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 21 day of May, 2018,
in Tallahassee, Florida.



Erik Swenk, Esq.
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]

May 22, 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. 18N-00017

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 12, 2018, at 9:56 a.m., at [REDACTED]

[REDACTED]

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: [REDACTED] Nursing Home Administrator (NHA)

ISSUE

Federal regulations limit the reasons for which a Medicaid or Medicare certified nursing home may discharge a patient. At issue is whether or not the nursing home's action to transfer and discharge the petitioner is an appropriate action based on the federal regulations at 42 C. F. R. § 483.15. The nursing home is seeking to transfer and discharge the petitioner because: (1) her needs cannot be met in this facility and (2) the

safety of other individuals in this facility is endangered. The burden of proof is clear and convincing evidence and is assigned to the facility.

The only issue before the hearing officer is whether the discharge was in accordance with federal regulations. Any issues concerning petitioner's allegations of improper protocol of the facility staff, or treatment the petitioner received while residing at the facility are not within the jurisdiction of the hearing officer.

PRELIMINARY STATEMENT

By Nursing Home Transfer and Discharge Notice, dated January 29, 2018, the respondent informed the petitioner that she was to be discharged from the facility effective February 28, 2018. On February 22, 2018, the petitioner timely requested an appeal to challenge the respondent's action.

[REDACTED]

[REDACTED] Administrator in Training, appeared as witnesses for the respondent.

During the hearing, the petitioner did not present any exhibits. The respondent introduced seven exhibits which were accepted into evidence. The record was left open for an additional 15 minutes for the respondent to submit copies of some of the evidence to the undersigned. The evidence was received and marked as the Respondent's Exhibits 1 through 7. The evidence contains the petitioner's documentation of contacts with facility's staff, an Admission form and Evaluation Form, Nurse's Notes, Social Service Progress Notes in addition to other documents. The record was closed on April 12, 2018.

No representative from the Agency for Health Care Administration (AHCA) was present.

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 has been residing in the respondent's facility since July 27, 2017. Petitioner is very alert and makes her own healthcare decisions. She was admitted as a therapy patient and as such, it was anticipated her time in the facility would be short-term, not long-term.
2. Upon entering the nursing facility, the petitioner was assigned May 3, 2018 as a target date for her discharge. Her progress was set to be reviewed on February 7, 2018. The facility has been discussing discharge planning process with the petitioner to home with family or an Adult Living Facility (ALF) since her arrival, see Respondent's Exhibit 5.
3. On July 28, 2017, the petitioner signed a Resident/Patient, Family & Visitor Smoking Safety Education & Acknowledgment form agreeing to follow the facility's smoking policy, see Respondent's Exhibit 2 below. The form indicates the facility strongly recommends the use of a smoking apron for all smokers and included the following:

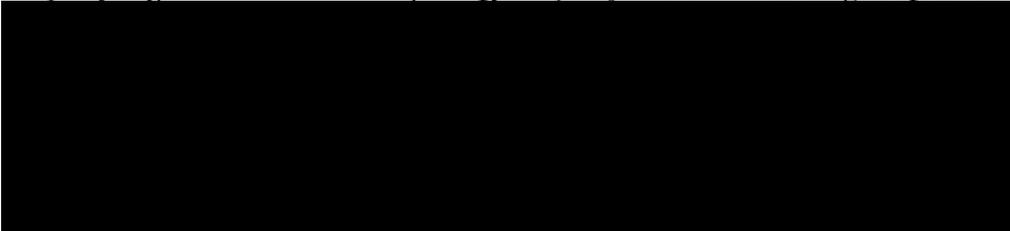
GUIDELINES

1. Smoking materials should be labeled with the Resident's/Patient's name & will be maintained in a secure location. Residents/Patients *may not* keep any smoking materials in their room including but not limited to: Lighters, Matches, Cigarettes, Pipes, Cigars, or any other smoking material. Matches & lighters and other smoking materials are available from the staff for Resident/Patient use at smoking times posted by the facility. Facility staff will provide & assist each resident/patient with assistance needed during the posted smoking period.

NOTE: Residents/Patients may not keep lighters/matches or any other smoking paraphernalia on their person or in their room.

2. Staff member assigned to the smoking area will monitor the area & distribute cigarettes & matches/lighter in addition to conducting walking rounds to observe & intervene for safety issues & to provide supervision & intervention when appropriate.
3. If the Resident/Patient is receiving oxygen, staff members will assist with removal prior to entering the designated smoking area. Once the smoking session is completed the staff will assist in reapplying the oxygen as ordered.
4. Family members or visitors may accompany the Resident/Patient to the designated smoking area at the designated times, however assistance should not be provided unless there is a staff member in attendance.
5. Residents/Patients, families or visitors should not provide assistance to other Residents wishing to smoke.

I have read the above policy and have had the opportunity to ask questions. I agree to abide by the facility policy. I understand that failure to abide by this policy could lead to discharge from the facility.



4. Residents are prohibited from possessing cigarettes, e-cigarettes and lighters on their person or in their rooms. Residents are only allowed to smoke during designated times and in designated areas. A staff member must be present during smoking periods.

5. Alert residents are allowed to leave the facility anytime. However, they are not allowed to be out overnight.

6. Petitioner has been signing herself out of the facility at all hours to smoke outside of the facility without any staff supervision.

7. On October 9, 2017, the facility's alarm system was activated when the petitioner tried to exit the main entrance to go out to smoke. Behavior notes entered by a

registered nurse on October 10, 2017, indicate that the petitioner failed to follow the facility's smoking protocols for smoking in non-designated areas.

8. On November 2, 2017, the petitioner exited the facility around 12:00 a.m. and was observed smoking outside in a non-designated area.

9. Progress notes on the petitioner's file indicates on January 12, 2018, the social worker observed the petitioner sitting in the front porch ready to wheel down to go smoke. He pulled her to the side and informed her that she cannot smoke there. He provided the petitioner with a copy of the smoking policy agreement which she signed on July 28, 2017, see Respondent's Exhibit 7.

10. On January 17, 2018, law enforcement was called to the facility after the petitioner reported she was being threatened by another resident's visitor. The facility's report indicates that the petitioner was upset when her choice of music was no longer being played and that witnesses to the incident pointed to the petitioner as the aggressor. Two witnesses provided written statement to the facility indicating that the petitioner had called someone and asked him to bring a firearm to the facility to assist her. AHCA, DCF, and Broward Sheriff Office (BSO) declined to accept a formal report, see Respondent's Exhibit 6.

11. On January 29, 2018, a Nursing Home Transfer and Discharge notice was issued to the petitioner. The reasons listed on the discharge notice are: (1) her needs cannot be met in this facility and (2) the safety of other individuals in this facility is endangered. There was a brief explanation, "Not following Smoking Policy or Designated times and areas and threatening to shoot up facility". The notice was signed by [REDACTED] M.D. and the petitioner, see Respondent's Exhibit 1.

12. The respondent believes the petitioner's possession of cigarettes, and lighters on her person is a danger to others as these items may accidentally cause a fire.

Additionally, the respondent believes that her continued unsupervised smoking episodes are violations of the smoking policy. Additionally, the respondent explained that the petitioner has psychological needs that the facility cannot provide. Finally, the respondent explained that the petitioner has been accepted at different facilities, but she declined to even visit them. The respondent maintains that the petitioner continues to violate smoking protocols even after the discharge notice was issued to her for doing so.

13. The petitioner did not dispute the smoking related charges brought forward by the respondent. She acknowledged being aware of the smoking policy, and leaving the facility at night to go across the street to smoke. She does not believe she is a danger to herself or to others. She believes she can still benefit from the services provided by the facility and that she is being discharged for speaking her mind. She maintains that she has no place to go. She does not believe she has any psychological problems.

14. The only issue before the hearing officer is whether the discharge was in accordance with federal regulations. Any issues concerning petitioner's allegations of improper protocol by facility staff, medication changes or diagnoses, or treatment the petitioner received while residing at the facility (Respondent's Exhibits 1, 2, 3 & 5) are not within the jurisdiction of the hearing officer. These issues must be addressed with AHCA.

15. As of the day of this hearing, the petitioner remains in the facility pending a hearing decision. Despite her multiple complaints about the services there, the

petitioner wants to remain at the facility. She believes the respondent's action to discharge her is retaliation because she reported falling at the facility.

16. At the request of the undersigned, AHCA was to conduct an on-site inspection of the facility and provide a written response to the undersigned. As of the day of this order, a response has not been filed with the office as to the outcome of the inspection.

CONCLUSIONS OF LAW

17. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes.

18. Federal Regulations at 42 C. F. R. § 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; (emphasis added)

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for

his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

...

(2) *Documentation.* When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

...

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—

...

(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section (emphasis added).

...

(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.

(ii) Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

(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.

19. On January 29, 2018, the facility issued a discharge notice to the petitioner. The facility's reasons for discharging the petitioner are: (1) her needs cannot be met in this facility and (2) the safety of other individuals in this facility is endangered. These are two of the reasons permitted for discharge from a facility in accordance with the above federal regulation.

20. Section 400.02555, Florida Statutes, 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.

21. In accordance with the above federal regulation and statute, the notice was signed by a physician. The notice also indicated the reasons and effective date of the discharge, the location to which the petitioner is to be discharged, and the petitioner's appeal rights along with other required assistance information.

22. The undersigned reviewed the findings and evidence in regards to (1) her needs cannot be met in this facility. The findings and evidence provided do not include enough information on the petitioner for the undersigned to conclude that the petitioner's needs can no longer be met in the facility at the time she was issued the Nursing Home Transfer and Discharge Notice. The undersigned concludes the respondent has NOT met the burden of proof to show the petitioner should be discharged based on this rationale.

23. The undersigned reviewed the findings, evidence, and testimony in regards to (2) the safety of other individuals in this facility is endangered. The findings show the petitioner acknowledges her verbal aggression and forceful tone when she is trying to make a point. The findings show the petitioner possesses materials that are deemed unsafe when not properly stored and used. The findings also show other residents and staff view her behavior as threatening. The findings further show law enforcement was called in to diffuse a possible volatile situation involving the petitioner and her reference

to have a firearm brought to the facility. Finally, the respondent is concerned that the petitioner's verbal aggression may turn physical.

24. Based on the evidence presented, the nursing facility has established that the safety of other individuals in this facility is endangered based on the petitioner's continued defiance of the facility's smoking protocols. 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. After careful review of the evidence and testimonies, the undersigned concludes that the respondent has MET the burden of proof to show the petitioner may be discharged based for this reason.

25. 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.

26. Any discharge by the facility must comply with all applicable federal regulations, statutes, and the Agency for Health Care Administration requirements. Should the 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.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is DENIED. The facility may proceed with its proposed discharge action 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 22 day of May, 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: , Respondent
,
Agency for Health Care Administration

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

FILED

Jun 06, 2018

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18N-00021

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a nursing home discharge hearing in the above-referenced matter on April 25, 2018 at 1:12 p.m., at [REDACTED] [REDACTED] Florida.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: [REDACTED], Administrator

STATEMENT OF ISSUE

At issue is the facility's intent to discharge the petitioner due to non-payment of a bill for services based on federal regulations found at 42 C.F.R. § 483.15. The facility has the burden of proof to establish by clear and convincing evidence that the discharge is appropriate.

PRELIMINARY STATEMENT

On February 26, 2018, the respondent issued a Discharge Notice to the petitioner informing him that he was to be discharged from the nursing facility effective March 28, 2018, due to (1) non-payment of bill for services, (2) your needs cannot be met in this facility and (3) the safety of other individuals in this facility is endangered. There was no physician's signature on the Discharge Notice nor was there a physician's order for discharge attached to the Discharge Notice.

On March 5, 2018, the petitioner timely requested a hearing to challenge the facility's action. The undersigned will only address the issue of non-payment in this order as there must be either a physician signature on the Discharge Notice or an attached physician's order of dismissal.

Appearing as a witness for the petitioner was [REDACTED], ombudsman, with the Florida Ombudsman Program.

Appearing as witnesses for the respondent were [REDACTED], Director of Nursing, [REDACTED], Business Office Manager and [REDACTED] for the facility.

Evidence was received and entered as the Respondent's Composite Exhibit 1. The record was held open until May 5, 2018 for the petitioner to provide proof of his payments to the nursing facility. The petitioner requested additional time to provide his evidence. Additional time was granted and the record was kept open until May 16, 2018. No additional evidence was received. The record was closed on May 16, 2018.

FINDINGS OF FACT

1. The petitioner (age 58) was admitted to the nursing facility on October 13, 2017. He was receiving Medicaid when he entered the nursing facility and had a patient

responsibility of \$1,024 for the month. Effective November 2017 through December 2017, the petitioner's patient responsibility changed to \$804, in January 2018; his patient responsibility changed to \$1,046, in February 2018 it was \$826 and March 2018 it was \$827. The petitioner receives gross monthly Social Security Disability Income (SSDI) of \$1,152.

2. The respondent prorated the petitioner's patient responsibility for October 2017 from the date he was admitted to the Nursing Facility. He was billed \$627.57 for October 2017. The respondent asserted the petitioner did not pay his patient responsibility for October 2017, December 2017, January 2018 and April 2018. Additionally, the respondent asserted that the petitioner only made partial payments of \$325 for November 2017, \$700 for February 2018 and \$580 for March 2018 (Respondent's Composite Exhibit 1).

3. The nursing facility provided the petitioner with monthly statements with the balance owed each month. In addition to the monthly statements, facility staff met with the petitioner each month and discussed payment options. The nursing facility advised the petitioner to sign his SSDI check over to the facility but he refused (Respondent's Composite Exhibit 1).

4. The respondent provided its transaction report of the facility's charges to the petitioner and the petitioner's payments to the facility. The report shows that the petitioner has an outstanding balance of \$4,156.57 owed to the facility as of May 2018.

5. At the hearing, the petitioner disputed owing any money to the nursing facility and did not agree with his patient responsibility as determined by the Department of Children and Families. The petitioner asserts that his patient responsibility should be

lower as he has a child support garnishment from his SSDI. The record was held open for the petitioner to provide his payments made to the nursing facility but he has not provided any evidence to support his claim.

CONCLUSIONS OF LAW

6. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes.

7. Federal Regulations appearing at 42 C.F.R. § 483.15 set forth the reasons a facility may involuntarily discharge a resident as follows:

(c) *Transfer and discharge*—(1) *Facility requirements*—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;... **(emphasis added)**

(F) The facility ceases to operate.

8. The above authority allows for a resident to be discharge from the Nursing Facility for failure to pay for his or her stay.

9. The undersigned reviewed the petitioner's patient responsibility and the payments he made to the facility. The following table shows the actual charges and the petitioner's payments, resulting in an outstanding balance owed to the facility.

Months	Patient Responsibility	Amount Paid
Oct-17	\$627.57	\$0.00
Nov-17	\$804.00	\$325.00
Dec-17	\$804.00	\$0.00
Jan-18	\$1,046.00	\$0.00
Feb-18	\$826.00	\$576.00
Feb-18	\$0.00	\$124.00
Mar-18	\$827.00	\$580.00
Apr-18	\$0.00	\$0.00
May-18	\$827.00	\$0.00
Total	\$5,761.57	\$1,605.00
	\$5,761.57	
	-\$1,605.00	
Balance Owed	\$4,156.57	

10. According to the above authority, the facility may not discharge a resident from its facility except for certain reasons, one of which is when the resident has failed, after reasonable and appropriate notice, to pay for their stay at the facility. The petitioner acknowledged that he was informed that he owed the facility for services but claimed that he paid the facility and does not have an outstanding balance. The petitioner was given an opportunity to provide proof of his payments to the facility but has not provided such evidence. The facility has established that it is owed for services provided to the petitioner in the amount of \$4,156.57.

11. The hearing officer concludes that the facility has given the petitioner reasonable and appropriate notice to pay for his stay at the facility. The Discharge Notice states that a doctor must sign the Discharge Notice or a written order for discharge must accompany the Discharge Notice except for “Your bills for service at the facility has not been paid” and “This facility is closing.” As this ruling is for a nonpayment for service, the Discharge Notice does not need to be signed by a doctor. This is one of the six reasons provided in 42 C.F.R. § 483.15 for which a nursing facility may involuntarily discharge a resident.

12. Establishing the reason for a discharge is lawful is just one step in the discharge process. The nursing home must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

13. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration’s health care facility complaint line at (888) 419-3456.

DECISION

This appeal is denied, as the facility’s action to discharge the petitioner is in accordance with Federal Regulations. The respondent may proceed with the discharge,

as described in the Conclusions of Law and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm.255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 06 day of June, 2018,

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], Respondent
[REDACTED]
Agency for Health Care Administration

FILED

Jun 13, 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. 18N-00024

PETITIONER,

Vs.

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned on May 18, 2018 at 11:00 a.m. at the [REDACTED] [REDACTED] located in [REDACTED], Florida.

APPEARANCES

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

For the Respondent: [REDACTED], Administrator

ISSUE

At issue is whether or not the nursing home's action to discharge the petitioner is an appropriate action based on the federal regulations. The nursing home is seeking to discharge the petitioner because his health has improved and he no longer needs nursing home services.

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 and Section 400.0255, Florida Statutes.

PRELIMINARY STATEMENT

By notice dated March 19, 2018, the respondent informed the petitioner that it was seeking to discharge/transfer him from its facility because his health had improved and he no longer required nursing home services. The notice was also signed by a physician. The petitioner timely requested a hearing on the matter.

Appearing as witnesses for the respondent were [REDACTED], Director of Social Services, and [REDACTED], MDS Coordinator.

The petitioner did not submit any documents as evidence for the hearing.

The facility's notice of discharge was entered into evidence as Respondent Exhibit 1.

After the hearing was concluded, the Agency for Health Care Administration (AHCA) submitted a letter dated May 17, 2018 which indicated that it found no violations during an unannounced visit on May 3, 2018 to the facility. This was entered into the record as the Hearing Officer's Exhibit I.

FINDINGS OF FACT

1. The petitioner was admitted into the skilled nursing facility in June, 2016. He needed extensive assistance at that time with his activities of daily living (ADLs). His

condition has since improved and he is now independent in his daily living activities. He is currently 62 years of age.

2. The petitioner's wife agreed that her husband is much improved, but she stated he still has [REDACTED] and he currently has a [REDACTED]. His primary diagnosis is [REDACTED], which causes him to display symptoms of [REDACTED]. The petitioner's wife wants to make sure he can remain safe at home because she works outside the home. The petitioner has been approved for Social Security Disability benefits and is covered by both Medicare and Medicaid.

CONCLUSIONS OF LAW

3. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

4. Federal Regulations appearing at 42 C.F.R. § 483.15 set forth the reasons a facility may involuntarily discharge a resident, as follows: Admission, transfer and discharge rights.

(c) Transfer and discharge---(1) Facility requirements---(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. 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.

5. Section 400.0255, Florida Statutes, explains that discharge notices indicating a medical reason for discharge must be signed by the treating physician or facility medical director or include an attached written discharge order. The authority reads in pertinent 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. **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.**
(emphasis added)

6. Based on the evidence presented, the nursing facility has established that the petitioner no longer needs nursing home services. 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.

7. Based upon the evidence presented, the undersigned concludes that the nursing facility has established by clear and convincing evidence that the petitioner's condition has sufficiently improved so that he no longer needs nursing home services.

8. Establishing that the reason for a discharge is lawful is just one step in the discharge process. The nursing home must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

9. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the appeal is denied. The facility may proceed with discharge of the petitioner.

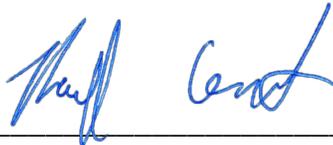
NOTICE OF RIGHT TO APPEAL

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 June, 2018,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], Petitioner
[REDACTED],
Respondent
[REDACTED], RN
Agency for Health Care Administration
[REDACTED]

FILED

Jun 15, 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. 18N-00030

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative nursing home discharge hearing in the above-styled matter on May 30th, 2018, at 10:00 a.m. at the above-mentioned facility in [REDACTED] Florida.

APPEARANCES

For the Petitioner: [REDACTED], Petitioner's daughter.

For the Respondent: [REDACTED].

STATEMENT OF ISSUE

The petitioner is appealing the respondent's refusal to readmit him back to the facility ([REDACTED]) in the event that he is discharged from the hospital.

PRELIMINARY STATEMENT

The petitioner was not present, but was represented by his daughter as described above with authorization as his legal guardian.

Appearing as witnesses for the respondent were: [REDACTED], Social Worker; [REDACTED], Social Work Supervisor; [REDACTED], Nursing Manager; and [REDACTED], Risk Manager. However, only [REDACTED], Social Work Supervisor testified. Additionally, a copy of the Notice of Hearing was issued to the Agency for Health Care Administration (AHCA) to allow a representative to appear; however, nobody from AHCA had appeared, and the undersigned proceeded with the hearing.

[REDACTED], Interpreter ID # 24663 from [REDACTED] Services acted as a Spanish language interpreter for the hearing.

The petitioner did not submit any documents for consideration.

The respondent presented Exhibits one and two, which were marked into evidence.

By way of a Nursing Home Transfer and Discharge Notice dated March 10th, 2018, the respondent notified the petitioner of its intention to discharge him from the facility effective immediately due to, “your needs cannot be met in this facility.” (Respondent’s Exhibit 1.)

By way of a second Nursing Home Transfer and Discharge Notice dated March 19th, 2018, the respondent notified the petitioner, “your needs cannot be met in this facility. Resident is currently hospitalized at [REDACTED] There is currently no availability at this time 3/19/18.” (Respondent’s Exhibit 2.)

On March 30th, 2018, the petitioner filed an appeal to challenge the respondent’s action not to keep a bed open.

FINDINGS OF FACT

1. The petitioner, currently 81 years of age, was a resident of [REDACTED] - [REDACTED] since 2010. The petitioner is an unfunded resident; he has neither Medicaid nor third-party insurance, and he does not pay privately. At the time of the hearing, the petitioner is a patient at [REDACTED]

2. The respondent issued a Nursing Home Transfer and Discharge Notice on March 10th, 2018, stating, “your needs cannot be met in this facility.” A copy of the notice was provided to and acknowledged by the petitioner’s daughter, who represented the petitioner at the hearing. The petitioner was discharged from the facility to [REDACTED] on March 10th, 2018, based on doctor’s orders, due to severe medical conditions, the needs of which could not be met at the facility. (Respondent’s Exhibit 1.)

3. On March 19th, 2018, while the petitioner was still at [REDACTED], the respondent issued a second Nursing Home Transfer and Discharge Notice stating, “your needs cannot be met in this facility” with additional comments, “there is currently no availability at this time 3/19/18.” A copy of this notice was issued to the petitioner’s daughter. (Respondent’s Exhibit 2.)

4. The respondent does not know the petitioner’s whereabouts after his discharge to [REDACTED].

5. As per the respondent, there is a requirement for an eight (8) day bed-hold; however, it only applies for Medicaid residents. Since the petitioner is an unfunded resident and not a Medicaid resident, the requirement does not apply to the petitioner. Regardless, the respondent held the bed open for the petitioner for eight (8) days after his discharge to

████████████████████ as a courtesy, in recognition of his long residency in good standing at the facility.

6. As of March 19th, 2018, (nine (9) days after his discharge), the petitioner was not ready to be discharged from ████████████████████ to ████████████████████ | ████████████████████ ████████████████████; therefore, the respondent terminated the bed hold. As per the administrator, the facility operates at maximum capacity, and it could not hold a bed open for a resident indefinitely.

7. On March 28th, 2018, the petitioner was discharged from ████████████████████ and was admitted to ████████████████████ r Nursing Home.

8. On May 22nd, 2018, the petitioner was discharged from ████████████████████ Home to ████████████████████. As of the time of the hearing, the petitioner remains at ████████████████████ ████████████████████. It is not clear if the petitioner will ever be in a condition to be discharged from the hospital to a nursing home. The petitioner however, wants the respondent to hold a bed open for him indefinitely at ████████████████████, if and when he is discharged.

9. The petitioner was satisfied with the services he received at ████████████████████ ████████████████████ while he was resident there, and he felt like at home at the facility; therefore, would like to return there due to his emotional and physical needs. The petitioner does not want to return to ████████████████████, from which he was discharged to the hospital he is currently admitted.

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 § 400.0255(15), Florida Statutes.

11. Jurisdictional boundaries to conduct this hearing have been assigned to the Department by Federal Regulations appearing at 42 C.F.R. § 431.200 (c)(1).

12. Federal regulations 42 C.F.R. § 483.206 address “Transfers, discharges and relocations subject to appeal”, and in relevant part states:

(a) “Facility” means a certified entity, either a Medicare SNF or a Medicaid NF (See §483.5).

(b) A resident has appeal rights when he or she is transferred from—

(1) A certified bed into a noncertified bed; and

(2) A bed in a certified entity to a bed in an entity which is certified as a different provider.

(c) A resident has no appeal rights when he or she is moved from one bed in the certified entity to another bed in the same certified entity.

13. Additionally, 42 C.F.R. § 483.15 addresses “Admission, transfer, and discharge rights, and 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**; *[emphasis added]*

(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

(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.

(ii) Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;

(D) **An immediate transfer or discharge is required by the resident's urgent medical needs**, [*emphasis added*] under paragraph (c)(1)(i)(A) of this section; or

(E) A resident has not resided in the facility for 30 days

14. Florida Statutes 400.0255 addresses “Resident transfer or discharge; requirement and procedures”, and in part states:

(1) As used in this section, the term:

(a) "Discharge" means to move a resident to a noninstitutional setting when the releasing facility ceases to be responsible for the resident's care.

(b) "Transfer" means to move a resident from the facility to another legally responsible institutional setting.

(2) Each facility licensed under this part must comply with subsection (9) and s. 400.022(1)(p) when deciding to discharge or transfer a resident.

(3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer. 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.

... (5) A resident of any Medicaid or Medicare certified facility may challenge a decision by the facility to discharge or transfer the resident.

(6) A facility that has been reimbursed for reserving a bed and, for reasons other than those permitted under this section, refuses to readmit a resident within the prescribed timeframe shall refund the bed reservation payment.

(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

... (10)(a) A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge. The resident, or the resident's legal representative or designee, may request a hearing at any time within 90 days after the resident's receipt of the facility's notice of the proposed discharge or transfer.

... (15)(a) The department's Office of Appeals Hearings shall conduct hearings under this section. The office shall notify the facility of a resident's request for a hearing.

... (d) The decision of the hearing officer shall be final. Any aggrieved party may appeal the decision to the district court of appeal in the appellate district where the facility is located. Review procedures shall be conducted in accordance with the Florida Rules of Appellate Procedure.

... (17) The provisions of this section apply to transfers or discharges that are initiated by the nursing home facility, and not by the resident or by the resident's physician or legal guardian or representative.

15. The above-cited rules and regulations inform that there are several reasons justifying a discharge; one of which is that the resident's need cannot be met at the facility. The facility discharged the petitioner to the hospital due to his needs cannot be met at the nursing facility. The petitioner is not challenging the discharge; rather the facility's refusal to hold a bed open for him indefinitely at the facility, should he be discharged from the hospital. Therefore, the undersigned has not considered the discharge; since that was not an issue raised by the petitioner. The petitioner's only issue is the facility's refusal to hold a bed open indefinitely, anticipating his discharge from the hospital; if and when it occurs, and the undersigned lacks jurisdiction over the subject matter.

DECISION

Based upon the foregoing Findings of Fact and the Conclusions of Law, the appeal is dismissed as non-jurisdictional.

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 15 day of June, 2018,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], Petitioner
[REDACTED], Respondent
[REDACTED], FO
Agency for Health Care Administration
[REDACTED]

Jun 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. 18N-00037

PETITIONER,

Vs.

CASE NO.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned on June 14, 2018 at 10:26 a.m. at the [REDACTED], located in [REDACTED], Florida.

APPEARANCES

For the Petitioner: The petitioner was not present and was represented by his son, [REDACTED]

For the Respondent: [REDACTED] Executive Director (ED) for [REDACTED] Nursing Home.

ISSUE

Federal regulations limit the reasons for which a Medicaid or Medicare certified nursing home may discharge a patient. At issue is whether or not the nursing home's action to transfer and discharge the petitioner is an appropriate action based on the

federal regulations at 42 C. F. R. § 483.15. The nursing home is seeking to transfer and discharge the petitioner because: (1) his needs cannot be met in this facility and (2) the safety of other individuals in this facility is endangered. The burden of proof is clear and convincing evidence and is assigned to the facility.

PRELIMINARY STATEMENT

By Nursing Home Transfer and Discharge Notice, dated April 16, 2018, the respondent informed the petitioner that he was to be discharged from the facility effective May 16, 2018. On April 19, 2018, the petitioner timely requested an appeal to challenge the respondent's action.

Appearing as a witness for the petitioner was the petitioner's son's girlfriend,

██████████.

Appearing as witnesses for the respondent were ██████████ Administrator in training, ██████████, Acting Director of Nursing (DON), and ██████████ ██████████, Social Services Director (SSD).

The Nursing Home Transfer and Discharge Notice was deficient by not including the discharge location. The Social Services Director remedied the Notice during the hearing to include the discharge location.

The respondent submitted evidence which was entered as the Respondent's Exhibit 1 and the Respondent's Composite Exhibit 2.

A letter dated June 5, 2018 from the Agency for Health Care Administration (AHCA) indicated that AHCA did not find the facility in violation of any laws or rules. This was entered as Hearing Officer's Exhibit 1.

The record was closed at the end of the hearing.

FINDINGS OF FACT

1. The petitioner has been residing in the respondent's facility since July 5, 2017. The petitioner was admitted for long-term care with diagnoses of [REDACTED] and [REDACTED]

2. The SSD contends that she was part of the discharge process and that she discussed with the petitioner's son that the petitioner is in need of a facility with [REDACTED]. The DON contends that petitioner's [REDACTED] condition has deteriorated to the point where he requires the care of a facility which is more skilled to provide care to residents in an [REDACTED]. The DON explained that a long term care facility is different from a facility that provides [REDACTED]. The DON explained that a facility that provides [REDACTED] is more suitable for the petitioner due to the specialized training the staff receives to care for patients who have [REDACTED]. The SSD explained that [REDACTED] facilities provide programs and activities that are geared towards its patients and that they have locked units. The ED contends that the petitioner's [REDACTED] has worsened since his admission. The ED contends that the petitioner needs to be in a locked unit, as he has been exhibiting exit-seeking behaviors; he wears a Wanderguard due to the risk for elopement. The SSD contends that it has to redirect the petitioner when he walks towards an exit.

3. The DON also contends that the petitioner has been put on one on one observation due to his aggressive behaviors, which consist of kicking, hitting, grabbing, and pushing. The DON contends that the petitioner also exhibits exit-seeking

behaviors. The ED contends that the petitioner was placed on one on one supervision due to his aggressive behaviors. The ED explained that the petitioner was placed on one on one supervision to protect other residents from potential harm. The DON contends that several workman's compensation claims have been requested by staff due to the petitioner's aggressive behavior. The DON contends that the petitioner choked a certified nursing assistant (CNA), who had marks on her neck, but chose not to seek medical treatment. The DON notes that the petitioner is tall. The DON contends that the petitioner goes to the other residents' rooms throughout the day, particularly at night, and would stand over their beds. The DON contends that this action would scare many of the residents. The DON contends that some of the residents have discharged from the facility because they felt unsafe due to the petitioner's action.

4. The Respondent's Composite Exhibit 2 includes the progress notes dated from July 7, 2017 through March 29, 2018. The DON explained that the progress notes document the residents' behavior. The DON referred to the progress notes dated July 7, 2017, which state: "...Resident exhibit combative behaviors, and currently on 1:1 observation. SSD spoke to son and scheduled 72 hr meeting on 07/11/17 at 12:30 p.m..." (Respondent's Composite Exhibit 2, page 6 of 6). The DON and ED referred to the progress notes dated October 5, 2017 (page 5 of 6), which state, "...Resident noted to be combative and hitting staff at times. Staff redirects. Resident remains on 1:1 supervision..." The progress notes dated February 23, 2018 at 8:55 state: "Pt was walking with his 1-1 aid and kept pulling her arm and he pulled her into the nutrition

room. Pt was very angry and yelling in Spanish when told that he could not go into the nutrition room.” The progress notes dated February 23, 2018 at 12:17 state: “Resident grabbing at staff. Resident grabbed CNA and pulled her around. PT yelling at the staff. Redirected to dining [sic] area to eat lunch and pt calmed down.”

5. The Respondent’s Exhibit 2 also includes the physician’s progress notes which document the examinations of the petitioner on the following dates: February 20, 2018 at 7:35; February 23, 2018 at 7:39; February 26, 2018 at 7:41; February 28, 2018 at 21:13; March 1, 2018 at 16:20; and March 9, 2018 at 10:13. The physician’s progress notes indicate that the petitioner continues to require 1:1 supervision due to a high risk of harm to himself and others. The physician’s notes also indicate that the petitioner is an elopement risk and requires Wanderguard. The physician’s notes are e-signed by [REDACTED], and [REDACTED], DO.

6. On April 16, 2018, the facility issued a Nursing Home Transfer and Discharge Notice advising petitioner that the effective date of the transfer was May 16, 2016. The reasons cited were, “Your needs cannot be met in this facility” and “The safety of other individuals in this facility is endangered.” The facility included on the notice the explanation that the petitioner “should be in a lock unit.”

7. The Notice was signed by the Administrator on April 12, 2018. The petitioner’s son also signed the Notice on April 16, 2018. The Nursing Home Transfer and Discharge Notice was signed by the petitioner’s physician, [REDACTED], on April 16, 2018.

8. The petitioner's witness and the petitioner's son do not dispute the petitioner's aggressive behaviors or the decline in his [REDACTED]. The petitioner's witness contends that the petitioner has significantly declined since April 2018, as he is not walking, is [REDACTED], and is sleeping most of the day. The petitioner's witness contends that he is losing weight because he is not eating. The petitioner's witness contends that hospice may be explored. The petitioner's witness argues that the petitioner had an untreated [REDACTED] that was not treated, according to the [REDACTED]. The petitioner's witness believes that the [REDACTED] may have caused the petitioner to become physically aggressive. The petitioner's witness believes that the petitioner is no longer a risk to anyone since he sleeps most of the day. The petitioner's witness contends that the petitioner is very weak when he attempts to get out of bed. The petitioner's witness is not sure that [REDACTED] will accept the petitioner due to his physically aggressive behaviors. The petitioner's witness explained that when she contacted [REDACTED], she was informed that it does not tolerate physical aggression, and that a resident is sent to a hospital if it occurs; she is concerned that the petitioner will not have a placement. The petitioner's witness contends that she and the petitioner's son are aware that the petitioner does wander but they were unaware of the exit-seeking behaviors and believe that there is a lack of communication.

9. The petitioner's son believes that the language barrier may cause his father to become frustrated, which may lead him to become defensive and physically aggressive. The petitioner's son does not agree that a new facility will rectify the situation, and that it

will cause more issues since he will not be familiar with his surroundings. The petitioner's son believes that moving the petitioner to a new facility will only put the responsibility on another facility. The petitioner's son contends that if the petitioner is moved to another facility, it will make it difficult for him to assist. The petitioner's son and petitioner's witness contends that the notes include only negative information.

10. The ED acknowledges that [REDACTED] and [REDACTED] conditions, such as [REDACTED], may lead to behavior issues. The ED believes that a language barrier does not cause one to be physically aggressive.

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 said authority, this order is the final administrative decision of the Department of Children and Families.

12. Federal Regulations appearing 42 C.F.R. § 483.15, sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

(c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

(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.

(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.

(ii) Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

(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.

13. On April 16, 2018, the facility issued a discharge notice to the petitioner.

The facility's reasons for discharging the petitioner are: (1) Your needs cannot be met in this facility and (2) The safety of other individuals in this facility is endangered. These

are two of the reasons permitted for discharge from a facility in accordance with the above federal regulation.

14. Section 400.02555, Florida Statutes, 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.

15. In accordance with the above federal regulation and statute, the notice was signed by a physician. The notice also indicated the reasons and effective date of the discharge, the location to which the petitioner is to be discharged, and the petitioner's appeal rights along with other required assistance information.

16. Based on the evidence presented, the nursing facility has established that the petitioner's "...needs cannot be met in this facility" and "The safety of other individuals in this facility is endangered". These are two of the six reasons provided in federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident.

17. Establishing that the reason for a discharge is lawful is just one step in the discharge process. The nursing home must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

18. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

DECISION

Based upon the forgoing Findings of Fact and Conclusions, the appeal is denied and the facility may proceed with its proposed discharge in accordance with the Agency for Health Care Administration's rules and regulations.

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 29 day of June, 2018,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], Petitioner

[REDACTED]
Agency for Health Care Administration
[REDACTED]s, Jr.

Jun 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. 18N-00037

PETITIONER,

Vs.

CASE NO.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned on June 14, 2018 at 10:26 a.m. at the [REDACTED], located in [REDACTED], Florida.

APPEARANCES

For the Petitioner: The petitioner was not present and was represented by his son, [REDACTED]

For the Respondent: [REDACTED] Executive Director (ED) for [REDACTED] Nursing Home.

ISSUE

Federal regulations limit the reasons for which a Medicaid or Medicare certified nursing home may discharge a patient. At issue is whether or not the nursing home's action to transfer and discharge the petitioner is an appropriate action based on the

federal regulations at 42 C. F. R. § 483.15. The nursing home is seeking to transfer and discharge the petitioner because: (1) his needs cannot be met in this facility and (2) the safety of other individuals in this facility is endangered. The burden of proof is clear and convincing evidence and is assigned to the facility.

PRELIMINARY STATEMENT

By Nursing Home Transfer and Discharge Notice, dated April 16, 2018, the respondent informed the petitioner that he was to be discharged from the facility effective May 16, 2018. On April 19, 2018, the petitioner timely requested an appeal to challenge the respondent's action.

Appearing as a witness for the petitioner was the petitioner's son's girlfriend,

[REDACTED].

Appearing as witnesses for the respondent were [REDACTED] Administrator in training, [REDACTED], Acting Director of Nursing (DON), and [REDACTED], [REDACTED], Social Services Director (SSD).

The Nursing Home Transfer and Discharge Notice was deficient by not including the discharge location. The Social Services Director remedied the Notice during the hearing to include the discharge location.

The respondent submitted evidence which was entered as the Respondent's Exhibit 1 and the Respondent's Composite Exhibit 2.

A letter dated June 5, 2018 from the Agency for Health Care Administration (AHCA) indicated that AHCA did not find the facility in violation of any laws or rules. This was entered as Hearing Officer's Exhibit 1.

The record was closed at the end of the hearing.

FINDINGS OF FACT

1. The petitioner has been residing in the respondent's facility since July 5, 2017. The petitioner was admitted for long-term care with diagnoses of [REDACTED] and [REDACTED]

2. The SSD contends that she was part of the discharge process and that she discussed with the petitioner's son that the petitioner is in need of a facility with [REDACTED]. The DON contends that petitioner's [REDACTED] condition has deteriorated to the point where he requires the care of a facility which is more skilled to provide care to residents in an [REDACTED]. The DON explained that a long term care facility is different from a facility that provides [REDACTED]. The DON explained that a facility that provides [REDACTED] is more suitable for the petitioner due to the specialized training the staff receives to care for patients who have [REDACTED]. The SSD explained that [REDACTED] facilities provide programs and activities that are geared towards its patients and that they have locked units. The ED contends that the petitioner's [REDACTED] has worsened since his admission. The ED contends that the petitioner needs to be in a locked unit, as he has been exhibiting exit-seeking behaviors; he wears a Wanderguard due to the risk for elopement. The SSD contends that it has to redirect the petitioner when he walks towards an exit.

3. The DON also contends that the petitioner has been put on one on one observation due to his aggressive behaviors, which consist of kicking, hitting, grabbing, and pushing. The DON contends that the petitioner also exhibits exit-seeking

behaviors. The ED contends that the petitioner was placed on one on one supervision due to his aggressive behaviors. The ED explained that the petitioner was placed on one on one supervision to protect other residents from potential harm. The DON contends that several workman's compensation claims have been requested by staff due to the petitioner's aggressive behavior. The DON contends that the petitioner choked a certified nursing assistant (CNA), who had marks on her neck, but chose not to seek medical treatment. The DON notes that the petitioner is tall. The DON contends that the petitioner goes to the other residents' rooms throughout the day, particularly at night, and would stand over their beds. The DON contends that this action would scare many of the residents. The DON contends that some of the residents have discharged from the facility because they felt unsafe due to the petitioner's action.

4. The Respondent's Composite Exhibit 2 includes the progress notes dated from July 7, 2017 through March 29, 2018. The DON explained that the progress notes document the residents' behavior. The DON referred to the progress notes dated July 7, 2017, which state: "...Resident exhibit combative behaviors, and currently on 1:1 observation. SSD spoke to son and scheduled 72 hr meeting on 07/11/17 at 12:30 p.m..." (Respondent's Composite Exhibit 2, page 6 of 6). The DON and ED referred to the progress notes dated October 5, 2017 (page 5 of 6), which state, "...Resident noted to be combative and hitting staff at times. Staff redirects. Resident remains on 1:1 supervision..." The progress notes dated February 23, 2018 at 8:55 state: "Pt was walking with his 1-1 aid and kept pulling her arm and he pulled her into the nutrition

room. Pt was very angry and yelling in Spanish when told that he could not go into the nutrition room.” The progress notes dated February 23, 2018 at 12:17 state: “Resident grabbing at staff. Resident grabbed CNA and pulled her around. PT yelling at the staff. Redirected to dining [sic] area to eat lunch and pt calmed down.”

5. The Respondent’s Exhibit 2 also includes the physician’s progress notes which document the examinations of the petitioner on the following dates: February 20, 2018 at 7:35; February 23, 2018 at 7:39; February 26, 2018 at 7:41; February 28, 2018 at 21:13; March 1, 2018 at 16:20; and March 9, 2018 at 10:13. The physician’s progress notes indicate that the petitioner continues to require 1:1 supervision due to a high risk of harm to himself and others. The physician’s notes also indicate that the petitioner is an elopement risk and requires Wanderguard. The physician’s notes are e-signed by [REDACTED], and [REDACTED], DO.

6. On April 16, 2018, the facility issued a Nursing Home Transfer and Discharge Notice advising petitioner that the effective date of the transfer was May 16, 2016. The reasons cited were, “Your needs cannot be met in this facility” and “The safety of other individuals in this facility is endangered.” The facility included on the notice the explanation that the petitioner “should be in a lock unit.”

7. The Notice was signed by the Administrator on April 12, 2018. The petitioner’s son also signed the Notice on April 16, 2018. The Nursing Home Transfer and Discharge Notice was signed by the petitioner’s physician, [REDACTED], on April 16, 2018.

8. The petitioner's witness and the petitioner's son do not dispute the petitioner's aggressive behaviors or the decline in his [REDACTED]. The petitioner's witness contends that the petitioner has significantly declined since April 2018, as he is not walking, is [REDACTED], and is sleeping most of the day. The petitioner's witness contends that he is losing weight because he is not eating. The petitioner's witness contends that hospice may be explored. The petitioner's witness argues that the petitioner had an untreated [REDACTED] that was not treated, according to the [REDACTED]. The petitioner's witness believes that the [REDACTED] may have caused the petitioner to become physically aggressive. The petitioner's witness believes that the petitioner is no longer a risk to anyone since he sleeps most of the day. The petitioner's witness contends that the petitioner is very weak when he attempts to get out of bed. The petitioner's witness is not sure that [REDACTED] will accept the petitioner due to his physically aggressive behaviors. The petitioner's witness explained that when she contacted [REDACTED], she was informed that it does not tolerate physical aggression, and that a resident is sent to a hospital if it occurs; she is concerned that the petitioner will not have a placement. The petitioner's witness contends that she and the petitioner's son are aware that the petitioner does wander but they were unaware of the exit-seeking behaviors and believe that there is a lack of communication.

9. The petitioner's son believes that the language barrier may cause his father to become frustrated, which may lead him to become defensive and physically aggressive. The petitioner's son does not agree that a new facility will rectify the situation, and that it

will cause more issues since he will not be familiar with his surroundings. The petitioner's son believes that moving the petitioner to a new facility will only put the responsibility on another facility. The petitioner's son contends that if the petitioner is moved to another facility, it will make it difficult for him to assist. The petitioner's son and petitioner's witness contends that the notes include only negative information.

10. The ED acknowledges that [REDACTED] and [REDACTED] conditions, such as [REDACTED], may lead to behavior issues. The ED believes that a language barrier does not cause one to be physically aggressive.

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 said authority, this order is the final administrative decision of the Department of Children and Families.

12. Federal Regulations appearing 42 C.F.R. § 483.15, sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

(c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

- (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
 - (D) The health of individuals in the facility would otherwise be endangered;
 - (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
 - (F) The facility ceases to operate.
- (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.
- (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.

(ii) Notice must be made as soon as practicable before transfer or discharge when—

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

(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.

13. On April 16, 2018, the facility issued a discharge notice to the petitioner.

The facility's reasons for discharging the petitioner are: (1) Your needs cannot be met in this facility and (2) The safety of other individuals in this facility is endangered. These

are two of the reasons permitted for discharge from a facility in accordance with the above federal regulation.

14. Section 400.02555, Florida Statutes, 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.

15. In accordance with the above federal regulation and statute, the notice was signed by a physician. The notice also indicated the reasons and effective date of the discharge, the location to which the petitioner is to be discharged, and the petitioner's appeal rights along with other required assistance information.

16. Based on the evidence presented, the nursing facility has established that the petitioner's "...needs cannot be met in this facility" and "The safety of other individuals in this facility is endangered". These are two of the six reasons provided in federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident.

17. Establishing that the reason for a discharge is lawful is just one step in the discharge process. The nursing home must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

18. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

DECISION

Based upon the forgoing Findings of Fact and Conclusions, the appeal is denied and the facility may proceed with its proposed discharge in accordance with the Agency for Health Care Administration's rules and regulations.

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 29 day of June, 2018,

in Tallahassee, Florida.



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

Copies Furnished To: [REDACTED], Petitioner

[REDACTED]
Agency for Health Care Administration
[REDACTED]s, Jr.