

Jul 03, 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-00056  
18F-00057  
18F-00058

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 07 Volusia  
UNIT: 88323

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on February 27, 2018, at 1:05 p.m. and reconvened on June 12, 2018, at 11:02 a.m. All parties appeared telephonically from different locations. The same parties appeared in both hearings.

**APPEARANCES**

For the Petitioner: [REDACTED]

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

**STATEMENT OF ISSUE**

Petitioner is appealing Department's (or Respondent's) action denying full Medicaid benefits for her children and enrollment in the Medically Needy (MN) Program

with an estimated share of cost (SOC) based on a new application. Petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

On January 2, 2018, Petitioner requested an appeal challenging her children enrollment in the MN Program.

During the first hearing, Petitioner submitted two separate evidence packets which were marked Petitioner's Exhibits 1 and 2. During the second hearing, Petitioner submitted an evidence packet which was marked as Petitioner's Exhibit 3. Respondent submitted a 31-page document which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The record was closed on June 12, 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, Petitioner's minor sons were receiving full Medicaid. Her 19-year-old daughter was enrolled in the MN Program with a \$2,749 SOC. The minor kids were last eligible for full Medicaid in August 2017.
2. In November 2017, Petitioner applied for Florida KidCare Medicaid benefits for the two youngest children and was to pay a \$460 monthly premium effective December 1, 2017. However, the benefits were terminated when she failed to make payments, see Petitioner's Exhibits 1 and 2.
3. On November 9, 2017, Petitioner submitted a web application to the Department requesting Medicaid benefits for her household. Petitioner's household then consisted of herself and her six children (ages 11 through 22). Adult children 21 and over are not

eligible for Family-Related Medicaid and not included in the Medicaid standard filing unit (SFU).

4. Petitioner is employed and earns \$1,699.96 biweekly. She is a tax filer with her minor children as her dependents. Petitioner's income is not in dispute.

5. Petitioner was seeking full Medicaid for her household. Initially, Respondent approved for Petitioner and four eligible children effective November 2017 each with an estimated SOC of \$4,793.

6. After review, Respondent used \$3,399.92 ( $\$1,699.96 \times 2$ ) used as countable monthly income for Petitioner. This amount is considered as modified adjusted gross income (MAGI) for the household. To determine Medicaid eligibility for the children, the household's MAGI of \$3,399.92 was compared to the income limit for children based on their age group in a household size of five eligible members (\$3,190).

7. As the income exceeded the maximum limit for Petitioner and her adult children, they were found ineligible for full Medicaid. As the income exceeded the maximum limit for children ages 6 through 18, the children were found ineligible for full Medicaid. As they were determined ineligible for full Medicaid, Respondent enrolled them in the Medically Needy (MN) Program.

8. To determine the children's estimated SOC the Medically Needy Income Level (MNIL) of \$684 (for a SFU size of five) was subtracted from the MAGI (\$3,399.92), resulting to the children's estimated SOC of \$2,715. The 19-year old was enrolled in a different MN Program with the same estimated SOC amount.

9. On November 17, 2017, the Department sent Petitioner a Notice of Case Action informing her that her household was enrolled in MN Program.

10. Respondent explained that the children are not eligible for full Medicaid because the household income exceeds the Family-Related Medicaid income limit for the household size. She explained that the children are enrolled in the Medically Needy Program and that the SOC was directly related to the household's gross income. She explained that the Department policies must be followed. She further explained how the Medically Needy Program works and advised Petitioner to submit medical bills every month for tracking to get her children's Medicaid activated.

11. Petitioner did not dispute the income used by the Department. She argued as follows: (1) that she cannot afford to add the children to her health plan with the county because it would cost her \$600 a month to do so; (2) that she could not afford to pay the \$460 monthly premiums required to cover just the two youngest children. Petitioner maintains that she cannot afford medical insurance for her household with her current financial situation.

12. On December 14, 2017, Respondent received a \$1,253 medical bill from [REDACTED] c for service provided to her daughter. That bill was not paid by Respondent because it was not enough to meet the SOC.

13. Petitioner is only challenging eligibility for the minor children. She is seeking full Medicaid or a lower SOC for them.

#### **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.

**Full Medicaid will now be addressed**

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

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

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

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

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

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

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

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

(MAGI) (d) defines Household Income. It states:

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

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

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

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

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

21. The Family-Related Medicaid income standard appears in The Department's Program Policy Manual (The Policy Manual), CFOP 165-22 at Appendix A-7. Effective February 2017, the Family-Related Medicaid income standard appears in the Policy Manual at Appendix A-7. It indicates that the Family-Related Medicaid income limits for a household of five with four children as \$3,190, and the Medically Needy Income Limit (MNIL) is \$684.

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).

23. The Policy Manual at 2230.0400 Standard Filing Unit (MFAM) states:

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

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

24. In accordance with the above controlling authorities, the Medicaid household group is Petitioner and four children (five members). The findings show the Department determined Petitioner's eligibility with a household size of five to determine Medicaid eligibility for the children. The undersigned concludes the Department correctly determined the petitioner's household size as five for Medicaid eligibility purposes based on the November 9, 2017 application.

25. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for Petitioner's children and did not find them eligible for full Medicaid as the household's MAGI is more than the income limit of \$3,190 for a household of five. The undersigned concludes that Petitioner's children are not eligible for full Medicaid under the Family-Related Medicaid Program. The undersigned recognizes Petitioner's concerns about her limited means; however, the controlling legal authorities do not allow for a more favorable outcome. The undersigned further concludes Medically Needy (MN) eligibility must be explored.

**The SOC amount will now be reviewed.**

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

27. 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.

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

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

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

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

29. In accordance with the above controlling authorities, Respondent determined petitioner's SFU as a household of five. To determine the children's SOC Respondent subtracted the Medically Needy Income Level of \$684 for a standard filing unit size of five from the household MAGI of \$3,399.92, resulting in an estimated SOC of \$2,715.

30. The hearing officer reviewed the SOC calculation done by the Department and could not find a more favorable outcome.

31. 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's children full Medicaid under the Family-Related Medicaid coverage group and their enrollment in the Medically Needy Program with a \$2,715 SOC is correct.

**DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 03 day of July, 2018,

in Tallahassee, Florida.



Roosevelt Reveil  
Hearing Officer  
Building 5, Room 255  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

**FILED**

Jul 16, 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-00636

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on February 15, 2018 at 11:04 a.m. The hearing was continued and reconvened on May 8, 2018 at 11:02 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**

Petitioner is appealing the Department's action of, January 23, 2018, enrolling him in the Medically Needy Program (MN) with a Share of Cost (SOC) rather than approving him 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 "7" respectively. The record was closed on May 8, 2018.

The hearing was held on February 15, 2018. Due to technical issues with the telephone, the hearing was continued and rescheduled for March 19, 2018. On March 19, 2018, the petitioner contacted the Office of Appeal Hearings (OAH) to request a continuance as he had a conflicting appointment. The request was granted and the hearing was reset to April 5, 2018. On April 5, 2018, the petitioner contacted OAH to request a continuance as he was in the hospital. The request was granted and the hearing rescheduled and held on May 8, 2018.

The Department presented evidence which was marked and accepted as Respondent's Exhibits "1" through "7" respectively. The petitioner did not submit any evidence for the undersign to consider. The record was closed on May 8, 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 applied for Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits on January 22, 2018.
2. At the time of the application, the petitioner was 56-years-old, disabled and was the sole member of his assistance group.

3. On January 22, 2018, the Department approved the petitioner's household for SNAP benefits of \$142 and Qualified Medicare Beneficiary (QMB) Medicaid and enrolled him in the Medically Needy(MN) program with an estimated Share of Cost (SOC) of \$573 for December 2017 and \$590 for February ongoing.

4. On January 23, 2018, the Department sent a Notice of Case Action (NOCA) to the petitioner informing him of its eligibility determination.

5. On January 25, 2018, the petitioner appealed the enrollment into the MN program. The approval of the SNAP and QMB benefits are not under appeal.

6. The petitioner asserts that he has limited income and cannot afford the co-pays and deductibles that he is required to pay. He believes that he should be eligible for full Medicaid with no SOC.

7. The respondent countered that the petitioner should contact the Agency for Health Care Administration (AHCA) for coverage and payment under the QMB Program. AHCA is responsible for administering Florida's Medicaid Program. AHCA contracts with Health Maintenance Organizations (HMOs) to provide prepaid, comprehensive, cost-effective medical services to enrolled Medicaid recipients.

8. The petitioner's sole source of income is Social Security Disability Income(SSDI) of \$790.

9. The respondent explained the petitioner's budget as follows:

The respondent calculated the petitioner's total countable income as \$770, after a \$20 unearned income disregard was subtracted from his \$790 SSDI benefits. The income standard for an aged/disabled individual to receive full Medicaid is \$1005. Although the

petitioner's total countable income is below this amount, he is not eligible for full Medicaid benefits because he is a Medicare recipient.

10. The respondent therefore enrolled the petitioner in the MN Program. To determine the \$590 SOC amount, the respondent determined the Medically Needy Income Level (MNIL) for a household size of one is \$180, this amount was subtracted from \$770.

\$790	unearned income
- 20	unearned income disregard
<hr/>	
\$770	countable unearned income
\$770	countable unearned income
-180	medically needy income limit for household of one
<hr/>	
\$590	share of cost

11. Although the petitioner testified to out-of-pocket medical expenses, no medical bills or receipts were provided for the undersigned to review.

### **CONCLUSIONS OF LAW**

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

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

14. 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.

15. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI-Related Medicaid programs:

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

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

...

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

16. Fla. Admin. Code R. 65A-1.701(20) defines MEDS-AD Demonstration Waiver as:

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

17. Section 409.904, Florida Statutes, sets forth the following regarding Medicaid:

Optional payments for eligible persons. —The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law...

(1) Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of

the federal poverty level, whose assets do not exceed established limitations, **and who is not eligible for Medicare** [emphasis added] ...

18. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 2040.0813.03, Technical Requirements for MEDS-AD (MSSI) states:

The individual must meet all of the following criteria:

1. Age or disability,
2. U.S. residency,
3. Citizenship,
4. Welfare enumeration,
5. Third party liability,
6. Application for other benefits they may be eligible to receive,
7. **Not be receiving Medicare** [emphasis added] ...

19. According to the above regulations, an individual who receives Medicare is not eligible to receive full Medicaid. In this instance, the petitioner has Medicare benefits through the Social Security Administration and therefore does not meet one of the technical requirements for full Medicaid.

20. The Code of Federal Regulations 20 C.F.R. § 416.1124 (c)(12), Unearned Income we do not count, states in part, "The first \$20 of any unearned income in a month..."

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

22. Fla. Admin. Code R. 65A-1.716(2), Income and Resource Criteria, states in relevant part:

Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size	Income Level
1	\$180

23. The respondent determined the petitioner's SOC by using his monthly SSDI of \$790 minus the \$20 unearned income disregard to calculate his total countable income of \$770. The respondent then subtracted the \$180 MNIL from his \$770 total countable income, which resulted in his SOC of \$590.

24. In careful review of the cited authorities and evidence, the undersigned concludes the Department's determination that the petitioner was not eligible for full Medicaid benefits as he did not meet one of the technical requirements (not receiving Medicare) and the enrollment of the petitioner in the MN Program with a SOC \$590 is correct.

### **DECISION**

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

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

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

FINAL ORDER (Cont.)  
18F-00636  
PAGE -8

DONE and ORDERED this 16 day of July, 2018,  
in Tallahassee, Florida.



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Ursula Lett-Robinson  
Hearing Officer  
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Tallahassee, FL 32399-0700  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

**FILED**

Aug 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. 18F-00940

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 April 3, 2018 at 3:09 p.m.; May 4, 2018 at 3:15 p.m.; and June 14, 2018 at 3:54 p.m.

**APPEARANCES**

For the Petitioner: [REDACTED], authorized representative

For the Respondent: Mary Triplett, economic self-sufficiency supervisor

**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 December 18, 2017, the Department informed the petitioner that her application for SSI-Related Medicaid was denied.

The petitioner requested a hearing on February 5, 2018 to challenge the Department's decision.

The petitioner was present and testified. The petitioner submitted documentary evidence which was admitted into the record as Petitioner's Exhibits 1 and 2.

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.

Hearing officer Christiana Gopaul-Narine was present as an observer during the April 3, 2018 portion of the proceeding.

During the June 14, 2018 portion of the proceeding, the petitioner requested the record be held open until close of business on July 2, 2018 for the submission of additional evidence. The petitioner later requested the deadline be extended until close of business on August 7, 2018. The undersigned granted both requests. However, no additional evidence was filed by the petitioner. The record was closed on August 7, 2018.

### **FINDINGS OF FACT**

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

1. The petitioner (age 40) filed an application for SSI Related-Medicaid with the Department on November 15, 2017. The petitioner is a single adult; she does not have minor children. The petitioner lives with her landlord and authorized representative, [REDACTED]. The petitioner asserted that she is disabled due to [REDACTED], [REDACTED]. (Petitioner testimony)

2. The petitioner is verbal and ambulates independently. She has an uneven gait and uses her hands to help maintain her balance. The petitioner can independently perform the activities of daily living (bathing, dressing, grooming, toileting), but requires verbal reminders to ensure the activities are completed properly. She feeds and takes medication by mouth. The petitioner is continent, but has occasional accidents. The petitioner has [REDACTED], but no other visual impairments. The petitioner was diagnosed with [REDACTED]. The petitioner takes several medications to address her physical and mental health issues. The petitioner completed high school; she received a standard diploma. She can read and write, but both asserted both skills are limited; she requires assistance managing business affairs and has issues with comprehension and long term memory. The petitioner has [REDACTED] and other behavioral issues which limit her ability to socialize and make lasting friendships. The petitioner works part-time (approximately

12 to 20 hours weekly) at [REDACTED] as a merchandiser (stocking store shelves).

(Petitioner testimony)

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 (SSA) or the Department. The petitioner had a pending disability application with SSA at the time of the hearing. 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 or about January 3, 2018 for a disability review. (Respondent's Exhibit 1)

4. DDD uses the applicant's available medical records and information obtained during a disability interview with the applicant to make the disability determination. In the instant case, DDD reviewed the petitioner's medical records from Ideal Family Practice, hearing and speech tests from [REDACTED], and psychological records from [REDACTED] (Respondent's Exhibit 1)

5. The 2017 physical exam conducted at Ideal Family Practice reads:

**Physical Exam**

**Patient is a 38-year-old female.**

**Chaperone: Chaperone: offered and declined.**

**Constitutional: General Appearance: healthy-appearing, well-nourished, and well-developed, Level of Distress: NAD, Ambulation: ambulating normally.**

**Psychiatric:** Insight: good judgement. Mental Status: normal mood and affect and active and alert. Orientation: to time, place, and person. Memory: recent memory normal and remote memory normal.

**Head:** Head: normocephalic and atraumatic.

**Eyes:** Lids and Conjunctivae: no discharge or pallor and non-injected. Pupils: PERRLA. Fundoscopic: no exudates or hemorrhages. EOM: EOMI. Sclerae: non-icteric. Vision: peripheral vision grossly intact and acuity grossly intact.

**ENMT:** Ears: no lesions on external ear, EACs clear, and TMs clear. Hearing: no hearing loss. Nose: no lesions on external nose, septal deviation, or sinus tenderness; nasal discharge and discharge—rhinorrhoea; post nasal drip; and nares patent and nasal passages clear. Lips, Teeth, and Gums: no mouth or lip ulcers or bleeding gums and normal dentition. Oropharynx: no erythema or exudates and moist mucous membranes and tonsils not enlarged.

**Neck:** Neck: supple, FROM, trachea midline, and no masses. Lymph Nodes: no cervical LAD or supraclavicular LAD. Thyroid: no enlargement or nodules and non-tender.

**Lungs:** Respiratory effort: no dyspnea. Percussion: no dullness, flatness, or hyperresonance. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal, good air movement, and CTA except as noted.

**Cardiovascular:** Apical impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Pulses including femoral / pedal: normal throughout.

**Abdomen:** Bowel Sounds: normal. Inspection and Palpation: no tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended.

**Musculoskeletal:** Motor Strength and Tone: normal tone and motor strength. Joints, Bones, and Muscles: no contractures, malalignment, tenderness, or bony abnormalities and normal movement of all extremities. Extremities: no cyanosis or edema.

**Neurologic:** Gait and Station: normal gait and station. Cranial Nerves: grossly intact. Sensation: grossly intact. Reflexes: DTRs 2+ bilaterally throughout. Coordination and Cerebellum: no tremor.

**Skin:** Inspection and palpation: no rash or jaundice and good turgor; eyelids with slight rash, dry, itchy with beetle skin  
**Nails:** normal.

(Respondent's Exhibit 1)

6. 2013 – 2017 psychological records from [REDACTED]

note a history of anxiety and depression. (Respondent's Exhibit 1)

7. 2007 – 2016 speech and hearing tests from [REDACTED] note

moderate to profound hearing impairment. (Respondent's Exhibit 1)

8. 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. (Rebecca Sills testimony)

9. DDD concluded that the petitioner was not disabled at step five of the disability analysis. DDD concluded that the petitioner's physical and mental health issues were not severe enough to prevent her from performing work in the national economy. DDD determined that the petitioner was capable of performing light, unskilled manual labor jobs such as laundry worker, domestic worker, and sales attendant.

(Respondent's Exhibit 1 and Rebecca Sills testimony)

10. The DDD medical examiner explained her conclusion that the petitioner's physical impairments were not severe enough to prevent her from performing work in the national economy in Assessment section of the Medical Evaluation:

MER/Findings: 12/11/17 PE: Gen: NAD, ambulating normally. Ears: no lesions on external ear, EACs clear, and TMs clear. Hearing: no hearing loss. Lungs: no dyspnea, no dullness, flatness, or hyperresonance; no wheezing, rales/crackles, or rhonchi, good air movement. CV: normal S1/S2, no murmurs, rubs, or gallops, RRR. MSK: normal tone and motor strength, normal movement of all extremities, no cyanosis or edema. Neurologic: normal gait and station, cranial nerves grossly intact, sensation grossly intact, coordination and cerebellum w/ no tremor. ROS: clmt reports no difficulty hearing and no ear pain.

Mental: Degree of Limitation: Understand, Remember, or Apply Information - none; Interact w/ Others - mild; Concentrate, Persist, or Maintain Pace - mild; Adapt or Manage Oneself - none.

PRW: Clmt worked as a Merchandiser, which can be described as Medium work per DOT Code 298.081-010.

ADLs: Clmt is able to complete personal care for self while seated, such as using a shower chair and safety arm. Clmt is able to complete light household chores like washing dishes. Clmt cannot perform tasks like vacuuming b/c the noise causes dizziness.

ADLs (cont): The clmt is currently work 18-24 hrs a week at Home Dept earning \$10 per hr. She is a Merchandiser who puts prices on items and occasionally has to look up items on a smart phone. Clmt was able to understand normal conversation during ADL call and did not need any clarification from the examiner, such as repeating a question or speaking louder.

Summary/Decision: 39 y/o female w/ [REDACTED] h/o [REDACTED] n/o acute [REDACTED] and [REDACTED]. Mental illness is not severely limiting. Clmt given a Light RFC. Clmt can perform work such as 1) Sales Attendant 299.677-010, 2) Laundry worker, domestic 302.685-010, or 3) Ironer 302.687-010. CLMT DENIED. N32 - VOCATIONAL RULE 202.21.

(Respondent's Exhibit 1 and Rebecca Sills testimony)

11. DDD refers claims of disability due to mental health disorders to consulting psychologists who record their findings and conclusions in a Psychological Evaluation.

The conclusion section of the petitioner's Psychological Evaluation reads:

Almost 40yo woman with hx of [REDACTED] and mood disorder, the latter responding well to Rx. She is working part time as a merchandiser. Treatment records reveal good control of mood symptoms with the benefit of Rx. She relates effectively as needed. ADLs and persistence/pace are adequate within her physical tolerances. Mental illness is not severely limiting.

(Respondent's Exhibit 1 and Rebecca Sills testimony)

12. DDD informed the Department that the petitioner did not meet the disability criteria via a transmittal on February 2, 2018. (Respondent's Exhibit 1)

13. The Department denied the petitioner's application on December 18, 2017, prior to receiving DDD's disability decision, in error. The Department's notice reads:

**Medicaid**

Your Medicaid application/review dated November 15, 2017 is denied for the following months:

<b>Name</b>	<b>Nov, 2017</b>	<b>Dec, 2017</b>	<b>Jan, 2018</b>
Jennifer Grogan	Ineligible	Ineligible	Ineligible

Reason: You failed to complete an interview necessary for us to determine your eligibility for this program

(Respondent's Exhibit 1)

14. The Department acknowledged that the denial notice was issued prematurely and contained the wrong denial reason (failure to complete interview). However, the Department did not issue a new notice in February 2018, after the denial decision from DDD, because the outcome (petitioner was ineligible for SSI-Related Medicaid) did not change. (Respondent's Exhibit 1 and Mary Triplett testimony)

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

16. The petitioner explained why she believes she is disabled in a written statement which reads in pertinent part:

Hello, my name is [REDACTED]. I turn 40 years old on February 3, 2018, and I was born on [REDACTED]. I have dark brown hair and hazel eyes. When I was born, I was born with a number of health conditions and multiple disorders.

I was born with fluid on my brain and at 8 months old had to have surgery and a Brain Tap to stop the fluids. I was diagnosed with [REDACTED] at this time, with disfunctioning motor skills. My head tilted forward and to the side as I was unable to hold my head up by myself until the age of 2 1/2 in 1980. After I was old enough to walk, I leaned forward and swung my arms heavily to balance my body. I had multiple disorders immediately from birth and the most pronounced was [REDACTED]. This caused a severe drainage of fluids from my mouth, my vagina and caused heavy coughing. It still is a major problem today with increased breathing problems, nonstop 7 days a week running nose, and sore throat. The doctors have tried every know medication to help and nothing has worked. This has caused many allergies, (over 35 of them) noted in my doctors.

Later on in growing years, by the 1<sup>st</sup> grade I was diagnosed as [REDACTED] by one doctor, and [REDACTED] by another. As time went on, by the 5<sup>th</sup> grade, I developed the full and complete disease disorder of [REDACTED] and [REDACTED]. I was born with [REDACTED] (known as complete nerv deafness) in both ears and I could only hear 35 % with the aid of specialized hearing aids. I am completely deaf bilaterally without the [REDACTED]

...  
Moving forward to today and bypassing a life time of pain, hurt and devastation, I will share my present. Because of a FULL life of disability, I am unable to survive on my own without support needed. I am unable to drive because of the disabilities; therefore, I am forced to use the [REDACTED] Connection public transportation for the disabled. I cannot apply for a job or be accepted for a full time job because people are naturally afraid of [REDACTED] people and disabled people with Discrimination. I am judged even before I sit down at an interview. I cannot become a sales person because I cannot drive to appointments and I cannot hear the caller on the phone to set appointments. I cannot be a cashier because my math skills are nonexistent as I still do not comprehend math or logic.

**When I did gain employment part time shifts, it took me a 2 hour time frame to go to work catching as many as 3 buses to get there and then return home after a 4 hour shift. How depressing this became all to find out I have been terminated again due to not being fast enough in the Publix bakery, or fast enough wiping down restaurant tables.**

**I am presently, now at December 20th, in a position where my boss at the Home depot is mentioning that I need to pick up the pace of my job labeling prices on products and stocking the shelves, I feel again termination is near and I am done with this game of ugliness.**

(Petitioner's Exhibits 1 & 2)

17. The petitioner's representative asserted that she is disabled and unable to care for her financial, physical and emotional needs. The representative described the petitioner in a written statement that reads in pertinent part:

**As you will see, Jennifer not only has been a disabled woman her entire life, she was raised in a broken home, divorced parents, and absolutely no proper care as a young adult. Jennifer has no savings, no IRA, no fund provided by the parents, no health insurance whatsoever, and relies today totally on the family that took her off the streets, and has brought Light and GOD into her life. All of Jennifer's medical expenses, doctor visits and prescriptions have been paid for by James Whitney and Family since October 2016. This cannot continue. Jennifer's working status is getting weak, and may change again due to the very small part time hours she is given from Home Depot. Jennifer currently works 14 to 20 hrs per week at \$10.00 per hour. This is not a living pay scale in order for anyone to survive.**

(Petitioner's Exhibits 1 & 2)

18. The petitioner's representative addressed her hearing loss in a written statement:

**Jennifer has been diagnosed as [REDACTED] since birth and she wears computerized hearing aids to give her the ability to hear approximately 35 to 45% still today.**

(Petitioner's Exhibits 1 & 2)

19. The representative's written statement also addressed the petitioner's mental health issues:

**It is Written in Jennifer's Dr's reports from [REDACTED]**

**[REDACTED]  
[REDACTED]  
are damaged from birth and create the very strong emotional instability. The cause and effect is [REDACTED].  
Based on all of the doctor reports Jennifer spent several years combined in lock down, while medication after medication was prescribed and used to find a balance for stable guarded position. Jennifer to this day has very low concentration based on minutes and seconds, not by ¼ hr or hour measures. Jennifer is lucky if she remembers or understands directions on a job task by the time she reaches her spot on the Home Depot sales floor and has to ask the manager for instructions again and again as the hours move on. Jennifer's work schedule was just cut in February to 16 hours per week, and may change again.**

(Petitioner's Exhibits 1 & 2)

20. The petitioner and her representative asserted that she has never been able to hold down a long term job due to the severity of her mental and physical issues. The petitioner asserted that she loses jobs because she moves very slowly due to her physical impairments and processes information slowly due to her intellectual and mental health impairments. She cannot climb stairs, pick up heavy objects, operate heavy machinery or walk for long distances. Due to her lack of higher education, she is hired for manual labor jobs. However, those jobs require physical speed and strength which the petitioner asserted she lacks. (Testimony of petitioner and [REDACTED])

21. The petitioner's representative argued that DDD based its decision on clinical records from a walk-in clinic (Ideal Family Practice) that the petitioner visited only twice. The representative further argued that the petitioner was treated by nursing staff at the clinic for a severe cold/flu. The purpose of the visits was not to address her disabling physical and mental health issues. The representative argued that the clinic medical

records were insufficient documentation of the petitioner's health. The representative requested the record be held open until close of business on July 2, 2018 so that he could provide medical records from the petitioner's treating physicians. The deadline for filing the medical records was later extended until close of business on August 7, 2018 at the representative's request. The representative did not file additional evidence nor request another deadline extension. ( [REDACTED] testimony)

### **CONCLUSIONS OF LAW**

22. Pursuant to Section 409.285, Florida Statutes, the Department of Children and Families' Office of Appeal Hearings has jurisdiction over this proceeding.

23. This order is the final administrative decision of the Department of Children and Families pursuant to Section 409.285(2), Florida Statutes.

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

25. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

26. 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.

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

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

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 404.1509, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 of this subpart and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. See paragraphs (f) and (h) of this section and § 404.1560(b).

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. See paragraphs (g) and (h) of this section and § 404.1560(c).

28. Step one of the sequential analysis for disability is to determine if the individual is engaging in substantial gainful activity (20 C.F.R. § 404.1520(b) and 416.920(b)). The petitioner works part-time (12 to 20 hours weekly) at Home Depot, stocking shelves. DDD determined that this did not constitute substantial gainful activity and that she met step one criterion. The Undersigned will not be more restrictive than DDD. The undersigned concludes that the petitioner meets Step 1 criterion.

29. Step two of the sequential analysis for disability is to determine if the individual has an impairment that is "severe" or a combination of impairments that is "severe" (20 C.F.R § 404.1520(c) and 416.920(c)). DDD concluded that the petitioner's multiple physical and mental health impairments were severe. The undersigned concurs with DDD's determination at this step. Petitioner meets Step 2.

30. Step three of the sequential analysis for disability is to determine whether or not the individual's impairments meets or equals a listed impairment in Appendix 1 of the Social Security Act (20 C.F.R. § 404(P)). This Appendix includes listings under section [REDACTED], and section [REDACTED]

31. [REDACTED] in section [REDACTED] To meet the disability criterion under this listing an applicant must present with:

- A. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] v)).

OR

[REDACTED]

32. The petitioner asserted that her physical and cognitive functioning are both greatly impaired. However, her medical records show her functioning levels are within normal ranges. The undersigned concludes that the evidence fails to prove that the petitioner meets this listing.

33. [REDACTED] and other psychotic disorders, a mental disorder, is addressed in section 12.03. To meet the disability criterion under this listing an applicant must present with:

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

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

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

1. Delusions or hallucinations; or

2. Catatonic or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:

- a. Blunt affect; or
- b. Flat affect; or
- c. Inappropriate affect; or
- 4. Emotional withdrawal and/or isolation;

AND

B. Resulting in at least two of the following:

- 1. Marked restriction of activities of daily living; or
- 2. Marked difficulties in maintaining social functioning; or
- 3. Marked difficulties in maintaining concentration, persistence, or pace; or
- 4. Repeated episodes of decompensation, each of extended duration;

OR

C. Medically documented history of a chronic schizophrenic, paranoid, or other psychotic disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

- 1. Repeated episodes of decompensation, each of extended duration; or
- 2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
- 3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

34. The petitioner asserted she is unable to function in society alone; she has always had difficulty with socialization, making friends, and holding down jobs.

However, her psychological records note only a non-descript history of [REDACTED] and



[REDACTED]

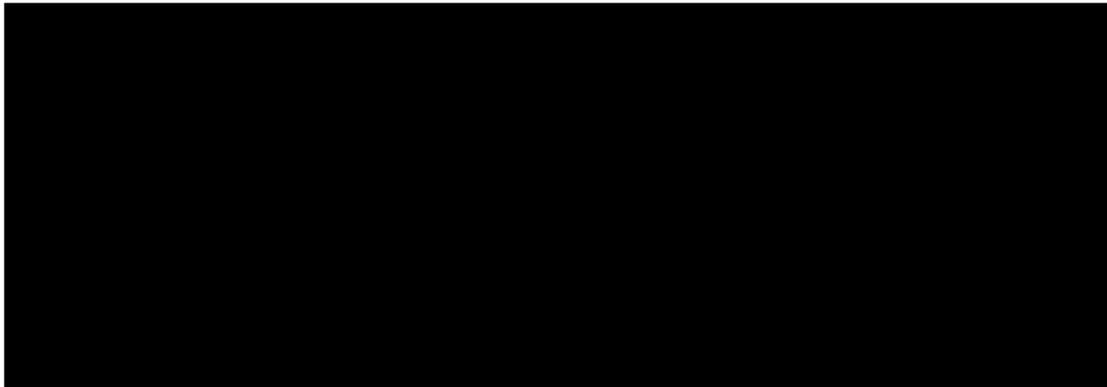
36. The petitioner's psychological records note a history of depression, but provide no additional details. The undersigned concludes that there is insufficient information to conclude that the petitioner meets this listing.

37. [REDACTED] is addressed in section [REDACTED]. To meet the disability criterion under this listing an applicant must present with:

A. [REDACTED]

■

[REDACTED]



38. The petitioner asserted that she is [REDACTED], but no psychological records or IQ test scores were offered into evidence to support her position. The petitioner obtained a general high school diploma. She can read and write, though asserted deficits in both skills. The undersigned concludes that there is insufficient information to conclude that the petitioner meets this listing.

39. Hearing loss not treated with [REDACTED] is addressed in section 2.10. To meet the disability criterion under this listing an applicant must present with:



40. Medical records conclude moderate to profound hearing loss, but did not include testing scores or descriptive notes. The undersigned concludes that there is insufficient information to conclude that the petitioner meets this listing.

41. Regarding Step 3 of the sequential analysis, the undersigned concludes that the petitioner's impairments do not meet or equal a listing in Appendix 1 of the Social Security Act (20 C.F.R. § 404(P)).

42. Step four of the sequential analysis for disability is to determine if the individual's impairments prevent her performing past relevant work. The petitioner is 40 years old and has worked a series of manual labor jobs, usually requiring medium physical exertion. DDD concluded that the petitioner was no longer capable of performing work that required medium exertion. DDD concluded that the petitioner was still capable of work which required light exertion. The undersigned concurs with DDD's conclusion at this step. The petitioner meets step four criterion.

43. Step five of the sequential analysis for disability is to determine if the individual has the capacity to do any work in the national economy. The cumulative evidence proves that the petitioner is verbal and ambulatory, though her gait is uneven. The petitioner has a high school education; she can read and write with enough proficiency to hold down manual labor jobs and is capable of work that requires light physical exertion. The petitioner has a history of [REDACTED], but there are no psychological records which prove that the impairments are severe enough to prevent the petitioner from working. The undersigned concludes that the petitioner is capable of performing work in the national economy. Therefore, the undersigned concludes that the petitioner fails the disability criterion at step five.

44. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the petitioner failed to meet her burden in this matter. The

evidence proves that the petitioner does not meet the SSI-Related Medicaid disability requirement. 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 29 day of August, 2018,

in Tallahassee, Florida.



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Leslie Green  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Fax: 850-487-0662  
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Copies Furnished To: [REDACTED]  
Office of Economic Self Sufficiency

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Aug 01, 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-01496

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 12, 2018 at 3:07 p.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:

Ed Poutre  
Economic Self Sufficiency Specialist II  
Department of Children and Families

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action of denying his Institutional Care Program ("ICP") recertification application for the period of August 2017 through

December 2017. 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 3, 2018. The undersigned and the respondent appeared for the hearing. The petitioner or authorized representative, failed to appear for the hearing. On April 4, 2018, the petitioner's authorized representative submitted a letter to the Office of Appeal Hearings requesting the hearing be rescheduled due to a family emergency. The hearing was rescheduled with good cause for May 1, 2018.

On May 1, 2018, the respondent requested a continuance as both parties did not receive each other's evidence. There was no objection from the petitioner's authorized representative. The hearing was rescheduled for June 12, 2018.

The petitioner submitted eight exhibits which were marked and entered as Petitioner's Exhibits "1" through "8." The respondent submitted eight exhibits which were marked and entered as Respondent's Exhibits "1" through "8." The record was left open through June 15, 2018 for the respondent to provide additional information on Asset Verification System ("AVS") policy, AVS response, hardship response and policy. On June 14, 2018, the respondent provided the above mentioned additional evidence that was marked and entered into evidence as Respondent's Exhibits "9" through "13." The record was closed on June 15, 2018.

On June 18, 2018, the undersigned issued an Order Reopening the Record for Additional Evidence giving the respondent ten days to provide all applications dated between June 15, 2017 through December 15, 2017, as well as notices generated by

the Department, running record comments and documents submitted by the petitioner or authorized representative during this period.

On June 28, 2018, the respondent submitted the additional information needed. It was marked and entered into evidence as Respondent's Exhibits "14" through "32." The record was closed the same day.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner had ICP Medicaid through July 31, 2017.

2. On October 30, 2017, an ICP Medicaid application was submitted for the petitioner. A financial release form signed by the petitioner was also submitted to the Department on this date giving the agency permission to access any of the petitioner's financial records (Resp. Exh. 12). A previous recertification application was submitted on August 17, 2017 to secure retroactive ICP Medicaid back to August 2017 (Resp. Exh. 15).

3. On November 2, 2017, the Department received a Data Exchange AVS response indicating that the petitioner holds a checking account with Huntington National Bank with a current balance of \$7,131.69. This response shows that the bank account is co-owned with [REDACTED]. The account appears to be opened from at least July 2017 through October 2017. The AVS response also showed a checking and savings account with Wells Fargo Bank with a balance of \$804.06 and \$42.08 respectively for the month of September 2017 (Resp. Exh. 10).

4. On November 3, 2017, the Department mailed a Notice of Case Action ("NOCA") to the petitioner and his authorized representative requesting bank

statements from the last three months of all accounts owned alone or with someone else by November 13, 2017 (Resp. Exh. 25).

5. On November 30, 2017, the Department mailed a NOCA to the petitioner informing him that his Medicaid was denied as the value of his assets was too high for the program (Resp. Exh. 26).

6. On December 15, 2017, an ICP Medicaid application was submitted for the petitioner requesting retroactive Medicaid back to September 2017 (Resp. Exh. 2). An application was also submitted in October 2017 to ensure retroactive eligibility for August 2017. The petitioner (71) was residing at [REDACTED]. The petitioner was residing there from 2015 until he passed away on December 17, 2017.

7. On December 21, 2017, the respondent mailed a NOCA to the petitioner's authorized representative requesting bank statements from [REDACTED] (Resp. Exh. 3). This was the first notice that referenced the bank's name.

8. On January 5, 2018, the authorized representative for the petitioner faxed over a letter from the petitioner's power of attorney that manages all of the petitioner's finances. This letter stated that the petitioner never revealed an account with [REDACTED] and the bank will not disclose any information to him without going there in person. This bank is only located in Ohio and since the petitioner is deceased, the power of attorney is unable to do anymore. He claims that the petitioner had no access to any of the funds in the [REDACTED] account and was unable to leave the nursing home at any time during his stay (Resp. Exh. 4).

9. On January 16, 2018, the Department denied the petitioner's application as the client passed away and was over assets.

10. On January 17, 2018, the petitioner's authorized representative attempted to reach the Department to discuss the case but was informed that they did not have documentation on file indicating she was the authorized representative (Resp. Exh. 8). Later that day, the authorized representative faxed over an Appointment of a Designated Representative form (Resp. Exh. 5). On January 18, 2018, the authorized representative called the Department again but they had no record of the form on file at that time. She was told to resubmit the form. On January 22, 2018, the Department received the authorized representative form. On January 26, 2018, the authorized representative contacted the Department requesting the case to be reviewed for a hardship.

11. On February 22, 2018, a hearing was requested timely by the petitioner's authorized representative.

12. The respondent explained that the Department added up the [REDACTED] Bank account and the two Wells Fargo accounts ( $\$7,131.69 + 42.08 + 804.06 = \$7,977.83$ ) to come up with a total asset value of  $\$7,977.83$ . The respondent stated that the asset limit for a single adult is  $\$2,000$ . The Department did not receive verification showing spend down to make the petitioner eligible. The petitioner's assets were over the asset limit making him ineligible for ICP Medicaid.

13. After the hearing, additional evidence was submitted by the respondent. This information indicates that on January 29, 2018, the Department received bank statements from [REDACTED] for the petitioner. It shows a balance of  $\$7,131.69$

and states that it is in trust for [REDACTED]. Based off the petitioner's death certificate, these are the petitioner's parents (Pet. Exh. 1). These bank statements show the balance was at that amount from March 23, 2017 through December 19, 2017 (Resp. Exh. 31). These bank statements appear to be provided by [REDACTED]

14. In the additional evidence packet provided by the respondent it shows that the petitioner received notices on September 20, 2017 (Resp. Exh. 20), October 30, 2017 (Resp. Exh. 24), and November 30, 2017 (Resp. Exh. 26), each notice stating that Medicaid was denied due to over assets. Per the running record comments, it was not until January 17, 2018, that the authorized representative started contacting the Department in regards to the questionable assets.

15. The petitioner's authorized representative requested a hardship as the authorized representative and power of attorney are unable to get the necessary information. The respondent contacted their Program Office for a clarification and was informed that the AVS response is considered verified upon receipt and since the petitioner is deceased that a hardship does not apply. If a joint owner can rebut the fact that the client's name was on the account but it wasn't his money the Department indicated that they may be able to award ICP Medicaid to the petitioner (Resp. Exh. 9).

#### **CONCLUSIONS OF LAW**

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

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

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

19. 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.”

20. 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... The designated representative is authorized 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.

21. Fla. Admin. Code R. 65A-1.204, Rights and Responsibilities, sets forth:

(1) An individual has the right to apply for assistance, to have eligibility determined, and if found eligible, to receive benefits. The applicant for or recipient of public assistance must assume the responsibility of furnishing information, documentation and verification needed to establish eligibility. If the information, documentation or verification is difficult for the individual to obtain, the Department must provide assistance in obtaining it when requested or when it appears necessary.

22. Fla. Admin. Code R. 65A-1.205 address the eligibility determination process and states in relevant part:

(1)(a) The Department must determine an applicant’s eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant’s responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic

appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time. If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.

...

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension...

23. The above cited authorities state that the petitioner's representative can act on his/her behalf for the application and the representative assumes the same rights and responsibilities as the applicant. It is the petitioner's responsibility to furnish information needed to establish eligibility. If the respondent determines that additional information is required to establish eligibility, they must notify the petitioner so that he, or she, can provide the requested information. Though the respondent is directed to provide assistance in obtaining verification when requested, the ultimate responsibility for providing this verification rests with the petitioner. If the petitioner does not provide required verifications or information the application will be denied. The petitioner or authorized representative did not indicate to the Department prior to the denial of the application that they were having issues in getting the necessary bank statement.

24. The evidence demonstrates that the Department correctly mailed the authorized representative a pending letter on December 21, 2017, stating that it required verification of the bank account from [REDACTED] to establish eligibility. No evidence was presented to establish that the value of this asset was equal to or less than \$2,000 during the review period and the application was denied.

25. Fla. Admin. Code R. 65A-1.710 defines SSI-Related Medicaid Coverage Groups and states in relevant part:

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

...

(2) Institutional Care Program (ICP). A coverage group for institutionalized aged, blind or disabled individuals (or couples) who would be eligible for cash assistance except for their institutional status and income as provided in 42 C.F.R. §§435.211 and 435.236. Institutional benefits include institutional provider payment or payment of Medicare coinsurance for skilled nursing facility care.

26. 20 C.F.R. § 416.1201, Resources; general, states in relevant part:

(a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.

...

(b) Liquid resources. Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit) and similar items. Liquid resources, other than cash, are evaluated according to the individual's equity in the resources. (See §416.1208 for the treatment of funds held in individual and joint financial institution accounts.)

27. Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility

Criteria, 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...

(2) Exclusions...

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

(b) The value of a life estate interest in real property is excluded.

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

(d) The individual, and their spouse, may designate up to \$2,500 each of their resources for burial funds for any month, including the three months prior to the month of application. The designated funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The \$2,500 is not reduced by the value of excluded life insurance policies or irrevocable burial contracts. The funds may be commingled in the retroactive period.

(e) One automobile is excluded, regardless of value.

(f) Property that is essential to the individual's self-support ...

(g) An individual who is a beneficiary under a qualified state Long-Term Care Insurance Partnership Policy...

28. Fla. Admin. Code R. 65A-1.716, Income and Resource Criteria, establishes the resource limits for SSI-Related Programs as \$2,000 per individual.

29. The above cited authorities state that bank accounts are considered assets for SSI-Related Medicaid Programs, including ICP, and that resources cannot exceed \$2,000 for an individual. This income does not meet any of the exclusions listed in the authority cited above to allow the Department to exclude it from the asset calculation.

30. The findings show that the petitioner had a checking account at [REDACTED] Bank with a balance over the asset limit for the months at issue, which were not spent down to under the asset limit for an individual. No evidence was presented to establish that the value of this asset was equal to or less than \$2,000 during the review period in question.

31. After considering the evidence and the appropriate authorities above, the hearing officer concludes that the respondent's action to deny the petitioner's ICP application for the period of August 2017 through December 2017 was correct.

**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 01 day of August, 2018,  
in Tallahassee, Florida.

*Ashley Brunelle*

---

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  
[REDACTED] Office of Economic Self Sufficiency  
[REDACTED]

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

**FILED**

Aug 30, 2018

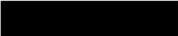
Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 18F-01769

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 05 Marion  
UNIT: 88222

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 30, 2018 at 2:30 PM. Pursuant to notice, the undersigned reconvened the telephonic administrative hearing in the above-referenced matter on June 28, 2018 at 1:00 p.m.

**APPEARANCES**

For Petitioner: , Co-Representative for Petitioner

For Respondent: Brian Meola, Esq., Department of Children and Families

**STATEMENT OF ISSUE**

Petitioner appeals Respondent's action denying her Institutional Care Program (ICP) Medicaid benefits between November, 2017 and September, 2018, due to the imposition of a penalty for an improper transfer of assets within the sixty (60) month look-back period. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

Pursuant to notice, this hearing was initially scheduled for March 28, 2018 at 11:00 a.m. On March 22, 2018, Respondent requested a continuance to accommodate mailing time of Petitioner's record file as requested by Petitioner's representative. As Petitioner did not respond with an objection, this hearing was rescheduled, pursuant to notice, for May 30, 2018 at 2:30 p.m.

On May 30, 2018, [REDACTED] appeared as co-representative for Petitioner. [REDACTED] appeared as a witness and co-representative for Petitioner. Shane Deboard, Esq., Department of Children and Families, appeared and represented Respondent. Kane Lamberty, Department of Children and Families Central Region Policy Unit, appeared as a witness for Respondent. Priscilla Peterson, Hearing Officer, Office of Appeal Hearings, appeared as an observer without party objection.

Subsequent to convening the May 30, 2018 hearing, the hearing was continued to allow the parties to submit additional evidence and objections. Pursuant to notice, the May 30, 2018 hearing reconvened on June 28, 2018 at 1:00 p.m. [REDACTED] appeared as representative for Petitioner. Brian Meola, Esq., Department of Children and Families, appeared and represented Respondent. Kane Lamberty, Department of Children and Families Central Region Policy Unit, appeared as a witness for Respondent. Priscilla Peterson, Hearing Officer, Office of Appeal Hearings, appeared as an observer without party objection.

Petitioner submitted an evidence packet consisting of fourteen exhibits, ten of which were admitted into evidence and marked as Petitioner's Exhibits "1" – "10." The undersigned excluded final orders from previous appeals as non-binding authority, as

well as all exhibits submitted in duplicate. Respondent submitted an evidence packet consisting of fifteen exhibits, thirteen of which were admitted into evidence and marked as Respondent's Exhibits "1" – "13." The undersigned excluded final orders from previous appeals as non-binding authority, as well as an exhibit submitted in duplicate. The record closed June 28, 2018.

### FINDINGS OF FACT

1. Petitioner, date of birth [REDACTED] (Respondent's Exhibit 2, Page 3), has resided at [REDACTED] since January 23, 2017 (*Id.* at 4).
2. On February 21, 2017, Petitioner submitted an application for a purchase in [REDACTED] [REDACTED] (Respondent's Exhibit 11), through her authorized representative, [REDACTED] (CC) (*Id.* at 11-12), along with a check in the amount of \$100,000.00 (*Id.* at 31).
3. The [REDACTED] application included an information page informing Petitioner of Appointments of Designated Representatives used for Medicaid applications, which stated, in relevant part:

Florida DCF program manual section 660:

**0640.0109 Designated Representatives (MSSI) A designated representative may be appointed or self-designated to act on behalf of the household... An applicant must authorize a designated representative in writing prior to eligibility determination or anytime during the review period.**

#### **42 CFR § 435.907 Application.**

(a) *Basis and implementation.* In accordance with section 1413 of the Affordable Care Act, the agency must accept an application from the

applicant, **authorized representative**, and any documentation required to establish eligibility-

**42 CFR § 435.908 Assistance with application and renewal.**

(b) The agency must allow individual(s) of the applicant or beneficiary's choice to assist in the application process or during a renewal of eligibility.

[emphasis added by ██████████ *Id.* at 10).

4. On February 22, 2017, CC accepted authority as Petitioner's representative, which allowed him to receive compensation for offering an opinion on the suitability of Petitioner's purchase in conjunction with her pending, or anticipated, applications for federal and state health benefits (*Id.* at 12-13).

5. In the Designated Representative Questionnaire, CC acknowledged the statement, "I represent that I have been appointed by [Petitioner] to make recommendations to said party on the suitability of ██████████ ] to the extent that said investment will comply with the clients desire to qualify for federal/state benefits currently applied for," and also at that time elected to be compensated (*Id.* at 14).

6. Also, on February 22, 2017, ██████████ accepted Petitioner's payment and issued her a Subscriber Certificate for 10,000 units (*Id.* at 1-2). The Conditions of Ownership were as follows:

1. Subscription is in the face amount of **\$100,000**.
2. Subscription ownership is **irrevocable** upon issuance of this certificate.
3. Subscription ownership is **unassignable** upon issuance of this certificate.
4. There is **no secondary market** and subscriber investment is illiquid until Maturity.
5. Subscription provides a **monthly income** of \$333.33 from the resulting interest rate of **4% per annum**.

6. Payment will be made on the 25<sup>th</sup> day of each month.
7. Payment of interest is **irrevocably assigned** to: Joan M. Newell.

[emphasis added by ██████████ (*Id.* at 2).

7. On March 16, 2017, Petitioner, by and through CC, submitted an application for ICP Medicaid benefits (Respondent's Exhibit 2).
8. Sometime in July, 2017, Respondent approved Petitioner's application for ICP Medicaid benefits (Respondent's Testimony).
9. In determining eligibility for ICP Medicaid benefits, Respondent must verify if disposal or conversion of resources for less than fair market value (FMV) occurred, on or after the 60-month look back period.
10. The look back period was established to deter applicants from transferring assets for less than FMV for the sole purpose of qualifying for Medicaid.
11. Sometime after approving Petitioner's March 16, 2017 application for ICP Medicaid benefits, Respondent became aware of a transfer of assets by Petitioner, determined it incorrectly approved her for ICP Medicaid benefits, and subsequently terminated her ICP Medicaid benefits, of which Petitioner filed an initial appeal (*Id.*).
12. On November 28, 2017, Respondent mailed a Notice of Case Action (NOCA) to CC notifying that Petitioner's application for Medicaid benefits dated November 16, 2017 was approved (Respondent's Exhibit 1, Page 10). Petitioner subsequently withdrew her initial appeal (Petitioner's Testimony).
13. A couple months after Petitioner withdrew from her appeal, she learned that her Medicaid was opened for MIT Medicaid rather than ICP Medicaid (*Id.*). MIT is a Medicaid

category that provides full Medicaid for clients who are penalized for asset transfers, excluding skilled nursing facility room and board expenses (Respondent's Testimony).

14. On March 2, 2018, Petitioner, by and through CC, filed a new application for ICP Medicaid benefits (Respondent's Exhibit 4). The March 2, 2018 application for ICP Medicaid is the issue under the present appeal.

15. On March 5, 2018, Respondent mailed a NOCA to Petitioner at her living address and mailing address, and to CC at his address of record, which stated in relevant part:

We have determined that you gave away, reduced the value of, or sold the following asset(s) or income for less than fair market value.

LIQUID-ASSET (*asset/income*)

The uncompensated value of the transferred asset is \$100,000.00.

The uncompensated value amount is the difference between what the asset or income was worth (fair market value) and the value of what you received for the asset or income.

When you give an asset or income away, reduce the value of it, or sell it for less than it is worth, we presume that you did this to receive Medicaid long term care benefits. This action may result in a penalty period and you will be ineligible for Medicaid Institutional Care program, Institutional Hospice, Home and Community Based Services programs, and Program of All-Inclusive Care for the Elderly, unless you present to us clear and convincing evidence that:

- You gave away, reduced the value of, or sold the asset (or income) solely for a reason other than to receive Medicaid, OR
- You would have a hardship situation if you cannot pay for food, a place to live, clothing, or other necessities of life; or your life or health would be endangered because you cannot pay for medical care. In order for the undue hardship waiver provision to apply, you must make all efforts to get the transferred asset (or income) back, or receive fair compensation.

**You or your designated representative must contact the eligibility specialist whose name and telephone number appear above within**

**15 calendar days of the mailing date on this notice if you wish to discuss this matter.**

...

If we do not hear from you within 15 calendar days of the mailing date on this notice, we will conclude that you made the transfer for the purpose of receiving Medicaid long term care services. We will send you a formal notice of your Medicaid eligibility status, including your rights to a fair hearing, when the final eligibility determination is complete.

(Respondent's Exhibit 10).

16. Petitioner filed this appeal prior to Respondent's eligibility determination indicated on the March 5, 2018 NOCA (Appeal Record).

17. [REDACTED], Petitioner's co-representative, stipulated on the record that he is employed with [REDACTED] and is responsible for strategic planning (Petitioner's Testimony).

18. Petitioner also stipulated, on the record, that an elder law attorney, who was also on the board of [REDACTED] at the time of Petitioner's March 16, 2017 application for ICP Medicaid benefits, directed Petitioner and CC to purchase a subscription in [REDACTED] for the purpose of becoming Medicaid eligible (*Id.*).

19. Respondent argued that Petitioner's \$100,000.00 was previously a liquid available asset and that to date Petitioner has not yet had her \$100,000.00 investment returned (Respondent's Testimony). Petitioner did not object to either of these statements (Hearing Record).

20. Respondent stipulated, on the record, that Petitioner converted her \$100,000.00 available and countable asset to an unavailable and excludable asset (Respondent's Testimony). However, this also decreased the asset value to \$0.00 (*Id.*).

21. Respondent further argued that the new \$0.00 asset value was due to Petitioner transferring an asset worth \$100,000.00 to an asset that now only receives \$333.33 per month in interest, which would take Petitioner 25 years and 1 month to collect the full investment in return (*Id.*). Furthermore, that based on Petitioner's age of 87 years at the time of her March 16, 2017 application for ICP Medicaid benefits and based on life expectancy tables, Petitioner is only expected to live for another 5.87 years (*Id.*).

22. Petitioner argued that, based on [REDACTED] "Operating Agreement," "[t]he initial Book Value of any asset contributed by a member to the Company shall be the fair market value of such asset, as determined by the contributing Member and the Company," (Petitioner's Exhibit 3, Page 1) and that the value is determined by the member and the company as \$100,000.00 as indicated on the Subscriber Certificate (Petitioner's Testimony).

23. Petitioner further argued that the Subscriber Certificate indicates that Petitioner's investment is only illiquid until maturity (Respondent's Exhibit 11, Page 2), and that maturity is also defined in [REDACTED] "Operating Agreement" as 5 – 7 years (Petitioner's Exhibit 3, Page 5), at which point Petitioner could liquidate her investment (Petitioner's Testimony).

24. However, the undersigned notes that [REDACTED] "Operating Agreement" is not signed or executed by any party, including Petitioner, that would give rise to her agreement to the terms under said "Operating Agreement," and outside the exclusive terms set forth in the Subscription Certificate (Petitioner's Exhibit 3, Page 42).

25. Petitioner also argued that because her purchase of 10,000 units in [REDACTED] did not change ownership or face value, there was no disposal of the asset, and as such

the purchase was a conversion rather than a transfer, which is not subject to the transfer policies used by Respondent (Petitioner's Testimony). Petitioner provided a number of Department Policies (Petitioner's Exhibit 8), particularly 1640.0409, Conversion of Assets, in support of her argument (Petitioner's Testimony).

26. Respondent argued that Petitioner provided a rewritten Appendix A-8 "Transfer Penalty Determination Process", that is not attributable to anyone, and of which included two additional steps, steps 2 and 23 (Respondent's Exhibit 6), not included in the promulgated Appendix A-8 as used by Respondent in its determination process (Respondent's Exhibit 7). In addition, this rewritten Appendix A-8 directs an eligibility specialist in step 2 to consider [REDACTED] contract as a conversion that makes the new asset inaccessible due to legal contract restrictions, thus unavailable, and directs the specialist straight to step 23 without determining the real purpose of the transfer (Respondent's Exhibit 6).

27. Furthermore, given Petitioner's age, that she only receives \$333.33 monthly in interest, and her life expectancy, she will never recover the full \$100,000.00 and that this results in the disposal of an asset for less than fair market value, which is subject to transfer policies (Respondent's Testimony). Respondent provided a number of Department Policies (Respondent's Exhibit 8), particularly 1640.0606, Transfer of Assets and Income in support of its argument (Respondent's Testimony).

#### **CONCLUSIONS OF LAW**

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

section 409.285 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.

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

30. The United States Code, Title 42, Section 1396p(c)(2), Taking into account certain transfers of assets, is referenced in the Florida Administrative Code Rule 65A-1.712(3)(c), and states in relevant part:

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

- (i) the spouse of such individual;
- (ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;
- (iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or
- (iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets—

- (i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,
- (ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,
- (iii) were transferred to, or to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

**(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or**

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

[Emphasis added].

31. The Florida Administrative Code Rule 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states in relevant part:

(3) Transfer of Resources and Income. According to 42 U.S.C. §1396p(c), **if an individual, the spouse, or their legal representative, disposes of resources or income for less than fair market value on or after the look back date, the Department must presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for ICP, Institutional Hospice or HCBS Waiver Programs.** The Department will mail a Notice of Determination of Assets (or Income) Transfer, CF-ES 2264, 02/2007, incorporated by reference, to individuals who report a transfer for less than fair market value, incorporated herein by reference), advising of the opportunity to rebut the presumption and of the opportunity to request and support a claim of undue hardship per subparagraph (c)5., below. If the Department determines the individual is eligible for Medicaid on all other factors of eligibility except the transfer, the individual will be approved for general Medicaid (not ICP, Institutional Hospice or HCBS Waiver Programs) and advised of their penalty period using the Medicaid Transfer Disposition Notice, CF-ES 2358, 07/2013, <http://www.flrules.org/Gateway/reference.asp?No=Ref-03212>, incorporated by reference. Transfers of resources or income made prior to January 1, 2010 are subject to a 36 month look back period, except in the case of a trust treated as a transfer in which case the look back period is

60 months. **Transfers of resources or income made on or after January 1, 2010 are subject to a 60 month look back period.**

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

(b) When funds are transferred to a retirement fund, including annuities, within the transfer look back period the Department must determine if the individual will receive fair market compensation in their lifetime from the fund. If fair compensation will be received in their lifetime there has been no transfer without fair compensation. If not, the establishment of the fund must be regarded as a transfer without fair compensation. Fair compensation shall be calculated based on life expectancy tables published by the Office of the Actuary of the Social Security Administration. See Rule 65A-1.716, F.A.C.

...

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

...

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

...

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

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

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

1. An individual who disposes of a resource for less than fair market value or reduces the value of a resource prior to incurring a medical or other

health care related expense which was reasonably capable of being anticipated within the applicable transfer look back period shall be deemed to have made the transfer, in whole or part, in order to qualify for, or continue to qualify for, medical assistance.

...

5. Compensation for a resource may be received in the form of cash, real or personal property or other valuable consideration provided.

Compensation is the gross amount paid or to be paid for the resource based on the agreement at the time of transfer, or contract for sale, if earlier. Compensation received in the form of real or personal property is valued according to its fair market value (FMV). Fair market value is defined as the price for which a resource can reasonably be expected to sell on the open market. If compensation for the resource is in the form of jointly owned real or personal property, the value of the compensation received is the FMV of the fractional interest in the real or personal property transferred or received. Expenses attributed to the sale of a resource do not reduce the value of the compensation.

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

**(f) The uncompensated value of a transferred resource is the difference between the fair market value of the transferred resource at the time of the transfer, less any outstanding loans, mortgages or other encumbrances on the resource, and the amount of compensation received at or after the time of the transfer.**

[Emphasis Added].

32. The Florida Administrative Code Rule 65A-1.716, Income and Resource Criteria, as referenced in the Florida Administrative Code Rule 65A-1.712(3)(b) above, states in relevant part, in subsection (e), "[t]he following life expectancy tables are compiled from information published by the Office of the Chief Actuary of the Social Security Administration," and defines the life expectancy of an 87-year-old female as 5.87 years.

33. The above cited authorities state that for an individual to avoid becoming ineligible for medical assistance due to a transfer of assets, the assets must be disposed of at fair market value or other valuable compensation, disposed of exclusively for a purpose other than to qualify for medical assistance, or all assets transferred for less than fair market value must have been returned to the individual. Furthermore, if the instrument or document does not allow for fair compensation or return within the lifetime of the individual any potential exemption from penalty or consideration for eligibility purposes is void. The remaining life expectancy of Petitioner is 5.87 years. If an individual disposes of resources for less than fair market value on or after the look back date, the Department must presume that the disposal of resources was to become Medicaid eligible and impose a period of ineligibility for ICP, Institutional Hospice or HCBS Waiver Programs. The look back period for a transfer made after January 1, 2010 is 60 months.

34. The undersigned concludes that Petitioner's \$100,000.00 was a liquid and countable asset prior to its disposal. Once disposed of, it was disposed for less than fair market value, or other valuable compensation, as Petitioner only received \$333.33 per month in interest in return, despite the face value on the Subscriber Certificate, which is a payment that makes it virtually impossible for Petitioner to receive fair compensation, or see her asset returned, within her remaining 5.87-year lifetime. Though, the maturity date on the Operating Agreement indicates the investment matures in 5-7 years, which in and of itself is a curious maturity period given Petitioner's remaining lifespan falls right in the middle thereof, the Operating Agreement was not signed by Petitioner so those terms of the Operating Agreement are not part of the agreement under the Subscriber

Certificate. As such, the Subscriber Certificate includes the exclusive terms of the agreement and the term “maturity” in the Subscriber Certificate remains ambiguous and undefined.

35. The undersigned also concludes that Petitioner failed to show Respondent that the disposal of her \$100,000.00 asset was for a purpose exclusively other than to receive medical assistance. In fact, to the contrary, Petitioner stipulated on the record that an elder law attorney, who also happened to be on the board of [REDACTED] at the time of Petitioner’s March 16, 2017 application for ICP Medicaid benefits, specifically instructed both Petitioner and CC to purchase a subscription in [REDACTED] for the exclusive purpose of becoming Medicaid eligible. Furthermore, Petitioner’s application to [REDACTED] clearly indicated this same intent, specifically, in the Designated Representative Questionnaire, CC acknowledged the statement, “I represent that I have been appointed by [Petitioner] to make recommendations to said party on the suitability of investment in [REDACTED] to the extent that said investment will comply with the clients desire to qualify for federal/state benefits currently applied for,” of which CC also elected to be compensated.

36. Lastly, the undersigned concludes that Petitioner’s \$100,000.00 has not been returned to her. This was the last of the three options afforded to Petitioner to avoid becoming ineligible for medical assistance due to a transfer of assets. As the disposal of Petitioner’s \$100,000.00 asset occurred well within the 60-month look back period from her March 16, 2017 application for SSI Medicaid benefits, in fact only 3 weeks prior to her application, Respondent imposed a penalty of ICP Medicaid benefit ineligibility against Petitioner.

37. The ACCESS Florida Program Policy Manual, CFOP 165-22, sets forth the following:

1640.0409 Conversion of Assets (MSSI, SFP)

Proceeds, including cash, from the sale of an asset or conversion of an asset from one form to another are considered assets rather than income. The proceeds of the item to which the asset is converted must be evaluated to determine if they affect eligibility, and if so, the value of the new asset.

Verification concerning the new asset must be obtained regardless of whether a liquid or nonliquid asset is involved. For example, an individual may have an automobile (nonliquid asset) which he sells for cash (liquid asset), or he may have cash, which he uses to purchase an automobile. In either case, the conversion or sale does not result in income to the individual. The newly acquired item is an asset subject to all asset valuation policy.

1640.0606 Transfer of Assets and Income (MSSI)

Apply transfer of assets and income policy to the Institutional Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services Programs (HCBS), and the Program for All-Inclusive Care for the Elderly (PACE). Apply this policy to transfers made by SSI-Direct Assistance (cash) recipients applying for these programs as well as non-SSI recipients.

...

A transfer occurs when an individual, their spouse, a legally authorized representative, or a joint owner of a jointly held asset does not receive fair compensation when:

1. disposing of an asset (by selling it or giving it away) or decreases the extent of the individual's or spouse's ownership interest in an asset; or
2. decreasing the value of a countable asset in the process of converting it to an excluded asset.

When an asset or income is disposed of or transferred for less than fair market value within the transfer look-back period, the individual may be ineligible for Medicaid nursing facility services and HCBS services for a specified period of time.

...

If a person is ineligible due to the uncompensated value of a transfer, they are ineligible for Medicaid nursing facility, HCBS or PACE services. However, they are entitled to regular Medicaid benefits if they meet all other factors of eligibility (including level of care). This coverage group is identified as "MI T" on the FLORIDA system.

...

38. The above cited authorities define when proceeds from the sale of an asset, or conversion of an asset from one form to another, are considered an asset rather than income as well as the definition of when a transfer occurs. Policy 1640.0409 simply defines what must be considered an asset rather than income. Policy 1640.0606 defines a transfer as not receiving fair compensation when disposing or decreasing ownership interest in an asset, or decreasing the value of a countable asset in the process of converting it to an excluded asset.

39. The undersigned concludes that Policy 1640.0409 simply defines when the sale or conversion of an asset remains an asset, rather than income, for purposes of determining eligibility based on asset and income limits.

40. The undersigned, regarding Policy 1640.0606, understands Petitioner's argument that if an individual receives fair compensation while decreasing the value of a countable asset in the process of converting it to an excluded asset, it is not considered a transfer, and as such is not subject to transfer policy. However, the undersigned concludes that this is far from the case in this appeal. Even though, the Subscriber Certificate indicates a face value of \$100,000.00, Petitioner is only compensated for that conversion in the amount of \$333.33 per month, which will take her 25 years and 1 month to recover or receive fair compensation for, while her life expectancy dictates she has only 5.87 years left to live. As a result, the undersigned concludes Petitioner did not

receive fair compensation for this conversion, which makes it a transfer subject to transfer policy.

41. Furthermore, the undersigned concludes Petitioner's conversion/transfer argument is unjustified. Petitioner, herself, treated the purchase of 10,000 units in [REDACTED] as a transfer. This is supported by Petitioner's submittal of its own rewritten Appendix A-8, titled "Transfer Penalty Determination Process", which included two additional steps, steps 2 and 23, not included in the promulgated Appendix A-8, and which directed an eligibility specialist in step 2 to consider [REDACTED] contract as a conversion that makes the new asset inaccessible due to legal contract restrictions, thus unavailable, and directed the specialist straight to step 23 without determining the real purpose of the transfer.

42. In careful review of the authorities and evidence, the undersigned concludes Petitioner did not meet the burden of proof showing that the imposition of a penalty for an improper transfer of assets within the 60-month look-back period for ICP Medicaid benefits, between November, 2017 and September, 2018, was improper. Petitioner failed to show that the asset transfer was intended for fair compensation, Petitioner failed to show that the asset transfer was for any other purpose other than to receive ICP Medicaid, and Petitioner failed to show that the transferred asset had been returned to her. The undersigned concludes Respondent's action denying Petitioner's ICP Medicaid benefits between November, 2017 and September, 2018, due to the imposition of a penalty for an improper transfer of assets within the sixty (60) month look back period, 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 30 day of August, 2018,

in Tallahassee, Florida.



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

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

**FILED**

Jul 06, 2018

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-01823

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 18 Seminole  
UNIT: 88007

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an in-person administrative hearing in the above-referenced matter at 2:26 p.m. on May 23, 2018, in [REDACTED] Florida.

**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 reapprove [REDACTED], the petitioner's son, in the Medically Needy (MN) Program, is proper. The petitioner is requesting full Medicaid for her son. The respondent carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

██████████ (KK) was present and did not testify. Shahab Kaedi (SK), KK's father, was present and testified. Alma Patino, Hearing Officer and Leonard Jackson, Hearing Officer, were present as observers.

The petitioner submitted one exhibit, entered as Petitioner Exhibit "1". The respondent submitted eight exhibits, entered as Respondent Exhibits "1" through "8". The record remained open until May 25, 2018, for the respondent to submit another exhibit. The exhibit was received timely and entered as Respondent Exhibit "9". The record was closed on May 25, 2018.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, KK was enrolled in the MN Program with a \$726 Share of Cost (SOC) (Respondent Exhibits 6 and 9).
2. On December 4, 2017, the petitioner submitted a recertification web public assistance benefit application for her household (Respondent Exhibit 2).
3. The petitioner's household includes the petitioner, SK, the petitioner's husband, and their two sons; KK, age 20, and AK, age 19. Both KK and AK are full-time college students. The application lists \$1,311 Social Security Disability Income (SSDI) for SK. Medicaid is one of the benefits listed on the application. Medicaid for KK is the only issue.
4. The Department determines Family-Related Medicaid based on the Standard Filing Unit (SFU). SFU are members of the household whose needs and income must be included or excluded in determining Medicaid eligibility.

5. The SFU is determined by applying one of three rules: (1) Filer Rule, tax payer filing taxes and not claimed as a tax dependent, (2) Dependent Rule, claimed as a tax dependent and (3) Non-Filer Rule, neither files a tax return nor is claimed as a tax dependent.

6. SK testified that no one in the household files tax returns.

7. The Department applied rule three (3) Non-Filer Rule, neither files a tax return nor is claimed as a tax dependent, due to no one in the household filing a tax return.

8. On December 12, 2017, the Department completed a telephone with the petitioner for the December 4, 2017 application. The petitioner reported AK attends college in Chicago (Respondent Exhibit 7, page 59).

9. The Department verified SK receives \$1,311 SSDI (Respondent Exhibit 4). The Department's January 2018 SOC calculation for KK included the petitioner, SK and KK.

The Medically Needy Income Limit (MNIL) for a household size of three is \$486:

\$1,311	SK's SSDI
<u>-\$ 486</u>	<u>MNIL for a household size of three</u>
\$ 825	SOC

10. On December 6, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying KK's SOC increased from \$726 to \$825, effective January 1, 2018 (Respondent Exhibit 1, page 14).

11. SK's SSDI increased from \$1,311 to \$1,337 in December 2017 (Respondent Exhibit 4, page 48). The following is the Department's SOC calculation for KK using the new SSDI amount (Respondent Exhibit 5, page 51):

\$1,337	SK's SSDI
<u>-\$ 486</u>	<u>MNIL for a household size of three</u>
\$ 851	SOC

12. On December 8, 2017, the Department mailed the petitioner a NOCA, notifying KK's SOC increased from \$825 to \$851, effective January 1, 2018 (Respondent Exhibit 1, page 11).

13. The respondent's representative explained that according to the Department's policy, AK should also be included in KK's SOC determination. The Department included the petitioner, SK, AK and KK in the calculation (Respondent Exhibit 5). The MNIL for a household size of four is \$585:

\$1,337	SK's SSDI
<u>-\$ 585</u>	<u>MNIL for a household size of four</u>
\$ 752	SOC

14. On April 13, 2018, the Department mailed the petitioner a NOCA, notifying KK's SOC decreased from \$851 to \$752, effective May 2018 (Respondent Exhibit 1).

15. The respondent's representative stated KK met his SOC for the previous months.

16. KK's [REDACTED] in May 2015, he also suffers from [REDACTED].

17. On March 5, 2018, KK applied for disability through the Social Security Administration (SSA). The SSA has not yet made a disability determination (Respondent Exhibit 4).

18. SK argued that KK is very ill and medical specialists do not accept MN; therefore, KK requires full Medicaid.

19. The respondent's representative explained for KK to be eligible for full Medicaid, the household income limit cannot exceed \$364 monthly.

20. SK argued that due to KK's illness, KK requires Medicaid past the age of 21.

21. The respondent's representative stated, if the SSA denies KK disability, he can appeal the SSA denial decision. The respondent's representative said that KK can also

apply for disability Medicaid through the Department; however, eligibility will be determined based on the SSA decision.

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

24. *Florida Administrative Code* R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria, defines SFU and in part states:

(7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested...The following are illustrations of SFU determinations:

**(b) If assistance is requested for a child in an intact family, the child, the child's parents, and all siblings who have no income must be included in the SFU.** (emphasis added) Any siblings who have income or any other related fully deprived children are optional members...

25. *Florida Administrative Code* R. 65A-1.707, Family-Related Medicaid Income and Resource Criteria, in part states, "(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..."

26. Title 42 of the Code of Federal Regulations § 435.603 "Application of modified adjusted gross income (MAGI)" states:

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

(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid...

(3) (b) ...Family size means the number of persons counted as members of an individual's household...

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

(f) Household...

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

(emphasis added)

(i) The individual's spouse;

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

**(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's parents and siblings under the age specified in paragraph (f)(3)(iv) of this section.** (emphasis added)

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

(A) Age 19; or

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

(j) Eligibility Groups for which MAGI-based methods do not apply. The financial methodologies described in this section are not applied in determining the Medicaid eligibility of individuals described in this paragraph. The agency must use the financial methods described in §435.601 and §435.602 of this subpart.

(6) Individuals who are being evaluated for coverage as medically needy under subparts D and I of this part, but only for the purpose of determining eligibility on such basis...

27. Title 42 of the Code of Federal Regulations § 435.602, Financial responsibility of relatives and other individuals, in part states:

(2) (ii) In relation to **individuals under age 21** (as described in section 1905(a)(i) of the Act), **the financial responsibility requirements and methodologies that apply include considering the income and resources of parents** (emphasis added) or spouses whose income and resources will be considered if the individual under age 21 were dependent under the State's approved State plan under title IV-A of the Act...

28. The above authorities explain SK's income must be counted in KK's Medicaid eligibility; and all four household members are included in KK's Medicaid eligibility.

29. *Florida Administrative Code R. 65A-1.716*, Income and Resource Criteria, explains: "(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size: Family Size 4, Monthly Income Level \$364..."

30. The above authority explains, for KK to be eligible for full Medicaid, the income for a household size of four, cannot exceed \$364 monthly. SK's \$1,337 SSDI household income exceeds \$364; therefore, KK is not eligible for full Medicaid. The next available Program is MN with a SOC.

31. *Florida Administrative Code R. 65A-1.707*, Family-Related Medicaid Income and Resource Criteria, in part states:

(1)(a) ...For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost...

(2) The department considers income in excess of the medically needy income level available to pay for medical care and services. Available income from a one month period is used to determine the amount of excess countable income available to meet medical care and services. To be allowable, a paid expense may not have been previously deducted from countable income during a period of eligibility. The department deducts allowable medical expenses which are not subject to third party payment while unpaid and still owed, or paid during the current month, or

incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months from countable income that exceeds the medically needy income level...

32. The above authority explains the SOC is determined by subtracting the income level (MNIL) from the household gross income.

33. The Department's Program Policy Manual, at Appendix A-7, sets forth the MNIL at \$585 for a household size of four and the Medicaid Income limit for parents and children age 19 and 20 at \$364.

34. In accordance with the above authorities, the Department calculated KK's SOC by deducting \$585 (MNIL for a household size of four) from \$1337 (SK's SSDI) to arrive at \$772 SOC.

35. In careful review of the above authorities and evidence, the undersigned concludes the Department met its burden of proof. The Hearing Officer concludes the Department's action to reapprove KK in the MN Program, 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 06 day of July, 2018,

in Tallahassee, Florida.



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

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

**FILED**

Jul 13, 2018

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 18F-02112

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 05 Marion  
UNIT: 09DDD

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 7, 2018 at 8:30 a.m.

**APPEARANCES**

For Petitioner:  Petitioner's Mother

For Respondent: Sylma Dekony, Economic Self Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner appeals Respondent's action denying her Medicaid Disability application dated February 23, 2018. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

Pursuant to notice, this hearing was initially scheduled for April 5, 2018 at 9:45 a.m. On March 30, 2018, Petitioner submitted a request to continue the April 5, 2018

hearing. As Respondent proposed no objection to Petitioner's request, the undersigned rescheduled the April 5, 2018 hearing for May 7, 2018 at 8:30 a.m.

Petitioner appeared at the May 7, 2018 hearing. [REDACTED] (PK), Petitioner's mother, appeared and represented Petitioner without party objection.

Petitioner submitted no exhibits at the hearing. Respondent submitted an evidence packet consisting of seven exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" – "7." The undersigned held the record open until 5 p.m. on May 14, 2018 to allow time for Petitioner to provide a copy of the Social Security Administration (SSA) disability denial letter. On May 10, 2018, Petitioner timely submitted two SSA denial letters, which were entered into evidence and marked as Petitioner's Exhibit "1" and "2." The record closed on May 14, 2018.

#### **FINDINGS OF FACT**

1. On February 23, 2018, Petitioner, age 48, submitted an on-line application for Food Assistance, Medicaid Disability, and the Medicare Savings Plan for herself (Respondent's Exhibit 3). Petitioner's Medicaid Disability denial is the only issue.

2. PK described Petitioner's disabling conditions as a [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (PK's

Testimony).

3. Petitioner's February 23, 2018 Medicaid Disability application indicated that her health conditions had not changed since her last disability denial by the SSA (Respondent's Exhibit 3, Page 5).
4. On December 29, 2015, Petitioner applied for disability through the SSA (Respondent's Exhibit 5).
5. On May 17, 2016, the SSA denied Petitioner's disability application with denial code N32, which means "capacity for substantial gainful activity, other work, no visual impairment" (*Id.*).
6. Petitioner is appealing the SSA denial through an attorney; an appeal hearing has been scheduled for July 16, 2018 (PK's Testimony).
7. Respondent did not make an independent disability decision on Petitioner's Medicaid Disability application. Instead, it adopted the SSA decision and denied Petitioner's application based on that decision, as she did not meet the technical requirements of age (at least 65) or disability.
8. On February 28, 2018, Respondent mailed Petitioner a Notice of Case Action notifying that her February 23, 2018 Medicaid Disability application was denied, with the reason that no household members meet the disability requirement (Respondent's Exhibit 2, page 1).
9. PK claimed Petitioner has new or worsened medical conditions that the SSA is unaware of (PK's Testimony).
10. The undersigned left the record open for Petitioner to provide the May 17, 2016 SSA denial letter indicating what conditions it considered during its review of her disability application.

11. On May 10, 2018, Petitioner provided a copy of the denial letter that indicated the conditions the SSA considered for her December 29, 2015 disability application (Petitioner's Exhibit 2, Page 1). The conditions were listed as a heart condition, open heart surgery, and mental health (*Id.*).

### **CONCLUSIONS OF LAW**

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

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

14. Florida Administrative Code 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...

15. The Code of Federal Regulations Title 42, Section 435.541, Determinations of Disability, states in relevant part:

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

...

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

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

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

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

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

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

...

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

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

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

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

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

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

...

16. The above cited 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 SSA, or there is a deterioration of an existing condition that the SSA refuses to consider.

17. In accordance with the above authority, Respondent denied Petitioner's February 23, 2018 Medicaid Disability application, due to adopting the SSA denial decision.

18. Petitioner is appealing the May 17, 2016 SSA denial through an attorney, and as Petitioner has an upcoming appeal with the SSA scheduled for July 16, 2018, has no new or worsened medical conditions that the SSA has refused to consider.

19. Furthermore, Petitioner's February 23, 2018 Medicaid Disability application indicated that she had no new or worsening conditions since her last disability denial by the SSA.

20. 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 23, 2018 Medicaid Disability application. The undersigned concludes Respondent's action denying Petitioner's February 23, 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 13 day of July, 2018,

in Tallahassee, Florida.



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

**FILED**

Jul 16, 2018

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 18F-02218  
18F-03556  
18F-03557

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 06 Pinellas  
UNIT: 88272

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on April 30, 2018 at 11:19 a.m. The hearing was reconvened on May 30, 2018 at 10:06 a.m. All parties appeared telephonically from different locations for both hearings.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se

For the Respondent: Lorry Beauvais  
Economic Self-Sufficiency Specialist II  
Department of Children and Families

### **STATEMENT OF ISSUE**

At issue is the following:

I. The respondent's action to authorize \$144 in Supplemental Nutrition Assistance Program ("SNAP") benefits for February 2018 and \$360 for March 2018. The petitioner is only challenging the SNAP benefits for February and March 2018.

II. The respondent's action to deny the petitioner's application for Temporary Cash Assistance ("TCA").

III. The respondent's action to deny full Medicaid for the petitioner and enroll her in the Medically Needy ("MN") program with a Share of Cost ("SOC") for January through March 2018.

The burden of proof was assigned to the petitioner by a preponderance of evidence for all three appeals.

### **PRELIMINARY STATEMENT**

The hearing was originally scheduled to convene on April 10, 2018 but the petitioner did not receive the appointment letter or evidence from the Department timely. The hearing was rescheduled with good cause and convened on April 30, 2018.

The initial hearing convened on April 30, 2018. The hearing was reconvened on May 30, 2018 to allow the petitioner an opportunity to review the evidence packet submitted by the Department.

The petitioner submitted four exhibits which were marked and entered as Petitioner's Exhibits "1" through "4." The respondent submitted thirty-two exhibits which were marked and entered as Respondent's Exhibits "1" through "32." The record was left open through June 6, 2018 for the respondent to provide additional information

regarding Hurricane Irma and recertification, a food stamp proration chart and proof of all applications the petitioner submitted. On June 6, 2018, the respondent provided the above mentioned additional evidence that was marked and entered into evidence as Respondent's Exhibits "33" through "35." The record was closed the same day.

### **FINDINGS OF FACT**

1. Prior to the action under review, the petitioner was receiving SNAP benefits of \$504 a month through January 31, 2018 and SOC Medicaid for the petitioner through March 2018. The respondent explained that her original SNAP certification should have ended October 31, 2017 but since she was due for recertification and was in the disaster zone, the Department extended the certification to January 31, 2018 (Resp. Exh. 34).

2. On February 19, 2018, the petitioner submitted an electronic application for SNAP and Medicaid benefits to the Department (Resp. Exh. 3). This was the first application or recertification the Department received from the petitioner since May 16, 2017 (Resp. Exh. 35).

3. On February 21, 2018, the petitioner completed an abbreviated interview with the Department. The petitioner applied for one adult and two children who were living in the household. The petitioner's income is child support of \$300 a week and Social Security Disability Income ("SSDI") of \$821 a month. Her expenses include rent of \$2,100 with all utilities included as she lives in a hotel. She also pays a phone expense of \$50 a month (Resp. Exh. 22).

4. The respondent verified the SSDI of \$821 a month through the State Online Query (Resp. Exh. 19). The child support income of \$300 per week was verified through the Massachusetts Department of Revenue (Resp. Exh. 20).

5. On March 6, 2018, a NOCA was mailed to the petitioner by the Department, stating that cash assistance was denied for March and April 2018 with the reasons of: "Your household's income is too high to qualify for this program. The value of your assets is too high for this program. Income of brother or sister." Food Assistance was approved for February 2018 in the amount of \$36, March 2018 in the amount of \$90 and April 2018 through July 2018 in the amount of \$459. This NOCA also informed the petitioner that the Medically Needy for all household members will end on March 31, 2018 (Resp. Exh. 23).

6. On March 16, 2018, the petitioner submitted a reported change to the Department stating that the FBI is investigating a fraud complaint and stating her SSDI has ended (Resp. Exh. 10).

7. On March 19, 2018, the petitioner timely requested a hearing for SNAP benefits. It was revealed during the respondent's prehearing review that the petitioner was disputing TCA and Medicaid as well. These appeals were later added by the respondent on April 30, 2018.

8. On March 26, 2018, a NOCA was mailed to the petitioner by the Department, stating that SNAP benefits for May 2018 through July 2018 are now \$504 a month (Resp. Exh. 4).

9. On April 9, 2018, the petitioner submitted an electronic application to the Department applying for cash assistance, SNAP benefits and Medicaid (Resp. Exh. 27).

10. On this application, she indicated that each child receives \$650 a month in child support income and she has assets of a checking account of \$400 and a 2015 Volkswagen Tiguan that she owes \$13,000 on. Her household composition and expenses remained the same from her previous application.

11. On April 10, 2018, a NOCA was mailed to the petitioner by the Department stating that cash assistance was denied for April 2018 and May 2018 with the reason of: "Your household's income is too high to qualify for this program. The value of your assets is too high for this program. Income of brother or sister." Food Assistance benefits will stay the same and the two minor children are eligible for Medicaid (Resp. Exh. 28).

**SNAP ISSUE WILL BE ADDRESSED FIRST:**

12. The petitioner claims that she was not aware that her SNAP certification was extended as she did not receive a notice regarding this so she completed a recertification application in October 2017. The petitioner did not know of the exact date and did not have access to the application. She requested access to all her previous applications as they were no longer showing up on her My Access Account online. The respondent explained that she will give the petitioner the website on which she can make the request.

13. The petitioner stated that the Department misreported her income in the household as it indicates on her February 19, 2018 application a gross monthly income of \$6,072.90 (Pet. Exh. 1). The Department explained that this calculation was done by adding up all the amounts she listed on the application under earned and unearned income. The respondent informed her this was not completed by the Department and

that the Department did not use this figure in calculating her benefits. All income was verified by the Department. The petitioner does not agree that she reported this income on the application.

14. The respondent determined the petitioner's SNAP budget for March 2018 as follows (Resp. Exh. 17):

\$2,021.00	total unearned income (SSDI & child support income)
- 160.00	standard deduction
<hr/>	
\$1,861.00	adjusted income
\$2,100.00	shelter costs
+ 45.00	utility standard (phone expense)
<hr/>	
\$2,145.00	shelter/utility costs
- 930.50	shelter standard (50% of adjusted net income)
<hr/>	
\$1,214.50	excess shelter/deduction
\$1,861.00	adjusted income
- 1,214.50	shelter deduction (uncapped)
<hr/>	
\$ 646.50	food stamp adjusted income
\$ 504.00	thrifty food plan for household of three
- 194.00	benefit reduction (30% of \$646.50)
<hr/>	
\$ 310.00	monthly allotment

15. The respondent explained that the petitioner was only eligible to receive \$310 for the month of March but due to an agency error, she was issued \$360. The Department used the same calculation as shown above for February 2018, except the benefits were prorated based off the date the Department received the application. The respondent explained that the Department also erred in calculating the prorated benefits for February 2018 by using  $\$360 \times .40 = \$144$  and it should have been  $\$310 \times .40 = \$124$ . An additional \$70 SNAP benefits were awarded to the petitioner due to the Department's error (Resp. Exh. 33).

16. The petitioner stated that she did not receive an SSDI payment in March 2018 as she received a letter from Social Security stating she was overpaid disability benefits (Pet. Exh. 1, pg. 24). The respondent replied that the State Online Query that provides information from the Social Security Administration shows that she did receive a payment in March 2018 and that was her last payment (Resp. Exh. 19).

17. The respondent stated that the loss of SSDI was not reported to the Department until March 16, 2018. Therefore, this change in income went into effect for the following month of benefits, April 2018.

18. The respondent explained that an additional auxiliary of \$504 was also issued on April 21, 2018 to supplement April benefits that was issued manually by the Department due to the pending hearing at the time (Resp. Exh. 16).

19. The petitioner is only appealing the amount received for February and March, stating that the total of those months is equal to \$504 but she is entitled to \$504 for each of those months so she is being shorted over \$500 as her income has not changed.

**TCA ISSUE WILL NOW BE ADDRESSED:**

20. The respondent explained that to determine eligibility for TCA the Department added up the petitioner's income which was listed as \$1,300 child support for the month of April, per the April 9, 2018 application. Based off a household size of three the income limit is \$303 and the petitioner's income exceeds that amount.

21. In regards to the petitioner's assets, the petitioner has a vehicle with a value of \$7,425 and liquid assets of \$400 which total \$7,825. The asset limit is \$2,000 so the petitioner is also over the asset limit by \$5,825.

22. The petitioner explained that she does not know how her car is worth that much as she is still making car payments on it. The Department explained that once the assets are corrected she is still over the income limit and not eligible for cash assistance.

23. The petitioner questioned why the denial notice states "Income of brother or sister" when her siblings are not included in the case. The respondent responded that the processor used an incorrect code when denying the TCA and the correct reason for denial was the petitioner was over income and over assets.

**MEDICAID ISSUE WILL NOW BE ADDRESSED:**

24. On December 11, 2017, a NOCA was mailed to the petitioner by the Department informing her that her MN SOC Medicaid will increase from \$418 to \$434 a month starting January 1, 2018 due to a cost of living adjustment for SSI/SSA (Resp. Exh. 14).

25. The respondent determined the petitioner was ineligible for full Medicaid benefits for January through March 2018 due to her SSDI of \$821 a month was over the income standard of \$303. Because the petitioner is over the income limit for full Medicaid, the next Medicaid coverage considered is MN. The respondent explained that the Medicaid budget does not include child support income. Once the petitioner's SSDI ended April 1, 2018, the petitioner was eligible for full Medicaid benefits as she no longer had countable income for the Medicaid budget (Resp. Exh. 18).

26. On March 6, 2018, a NOCA was mailed to the petitioner by the Department informing her that she is eligible for continued Medicaid coverage (Resp. Exh. 23). The respondent stated that the petitioner currently receives full Medicaid benefits.

### CONCLUSIONS OF LAW

27. 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.

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

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

### SNAP ISSUE WILL BE ADDRESSED FIRST:

30. 7 C.F.R. § 273.9 addresses income and deductions in SNAP. It states, in relevant part:

(a) *Income eligibility standards...*

(1) The gross income eligibility standards for SNAP...

(b) *Definition of income.* Household income shall mean all income from whatever source excluding only items specified in paragraph (c) of this section.

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

(ii) Annuities; pensions; retirement, veteran's, or **disability benefits**; 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... *(emphasis added)*

(iii) **Support or alimony payments made directly to the household from nonhousehold members...** *(emphasis added)*

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

(1) *Standard deduction...*

(2) *Earned income deduction...*

(3) *Excess medical deduction...*

(4) *Dependent care...*

(5) *Optional child support deduction...*

(6) *Shelter costs* —(i) *Homeless shelter deduction.* A State agency may provide a standard homeless shelter deduction of \$143 a month to households in which all members are homeless individuals but are not receiving free shelter throughout the month. The deduction must be

subtracted from net income in determining eligibility and allotments for the households. The State agency may make a household with extremely low shelter costs ineligible for the deduction. A household receiving the homeless shelter deduction cannot have its shelter expenses considered under paragraphs (d)(6)(ii) or (d)(6)(iii) of this section. However, a homeless household may choose to claim actual costs under paragraph (d)(6)(ii) of this section instead of the homeless shelter deduction if actual costs are higher and verified. A State agency that chooses to provide a homeless household shelter deduction must specify in its State plan of operation that it has selected this option.

(ii) *Excess shelter deduction.* Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions...

(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);

31. The Department's Program Policy Manual, CFOP 165-22, Appendix A-1, sets forth a \$160 standard deduction and \$504 maximum SNAP benefit for a household size of three. Rule 65A-1.603 of the Fla. Admin. Code sets forth a telephone standard of \$45.

32. 7 C.F.R. § 273.10(e), covers calculating net income and benefit levels in SNAP and states:

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

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

...

(C) Subtract the standard deduction.

...

(H) Total the allowable shelter expenses to determine shelter costs... Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost...

(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...

(2) *Eligibility and benefits...*

(ii)(A)... the household's monthly allotment shall be equal to the maximum food stamp allotment for the household's size reduced by 30 percent of the household's net monthly income as calculated in paragraph (e)(1) of this section. If 30 percent of the household's net income ends in cents, the State agency shall round in one of the following ways:

(1) The State agency shall round the 30 percent of net income up to the nearest higher dollar

33. In accordance with the above cited authorities, the petitioner's total SSDI of \$821 and child support income of \$1200 was counted in the SNAP determination. The above authorities also set forth income and deductions in the SNAP benefit determination. The respondent included the household's unearned income, and allowable deductions (standard deduction, shelter cost, and utility standard) in determining the petitioner's SNAP benefit budget.

34. 7 C.F.R. § 273.2 (j)(2) establishes the broad-based categorically eligible standard which "requires participants to have a gross monthly income at or below 200 percent of the Federal poverty level."

35. The petitioner is a broad-based categorically eligible ("BBCE") household and needs only to have gross income at or less than 200% of the FPL to be eligible for SNAP.

36. 7 C.F.R. § 273.12 Requirements for change reporting households, states in pertinent part:

(c) *State agency action on changes.* The state agency shall take prompt action on all changes to determine if the change affects the household's eligibility or allotment...

...

(1) *Increase in benefits.* (i) For changes which result in an increase in a household's benefits, other than changes described in paragraph (c)(1)(ii)

of this section, the State agency shall make the change effective no later than the first allotment issued 10 days after the date the change was reported to the State agency. For example, a \$30 decrease in income reported on the 15th of May would increase the household's June allotment. If the same decrease were reported on May 28, and the household's normal issuance cycle was on June 1, the household's allotment would have to be increased by July.

37. The above cited authority states that changes that would result in an increase of benefits would go into effect the following month that it is reported. The petitioner reported her loss of SSDI on March 16, 2018, which would make the change go into effect for April benefits. The Department was correct in including the petitioner's SSDI for February and March 2018.

38. 7 C.F.R. § 273.10(a), Determination of eligibility and benefit level states in pertinent part:

(ii) A household's benefit level for the initial months of certification shall be based on the day of the month it applies for benefits...

(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 or whichever of the following formulae is appropriate:

(A) The State agency shall use a standard 30-day calendar or fiscal month. A household applying on the 31st of a month will be treated as though it applied on the 30th of the month.

....

$$\text{full month's benefits} \times \frac{(31 - \text{date of application})}{30} = \text{allotment}$$

(C) If after using the appropriate formula the result ends in 1 through 99 cents, the State agency shall round the product down to the nearest lower whole dollar. If the computation results in an allotment of less than \$10, then no issuance shall be made for the initial month.

39. In accordance with the above cited authority, the respondent prorated the petitioner's benefits for February 2018 based on the date of application ( $31-19=12/30=.40 \times 360 = \$144$ ). The respondent explained that \$360 was incorrectly used in the

proration calculation and the full month's benefits that should have been used in the proration was \$310. If this amount was used, the calculation would be:  $31-19=12/30=.40 \times 310 = \$124$ . In this case the Department issued \$144 in SNAP benefits to the petitioner while she was only entitled to \$124 for February 2018.

40. The undersigned reviewed the respondent's budget calculations and the petitioner's reported income and expenses using the rules cited above and did not find a more favorable outcome.

**TCA ISSUE WILL NOW BE ADDRESSED:**

41. Fla. Admin. Code R. 65A-4.209 Income in part states:

(2) To be financially eligible for TCA, the total average gross monthly income less any applicable disregards of the standard filing unit cannot exceed the applicable payment standard for the assistance group. These standards and disregards are found in Sections 414.095(10) and (11), F.S. Monthly net income is calculated based on average gross monthly family income, earned and unearned, less any applicable disregards in accordance with Section 414.095(12)(a), F.S. The monthly amount of the TCA payment is determined by subtracting the monthly net income from the applicable payment standard.

...

(b) Total gross monthly income includes earned and unearned income from all sources.

42. Section 414.095, Fla. Stat. explains standards and in part states:

(10) DETERMINATION OF LEVEL OF TEMPORARY CASH ASSISTANCE.—Temporary cash assistance shall be based on a standard determined by the Legislature, subject to availability of funds. There shall be three assistance levels for a family that contains a specified number of eligible members, based on the following criteria:

- (a) A family that does not have a shelter obligation.
- (b) A family that has a shelter obligation greater than zero but less than or equal to \$50.
- (c) A family that has a shelter obligation greater than \$50 or that is homeless.

The following chart depicts the levels of temporary cash assistance for implementation purposes:

THREE-TIER SHELTER PAYMENT STANDARD

Family Size	Zero Shelter Obligation	Greater than Zero Less than or Equal to \$50	Greater than \$50 Shelter Obligation
3	\$198	\$258	\$303

43. In accordance with the above authority a household size of three with a shelter obligation greater than \$50 is eligible for \$303 TCA; provided that the household monthly income does not exceed the \$303 payment standard.

44. The petitioner has a shelter obligation greater than \$50 and her \$1,300 monthly income exceeds the \$303 payment standard. Therefore, the petitioner is not eligible for TCA benefits.

45. The undersigned will not be reviewing the asset requirement of TCA as the petitioner did not pass the income requirement.

**MEDICAID ISSUE WILL NOW BE ADDRESSED:**

46. It is necessary to establish if a hearing was requested timely. Fla. Admin. Code R. 65-2.046 Time Limits in Which to Request a Hearing, sets forth regulatory requirements as follows:

(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 right to appeal under the RTI Program must be exercised within 30 calendar days from the date of receipt of the notice of adverse action pursuant to paragraph 65C-42.004(3)(a), F.A.C. The right to appeal under the Adoption Subsidy Program must be exercised within 21 calendar days from the receipt of the notice of adverse action pursuant to subsection

65C-16.013(2), F.A.C. Additionally, in the Supplemental Nutrition Assistance Program (SNAP), a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The 30-day time period under the RTI Program begins on the date the written notification is received. 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.

47. The petitioner made an initial request for appeal on April 30, 2018. In accordance with the above regulation, the last notice that was sent to the petitioner regarding her enrollment in Medically Needy Share of Cost Medicaid was dated December 11, 2017. The Department does not have any record of this notice being sent back to them as returned mail and the petitioner did not dispute receiving this notice.

48. The petitioner was aware during the period of January 2014 through March 2018 that she was not receiving full coverage Medicaid. It was not until the petitioner received a NOCA on March 6, 2018 that stated she was now eligible for full coverage Medicaid did she submit her request for hearing regarding her previous enrollment in SOC Medicaid.

49. The undersigned has determined that a request was made beyond 90 days from the date of the mailing of the notice and the petitioner did not exercise her rights to a hearing timely, the hearing officer lacks jurisdiction.

**DECISION**

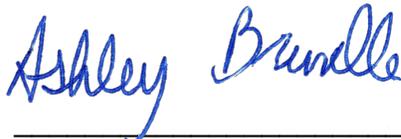
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals for SNAP and TCA are denied and the respondent's actions are affirmed. The appeal for Medicaid is dismissed as non-jurisdictional.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 16 day of July, 2018,

in Tallahassee, Florida.



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Ashley Brunelle  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
Fax: 850-487-0662  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency  
[REDACTED]

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

**FILED**

Jul 17, 2018

Office of Appeal Hearings  
Dept. of Children and Families



APPEAL NO. 18F-01828  
18F-02416

PETITIONER,

Vs.

CASE NO. 

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 14, 2018 at 2:15 p.m., at 



**APPEARANCES**

For the petitioner: , pro se

For the respondent: Jennie Rivera, ACCESS Economic Self-Sufficiency  
Specialist II

**STATEMENT OF ISSUE**

The petitioner is appealing the following:

I. The respondent's action to end her Supplemental Nutrition Assistance Program (SNAP) benefits, also known as Food Assistance, on February 28, 2018, due

to the respondent not receiving all the information requested to determine eligibility.

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

II. The respondent's action to deny her March 27, 2018 application and end her SNAP benefits on April 30, 2018. The petitioner carries the burden of proof by a preponderance of the evidence.

III. The respondent's action to terminate the petitioner's full Medicaid benefits and enroll her in the Medically Needy (MN) Program with a share of cost (SOC). The petitioner is seeking full Medicaid. The respondent carries the burden of proof by a preponderance of the evidence.

#### **PRELIMINARY STATEMENT**

The hearing was originally scheduled for April 10, 2018 at 8:30 a.m. On March 26, 2018, the petitioner contacted the Office of Appeal Hearings (OAH) and requested an earlier hearing date due to her surgery being cancelled because of changes to her Medicaid coverage. The undersigned was unable to give the petitioner an earlier hearing date due to being fully booked. On April 3, the petitioner contacted the OAH and requested a continuance of the April 10, 2018 hearing due to a family emergency. The undersigned granted the petitioner's continuance request and rescheduled the hearing for May 3, 2018 at 8:30 a.m.

On May 3, 2018, the undersigned, the respondent and the respondent's witness appeared for the scheduled hearing and waited fifteen minutes after the scheduled hearing time for the petitioner to appear. The petitioner did not appear for the May 3, 2018 hearing. On May 11, 2018, the undersigned closed the petitioner's appeals as

abandoned because the petitioner never contacted the OAH to request a reschedule and to explain the reason she did not appear at the May 3, 2018 hearing.

On April 30, 2018 and May 18, 2018, the petitioner requested two additional appeals regarding her SNAP benefits (18F-03473 and 18F-04073); and on May 21, 2018, she requested another appeal regarding her Medicaid benefits (18F-04105). The respondent explained these additional appeals (18F-03473, 18F-04073, and 18F-04105) were for the same issues as these previous appeals (18F-01828 and 18F-02416). The petitioner requested to reopen the previous appeals. As a result, the undersigned issued an Order to Show Good Cause on May 24, 2018, requiring the petitioner to submit a written response explaining the reason she did not attend the May 3, 2018 hearing. The petitioner had 10 days from the date of that Order to respond. On May 31, 2018, the petitioner submitted a written statement indicating she did not receive notice of the May 3, 2018 hearing and that she had requested an in-person hearing. The undersigned concluded good cause existed for the petitioner's non-appearance and granted her request to reopen the appeals and reschedule the hearing. The hearing was reset, as an in-person hearing, for June 14, 2018 at 2:15 p.m.

Wayne Reed, Investigator with the Office of Public Benefits Integrity (OPBI), appeared as a witness for the respondent.

At the outset of the hearing, the petitioner explained she is challenging the respondent's actions on the applications she submitted on January 16, 2018 and March 27, 2018 for SNAP and Medicaid Assistance benefits. On June 6, 2018, the respondent submitted documents regarding an application the petitioner submitted on May 3, 2018.

The undersigned will not address this additional information, as it is not relevant to the current issues. Therefore, said additional information received on June 6, 2018 was not accepted into evidence.

The petitioner did not submit any exhibits at the hearing. The respondent submitted eight exhibits, which were entered into evidence as Respondent's Exhibits "1" through "8". The record was held open until close of business on June 22, 2018 for submission of additional evidence from the parties. On June 14, 2018, the respondent submitted additional information, which was entered into evidence as Respondent's Exhibit "9". On June 15, 2018, the respondent's witness submitted a document, which was entered into evidence as Respondent's Exhibit "10". The petitioner did not submit any exhibits. The record closed on June 22, 2018.

#### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner was receiving SNAP benefits for herself and her four children (ages 23, 8, 3 and 1) and full Medicaid benefits for herself and her three minor children. The SNAP benefits were due to expire on February 28, 2018 and the Medicaid benefits were certified from July 2017 through June 30, 2018.
2. On January 16, 2018, the respondent mailed the petitioner a Notice of Eligibility Review to inform her she had to complete a review to continue her SNAP benefits beyond February 2018. On January 16, 2018, the petitioner submitted an on line application for SNAP and Medicaid benefits.
3. On the application, the petitioner reported her living address as [REDACTED]  
[REDACTED]. Her mailing address was listed as post

office [REDACTED]. No income or expenses were reported on the application.

4. On January 19, 2018, the petitioner completed a telephone interview for the January 16, 2018 application. During the interview, the petitioner confirmed her physical address reported on the application to be correct. She also reported that her husband<sup>1</sup> does not reside in the home but pays all the expenses directly to the companies. Based on the application and interview, the respondent authorized SNAP benefits for the petitioner through August 2018 (Respondent Exhibit 4, page 77).
5. On January 23, 2018, the respondent mailed the petitioner a Notice of Case Action (NOCA) informing the petitioner that it reviewed her eligibility and determined the household's SNAP benefits would stay the same.
6. After further review, the processor referred the case to OPBI on January 31, 2018. OPBI conducts upfront reviews on applications for public assistance to prevent fraud and over issuance of public assistance benefits. The respondent explained the petitioner's management and household composition were determined to be questionable. On February 1, 2018, the respondent mailed the petitioner a NOCA requesting she provide additional information by February 12, 2018. The NOCA indicated the following:

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<sup>1</sup> During testimony from the petitioner, she explained that her marital status remains married but separated.

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Dear [REDACTED]

The following is information about your eligibility.

---

Once you receive your case number you can go to [www.myflorida.com/accessflorida](http://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 the following information by February 12, 2018.

\*Proof of loans, contributions, or gifts used to pay your expenses this month or a statement from anyone paying your household's bill

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

Other - please see comments below

Provide a copy of the lease to include all pages with nothing marked out or whited out, a copy of the electric bill, the landlord's name & daytime contact phone number as well an unrelated collateral contact statement verifying your household composition, statement must include the name, address, daytime contact phone number and signature of the individual providing the statement for you. Provide proof of the income you have to purchase items for personal needs such as toilet paper.

7. The investigator accepted the referral on February 5, 2018 and conducted an investigation on February 6, 2018. During the course of the investigation, the investigator concluded that the petitioner, her husband and their children did not reside at the address reported on the January 16, 2018 application. The investigator concluded the petitioner's husband was residing in the household with the petitioner. The investigator testified he concluded the petitioner's husband lived with the petitioner based on the on-site property manager and neighbor's statements that the family had moved out three years ago. The petitioner's husband was added onto the petitioner's case. However, no documentary evidence was presented to support the investigator's allegation that the petitioner's husband resided in the same household with the petitioner during the January 16, 2018 application.

8. The investigator submitted Case Investigative Notes that indicate a field visit was completed on February 9, 2018 at the location of [REDACTED],

[REDACTED] According to these notes, the investigator spoke with the on-site community

manager, who explained that the petitioner and her family have not resided at said address since 2015. The investigator asserted that he mailed a pending notice to the petitioner's living address reported on the application, instructing her to contact the OPBI within ten (10) days to review the investigation findings. The investigator testified that the notice was returned as undeliverable. No notice was presented showing the mailed letter was returned and no specific date was given on when the notice was mailed to the petitioner and returned to the Department. It is unknown why the investigator did not send the notice to the post office box address reported on the application in question.

9. The respondent testified that on February 13, 2018 and February 15, 2018 (change report [REDACTED]), the petitioner faxed the respondent a statement indicating that she was no longer residing at the address reported on the application. She reported her new address was [REDACTED], [REDACTED]

10. On February 16, 2018, the respondent mailed the petitioner a NOCA notifying her SNAP benefits would end on February 28, 2018; the reason for the termination was listed as: "We did not receive all the information to determine eligibility".

11. The petitioner submitted to the respondent two statements from her husband on February 16, 2018 and February 22, 2018, the documents indicated that he pays the expenses directly to the companies and his email address is [REDACTED]. The petitioner also submitted a statement from her son (23) indicating that he was not employed, and his contact number listed as [REDACTED]. The petitioner testified the

phone number belongs to her husband. On March 6, 2018, the petitioner reported her son (23) no longer lived in the household.

12. The respondent explained the petitioner's SNAP benefits were terminated because the documents she provided were contradictory and questionable. The petitioner did not submit verification of a lease agreement, copies of utility bills, and a statement from an individual who does not reside in the household to verify her household composition. The SNAP benefits remained closed.

13. According to the Department's running record comments, the petitioner contacted the respondent requesting to speak to the investigator on February 23 and February 26, 2018 (Respondent Exhibit 4 pages 72 and 73). The investigator did not return her calls.

14. On March 27, 2018, the petitioner submitted an on-line application for SNAP benefits for herself and her three minor children, this application shows as a recertification. She reported on this application that her living address was [REDACTED]

[REDACTED] She reported her monthly expenses as rent of \$900.00, electric of \$235.00, trash of \$50.00 and water of \$33.00 and no income was reported.

15. According to the Department's running record comments, the March 27, 2018 application was a passive determination; therefore, no interview was required (Respondent Exhibit 4, page 4). The respondent approved the household for expedited SNAP benefits for March 2018 and April 2018.

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16. After further review of the history from the Department's case running record comments, the processor mailed the petitioner a NOCA on March 28, 2018, requesting she provide additional information by April 9, 2018. The NOCA indicated the following:

Dear [REDACTED]

The following is information about your eligibility.

---

**Once you receive your case number you can go to [www.myflorida.com/accessflorida](http://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 the following information by April 09, 2018.

\*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 loans, contributions, or gifts used to pay your expenses this month or a statement from anyone paying your household's bill  
Other - please see comments below

Please verify household composition, (where is Denva) verify earned income, or income from contribution, if no income explain how bills are getting paid

17. On April 2, 2018, the respondent completed a supervisory review with the petitioner. On March 30, 2018, the petitioner submitted a statement of rental obligation. The respondent reviewed the property appraiser website which showed the address reported on the application, [REDACTED], is owned by the petitioner and her husband (Respondent Exhibit 3). Based on the review, the respondent mailed the petitioner another NOCA on April 3, 2018, requesting the following additional information by April 13, 2018:

Dear Serbrena Alston,

The following is information about your eligibility.

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**Once you receive your case number you can go to [www.myflorida.com/accessflorida](http://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 the following information by April 13, 2018.

Other - please see comments below

PROVED STATEMENTS FROM [REDACTED] FAMILY MEMBERS WHO YOU STATED ARE RECEIVING MONEY FROM HIM TO HELP YOU PAY FOR HOUSEHOLD EXPENSES OUTSIDE OF WHAT MR. [REDACTED] IS PRESENTLY DIRECTLY PAYING. ALL STATEMENTS MUST BE DATED, SIGNED, EXPLAIN FREQUENCY OF MONEY RECEIVED, AMOUNT RECEIVED, AND HOW THEY ARE HELPING THE HOUSEHOLD.

18. The respondent presented evidence from the [REDACTED] Appraiser that showed the petitioner and her husband purchased the home located at [REDACTED] [REDACTED] on October 25, 2013. The respondent presented copies from the Driver and Vehicle Information Database (DAVE), also known as State of Florida Department of Highway Safety and Motor Vehicles. The document showed the petitioner's husband's address is [REDACTED]. The petitioner's husband transferred his 2007 BMW vehicle title on March 22, 2018 due to the vehicle was sold.

19. On April 27, 2018, the respondent mailed the petitioner a NOCA indicating her application for SNAP benefits dated March 27, 2018 was denied; the reason for the denial was listed as: "We did not receive all the information requested to determine eligibility". The household's full Medicaid benefits remained the same, the respondent approved full Medicaid benefits for the petitioner and her three minor children through July 31, 2018, pending the outcome of the hearing. Household composition and management were not verified.

20. The petitioner disputes the respondent's allegation that her husband resides in the household, she claims her husband lives in Jamaica. The petitioner argued that she was not given the opportunity to resolve any discrepancies. The petitioner explained she attempted to call the investigator numerous times and never received any returned calls. Additionally, the petitioner argued the respondent's action to include her husband on her case is incorrect as he is not living in her household. The petitioner explained she and her husband share the email address of [REDACTED] and confirmed

the husband's telephone number is [REDACTED] 3, the same number that the petitioner's son used as his contact number (see paragraph 11).

21. The petitioner clarified on record that her husband vendor pays the mortgage for the house where she and the children are residing. The mortgage is \$900.00 a month, it is not rent.

### **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.

### **JANUARY 16, 2018 APPLICATION FOR SNAP BENEFITS ISSUE**

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

- (a) Operation of SNAP offices and processing of applications—(1) Office operations...
- (2) Application processing. The application process includes filing and completing an application form, being interviewed, and having certain information verified. The State agency must act promptly on all applications and provide SNAP benefits retroactive to the month of application to those households that have completed the application process and have been determined eligible. States must meet application processing timelines, regardless of whether a State agency implements a photo EBT card policy. The State agency must make expedited service available to households in immediate need. Specific responsibilities of households and State agencies in the application process are detailed below...

(5) Notice of Required Verification. The State agency shall provide each household at the time of application for certification and recertification with a notice that informs the household of the verification requirements the household must meet as part of the application process. The notice shall also inform the household of the State agency's responsibility to assist the household in obtaining required verification provided the household is cooperating with the State agency as specified in (d)(1) of this section. The notice shall be written in clear and simple language and shall meet the bilingual requirements designated in §272.4(b) of this chapter. At a minimum, the notice shall contain examples of the types of documents the household should provide and explain the period of time the documents should cover....

(d) Household cooperation. (1) To determine eligibility, the application form must be completed and signed, the household or its authorized representative must be interviewed, and certain information on the application must be verified. If the household refuses to cooperate with the State agency in completing this process, the application shall be denied at the time of refusal. For a determination of refusal to be made, the household must be able to cooperate, but clearly demonstrate that it will not take actions that it can take and that are required to complete the application process. For example, to be denied for refusal to cooperate, a household must refuse to be interviewed not merely failing to appear for the interview. If there is any question as to whether the household has merely failed to cooperate, as opposed to refused to cooperate, the household shall not be denied, and the agency shall provide assistance required by paragraph (c)(5) of this section. The household shall also be determined ineligible if it refuses to cooperate in any subsequent review of its eligibility, including reviews generated by reported changes and applications for recertification. Once denied or terminated for refusal to cooperate, the household may reapply but shall not be determined eligible until it cooperates with the State agency. The State agency shall not determine the household to be ineligible when a person outside of the household fails to cooperate with a request for verification. The State agency shall not consider individuals identified as nonhousehold members under §273.1(b)(2) as individuals outside the household....

(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: ...

(iii) Utility expenses.... (vi) Residency. The residency requirements of §273.3 shall be verified... Verification of residency should be

accomplished to the extent possible in conjunction with the verification of other information such as, but not limited to, rent and mortgage payments, utility expenses, and identity. If verification cannot be accomplished in conjunction with the verification of other information, then the State agency shall use a collateral contact or other readily available documentary evidence. Documents used to verify other factors of eligibility should normally suffice to verify residency as well. Any documents or collateral contact which reasonably establish the applicant's residency must be accepted and no requirement for a specific type of verification may be imposed...

...

(x) Household composition. **State agencies shall verify factors affecting the composition of a household, if questionable.** (emphasis added)

Individuals who claim to be a separate household from those with whom they reside shall be responsible for proving that they are a separate household to the satisfaction of the State agency. Individuals who claim to be a separate household from those with whom they reside based on the various age and disability factors for determining separateness shall be responsible for proving a claim of separateness (at the State agency's request) in accordance with the provisions of §273.2(f)(1)(viii) ....

**(2) Verification of questionable information.** (i) The State agency shall verify, prior to certification of the household, all other factors of eligibility which the State agency determines are questionable and affect the household's eligibility and benefit level. The State agency shall establish guidelines to be followed in determining what shall be considered questionable information. These guidelines shall not prescribe verification based on race, religion, ethnic background, or national origin. These guidelines shall not target groups such as migrant farmworkers or American Indians for more intensive verification under this provision....

(3) State agency options. In addition to the verification required in paragraphs (f)(1) and (f)(2) of this section, the State agency may elect to mandate verification of any other factor which affects household eligibility or allotment level, including household size where not questionable. Such verification may be required Statewide or throughout a project area, but shall not be imposed on a selective, case-by-case basis on particular households.

...

(i) The State agency may establish its own standards for the use of verification, provided that, at a minimum, all questionable factors are verified in accordance with paragraph (f)(2) of this section and that such standards do not allow for inadvertent discrimination.

...

(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 or home visits.** (emphasis added) For example, documentary evidence may be considered insufficient when the household presents pay stubs which do not represent an accurate picture of the household's income (such as out-dated pay stubs) or identification papers that appear to be falsified.

(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....

(iii) Home visits. Home visits may be used as verification only when documentary evidence is insufficient to make a firm determination of eligibility or benefit level, or cannot be obtained, and the home visit is scheduled in advance with the household. Home visits are to be used on a case-by-case basis where the supplied documentation is insufficient. Simply because a household fits a profile of an error-prone household does not constitute lack of verification. State agencies shall assist households in obtaining sufficient verification in accordance with paragraph (c)(5) of this section.

**(iv) Discrepancies. Where unverified information from a source other than the household contradicts statements made by the household, the household shall be afforded a reasonable opportunity to resolve the discrepancy prior to a determination of eligibility or benefits.**

(emphasis added) The State agency may, if it chooses, verify the information directly and contact the household only if such direct verification efforts are unsuccessful. If the unverified information is received through the IEVS, as specified in §272.8, the State agency may obtain verification from a third party as specified in paragraph (f)(9)(v) of this section.

**(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.** (emphasis added)

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.

(6) Documentation. Case files must be documented to support eligibility, ineligibility, and benefit level determinations. Documentation shall be in sufficient detail to permit a reviewer to determine the reasonableness and accuracy of the determination.

...

(C) In cases where verification is incomplete, the State agency must have provided the household with a statement of required verification and offered to assist the household in obtaining required verification and allowed the household sufficient time to provide the missing verification. Sufficient time shall be at least 10 days from the date of the State agency's initial request for the particular verification that was missing.

25. Florida Administrative Code R. 65A-1.205, Eligibility Determination Process, states

in part:

(1) ...

(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time. If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.

...

(5) The Department can substantiate, verify or document information provided by the applicant/recipient as part of each determination of eligibility. For any program, **when there is a question about the validity of the information provided, the Department will ask for additional documentation or verification as required.** (emphasis added) The term verification is used generically to represent this process.

(a) Substantiation establishes accuracy of information by obtaining consistent, supporting information from the individual.

(b) Verification confirms the accuracy of information through a source(s) other than the individual. The Department can secure verification electronically, telephonically, in writing, or by personal contact...

26. The evidence presented indicates the telephone number to contact the petitioner's son (23) was the telephone number that belongs to the petitioner's husband and the petitioner testified she shares an email address [REDACTED] with her husband, this resulted in conflicting statements. Household composition was found questionable.

27. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 3610.1000 ACCESS INTEGRITY (FS), states:

ACCESS Integrity (AI) is an extension of the Department's public assistance eligibility process and operates within the purview of 7 CFR 273, 45 CFR 233, and Sections 414.095(16) and 414.39(10), Florida Statutes. It is a program designed to combat fraud and reduce misspent dollars in the Department's public assistance programs. Probable error prone cases are identified at the pre-eligibility (application/reapplication, certification/recertification) phase of the public assistance program. Once a case is identified as meeting error prone criteria, it is referred to the AI unit within the Region or Circuit where the public assistance unit resides. The AI unit then reviews the information provided by the individual or the authorized representative and verifies and documents the finding of fact as it relates to the information provided by the individual and the eligibility factors used to determine the individual's level of participation. **Once verification and documentation is completed, the recipient is given an opportunity to explain contradictory information and an eligibility determination is made.** (emphasis added)

28. The above authorities explain household composition, when found questionable, must be verified prior to approving the case. In this case, household composition and management were questionable. Testimony was given by the investigator regarding the petitioner's living situation to substantiate if the petitioner's husband was physically living in the home with the petitioner during the January 16, 2018 application. The investigator testified that he spoke to the on-site community manager who confirmed the petitioner and her family haven't lived at that location since 2015. According to the investigators findings, it was determined that the petitioner's husband was residing in the household with the petitioner. It is unknown how the investigator determined his findings. No evidence was submitted to support the respondent's allegation that the petitioner's husband was living in the same household during the petitioner's January 16, 2018 application. The investigator testified a pending notice was mailed to the petitioner to contact the investigator to allow the petitioner an opportunity to rebut the findings, the notice was mailed to [REDACTED], Florida. This was not the address reported on the petitioner's application as her mailing address. Her mailing address was listed as [REDACTED], Florida, [REDACTED]. Said notice was returned undeliverable. There was no evidence presented to show if any action was taken on the returned mail. The petitioner should have been afforded a reasonable opportunity to resolve the discrepancy by giving the household ten days to contact the investigator. The petitioner attempted to contact the investigator on February 23, 2018 and February 26, 2018. The investigator did not return her calls. Given the limited evidence presented, the undersigned concludes the respondent has

not met its burden in establishing that the petitioner's husband resided in the home during the January 16, 2018 application. The petitioner's husband should not have been included in the petitioner's case.

29. After careful review of the evidence and controlling legal authorities, the undersigned concludes that the Department was incorrect in that it did not allow the petitioner 10 days to respond or rebut the investigator's findings. Therefore, the undersigned hereby remands the matter to the respondent to complete the eligibility determination process for the petitioner's SNAP benefits. The respondent is ordered to remove the petitioner's husband from the case and to determine the SNAP eligibility for the petitioner and her minor children for the new eligibility period beginning March 1, 2018 through August 31, 2018, without duplicating benefits already issued. The respondent is to issue the petitioner a new notice with appeal rights upon completion.

**MARCH 27, 2018 APPLICATION FOR SNAP BENEFITS ISSUE**

30. The undersigned reviewed the documentary evidence and testimony submitted by the parties. As the undersigned is remanding the matter to the respondent to reprocess the petitioner's January 16, 2018 application and to determine her SNAP eligibility for the new certification period beginning March 1, 2018 through August 31, 2018, the issue regarding the denial of the petitioner's March 27, 2018 SNAP application is moot. As there is no better outcome the undersigned can provide, the issue regarding the March 27, 2018 SNAP application denial is hereby dismissed as moot.

**MEDICAID ASSISTANCE BENEFITS ISSUE**

31. The household was approved full Medicaid benefits beginning July 2017 through June 30, 2018, and there was no lapse in coverage. Due to the pending hearing, the respondent extended the petitioner's Medicaid benefits through July 31, 2018. Based on the respondent's action to correct and approve the petitioner's full Medicaid benefits through July 31, 2018, the undersigned concludes there is no matter to be decided by the undersigned regarding the Medicaid benefits. Therefore, the Medicaid issue is hereby dismissed as moot.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal regarding the January 16, 2018 SNAP application is granted and remanded to the respondent for corrective action as specified in the Conclusions of Law. The appeal regarding the March 27, 2018 SNAP application is dismissed as moot.

The appeal regarding the petitioner's full Medicaid benefits is dismissed as moot.

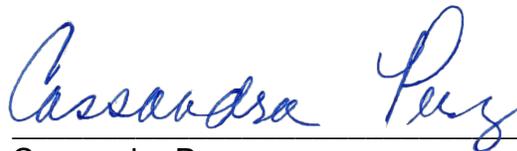
**ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.**

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 17 day of July, 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

Jul 12, 2018

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 18F-02673

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 15 Palm Beach  
UNIT: 88084

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on June 5, 2018 at approximately 8:38 a.m. CDT.

**APPEARANCES**

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

For the Respondent: Stacy Ann Mills,  
economic self-sufficiency specialist supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of March 12, 2018 terminating the petitioner's ongoing Medicaid coverage. The respondent carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "10".

The petitioner submitted a packet of information that was not admitted into evidence as it was duplicated within the respondent's exhibits.

The record was left open, with a deadline date of June 19, 2018, for both parties to submit additional evidence.

The information received from the respondent was admitted into evidence and marked as Respondent's Exhibits "11" through "14".

The information received from the petitioner was admitted into evidence and marked as Petitioner's Exhibits "1" through "3".

The respondent submitted the remainder of the requested documentation on June 21, 2018. The packet of information was admitted into evidence and marked as Respondent's Exhibit "15".

The record was closed June 21, 2018.

### **FINDINGS OF FACT**

1. The petitioner, a single, 46-year-old male with no dependents, received Title 19 related Medicaid from April 2011 through March 31, 2018 (Respondent's Exhibits 12 and 13).
2. On September 27, 2017, the petitioner applied with the Social Security Administration (SSA) for disability benefits. The application was denied October 13, 2017. The SSA treated the application as an application for Supplemental Security Income (SSI) cash benefits, rather than as an application for Social Security Disability

Insurance (SSDI). The application was denied with reason code N01, countable income exceeds Title XVI federal benefit rate (Respondent's Exhibit 15).

3. On March 8, 2018, the petitioner applied with the respondent for SSI-Related Medicaid. On this application the petitioner stated that he was disabled. He also reported that the SSA had denied his application on December 1, 2017 for disability related benefits as a disability had not been established. He reported having no earned or unearned income (Respondent's Exhibit 1).

4. On March 12, 2018, by notice of case action (NOCA), the petitioner was informed that his Medicaid benefits would end March 31, 2018 because no household members are eligible for this program (Respondent's Exhibit 2).

5. By NOCA dated March 26, 2018, the petitioner was notified that the SSA denial of his SSI cash application was not a denial of his possible eligibility for Medicaid. He was referred to contact the respondent within 30 days for a determination of Medicaid eligibility in Florida, as only Florida can deny Florida Medicaid. The petitioner testified that he was unsuccessful in his attempts to reach the Customer Call Center (Petitioner's Exhibit 2).

6. On May 2, 2018, the petitioner reapplied to the respondent for SSI-Related Medicaid (Respondent's Exhibit 9).

7. By NOCA dated May 3, 2018, the petitioner was pended for the submission of a signed Financial Release Form and verification of application/reapplication to the SSA for Social Security Disability, which notified the petitioner that "if you have been denied for disability for the Social Security Administration (SSA) and it has been less than a

year, DCF will adopt the decision by SSA unless you have a new or worsening condition” (Respondent’s Exhibit 4).

8. By NOCA dated May 4, 2018, the petitioner was informed of the requirement to have a phone interview and the need for him to provide a signed Authorization To Disclose Information Form, and Affidavit for Designated Representation Form, as well as proof of application with the SSA for disability benefits. He was also encouraged to read the disability pamphlet provided (Respondent’s Exhibits 6 and 7).

9. The petitioner provided signed copies of the Financial Information Release and Authorization To Disclose Information (Respondent’s Exhibit 8).

10. The respondent prepared a disability packet and forwarded it to the Division of Disability Determination (DDD) on May 30, 2018. This application is active, pending the decision of DDD (Respondent’s Exhibits 9 and 10).

11. The petitioner does not understand why he would have received Medicaid coverage for so long to have it terminated in March 2018. His condition and symptoms have not changed; [REDACTED]

[REDACTED]

[REDACTED] He stated he is appealing his recent SSA denial and is considering seeking counsel to assist with the appeal. He hopes that temporary relief can be provided by the respondent through this hearing process so he can receive the medical services he needs to survive.

12. The petitioner does not maintain that the SSA is unaware of any aspect of his physical condition or symptoms.

13. The respondent offered no explanation for the petitioner's past Medicaid eligibility. The Medicaid eligibility was terminated after the respondent becoming aware of the SSA's denial based on the petitioner's past income.

### **CONCLUSIONS OF LAW**

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

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

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

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

(4) Ex Parte Process.

(a) When a recipient's eligibility for Medicaid ends under one or more coverage groups, the department must determine their eligibility for medical assistance under any other Medicaid coverage group(s) **before terminating Medicaid coverage**. Both family-related Medicaid and SSI-related Medicaid eligibility are determined based on available information. If additional information is required to make an ex parte determination, it can be requested from the recipient, or, for SSI-related Medicaid eligibility, from the recipient or from the Social Security Administration.

(b) **All individuals** who lose Medicaid eligibility under one or more coverage groups **will continue to receive Medicaid until the ex parte redetermination process is completed**. If the department determines that the individual is not eligible for Medicaid, the individual will be sent a notice to this effect which includes appeal rights. The individual may appeal the decision and, if requested by the individual within 10 days of the decision being appealed, Medicaid benefits will be continued pending resolution of the appeal. (emphasis added)

18. The above-cited authority states that when Medicaid eligibility ends under one or more coverage groups an *ex parte* determination is required and until the *ex parte* determination process is completed all individuals who lose Medicaid eligibility will continue to receive Medicaid until the process is completed.

19. The findings show that the petitioner applied for SSI benefits in September 2017 with the SSA and was denied in October 2017 as he was found to be over the federal benefit rate. The denial by the SSA was not based on disability, rather income.

20. The findings show that by NOCA dated March 26, 2018 the respondent notified the petitioner to call the ACCESS Florida Customer Call Center within 30 days to determine eligibility for Medicaid.

21. The findings show that the petitioner's ongoing Medicaid benefit was terminated effective March 31, 2018.

22. According to the above-cited authorities, evidence and testimony, the undersigned concludes that the respondent did not meet the burden of proving the correctness of ending the petitioner's Medicaid effective March 31, 2018. An *ex parte* determination of possible Medicaid eligibility should have been started and the petitioner's Medicaid continued until the eligibility determination was made.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal granted. The respondent is ordered to reinstate the petitioner's Medicaid back to April 1, 2018. Once an *ex parte* decision is reached, if the petitioner is not satisfied with the result, a timely hearing request may be made, if desired.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 12 day of July, 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

**FILED**

Jul 31, 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-02705

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 07 Volusia  
UNIT: 88210

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 19, 2018, 2018, at 10:06 a.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: Ernestine Bethune, DCF Economic Self-Sufficiency Specialist (ESSS) II

**STATEMENT OF ISSUE**

At issue is the respondent's action to deny the petitioner's full Medicaid and to enroll her in Medically Needy (MN) Program with an estimated Share of Cost (SOC) at initial application is correct. The burden of proof was assigned to the petitioner by a preponderance of evidence.

### **PRELIMINARY STATEMENT**

On April 2, 2018, petitioner timely requested a hearing to challenge the Department's action. The appeal was continued from May 15, 2018 per petitioner's request.

At the hearing, the petitioner submitted an evidence packet which was marked Petitioner's Composite Exhibit 1. The respondent submitted nine (9) exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 9. The record was left open through June 26, 2018 for the petitioner to submit any additional information and extended through July 3, 2018 for the respondent to respond. The petitioner's evidence was timely received and marked as Petitioner's Composite Exhibit 2. The respondent's response was timely received and marked as Respondent's Exhibit 10. The record was closed on July 3, 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 applied for disability with Social Security Administration (SSA) in April 2017. Her application was denied in October 2017 on the contention that her disability would not last twelve months. She has appealed the denial and has retained legal counsel to help with the appeal process. Her scheduled hearing date is September 12, 2018.
2. On March 15, 2018, the petitioner submitted an online application requesting Family-Related Medicaid coverage for her household. The petitioner's household includes the petitioner and her infant son, see Respondent's Exhibit 2.

3. The petitioner is not employed. She receives \$2,563.60 per month in long-term disability insurance benefits from a private entity and this income is not taxable. The son receives \$340.40 in Social Security benefits from the father. The son is the petitioner's tax dependent. The household income is not in dispute.
4. Under the Affordable Care Act (ACA), the household income is based on the members' tax filing requirement. The requirement to file taxes determines whether an individual's income must be included in the household's modified adjusted gross income (MAGI). Depending on the state, there are some differences on the Income and household rules for the Federally Facilitated Marketplace insurance and Medicaid coverage, see Petitioner's Composite Exhibit 2.
5. Based on the household income, the petitioner was denied full Medicaid but approved for the MN benefits. The child was approved for full Medicaid.
6. On March 19, 2018, the respondent sent the petitioner a Notice of Case Action (NOCA) informing her she was approved for MN benefits. The estimated share of cost (SOC) was not mentioned, see Respondent's Exhibit 1.
7. The petitioner is seeking full Medicaid benefits for herself and is challenging her enrollment in the MN Program. In determining eligibility for Medicaid for the petitioner, her monthly disability benefits were considered as the MAGI. The respondent counted two members in the petitioner's standard filing unit (SFU). The household income was then compared to the income limit for an adult with a household size of two (\$241). The income exceeded the maximum limit, resulting in the petitioner being found ineligible for full Medicaid benefits.

8. As the petitioner was determined ineligible for full Medicaid, the respondent enrolled her in the MN Program. To determine the estimated SOC for the petitioner, the Medically Needy Income Level (MNIL) of \$387 for a standard filing unit size of two was subtracted from the MAGI (\$2,563.60), resulting in an estimated SOC of \$2,176, see Respondent's Exhibit 6.

9. The respondent explained that the petitioner was evaluated under the Family-Related Medicaid coverage group and since her household income exceeded the income limit, she was not eligible for full Medicaid. She explained that the petitioner's SOC amount is directly dependent on her disability insurance benefits.

10. The petitioner asserted as follows: (1) that her disability benefits are non-taxable income and should be excluded for the budget; (2) that she has medical issues that require medical attention; (3) that she cannot afford to buy medical insurance through the market place. She argues that income and household requirements should be the same for the Marketplace insurance and state Medicaid coverage. She explained that she is set to undergo several surgeries and needs the Medicaid coverage to afford them. She is seeking full Medicaid to cover all her medical expenses or a lower, more affordable SOC, so she can get the medical cares she needs to live a healthier life.

11. The record was left open for the petitioner to submit additional document to the Department for consideration. On July 2, 2018, the Department sent additional policy related to the petitioner's document, see Respondent's Exhibit 10.

#### **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 Rule 65-2.056 of the *Florida Administrative Code*.

**Full Medicaid will now be addressed**

14. 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.

15. Federal Regulations at 42 C.F.R. § 435.110 Parents and other caretaker relatives stated in pertinent part:

...(b) Scope. The agency must provide Medicaid to parents and other caretaker relatives, as defined in §435.4, and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in the State plan, in accordance with paragraph (c) of this section.

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

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

18. Rule 65A-1.716 of the *Florida Administrative Code*, Income and Resource Criteria, explains: “(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size...” The Family-Related Medicaid income limit for a two-member household is \$241.

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

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

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

...

(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.

...

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

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

(i) The individual's spouse;

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

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

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

(A) Age 19; or

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

...

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

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

Filer Rule: If the individual being tested for eligibility expects to file a tax return for the tax year in which eligibility is being determined and does not expect to be claimed as a tax dependent by someone else, the SFU includes the:

1. individual,
2. individual's spouse, if any, even if the individual and the individual's spouse are living separately and filing a joint tax return, and
3. all claimed tax dependents of the individual living inside or outside of the household.

...

Non-Filer Rule: If the individual being tested for eligibility is an adult that does not expect to file a tax return and does not expect to be claimed as a tax dependent by someone else, the SFU includes the:

1. individual,
2. individual's spouse, if any, living in the household, and
3. individual's children (biological, adopted and step) living in the household that are under the age of 19, or age 19 or 20 enrolled in school full-time.

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

22. Federal Regulations at 42 C.F.R. § 435.603(d), Application of modified gross income (MAGI), defines Household Income and states:

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

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

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

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

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

23. The Policy Manual at passage 1830.0900 addresses BENEFITS (MFAM) and states that “The gross benefit amount received is considered unearned income. Benefits are owned by the individual for whom they are intended unless the individual is not in the home and the benefits are not redirected.”

**Benefits included as unearned income are:**

1. railroad retirement payments including retirement, survivor, unemployment, sickness and strike benefits (Refer to the policy passage titled Children and Tax Dependents, within the Standard Filing Unit

Chapter, for exceptions regarding when to count a child or tax dependent's income)

2. Unemployment Compensation Benefit payments

3. severance pay

4. Social Security Administration Benefits including Title II Social Security benefits (Refer to the policy passage titled Children and Tax Dependents, within the Standard Filing Unit Chapter, for exceptions regarding when to count a child or tax dependent's income)

5. annuities, pensions, retirement **or disability payments**  
(emphasis added)

24. 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 KidCare and/or the Federally Facilitated Marketplace (FFM).

25. The Family-Related Medicaid income standard appears in the Policy Manual at Appendix A-7. Effective April 2018, the income limit for an adult parent with a household size of two is \$241, the standard disregard is \$146, the MNIL for a household of two is \$387, and the 5% MAGI deduction is \$69.

26. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner. The undersigned concludes the petitioner is not eligible for full Medicaid under the Family-Related Medicaid Program, even after applying the above-referenced disregards. The petitioner's income remains over the \$241 income standard. Therefore, the respondent proceeded to explore the Medically Needy Program. The undersigned recognizes the petitioner's concerns about her medical needs. However, the controlling legal authorities do not allow for any more favorable outcome.

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

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

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

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

28. Rule 65A-1.701 of the *Florida Administrative Code*, Definitions, defines Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month."

29. Rule 65A-1.702 of the *Florida Administrative Code*, 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.

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

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

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

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

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

32. In accordance with the above controlling authorities, the respondent determined the petitioner's countable household income to be \$2,563.60. The MNIL of \$387 was subtracted from the income to arrive at a \$2,176 SOC. The undersigned found no exception to these calculations. The hearing officer reviewed the respondent's SOC calculation and could not find a more favorable outcome.

33. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's action to deny the

petitioner full Medicaid under the Family-Related Medicaid coverage group and enroll  
petitioner in the Medically Needy Program with a \$2,176 SOC is correct.

**DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 31 day of July, 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

Jul 02, 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-02799

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 3, 2018 at 11:57 a.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se

For the Respondent: Riphard Nicholas, supervisor

**STATEMENT OF ISSUE**

At issue is the respondent's action to terminate full Medicaid for the petitioner's children and enroll them in Medically Needy (MN) Program with a \$3,246 Share of Cost (SOC). The burden of proof was assigned to the respondent by a preponderance of evidence.

### **PRELIMINARY STATEMENT**

Liliam, operator ID [REDACTED], with Language Line Solutions, provided interpreter services for the hearing.

The petitioner provided no exhibits. The respondent provided a 17-page evidence packet, which was marked and entered as Respondent's Exhibits "1" through "4". The record was left open through May 7, 2018 for additional information including the paystubs used in making the determination, Medicaid income standards, policy related to calculating the Medicaid budgets, and the updated MN budget. On May 4, 2018, the respondent submitted the requested information, which was marked and entered as Respondent's Exhibits "5" through "8".

On June 8, 2018, the undersigned issued an Order Requesting Documentation to Supplement the Record giving the respondent ten (10) days to provide the Notice of Case Action (NOCA) terminating Medicaid for the minor children. On June 22, 2018, after the due date, the respondent submitted a NOCA dated March 19, 2018, which was marked and entered as Respondent's Exhibit "9". The record was closed the same day.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner was receiving full Medicaid benefits for the household (Respondent's Testimony).
2. On March 19, 2018, the respondent sent the petitioner a NOCA informing him the Medicaid for the household would terminate on March 31, 2018 (Respondent's Exhibit 9).
3. On April 4, 2018, the petitioner submitted a web application requesting Family-Related Medicaid for his household (Respondent's Exhibit 2).

4. The petitioner's household included the petitioner, his wife (MB), his daughter (AB, 13 years old) and his son (GB, 8 years old). The petitioner and his wife file taxes jointly (Respondent's Exhibit 2).

5. The petitioner works for [REDACTED] and is paid \$1,200.55 bi-weekly (Respondent's Exhibit 7).

6. MB worked for [REDACTED] and was paid bi-weekly. The respondent determined the MB's income as \$1,430.87 per month based on State Wage Information Collection Agency (SWICA) database verified earned income (Respondent's Exhibit 2).

7. The respondent determined the petitioner's monthly income as \$3,834.41 (\$1,200.55 + \$1,200.55 + \$1,430.63) (Respondent's Exhibit 6).

8. The Medicaid income limit for a Standard Filing Unit (SFU) of four for children ages six to 18 is \$2,782 (Respondent's Exhibit 5).

9. The petitioner is over the income limit for full Medicaid for both minor children. MN with a SOC must be explored.

10. The respondent determined the petitioner's MN budget as follows (Respondent's Exhibit 6):

\$3,831.73	total reported income
- 585.00	medically needy income limit (MNIL)
<hr/>	<hr/>
\$3,246	SOC

11. On April 5, 2018 the respondent mailed the petitioner a Notice of Case Action (NOCA) informing the petitioner the household had been enrolled in the MN with a \$3,246 SOC (Respondent's Exhibit 1).

12. The petitioner timely requested the appeal.

13. The petitioner contends his children have several medical conditions and need the full Medicaid coverage.

14. The respondent states Medicaid determinations are made based on income in the household.

### **CONCLUSIONS OF LAW**

15. 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.

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

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

### **Full Medicaid benefits will be addressed first:**

18. Federal regulation 42 C.F.R. § 435.602(a) Financial responsibility of relatives and other individuals states in the pertinent part:

... (2) Basic requirements. Subject to the provisions of paragraphs (b) and (c) of this section, in determining financial responsibility of relatives and other persons for individuals under Medicaid, the agency must apply the following requirements and methodologies:

(i) Except for a spouse of an individual or a parent for a child who is under age 21 or blind or disabled, the agency must not consider income and resources of any relative as available to an individual.

(ii) In relation to individuals under age 21 (as described in section 1905(a)(i) of the Act), the financial responsibility requirements and methodologies that apply include **considering the income and resources of parents or spouses whose income and resources will be considered if the individual under age 21** were dependent under the State's approved State plan under title IV-A of the Act in effect as of July 16, 1996, whether or not they are actually contributed, except as specified

under paragraph (c) of this section. These requirements and methodologies must be applied in accordance with the provisions of the State's approved title IV-A State plan as of July 16, 1996. (*emphasis added*)

19. The above authority sets forth that children under the age of 21 must have the income and resources of their parents included in determining eligibility. In this instant case, the petitioner and his wife's income must be included when determining eligibility for the minor children in the home.

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

The SFU is determined for each individual by following one of three rules based on intended tax filing status for the upcoming tax year as reported by the applicant/recipient. Individuals cannot receive Medicaid benefits under more than one assistance group, but can have their income included in more than one assistance group...

Tax Dependent Rule: If the individual being tested for eligibility expects to be claimed as a tax dependent for the tax year in which eligibility is being determined, the SFU includes the:

1. individual,
2. individual's spouse, even if the individual and the individual's spouse are living separately and filing a joint return,
3. tax filer,
4. tax filer's spouse, if any, even if the tax filer and tax filer's spouse are living separately and filing a joint return, and
5. all claimed tax dependents of the tax filer living inside or outside of the household.

21. In accordance with the above cited authority and The Policy Manual, the respondent correctly determined the petitioner's eligibility with a household size of four, including the petitioner, his wife, and two mutual children.

22. Federal regulation 42 C.F.R. § 435.603 Application of modified gross income

(MAGI)(f) defines a Household for Medicaid:

...

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

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

(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.

23. 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).

24. The Policy Manual, Appendix A-7, effective October 1, 2017, lists the Family-Related Medicaid income limits for a household of four for children six to 18 as follows:

It does not provide a standard disregard for this group:

\$2,727 income standard

\$ 585 MNIL

\$ 103 MAGI

25. In accordance with the above controlling authorities, the undersigned reviewed the Medicaid eligibility for the petitioner's two minor children. Step 1: The total income counted in the budget is \$3,831.73. Step 2: There were no deductions provided. Step 3: There is no standard disregard provided for children six through 18. Step 4: The balance of \$3,831.73 is greater than the income limit of \$2,727 for a child six through 18 in a household of four. Step 5: The income of \$3,831.73 less the MAGI disregard of \$103 is \$3,728.73. The amount is greater than the income limit of \$2,727. The

undersigned concludes that the petitioner's two minor children are ineligible for Medicaid. The undersigned further concludes MN eligibility must be explored.

**Enrollment in MN and SOC amount will now be addressed:**

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

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

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

27. Fla. Admin. Code R. 65A-1.701 "Definitions" defines 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".

28. Fla. Admin. Code 65A-1.702 "Special Provisions" states in part:

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

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

29. Effective October 2017, The Policy Manual at Appendix A-7 lists the MNIL for children ages six to 18 in a household of four as \$585.

30. In accordance with above cited authority and The Policy Manual, the respondent determined the petitioner's countable household income to be \$3,831.73. The MNIL of \$585 was subtracted from the income to determine the petitioner's SOC as \$3,246.

31. Based on the testimony, evidence, and a review of the respondent's budget calculations, the undersigned has concluded that the respondent's action to terminate the petitioner's full Medicaid benefits and enroll the petitioner's two minor children in the MN program with a SOC of \$3,246 was within 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.

FINAL ORDER (Cont.)  
18F- 02799  
PAGE -10

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

*Pamela B. Vance*

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

**FILED**

Jul 13, 2018

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 18F-02967

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on May 11, 2018 at 12:09 p.m.

**APPEARANCES**

For Petitioner: [REDACTED], Authorized Representative/Benefits Coordinator, [REDACTED]

For Respondent: Lorry Beauvais, Economic Self Sufficiency Specialist II

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action denying her Medicaid application dated February 23, 2018, for failure to complete the disability interview.

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

### **PRELIMINARY STATEMENT**

The Florida Department of Children and Families (Department or respondent) determines eligibility for SSI-Related Medicaid programs. To be eligible for the SSI-Related Medicaid programs, an individual must be blind, disabled, or 65 years or older. The Department of Health's Division of Disability Determinations (DDD) conducts disability reviews regarding medical eligibility for individuals applying for disability benefits under the federal Social Security and Supplemental Security Income programs and the state Medically Needy Program. Once a disability review is completed, the disability application or claim is returned to the Department for a final determination of non-medical eligibility and the approval of any benefits due.

The petitioner submitted no exhibits. The respondent submitted an evidence packet consisting of eight (8) exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" – "8." The record was held open to allow the respondent to submit the screen shot of the petitioner's Document Verification System (DVS) account. The requested evidence was received on May 15, 2018 and marked as Respondent's Exhibit "9" and entered into the record. The record was closed May 15, 2018.

Kate Sampson, Economic Self Sufficiency Specialist II with the Department was present as an observer only. The petitioner had no objections to her observation of the hearing.

### **FINDINGS OF FACT**

1. On February 23, 2018, the petitioner's authorized representative (AR) submitted a web application ( [REDACTED] ) requesting SSI-Related Medicaid for the petitioner, see Respondent's Exhibit 3.
2. The petitioner is a 59-year-old married female with no minor children in the home. Her husband is not applying for benefits. The petitioner is a non-citizen, not aged or blind and has not yet been determined disabled. The petitioner is claiming a disability and requesting Emergency Medicaid for Aliens (EMA), see Respondent's Exhibit 3.
3. On February 28, 2018, the Department reviewed the application and updated the running record comments with the case status and the actions and/or verifications needed to process the case. The petitioner's identification was not discovered or authenticated at the time of the application. To comply with Customer Authentication (CA), the petitioner is required to provide proof of identity face to face, see Respondent's Exhibit 8.
4. On March 1, 2018, the respondent mail a pending Notice of Case Action (NOCA) to the AR's business address requesting a phone interview and additional information, including a completed and signed Authorization to Disclose Information Form and Affidavit for Designated Representative Form. The pending notice requested that the petitioner call (941) 554-0810 on or before March 12, 2018 between the hours of 8:00 a.m. and 4:00 p.m. to complete the phone interview, see Respondent's Exhibit 4.
5. On March 6, 2018 the DVS was updated and on March 7, 2018, the Department documented in the electronic case file running records (CLRC) case notes the receipt of

the Authorization to Disclose Information Form, the Affidavit for Designated Representative Form and the Doctor's statement regarding dates of service (February 1, 2018 through February 5, 2018) for the petitioner, see Respondent's Exhibit 8.

6. On March 9, 2018, the Department updated the CLRC noting that the case was still pending for the disability interview and the CA, see Respondent's Exhibit 8.

7. On March 20, 2018, the Department noted "no client contact" and that the case had been pending 25 days and no DDD interview or CA had been processed for this case, see Respondent's Exhibit 8.

8. The Work Item Details indicated that the required interview was not completed, see Respondent's Exhibit 2.

9. On March 28, 2018, the respondent mailed a NOCA informing the petitioner that her application dated February 23, 2018 was denied. The notice was mailed to the petitioner's home address and not to the AR's address, see Respondent's Exhibit 5.

10. The AR asserts that the petitioner went to the [REDACTED] office on February 28, 2018 and was told she needed to contact the Call Center to complete the interview.

11. The CLRC record does not reflect any contact with the petitioner on that date, see Respondent's Exhibit 9.

12. On March 30, 2018, the AR stated that she and the petitioner went to the Sarasota office and completed the CA but the case was already closed, Petitioner's testimony.

13. The AR argued that she never received the pending NOCA, Petitioner's testimony.

14. The address on the application for the AR and the address on the NOCA is [REDACTED]. The petitioner acknowledged that the address is correct.

15. The respondent submitted the DVS screen shot showing that no “returned mail” had been received for this case, see Respondent’s Exhibit 9.

16. The AR argued that the respondent should have given her a courtesy call before the case was denied and that the respondent did not follow the proper procedures. She asserted that she completed the application for the petitioner and input that if there were any questions or any other information needed to call her.

17. The respondent countered that an attempt was made to reach the AR on May 2, 2018 and a voice message left regarding this petitioner’s appeal and the respondent did not receive a return call, see Respondent’s Exhibit 9.

18. The AR asserted that she called the Customer Call Center and called [REDACTED] and left a voice message. She stated that no one returned her call.

19. The respondent replied that the Customer Call Center does not do disability interviews and that the appropriate number to call was on the March 1, 2018 NOCA.

#### **CONCLUSIONS OF LAW**

20. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to section 409.285 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.

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

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

(1)(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. **It is the applicant's responsibility to keep appointments with the eligibility specialist** (*emphasis added*) and furnish information, documentation and verification needed to establish eligibility. **If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time.** (*emphasis added*) If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.

....

(3) The Department conducts phone or face-to-face interviews with applicants/recipients or their authorized/designated representatives when required for the application or complete eligibility review process. The Department conducts face-to-face interviews upon request in the ACCESS Florida office, the applicant's/recipient's home, or other agreed upon location. The applicant/recipient or their authorized/designated representative must keep the interview appointment or reschedule the missed appointment.....

**(4) If an applicant or recipient does not keep an appointment without arranging another time with the eligibility specialist;** or does not sign and date the applications described in subsection (1); or does not submit required documentation or verification **the Department will deny benefits as it cannot establish eligibility.** (*emphasis added*)

23. In accordance with the above authorities, the respondent mailed the petitioner a NOCA on March 1, 2018 requesting that the petitioner call for a phone interview. eligibility. The petitioner was scheduled to call (941) 554-0810 for an interview on or before March 12, 2018 between the hours of 8:00 a.m. and 4:00 p.m. The NOCA also notified the petitioner that her application would be denied if an interview was not completed.

The AR asserted that she did not receive the pending NOCA that provided the interview information. The undersigned confirmed the AR's address on the record. The

Department verified that no returned mail was received for this case. 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.

24. In accordance with the above authorities, the respondent mailed the petitioner a NOCA on March 28, 2018, notifying the petitioner the request for Medicaid benefits dated February 23, 2018, was denied, due to not completing the interview.

25. The undersigned finds Petitioner's testimony arguing that she did not receive the NOCA pending for the interview persuasive. However, the undersigned also finds the respondent's testimony arguing that the NOCA was mailed to the AR's business address and no returned mail received by the Department equally persuasive.

Therefore, the undersigned is bound to decide solely from the documentary evidence. The undersigned concludes that the petitioner did not provide any documentary evidence that she called in a timely manner to conduct the interview. The respondent provided the Work Item Details, which do not indicate an interview completion date. The respondent also provided the CLRC notes, which recorded the attempts to reach the AR and included notations that the interview had not been conducted. The undersigned concludes that the AR did not complete the interview within 30 days and the respondent processed the application according to policy.

26. Based on the above findings of facts and conclusions of law, the undersigned concludes that the petitioner/AR failed to comply with the interview requirement within 30 days

**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 13 day of July, 2018,  
in Tallahassee, Florida.



Ursula Lett-Robinson  
Hearing Officer  
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1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To: [REDACTED] Petitioner  
Office of Economic Self Sufficiency

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

**FILED**

Jul 12, 2018

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-02973

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 in the above-referenced matter on May 17, 2018, at 9:42 a.m., in [REDACTED].

**APPEARANCES**

For the petitioner: [REDACTED]

For the respondent: Miriam Alvarez, Supervisor

**STATEMENT OF ISSUE**

At issue is the respondent's action to deny the petitioner's SSI Related Medicaid application based on the contention that he does not meet a qualified non-citizen status. The petitioner carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The petitioner's representative presented one exhibit which was accepted into evidence and marked as Petitioner's Composite Exhibit 1. The respondent also presented one exhibit which was accepted into evidence and marked as Respondent's Composite Exhibit 1. The record was held open until May 23, 2018, for the petitioner to provide additional evidence of his immigration status and for the Department provide the petitioner's application and the denial notice.

Present as witnesses for the petitioner were [REDACTED]

[REDACTED], friend from church. The petitioner was present for the hearing. The petitioner did not provide any additional exhibits. Additional time was allowed until June 1, 2018, for both parties to present additional exhibits. The respondent provided one additional exhibit which was accepted into evidence and marked as Respondent's Composite Exhibit 2. The record was closed on June 1, 2018.

**FINDINGS OF FACT**

1. On January 11, 2018 and March 13, 2018, the petitioner's representative submitted an application for Institutional Care Program (ICP) Medicaid benefits on behalf of the petitioner. He is 96 years of age (Respondent's Composite Exhibit 2, page 24 and page 28). The petitioner receives Social Security retirement benefits and Medicare benefits (Petitioner's Composite Exhibit 1).
2. On January 12, 2018, the petitioner's representative provided his employment authorization card as proof that he was granted Temporary Protective Status (TPS).

3. On January 16, 2018, the respondent mailed the petitioner's representative a Notice of Case Action requesting proof of Immigration and Naturalization Status (INS)/alien card.
4. The respondent used the Department of Homeland Security, Systematic Alien Verification for Entitlements (SAVE) system to verify the petitioner's non-citizenship status. On June 8, 2017, the SAVE result indicated the petitioner was born in Haiti and was granted TPS with an expiration date July 22, 2017(Respondent's Composite Exhibit 1, page 6). Additionally an I-797A, Notice of Action dated July 14, 2017 indicates that the petitioner was granted TPS valid between July 23, 2017 and January 22, 2018. The same notice states that while you are under TPS you may be deemed ineligible for Public Assistance (Petitioner's Composite Exhibit 1 and Respondent's Composite Exhibit 1, page 18). A second I-797A, Notice of Action dated May 4, 2018, indicated that the petitioner was granted TPS effective January 23, 2018 through July 22, 2019. This notice also indicates individuals with TPS may be deemed ineligible for Public Assistance (Respondent's Composite Exhibit 2, page 8).
5. The respondent reviewed the case and determined the petitioner was not eligible for ICP Medicaid benefits based on his non-citizen status (TPS).
6. On January 11, 2018, the respondent issued a Notice of Case Action denying the petitioner's ICP Medicaid benefits.
7. On April 13, 2018, the petitioner's representative requested a hearing on behalf of the petitioner to challenge the respondent's action.
8. At the hearing, the respondent argued that the policy does not allow individuals with TPS to be eligible for ICP Medicaid benefits, only for Emergency Medicaid for

Aliens (EMA). At the hearing, the respondent confirmed the petitioner earned 40 quarters of work credit but is still ineligible for ICP Medicaid base on his TPS.

9. The petitioner's representative argued the petitioner was previously issued a Medicaid number [REDACTED] and his TPS status should not prevent him from being eligible for ICP 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. Fla. Admin. Code § 65A-1.710 "SSI-Related Medicaid Coverage Groups" states in relevant part:

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

...

(2) Institutional Care Program (ICP). A coverage group for institutionalized aged, blind or disabled individuals (or couples) who would be eligible for cash assistance except for their institutional status and income as provided in 42 C.F.R. §§ 435.211 and 435.236. Institutional benefits include institutional provider payment or payment of Medicare coinsurance for skilled nursing facility care.

13. Fla. Admin. Code R. 65A-1.301 addresses Citizenship requirement and states in the pertinent part:

(1) The individual whose needs are included must meet the citizenship and noncitizen status established in: P.L. 104-193, The Personal Responsibility and Work Opportunity Reconciliation Act of 1996; P.L. 105-

33, the Balanced Budget Act of 1997; P.L. 105-185, the Agricultural Research, Extension, and Education Reform Act of 1998; P.L. 105-306, the Noncitizen Benefit Clarification and Other Technical Amendments Act of 1998; P.L. 109-171, the Deficit Reduction Act of 2005; and, the Immigration and Nationality Act.

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

14. The above cited authority states that the Department must verify the immigration status of noncitizens through the SAVE system. In this case the petitioner's immigration status was verified as TPS. The respondent determined that TPS is not a qualified non-citizen status eligible for Medicaid benefits.

15. The Policy Manual, section 0240.0103 addresses Eligibility Criteria (MSSI, SFP) and states:

The specific criteria for each SSI-Related Program will be listed under the program name below. To be eligible for any SSI-Related Program, an individual must meet general (technical) criteria, income, and asset requirements which vary by program, and any special criteria for a particular program.

For all SSI-Related Programs, the individual must meet the following technical eligibility criteria:

1. aged (65 or older), blind (does not apply to MEDS), or disabled;
2. U.S. resident;
3. Florida resident;
4. U.S. citizen or qualified noncitizen (except for EMA);
5. provide, or file for, an SSN (except for EMA);
6. file for all other benefits to which he may be entitled; and
7. assign rights to state to collect private health insurance (for MA-SSI only).

16. The above states that an individual must be a U.S citizen or a qualified non-citizen in order to be eligible for Medicaid.
17. The Policy Manual passage 1440.0114 addresses Verification Requirements for Noncitizens (MSSI, SFP). It states, “The eligibility specialist must verify the immigration status of all non-citizens applying for or receiving Medicaid through the U.S. Citizenship and Immigration Services (USCIS). The Verification Information System-Customer Processing System (VIS-CPS) is used to verify the immigration status”.
18. The Policy Manual passage, 1440.0117 addresses Assistance for Ineligible Noncitizens (MSSI, SFP). It states, “Any noncitizen who does not have an eligible qualified noncitizen status is not eligible for Medicaid on the factor of citizenship. These noncitizens may be eligible for Medicaid through Emergency Medical Assistance for Aliens (EMA), if they meet all other eligibility criteria”.
19. The Code of Federal Regulations at 42 C.F.R. § 435.4 states, “*Qualified non-citizen* includes the term “qualified alien” as defined at 8 U.S.C. 1641(b) and (c).”
20. The U.S. Code at 8 U.S.C. §1641(b) and (c) defines qualified alien as follows:

**(b) Qualified alien**

For purposes of this chapter, the term “qualified alien” means an alien who, at the time the alien applies for, receives, or attempts to receive a Federal public benefit, is—

- (1) an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act [8 U.S.C. 1101 et seq.],
- (2) an alien who is granted asylum under section 208 of such Act [8 U.S.C. 1158],
- (3) a refugee who is admitted to the United States under section 207 of such Act [8 U.S.C. 1157],
- (4) an alien who is paroled into the United States under section 212(d)(5) of such Act [8 U.S.C. 1182(d)(5)] for a period of at least 1 year,
- (5) an alien whose deportation is being withheld under section 243(h) of such Act [8 U.S.C. 1253] (as in effect immediately before the effective

date of section 307 of division C of Public Law 104–208) or section 241(b)(3) of such Act [8 U.S.C. 1231(b)(3)] (as amended by section 305(a) of division C of Public Law 104–208),

(6) an alien who is granted conditional entry pursuant to section 203(a)(7) of such Act [8 U.S.C. 1153(a)(7)] as in effect prior to April 1, 1980;<sup>1</sup> or

(7) an alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).

(c) Treatment of certain battered aliens as qualified aliens

For purposes of this chapter, the term “qualified alien” includes—

(1) an alien who—

(A) has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the alien and the spouse or parent consented to, or acquiesced in, such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) has been approved or has a petition pending which sets forth a prima facie case for—

(i) status as a spouse or a child of a United States citizen pursuant to clause (ii), (iii), or (iv) of section 204(a)(1)(A) of the Immigration and Nationality Act [8 U.S.C. 1154(a)(1)(A)(ii), (iii), (iv)],

(ii) classification pursuant to clause (ii) or (iii) of section 204(a)(1)(B) of the Act [8 U.S.C. 1154(a)(1)(B)(ii), (iii)],

(iii) suspension of deportation under section 244(a)(3) of the Immigration and Nationality Act [8 U.S.C. 1254(a)(3)] (as in effect before the title III–A effective date in section 309 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996).<sup>2</sup>

(iv) status as a spouse or child of a United States citizen pursuant to clause (i) of section 204(a)(1)(A) of such Act [8 U.S.C. 1154(a)(1)(A)(i)], or classification pursuant to clause (i) of section 204(a)(1)(B) of such Act [8 U.S.C. 1154(a)(1)(B)(i)];<sup>3</sup>

(v) cancellation of removal pursuant to section 240A(b)(2) of such Act [8 U.S.C. 1229b(b)(2)];

21. The above authority does not list TPS as a qualified alien.

22. The U.S. Code at 8 U.S.C. § 1612, Limited eligibility of qualified aliens for certain

Federal programs, sets forth:

(a) Limited eligibility for specified Federal programs

(1) In general

Notwithstanding any other provision of law and except as provided in paragraph (2), an alien who is a qualified alien (as defined in section 1641

of this title) is not eligible for any specified Federal program (as defined in paragraph (3))

(2) Exceptions

(A) Time-limited exception for refugees and asylees

With respect to the specified Federal programs described in paragraph

(3), paragraph (1) shall not apply to an alien until 7 years after the date—

(i) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act [8 U.S.C. 1157];

(ii) an alien is granted asylum under section 208 of such Act [8 U.S.C. 1158];

(iii) an alien's deportation is withheld under section 243(h) of such Act [8 U.S.C. 1253] (as in effect immediately before the effective date of section 307 of division C of Public Law 104–208) or section 241(b)(3) of such Act [8 U.S.C. 1231(b)(3)] (as amended by section 305(a) of division C of Public Law 104–208);

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

(v) an alien is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100–202 and amended by the 9th proviso under migration and refugee assistance in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100–461, as amended)

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

**(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified non-citizens), qualified non-citizens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified non-citizens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Non-Citizen status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is a non-citizen in a satisfactory immigration status**(emphasis added).

(ii) The eligibility of qualified non-citizens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.

(3) For purposes of paragraphs (a)(1) and (2), of this section, a declaration of citizenship or satisfactory immigration status may be provided, in writing and under penalty of perjury, by an adult member of the individual's

household, an authorized representative, as defined in §435.923, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant provided that such individual attests to having knowledge of the individual's status.

(b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified non-citizens subject to the 5-year bar or who are non-qualified non-citizens who meet all Medicaid eligibility criteria, except non-qualified non-citizens need not present a social security number or document immigration status.

24. The authorities above allow for states to provide Medicaid benefits to qualified non-citizens. The petitioner has not provided evidence that he is a qualified non-citizen.

Therefore, he has not met his burden of proof.

25. After carefully reviewing the evidence, testimony and controlling legal authorities cited above, the undersigned concludes that the petitioner is not eligible for Medicaid as he is not a qualified non-citizen. The respondent's action to deny the petitioner's ICP Medicaid benefits based on his Temporary Protective Status was in accordance with the above authorities.

### **DECISION**

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

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

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

FINAL ORDER (Cont.)  
18F-02973  
PAGE -10

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

DONE and ORDERED this 12 day of July, 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  
[REDACTED]

**FILED**

Jul 17, 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-03087

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 23, 2018 at 1:49 p.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se

For the Respondent: Mary Triplett, supervisor

**STATEMENT OF ISSUE**

At issue is the respondent's action to deny the petitioner's request for Medicaid under the SSI-Related Medicaid program at application. The burden of proof was assigned to the petitioner by a preponderance of evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted a 37-page evidence packet, which was marked and entered as Petitioner's Composite Exhibit "1". The respondent submitted a 29-page evidence packet, which was marked and entered as Respondent's Exhibits "1" through "7".

### **FINDINGS OF FACT**

1. The Department of Children and Families (DCF, respondent) determines eligibility for SSI-Related Medicaid programs. To be eligible, an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility for individuals applying for disability benefits under the state Medically Needy Program. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and approval of any benefits due.
2. Prior to the action under appeal, on May 15, 2017, the petitioner (53 years old) submitted an application to the Social Security Administration (SSA) claiming a disability due to a back disorder and anxiety.
3. The petitioner suffers from issues of the cervical spine, [REDACTED]; [REDACTED]; [REDACTED]; nerve damage. The petitioner is in constant pain, including numbness down her face and arm (Petitioner's Composite Exhibit 1).
4. The petitioner has not worked in over two years.
5. SSA denied the petitioner's claim of disability on November 2017. On February 22, 2018, an appeal was filed with SSA (Petitioner's Testimony).
6. On January 2, 2018, the petitioner submitted an electronic web application to recertify her Supplemental Nutrition Assistance Program (SNAP) benefits and an

application for Medicaid under the SSI-Related Medicaid Program (Respondent's Exhibit 2).

7. The petitioner is the only household member and is not pregnant. The petitioner has no income and incurs no expenses (Respondent's Exhibit 2).

8. The petitioner claims no new disabling condition at this time that has not been previously considered by SSA (Petitioner's Testimony).

9. On January 8, 2018, the respondent submitted the petitioner's disability application to DDD citing back disorder and anxiety (Respondent's Exhibit 3).

10. On January 23, 2018, the petitioner's disability claim was denied by DDD, citing it as a Hankerson using code "N32: Capacity for substantial gainful activity, other work, no visual impairment" (Respondent's Exhibits 4 and 6).

11. On January 24, 2018, the respondent sent the petitioner a Notice of Case Action informing her the application for Medicaid had been denied: "Reason: You or a member(s) of your household do not meet the disability requirement. No household members are eligible for this program" (Respondent's Exhibit 1).

12. The petitioner timely requested the appeal.

13. The petitioner states she is in need of insurance and help with her pain management.

14. The respondent explained that the petitioner's application for Medicaid was denied because SSA has determined that she is not disabled and DDD has adopted the same decision based on policy. The respondent further explained that once DDD determined the petitioner is not disabled, the respondent must deny the application for Medicaid under the SSI-Related Medicaid Program for people under the age of 65.

### **CONCLUSIONS OF LAW**

15. 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.

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

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

18. Medicaid eligibility is based on Federal Regulations. There are two categories of Medicaid that the respondent determines eligibility for: (1) Family-Related Medicaid for parents and children, and pregnant women, and (2) Adult-Related (referred to as SSI-Related Medicaid) for disabled adults and adults 65 and older.

19. Fla. Admin. Code R. 65A-1.711, 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.

20. The Code of Federal Regulations at 42 C.F.R. § 435.000 sets forth the definition and determination of disability and states in relevant part: "Definition of disability (a) Definition. The agency must use the same definition of disability as used under SSI..."

21. Federal Regulations at 42 C.F.R. § 435.541 "Determination of Disability," states:

- (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
  - (1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.
  - (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.
- (b) Effect of SSA determinations.
  - (1) Except in the circumstances specified in paragraph (c)(3) of this section—
    - (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
    - (ii) If the SSA determination is changed, the new determination is also binding on the agency.
  - (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.
- (c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
  - (1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.
  - (2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.
  - (3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

- (4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—
- (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
  - (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

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

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

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

23. 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). (emphasis added)**
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.

24. According to the above cited authorities and The Policy Manual, 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. DDD cannot make a decision while a previous SSA decision is under appeal. It further states a disability decision can only be made by DDD if the SSA refuses to reconsider an unfavorable disability decision or the applicant no longer meets SSI non-disability criteria such as income and assets.

25. The petitioner's unfavorable disability decision is currently under appeal and she claims no new or worsening condition not previously considered by SSA.

26. Fla. Admin. Code R. 65A-1.703 Family-Related Medicaid Coverage Groups in part state:

(1) The department provides mandatory Medicaid coverage for individuals, families and children described in section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule...

(5) Medicaid for pregnant women...

27. The undersigned also looked at eligibility for the petitioner in the Family-Related Medicaid Program. The evidence submitted establishes that the petitioner has no minor

children in her household and is not pregnant. Therefore, the petitioner is not eligible for Family-Related Medicaid.

28. Based on the evidence and testimony presented, the above cited rules and regulations, the undersigned concludes the respondent's action to deny the petitioner's request for Medicaid is proper.

29. The undersigned has explored all other Medicaid groups and did not find a more favorable outcome.

### **DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this   17   day of   July  , 2018,

in Tallahassee, Florida.



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

**FILED**

Jul 11, 2018

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

PETITIONER,

Vs.

APPEAL NO. [REDACTED]

CASE NO. 1202397298

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 15 Palm Beach  
UNIT: 88998

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 6, 2018, at 2:00 p.m. All Parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED] Designated Representative (DR)  
Patient Advocate with Good Samaritan Medical  
Center

For the Respondent: Mary Triplett, ACCESS supervisor

**STATEMENT OF ISSUE**

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

### **PRELIMINARY STATEMENT**

On April 12, 2018, the DR filed an appeal requesting Medicaid benefits for her client.

Petitioner did not present any exhibits into evidence. Respondent presented three (3) exhibits which were accepted into evidence and marked as Respondent Exhibits "1" through "3" respectively. The record was left open through end of business day for Respondent to submit additional information. It was extended through June 11 per Respondent's request. The information was timely received and marked as Respondent Exhibit 4. Exhibit 4 is a composite exhibit. The record was closed on June 11, 2018.

### **FINDINGS OF FACT**

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

1. Prior to the action under appeal, Petitioner received a favorable disability decision from the state Division of Disability Determination (DDD) office in October 2016. She was approved for one year and was assigned October 1, 2017 as her disability review date.
2. On October 27, 2016, Petitioner applied for disability with the Social Security Administration (SSA). On March 10, 2017, SSA denied Petitioner's application with reason code N36 (NONPAY Insufficient or no medical data furnished, no visual impairment.), see Respondent's Exhibit 4.
3. Petitioner [REDACTED] is 60. She does not meet the aged criteria for SSI-Related Medicaid benefits. She is not pregnant, has no minor children and does meet

the technical requirement for Family-Related Medicaid. Petitioner did not allege blindness. Disability must be established to determine Medicaid eligibility.

4. 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. DDD conducts disability reviews regarding Medicaid eligibility for individuals applying for disability benefits under the state MEDS-AD, Medically Needy, and Emergency Medicaid for Alien Programs. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and effectuation of any benefits due.

5. On March 7, 2018, the DR submitted an online application requesting Medicaid benefits through the Department's SSI-Related Medicaid Program. On that application, the DR reported that Petitioner was disabled and was receiving \$1,900 in Social Security (SS) benefits. Applications are good for sixty days. The 60<sup>th</sup> day of this application is May 6, 2018. Work Item Details screens indicate that Petitioner was not pended for an interview, see Respondent's Exhibit 3, pages 1-2.

6. On April 9, 2018, the Department sent Petitioner a Notice of Case Action indicating that her March 7, 2017 application for SSI-Related Medicaid was denied because she failed to complete an interview necessary to determine her eligibility for the program.

7. Respondent explained that it denied Petitioner's SSI Related Medicaid application because SSA data exchanges did not confirm that Petitioner was disabled as alleged on the application and that SSA has determined that the medical information she submitted was not sufficient enough for them to determine whether or not she was

disabled. Additionally, she explained that Petitioner was denied by SSA less than a year from the application date. She explained, once SSA reached that decision, Respondent was forced to close SSI Medicaid previously approved for Petitioner based on a favorable disability decision from DDD. She explained that SSA decision invalidates the DDD decision and must be accepted by the Department as final. Respondent explained that since Petitioner has failed to submit to a disability interview, a DDD review could not be initiated, resulting in Petitioner's application being denied. She further explained that since Petitioner's March 7, 2018 is over sixty days, she will need to reapply.

8. The DR asserted that Petitioner was eligible for Medicaid last year and was not aware that SSA has denied her claim for disability. She explained that she has lost contact with Petitioner and was unable to ascertain her current conditions. The DR maintains that Petitioner's previous favorable DDD decision should be valid on its own, independent from the SSA decision. She is seeking Medicaid coverage to pay Petitioner's medical services.

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

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

11. Medicaid eligibility is based on federal regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents, children, and pregnant women, and (2) Adult-Related (referred to as SSI-Related Medicaid) for disabled adults and adults 65 or older.

12. Fla. Admin. Code R. 65A-1.703, Family-Related Medicaid Coverage Groups, in part states:

(1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule...

(5) Medicaid for pregnant women...

13. The evidence submitted establishes that Petitioner does not have a minor child in the home and is not pregnant. She is not age 65 or older and has not been considered disabled by the SSA. Therefore, the Department considered Petitioner for SSI-Related Medicaid.

14. The Fla. Admin. Code, Section 65A-1.710 et seq., sets forth the rules of eligibility for Elderly and Disabled Individuals Who Have Income of Less Than the Federal Poverty Level. For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. This regulation defines disability as follows:

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 which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy...

15. Federal Regulations at 42 C.F.R. § 435.540(a) sets forth the definition and determination of disability and states, “the agency must use the same definition of disability as used under SSI...”
16. Federal Regulations at 42 C.F.R. § 435.541 “Determination of Disability,” states:
- (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
    - (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.
  - (b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-
    - (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
    - (ii) If the SSA determination is changed, the new determination is also binding on the agency.
    - (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except In cases specified in paragraph (c) (4) of this section.
  - (c) ***Determinations made by the Medicaid agency.*** The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:
    - (1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; **or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability [emphasis added].**
17. The Department’s Program Policy Manual (The Policy Manual), CFOP 165-22 at passage 1440.1204 “Blindness/Disability Determinations (MSSI, SFP)” states that “If

Social Security determines that an individual is not disabled, the decision generally replaces that which was made by the state.”

18. 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.

19. The Policy Manual at passage 1440.1206 Change in Disability Determination by SSA (MSSI, SFP) states:

When the Social Security Administration (SSA) renders a disability decision that is different than that made by DCF, the SSA decision must be adopted unless the SSA decision was based on a condition different than that which the state reviewed.

If SSA determines the individual is not disabled or that the disability has ceased, action must be taken to close the SSI-Related Medicaid benefits on FLORIDA that are based upon disability, allowing for ten days advance notice of adverse action. Should the individual file a timely appeal with SSA, Medicaid benefits must be continued, pending a final decision by SSA.

If SSA renders a favorable disability decision on a case previously determined not disabled by the Department, the Department must adopt the SSA decision. Standard application processing policy applies.

20. In this instant case, SSA has determined that Petitioner's medical information was insufficient to determine whether or not she was disabled months after receiving a favorable decision from DDD. Additionally, Respondent testified that Petitioner's application for SSI-Related Medicaid was denied because she failed to show up for her interview, however there is no evidence to support that an interview notice was sent to her.

21. The findings also show that the SSA decision adopted was N36, insufficient evidence. Without sufficient information, the SSA decision would not be based on a disability determination (Five-Step). Since Petitioner was denied by SSA due to "insufficient evidence (N36)" this would not be considered a decision on disability. So, Respondent cannot adopt an "insufficient evidence" decision as final. Besides, Respondent provided no evidence that an interview notice was sent to Petitioner.

22. In careful review of the cited authorities, evidence and testimony, the undersigned concludes Petitioner has met her burden of proof by demonstrating that Respondent incorrectly denied her request for the SSI-related Medicaid Program.

23. Therefore, the undersigned remands the case to Respondent for further development. In accordance with the controlling legal authorities, Respondent is hereby

ordered to send the appropriate interview notice to Petitioner, which is required to initiate an independent disability review. Respondent shall issue a Notice of Case Action when the review is completed and said notice shall include appeal rights.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is REMANDED to the Department for an independent disability determination protecting the March 7, 2018 application date. Once the new review is completed, Respondent shall issue written notice including appeal rights to the petitioner.

**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 July, 2018,

in Tallahassee, Florida.



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

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

**FILED**

Aug 22, 2018

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-03185

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 05 Sumter  
UNIT: 09ICP

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 19, 2018 at 2:30 p.m.

**APPEARANCES**

For Petitioner: [REDACTED], Petitioner's Representative

For Respondent: Stan Jones, Economic Self Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner appeals Respondent's action denying her Institutional Care Program (ICP) Medicaid application. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

Pursuant to notice, the undersigned initially set this appeal for hearing for June 7, 2018 at 8:30 a.m. On June 6, 2018, Petitioner's representative requested a

continuance, of which Respondent indicated no objection. Pursuant to notice, the June 7, 2018 hearing was continued for July 19, 2018 at 2:30 p.m.

Petitioner submitted one exhibit, which was entered into evidence and marked as Petitioner's Exhibit "1." Respondent submitted five exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" – "5." The record remained open until 5:00 p.m. on July 20, 2018 for Respondent to provide additional supporting evidence. On July 19, 2018, Respondent timely submitted eight additional exhibits, which were entered into evidence and marked as Respondent's Exhibits "6" – "13." The record closed on July 20, 2018.

#### **FINDINGS OF FACT**

1. Petitioner was admitted to [REDACTED] on March 25, 2017 (Respondent's Exhibit 2, Page 3).
2. On August 28, 2017, Petitioner's representative submitted an initial application for ICP Medicaid benefits on Petitioner's behalf (Respondent's Exhibit 6).
3. The August 28, 2017 ICP application indicated Petitioner had no assets and received Social Security Income in the monthly amount of \$1,800.00 (*Id.* at 4 – 5).
4. On February 8, 2018, Petitioner's representative submitted a subsequent application for ICP Medicaid benefits on Petitioner's behalf (Respondent's Exhibit 2).
5. The February 8, 2018 ICP application indicated Petitioner had no assets and received no earned or unearned income (*Id.* at 3 - 4).
6. On April 13 and June 28, 2018, Petitioner's representative submitted two additional applications for ICP Medicaid benefits on Petitioner's behalf (Respondent's Exhibits 11 & 12).

7. While processing Petitioner's ICP applications, Respondent learned of two pension incomes in addition to the Social Security income reported on the August 28, 2017 ICP application (Respondent's Exhibit 5, Page 4).

8. On February 12, 2018, Respondent mailed a Notice of Case Action (NOCA) to Petitioner, and to a CCC representative, at CCC's address of record requesting the following information by February 22, 2018:

Please complete and sign the Informed Consent Form  
Please complete and sign the Affidavit for Designated Representative Form

The following information is needed to complete this application: signed financial release/ 8-2017 to current bank statements (bank name on all pages)/ verification of all income & all assets which included life insurance/face/cash value (2018){NOTE\*copies of check, direct deposit on bank statements & year-end tax statements 1099\_R forms are not proof}/ proof of any medical or RX premiums / it appears from your application that you may have too much income to qualify for Medicaid services without setting up a qualified income trust. You may wish to seek legal advice to set up an income or Miller trust. Provide a copy of the income trust document, if done by power of attorney need a copy of that document. Provide proof from the bank of the income trust account & all deposits made.

(Respondent's Exhibit 3, Pages 1 – 16).

9. Also, on February 12, 2018, Respondent mailed a NOCA to Petitioner, and to a CCC representative, at CCC's address of record requesting the following information also due by February 22, 2018:

Please Complete and sign the "Financial Information Release" form  
Proof of income and assets for each month you are requesting retroactive Medicaid

(*Id.* at 17 – 28).

10. On March 13, 2018, Respondent mailed a NOCA to Petitioner, and to a CCC representative, at CCC's address of record informing her that her ICP application dated February 8, 2018 was denied for November, 2017 through April, 2018 as Respondent did not receive all information requested to determine eligibility (*Id.* at 29 – 36).

11. Petitioner's representative argued that CCC was initially receiving help from Petitioner's son regarding her ICP Medicaid applications (Petitioner's Testimony), but that he passed away suddenly on December 4, 2017 (Petitioner's Exhibit 1, Page 6).

12. Petitioner's representative also argued that Petitioner passed away on May 8, 2018, making it impossible for them to further verify any of the information requested by Respondent (Petitioner's Testimony).

13. Petitioner's representative further provided a "Certificate of Incapacity" signed by a physician at Brownwood Care Center, dated April 14, 2017 (Petitioner's Exhibit 1, Page 5), and argued this should exempt Petitioner from the verification requirements for her ICP Medicaid eligibility (Petitioner's Testimony).

14. Respondent argued that only individuals in a comatose state are exempt from the verification requirements for ICP Medicaid eligibility (Respondent's Testimony).

15. Respondent further argued, that even if Petitioner's income could be verified, there is no way to create the necessary qualified income trust that would allow for Petitioner's ICP Medicaid eligibility now that she is deceased (*Id.*).

#### **CONCLUSIONS OF LAW**

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

section 409.285 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.

17. This hearing was held as a de novo proceeding pursuant to Florida

Administrative Code Rule 65-2.056.

18. Florida Administrative Code Rule 65A-1.710 defines SSI-Related Medicaid

Coverage Groups and states in relevant part:

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

...

(2) Institutional Care Program (ICP). A coverage group for institutionalized aged, blind or disabled individuals (or couples) who would be eligible for cash assistance except for their institutional status and income as provided in 42 C.F.R. §§ 435.211 and 435.236. Institutional benefits include institutional provider payment or payment of Medicare coinsurance for skilled nursing facility care.

19. The Code of Federal Regulations Title 20, Section 416.1100, Income and SSI

eligibility, as referenced in the Florida Administrative Code Rule 65A-1.713 below,

states in relevant part:

You are eligible for supplemental security income (SSI) benefits if you are an aged, blind, or disabled person who meets the requirements described in subpart B and who has limited income and resources. Thus, the amount of income you have is a major factor in deciding whether you are eligible for SSI benefits and the amount of your benefit. We count income on a monthly basis. Generally, the more income you have the less your benefit will be. If you have too much income, you are not eligible for a benefit...

20. Florida Administrative Code Rule 65A-1.713, SSI-Related Medicaid Income

Eligibility Criteria, states in relevant part:

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

...

(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.

...

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. §416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:

(a) In-kind support and maintenance is not considered in determining income eligibility.

(b) Exclude total of irregular or infrequent earned income if it does not exceed \$30 per calendar quarter.

(c) Exclude total of irregular or infrequent unearned income if it does not exceed \$60 per calendar quarter.

(d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS.

(e) Interest and dividends on countable assets are excluded, except when determining patient responsibility for ICP, HCBS and other institutional programs.

21. The above cited authorities state that an ICP Medicaid applicant's income is an integral part of determining an applicant's eligibility for ICP Medicaid benefits. Therefore, Respondent was correct to request verification of Petitioner's income received through her pension accounts and through Social Security.

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

(1) (a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time. If the information,

documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.

...

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension...

23. The above cited authority states that it is Petitioner's responsibility to furnish information needed to establish eligibility. If Respondent determines that additional information is required to establish eligibility, it must notify Petitioner so that he, or she, can provide the requested information. Though Respondent is directed to provide assistance in obtaining verification when requested, the ultimate responsibility for providing this verification rests with Petitioner. If Petitioner does not provide required verifications or information the application will be denied.

24. As required, on February 12, 2018, Respondent notified Petitioner that it required verification of her income in order to establish eligibility. Respondent provided additional time, based on subsequent ICP applications, for Petitioner to provide the required income verification to determine eligibility. However, ultimately the responsibility to

provide verification rested with Petitioner and she failed to provide the required verification.

25. The ACCESS Florida Program Policy Manual, Section 1640.0319, [REDACTED] Individual, states, “[a]ny asset owned by a [REDACTED] individual will be excluded when there is no known legal guardian or other individual who can access the asset.”

26. The above exclusion applies only to assets. There is no related policy that applies to income. As Petitioner’s ICP Medicaid application was primarily denied for failure to provide income verification or proof of a qualified income trust, Petitioner’s argument that her incapacitation should exclude her from the verification requirements is moot.

27. In careful review of the cited authorities and evidence, the undersigned concludes Petitioner did not meet her burden of proof that Respondent’s action denying her February 8, 2018 ICP Medicaid application was incorrect. The undersigned concludes Respondent’s action denying Petitioner’s February 8, 2018 ICP Medicaid application, due to failing to provide verification of her income, 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 22 day of August, 2018,

in Tallahassee, Florida.



Erik Swenk, Esq.  
Hearing Officer  
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1317 Winewood Boulevard  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Jul 17, 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-03215

PETITIONER,

Vs.

CASE NO. [Redacted]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 19 St. Lucie  
UNIT: 88651

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on May 16, 2018, at 9:30 a.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner:      Petitioner was present, but verbally authorized [Redacted] to speak on her behalf.

For the Respondent:      Patricia Roy, DCF supervisor

**STATEMENT OF ISSUE**

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

**PRELIMINARY STATEMENT**

The Florida Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid Programs. To be eligible an individual must be blind, disabled, or 65 years or older. The Division of Disability Determination (DDD) conducts disability reviews regarding Medicaid eligibility for individuals applying for disability benefits under the state MEDS-AD, Medically Needy, and Emergency Medicaid for Alien (EMA) Programs. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and effectuation of any benefits due.

Rebecca Sills, DDD Program Administrator, appeared as a witness for the Department.

At the hearing, Petitioner submitted a 39-page document which was accepted into evidence and marked as Petitioner's Composite Exhibit 1. Respondent submitted seven (7) exhibits which were accepted and marked as Respondent's Exhibits 1 through 7. Exhibit 7 is a composite exhibit related to the information DDD used to make its disability determination.

**FINDINGS OF FACT**

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

1. Prior to the issue under this appeal, Petitioner had been suffering from low back pain. Her medical records show the following medical issues and their onset dates:

<u>Problem Description</u>	<u>Onset date</u>	<u>Chronic</u>
----------------------------	-------------------	----------------

	8/10/2017	N
---	-----------	---

[REDACTED] knee, subsequent encounter	11/14/2016	N
[REDACTED]	08/10/2017	N
[REDACTED]	08/10/2017	N
[REDACTED]	08/02/2017	N
[REDACTED], initial encounter	08/02/2017	N
[REDACTED], left initial encounter	11/11/2015	N
[REDACTED]	11/11/2015	N
[REDACTED], unspecified ligament, subsequent encounter	12/05/2016	N
[REDACTED]	06/14/2017	N

2. Petitioner has previously applied for Social Security disability (SSD) with Social Security Administration (SSA) in 2016 and was denied. SSA considered [REDACTED] [REDACTED], in addition to Fibroid, Fibromyalgia and Chronic fatigue. Petitioner has appealed the SSA decision.

3. Petitioner [REDACTED] is 53-year old female with 12 years of educational experience. She does not meet the aged criteria for SSI-Related Medicaid benefits. She is not pregnant; does not have a minor child and no longer meets the technical requirement for the Family-Related Medicaid category. Petitioner did not allege blindness. Disability must be established to determine Medicaid eligibility.

4. Petitioner is not currently employed, but previously worked as a housekeeper, an office assistant and a convenience store clerk for more than 15 years. She last worked in November 2016.

5. On January 30, 2018, Petitioner, then 52 years old, submitted an online application for Medicaid benefits through the Department's SSI-Related Medicaid Program.
6. On February 15, 2018, the Department initiated a disability review on Petitioner. Information obtained from Petitioner was forwarded to DDD for review.
7. DDD utilizes a federally regulated five-step sequential evaluation in determining disability. Below are the steps that are followed and what is evaluated in each step:
  - Is impairment severe? Yes.
  - Is it expected to last more than a year?
  - Does the impairment meet or equal a disability listing in the federal regulation? .
  - Can claimant perform previous related work (PRW)?
  - Can claimant perform other work?
8. DDD's Physical Residual Functional Capacity (PRFC) Assessment dated March 29, 2018, determined that all of Petitioner's recent physical exams are within normal limits with normal gait and no neurological deficits. Therefore, Petitioner is capable of:
  - Occasionally lift and/or carry 10 pounds.
  - Frequently lift and/or carry 10 pounds.
  - Stand and/or walk (with normal breaks) about 2 hours in an 8-hour workday.
  - Sit (with normal breaks) about 6 hours in an 8-hour workday.
  - Push and/or pull (included operation of hand and/or foot controls) as unlimited, other than as shown for lift and/or carry.
9. DDD Medical Evaluation Form dated March 29, 2018 indicates the following entry:

Subject:

Assessment: 52 YO alleging [REDACTED] Clmt reports past work as an office assistant, and reports a 12th grade education.

Is the impairment severe? Yes- [REDACTED]  
Meet or equal a listing? No [REDACTED]

ADLs: Clmt reports that bathing and dressing herself is difficult due to back pain, so her boyfriend needs to help her wash her hair and tie her shoes. Clmt reports that she's able to make simple meals for herself, but cannot stand for longer than 10 minutes. Clmt reports that she cannot do any household chores due to back pain. Clmt reports that she's able to drive short distances and uses an electric cart when grocery shopping. Clmt reports that she requires a walker, but that it was not prescribed. Clmt reports that she doesn't require it all the time, only when she knows that she's going to walk long distances. Clmt estimates that 15lb is the most that she's able to lift. Clmt reports that she does not go to church or participate in any other hobbies due to severe anxiety being around a crowd of people.

Physical: Clmt was evaluated by Dr. Rousch on 11/27/17 Clmt reported knee pain associated with a work injury and low back and hip pain. Clmt has PMH of low back pain which was treated with nerve blocks, which she reported had little to no relief. Upon evaluation clmt was noted to be wearing a knee brace. PE revealed normal strength in all extremities, with some resistance. Negative Hoffmann, negative clonus, negative babinski. Decreased sensory of R thigh. Tenderness over lumbar spine with palpable muscle spasms. positive SLR at 60 degrees in R and negative on L. Negative faber's. Decreased ROM due to pain of R hip. [REDACTED] Negative Lechman's and positive McMurray's. MRI of spine dated 8/7/17 revealed [REDACTED] At L3-4 there is a [REDACTED] and annular tear is noted. [REDACTED] MRI of R hip dated 8/4/17 [REDACTED] Clmt was also seen by [REDACTED] on 8/2/17 with complaint of R hip pain. PE revealed normal gait, passive and painful ROM of R knee.

Mental: The case was reviewed by Thomas L. Clark, PhD., who determined that the clmt's mental impairments are not severe- see PRTF.

Summary: Based on the available evidence, clmt's impairments do not meet or equal a listing at this time. Clmt is given a sedentary RFC. Therefore, according to vocational guidelines (voc rule 201.15) clmt is found to be NOT DISABLED. Therefore, clmt has the ability to return to past work. N31\*

10. Psychiatric Review Technique Form (PRTF) dated March 28, 2018 by Thomas Clark, Ph.D. addresses Petitioner's mental impairment. DDD finds that a medically determinable impairment is present, but it does not precisely satisfy the criteria for [REDACTED]. Petitioner's mental impairment was rated as being "not severe". The categories upon which the PRTF is based [REDACTED]. Petitioner shows no limitation when it comes understanding, remembering and applying information and adapting and managing herself. She was given a mild rating as far as difficulties in maintaining concentration, persistence, and pace and interacting with others. She was evaluated under listings of impairment 12.04.

CONSULTANT'S NOTES

[REDACTED] of recent onset in contest of injury at work with persisting physical symptoms and restrictions to activities. She was at work as recently as six months ago, with persistence severely limited by pain. Ongoing treatment records reveal good partial remission of her mood symptoms. She is broadly functional within her physical tolerance, with no more than mild limitations in functioning attributable to her mental illness per se. Not severe.

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

Step 1: Engaging in SGA. **N/A**

Step 2: Is there a MDI? **Yes**

Step 3: Does this impairment meet or equal a listing? **No**

Step 4: Is the claimant able to perform PRW? **Yes**

Step 5: was not completed.

12. DDD asserts Petitioner's condition is not serious enough to meet eligibility in the SSI-Related Medicaid, in that she has enough physical and mental functional capacities to perform substantial gainful activity. The witness testified that Petitioner's most recent medical records were reviewed and all relevant medical information was considered before issuing a decision.

13. Respondent's witness further testified that Petitioner maintains the functional capacity to perform light physical exertion and a full range of light work consistent with vocational rule 201.15 (Skilled or semiskilled—skills transferable). Light physical exertion entails having the capacity to stand and walk for six hours in an eight-hour day, lift 10 lbs. occasionally, and 10 lbs. frequently. Respondent's witness argued that Petitioner's skills are transferable and that she should be capable of performing the same types of jobs she is used to perform.

14. DDD reviewed Petitioner's medical records and determined that her conditions were not severe enough to prevent her from engaging in substantial gainful activity (SGA).

15. On March 29, 2018, DDD denied Petitioner's Medicaid Disability with reason code N31-NON-PAY "capacity for substantial gainful activity (SGA) -(customary past work, no visual impairment)".

16. On April 2, 2018, the Department mailed Petitioner a Notice of Case Action informing her that her January 30, 2018 Medicaid application was denied, "Reason: you or a member(s) of your household do not meet the disability requirement", see Respondent's Exhibits 1 through 6. On April 23, 2018, Petitioner timely requested a hearing.

17. Petitioner asserted that her current conditions are worsening by the day and that she has been avoiding appointments because she cannot afford to pay for doctors' visits. That she is constantly in pain and needs to rest on a regular basis. Petitioner maintains that she is physically and mentally unable to work. She is capable of functioning independently outside of her home and has not been hospitalized for a mental impairment within the past year.

18. On April 18, 2018, Petitioner was diagnosed with b [REDACTED]  
[REDACTED] That diagnosis was made after DDD rendered its decision. After discussing the risks benefits and alternatives to [REDACTED], Petitioner has elected to proceed with surgery, see Petitioner's Composite Exhibit 1 pages 22-27. She will report this condition to SSA. She is seeking Medicaid coverage to pay for much needed medical services while waiting on her disability appeal with SSA.

**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 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
20. This proceeding is a de novo proceeding pursuant to Florida Administrative Code R. 65-2.056.
21. Medicaid eligibility is based on federal regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents, children, and pregnant women, and (2) Adult-Related (referred to as SSI-Related Medicaid) for disabled adults and adults 65 or older.
22. Florida Administrative Code Rule 65A-1.703, Family-Related Medicaid Coverage Groups, in part states:
- (1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule...
  - (5) Medicaid for pregnant women...
23. The evidence submitted establishes that Petitioner does not have a minor child in the home and is not pregnant. She is not age 65 or older and has not been considered disabled by the SSA. Therefore, the Department considered Petitioner for SSI-Related Medicaid.
24. 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 are less than

65 years of age, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in 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.)

25. Federal Regulation 42 C.F.R. § 435.541(d)(2) provides that a state Medicaid determination of disability must be “in accordance with the requirements for evaluating evidence under the SSI program specified in 20 CFR 416.901 through 416.998.”

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

(a) General—(1) Purpose of this section. This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in § 416.905.

(2) Applicability of these rules. These rules apply to you if you are age 18 or older and you file an application for Supplemental Security Income disability benefits.

(3) Evidence considered. We will consider all evidence in your case record when we make a determination or decision whether you are disabled.

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

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. (See paragraph (f) and (h) of this section and § 416.960(b).)...

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. (See paragraph (g) of this section and § 416.960(c).)

(c) You must have a severe impairment. If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience.

27. The cited authority sets forth the five steps of a disability assessment. In evaluating Petitioner’s claim of disability, the sequential evaluation as set forth in 20

C.F.R. §416.920 is used.

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

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

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

[REDACTED]

31. Regarding Section [REDACTED] (specifically listing 1.04) the requirements are as follows:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

32. In terms of physical health, Petitioner remains quite functional. While she does have a history of musculoskeletal issues, her impairments do not rise to the level of severity required in listing 1.00. Petitioner is broadly functional within her physical tolerance, with no more than mild limitations in functioning.

33. Regarding Section 12.00: Mental Disorders-12.04 [REDACTED]

[REDACTED] (see 12.00B3), satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1 or 2:

1. [REDACTED]

[REDACTED]

[REDACTED]

B. [REDACTED]

[REDACTED]

[REDACTED]

34. The objective medical evidence failed to showed any one extreme limitation or marked limitation of two of the following areas of mental functioning: 1) Understand, remember and apply information, 2) Interact with others, 3) Concentrate, persist, or maintain pace, and 4) Adapt or manage oneself as required under this "listing". The evidence also failed to show a medically documented history of a [REDACTED] [REDACTED] of at least two years duration that has caused more than a minimal limitation of ability to do basic work activities with symptoms or signs currently attenuated by medication or psychosocial support. Accordingly, Petitioner's impairments do not rise to the level of severity required for the above listing.

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

36. Regarding Section [REDACTED] which affect "cognitive limitations, mood disorders, and anxiety under 12.00" and

[REDACTED]

[REDACTED]”. These two listings were already addressed separately and together.

37. The fourth step requires determining whether Petitioner can still do past relevant work based on her residual functional capacity. The DDD assessment indicates petitioner appears capable of doing past work in the national economy. Since Petitioner has some mild restrictions in concentration, persistence & pace (CPP) and was recently diagnosed with [REDACTED], it would be appropriate to move on to step five.

38. The fifth step requires considering Petitioner’s residual functional capacity, age, education, and work experience to determine if she can adjust to other work. The evidence indicates Petitioner is a 53-year-old female with 12 years of educational experience with past relevant work history as a housekeeper, an office assistant or a store clerk. The DDD assessment shows Petitioner would be capable of performing light exertional activity based on her current physical and mental impairments; this is consistent with the cumulative evidence.

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

40. In sum, Petitioner is not eligible for Medicaid under any of the Family-Related coverage groups because she is not pregnant and has no minor children. She is not eligible for Medicaid under the SSI-Related Medicaid coverage group because she is not aged (over 65), blind, and does not meet the disability criteria because she is capable of SGA. The petitioner did not meet her burden of proof. Thus, Petitioner does not meet the technical criteria to receive Medicaid, as she is not considered to be disabled pursuant 20 C.F.R. §416.969.

### **DECISION**

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

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

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

FINAL ORDER (Cont.)

18F-03215

PAGE -16

DONE and ORDERED this 17 day of July, 2018,  
in Tallahassee, Florida.



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Roosevelt Reveil  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Fax: 850-487-0662  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

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

**FILED**

Jul 18, 2018

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-03218

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 05 Hernando  
UNIT: 88129

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 14, 2018 at 1:33 p.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se

For the Respondent: Susan Martin, Operations Management Consultant I

**STATEMENT OF ISSUE**

At issue is whether the respondent's action to close the petitioner's Medicaid at the end of the certification period is proper. 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 packet of documents which were entered into evidence and marked as Respondent's Exhibits "1" through "9."

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner submitted a Medicaid application on April 5, 2016 and was later approved for Medicaid through February 2017. The Department ("DCF") stated that the system automatically extended the petitioner's Medicaid for another year through April 30, 2018 even though she was only eligible for a 12-month certification.

2. The petitioner is 63 years old, lives by herself, and states she was declared permanently disabled by DCF and worker's compensation.

3. The petitioner stated that she applied for Social Security Disability in 2000 but was denied and did not appeal their decision.

4. On March 28, 2018, the Department mailed a Notice of Eligibility Review ("NOER") to the petitioner informing her that benefits will end and to complete and return the enclosed form by April 9, 2018 (Resp. Exh. 6). The petitioner testified that she did not receive this notice and the Department has no record of returned mail (Resp. Exh. 3).

5. On April 19, 2018, the Department mailed a Notice of Case Action ("NOCA") to the petitioner informing her that her Medicaid benefits will end April 30, 2018 as she failed to complete a renewal (Resp. Exh. 7). The petitioner testified that she did not

receive this notice until May 4, 2018. She has been having issues with her mail not coming to her timely and has complained to the postal service multiple times.

6. On April 23, 2018, the petitioner timely requested a hearing.

7. While reviewing the case prior to hearing, the Department discovered that the petitioner had a previous appeal in 2000 that granted disability to the petitioner but does not have record of the disability review date as they do not have the Final Order. The Department contacted the Office of Appeal Hearings and were informed that records are destroyed after five years and that no copy of the final order is available. The petitioner was appalled that no one has her medical information that she has submitted over the past 18 years.

8. On May 7, 2018, the respondent sent paperwork to the Division of Disability Determination (“DDD”) to clarify when she was determined disabled by the Social Security Administration (“SSA”) and when her next review date was but no response was received at the time of the hearing (Resp. Exh. 5). The respondent explained without this information they would still be able to determine if the petitioner was eligible for Medicaid once they received an application for the benefit.

9. The respondent stated that since the petitioner received the full certification period of Medicaid that she would need to submit another application with DCF for Medicaid, complete an interview to determine disability and then attempt to apply for Supplemental Security Income (“SSI”) with SSA.

10. The petitioner stated that she is “not jumping through any more hoops.” She claims that she has not had substantial medical coverage for three years and has not used Medicaid. She also stated that “people that need the care are not getting it” and

that she does not want Medicaid, she just wants to vent. At the time of the hearing, the petitioner had not submitted an application for Medicaid.

### **CONCLUSIONS OF LAW**

11. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding, pursuant to § 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 proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

14. Fla. Admin. Code R. 65A-1.204 Rights and Responsibilities states:

(1) An individual has the right to apply for assistance, to have eligibility determined, and if found eligible, to receive benefits. The applicant for or recipient of public assistance must assume the responsibility of furnishing information, documentation and verification needed to establish eligibility. If the information, documentation or verification is difficult for the individual to obtain, the Department must provide assistance in obtaining it when requested or when it appears necessary.

15. The ACCESS Florida Program Policy Manual ("The Policy Manual") CFOP 165-22, passage 0640.0100 addresses Application for Assistance (MSSI, SFP) states, "An individual must submit an application at initial application, reapplication, and requests for additional types of assistance."

16. The Policy Manual, passage 0840.0100 addresses Eligibility Reviews (MSSI, SFP) and states, "For applications assign a 12-month review period from the month of disposition, unless eligibility does not begin until a future month. At review assign a 12-month review period from the month following disposition."

17. The above-cited authorities state an individual has the right to apply for benefits and the respondent cannot determine eligibility for SSI-Related Medicaid for more than a 12-month cycle. The petitioner was notified that her Medicaid benefits were ending. Even though the petitioner claims she did not receive the NOER, she did receive the NOCA on May 4, 2018. When she received the notice, the petitioner could still apply for benefits and there would not be a lapse in her Medicaid coverage. The petitioner had the responsibility to apply for benefits if she wished to continue receiving them, and she has not submitted a new application for redetermination of Medicaid.

18. In careful review of the cited authorities and evidence, the undersigned concludes the respondent's action to terminate the petitioner's Medicaid was within the rules of the program. The petitioner received more than a full year of SSI-Related Medicaid and has not submitted a new application to have eligibility determined.

### **DECISION**

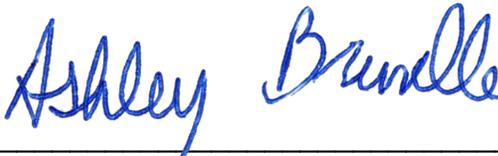
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is hereby denied and the respondent's actions are affirmed.

**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  18  day of  July , 2018,

in Tallahassee, Florida.



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

Jul 23, 2018

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

[REDACTED]

APPEAL NO. 18F-03260

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

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**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 24, 2018 at 1:19 p.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se

For the Respondent: Gayle Stewart, supervisor

**STATEMENT OF ISSUE**

At issue is the respondent's action to terminate the petitioner's Transitional Medicaid. The burden of proof was assigned to the respondent by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The petitioner submitted no exhibits during the hearing. The respondent submitted no exhibits during the hearing. The record was left open through June 7,

2018 for additional information including all Notices of Case Action related to the case, documentation of the petitioner's Medicaid coverage, income standards for Medicaid, Medically Needy (MN) budget, policy related to transitional Medicaid, May 3, 2018 application, and running record comments (CLRC) related to the case beginning May 2017. On May 25, 2018, the respondent submitted a 116-page evidence packet which was marked and entered as Respondent's Exhibit "1" through "21". The record was closed the same day.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner was receiving full Medicaid through the Transitional Medicaid program effective May 2017 (Respondent's Exhibit 12).
2. On April 20, 2018, the respondent sent the petitioner a Notice of Case Action (NOCA) informing her that her Medicaid would end on April 2018, "Reason: Either your 12 months of eligibility will expire or, in accordance with Florida Administrative Code 65a-1.704(3), you did not return your periodic report form" (Respondent's Exhibit 2).
3. The petitioner timely requested the appeal.
4. On May 3, 2018, the petitioner submitted a web application requesting Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits. Medicaid benefits are the only issue (Respondent's Exhibit 21).
5. On May 10, 2018, the petitioner completed an eligibility interview. The petitioner's household included the petitioner and three minor children (DG, KG, DB). The petitioner works and is paid \$250 weekly. The petitioner also received child support (CS) income of \$193 and \$96 for April 2018 for DB. The petitioner stated everyone in the household is tax dependent on her (Respondent's Exhibit 21).

6. The petitioner's income of \$1,000 per month is over the income standard of \$364 per month for an adult in a household of four to be eligible for full Medicaid. MN was explored for the petitioner (Respondent's Testimony).
7. On May 18, 2018, the respondent sent the petitioner a NOCA informing her she would be eligible for Medicaid coverage under the MN program (Respondent's Exhibit 16).
8. The petitioner attests no one told her she would only receive Transitional Medicaid for a year. She states she needs at least six more months of full Medicaid coverage to complete all doctor's visits.
9. The respondent states all Medicaid coverages are reviewed after one year of coverage or sooner if a change occurs in the household.

#### **CONCLUSIONS OF LAW**

10. 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.
11. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.
12. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.
13. The department determines Medicaid eligibility based on the household's circumstances. When the household consists of parents and children, Medicaid eligibility is determined under Family-Related Medicaid policy.

14. Federal regulation 42 C.F.R. § 435.110, Parents and other caretaker relatives, states in pertinent part:

... (b) Scope. The agency must provide Medicaid to parents and other caretaker relatives, as defined in §435.4, and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in the State plan, in accordance with paragraph (c) of this section.

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

...  
(4) Ex Parte Process.  
(a) When a recipient's eligibility for Medicaid ends under one or more coverage groups, the department must determine their eligibility for medical assistance under any other Medicaid coverage group(s) before terminating Medicaid coverage...  
(b) All individuals who lose Medicaid eligibility under one or more coverage groups will continue to receive Medicaid until the ex parte redetermination process is completed.

16. Section 445.029, Fla. Stat., Transitional medical benefits, states in pertinent part:

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

17. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22 at passage 2030.0203, Transitional Coverage (MFAM), defines transitional coverage:

“Transitional coverage provides extended coverage for up to 12 months, beginning with the month of ineligibility...Conditions that must be met: 1. The assistance group must be ineligible for Medicaid based on initial receipt of earned income or receipt of increased earned income by the parent or caretaker relative.”

18. Fla. Admin. Code R. 65A-1.716, Income and Resource Criteria, states in pertinent part: “(2) Medicaid income and payment eligibility standards and Medically Needy

income levels are by family size as follows: Family Size: 4, Monthly Income Level: \$364”.

19. In accordance with the above cited authorities, the income limit for an adult, in a household of four, to be eligible for full Medicaid is \$364. In this instant case, the petitioner’s earned income of \$1,000 per month ( $\$250 \times 4$ ) caused the petitioner to be determined ineligible for full Medicaid. The respondent determined the petitioner’s eligibility under the MN program, prior to terminating the full Medicaid. The petitioner received Transitional Medicaid for twelve months, due to the Medicaid being terminated solely because of income.

20. The respondent provided the transitional coverage beginning May 1, 2017 through April 30, 2018. The respondent is required to provide Medicaid for a minimum of 12 months to all household members once Medicaid is lost due to income, based on Fla. Stat. and department policy.

21. In careful review of the testimony and evidence, the undersigned concludes the respondent provided Transitional Medicaid to the petitioner for 12 months, effective May 1, 2017 through April 30, 2018.

22. Based on the evidence and cited authorities, the undersigned concludes the respondent’s action to terminate the petitioner’s Transitional Medicaid 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 23 day of July, 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**

Jul 18, 2018

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

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-03305

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 20 Lee  
UNIT: 88287

RESPONDENT.

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**FINAL ORDER**

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on May 30, 2018 at 12:32 p.m. All parties appeared by telephone from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED] spouse

For the Respondent: Ed Poutre,  
Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of February 2, 2018, enrolling him into the Medically Needy Program (MN) with a Share of Cost (SOC) rather than approving him 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.

████████████████████ with Propio Language Services provided interpreter services for the pre-hearing conference and the first few minutes of the hearing. Jorge ██████████ with Language Line Solutions provided interpreter services for the remainder of the hearing.

The Department presented evidence which was marked and accepted as Respondent's Exhibits "1" through "8" respectively. The record was held open through June 8, 2018 to allow the Petitioner to submit unpaid medical expenses. No bills or expenses were received. The record was closed on June 8, 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 applied for Medicaid and Supplemental Nutrition Assistance Program (SNAP) benefits on January 22, 2018, see Respondent's Exhibit 3.
2. At the time of the application, the petitioner was 48-years-old, disabled and his household consisted of himself, his wife, age 53, and two children ages 18 and 12.
3. On January 31, 2018, the petitioner submitted another application for Supplemental Security Income-Related (SSI) Medicaid for himself, see Respondent's Exhibit 1. The respondent processed the January 22, 2018 application and noted in the CLRC comments that the January 31, 2018 application was a duplicate, see Respondent's Exhibits 1 & 8.

4. The household's income is Social Security Disability Income(SSDI) of \$1,028 for the petitioner and \$313 in Social Security Survivor's (SSA) benefits for the 12-year-old.

5. On February 1, 2018, the Department approved the petitioner's household for SNAP benefits of \$467 effective March 2018 and full Medicaid for the 12-year-old and enrollment in the Medically Needy(MN) program with an estimated SOC for the petitioner, his wife and the 18-year-old.

6. On February 2, 2018, the Department sent a Notice of Case Action (NOCA) to the petitioner informing the household of its eligibility determination.

7. On April 25, 2018, the petitioner appealed his enrollment into the MN program. The approval of the SNAP benefits and the enrollment of his spouse and 18-year-old into the MN program are not under appeal, Petitioner's testimony.

8. The petitioner argues that he was in receipt of full Medicaid and he needs full Medicaid not MN Medicaid. His doctors will not accept the MN Medicaid until he meets the SOC and he has limited income and cannot afford the monthly out-of-pocket expenses. He believes that he should be eligible for full Medicaid.

9. The respondent explained that the petitioner was formerly in receipt of SSI until February 2018. Because he was approved for Social Security Disability Income (SSDI), he was no longer eligible for SSI or SSI-Related Medicaid as the amount of his SSDI is greater than the SSI maximum amount. Therefore, the petitioner was enrolled into the MN program with a SOC.

10. Based on his income, the petitioner's SOC was computed to be \$828, see Respondent's Exhibit 5.

11. The Department stated that on May 23, 2018, the petitioner's pharmacy submitted a bill for tracking for over \$2,000 which met the SOC for May and the petitioner was eligible for benefits May 23, 2018 through May 31, 2018. The petitioner stated that he still has an outstanding bill from [REDACTED] for over \$5,000 received on May 10, 2018. The Department countered that that bill has not been submitted for tracking as of the date of the hearing. If submitted, the petitioner's eligibility would begin from the earlier date, Respondent's and Petitioner's testimony.

12. The respondent explained the petitioner's budget as follows:  
The petitioner's total countable income as \$1,008, after a \$20 unearned income disregard was subtracted from his \$1,028 SSDI benefits. The income standard for an aged/disabled individual to receive full Medicaid is \$885. The petitioner's total countable income is above this amount, he is not eligible for full Medicaid benefits because he is over the income standard.

13. The respondent therefore enrolled the petitioner in the MN Program. To determine the \$828 SOC amount, the respondent determined the Medically Needy Income Level (MNIL) for a household size of one is \$180, this amount was subtracted from \$1,008.

\$1,028	unearned income
- 20	unearned income disregard
<hr/>	<hr/>
\$1,008	countable unearned income
\$1,008	countable unearned income
- 180	medically needy income limit for household of one
<hr/>	<hr/>
\$ 828	share of cost

14. Although the petitioner testified to out-of-pocket medical expenses, no medical bills or receipts were provided for the undersigned to review.

**CONCLUSIONS OF LAW**

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

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

17. Fla. Admin. Code R. 65A-1.710, 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.

18. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI-Related Medicaid programs:

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

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

...

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

19. The Social Security Administration's Program Operations Manual System (POMS), SI 00501.154(3)(b) Determining When Couple Computation Rules Apply states in pertinent part:

If couple computation rules do not apply for the month based on SI 00501.154A.2.a., SI 00501.154A.2.b., or SI 00501.154A.2.c., and if one spouse is ineligible for any reason (except deeming), his/her income and resources are deemed to the other spouse for the month.

20. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage, 2240.0610 Couple/One Requests Medicaid (MSSI) states:

The following policy is applicable ... to ... Medically Needy...  
If an individual is living with their spouse and only one is requesting or receiving Medicaid (or the spouse does not meet the technical criteria for the program), the income and assets must be deemed from the spouse who is not requesting assistance (or who does not meet the technical criteria). If there is not enough income to be deemed, the income standard for one is used.

21. According to the above authorities, the spouse is ineligible for SSI as she is not aged, disabled or blind, consequently her income and resources are deemed to her husband. As she has no income, she has failed the deeming test (she does not have any excess income to provide to her husband) and he is therefore treated as a household of one.

22. The Code of Federal Regulations 20 C.F.R. § 416.1124 (c)(12), Unearned Income we do not count, states in part, "The first \$20 of any unearned income in a month..."

23. Accordingly, the respondent excluded the first \$20 of the petitioner's SSDI of \$1,028 leaving a net balance of \$1,008.

24. Fla. Admin. Code R. 65A-1.701(20) defines MEDS-AD Demonstration Waiver as:

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.

25. 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.

26. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI-Related Medicaid programs:

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

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

...

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

27. The Policy Manual, CFOP 165-22, Appendix A-9, sets forth the income standards for MEDS-AD for an individual, effective January 2018, as \$885.

28. The above controlling authorities explain that the full coverage Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-Related program is for individuals who are not receiving Medicare and whose income does not exceed 88% of the poverty level. The above authorities also explain that the Medically Needy program is for aged, blind or disabled individuals who do not qualify for full Medicaid due to their income. The income standard for the MEDS-AD program is set at \$885 for an individual. The findings show that the petitioner is not receiving Medicare but his income of \$1028 (at the time of the Department's action in February 2018) exceeds the guidelines set for the program. Therefore, the undersigned concludes that the petitioner does not qualify for full-coverage Medicaid.

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

30. Fla. Admin. Code R. 65A-1.716(2), Income and Resource Criteria, states in relevant part:

Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

<u>Family Size</u>	<u>Income Level</u>
1	\$180

31. The respondent determined the petitioner's SOC by using his monthly SSDI of \$1,028 minus the \$20 unearned income disregard to calculate his total countable

income of \$1,008. The respondent then subtracted the \$180 MNIL from his \$1,008 total countable income, which resulted in his SOC of \$828. The petitioner did not submit any recurring medical expenses or outstanding medical bills to the respondent for further reduction of the SOC.

32. The Policy Manual, CFOP 165-22, passage, 2240.0601 Family and SSI-Related Medicaid Groups states:

Sometimes a family has members who are requesting or receiving assistance in both Family and SSI-Related coverage groups. This occurs due to the TCA standard filing unit policy and SSI budgeting requirements and when SSI income policy is more advantageous to the SSI-Related Medicaid member. When this happens, one or more members must be included in two SFUs, although they would be eligible for only one type of coverage.

33. The Policy Manual, CFOP 165-22, passage, 2240.0602 Example of Dual SFU (MSSI) states:

A family consisting of two parents (married to each other) and their two mutual children apply for assistance. The father is disabled.... All family members' needs, income, and assets would be considered in determining eligibility for the Family-Related Medicaid group. Both parents must be treated as a couple and their needs, income, and assets would be considered in determining the father's eligibility for MSSI.

34. As the petitioner has children in the household, a more advantageous share of cost may be possible for the petitioner under the Family-related Medicaid Program.

16. Fla. Admin. Code R. 65A-1.707 addresses Family-Related Medicaid and Income Resource Criteria, stating in pertinent part:

(1)(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. To be financially eligible for family-related Medicaid, except for Medically Needy

coverage, the coverage group's gross income minus the \$90 earned income disregard cannot exceed the consolidated need standard (CNS) (100% of the federal poverty level). For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C. For the CNS criteria, refer to subsection 65A-1.716(1), F.A.C. For the payment standard income levels, refer to subsection 65A-1.716(2), F.A.C.

35. The Policy Manual, CFOP 165-22, section 2030.1000 "NON-PREGNANT ADULT AND CHILDREN (MFAM)" states in part, "Parents, caretaker relatives, and their children under age 18 may receive 1931 Medicaid coverage when household income is equal to or below the payment standard and the \$2,000 asset limit. For two-parent families, at least one child must be a mutual child, who cannot be an unborn child."

36. The Policy Manual, CFOP 165-22, at A-7 shows that for a household of four the payment standard is \$364.

37. Countable household income of \$1,341 exceeds the \$364 Family-Related Medicaid income limit for four people. The above authority explains for non-pregnant adults in the family-track Medicaid Programs, the income must be below the applicable payment standard.

38. Fla. Admin. Code R. 65A-1.713 sets forth income budgeting and the methods of determining the share of cost and states in relevant part:

(c) Medically Needy. The amount by which the individual's 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 Rule 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. 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...

39. The Policy Manual, CFOP 165-22 at A-7 shows that for a household of four the Medically Needy Income Limit (MNIL) is \$585.

40. The Department's Transmittal C-16-09-0008, states in part:

**Medically Needy Program**

When determining eligibility for the Medically Needy Program, exclude a child with countable income from the Medically Needy budget if it is beneficial to the individual whose eligibility is being determined (i.e. a lower share of cost).

41. The coverage group's countable income of \$1,341 minus the child's income of \$313 equals the gross income of the petitioner of \$1028. The petitioner's income of \$1,028 less the MNIL of \$585 for four people results in a share of cost of \$443.

42. The undersigned concludes that the petitioner has a more advantageous SOC in the Family-related Medically Needy coverage group as the Family-related SOC is \$443 compared to the SSI-related SOC of \$828. that the Department's share of cost calculation under the Family-related Medicaid program is correct.

43. Based on the above rules, regulations and statutes, the undersigned concludes that the respondent correctly determined that the petitioner is not eligible for full Medicaid due to his income and correctly enrolled him into the MN program with a SOC. Further, the undersigned concludes that a more favorable outcome is available by using the Family-related Medicaid budgeting for the petitioner's Medically Needy SOC.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are decided as follows:

- 1) The Medicaid appeal is denied.
- 2) The appeal is granted for the petitioner. He has a more advantageous share of cost in the Family-Related Medically Needy coverage group as explained in the Conclusions of Law. The Department is to take corrective action and redetermine the Medically Needy coverage under the Family-related program for petitioner. A new notice is to be issued once the redetermination is complete.

**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 July, 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

FINAL ORDER (Cont.)

18F-03305

PAGE -13

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

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

**FILED**

Jul 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-03309

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 18 Brevard  
UNIT: 88991

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 12:15 p.m. on June 8, 2018.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:

Stan Jones, ACCESS  
Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

At issue is whether the respondent's (Department) action to deny the petitioner Institutional Care Program (ICP) Medicaid for March 2018, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The petitioner submitted two exhibits, entered as Petitioner Exhibits "1" and "2".  
The respondent submitted six exhibits, entered as Respondent Exhibits "1" through "6".  
The record was closed on June 8, 2018.

### **FINDINGS OF FACT**

1. On January 8, 2018, prior to the action under appeal, the petitioner's husband (WM) and Power of Attorney (POA), signed the petitioner's name on a "Withdrawal Request Form for Annuity Contract [REDACTED]"; requesting "full surrender" of the petitioner's annuity (Respondent Exhibit 4).

2. On February 19, 2018, WM signed the petitioner's name on an [REDACTED] [REDACTED] "Qualified Disbursement Request Form" (withdrawal request), requesting "full surrender" of the petitioner's [REDACTED] (Petitioner Exhibit 2, page 7).

3. On February 20, 2018, WM signed a "Declaration of the Legally Responsible Relative" (Respondent Exhibit 4, page 68) also referred to as "Spousal Refusal". The form states in part:

I declare that I refuse to make my income and/or resources available for the cost of necessary medical care and services for the Medicaid applicant/recipient listed above.

4. Also on February 20, 2018, WM signed the petitioner's name on an "Assignment of Rights to Support" (Respondent Exhibit 4, page 69). The following is the form:



### ASSIGNMENT OF RIGHTS TO SUPPORT

I, [REDACTED], currently residing at  
338 Cyprus Dr Cocoa Beach FL 32931  
Street Address City, State, Zip Code  
 County of Brevard, State of Florida,

Having applied to the State of Florida for benefits pursuant to Title XIX of the Social Security Act and subsection 409.904(3), Florida Statutes, and in consideration of the receipt of such benefits, do understand that by accepting said benefits I:

1. Assign to the State of Florida any and all right, claim, title, and interest which I have to any support obligation owed, due and owing from my spouse,

[REDACTED] of  
338 Cyprus Dr Cocoa Beach FL 32931  
Street Address City, State, Zip Code

2. Assign to the State of Florida the right to maintain or prosecute any and all legal causes of action to establish, determine or enforce judicial orders for my support.

I further understand that:

1. This assignment shall remain in full force and effect so long as I shall receive any benefits from the State of Florida pursuant to Title XIX of the Social Security Act and subsection 409.904(3), Florida Statutes, and shall further remain in full force and effect until the State of Florida is reimbursed, to the extent of my herein assigned rights, for any and all payments made to me from October 1, 1989 and henceforth, or until my right, claim, title and interest in said support is otherwise terminated by law.
2. This assignment shall be limited to the total dollar amount provided to me by the State of Florida pursuant to the aforesaid federal law.

WITNESS, this my hand, this 20 day of Feb 2018

Medicaid Number: \_\_\_\_\_

County: Brevard

5. On February 23, 2018, [REDACTED] mailed the petitioner a letter, notifying her annuity was valued at \$34,799.89, \$6,959.97 was adjusted for Federal Income Tax, leaving

\$27,839.92 as “the cash surrender value/cash value” (Petitioner Exhibit 2). [REDACTED] also issued the petitioner a check on February 23, 2018, for \$27,839.92.

6. On February 28, 2018, \$27,839.92 was deposited into [REDACTED], account [REDACTED] (Respondent Exhibit 4, page 66). The names on the account are: the petitioner, [REDACTED], POA.

7. The respondent’s representative argued WM acted on behalf of the petitioner, by depositing the \$27,839.92 into the bank account; after the assignment of rights and spousal refusal forms were signed on February 20, 2018.

8. On March 1, 2018, the petitioner was admitted to [REDACTED] WM lives in the community and is referred to as the community spouse; the petitioner is referred to as the institutional spouse, for ICP purposes.

9. On March 2, 2018, \$27,839.92 was withdrawn from the [REDACTED] account [REDACTED] (Respondent Exhibit 4, page 66). The respondent’s representative alleges the \$27,839.92 was deposited into WM’s account [REDACTED].

10. The AR agreed the \$27,839.92 was removed from account [REDACTED] and was placed in a new account (account number not provide) on that date. The AR read a statement written by [REDACTED] handled the petitioner’s estate (Petitioner Exhibit 1). The statement in part reads, “The transfer date was not 3/2/2018. The money was placed in the new account on that date.”

11. The AR alleged that in accordance with the Department’s policies 1640.0314.01, 1640.0314.03 and 1640.0609.05, the \$27,839.92 cannot be considered the petitioner’s.

12. On March 21, 2018, the AR submitted an ICP application for the petitioner (Respondent Exhibit 1).

13. On March 25, 2018, the petitioner passed away.

14. On April 23, 2018, the Department mailed the petitioner a Notice of Case Action, notifying the March 21, 2018 application was denied. The denial reason, "We did not receive all the information requested to determine eligibility." (Respondent Exhibit 2, page 47).

15. The respondent's representative stated that the denial reason stated above (#14) is incorrect; and the correct denial reason was due to, "Transferred funds to the community spouse after the spousal's refusal was signed, causing a transfer of asset."

16. The AR argued the petitioner's liquidation process was started on January 8, 2018, prior to the assignment of rights and spousal refusal forms were signed on February 20, 2018; therefore, there should be no transfer penalty.

17. The AR read a statement written by [REDACTED]. The statement in part reads:

**Additionally, it follows that, if DCF considers the transfer to be made on 3/2/2018, the \$27,839.92 would then be considered the asset of both spouses. This would be the only asset that DCF is allowed to consider in the names of the spouses for qualification purposes, and since it is far below the 2018 allowance of \$123,600 for the community spouse and \$2,000 for the institutional spouse, \$125,600 combined [REDACTED] was eligible regardless of the transfer being made prior to the spousal refusal signing. To our knowledge, the rule for allowable assets in the names of both spouses does not change when a spousal refusal is made for certain assets. The spousal refusal may be for certain assets over the allowable limit, rather than all assets held by the community spouse. As such, [REDACTED] was not over the asset limit at the time of the transfer.**

**In conclusion [REDACTED] application was denied in error since she was financially eligible prior to making the transfer of the \$27,839.92 as spouses are allowed to have \$125,600 between them; the transfer was actually made on 2/19/2018 when all paperwork was submitted to the institution (see attachment); and because no penalty can result from a transfer between spouses and as such, even if DCF wanted the money out of [REDACTED] name for approval, it was out of her name and in her spouses name only in March [REDACTED] should receive her full Medicaid benefit for March.**

18. The respondent's representative argued that on February 23, 2018, the \$27,839.32 check was issued to the petitioner; the petitioner's husband signed the Spousal Refusal on February 20, 2018; therefore, only the petitioner was over the asset limit for ICP on February 23, 2018.

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

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

21. The AR argued that in accordance with the Department's policies 1640.0314.01, 1640.0314.03 and 1640.0609.05, the \$27,839.92 cannot be considered the petitioner's.

22. ACCESS Florida Program Policy Manual (Policy Manual), CFOP 165-22, passage 1640.0314.01, Assets Available to Spouse (MSSI), in relevant part states:

**If after declaring and verifying assets**, (emphasis added) the community spouse refuses to make them available to the individual, the institutionalized spouse may assign his rights of support to the state and obtain institutional care benefits (refer to passages 1640.0314.03 and 1640.0314.04 for policy). Community spouses who refuse to make their assets available to the institutionalized spouse are not entitled to a community spouse income allowance.

23. The above policy addresses spousal refusal from the community spouse (WM) to the institutional spouse (petitioner) "after declaring and verifying assets". In this case WM did not declare or verify his assets.

24. Policy Manual, CFOP 165-22, passage 1640.0314.03, Assignment of Rights to Support (MSSI), states:

If the community spouse refuses to make available assets attributed to the institutionalized spouse, the institutionalized spouse may assign his rights of support to the state and obtain institutional care benefits. **This situation may arise when assets allocated to the individual actually solely belong to the community spouse who, in turn, refuses to make them available to the individual.** (emphasis added)

The institutionalized spouse may complete CF-ES Form 2504, Assignment of Rights to Support, which allows the state to pursue recovery from the community spouse. The original copy of this form is to be sent to Headquarters Program Policy, in Tallahassee, Attention: SSI-Related Medicaid Program staff. This form is not an option that an eligibility specialist suggests to an ineligible couple, but rather a solution to an existing situation which is brought to the eligibility specialist's attention. When all conditions in passage 1640.0314.04 are met, the allocated assets being withheld by the community spouse will no longer be considered available to the institutionalized spouse.

If the institutionalized spouse does not assign the rights of support to the state, continue to consider the assets available to the institutionalized individual.

25. The above policy addresses assignment of rights to support by the institutionalized spouse, "when assets allocated to the individual actually solely belongs to the community spouse who, in turn, refuses to make available assets attributed to the institutionalized spouse". In this case, the asset (prior to the transfer) belonged to the petitioner, not WM.

26. Policy Manual, CFOP 165-22, passage 1640.0609.05, Allowable Transfers (MSSI), states:

**The following transfers are considered "allowable" and no period of ineligibility will be imposed:**

- 1. Transfers by individuals who are not applying for or receiving ICP,** (emphasis added) institutionalized MEDS-AD, institutionalized Hospice, HCBS, or PACE;
2. Transfers of assets which are excluded because they are not marketable;

3. Transfers of life estate in property previously owned by the individual;
4. Transfers where fair compensation is received. An example would be assets used to make a purchase for an applicant or recipient or used to pay (or repay) a valid debt equal to the fair market value of the asset. In order for the debt to be considered a valid debt, it must be a legally enforceable debt. An informal loan will be considered to be a valid debt provided it meets the criteria for a bona fide loan set forth in passage 1640.0560.01 and 1640.0560.02.
5. A transaction in which an individual makes burial arrangements with a funeral director and places funds in a burial trust is considered a purchase.
6. Transfers to the individual's blind or disabled child (adult or minor) or to a trust described in passage 1640.0576.08, established solely for the benefit of the individual's disabled adult child;
7. Transfers to a trust (including a qualified trust for the disabled, as described in passage 1640.0576.08) for the sole benefit of a disabled individual under age 65;
8. Transfers of the individual's income to a qualified income trust (see passages 1840.0110 and 1840.0111);
9. Interspousal transfers made on or after October 1, 1989;
10. Transfers of assets to a third party by the individual applying for nursing home care (ICP, institutionalized MEDS-AD, institutionalized Hospice) or HCBS Programs or by the individual's spouse, if the third party intends to use the funds for the sole benefit of the individual's spouse (see passage 1640.0609.06);
11. Transfers of excluded assets other than homestead or real property excluded from countable assets due to a bona fide effort to sell; and Note: Transfer of homestead property is allowable if it meets the criteria as set forth in 1640.0609.03.
12. Transfers made by the spouse of an HCBS individual of any of the spouse's individually owned assets.

27. In accordance with the above policy, "transfers are considered "allowable" and no period of ineligibility will be imposed [for] Transfers by individuals who are not applying for or receiving ICP."

28. The evidence submitted establishes the petitioner was applying for ICP; and establishes that the petitioner did not meet any of the 12 conditions listed in the above policy.

29. *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...

(4) Spousal Impoverishment. The Department follows policy in accordance with 42 U.S.C. § 1396r-5 for resource allocation and income attribution and protection when an institutionalized individual, including a hospice recipient residing in a nursing facility, has a community spouse...

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

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

1. The institutionalized individual is not eligible for Medicaid Institutional Care Program because of the community spouse’s resources and the community spouse refuses to use the resources for the institutionalized spouse; and
2. The institutional spouse assigns to the State any rights to support from the community spouse by submitting the Assignment of Rights to Support, Form CF-ES 2504, PDF 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.

30. In accordance with the above authority, “The institutionalized spouse shall not be determined ineligible based on a community spouse’s resources if all of the following [four] conditions are found to exist.”

31. The evidence submitted establishes the petitioner met conditions one and two in the above authority. However, conditions three and four were not met. Condition three, the petitioner had access to the \$27,839.32, prior to the transfer. Condition four, the

petitioner's \$27,839.32 could have provided the means to pay for the petitioner's one month stay at the nursing facility.

32. *Florida Administrative Code* R 65A-1.712, SSI-Related Medicaid Resource

Eligibility Criteria, in part states:

(3) Transfer of Resources and Income...

(b)3.(c) **4. A transfer penalty shall not be imposed if the individual provides proof that they disposed of the resource or income solely for some purpose unrelated to establishing eligibility.** (emphasis added)

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

33. In accordance with the above authority, "A transfer penalty shall not be imposed if the individual provides proof they disposed of the resource...solely for some purpose unrelated to establishing eligibility."

34. The evidence submitted establishes that WM transferred the petitioner's \$27,839.92, solely for the purpose of establishing ICP eligibility for the petitioner.

35. ACCESS Program TRANSMITTAL PC100603, Spousal Refusal to

Support/Transfer, in part states:

**Statement of Question: Are transfers from the institutional spouse, who has signed the *Assignment of Rights To Support*, to a community spouse that refuses to support an allowable transfer?**

Central Office Response: Under spousal impoverishment policies, inter-spousal transfers of assets during the initial eligibility determination are permitted without the consequence of a potential transfer of asset penalty against the institutional spouse. This is because all countable assets belonging to both spouses are considered in determining if the institutionalized spouse is eligible for Medicaid.

However, since the community spouse has refused to use his/her assets for the support of the institutionalized spouse, we no longer consider the case under the spousal impoverishment policies. We treat the institutionalized spouse as if he/she were an individual and consider only the applicant's assets when deciding if the total assets fall within the program limits for an individual. Staff should not consider a community spouse's assets when determining the institutional spouse's eligibility if a valid

If the institutionalized applicant now chooses to transfer the "newly discovered" assets to his/her spouse, we must consider that the client has transferred assets to become Medicaid eligible and determine if a penalty period should be imposed. If funds are transferred, the client has willingly given away assets to become Medicaid eligible without any intent of receiving fair compensation.

If the "newly discovered" assets are kept by the institutional spouse, they must be considered available and countable when determining if the institutionalized spouse's assets are within the program asset limit.

36. In accordance with the above Department's Transmittal, once a spousal refusal is signed, the impoverishment policy no longer applies; and when the ICP applicant transfers assets to the community spouse after the spousal refusal is signed a transfer penalty is imposed.

37. In this case, a transfer penalty could not be imposed because the petitioner passed away on March 25, 2018, and ICP is being requested only for March 2018.

38. The AR argued the petitioner's liquidation process was started on January 8, 2018, prior to the assignment of rights and spousal refusal forms being signed on February 20, 2018; therefore, there should be no transfer penalty.

39. The evidence submitted establishes, WM signed the petitioner's name on a "Withdrawal Request Form for Annuity Contract [REDACTED] on January 8, 2018, and on February 19, 2018, WM signed the petitioner's name on a "Qualified Disbursement Request Form Contract [REDACTED] 5", requesting full surrender of the petitioner's annuity.

40. The evidence submitted establishes that on February 20, 2018, WM signed a Spousal Refusal, refusing his income and assets to the petitioner; WM also signed the Assignment of Rights to Support, assigning the State of Florida all rights on the petitioner's behalf on February 20, 2018.

41. The evidence submitted establishes, the petitioner was admitted to the nursing facility on March 1, 2018, and on March 2, 2018, WM withdrew \$27,839.92 from a bank account belonging to him and the petitioner (along with two other individuals); which was deposited into a different account.

42. The AR argued if the Department "considers the transfer to be made on 3/2/18, the \$27,839.92 would be considered the assets of both spouses."

43. The evidence submitted establishes the interspousal transfer took place on March 2, 2018; which was after February 20, 2018, when WM signed the Spousal Refusal and Assignment of Rights to Support. Therefore, the asset did not belong to the petitioner or her husband.

44. After careful review of the cited authorities and evidence, the undersigned concludes the \$27,839.92 interspousal transfer occurred solely for the purpose of establishing ICP Medicaid eligible for the petitioner.

45. The Hearing Officer concludes the petitioner did not meet the burden of proof. The Department's action to deny the petitioner ICP Medicaid for March 2018, 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 24 day of July, 2018,

in Tallahassee, Florida.



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

**FILED**

Jul 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. 18F-03394

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 09 Osceola  
UNIT: 66032

RESPONDENT.

**FINAL ORDER**

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:58 a.m. on June 8, 2018.

**APPEARANCES**

For the Petitioner: [REDACTED] ro 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 re-enroll the petitioner and his wife in the Medically Needy (MN) Program with a \$1,443 share of cost (SOC), is proper. The respondent carries the burden of proof by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The petitioner submitted three exhibits, entered as Petitioner Exhibits “1” through “3”. The respondent submitted five exhibits, entered as Respondent Exhibits “1” through “5”. The record remained open until June 11, 2018, for both parties to submit additional evidence. The evidence was received timely and entered as Petitioner Exhibit “4” and Respondent Exhibit “6”. The record was closed on June 11, 2018.

**FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner and his wife were enrolled in the MN Program with a \$1,966 SOC.
2. On April 20, 2018, the petitioner submitted a web public assistance benefit application for him and his wife. Medicaid is one of the benefits listed on the application and the only benefit at issue (Respondent Exhibit 1). The application lists Social Security Disability Income (SSDI) as the household income; \$1,045 for the petitioner and \$913 for the petitioner’s wife.
3. The Department calculated the SOC (Respondent Exhibit 6) for the petitioner and his wife as follows:

\$1,045	petitioner’s SSDI
+\$ 913	petitioner’s wife’s SSDI
<hr/>	
\$1,958	household income
-\$ 20	unearned income deduction
-\$ 254	Medicare premium
-\$ 241	MN income level (MNIL) for household of two
<hr/>	
\$1,443	SOC

4. On April 26, 2018, the Department mailed the petitioner a Notice of Case Action, notifying the April 20, 2018 application was approved and the SOC was decreased from \$1,966 to \$1,443, effective June 2018 (Respondent Exhibit 2, page 23).

5. The petitioner argued that in accordance with the Achieving a Better Life Experience (ABLE) Act, the Department is to exclude the household income or include their monthly expenses in the SOC calculation; which would make their SOC zero.
6. The petitioner and his wife have ABLE accounts. An ABLE account is a tax advantage account for disabled individuals, to allow them to save money for disability-related expenses.
7. The petitioner alleges the ABLE Act allows deposits of up to \$15,000 from outside sources and \$12,060 from employment into the ABLE account.
8. The petitioner argued that in accordance with the Department's "Policy TRANSMITTAL NO P-16-09-0006", dated September 1, 2016; deposits to ABLE accounts are counted in the eligibility determination and withdrawals, paid from an ABLE account, are excluded as qualified disability expenses (QDE).
9. The petitioner argued his and his wife's ABLE accounts for January 1, 2018, to March 31, 2018, show his wife withdrew \$1,400 for QDE and he withdrew \$960 for QDE (Petitioner Exhibit 3). The following are summaries of the ABLE accounts:

**ACCOUNT ADMINISTRATOR:**

██████████

**BENEFICIARY:**

██████████

**ACCOUNT NUMBER:**

3500000094

**2018 YTD Transaction Summary**

---

Opening Balance	\$253.63	
+Contributions	\$1,200.00	
+Gifting Contributions	\$0.00	
-Withdrawals	(\$1,400.00)	
-Fees	(\$15.00)	
+/- Gain/Loss	(\$12.23)	
+Rollover In	\$0.00	
<b>Total Ending Balance</b>	<b>\$26.40</b>	<b>Basis: \$0.00 Earnings: \$0.00</b>

**Quarterly Account Activity**  
January 1, 2018 to March 31, 2018

Portfolio Name	Opening Balance	Contributions	Transfers	Withdrawals	Fees	Gain/Loss	Closing Balance
Conservative Portfolio	\$203.44	\$960.00	\$0.00	(\$1,119.02)	(\$12.00)	(\$11.29)	\$21.13
US Bond Fund	\$50.19	\$240.00	\$0.00	(\$280.98)	(\$3.00)	(\$0.94)	\$5.27
<b>Total</b>	<b>\$253.63</b>	<b>\$1,200.00</b>	<b>\$0.00</b>	<b>(\$1,400.00)</b>	<b>(\$15.00)</b>	<b>(\$12.23)</b>	<b>\$26.40</b>

**Account Investment Summary**  
As of March 31, 2018

Portfolio Name	Units	Unit Value	Value
Conservative Portfolio	1.912900	\$11.045096	\$21.13
US Bond Fund	0.535600	\$9.835188	\$5.27
<b>Total Account Value</b>			<b>\$26.40</b>

ACCOUNT ADMINISTRATOR:

[REDACTED]

BENEFICIARY:

[REDACTED]

ACCOUNT NUMBER:

3500000116

**2018 YTD Transaction Summary**

Opening Balance	\$129.24		
+Contributions	\$1,200.00		
+Gifting Contributions	\$0.00		
-Withdrawals	(\$960.00)		
-Fees	(\$5.00)		
+/- Gain/Loss	(\$10.43)		
+Rollover In	\$0.00		
		<b>Basis: \$0.00</b>	<b>Earnings: \$0.00</b>
<b>Total Ending Balance</b>	<b>\$353.81</b>		

**Quarterly Account Activity**  
January 1, 2018 to March 31, 2018

Portfolio Name	Opening Balance	Contributions	Transfers	Withdrawals	Fees	Gain/Loss	Closing Balance
Conservative Portfolio	\$103.70	\$960.00	\$0.00	(\$767.21)	(\$3.98)	(\$10.20)	\$282.31
US Bond Fund	\$25.54	\$240.00	\$0.00	(\$192.79)	(\$1.02)	(\$0.23)	\$71.50
<b>Total</b>	<b>\$129.24</b>	<b>\$1,200.00</b>	<b>\$0.00</b>	<b>(\$960.00)</b>	<b>(\$5.00)</b>	<b>(\$10.43)</b>	<b>\$353.81</b>

**Account Investment Summary**  
As of March 31, 2018

Portfolio Name	Units	Unit Value	Value
Conservative Portfolio	25.559600	\$11.045096	\$282.31
US Bond Fund	7.269400	\$9.835188	\$71.50
<b>Total Account Value</b>			<b>\$353.81</b>

10. The respondent's representative argued that the above accounts do not identify what the withdrawals were for.

11. The petitioner submitted an itemized statement showing the alleged expenses paid with the withdrawals; the expenses included automobile insurance, cable, home insurance, cell phone, house cleaning services, condo fees and utilities (Petitioner Exhibit 4).

12. The respondent's representative stated expenses allowed in the SOC determination include: medical insurance premiums, uncovered prescription costs and medical equipment not covered by insurance.

13. The petitioner argued that in accordance with the ABLE Act allowable, QDE in the SOC determination include all the expenses he has listed in his itemized statement; which would make his SOC zero.

#### **CONCLUSIONS OF LAW**

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

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

16. Section 1009.986, Florida Statutes, Florida ABLE program, states in part:

(1) LEGISLATIVE INTENT. —It is the intent of the Legislature to establish a **qualified ABLE program in this state which will encourage and assist the saving of private funds in tax-exempt accounts in order to pay for the qualified disability expenses of eligible individuals with disabilities.** (emphasis added) The Legislature intends that the qualified

ABLE program be implemented in a manner that is consistent with federal law authorizing the program and that maximizes program efficiency and effectiveness.

(2) DEFINITIONS.—As used in ss. 1009.987 and 1009.988 and this section, the term:

(a) “ABLE account” means an account established and maintained under the Florida ABLE program...

(d) “Eligible individual” has the same meaning as provided in s. 529A of the Internal Revenue Code.

(e) “Florida ABLE program” means the qualified ABLE program established and maintained under this section by Florida ABLE, Inc.

(f) “Internal Revenue Code” means the United States Internal Revenue Code of 1986, as defined in s. 220.03(1), and regulations adopted pursuant thereto.

(g) “Participation agreement” means the agreement between Florida ABLE, Inc., and a participant in the Florida ABLE program.

(h) “Qualified ABLE program” means the program authorized under s. 529A of the Internal Revenue Code which may be established by a state or agency, or instrumentality thereof, to allow a person to make contributions for a taxable year to an ABLE account established for the purpose of meeting the qualified disability expenses of the designated beneficiary of the ABLE account.

(i) “Qualified disability expense” has the same meaning as provided in s. 529A of the Internal Revenue Code.

17. Internal Revenue Code Title 42 U.S.C. § 529A, Qualified ABLE programs, in part

states:

(a) General rule

**A qualified ABLE program shall be exempt from taxation** (emphasis added) under this subtitle.

(b) Qualified ABLE program

For purposes of this section—

(1) In general

The term “qualified ABLE program” means a program established and maintained by a State, or agency or instrumentality thereof—

**(A) under which a person may make contributions for a taxable year, for the benefit of an individual who is an eligible individual for such taxable year, to an ABLE account which is established for the purpose of meeting the qualified disability expenses of the designated beneficiary of the account,** (emphasis added)

(B) which limits a designated beneficiary to 1 ABLE account for purposes of this section,

(C) which meets the other requirements of this section...

**(c) Tax treatment**

**(1)(B) Distributions for qualified disability expenses**

**For purposes of this paragraph, if distributions from a qualified ABLE program—**

**(i) do not exceed the qualified disability expenses of the designated beneficiary, no amount shall be includible in gross income...**

**(e) (1) Eligible individual**

**An individual is an eligible individual for a taxable year if during such taxable year—**

**(A) the individual is entitled to benefits based on blindness or disability under title II or XVI of the Social Security Act, and such blindness or disability occurred before the date on which the individual attained age 26...**

**(5) Qualified disability expenses**

**The term “qualified disability expenses” means any expenses related to the eligible individual’s blindness or disability which are made for the benefit of an eligible individual who is the designated beneficiary, including the following expenses: education, housing, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management and administrative services, legal fees, expenses for oversight and monitoring, funeral and burial expenses, and other expenses, which are approved by the Secretary under regulations and consistent with the purposes of this section.**

**(6) ABLE account**

**The term “ABLE account” means an account established by an eligible individual, owned by such eligible individual, and maintained under a qualified ABLE program... (emphasis added)**

18. The above authorities explain the “ABLE program/account” is a tax advantage

account for disabled individuals to save money for disability-related expenses. It

explains for tax treatment distributions (ABLE account withdrawals) are not included in

gross income.

19. The petitioner argued that in accordance the Department’s “Policy TRANSMITTAL

NO P-16-09-0006” his income is excluded and his QDE need to be excluded in his SOC

calculation.

20. ACCESS Program TRANSMITTAL NO.: P-16-09-0006, "Achieving a Better Life Experience (ABLE) Accounts Exclusion," states in part:

What is an ABLE account?

An ABLE account is a tax sheltered account used for disability-related expenses of an individual entitled to Social Security benefits based on blindness or disability, or a certification of disability signed by a physician prior to age 26. Each state's ABLE Program will determine if the individual meets the qualifying factors to establish an ABLE account. The Florida Prepaid College Board will complete this determination for accounts established in Florida.

Policy

**ABLE accounts not exceeding \$100,000 are excluded as an asset for all programs.** (emphasis added) Amounts over \$100,000 are counted in the asset determination. The current total annual limit for donations to an ABLE account is \$14,000 for 2015. The amount will be adjusted annually for inflation.

**ABLE Account Verification:**

- When an individual is not potentially over the asset limit based on the sum of all assets including the ABLE account, staff may accept client statement of the ABLE account and exclude it from the budget.
- When an individual is potentially over the asset limit based on the sum of all assets including an ABLE account, staff must request verification to confirm the account can be excluded as an ABLE account....
- The application must not be denied if verification of an ABLE Account is the only outstanding verification needed to process the case. If the individual requires assistance with obtaining verification of an ABLE account, regional staff may contact their Region's Program Office staff to contact the Florida Prepaid College Board to obtain verification.

**Deposits (Contributions to an ABLE account are:**

- **Excluded as an asset**
- **Contributions by others to an ABLE account are excluded as income to the beneficiary of the account**
- **Income of the beneficiary is counted in the eligibility determination, even if subsequently deposited into an ABLE account** (emphasis added)
- Any interest, dividend or other earnings increase to an ABLE account is excluded as income

**Withdrawals (Distributions) paid from an ABLE account are:**

- **Excluded as income to the individual** (emphasis added)
- If individual receives a distribution from their ABLE account but does not spend it, the ABLE funds remain excluded as an asset, even if co-mingled with other assets, as long as they are identifiable. Do not deny or terminate benefits without verification that the ABLE funds were identified and deducted from the total value of the asset

**ABLE Accounts Funds for SSI Recipients:**

- Funds accrued in an ABLE account up to \$100,000 are excluded as an asset with no effect on the individual's eligibility for Supplemental Security Income (SSI) payment and Medicaid coverage.
- Funds accrued in an ABLE account in excess of \$100,000 continue to be excluded as an asset; however, the individual's SSI payment is suspended. They remain Medicaid eligible

21. The above Transmittal explains contributions into the ABLE account are excluded as an asset and withdrawals from ABLE accounts are excluded as income. It does not state the withdrawals are to be excluded as an expense in the Medicaid determination.

22. The petitioner argued that in accordance with the ABLE Act, his monthly expenses such as: automobile insurance, cable, home insurance, cell phone, house cleaning services, condo fees, utilities, should be deducted as a QDE in his SOC determination.

23. Title 42 Code of Federal Regulations § 436.831, addresses financial requirements for the Medically Needy, and in part states:

...

(e) Determination of deductible incurred expenses:

(1) Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, copayments, or deductibles imposed...

(2) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan;

(3) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration or scope of services...

24. The above authority lists allowable expenses in determining Medicaid eligibility. It does not include QDE as defined in the above authority (#17). QDE are strictly for tax treatment purposes in accordance with the above authority (#17).

25. In careful review of the cited authorities and evidence, the undersigned concludes the Department met its burden of proof. The Hearing Officer concludes the Department's action to re-enroll the petitioner and his wife in the MN Program with a \$1,443 SOC, is proper.

### **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 25 day of July, 2018,

in Tallahassee, Florida.



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

Jul 03, 2018

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 18F-03471  
18F-04335

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 19 Martin  
UNIT: 88510

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on May 23, 2018, at 2:20 p.m. and reconvened on June 11, 2018, at 3:30 p.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner:  was present in both hearings.

For the Respondent: Nardalisa Figueroa, Economic Self-sufficiency Specialist II, represented the Department at the first hearing.  
Patricia Roy, DCF Supervisor, represented the Department at the second hearing.

### **STATEMENT OF ISSUE**

At issue is whether the respondent's action denying petitioner's Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that she does not meet the disability criteria is correct. Also at issue is whether the respondent issued the correct Supplemental Nutrition Assistance Program (SNAP) benefits level to the petitioner based on the household income and expenses. The petitioner carries the burden of proof by the preponderance of evidence on both issues.

### **PRELIMINARY STATEMENT**

By a Notice of Case Action (NOCA) dated March 29, 2018, the respondent informed the petitioner that she was approved \$140 in SNAP benefits effective May 1, 2018. A separate notice was sent to the petitioner on April 20, 2018 informing her that she was denied Medicaid benefits due to not meeting disability requirement. On April 30, 2018, the petitioner timely requested a hearing to challenge the Department's actions.

During the first hearing for Medicaid, the petitioner verbally authorized her friend, [REDACTED] to speak on her behalf. At the hearing, the petitioner submitted a 31-page evidence packet which was marked Petitioner's Composite Exhibit 1. The respondent submitted seven (7) exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 7. The record was left open through May 30, 2018 for the petitioner to submit any information related to her disability application. The evidence was timely received and marked as Petitioner's Composite Exhibit 2. The record on the Medicaid hearing was closed on May 30, 2018.

During the second hearing (SNAP), the petitioner did not provide any evidence for the undersigned to consider. The respondent submitted nine (9) additional exhibits which were accepted into evidence and marked as Respondent's Exhibits 8 through 16.

### **FINDINGS OF FACT**

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

1. In October 2016, the petitioner applied for disability with the Social Security Administration (SSA). SSA considered [REDACTED]" and [REDACTED]" and determined that the petitioner was not disabled. In May 2017, SSA denied the petitioner's application with reason code N35 (Impairment severe at time of adjudication but not expected to last twelve months-no visual impairment). The petitioner has appealed the SSA denial and has retained legal counsel to assist her with her disability case.
2. The petitioner [REDACTED] is 50 years old. She does not meet the aged criteria for SSI-Related Medicaid benefits. She is not pregnant, has no minor children and does meet the technical requirement for Family-Related Medicaid. The petitioner did not allege blindness. Disability must be established to determine Medicaid eligibility.
3. The petitioner has been determined disabled by Florida Retirement System (FRS) and receives \$637.20 monthly pension benefit from the State of Florida, Division of Retirement. This amount includes a \$59.40 health insurance subsidy. FRS disability is different from SSA disability for SSI-Related Medicaid eligibility purposes. She currently has medical insurance coverage.

4. The Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid Programs. To be eligible an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility for individuals applying for disability benefits under the state Medically Needy Program. Once a disability review is completed, the claim is returned to DCF for a final determination of eligibility and effectuation of any benefits due.

5. On March 20, 2018, the petitioner submitted an online application requesting Medicaid as and additional benefit through the Department's SSI-Related Medicaid Program. On that application, the petitioner reported that she has been diagnosed with anxiety and depression due to pain caused by regional pain syndrome (RPS). She also reported the following expenses: \$500 for rent (utilities included) and \$46.50 for telephone. She also reported several monthly recurring medical expenses, see Respondent's Exhibit 1.

6. The petitioner is taking various medications to alleviate her pain.

7. On April 9, 2018, the Department sent the petitioner a Notice of Case Action indicating that she needed to complete and return a disability application by April 19, 2018, see Respondent's Exhibit 3.

8. Information obtained from the petitioner was forwarded to DDD for review on April 13, 2018. DDD received petitioner's disability package from the Department for a disability review. The DDD has access to Social Security information. Case notes from DDD Transmittal indicate petitioner's medical conditions to be [REDACTED] and [REDACTED]. DDD determined these medical were already known and considered by SSA

and will be addressed in the course of her appeal before an administrative law judge (ALJ).

9. On April 19, 2018, DDD denied the petitioner's claim of disability by adopting the SSA denial (N35). DDD did not make an independent determination, as it considered petitioner's medical conditions to be the "same allegations", see Respondent's Exhibit 4

10. Prior to the action under appeal, the petitioner has been receiving Supplemental Nutrition Assistance Program (SNAP) benefits from the Department. The last month of her certification period was April 2018 and she received \$167 for that month. The health insurance subsidy was not included in the budget.

11. The petitioner is the only member of her household. The petitioner is not allowed excess medical expenses. She is subject to both the gross and the net income tests. She is also subject to a shelter cap.

12. To begin the SNAP budgeting process, the petitioner's FRS benefits of \$637.20 was reduced by the standard income deduction of \$160 to arrive at the adjusted income of \$477.20, 50% of which becomes shelter standard (\$238.60). With total shelter/utility costs of \$545 (\$500 for rent + \$45 telephone), the petitioner was allowed \$306.40 shelter deduction, resulting in the SNAP adjusted income to be downward adjusted to \$170.80. A 30% benefit reduction occurred in the amount of \$52 ( $\$170.80 \times 30\%$ ), resulting in the petitioner's household being eligible for \$140 ( $\$192$  minus \$52) when subtracted from the maximum allotment, see Respondent's Exhibit 12.

13. On April 20, 2018, the Department sent the petitioner a Notice of Case Action indicating that her application for SSI-Related Medicaid was denied due to not meeting

the disability criteria. A separate notice sent on March 29, 2018 informed her that she was approved \$140 in SNAP benefits effective May 1, 2018.

14. The respondent explained that it denied the petitioner's SSI Related Medicaid application because SSA has determined that the severity of her medical condition will not last at least 12 months and DDD adopted the decision. The respondent explained that SSA decision is binding and must be accepted by the Department as final. The respondent explained that the SNAP benefits level is based on the petitioner's FRS benefits and her reported expenses at the time of action. She explained that the petitioner's health insurance subsidy was not included in the prior certification period. That is the reason for the decrease from \$167 in April 2018 to \$140 effective May 2018.

15. The petitioner's representative argued as follows: (1) that FRS has already determined the petitioner is disabled and that DDD should have made the same decision; (2) that the petitioner suffers from [REDACTED]; (3) that she needs assistance with activities of daily living. The petitioner is reporting [REDACTED] as a new condition. The representative maintains the Department's action is improper.

16. The petitioner did not dispute the facts presented by the respondent. During the hearing, she reported \$22.35 in recurring medical insurance expenses and an unspecified amount for transportation to go her doctor's appointments. She argued that she has no money left to buy food after paying her bills. The respondent explained that all expenses previously reported to the Department were considered. She maintains that the petitioner is not elderly or disabled; therefore, she is not allowed excess medical expenses.

17. As of the day of the most recent hearing, the petitioner's appeal with SSA is still pending. She is seeking Medicaid coverage so she can receive better treatment for her medical conditions and an increase in her SNAP benefits level.

### **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.

### **The SSI-Related Medicaid issue will be addressed first.**

20. 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.

21. 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..."

22. Federal Regulations at 42 C.F.R. § 435.541 "Determination of Disability," states:

- (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
  - (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.
- (b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-
  - (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
  - (ii) If the SSA determination is changed, the new determination is also binding on the agency.
  - (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except In cases specified in paragraph (c) (4) of this section.
- (c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...
  - (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-
    - (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
    - (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
    - (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-
      - (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
      - (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

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

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

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

24. 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.

25. 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, worsening and deteriorating of conditions is directed to the SSA. In this instant case, SSA has determined that the petitioner's medical impairment is not expected to last at least 12 months. The petitioner has alleged [REDACTED] as a new condition, but did not submit any relevant medical evidence to support her claim.

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

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

**The SNAP benefit level will now be addressed.**

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

(a) *Income eligibility standards.* Participation in the Program shall be limited to those households whose incomes are determined to be a substantial limiting factor in permitting them to obtain a more nutritious diet. Households which contain an elderly or disabled member shall meet the net income eligibility(sic) standards for SNAP. Households which do not contain an elderly or disabled member shall meet both the net income eligibility standards and the gross income eligibility standards for SNAP. Households which are categorically eligible as defined in §273.2(j)(2) or 273.2(j)(4) do not have to meet either the gross or net income eligibility standards. The net and gross income eligibility standards shall be based on the Federal income poverty levels established as provided in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)).

(2) The net income eligibility standards for SNAP shall be as follows:

(i) The income eligibility standards for the 48 contiguous States and the District of Columbia, Guam and the Virgin Islands shall be the Federal income poverty levels for the 48 contiguous States and the District of Columbia.

(b) Definition of income...

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

(ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits...

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

(1) *Standard deduction*—

(2) Earned income deduction.

(3) Excess medical deduction. That portion of medical expenses in excess of \$35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in §271.2. Spouses or other persons receiving benefits as a dependent of the SSI or disability and blindness recipient are not eligible to receive this deduction but persons receiving emergency SSI benefits based on presumptive eligibility are eligible for this deduction....

(4) Dependent care.

(5) Optional child support deduction.

(6) Shelter costs—

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

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

(iii) Standard utility allowances...

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

29. The respondent must follow these federal budgeting guidelines when determining eligibility. The regulation directs the Department to consider the FRS pension benefit as income that must be included in the eligibility determination.

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

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

(A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income. Net losses from the self-employment income of a farmer shall be offset in accordance with Sec. 273.11(a)(2)(iii).

(B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions.

(C) Subtract the standard deduction.

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

...

(H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50

percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.

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

31. 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 and an excess shelter deduction from her gross income to equal her net income. She was not allowed any excess medical expenses because she is not disabled and is not over 60 years old. There is no indication that the petitioner was eligible for any other deductions.

32. The SNAP standards for income and deductions appear in the Policy Manual at Appendix A-1. Effective October 1, 2017, the standard deduction for a one-person assistance group is \$160, the telephone standard is \$45 and the maximum SNAP benefits is \$192.

33. After considering the evidence, the petitioner's testimony, the respondent's testimony and the appropriate authorities cited above, the hearing officer concludes that the respondent's action to approve \$140 in Supplemental Nutrition Assistance Program Benefits for the petitioner effective May 2018 is correct. The hearing officer cannot conclude that the petitioner is eligible for any additional benefits based on the income and expenses presented and the above-cited rules. The petitioner has failed to meet

her burden that she is eligible for any additional SNAP benefits with the income and expenses reported.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied. The Department's actions are affirmed.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 03 day of July, 2018,  
in Tallahassee, Florida.

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

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

**FILED**

Jul 16, 2018

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 18F-03570

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

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

**APPEARANCES**

For the Petitioner:

[REDACTED], wife of petitioner

For the Respondent:

Ernestine Bethune,  
Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of April 13, 2018 denying his application for SSI-Related Medicaid due to not meeting the disability requirement. The petitioner carries the burden of proof by the preponderance of evidence.

## **PRELIMINARY STATEMENT**

The Department submitted evidence on June 12, 2018. The petitioner reported non-receipt of the evidence prior to hearing, but requested the appeal proceed without him having a copy of the evidence.

The record was held open for the Department to issue a new copy of the evidence to the petitioner, submit supplemental evidence to both the undersigned and the petitioner no later than June 21, 2018. The record also remained open to allow time for the petitioner to submit any written response to the evidence no later than June 29, 2018.

The Department submitted supplemental evidence on June 19, 2018.

The undersigned issued an order on June 20, 2018 to enter the evidence into the record if no objections were received by the deadline. A copy of both portions of the evidence were attached to the order to ensure the petitioner received a copy of the evidence.

The evidence received on June 12, 2018 was entered as Respondent's Exhibit 1. The evidence received on June 19, 2018 was entered as Respondent's Exhibit 2.

No response was received from the petitioner.

The record closed on June 29, 2018.

## **FINDINGS OF FACT**

1. The petitioner filed an application for SSI-Related Medicaid on March 7, 2018. The application reflects the household consists of the petitioner and his wife only. The petitioner is age 60.

2. The Department issued a Notice of Case Action on April 13, 2018 denying his application for SSI-Related Medicaid. The reason given on the notice was “You or a member of your household do not meet the disability requirement”.

3. The petitioner applied for Social Security Disability and was originally denied on July 27, 2016.

4. The petitioner appealed the most recent Social Security disability denial on February 24, 2017.

5. The Department explained the petitioner was denied disability with a reason code N36 which means “non-pay – insufficient or no medical data furnished”.

6. The Department explained the decision made by Social Security was adopted.

7. The Department did not submit the case an independent disability determination as the petitioner has a pending appeal with the Social Security Administration.

8. The Department expressed the understanding that if Social Security makes a disability decision within the previous 12 months, the decision must be adopted and the Department is unable to make an independent determination.

### **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:**

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

...

(e) Medical and nonmedical evidence. The agency must obtain a medical report and other nonmedical evidence for individuals applying for Medicaid on the basis of disability. The medical report and nonmedical evidence must include diagnosis and other information in accordance with the requirements for evidence applicable to disability determinations under the SSI program specified in 20 CFR part 416, subpart I.

(emphasis added)

16. The undersigned explored potential eligibility for SSI-Related Medicaid for the petitioner. The findings show the petitioner was 60 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.

17. The findings show the petitioner applied for Social Security disability and was denied on July 26, 2016. The findings show the petitioner appealed the denial of Social Security disability in February 2017. The findings show the decision made was an N36 decision which means "non-pay insufficient or no medical data furnished". The undersigned concludes SSA did not make a disability determination in this case. The undersigned further concludes the Department should have requested a disability determination be made in this matter as one was not made by SSA.

## DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is remanded to the Department for a determination of disability to be completed. The Department is to issue a Notice of Case Action, to include appeal rights, upon completion of the disability decision.

## NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 16 day of July, 2018,

in Tallahassee, Florida.



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Melissa Roedel  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
Fax: 850-487-0662  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Jul 18, 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-03713  
18F-05180

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 07 Volusia  
UNIT: 88323

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 26, 2018, at 8:32 a.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner: 

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

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's (or Respondent) action denying Petitioner's Medicare Saving Plan (MSP) or Buy-in Program. Also at issue is the Department's action denying full Medicaid for Petitioner and enrolling her in the Medically Needy (MN) Program with a high estimated share of cost (SOC). Petitioner is

seeking MSP benefits and full Medicaid or a lower SOC. Petitioner carries the burden of proof by the preponderance of evidence for both Programs.

### **PRELIMINARY STATEMENT**

On June 4, 2018, Petitioner requested a hearing to challenge the denial of her MSP benefits and her enrollment in the MN Program.

At the hearing, Petitioner indicated she did not pick up the Respondent's evidence packets from her Post Office Box, but elected to go forward with the hearing.

During the hearing, Petitioner did not provide any evidence for the undersigned to consider. Respondent submitted eleven (11) exhibits which were accepted and marked as Respondent's Exhibits 1 through 11.

### **FINDINGS OF FACT**

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

1. Prior to the action under appeal, Petitioner was enrolled in the Medically Needy Program with an estimated \$1,199 SOC from February 2018 through April 2018. Petitioner last received MSP in January 2018 and no Part B premiums were included in her SOC calculation for the above-mentioned months.
2. On May 1, 2018, Respondent received an application requesting Medicare Savings Plan (MSP) from Petitioner. Petitioner's household includes her and her wife. The wife is not applying for any benefits. She is not counted in any of the standard filing units (SFU). Petitioner has been Medicare eligible and was responsible for her Part B premiums (\$134) at the time of the application.

3. MSP, also known as the Buy-in Program, includes Qualified Medicare Beneficiary (QMB), Special Low-Income Medicare Beneficiary (SLMB) and Qualified Individuals 1 (QI1), each with a different income limit. To be eligible for these benefits, applicants have to meet certain income guidelines. QI1 has the highest income limit. From April 2017 through March 2018, it is \$1,357 for an individual and \$1,827 for a couple. Effective April 2018, the limit is \$1,366, for an individual and \$1,852 for a couple, see Respondent Exhibit 6.

4. In 2017, Petitioner's monthly SS benefits was \$1,371. Effective 2018, she receives \$1,399 after a cost-of-living adjustment (COLA). The SS income is not in dispute.

5. The case was processed and denied due to excess income. On May 3, 2018, Respondent sent a Notice of Case Action (NOCA) to Petitioner informing her that she was denied QI1 due to household income being too high for the program, see Respondent Exhibit 1.

6. Petitioner was seeking MSP. The Department's representative explained its action to enroll Petitioner in the Medically Needy Program with a share of cost. The share of cost amount is directly dependent on Petitioner's SS benefits minus allowable deductions. She explained that Petitioner's MSP was denied because her SS income (minus \$20 deduction) exceeds the \$1,366 program income limit for an individual to be eligible, see Respondent's Exhibit 5.

7. The Department's representative explained that in accordance with the Department's policy, Petitioner's gross income must be used for the month received in all eligibility determination. Based on Petitioner's SS income effective January 2018,

she is no longer eligible for any of the Buy-in Programs using the May 1, 2018 application.

8. Petitioner disagrees with the income used by Respondent. She argues that this little increase should not be counted, resulting in her being kicked out of the Buy-in Program. Petitioner maintains that the current agency practice vis-à-vis the Buy-in eligibility determination is not fair and should be changed. She argues that her eligibility should be based on a two-member household (her and her wife). She is seeking Q11 coverage from effective February 2018 to cover Petitioner's Part B premiums based on the May 1 application.

9. Petitioner was seeking full Medicaid or a lower SOC for herself. Respondent explained the Medically Needy Program as follows: between February 2018 and April 2018, Petitioner's monthly SS income of \$1,399 was reduced by a \$20 standard income disregard, followed by a \$180 Medically Needy Income Level (MNIL) deduction for one person to arrive at the estimated share of cost of \$1,199. Effective May 2018, Petitioner's initial SOC of \$1,199 was reduced by the \$134 Part B premiums, resulting in the final estimated SOC to be \$1,065, see Respondent's Exhibit 9.

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

11. Petitioner did not dispute the income amount used by the Department in the eligibility process, but asserted as follows: (1) that she has serious health issues that require constant monitoring, resulting in recurring medical expenses; (2) that her SOC

has been going up and down for no apparent reasons and (3).that most medical providers do not understand or accept SOC as Medicaid. She is seeking MSP benefits effective February 2018 and full Medicaid to cover all of her medical expenses or a lower, more affordable SOC, so she can access the medical procedures she needs.

12. The undersigned offered Petitioner to keep the record open to give her time to collect the necessary medical bills and provide them to the Department for consideration, but she declined, citing the providers have refused to give her own medical bills due to HIPAA regulations.

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

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

#### **Denial of QI 1 Medicare Savings Program (MSP) will be addressed first.**

15. Federal Regulations at 20 C.F.R. § 416.1123, How we count unearned income, states in part:

(b) *Amount considered as income.* We may include more or less of your unearned income than you actually receive.

(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums.

16. The above regulation explains that the gross amount is considered as income for Medicaid eligibility. The Department must follow this guideline.

17. Federal Regulations at 20 C.F.R. § 416.1124, Unearned income we do not count, states in part:

(a) *General.* While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount...We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the \$20 general exclusion described in paragraph (c)(12).

18. 20 C.F.R. § 416.1124(c) (12) establishes a \$20 disregard for “the first \$20 of any unearned income in a month” and income can be reduced by that amount.”

19. The above regulations explain that only a \$20 general exclusion is applied in the SSI-Related Medicaid Program.

20. Fla. Admin. Code R. 65-1.702 Medicaid Special Provisions, in relevant 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...

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

21. Fla. Admin. Code R. 65A-1.713(1) further addresses the “SSI-Related Medicaid Income Eligibility Criteria” stating:

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

...

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

22. Federal Regulations at 20 C.F.R. § 416.121 "Types of Unearned Income" states in relevant part: "(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, veteran's benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits."

23. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22 at Appendix A-9 shows the Income Limit for a QMB Couple as \$1,354, SLMB Couple as \$1,624, and QI1 Couple as \$1,827 from April 2017 through March 2018. Effective April 2018, it shows the Income Limit for a QMB Couple as \$1,372, SLMB Couple as \$1,646, and QI1 Couple as \$1,852.

24. In this instant case, Petitioner's wife was not included in the MSP eligibility determination. No income was deemed from her because she does not have any. Respondent deducted \$20 from Petitioner's new SS amount of \$1,399 (COLA included) to arrive at \$1,379 as countable income. This amount was compared to the QI1 income limit of \$1,357 (for an individual), resulting in Petitioner's MSP being denied effective February 2018.

25. The Court held in Winick v. Dep't of Children and Family Services, 161 So.3d 464 (Fla. 2d DCA 2014), where an individual who receives Medicare Part A is

applying for the Medicare Buy-In Program and lives with his/her spouse, the Department must determine eligibility using the family size of two.

26. The facts show Petitioner is married and living with her wife. She is the only one in the household receiving Medicare, and she is requesting assistance with the payment of her Medicare Part B premiums. Petitioner's income of \$1,399 minus \$20 disregard, equals income of \$1,379. Therefore, the undersigned applies the Winick decision to this appeal. It is concluded that Respondent erred in applying the individual income standard to Petitioner.

27. Petitioner last received MSP benefits in January 2018. In careful review of the cited authorities, evidence and testimony, the undersigned concludes Petitioner has met her burden of proof by demonstrating that Respondent incorrectly denied her request for MSP benefits based on her household income and composition. Therefore, the undersigned remands the case to Respondent to approve MSP benefits based on the income guideline for a couple protecting the May 1, 2018 application.

**Denial of full Medicaid & enrollment in MN will be addressed now.**

28. The Department determines Medicaid eligibility based on the household circumstances. 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. Petitioner was evaluated under the SSI-Related Medicaid coverage group.

29. 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.

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

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

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

32. Petitioner is a Medicare recipient; therefore, not qualified for full Medicaid. She was evaluated for the Medically Needy Program.

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

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

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

- (1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m)...
- (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of

income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services...

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

35. The above authorities also define Medically Needy and Share of Cost (SOC).

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

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

37. Since Petitioner was not eligible for full Medicaid, the Department proceeded to explore further Medicaid eligibility by deducting the \$180 Medically Needy Income Level deduction for one from her resulting income. After these deductions, the share of cost was determined to be \$1,199. It was further reduced by an additional \$134 for self-paying her Medicare Part B premiums, resulting in the final estimated SOC to be \$1,065.

38. Based on the evidence, testimony, and the controlling authorities, the undersigned concludes that the Department correctly determined that Petitioner is not eligible for full Medicaid benefits and should be enrolled in the Medically Needy Program. No errors were found in the calculation of the amount of the share of cost. Petitioner has failed to meet her burden that she was eligible for full Medicaid or a lower share of cost.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are decided as follows:

- 1) The MSP appeal is granted and REMANDED to Respondent for corrective actions. **Respondent is ordered to approve MSP benefits for Petitioner protecting the May 1, 2018 application.**
- 2) The 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 18 day of Julv, 2018,

in Tallahassee, Florida.



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Roosevelt Reveil  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Office of Economic Self Sufficiency

Aug 01, 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-03770

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on June 7, 2018 at 1:32 p.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner: [REDACTED] pro se

For the Respondent: Rhonda Lanum, supervisor

**STATEMENT OF ISSUE**

At issue is the respondent's action to terminate the petitioner's Medicare Savings Plan (MSP) benefit. The burden of proof was assigned to the respondent by a preponderance of the evidence.

**PRELIMINARY STATEMENT**

The petitioner submitted a 12-page evidence packet, which was marked and entered as Petitioner's Composite Exhibit "1". The respondent submitted a 19-page

evidence packet, which was marked and entered as Respondent's Exhibits "1" through "8". The record was left open through June 14, 2018 for additional information including income standards for Medicaid eligibility and Notices of Case Action related to the case. On June 11, 2018, the petitioner contacted the Office of Appeal Hearings, requesting more time to submit additional information. The request was granted and the record was left open through June 19, 2018. On June 14, 2018, the respondent submitted the requested information, which was marked and entered as Respondent's Exhibits "9" through "13". On June 18, 2018, the petitioner submitted 30-pages of additional information, which was marked and entered as Petitioner's Composite Exhibit 2. The record was closed the same day.

#### **FINDINGS OF FACT**

1. MSP is a Medicaid Buy-in Program in which the State of Florida pays the Medicare Part B premiums. Effective April 1, 2018, to be eligible for the MSP, an individual's income (minus any applicable income disregards) cannot exceed the following income standard for an individual: Qualified Medicare Beneficiary Medicaid (QMB) \$1,012, Special Low-Income Medicare Beneficiary \$1,214, or Qualifying Individual -1 (QI-1) \$1,366 (Respondent's Exhibit 8).
2. On January 12, 2018, the petitioner submitted a paper application requesting Supplemental Nutrition Assistance Program (SNAP) benefits, cash assistance, and Medicaid benefits. MSP is the only benefit at issue (Respondent Exhibit 1).
3. The petitioner [REDACTED] is the only household member. The petitioner has been determined disabled by the Social Security Administration (SSA) and received \$1,745 in Social Security Disability Income (SSDI) per month (Respondent's Exhibit 6).

4. The petitioner pays mortgage of \$191 per month, homeowner's association fees of \$436 per month, electric of \$75 per month, and telephone expense of \$75 per month.

The petitioner also pays a Medicare Part B premium of \$134 per month (Respondent's Exhibit 1).

5. The respondent determined the petitioner's MSP budget as follows:

\$1,745	total unearned income
- 20	unearned income disregard
<hr/>	<hr/>
\$1,725	countable unearned income

6. The income limit for MSP coverage is \$1,366. The petitioner's income is over the income limit for MSP.

7. On February 9, 2018, the respondent sent the petitioner a Notice of Case Action (NOCA) informing her the request for Qualified Medicare Beneficiary Medicaid (QMB) was approved for January 2018, February 2018, March 2018 and ongoing (Respondent's Exhibit 11).

8. On February 15, 2018, the respondent sent the petitioner a NOCA informing her she was ineligible for Qualifying Individual 1, "Reason: Your household's income is too high to qualify for this program" (Respondent's Exhibit 10).

9. The petitioner timely requested the appeal.

10. The petitioner contends she has many expenses that the department is not taking into consideration. She also states it's unfair that they would take away the coverage.

11. The respondent contends the petitioner is over the income limit and an error was made in the initial determination of eligibility.

**CONCLUSIONS OF LAW**

12. 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.

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

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

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

...

(12) Limits of Coverage.

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

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

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

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

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

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

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

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

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

17. The Department's Policy Manual (The Policy Manual), CF-OP 165-22, at Appendix A-9, identifies MSP income standards for an individual, effective April 1, 2018 as follows:

<u>QMB</u>	<u>SLMB</u>	<u>QI1</u>
\$1,012	\$1,214	\$1,366

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

19. In accordance with the above-mentioned authorities and policy manual, the respondent deducted \$20 unearned income disregard from the household's total unearned income of \$1,745 to arrive at \$1,725. The highest income for any level of MSP is \$1,366.

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

21. Based on the cited authorities and evidence, the undersigned concludes the respondent followed rule in terminating the petitioner's MSP benefit due to exceeding the income standard set for an individual.

**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 01 day of August, 2018,

in Tallahassee, Florida.



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Pamela B. Vance  
Hearing Officer  
Building 5, Room 255  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Aug 30, 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-03771

PETITIONER,

Vs.

CASE NO. [Redacted]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 17 Broward  
UNIT: 88624

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on July 19, 2018 at 11:49 a.m. All parties appeared telephonically from different locations.

**APPEARANCES**

For the Petitioner: [Redacted] pro se

For the Respondent Verma Jordan, ESS II

**STATEMENT OF ISSUE**

At issue is the respondent's action to deny the petitioner's request for SSI-Related Medicaid due to being over the asset limit at application. The burden of proof was assigned to the petitioner by a preponderance of evidence.

**PRELIMINARY STATEMENT**

Gary DeFalco, the petitioner's son in law, appeared as a witness for the petitioner. Noemi Brown, ESS I, appeared a witness for the respondent.

The petitioner submitted no exhibits. The respondent submitted a 17-page evidence packet, which was marked and entered as Respondent's Exhibits "1" through "17". The record was left open through July 26, 2018 for additional information including the application submitted by the petitioner, policy related to the asset verification system (AVS), the running record comments (CLRC), any updates made to the case including new notices issued to the petitioner, and policy related to the transfer of assets. On July 23, 2018, the respondent submitted the CLRC, policy related to the AVS, and policy related to the transfer of assets, which was marked and entered as Respondent's Exhibits "11" through "16". On July 26, 2018, the petitioner submitted a seven-page evidence packet, which was marked and entered as Petitioner's Exhibits "1" through "6". The record was closed the same day. On August 14, 2018, the respondent submitted the application submitted by the application. Although it was submitted after the record was closed, the undersigned relied upon the application in making a decision. The application was marked and entered as Respondent's Exhibit "17".

#### **FINDINGS OF FACT**

1. On February 28, 2018, the petitioner (81 years old) submitted an electronic web application requesting Medicaid benefits. The respondent reported \$42,000 in a Bank of America account (Respondent's Exhibit 17).
2. On March 2, 2018, the petitioner completed an eligibility interview. The petitioner receives \$594.10 per month from Social Security Administration (SSA) for his retirement. He also receives \$362.63 per month from his IRA (Petitioner's Testimony).

3. On March 5, 2018, the respondent mailed the petitioner a Notice of Case Action (NOCA) (Respondent's Exhibit 7) stating:

We need the following information by March 15, 2018.

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

PLEASE SUBMIT FORM 2515 FROM ADRC OR SUPPORT COORDINATOR.

4. The petitioner returned the "Certification of Enrollment Status Home and Community Based Services (HCBS)" (Respondent's Exhibit 2).
5. On April 2, 2018, the respondent mailed the petitioner a NOCA informing him the application for Medicaid was denied: "Reason: We did not receive all information needed to determine eligibility" (Respondent's Exhibit 8).
6. On April 16, 2018, the respondent mailed the petitioner a NOCA (Respondent's Exhibit 9):

We need the following information by April 26, 2018.

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

PLEASE SUBMIT BANK STATEMENTS FOR 2/18 & 3/18, AND VERIFICATION OF ALL INCOME.

7. On April 24, 2018, the respondent received an asset verification data match which showed the petitioner's name listed on four separate accounts. The petitioner was the sole owner on Bank of America other account (account number ending in [REDACTED]) with a balance of \$2,735.32, sole owner on Bank of America other account (account number ending in [REDACTED] with a balance of \$70,889.54, co-owner along with two other account owners on Bank of America checking account (account number ending in [REDACTED] with a

balance of \$47,146.89 and co-owner with his deceased wife on Bank of America revocable trust account (account number ending in 5295) with a balance of \$292.89 (Respondent's Exhibits 3 through 6).

8. On April 30, 2018, the respondent mailed the petitioner a NOCA informing him his request for Medicaid was denied: "Reason: The value of your assets is too high for this program" (Respondent's Exhibit 10).

9. The petitioner timely requested the appeal.

10. The respondent states the petitioner is over the asset limit of \$2,000 and is therefore, ineligible for the Medicaid benefits.

11. The petitioner's witness states his father has [REDACTED]'s and [REDACTED] and he has power of attorney over his father and his finances. He was unaware of the account ending in 1155 until the petitioner's wife died several months ago. He further states that account was then used to pay his father's expenses because his income is less than his monthly expenses and is now closed.

12. The account ending in 5156 is an IRA account that his father is receiving \$362.63 per month from as income. The account ending [REDACTED] was set up by the children so that he could have a place to deposit his father's SSRE check monthly, the petitioner has no access to the funds and cannot spend any of the money in the account (Petitioner's Exhibits 2 through 5).

13. The petitioner's witness further states no one gave him an opportunity to prove his father did not own the funds in the account.

14. The respondent purports the department does not allow the applicant to rebut the information if it is not reported by the client during the application period.

**CONCLUSIONS OF LAW**

15. 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.

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

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

18. 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., 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.

19. Fla. Admin. Code 65A-1.716 Income and Resource Criteria states: "(5) SSI-Related Program Standards. (a) SSI (42 U.S.C. §§1382 – 1383c) Resource Limits: 1. \$2,000 per individual."

20. Fla. Admin. Code R. 65A-1.303, Assets, states in part:

- (1) Specific policies concerning assets vary by program and are found in federal statutes and regulations and Florida Statutes.
- (2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.
- (3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf.

21. The above cited authorities define assets and further establishes rules set for determining availability of assets and where it is considered countable in determining eligibility. For a household of one, the asset limit is established as \$2,000.

22. In this instant case, the respondent denied the petitioner's application due to being over the asset limit based on the data exchange received documenting bank accounts that included the petitioner's name.

23. Federal Regulations at 20 C.F.R. §416.1208 How funds held in financial institution accounts are counted, addresses funds in bank accounts are counted and the process of rebutting ownership of funds in jointly owned accounts:

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

(c) *Jointly-held account*—(1) Account holders include one or more SSI claimants or recipients. If there is only one SSI claimant or recipient account holder on a jointly held account, we presume that all of the funds in the account belong to that individual. If there is more than one claimant or recipient account holder, we presume that all the funds in the account belong to those individuals in equal shares.

(2) *Account holders include one or more deemors*. If none of the account holders is a claimant or recipient, we presume that all of the funds in a jointly-held account belong to the deemor(s), in equal shares if there is more than one deemor. A deemor is a person whose income and resources are required to be considered when determining eligibility and computing the SSI benefit for an eligible individual (see §§416.1160 and 416.1202).

(3) *Right to rebut presumption of ownership*. If the claimant, recipient, or deemor objects or disagrees with an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, we give the individual the opportunity to rebut the presumption. Rebuttal is a procedure as described in paragraph (c)(4) of this section, which permits an individual to furnish evidence and establish that some or all of the funds in a jointly-held account do not belong to him or her. Successful rebuttal establishes that the individual does not own some or all of the funds. The effect of successful rebuttal may be retroactive as well as prospective.

Example: The recipient's first month of eligibility is January 1993. In May 1993 the recipient successfully establishes that none of the funds in a 5-year-old jointly-held account belong to her. We do not count any of the funds as resources for the months of January 1993 and continuing.

(4) *Procedure for rebuttal*. To rebut an ownership presumption as described in paragraph (c)(1) or (c)(2) of this section, the individual must:

(i) Submit his/her statement, along with corroborating statements from other account holders, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;

(ii) Submit account records showing deposits, withdrawals, and interest (if any) in the months for which ownership of funds is at issue; and

(iii) Correct the account title to show that the individual is no longer a co-owner if the individual owns none of the funds; or, if the individual owns only a portion of the funds, separate the funds owned by the other account

holder(s) from his/her own funds and correct the account title on the individual's own funds to show they are solely-owned by the individual.

24. The Department's Program Policy Manual (The Policy Manual), CFOP 165, at passage 1640.0302.01 Joint Ownership of Bank Accounts (MSSI, SFP) states in the relevant part:

When an individual is a joint account holder who has unrestricted access to the funds in the account, you must presume all of the funds in the account are owned by the individual. This presumption is made regardless of the source of the funds.

If the individual alleges the funds in the account belong to someone else, you must allow the individual to submit evidence to challenge this presumption. If the challenge is successful, do not count the funds in the account as an asset to the individual for any month. If the challenge to the presumption of ownership is not successful, you must consider the funds as an asset to the individual. This policy applies to checking accounts, savings accounts, certificates of deposit and other jointly owned financial accounts.

25. The Policy Manual at passage 1640.0302.04 Proof Needed to Rebut Ownership (MSSI, SFP), states in the relevant part:

When an individual has unrestricted access to the funds in a joint account but does not consider himself an owner of part or all of the account funds, you must advise the individual that:

1. the funds are presumed to be his; and
2. he may rebut the presumption of ownership by presenting proof the funds belong to someone else.

To rebut the presumption of ownership, the individual must provide the following information:

**First**, the individual must provide a written statement and corroborating evidence from the financial institution(s) and other sources to substantiate:

1. any claims about ownership of the funds or interest from the funds;
2. the reasons for establishing the joint account;
3. whose funds were deposited into the account;
4. who made withdrawals from the account; and
5. information on how withdrawals were spent.

**Second**, the individual must provide a written statement from the joint owner(s) explaining their understanding of the ownership of the account(s); that is, claims of ownership, why the account was set up, who deposited funds, withdrew funds and used the account.

When an individual is a co-owner of an account with someone who is incompetent or a minor, the corroborating co-owner statement is not necessary. You must obtain a corroborating statement from a third party who has knowledge of the circumstances.

If there is no third party or the individual is unable to provide all bank verification, you must make a rebuttal determination based on the evidence submitted. Enter an explanation on CLRC why no written corroborating statement was obtained from the joint owner.

To successfully rebut ownership of a joint account, the evidence must clearly support that the individual is not a joint owner of the funds.

26. The above cited authorities explain the department must allow applicants who assert that funds in a bank account belong to someone else an opportunity to prove their claims and if proven, the funds do not count as an asset for any month.

27. In this instant case, the petitioner's witness claims the funds belong to the petitioner's children and the only funds in the account that belong to him are from his SSRE monthly payments. Further, the petitioner's witness claims he was never given the opportunity to rebut the ownership of the funds in the bank accounts that show the petitioner and other family members as joint account holders.

28. The evidence proves that the petitioner reported the funds in account ending [REDACTED] with Bank of America on his original request for benefits, which contradicts the respondent's testimony that the petitioner did not report the account. The petitioner was not allowed to rebut the ownership of the account.

29. In careful review of the evidence, testimony, and cited authorities, the undersigned concludes the respondent did not follow rule and allow the petitioner to rebut the ownership of any or all funds listed in the Bank of America bank accounts, which caused the countable asset value to exceed the asset limit of \$2,000. The respondent is ordered to allow the petitioner the opportunity to provide any rebuttal evidence needed to completed the review. Once the review is completed, the respondent shall issue a written notice stating the results. The notice shall include appeal rights.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is hereby granted and remanded for further development.

### **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- 03771  
PAGE -11

DONE and ORDERED this 30 day of August, 2018,  
in Tallahassee, Florida.



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Pamela B. Vance  
Hearing Officer  
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1317 Winewood Boulevard  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

**FILED**

Jul 16, 2018

Office of Appeal Hearings  
Dept. of Children and Families

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

[REDACTED]

APPEAL NO. 18F-03776

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 14 Bay  
UNIT: 88146

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 12, 2018 at 1:53 p.m.

**APPEARANCES**

For the Petitioner: [REDACTED]

For the Respondent: Sheila Rushing, ACCESS Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of April 30, 2018 denying his application for SSI-Related Medicaid due to not meeting the disability requirement. The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The Department submitted evidence on June 5, 2018 in this matter. This was entered as Respondent's Exhibit 1. The petitioner did not submit evidence in this matter.

The record closed on July 12, 2018.

### **FINDINGS OF FACT**

1. The petitioner, through designated representative, applied for SSI-Related Medicaid on April 4, 2018. He is the only individual listed on the application. He is 52 years old. He is requesting Medicaid to begin February 2018. (Respondent's Exhibit 1, pages 3 through 6)

2. The Department submitted the case for review with the Division of Disability Determinations (DDD) on April 17, 2018. (Respondent's Exhibit 1, page 21)

3. DDD returned the Disability Determination and Transmittal to the Department on April 24, 2018 citing a decision previously made by the Social Security Administration (SSA) in March 2018 was adopted. The decision issued by SSA was an N36. DDD noted a hearing is pending in that matter. (Respondent's Exhibit 1, page 21).

4. The Department explained that an N36 denial means: "non-pay – insufficient or no medical data furnished".

5. The Department issued a Notice of Case Action on April 30, 2018 denying the petitioner's application for SSI-Related Medicaid. The reason for the denial was "You or a member(s) of your household do not meet the disability requirement". The Notice was issued to both the petitioner and the designated representative.

(Respondent's Exhibit 1, pages 7 through 14)

6. The designated representative's copy of the Notice of Case Action was returned to the Department. The Notice was resent to the designated representative at her updated address on June 1, 2018. (Respondent's page 15)

7. The representative reported the petitioner does have a history of strokes.

8. The petitioner was admitted to [REDACTED] [REDACTED] on or about February 27, 2018. At that time, the representative reports he was able to walk and communicate with staff. On or about March 1, 2018, the petitioner suffered another [REDACTED] [REDACTED]. This has left him unable to communicate other than saying his name and answering yes and no to questions. The representative also advised he is unable to feed or toilet himself. She is aware that he moves from the bed to a chair, but is uncertain if that is done by a lift or if he is able to take a couple of steps to move from bed to chair. The petitioner remains hospitalized at [REDACTED]

9. To the representative's knowledge SSA has not reviewed the case since the updated medical information was provided to SSA. She has not received any refusal from SSA to review the updated information on worsened condition (new [REDACTED] in March 2018).

### **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. 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.

13. 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.

14. 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).

15. 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.)

16. 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:**

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

...

(e) Medical and nonmedical evidence. The agency must obtain a medical report and other nonmedical evidence for individuals applying for Medicaid on the basis of disability. The medical report and nonmedical evidence must include diagnosis and other information in accordance with the requirements for evidence applicable to disability determinations under the SSI program specified in 20 CFR part 416, subpart I.  
(emphasis added)

17. The undersigned explored potential eligibility for SSI-Related Medicaid for the petitioner. The findings show the petitioner was 52 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.

18. The findings show the petitioner applied for Social Security disability and was denied on March 2018. The findings show the petitioner appealed the denial of Social Security disability. The findings show the decision made was an N36 decision which means "non-pay insufficient or no medical data furnished". The undersigned concludes SSA did not make a disability determination in this case. The undersigned further concludes the Department should have requested a disability determination be made in this matter as one was not made by SSA.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is remanded to the Department for a determination of disability to be completed. The Department is to issue a Notice of Case Action, to include appeal rights, upon completion of the disability decision.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 16 day of July, 2018,

in Tallahassee, Florida.



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Melissa Roedel  
Hearing Officer  
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1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

**FILED**

Aug 10, 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-03889

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 08 Alachua  
UNIT: 88102

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 1, 2018 at 10:14 a.m.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se

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

**STATEMENT OF ISSUE**

At issue the petitioner's eligibility for SSI-Related Medicaid. The petitioner holds the burden of proof by a preponderance of evidence.

**PRELIMINARY STATEMENT**

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

By notice dated March 6, 2018, the Department informed the petitioner that his “Medically Needy application/review dated February 2, 2018” was denied for February 2018 – April 2018 because the value of his assets were too high for the program.

By notice dated April 19, 2018, the Department again informed the petitioner that his “Medically Needy application/review dated March 19, 2018” was denied for March 2018 – May 2018 because the value of his assets were too high for the program.

By notice dated April 30, 2018, the Department informed the petitioner that his application for Medically Needy dated April 26, 2018” was approved and that he was enrolled with an \$858 monthly estimated share of cost for the months of March 2018 - June 2018 and ongoing.

On May 11, 2018, the petitioner requested a hearing, seeking Medicaid coverage for the months of January 2018 and February 2018.

There were no additional witnesses for the petitioner. The petitioner submitted documentary evidence which was admitted into the record as Petitioner’s Exhibits 1 and 2.

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

The hearing record was closed on August 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 (age 40) is a single male adult, without minor children. The petitioner has outstanding medical bills (he estimates a balance in the thousands of dollars) that were not covered by his Florida Blue health insurance plan. He is seeking Medicaid coverage to help pay these medical expenses. (Testimony of petitioner)

2. The petitioner filed multiple Medicaid applications with the Department December 2017 - April 2018. The Department denied all except the last of the applications. (Department testimony)

3. The petitioner filed the first application with the Department on December 11, 2017. The Department denied the application on January 10, 2018 because the petitioner did not return information (disability packet) necessary to determination eligibility. (Department testimony)

4. The petitioner filed a second application with the Department on February 2, 2018. The Department denied the application on March 6, 2018 because the petitioner's countable assets (\$15,000 bank account with Bank of America) exceeded the applicable Medicaid asset limit (\$5,000). (Department testimony and Respondent Exhibit 1)

5. The petitioner filed a third application with the Department on March 19, 2018. The Department denied the application on April 19, 2018 because the petitioner's countable assets (\$15,000 bank account with Bank of America) again exceed the applicable asset limit (\$5,000). (Department testimony and Respondent Exhibit 1)

6. The petitioner filed a fourth application with the Department on April 26, 2018. The Department approved the application on April 30, 2018. The Department enrolled

the petitioner in the SSI-Related Medically Needy Program with an \$858 estimated monthly share of cost for the months of March 2018 and ongoing. (Respondent's Exhibit 1)

7. The petitioner requested a hearing; he is seeking Medically Needy benefits for the months of January 2018 and February 2018. (Petitioner testimony)

8. The petitioner acknowledged receiving two large deposits into his banking account during the month of January 2018, totaling \$15,000. The petitioner explained that funds were a student loan for graduate school. He withdrew from the graduate program and never used the funds for educational expenses. The petitioner admitted that his bank account balance exceeded \$5,000 for the months in question (February 2018 – June 2018), but argued that the loan should not be counted as an asset because he is responsible for paying back the money to the lender. (Petitioner testimony and Petitioner's Exhibits 1-2)

9. The Department explained that the petitioner does not qualify for Family-Related Medicaid because he does not have minor children. The petitioner answered "yes" the application question which asked if he had a disability, so the Department reviewed his eligibility under the SSI-Related Medicaid category. To be eligible for SSI-Related Medicaid, the Department or the Social Security Administration (SSA) must determine that the applicant meets the disability criteria. SSA has not determined that the petitioner is disabled and the Department never sent his case to its own disability review team, the Division of Disability Determination (DDD). The Department asserted

that it erred in approving the petitioner's Medicaid application without this criteria (disability determination) being met. (Department testimony)

10. In addition to meeting the disability criteria, SSI-Related applicants must meet other eligibility factors, such as the designated income and asset limits. The Department determined that the petitioner's approximately \$1,000 gross monthly income exceeded the \$885 full coverage SSI-Related Medicaid limit for an individual and enrolled him in the Medically Needy Program with an \$858 estimated monthly share of cost. (Respondent's Exhibit 1)

11. Regarding the asset criteria, the Department explained that its rules state that student loans deposited into an applicant's bank account are counted as assets the month after the month of receipt. The petitioner deposited a \$15,000 student loan into his bank account in January 2018. The funds were an excluded asset in January 2018. The petitioner's lowest bank account balance during the month of January 2018 was approximately \$4,000. The Department determined that he met the \$5,000 Medically Needy asset limit for that month and processed the unpaid medical bills he filed for January 2018. The Department determined that the petitioner met his share-of-cost on or about January 15, 2018 and opened SSI-Related Medicaid coverage for him from that date until the end of the month. The Department determined that the petitioner was over the asset limit (\$15,000 countable assets exceeded \$5,000 limit) for February 2018 and denied coverage for that month. (Department testimony and Respondent's Exhibit 1)

12. The Department testified that the petitioner's bank account balance was never less than \$5,000 February 2018 and ongoing. The Department erred when it notified the petitioner in April 2018 that he met the Medically Needy eligibility criteria March 2018 – June 2018 and ongoing. The Department realized its mistake on or about June 20, 2018 and closed the petitioner's Medically Needy assistance group effective June 30, 2018. The Department suppressed (did not issue) the termination notice. The petitioner was not aware prior to the hearing that his case was closed. The Department acknowledged that it should not have suppressed the termination notice. Program rules require that the Department send recipients written notice prior to any adverse action, advising them of the reason for the action, the effective date of the action, and appeal rights. (Department testimony and Respondent's Exhibit 1)

### **CONCLUSIONS OF LAW**

13. Pursuant to Section 409.285, Florida Statutes, the Department of Children and Families' Office of Appeal Hearings has jurisdiction over this proceeding.

14. This order is the final administrative decision of the Department of Children and Families pursuant to Section 409.285(2), 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(5) defines a Medically Needy Program as, "A Medicaid coverage group, as allowed by 42 U.S.C. 139a and §1963d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources."

17. Fla. Admin. Code R. 65A-1.712 states that Medicaid applicants must meet the applicable resource limit. Appendix A-9 of the Department's Policy Manual reflects maximum asset value for a Medically Needy individual of \$5,000.

18. 20 C.F.R. § 416.1208 and Fla. Admin. Code R. 65A-1.303 explain that funds held in a bank or other financial institution are considered countable assets if the individual has unrestricted access to the funds.

19. 20 C.F.R. § 416.1236 addresses exclusions from resources and includes a provision for the exclusion of undergraduate educational loans. The authority does not include an exclusion for graduate school educational loans.

20. The Department's Policy Manual passages cited below address bank accounts and student loans in the SSI-Related Medicaid Program:

**1640.0502 Checking and Savings Accounts (MSSI, SFP)**

The asset value is the balance in the account on the date on which eligibility is established. If the total asset value of the account does not affect eligibility, it is not necessary to determine the amount of any transactions that have not cleared the account or the individual's portion of a joint bank account. However, the individual still may be given the opportunity to rebut full or partial ownership to ensure that future changes to the account will not affect his eligibility.

**1640.0556 Loans (MSSI, SFP)**

A loan is a transaction when one party (lender) advances money to another party (borrower) who promises to repay the debt in full within the borrower's lifetime. Repayment of loans may or may not include interest. A loan may take the form of a formal written document or an informal verbal agreement.

**1640.0560.01 Evaluating Loans (MSSI, SFP)**

...

**When the individual is the borrower:**

1. The loan agreement itself is not an asset.

2. Cash proceeds of a loan may be an included asset if retained into the month following the month of receipt.
3. Cash proceeds of a bona fide loan are not income in the month of receipt.
4. When the loan is not bona fide, cash proceeds are income in the month of receipt.

21. The above cited authorities address resources in the SSI-Related Medicaid Program. The petitioner received a \$15,000 loan for graduate school in January 2018 and deposited the loan funds into a bank account to which he has unrestricted access and is the sole owner. The petitioner later withdrew from graduate school; the loan funds remained in his bank account from at least February 2018 – June 2018. The controlling legal authorities explain that monies received from graduate school loans are counted as an asset if they remain in an applicant's bank account the month after the month of receipt and the owner has unrestricted access to the funds. The petitioner's countable asset value of \$15,000 exceeded the \$5,000 Medically Needy income limit February 2018 and ongoing. The petitioner argued that the funds should be excluded because he must repay the loan. The controlling legal authorities do not include a provision under which the proceeds from the loan would be excluded as a countable asset for the reasons set forth by the petitioner. The petitioner was ineligible for SSI-Related Medically Needy February 2018 and ongoing due to assets in excess of program limits.

22. 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.

23. 42 C.F.R. § 435.541, standards for state disability determinations, explains that disability determinations must be made by SSA or the Department.

24. The petitioner (age 40) is a single male adult without minor children. He is not eligible for Family-Related Medicaid. To be eligible for SSI-Related Medicaid, the Department or SSA must determine that he is disabled. As of the date of the hearing, neither Agency had determined that the petitioner is disabled. Accordingly, the petitioner is not eligible for participation in the SSI-Related Medicaid Program.

25. The Department erroneously approved Medically Needy benefits for the petitioner effective March 2018 and ongoing (enrolled the petitioner in the Medically Needy Program with an estimated share of cost). The Department realized its mistake in June 2018 and terminated the petitioner benefits effective June 30, 2018. The Department did not issue a termination notice to the petitioner. These facts are not disputed. The Department's failure to issue a termination notice violates 42 C.F.R. § 431.206(b) which states that a Medicaid agency must inform an individual in writing before it reduces or terminates the individual's benefits. The written notice must inform the individual of the reason for the action, hearing rights, and method to request a hearing.

26. The Department's failure to determine if the petitioner met the necessary disability criteria would warrant remanding the case for further development if he had not already been determined ineligible due to assets in excess of program limitations.

27. The Department's failure to notify the petitioner that it terminated his enrollment in the SSI-Related Medically Needy Program would warrant remanding the case for further development were it not for the fact that the only remedy available to the petitioner to address this error would be a fair hearing, which he has already received.

### **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 10 day of August, 2018,  
in Tallahassee, Florida.



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

**FILED**

Jul 09, 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-03905

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 07 St. Johns  
UNIT: 88329

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 28, 2018 at 11:13 a.m.

**APPEARANCES**

For the Petitioner: The petitioner was present and represented herself.

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

**ISSUE**

At issue is the Department's action on May 3, 2018 on May 3, 2018 to deny the petitioner's application for the Qualifying Individual 1 (QI-1) program due to not meeting the income guidelines for a couple.

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

### **PRELIMINARY STATEMENT**

Evidence was received and entered as the Respondent's Exhibits 1 and 2. No evidence was received from the petitioner.

The record was closed at the conclusion of the hearing.

### **FINDINGS OF FACT**

1. On May 4, 2018, the petitioner, age 70, applied for QI-1 for herself. The petitioner is married and resides with her husband, age 56. The petitioner and her husband are enrolled in the Medically Needy (MN) program with a share of cost; this program is not at issue.

2. The Department included in the QI-1 budget, Social Security income in the gross amount of \$869 for the petitioner and Social Security income in the gross amount of \$1131 for the petitioner's husband. The total income included in the QI-1 budget was \$2000. The \$20 unearned income disregard was subtracted from the total gross income, which resulted in a countable unearned income of \$1980 (Respondent's Exhibit 2).

3. The Department determined that the petitioner is ineligible for the QI-1 program, as the income exceeded the QI-1 income standard for a couple in the amount of \$1827 (at the time of the Department's action).

4. The petitioner argues that her income is over the income limit by a small amount; therefore, she believes that the Department should allow her to be able to receive benefits under the QI-1 program. The petitioner does not dispute the income included in the Department's calculations. The petitioner argues that she considers her

“take home” pay to be her gross income, because she does not receive \$869 after the Medicare premium is taken out of her Social Security income. The petitioner explained that her husband is not yet eligible to receive Medicare. The petitioner argues that she was receiving coverage under the Medicare Savings Program (MSP) in the past to assist in paying her Medicare premium. The petitioner acknowledges that her husband recently began receiving Social Security income. The petitioner believes that her and her husband’s income is \$1866 after the premium has been taken out to reduce her income and believes she is entitled to receive benefits under the QI-1 program.

5. The Department contends that it is required to use the gross monthly income in the QI-1 budget. The Department contends that the petitioner is not entitled to receive any other deductions to her income. The Department contends that its records show that the petitioner last received coverage under the MSP in January 2018; this was undisputed. The Department contends that its policy does not include any exceptions that would allow eligibility for the MSP if a household’s income exceeds the income limit.

### **CONCLUSIONS OF LAW**

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

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

8. Fla. Admin. Code R. 65A-1.709 SSI-Related Medicaid Coverage states, “SSI-related Medicaid provides medical assistance to eligible individuals who are aged, blind or disabled in accordance with Titles XVI and XIX of the Social Security Act and Chapter 409, F.S.”

9. Federal Regulations at 20 CFR § 416.1121 Types of unearned income states:

Some types of unearned income are—

(a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker’s compensation, railroad retirement annuities and unemployment insurance benefits.

10. Federal Regulations at 20 CFR § 416.1123, How we count unearned income.

(a) *When we count unearned income.*

We count unearned income at the earliest of the following points: When you receive it or when it is credited to your account or set aside for your use. We determine your unearned income for each month. We describe an exception to the rule on how we count unearned income in paragraph (d) of this section.

(b) *Amount considered as income.* We may include more or less of your unearned income than you actually receive.

(1) We include more than you actually receive where another benefit payment (such as a social security insurance benefit) (see § 416.1121) has been reduced to recover a previous overpayment. You are repaying a legal obligation through the withholding of portions of your benefit amount, and the amount of the debt reduction is also part of your unearned income. *Exception:* We do not include more than you actually receive if you received both SSI benefits and the other benefit at the time the overpayment of the other benefit occurred and the overpaid amount was included in figuring your SSI benefit at that time.

(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment **such as payment of your Medicare premiums (emphasis added).**

11. The above authorities explain that unearned income, such as Social Security income, are included as income in determining eligibility for the Medicaid programs. Also included as income are amounts withheld to pay Medicare premiums. The findings show that the petitioner and her husband are receiving Social Security income. The petitioner's income is reduced by amounts withheld to pay her Medicare premium. Therefore, the undersigned concludes that the Department was correct to include the Social Security income, along with including as income the amounts withheld to pay the Medicare premiums, in its calculations.

12. Fla. Admin. Code R. 65A-1.702 Special Provisions 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.)

13. Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility

Criteria states:

- (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
- (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
- (g) For SLMB, income must be greater than 100 percent of the federal

poverty level but equal to or less than 120 percent of the federal poverty level.

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

14. The above authority explains that an individual must have income that is within the income limits established by the federal and state law as well as the Medicaid State plan. An individual may qualify for the QMB program if her income is less than or equal to the federal poverty level after applying exclusions to the income. The SLMB program requires income to be greater than 100% of the federal poverty level but equal to or less than 120% of the federal poverty level. An individual must have income greater than 120% of the poverty level but equal to or less than 135% of the federal poverty level to be eligible for QI-1. QI-1 only allows payment of the Part B Medicare premium through Medicaid. The undersigned was unable to locate any governing authorities that would allow coverage for the MSP if income exceeded the income limit by a small amount.

15. The Department's Program Policy Manual at Appendix A-9, effective January 2018, sets forth that the income limit for QMB benefits as a QMB Individual at \$1005 and a QMB Couple at \$1354; SLMB benefits for a SLMB Individual at \$1206 and a SLMB Couple at \$1,624; and QI-1 benefits for a QI-1 Individual at \$1357 and a QI1 couple at \$1827; this was the income limit for the QI-1 Couple at the time of the Department's action. The Appendix A-9, effective July 1, 2018, sets for the income limit for QMB benefits as a QMB Individual at \$1012 and a QMB Couple at \$1372; SLMB benefits for a SLMB Individual at \$1214 and a SLMB Couple at \$1,646; and QI-1

benefits for a QI-1 Individual at \$1366 and a QI1 couple at \$1852.

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

17. The Department’s Program Policy Manual, CFOP 165-22, passage 2440.0322 Standard Disregard (MSSI) states in part,

This policy applies to MEDS-AD, MN, QMB, SLMB, QI-1, Working Disabled, Protected Medicaid and EMA. A \$20 per month standard disregard applies to any type (earned or unearned) of income other than income which is provided on the basis of need. The amount of the disregard is not increased for a couple, regardless of whether one or both individuals have income.

18. The above authorities state that for the QI-1 program, a \$20 per month standard disregard is allowed to reduce the amount in unearned income in determining eligibility for the program. An eligible couple only gets one \$20 disregard.

19. The Department’s Program Policy Manual (Manual), CFOP 165-22, passage 2240.0604.07 Married and Living with Spouse (MSSI, SFP) states:

The policy in this section is applicable only to MEDS-AD, Medically Needy, Protected Medicaid, Working Disabled, QMB, SLMB, QI-1, OSS and HCDA.

When an individual alleges being married to and living with a person who is aged, blind, or disabled, the individual's statement as to the relationship will be accepted. The application will be processed as that of an eligible individual and eligible spouse.

20. The Department’s Manual, CFOP 165-22, passage 2240.0611 Couple/Both Request Medicaid (MSSI) states:

The following policy is applicable only to MEDS-AD, QMB, SLMB, QI-1, EMA, Protected Medicaid, Medically Needy and Working Disabled Programs.

If an eligible individual is living with an eligible spouse, the income standard for two must be used. Eligibility as a couple must be determined using both spouses' income and assets.

Income is not allocated to family members or dependents.

If an eligible individual is living with their ineligible spouse, the income and assets must be deemed from the spouse who is not eligible for or requesting assistance. If there is not enough income to be deemed, the income standard for one must be used. If there is enough income to deem, the individual must first pass the individual test for one. If they pass the individual income test, they must also pass the couple standard using deemed income from the spouse...

21. The Court held in Winick v. Dep't of Children and Family Services, 161 So.3d 464 (Fla. 2d DCA June 2014), where an individual who receives Medicare Part A and is applying for the Medicare Buy-In Program and lives with his/her spouse, the Department must determine eligibility using the family size of two.

22. The findings show that the petitioner is married and living with her husband. The findings also show that the petitioner is the only one in the household receiving Medicare and is requesting assistance with the payment of her Medicare Part B premium. The findings show that the petitioner's husband is receiving \$1131 in Social Security income. Therefore, the undersigned applies the Winick decision to this appeal. It is concluded that the respondent is correct in applying the couple income standard to petitioner. The Department's Program Policy Manual at Appendix A-9 (effective January 2018) shows the Income Limit for a QI-1 Couple as \$1,827. The Department's Program Policy Manual at Appendix A-9 (effective July 2018) shows the Income Limit for a QI-1 Couple as \$1,852. The petitioner's income of \$2000 minus \$20 disregard, equals income of \$1980, which exceeds the income limit for a QI-1 couple. The

undersigned concludes that the petitioner is ineligible for the MSP under the QI-1 program.

23. Based on the above findings and conclusions of law, the undersigned concludes that the respondent was correct in its denial of the petitioner's application for benefits under the QI-1 program.

### **DECISION**

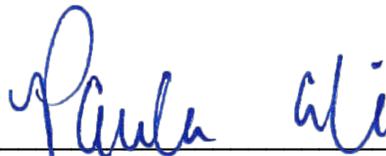
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

### **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 09 day of July, 2018,

in Tallahassee, Florida.



---

Paula Ali  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
Office: 850-488-1429  
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FINAL ORDER (Cont.)

18F-03905

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

Aug 30, 2018

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 18F-03934

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 06 Pasco  
UNIT: 88261

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on June 12, 2018 at approximately 9:33 a.m. CDT.

**APPEARANCES**

For the Petitioner: , *pro se*

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

**STATEMENT OF ISSUE**

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

**PRELIMINARY STATEMENT**

On June 12, 2018, [REDACTED], the petitioner's son, appeared as a witness for the petitioner.

The Florida Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid programs. To be eligible an individual must be blind, disabled, or 65 years or older. The Department of Health's Division of Disability Determinations (DDD) conducts disability reviews regarding medical eligibility for individuals applying for disability benefits under the federal Social Security and Supplemental Security Income programs and the state Medically Needy Program. Once a disability review is completed, the claim is returned to DCF for a final determination of non-medical eligibility and effectuation of any benefits due.

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

An Interim Order continuing and rescheduling the hearing was issued on June 27, 2018. The respondent was instructed to have a representative from DDD present at the rescheduled hearing. The hearing was rescheduled for July 19, 2018 at 3:00 EDT.

Ed Poutre appeared for the respondent on June 12, 2018.

Lorry Beauvais appeared for the respondent on July 19, 2018.

Donald Burdick (DB), unit supervisor for DDD, was present on July 19, 2018 and appeared as a witness for the respondent.

### **FINDINGS OF FACT**

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

1. The petitioner is a 41-year-old female with no minor children in her household.
2. On January 31, 2018, the petitioner's twins became 18-years-old. Prior to the issue under this appeal, the petitioner had been receiving Medicaid coverage under the Family-Related Medicaid Program, having eligible minor children in her household.
3. With no minor children in her household, the petitioner's Family-Related Medicaid eligibility was terminated effective February 1, 2018.
4. On January 25, 2018, the petitioner submitted an application for herself and her family requesting SNAP (Supplemental Nutrition Assistance Program) benefits, Family Medicaid and SSI-Related Medicaid (Respondent's Exhibit 2). Only the SSI-Related Medicaid is at issue.
5. The petitioner testified that she visited the respondent's office to submit her medical records. These records were in a four-inch binder. She was told that what she requested to be submitted was too much to copy. The entirety of the medical record provided by the petitioner was not accepted by the respondent. 93 pages were copied for inclusion in the respondent's disability packet. The petitioner informed the respondent that she would request her medical provider to fax her medical records (Respondent's Exhibit 6).
6. On February 23, 2018, the respondent submitted a disability determination packet to DDD.

7. On March 1, 2018, the petitioner applied for disability benefits with the Social Security Administration (SSA). This is the third time the petitioner has applied for SSA disability benefits. The current application is still in progress. The petitioner has obtained counsel to assist her with the SSA application. She had previously applied for disability in 2013, which resulted in a determination in March 2017 of not disabled after consideration by an Appeal Council. The application is currently coded H80, "Early input" (Testimony and Respondent's Exhibit 4).

8. DDD's decision was sent to the respondent on March 28, 2018. The primary diagnosis was [REDACTED]. There was no secondary diagnosis listed. The petitioner was determined not to be disabled. The medical evaluation states that the petitioner's impairment is severe, but that it does not meet or equal a listing, and that although she has no prior work history, she should be able to engage in substantial gainful activity (SGA). DDD denied the petitioner's application on the contention that she is capable of performing other work. The reason code given for the denial was N32, "Non-pay – Capacity for substantial gainful activity – other work, no visual impairment" (Respondent's Exhibit 5).

9. The petitioner is concerned that the totality of her medical situation was not considered in the DDD decision. Upon discussion of the contents of the disability packet and the comments in it from the examiner, the petitioner agreed that it was very probable that all her multiple medical issues were included in the medical records sent to DDD; however, she believes that if the entire record, covering over 10 years, was allowed to be submitted the result, would have been different.

10. The medical issues recorded in the disability packet include, "[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]" (Respondent's Exhibit 5). The petitioner added [REDACTED]

[REDACTED].

11. DDD utilizes a federally regulated five-step sequential evaluation in determining disability. The Medical Evaluation form dated March 28, 2018 indicates the steps that are followed and what is evaluated in each step:

-Is impairment severe? Yes.

-Does the impairment meet or equal a disability listing in the federal regulation?  
No.

-Can the claimant perform previous related work (PRW)? No.

-Can claimant perform other work? Yes.

#### ADLs

Clmt is able to provide personal care for self. Clmt is able to complete grocery shopping while leaning on a cart. Clmt lives w/ her children who are 18 y/o twins, and an "older" son. During the day, clmt wakes her kids up for school, goes to doctor's appts, eats. Takes Rx's, and complete household chores. Clmt stated that she is able to drive, but if she believes her sugar levels are not controlled then she will get a ride from others. Clmt has never hospitalized sue to mental health. Clmt's highest level of education is the 12<sup>th</sup> grade. Clmt ambulates w/o assistance. [REDACTED]

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

Step 1: Engaging in SGA. **N/A**

Step 2: Is there a MDI? **Yes**

Step 3: Does this impairment meet or equal a listing? **No**

Step 4: Is the claimant able to perform PRW? **No**

Step 5: Is the claimant able to perform other work? **Yes**

13. DDD determined that the petitioner's impairment was severe but did not meet a listing. Although the petitioner has no prior work history, DDD determined that she could perform other work. Based on the medical records submitted to the respondent's office on February 27, 2018 and the respondent's March 16, 2018 telephone interview with DDD, the respondent's residual functional capacity was determined to be "sedentary" as she could stand or walk for two hours a day and sit for six hours a day. With a residual functional capacity of sedentary, DDD determined the petitioner could perform work in the national economy such as that of an order clerk, addresser, or pager and was therefore denied (Testimony of DB and Petitioner's Exhibit 5).

14. The petitioner raised the issue of her [REDACTED] and her son testified that she has had [REDACTED] one resulting in the [REDACTED], beginning in 2008. [REDACTED] were included in the medical information provided to DDD. They have been random. Her son stated the interval of seizure activity was six months or more.

15. The respondent explained that since DDD had determined that the petitioner does not meet its disability criteria, her Medicaid application was denied. The petitioner asserted that her current conditions are worsening by the day and that she has been avoiding appointments because she cannot afford to pay for doctors' visits. She is constantly in pain and needs to rest on a regular basis. The petitioner maintains that she is physically and mentally unable to work. She is seeking Medicaid coverage to pay for much needed medical services while waiting on her disability appeal with SSA.

### **CONCLUSIONS OF LAW**

16. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.
17. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
18. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.
19. Medicaid eligibility is based on federal regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents, children, and pregnant women, and (2) Adult-Related (referred to as SSI-Related) Medicaid for disabled adults and adults 65 or older.
20. Fla Admin. Code R. 65A-1.703, Family-Related Medicaid Coverage Groups, in part states:
  - (1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule...
  - (5) Medicaid for pregnant women...
21. The petitioner last received Family-Related Medicaid coverage in January 2018 when her children were minors. The evidence submitted establishes that the petitioner no longer has a minor child in the home and is not pregnant. She is not age 65 or older and has not been considered disabled by the SSA; therefore, the Department considered the petitioner for SSI-Related Medicaid.

22. 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. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education and work experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.)

23. Additionally, 42 C.F.R. § 435.541 Determination of Disability, provides that a state Medicaid determination of disability must be in accordance with the requirements for evaluation evidence under the SSI program, 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.

(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-

(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.

24. The Department's 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...

25. Federal Regulation at 20 C.F.R. § Evaluation of disability of adults, in general,

states in part:

(a) *General—(1) Purpose of this section.* This section explains the five-step sequential evaluation process we use to decide whether you are disabled, as defined in §416.905.

(2) *Applicability of these rules.* These rules apply to you if you are age 18 or older and you file an application for Supplemental Security Income disability benefits.

(3) *Evidence considered.* We will consider all evidence in your case record when we make a determination or decision whether you are disabled. See §416.920b.

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

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in §416.909, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 to subpart P of part 404 of this chapter and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. See paragraphs (f) and (h) of this section and §416.960(b).

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. See paragraphs (g) and (h) of this section and §416.960(c).

(c) *You must have a severe impairment.* If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience.

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

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

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

29. The third step requires determining whether the petitioner's impairments meet or equal the "Listing of Impairments" indicated in Appendix 1 subpart P of section 404 of the Social Security Act.

30. The petitioner's primary diagnosis was [REDACTED] of the [REDACTED]. The associated Listing reads as follows:

[REDACTED]

31. As of February 27, 2018, the petitioner was found to have normal speech, coordination and ambulation, was able to stand or walk for two hours and with appropriate breaks for movement, sit for six hours. Based on the evidence, cited authorities and testimony, the undersigned concludes that the petitioner's condition does not meet this listing.

32. Seizures were voiced as a concern during the hearing and the listing for the related neurological disorder was examined. The Listing reads as follows:

[REDACTED]

33. Based on the testimony, evidence and cited authorities, the undersigned concludes that the petitioner's [REDACTED] do not meet the listing as they do not meet the criteria concerning frequency nor cause sufficiently severe limitations as numbered above.

34. The fourth step requires determining whether the petitioner can still do past relevant work based on her residual functional capacity. The petitioner has no prior work history; therefore, it is appropriate to move on to step five.

35. The fifth step requires considering the petitioner's residual functional capacity, age, education, and work experience to determine if she can adjust to other work. The evidence indicates the petitioner is a 41-year-old female with 12 years of educational experience with no past relevant work history. The DDD assessment shows the petitioner would be capable of performing in exertional activity comparable to that of a sedentary individual. Based on the current physical and mental impairments; this is consistent with the cumulative evidence.

36. While the evidence shows the petitioner has some medically determinable impairments, these impairments should not preclude her from adjusting to work in the national economy. Based on the totality of the evidence presented, the petitioner should be capable of performing sedentary work. According to the Dictionary of Occupational Titles, some sedentary jobs include Order Clerk 209.567-014, Addresser 209.587-010 and Pager 654.687-014. Considering this, the petitioner is found not disabled at step five, which is in accordance with medical-vocational guideline 201.27. See 20 C.F.R. § 416.969.

### **DECISION**

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

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

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

court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 30 day of August, 2018,

in Tallahassee, Florida.



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Gregory Watson  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
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Copies Furnished To: [REDACTED], PETITIONER  
OFFICE OF ECONOMIC SELF SUFFICIENCY

**FILED**

Jul 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-03937

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 05 Lake  
UNIT: 88222

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on June 4, 2018 at approximately 9:45 a.m.

**APPEARANCES**

For Petitioner: [REDACTED] *pro se*

For Respondent: Stan Jones, Economic Self-Sufficiency specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing 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.

Petitioner carries the burden of proof by a preponderance of the evidence on this issue.

### **PRELIMINARY STATEMENT**

Petitioner submitted a packet of documents that was entered into evidence as Petitioner's Composite Exhibit 1.

The Department submitted a packet of information that was admitted into evidence and marked as Respondent's Composite Exhibit 1.

### **FINDINGS OF FACT**

1. On April 4, 2018, Petitioner applied for Medicare Savings Plan (MSP) for a household size of two; listing just herself and her husband. For monthly income, Petitioner reported \$1401 in disability benefits from the Social Security Administration (SSA.)
2. Using its Data Exchange System with the Social Security Administration, Respondent verified Petitioner's gross monthly income from SSA is \$1401.
3. The Department combined Petitioner's verified income from the two sources, and determined Petitioner's monthly gross income as \$1,401. Based on the gross income, Respondent determined Petitioner's eligibility for the MSP utilizing the SSI-Related Programs -- Financial Eligibility Standards: April 1, 2018.
4. 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, coinsurance 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 \$1,1214; and for QI1, 135% of the FPL, currently \$1,366.

5. When 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.

6. In Petitioner's case, her verified gross income is \$1,401. The only deduction Petitioner is eligible to receive is a standard unearned income disregard of \$20, which when deducted from \$1,381.00, left Petitioner with a total countable income of \$1,381.00. Respondent compared Petitioner's total countable income of \$1,381.00 to the QMB income standard of \$1,012 first, and 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 Petitioner's countable income exceeded the income standard for all three, she failed to qualify for any one of the MSP.

7. On May 9, 2018, Respondent issued a NOCA notifying 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

8. Respondent stated that according to its policy, the only allowable deduction is the \$20 from the unearned income. Since the SSA are considered as unearned income, Petitioner is only entitled to a maximum disregard of \$20.

**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. Stat. FINAL ORDER (Cont.) 18F-03860 PAGE -5

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

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.* ] 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. Respondent must follow these guidelines when determining eligibility for Petitioner. The findings established that the Department did follow those guidelines. Petitioner's total countable income of \$1,381.00 exceeds the income standard of \$1,366 for the QI1 program; therefore, Petitioner is not eligible. There are no exceptions found in the regulations which would allow a different outcome for Petitioner. Therefore, the undersigned concludes that Respondent's action to deny 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, Petitioner's appeal is hereby denied, and Respondent's action is affirmed.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this  18  day of  July , 2018,

in Tallahassee, Florida.



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

Aug 29, 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-04019

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 17 Broward  
UNIT: 88998

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 11, 2018 at 3:05 p.m. The hearing was reconvened on August 3, 2018 at 1:31 p.m.

**APPEARANCES**

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

For the Respondent: Norman Cohen, Economic Services Self-Sufficiency Specialist II and Mary Triplett, Supervisor (for July 11, 2018 hearing) and Janet Turnbull, Economic Services Self-Sufficiency Specialist II (for August 3, 2018 hearing).

### **STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of May 16, 2018 to deny his application for Medicaid. Petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The hearing was scheduled for June 20, 2018; Petitioner did not appear. Good cause was determined and the hearing was rescheduled for July 11, 2018. The hearing convened on July 11, 2018; Petitioner did not receive the department's evidence. The hearing was rescheduled for July 18, 2018; Petitioner did not appear. Good cause was again determined and the hearing was rescheduled for August 3, 2018. The hearing convened and the record was held open through August 17, 2018 for supplemental evidence; the record closed on August 17, 2018.

The department presented evidence during the July 11, 2018 hearing. This evidence was entered as Respondent Composite Exhibit 1. Petitioner presented evidence along with his good cause explanation on July 19, 2018; this was entered as Petitioner's Composite Exhibit 1. The department submitted supplemental evidence on August 3, 2018, entered as Respondent Composite Exhibit 2. Petitioner submitted supplemental evidence on August 8, 2018, entered as Petitioner Exhibit 2.

### **FINDINGS OF FACT**

1. Petitioner is 41 years old.

2. He filed an application for Medicaid with the department on December 11, 2017 as a disabled adult. The department erroneously approved the Medicaid application.

Petitioner received Medicaid in error from September 2017 through December 2017.

3. Petitioner filed an additional application for Medicaid with the department on January 27, 2018 as a disabled adult. He also filed an application for Supplemental Security Income (SSI) with the Social Security Administration (SSA).

4. Petitioner has [REDACTED]  
[REDACTED]  
[REDACTED] that needs to be removed,  
[REDACTED] and [REDACTED] (Petitioner Composite Exhibit 1)

5. The SSA determined Petitioner was not disabled and issued its denial decision on May 9, 2018. The conditions reviewed were: [REDACTED]  
[REDACTED]

[REDACTED] SSA stated in its denial notice:

[W]e have determined that you can still meet many of the physical demands of work. Although we realize you may need treatment for your condition, and it may limit your ability to perform you past work, disability cannot be established because you are still capable of performing work that requires less physical effort.

Petitioner has filed an appeal on the SSA denial action. (Petitioner's Exhibit 2)

6. The Division of Disability Determinations (DDD) did not make an independent disability determination when Petitioner filed the January 27, 2018 application for Medicaid with the department. Instead, DDD adopted the disability denial decision

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<sup>1</sup> Petitioner Composite Exhibit 1 at 18

made by the SSA on May 9, 2018 on the following day, May 10, 2018. The department then issued its Medicaid denial notice on May 16, 2018 indicating the reason for the denial as, "You or a member(s) of your household do not meet the disability requirement. No household members are eligible for this program."

7. Petitioner believes he has been disabled since the age of 14 with the diagnosis of [REDACTED]. He has multiple conditions which he believes prevent him from working. He was diagnosed with a new condition of [REDACTED] on August 3, 2018. This condition was not reviewed by SSA and was diagnosed after the department's denial action.

8. The department issued a Notice of Case Action on June 25, 2018 to Petitioner as a result of the May 9, 2018 SSI denial. The notice informed Petitioner to call the department's Customer Call Center within 30 days if he would like to have Medicaid eligibility determined by the department. Petitioner read this letter during the hearing and described it as a second SSI denial action dated June 25, 2018. (Petitioner Composite Exhibit 1 at 21)

#### **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 Rule 65-2.056, *Florida Administrative Code*.

11. Petitioner held the burden of proof by a preponderance of the evidence. Rule

65-2.060 *Florida Administrative Code* informs that the burden is upon the Petitioner if an application for benefits is denied.

12. Rule 65A-1.711, *Florida Administrative Code*, “SSI-Related Medicaid Non-Financial Eligibility Criteria” states in 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)...(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).

13. The above rule defines eligibility for Medicaid for the SSI or Adult-Related Medicaid coverage group and states an individual must be age 65 or older, or disabled as defined in 20 C.F.R. §416.905 which states, “Basic definition of disability for adults...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. Title 42 of the Code of Federal Regulations Section 435.541, “Determinations of disability” states in part:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability... (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. The above federal regulation states that the agency must make a determination of disability in certain situations; one of the situations is when the individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination

16. The department's Program Policy Manual, CFOP 165-22, passage 1440.1205 "Exceptions to State Determination of Disability" 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.

17. The above-cited federal regulation and department's policy sets forth the procedure required when an individual applies to both the department and the SSA as a disabled adult. When the SSA has made a disability decision within 12 months of the individual's Medicaid application, the department is not to duplicate that disability determination and

is to instead, adopt that decision as the disability determination for the Medicaid application.

18. The above federal regulation directs the department to make an independent disability decision when the individual alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination. Based on the evidence and testimony, in comparing the conditions stated by Petitioner (and shown in the evidence) and the conditions reviewed by SSA, the undersigned concludes that Petitioner's [REDACTED] was not reviewed by SSA in its denial determination. Therefore, in accordance with the controlling authorities, the undersigned concludes that the department must make an independent disability determination. The undersigned also notes that Petitioner received a new diagnosis of [REDACTED] after the department's denial action.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and the department is to reverse its denial action to allow for an independent disability determination. Upon completion of the eligibility determination, the department is to issue a notice to Petitioner informing of the results. The department is to follow its policy on taking action to comply with the hearing decision within 10 calendar days following receipt of a Final Order to begin the process of the independent disability determination.

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

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

FINAL ORDER (Cont.)

18F-04019

PAGE - 9

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 August, 2018, in

Tallahassee, Florida.



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

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

**FILED**

Aug 30, 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-04140

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 July 18, 2018 at 11:47 a.m.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:

Delecia Greene, ACCESS Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of May 9, 2018 enrolling her in the Medically Needy program. The petitioner is seeking approval of full SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

**PRELIMINARY STATEMENT**

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

The record was held open for additional information from both parties. The information was due no later than July 31, 2018.

The Department submitted additional information on July 18, 2018 which was entered as Respondent's Exhibit 2.

The petitioner submitted information to the Department on July 19, 2018 which was forwarded to the Office of Appeal Hearings on her behalf on July 20, 2018. The undersigned reviewed the document as the Department indicated there were duplicate pages received. The undersigned removed all duplicate pages from the admitted exhibit, total of 10 pages were included in Petitioner's Exhibit 2.

The record closed on July 31, 2018.

#### **FINDINGS OF FACT**

1. The petitioner submitted an application on April 11, 2018 for Medicaid benefits. The petitioner was also seeking approval of the Medicare Savings Program (MSP). The application indicates the petitioner is disabled and receives Medicare Part A and B. (Respondent's Exhibit 1, pages 1 through 4)

2. The Department issued a Notice of Case Action dated April 12, 2018. This Notice informed the petitioner that the Department needed her current year Social Security Award letter and past medical bills for retroactive review. (Respondent's Exhibit 1, page 5)

3. The Department issued a Notice of Case Action dated May 9, 2018. This Notice informed the petitioner that she was enrolled in the Medically Needy program beginning April 2018 with a Share of Cost (SOC) of \$1,129. The Notice also informed the petitioner that she was denied eligibility in the Qualifying Individuals 1 (QI 1)

program as her income was too high to qualify. (Respondent's Exhibit 1, pages 6 through 8)

4. The Department documented in the case notes on May 22, 2018 a discussion with a representative for the petitioner. The Department explained with the Social Security Income of \$1,168 and Social Security Disability Income of \$395, the petitioner was over the income limit for full Medicaid and the MSP. (Respondent's Exhibit 1, page 9 and 10)

5. The petitioner's Social Security Award letter informed her of her Social Security benefit amount effective for 2018 as \$1,168 per month. (Respondent's Exhibit 2, page 2)

6. The petitioner's Social Security Disability Income (SS DI) is \$395. The petitioner's Medicare premium of 134 is deducted from this benefit. The benefit amount is \$227. (Respondent's Exhibit 2, page 1 and 3)

7. The petitioner also has a \$34 deduction from her SS DI of \$34 which is a recoupment of overpaid SS DI benefits.

8. The Department explained the application the petitioner received for Medicaid originated from the Social Security Administration. The application informs the customer they might qualify for extra benefits under Medicaid.

9. The Department explained the income limit to receive full Medicaid is currently \$891 per month for an individual. The Department identified the income limit to receive the Medicare Savings Program is \$1,366.

10. The Department explained they use the gross income amount (before any deductions) to determine a customer's eligibility for SSI-Related Medicaid.

11. The Department explained if they know of recurring medical expenses, such as prescriptions, Medicare or other medical insurance premiums, or copays at physicians she sees every month, they can include them as recurring medical expense to aid in reducing her share of cost.

12. The Department found the petitioner had reported her Medicare premium of \$134 and other recurring medical expenses that totaled \$100 which allowed for an additional \$234 deduction for recurring medical expense in her Medically Needy budget.

13. The Department explained the petitioner's share of cost was established as follows: The gross SS DI of \$395 was added to the SS benefit of \$1,168 to reach at total gross income of \$1,563. The Department allowed a standard deduction of \$20 to reach a countable income of \$1,543 ( $\$1,563 - \$20 = \$1,543$ ). The Department then deducted the Medically Needy Income Level for one person which is \$180 to reach a share of cost of \$1,363 ( $\$1,543 - \$180 = \$1,363$ ). The Department then deducted recurring medical expense of \$234 which leaves a share of cost of \$1,129 ( $\$1,363 - \$234 = \$1,129$ ). (Respondent's Exhibit 1, page 22 and 23)

14. The petitioner submitted medical expenses post hearing for the Department to review to update her share of cost. (Petitioner's Exhibit 2)

15. The Department explained to the customer how the Medically Needy Share of Cost program worked. The Department also explained what the petitioner needed to do when she incurred medical expenses outside of the reported recurring expenses.

**CONCLUSIONS OF LAW**

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

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

**SS-RELATED MEDICAID / MEDICALLY NEEDY**

18. Florida Admin. Code R. 65A-1.701, Definitions, defines the following programs:

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

...

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

19. The findings show the petitioner is a Medicare recipient. In accordance with the above controlling authority, the undersigned concludes the petitioner does not qualify for full SSI-Related Medicaid (MEDS-AD) as she also receives Medicare. The undersigned further concludes the Department correctly proceeded to review the petitioner's eligibility under the SSI-Related Medically Needy (Share of Cost) program.

20. 20 C.F.R. § 416.1121, Types of unearned income, states in relevant part:

Some types of unearned income are—

(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

21. 20 C.F.R. § 416.1124, Unearned income we do not count, states in relevant part:

(c) Other unearned income we do not count. We do not count as unearned income—

...

(12) The first \$20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need.

22. Florida Admin. Code R. 65A-1.702, Special Provisions, states in relevant part:

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

...

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

23. Florida Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in relevant part:

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. §1396 (2000 Ed., Sup. IV) (incorporated by reference), or another less restrictive option is elected by the state under 42 U.S.C. §1396a(r)(2) (2000 Ed., Sup. IV) (incorporated by reference). 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.

...

(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.

24. Florida Admin. Code R. 65A-1.716, Income Resource Criteria, (2) lists the Medically Needy Income Level for a household of one as \$180.

25. The findings show the petitioner receives SS DI in the gross amount of \$395. The findings also show the petitioner receives SS income in the gross amount of \$1,168. In accordance with the above controlling authorities, the undersigned concludes the Department must include the gross income amounts when calculating the petitioner's Medically Needy Share of Cost (SOC). The undersigned concludes the total gross income is \$1,563 ( $\$395 + \$1,168 = \$1,563$ ). The above authorities require the Department to disregard \$20 of the income leaving a countable income of \$1,543

(\$1,563 - \$20 = \$1,543). The authorities also require the Department to deduct the Medically Needy Income Level (MNIL) for the household size to obtain the share of cost. The authorities provide the MNIL for a household size of one is \$180. The countable income of \$1,543 less \$180 leaves a share of cost of \$1,363 ( $\$1,543 - \$180 = \$1,363$ ).

26. The authorities also allow for the petitioner's medical insurance premiums and recurring medical expenses to be deducted from the share of cost. The findings show the petitioner has a Medicare premium of \$134 per month and \$100 in reported recurring medical expenses. The undersigned concludes the petitioner had a reported \$234 ( $\$134 + \$100$ ) to be included as recurring medical expenses. The share of cost of \$1,363 less the recurring medical expenses leaves a reduced share of cost of \$1,129.

27. The undersigned concludes the Department correctly calculated the petitioner's share of cost based on the income and known expenses.

28. The findings show the petitioner has submitted additional medical expenses to be considered in her recurring medical expenses. The undersigned reviewed Petitioner's Exhibit 2. The undersigned concludes several of these expenses are already included in the recurring medical expense allowed. The Department is to review the documentation provided to determine if any additional recurring medical expense can be granted to the petitioner.

#### MEDICARE SAVINGS PROGRAM

29. Florida Admin. Code R. 65A-1.702, Special Provisions, states in relevant part:

(12) Limits of Coverage.

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

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

...

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

30. The Department's Program Policy Manual, CFOP 165-22, section 1440.1504, Receipt or Entitlement to Medicare Part A (MSSI) states in relevant part:

Individuals must be enrolled in Medicare Part A as a condition of eligibility for Qualified Medicare Beneficiary (QMB).

...

Individuals must be enrolled in Medicare Part A as a condition of eligibility for Special Low-Income Medicare Beneficiary (SLMB) and Qualifying Individuals 1 (QI1).

31. The findings show the petitioner is enrolled in Medicare Part A. The undersigned concludes the petitioner meets the criteria of being enrolled in Medicare Part A to receive the Medicaid Savings Program.

32. Florida Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in relevant part:

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

...

(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

...

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

...

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

33. The Department's Policy Manual, Appendix A-9, SSI-Related Programs – Financial Eligibility Standards effective July 1, 2017 lists the following standards for individuals: The income limit to receive Qualified Medicare Beneficiaries (QMB) as \$1,005. The income limit to receive Special Low-Income Medicare Beneficiaries (SLMB) as \$1,206. The income limit to receive Qualifying Individuals 1 (QI 1) as \$1,357.

34. The Department's Policy Manual, Appendix A-9, SSI-Related Programs – Financial Eligibility Standards effective July 1, 2018 lists the following standards for individuals: The income limit to receive Qualified Medicare Beneficiaries (QMB) as \$1,012. The income limit to receive Special Low-Income Medicare Beneficiaries (SLMB) as \$1,214. The income limit to receive Qualifying Individuals 1 (QI 1) as \$1,366.

35. The petitioner's total household income of \$1,563 less the \$20 unearned income deduction leaves a countable income of \$1,543 ( $\$1,563 - \$20 = \$1,543$ ). The petitioner's countable household income exceeds the income limit to receive QMB, SLMB or QI 1. The undersigned concludes the petitioner does not qualify for the Medicare Savings Program.

### **DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 30 day of August, 2018,

in Tallahassee, Florida.



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

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

**FILED**

Jul 27, 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-04157

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 19, 2018 at 2:52 p.m.

**APPEARANCES**

For the Petitioner:

[REDACTED]

For the Respondent:

Sheila Rushing, ACCESS Supervisor

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of April 12, 2018 enrolling him in the SSI-Related Medically Needy Share of Cost Program. The petitioner wishes to receive full SSI-Related Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The Department submitted evidence on July 5, 2018, which was entered as Respondent's Exhibit 1. The Department submitted supplemental evidence on July 17, 2018, which was entered as Respondent's Exhibit 2.

The petitioner did not submit any evidence in this matter.

The record closed on July 19, 2018.

### **FINDINGS OF FACT**

1. The petitioner filed an application for SSI-Related Medicaid on April 5, 2018. The petitioner indicated on his application that he is disabled and his Social Security Retirement income is \$955 he has medical expenses. (Respondent's Exhibit 1, page 20 through 26)

2. The Department determined the petitioner's income exceeded the income limit to receive full SSI-Related Medicaid. The Department proceeded to determine the petitioner's Medically Needy Share of Cost (SOC). The Department used the reported income of \$955 less a \$20 unearned income disregard and less the Medically Needy Income Limit (MNIL) of \$180 to establish the petitioner's SOC as \$755 ( $\$955 - \$20 - \$180 = \$755$ ). (Respondent's Exhibit 1, page 31)

3. The Department issued a Notice of Case Action on April 12, 2018. The Notice informed the petitioner that his application dated April 5, 2018 was approved for Medically Needy with a share of cost of \$755. (Respondent's Exhibit 1, pages 27 through 30)

4. The petitioner filed a change report on April 26, 2018. The report included correction of Social Security amount to \$941, medical expenses as well as utility expenses. (Respondent's Exhibit 1, pages 1 through 4)

5. The Department used a data exchange with the Social Security Administration to establish the petitioner's correct income amount beginning January 2018 as \$941. (Respondent's Exhibit 1, page 17)

6. The Department recalculated the petitioner's Medically Needy SOC using the total income of \$941 less the \$20 unearned income disregard and less the MNIL of \$180 to reduce the petitioner's SOC to \$741 effective April 2018 ( $\$941 - \$20 - \$180$ ). (Respondent's Exhibit 1, page 16)

7. The Department issued a Notice of Case Action on May 7, 2018. The Notice shows the share of cost was set as \$741 effective April 2018. (Respondent's Exhibit 1, pages 5 through 8)

8. The Department provided Running Record Comments from the petitioner's case. The Department explained these comments reflect any updates made to the petitioner's case.

9. The Department recorded an update in the case comments on May 4, 2018 updating the Social Security income to \$941. (Respondent's Exhibit 1, page 12)

10. The Department recorded an update in the case comments on June 25, 2018 the completion of a supervisory review and update to the petitioner's Supplemental Nutritional Assistance Program benefits. (Respondent's Exhibit 1, pages 9 and 10)

11. The Department continued review of the case and conferred with their program office to determine how to include the petitioner's monthly prescriptions and medical supplies as an expense to reduce the petitioner's share of cost.

12. The Department received confirmation and instruction from the program office to include the petitioner's prescriptions (\$125) and monthly medical supplies (\$40) as medical expenses in his SOC calculation ( $\$125 + \$40 = \$165$ ). (Respondent's Exhibit 2, page 5)

13. The Department update the petitioner's SOC using his income of \$941 less the \$20 unearned income disregard, MNIL of \$180, and the reported medical expenses of \$165 to establish the updated SOC effective April 1, 2018 to \$576 ( $\$941 - \$20 - \$180 - \$165 = \$576$ )

14. The Department issued a Notice of Case Action on July 17, 2018 to inform him of the decrease in his Medically Needy Share of Cost at \$576 effective April 1, 2018.

15. The petitioner expressed concern that the Department was not considering his disability as a criteria making him eligible for SSI-Related Medicaid. The petitioner cited the Department did not complete a disability interview on his application filed on April 5, 2018 as the basis for this concern.

16. The Department found a disability determination was previously completed by the Division of Disability Determinations (DDD) in July 2016. According to DDD entries, the petitioner was established as disabled beginning April 1, 2016. The petitioner's disability is not due for review until July 1, 2023. (Respondent's Exhibit 1, page 32)

17. The Department explained a new disability interview or determination was not required based on the information found within the petitioner's case file from a previous application.

18. The Department explained that the criteria for receiving Family-Related Medicaid includes having a minor child in the home. The Department further explained the criteria for receiving SSI-Related Medicaid includes either being over age 65 OR being disabled. The Department summarized that since the petitioner is under age 65, if his disability had not been considered, he would have been denied for SSI-Related Medically Needy.

19. The petitioner expressed concern that he is unable to see a doctor or a specialist for his medical conditions (heart, thyroid, diabetes, and COPD) as no doctor or specialist will accept the Medically Needy benefit even with the reduced SOC.

20. The petitioner reported he had found online at benefits.gov that if an individual resides in Florida, is disabled and receives less than \$16,040, they can receive Medicaid. The petitioner states he meets these requirements, but is still denied full Medicaid by the Department.

21. The Department explained the monthly income limit for full Medicaid is \$891. (Respondent's Exhibit 1, page 40)

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

24. Florida Admin. Code R. 65A-1.701, Definitions, states in relevant part:

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

...

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

25. 20 C.F.R. § 416.1121, Types of unearned income, states in relevant part:

Some types of unearned income are—

(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, **social security benefits**, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.  
(emphasis added)

26. 20 C.F.R. § 416.1124, Unearned income we do not count, states in relevant part:

(a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount.... Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the \$20 general exclusion described in paragraph (c)(12) of this section.

...

(c) Other unearned income we do not count. We do not count as unearned income—

- (1) Any public agency's refund of taxes on real property or food;
- (2) Assistance based on need which is wholly funded by a State or one of its political subdivisions....
- (3) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses....
- (4) Food which you or your spouse raise if it is consumed by you or your household;
- (5) Assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any Federal statute because of a catastrophe which the President of the United States declares to be a major disaster....
- (6) The first \$60 of unearned income received in a calendar quarter **if you receive it infrequently or irregularly**....
- (7) Alaska Longevity Bonus payments made to an individual who is a resident of Alaska and who, prior to October 1, 1985:...
- (8) Payments for providing foster care to an ineligible child...
- (9) Any interest earned on excluded burial funds...
- (10) Certain support and maintenance assistance as described in §416.1157;
- (11) One-third of support payments made to or for you by an absent parent if you are a child;
- (12) The first \$20 of any unearned income in a month** other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need....
- (13) Any unearned income you receive and use to fulfill an approved plan to achieve self-support...
- (14) The value of any assistance paid with respect to a dwelling unit under—
  - (i) The United States Housing Act of 1937;
  - (ii) The National Housing Act;
  - (iii) Section 101 of the Housing and Urban Development Act of 1965;
  - (iv) Title V of the Housing Act of 1949; or
  - (v) Section 202(h) of the Housing Act of 1959;
- (15) Any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement....
- (16) The value of any commercial transportation ticket, for travel by you or your spouse...
- (17) Payments received by you from a fund established by a State to aid victims of crime;
- (18) Relocation assistance provided you by a State or local government...
- (19) Special pay received from one of the uniformed services pursuant to 37 U.S.C. 310;
- (20) Interest or other earnings on a dedicated account which is excluded from resources. (See §416.1247);

- (21) Gifts from an organization as described in section 501(c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of such Code, to, or for the benefit of, an individual who has not attained 18 years of age and who has a life-threatening condition....
- (22) Interest and dividend income from a countable resource or from a resource excluded under a Federal statute other than section 1613(a) of the Social Security Act; and
- (23) AmeriCorps State and National and AmeriCorps National Civilian Community Corps cash or in-kind payments to AmeriCorps participants or on AmeriCorps participants' behalf....
- (24) Any annuity paid by a State to a person (or his or her spouse) based on the State's determination that the person is:
  - (i) A veteran (as defined in 38 U.S.C. 101); and
  - (ii) Blind, disabled, or aged.(emphasis added)

27. 83 FR 2642, Annual Update of the HHS Poverty Guidelines, states in relevant part:

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update the poverty guidelines at least annually, adjusting them on the basis of the Consumer Price Index for All Urban Consumers (CPI-U). The poverty guidelines are used as an eligibility criterion by Medicaid and a number of other Federal programs. The poverty guidelines issued here are a simplified version of the poverty thresholds that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

...  
The following guideline figures represent annual income.

**2018 POVERTY GUIDELINES FOR THE  
48 CONTIGUOUS STATES AND THE  
DISTRICT OF COLUMBIA**

Persons in family/household	Poverty guideline
1 .....	\$12,140
2 .....	16,460

28. The above controlling authority lists the poverty guideline for a household of one to have an annual income of \$12,140. The above controlling authority shows

that to receive SSI-Related full Medicaid (MEDS-AD) the individual must have income less than 88 percent of the federal poverty level. The annual income amount of \$12,140 multiplied by 88% is \$10,683 ( $\$12,140 \times 88\% = \$10,683$ ). The annual income of \$10,683 divided by 12 equals a monthly amount of \$890.25, which is rounded up to \$891 ( $\$10,683 / 12 = \$890.25$  rounded up to \$891).

29. The Department Program Policy Manual (165-22), Appendix A-9, SSI-Related Programs, effective April 1, 2018, lists the income limit for an individual to receive MEDS-AD (Full Community Medicaid) as \$891.

30. The findings show the petitioner receives Social Security Retirement Income in the amount of \$941 per month. In accordance with the above controlling authorities, the undersigned concludes the Department correctly coded the Social Security retirement income as unearned income.

31. The above controlling authorities allow for the deduction of a \$20 unearned income disregard in the calculation of the petitioner's eligibility for SSI-Related Medicaid. The undersigned reviewed the complete list of disregards of unearned income and found no other disregard for which the petitioner qualifies listed. The undersigned concludes the petitioner's gross Social Security retirement income of \$941 less the \$20 unearned income disregard leaves a countable income for the petitioner of \$921.

32. The above controlling authorities list the income standard to receive full Medicaid as \$891. The undersigned concludes the petitioner's countable income of \$921 is greater than the income standard for full Medicaid. The undersigned concludes

the Department correctly proceeded to the determination of Medically Needy eligibility when the petitioner's income exceeded the income standard for full Medicaid.

33. The findings show the petitioner has seen on the internet the annual income must be less than \$16,040 which is approximately \$1,336 per month. While the undersigned notes the website listing would lead one to believe the petitioner's income falls well within the range of eligibility for Medicaid, the undersigned concludes this website is not promulgated into law and therefore cannot be relied upon in the determination of eligibility for full Medicaid.

34. Florida Admin. Code R. 65A-1.702, Special Provisions, states in relevant part:

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

...

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

35. Florida Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in relevant part:

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

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

...

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

...

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

...

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. §1396 (2000 Ed., Sup. IV) (incorporated by reference), or another less restrictive option is elected by the state under 42 U.S.C. §1396a(r)(2) (2000 Ed., Sup. IV) (incorporated by reference). When averaging income, all income from the most recent consecutive four weeks shall be used if it is representative of future earnings. A longer period of past time may be used if necessary to provide a more accurate indication of anticipated fluctuations in future income.

...

(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.

36. Florida Admin. Code R. 65A-1.716, Income Resource Criteria (2) lists the Medicaid income and payment eligibility standards and Medically Needy income level for a household size of one as \$180.

37. The findings show the Department initially used the petitioner's reported income on his application of \$955 to calculate the petitioner's share of cost to be \$755 effective April 2018. The findings also show the Department corrected the petitioner's reported income amount to \$941 which reduced the petitioner's share of cost to \$741 effective April 2018. The findings further show the Department, using the corrected income of \$941 recalculated the petitioner's share of cost as follows: \$941 less the \$20 unearned income disregard is \$921. The countable income of \$921 less the Medically Needy Income Level (MNIL) of \$180 leaving a share of cost of \$741. The Department further reduced the share of cost of \$741 by deducting the reported recurring medical expenses of \$165 to reach the reduced share of cost of \$576. The findings show the Department made this update effective April 2018 which is the month of application. The undersigned concludes the Department correctly calculated the petitioner's share of cost.

38. The findings show the petitioner inquired for other household expenses such as rent, mortgage, utilities, and food to be included in the expenses allowed in the calculation of his Medicaid eligibility. The undersigned reviewed all pertinent rules and regulations and found no such allowances in the determination of Medicaid eligibility or in the reduction of the share of cost.

**DECISION**

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

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 27 day of July, 2018,

in Tallahassee, Florida.



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

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

**FILED**

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

Aug 28, 2018

Office of Appeal Hearings  
Dept. of Children and Families

[REDACTED]

APPEAL NO. 18F-04252

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 05 Sumter  
UNIT: 66292

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on June 27, 2018 at 8:30 a.m.

**APPEARANCES**

For Petitioner: [REDACTED], Petitioner's Representative

For Respondent: Stan Jones, Economic Self Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner appeals Respondent's action denying his State Medicaid Disability application, dated May 3, 2018, by adopting the Social Security Administration's (SSA) October 23, 2017 decision denying Petitioner's Federal Medicaid Disability application. Petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

**PRELIMINARY STATEMENT**

Petitioner appeared at the hearing. Suzanne Sanderson (SS), Petitioner's friend, appeared and represented Petitioner without party objection.

On June 25, 2018, Petitioner submitted an evidence packet, by fax, to the Office of Appeal Hearings. The undersigned did not receive Petitioner's evidence packet until after the completion of the hearing. Furthermore, after numerous opportunities at the hearing allowing for both parties to introduce evidence or testimony, Petitioner failed to introduce his evidence packet by which Respondent had an opportunity to object or respond to said evidence, and by which the evidence could be considered. As such, Petitioner's evidence packet was not entered into evidence. In addition, though Petitioner's evidence packet supports his argument that he suffers from adverse medical conditions, it is irrelevant as to the issue of whether or not Respondent was obligated to adopt the SSA's adverse Medicaid Disability decision.

Respondent submitted an evidence packet consisting of seven exhibits, which were entered into evidence and marked as Respondent's Exhibits "1" – "7." The record remained open until 5:00 p.m. on June 27, 2018, to allow Respondent time to provide Petitioner's Division of Disability Determination (DDD) application. On June 27, 2018, Respondent timely submitted Petitioner's DDD application, which was entered into evidence and marked as Respondent's Exhibit "8." The record closed on June 27, 2018.

### **FINDINGS OF FACT**

1. On May 3, 2018, Petitioner, age 43, submitted an on-line application for Food Assistance and Medicaid Disability for himself (Respondent's Exhibit 2). Petitioner's Medicaid Disability denial is the only issue.
2. SS described Petitioner's disabling conditions as [REDACTED] that have required surgery in the past, and will require surgery in the future; [REDACTED]; and [REDACTED] (SS's Testimony).

3. Petitioner's May 3, 2018 Medicaid Disability application indicated that his health conditions had not changed since his last disability denial by the SSA (Respondent's Exhibit 2, Page 3).
4. On May 7, 2018, Petitioner indicated during his interview that his disabling conditions had changed (Respondent's Exhibit 7, Page 6). SS indicated that Petitioner's existing disabling conditions had worsened since his last disability denial by the SSA (SS's Testimony).
5. On September 14, 2017, Petitioner applied for disability through the SSA (Respondent's Exhibit 4).
6. On October 23, 2017, the SSA denied Petitioner's disability application with denial code N32, which means "capacity for substantial gainful activity, other work, no visual impairment" (*Id.*).
7. Petitioner is appealing the SSA denial through an attorney; an appeal hearing has not yet been scheduled as of the date of this hearing (SS's Testimony).
8. On May 7, 2018, Respondent electronically sent Petitioner's medical documents for review to DDD (Respondent's Exhibit 7, Page 7). DDD is responsible for making Medicaid Disability determinations for the Department.
9. On May 11, 2018, DDD denied Petitioner's disability application with denial code N32, which means "capacity for substantial gainful activity, other work, no visual impairment" (Respondent's Exhibit 8, Page 1). Respondent did not make an independent disability decision on Petitioner's Medicaid Disability application. Instead, it adopted the SSA decision and denied Petitioner's application based on that decision, as he did not meet the technical requirements of age (at least 65) or disability.

10. On May 15, 2018, Respondent mailed Petitioner a Notice of Case Action notifying that his May 3, 2018 Medicaid Disability application was denied, with the reason that no household members meet the disability requirement (Respondent's Exhibit 3, Page 8).

11. Petitioner did not claim to have new or worsened medical conditions that the SSA was unaware of or refused to consider (Petitioner's Testimony).

### **CONCLUSIONS OF LAW**

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

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

14. Florida Administrative Code Rule 65A-1.711, 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...

15. The Code of Federal Regulations Title 42, Section 435.541, Determinations of Disability, states in relevant part:

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

...

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

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

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

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

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

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

...

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

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

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

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

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

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

...

16. The above cited 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.

17. In accordance with the above authority, Respondent denied Petitioner's May 3, 2018 Medicaid Disability application, due to adopting the SSA denial decision.

18. Petitioner is appealing the October 23, 2017 SSA denial through an attorney, and though claims to have worsening conditions, has no new or worsened medical conditions that the SSA is unaware of or has refused to consider.

19. In careful review of the cited authority and evidence, the undersigned concludes that Petitioner did not meet the burden of proof to indicate Respondent incorrectly denied his May 3, 2018 Medicaid Disability application. The undersigned concludes Respondent's action denying Petitioner's May 3, 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 28 day of August, 2018,

in Tallahassee, Florida.



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

**FILED**

Jul 30, 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-04387

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 07 St. Johns  
UNIT: 88882

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 12, 2018 at 9:37 a.m.

**APPEARANCES**

For the Petitioner: The petitioner is now deceased and was represented by her son, [REDACTED].

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

**ISSUE**

At issue is the Department's action on May 25, 2018 to deny the petitioner's application for Institutional Care Program (ICP) Medicaid for the months of January 2018 and February 2018 due to being over the income limit.

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

### **PRELIMINARY STATEMENT**

Evidence was received and entered as the Petitioner's Exhibits 1 and 2 and the Respondent's Exhibits 1 and 2.

The record was closed at the conclusion of the hearing.

### **FINDINGS OF FACT**

1. The petitioner's representative applied for Institutional Care Program (ICP) Medicaid on April 4, 2018 (*Respondent's Exhibit 2, pages 10 through 14*). The reported income was Social Security income in the amount of \$1071 and retirement income in the amount of \$1593.10, for a total income of \$2664.10.

2. The respondent contends that the income limit for ICP is \$2205. The Department determined that the petitioner's income exceeded the income limit and required \$459.10 to be deposited into a Qualified Income Trust (QIT) in order to meet the income limit.

3. The petitioner's representative contends that the petitioner began residing in the nursing home in December 2017. The petitioner passed away at the age of 80 on March 16, 2018. The petitioner is not seeking approval for December 2017. The petitioner is seeking ICP approval for the months of January 2018 and February 2018.

4. The Department explained that the months of January 2018 and February 2018 were not approved because the QIT was not properly funded. The respondent contends that \$175 was deposited for the month of December 2017, \$350 was deposited for the month of January 2018, and \$413.20 was deposited for February

2018. The respondent contends that the QIT was properly funded for the month of March 2018.

5. The petitioner's son does not dispute that the QIT was not properly funded for the months of January 2018 and February 2018. The petitioner's son is seeking a hardship for not properly funding the account for those months. The petitioner's son explained that the QIT was not properly funded for December 2017 because the family was not expecting the petitioner to reside in a nursing home. The petitioner's son further explained that the petitioner's living expenses had already been deducted from her income; therefore, there was not enough money to deposit into the QIT. The petitioner's son argues that the petitioner's bank account was closed in January 2018 when her car payment was voided; therefore, there was not a bank account available in which to deposit the petitioner's Social Security income. The petitioner's son argues that the petitioner did not receive her Social Security income until later. The petitioner's son argues that there was not an account where his mother's Social Security income could be direct deposited for the months of January 2018 and February 2018. The petitioner's son argues that there was not enough money to properly fund the QIT for January 2018 and February 2018 because the family had to pay an attorney.

6. The Department explained that if the individual's income is over the income limit, he or she would need to properly fund the QIT. The Department contends that its policy does not allow any hardships for an improperly funded QIT.

**CONCLUSIONS OF LAW**

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

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

9. Federal Regulations at 20 CFR § 416.1121 Types of unearned income states:

Some types of unearned income are—

(a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

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

11. The Fla. Admin. Code at R. 65A-1.713 sets forth the SSI-Related Medicaid income eligibility criteria and states:

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

(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in Rule 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for

institutional care services by establishing an income trust which meets criteria set forth in Rule 65A-1.702(15), F.A.C...

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. §416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:

(d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS.

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

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. § 1396 (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)...

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

**1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month (emphasis added).**

12. The Department's Program Policy Manual, CFOP 165-22, passage

1840.0110 Income Trusts (MSSI), states:

.....

To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-9 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust.....

The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested.** This may

require the individual to begin funding an executed income trust account prior to its official approval by the Circuit Legal Counsel (emphasis added).

13. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, includes the Eligibility Standards for SSI-Related Programs, effective April 2017. The chart lists the income limit for an individual under the ICP Medicaid program as \$2205 at the time of the Department's action.

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

Step 2: If the monthly amount of income designated to go into the trust is subtracted from (excluded) the individual's gross income, is the individual's remaining income (outside the trust) below the institutional care income limit? (The eligibility specialist must verify how much income is designated to go into the trust account each month.)

Cite: 42 CFR 435.236 and 435.1005; and subsection 409.904 (3), Florida Statutes.

Background: The trust language does not have to indicate a specific amount of income will go into the trust account monthly; however, documentation must confirm that adequate funds are placed into the account each month to reduce the individual's available income outside the account to within the Institutional Care Program limits.

Policy: Income cannot be excluded until it is placed into the trust. The individual is not eligible on the factor of income until his countable income (income outside the trust) is below the institutional care income limit.

Trusts cannot be funded retroactively.

15. The above authorities explain that to be eligible for the ICP Medicaid program, an individual may not have gross income that exceeds 300% of the federal benefit rate after allowable deductions. Individuals whose income exceeds the income limit may qualify for ICP Medicaid by funding a QIT account that meets the criteria. For the ICP program, the Department determines if an individual's income qualifies him or her for the program by including his or her total gross income, excluding income placed

in the QIT account, for the month in which the income is received. The total gross income must be less than the ICP income standard for the individual to be eligible for each month. If an individual's gross income exceeds the ICP income standard, the individual or the legal authorized representative must deposit sufficient income into the trust account in the month received to reduce the countable income to within the program income standard. The deposit must be made for each month ICP coverage is requested. The income limit for an individual under the ICP program was \$2205 at the time of the Department's action. The findings show that the petitioner's QIT was funded for the month of January 2018 in the amount of \$350 and for the month of February 2018 in the amount of \$413.20. The petitioner's son does not dispute that the QIT was not properly funded for the months at issue.

16. According to the above controlling authorities, monthly income outside of the QIT is countable income and is compared to the limit of \$2205. The petitioner's income outside of the QIT exceeded the ICP income limit for January 2018 and February 2018. In this case, the petitioner's gross monthly income totaled \$2664.10. The applicable income limit for the ICP Program was \$2205. The findings show that the petitioner's family deposited into the QIT an undisputed \$350 for the month of January 2018 and an undisputed \$413.20 for the month of February 2018. The petitioner's son is seeking for the Department to allow a hardship to be granted in this case because the petitioner did not have a sufficient amount of money to properly fund the QIT. The petitioner's son's arguments and situation are recognized, however, the undersigned could find no legal authority that would allow for a hardship to be granted in situations of an improperly

funded QIT. Based on the controlling authorities, the undersigned concludes that the petitioner's son did not meet his burden to show that the Department incorrectly denied the petitioner's application for ICP Medicaid for the months of January 2018 and February 2018.

17. The undersigned concludes the Department's action to deny ICP eligibility for January 2018 and February 2018 was correct, as the petitioner's income exceeded the income limit.

### **DECISION**

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

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

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

DONE and ORDERED this 30 day of July, 2018,  
in Tallahassee, Florida.



---

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

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

**FILED**

Jul 30, 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-04509  
18F-04510

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 10, 2018 at 9:45 a.m.

**APPEARANCES**

For the petitioner: [REDACTED], pro se

For the respondent: Marcie Reyes, Bureau of Public Benefits Investigations, Investigator, also known as the Office of Public Benefits Integrity (OPBI)

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent's action to end her Supplemental Nutrition Assistance Program (SNAP) and Medicaid Assistance Benefits on June 30, 2018, due to the respondent not receiving all the information requested to determine eligibility. The respondent carries the burden of proof by a preponderance of the evidence on both issues.

### **PRELIMINARY STATEMENT**

Tim Duggan, Investigation Manager with the Bureau of Public Benefits Investigations, OPBI, appeared as a witness for the respondent.

The petitioner did not submit any exhibits at the hearing. The respondent submitted four exhibits, which were entered into evidence as Respondent's Exhibits "1" through "4". The record was held open until close of business on July 18, 2018 for submission of additional evidence from the parties. On July 11, 2018, the respondent submitted additional information, which was entered into evidence as Respondent's Exhibit "5". On July 10, 2018, the petitioner submitted documentation, which was entered into evidence as Petitioner's Exhibit "1". The record closed on July 18, 2018.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner was receiving SNAP and full Medicaid benefits for herself and her two children (ages 8 and 3). The SNAP and Medicaid benefits were due to expire on April 30, 2018.
2. On March 19, 2018, the respondent emailed the petitioner a Notice of Eligibility Review to inform her that she had to complete a review to continue her SNAP benefits. On April 4, 2018, the petitioner submitted an on-line application for SNAP benefits. On the application, the petitioner indicated her preferred method for receiving notices was by email address at [REDACTED] (Respondent Exhibit 1).
3. On April 17, 2018, the petitioner completed a telephone interview with the Department. Based on the interview and other qualifying factors, the respondent approved the petitioner's SNAP benefits for a six-month certification period from May

2018 through October 31, 2018. The Medicaid was approved for a year certification period from May 2018 through April 30, 2019.

4. On May 1, 2018, the respondent received a client complaint through the [REDACTED] [REDACTED] petitioner has been residing in the household with the children's biological father. The respondent referred the case to OPBI for an investigation.

5. During the course of the investigation, the investigator concluded that the petitioner, her children, and the children's biological father resided in the household together. The respondent explained, it had interviewed neighbors and took verbal statements regarding the petitioner's living arrangement. No testimony was given by the investigator who interviewed the neighbors (investigator was not present).

6. The respondent explained that on May 10, 2018, the investigator emailed an ACCESS Integrity Program Contact Notice (Respondent Exhibit 2) to the petitioner.

The notice indicated the following:

**You have applied for or are receiving public assistance from the State of Florida, and your case was referred to the ACCESS Integrity Program for review. After completing the review, we have determined:**

You have not reported everyone that lives at your address.

You have not accurately reported all your household income.

You have not accurately reported all your household assets.

Other: YOU ARE RESIDING WITH [REDACTED] YOU MUST SUBMIT A CHANGE ADDING HIM TO YOUR CASE AND PROVIDE PROOF OF HIS LAST 4 WEEKS GROSS INCOME. DUE BY 05/21/2018.

You must write your case number on all pages of verification provided and fax to 813-558-5719, send by mail to the below address or by email to [SCR.PBI.Info@myflfamilies.com](mailto:SCR.PBI.Info@myflfamilies.com).

You must contact the individual listed below by 05/21/2018 to discuss the results of your review. Failure to follow through with the above requirement may result in being unable to determine your eligibility.



verification fax from [REDACTED] and child support inquiry details which showed the address reported is [REDACTED]

11. The record was left open to allow the petitioner to submit documents to support her claims that the children's father does not reside in the household. The parties submitted the petitioner's MyAccess account notice history. The documents do not show an email notice was sent to the petitioner on May 10, 2018:

### Notice History

Notice Search : CASE # [REDACTED]  
Begin date 07/11/2017 End Date 07/10/2018 Search

<a href="#">View Notice</a>	<a href="#">Reg Date</a>	<a href="#">Mail Date</a>	<a href="#">UserId</a>	<a href="#">Notice Description</a>	<a href="#">Dup Reg Date</a>	<a href="#">Addr Ind</a>	<a href="#">Reg Dup</a>	<a href="#">Mail/Email Details</a>	<a href="#">Dup Notices</a>	<a href="#">Notice Method</a>
<a href="#">View Notice</a>	6/1/2018	6/4/2018	S85650	Reinstatement of Benefits		AICI/AMS	<input type="checkbox"/>			Email
<a href="#">View Notice</a>	6/1/2018	6/4/2018	S85650	Reinstatement of Benefits		AICI/AMS	<input type="checkbox"/>			Email
<a href="#">View Notice</a>	5/29/2018	5/30/2018	S70019	Discrepancy Notice		AICI/AMS	<input type="checkbox"/>			Email
<a href="#">View Notice</a>	5/29/2018	5/30/2018	S70019	Notice of Case Action		AICI/AMS	<input type="checkbox"/>			Email
<a href="#">View Notice</a>	5/29/2018	6/6/2018	S70019	Notice of Case Action		AICI/AMS	<input type="checkbox"/>			US Mail
<a href="#">View Notice</a>	4/30/2018	5/1/2018	TF5539	Notice of Case Action		AICI/AMS	<input type="checkbox"/>			Email

### CONCLUSIONS OF LAW

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

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

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

(a) Operation of SNAP offices and processing of applications—(1) Office operations...

(c) Filing an application...

(5) Notice of Required Verification. The State agency shall provide each household at the time of application for certification and recertification with a notice that informs the household of the verification requirements the household must meet as part of the application process. The notice shall also inform the household of the State agency's responsibility to assist the household in obtaining required verification provided the household is cooperating with the State agency as specified in (d)(1) of this section. The notice shall be written in clear and simple language and shall meet the bilingual requirements designated in §272.4(b) of this chapter. At a minimum, the notice shall contain examples of the types of documents the household should provide and explain the period of time the documents should cover....

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

(1) Mandatory verification...

(4) Sources of verification...

(iv) **Discrepancies. Where unverified information from a source other than the household contradicts statements made by the household, the household shall be afforded a reasonable opportunity to resolve the discrepancy prior to a determination of eligibility or benefits.**

(emphasis added) The State agency may, if it chooses, verify the information directly and contact the household only if such direct verification efforts are unsuccessful. If the unverified information is received through the IEVS, as specified in §272.8, the State agency may obtain verification from a third party as specified in paragraph (f)(9)(v) of this section.

15. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 3610.1000 ACCESS INTEGRITY (FS), states:

ACCESS Integrity (AI) is an extension of the Department's public assistance eligibility process and operates within the purview of 7 CFR 273, 45 CFR 233, and Sections 414.095(16) and 414.39(10), Florida Statutes. It is a program designed to combat fraud and reduce misspent dollars in the Department's public assistance programs. Probable error prone cases are identified at the pre-eligibility (application/reapplication, certification/recertification) phase of the public assistance program. Once a case is identified as meeting error prone criteria, it is referred to the AI unit within the Region or Circuit where the public assistance unit resides.

The AI unit then reviews the information provided by the individual or the authorized representative and verifies and documents the finding of fact as it relates to the information provided by the individual and the eligibility factors used to determine the individual's level of participation. **Once verification and documentation is completed, the recipient is given an opportunity to explain contradictory information and an eligibility determination is made.** (emphasis added)

16. Fla. Admin. Code R. 65A-1.203, Administrative Definitions, states in part:

Except as otherwise provided within, the following definitions apply to this chapter.

...

(12) Mail: Written communication delivered by the postal system. Written communication delivered electronically to public assistance applicants, recipients and authorized/designated representatives who choose to receive electronic communication.

17. The above authorities explain household composition when found questionable, must be verified. In this case, household composition was questionable. The respondent's witness testified that the investigator assigned to the case spoke to the petitioner's residential neighbors who confirmed the petitioner, her children and the children's biological father resided in the household. The investigator obtained verbal testimony from the neighbors. According to the investigator's findings, it was determined that the children's father was residing in the household with the petitioner. No testimony was given by the investigator who conducted the investigation or by the neighbors. No evidence was submitted to support the respondent's allegation that the petitioner's children's father was living in the same household. The respondent testified a pending notice was emailed to the petitioner [REDACTED] on May 10, 2018 to contact the investigator and to allow the petitioner an opportunity to rebut the findings. The parties presented a copy of the notice history, the undersigned could not locate the May 10, 2018 notice the respondent alleged was issued to the petitioner via

email or mailed. The undersigned concludes, based on the evidence presented, that the petitioner did not receive the May 10, 2018 notice.

18. On May 30, 2018, the respondent issued a Notice of Case Action via email to the petitioner ending her SNAP benefits and Medicaid Assistance due to not receiving all the information requested to determine eligibility. The respondent did not allow the petitioner 10 days to respond or rebut the investigator's findings. Therefore, the undersigned concludes that the Department was incorrect to end the petitioner's SNAP and Medicaid Assistance benefits.

19. After careful review of the evidence and controlling legal authorities, the undersigned concludes the respondent did not meet its burden of proof. Therefore, the undersigned hereby remands the matter to the respondent to allow the petitioner to submit the necessary documentation to have her eligibility for her SNAP and Medicaid Assistance benefits determined effective July 1, 2018, without duplicating benefits already issued. The respondent is to issue the petitioner a new notice with appeal rights upon completion. This remand does not guarantee benefits.

### **DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are granted and remanded to the respondent for corrective action in accordance with the above Conclusions of Law.

**ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR WITHIN (60) DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES.**

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 30 day of July, 2018,

in Tallahassee, Florida.



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

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

Aug 20, 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-04609

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 17 Broward  
UNIT: 88998

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 17<sup>th</sup>, 2018, at 9:00 a.m.

**APPEARANCES**

For the Petitioner: [REDACTED], pro se.

For the Respondent: Ketura Odestin, ACCESS  
Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

The petitioner is appealing the denial of his Medicaid application. The petitioner carries the burden of the proof by a preponderance of the evidence on this issue.

**PRELIMINARY STATEMENT**

Appearing as a witness for the petitioner was [REDACTED] Case Manager from

[REDACTED].

No exhibits were admitted on the record; however, a Notice of Case Action (NOCA) dated March 19<sup>th</sup>, 2018 is moved into evidence as respondent's exhibit 1 for reasons to be explained further herein.

The petitioner agreed to submit a new application and withdrew the hearing on the record, but after considering the testimony and the evidence, the Hearing Officer finds that the merits of the appeal must be properly addressed.

No NOCA regarding the issue under appeal was moved into evidence. Absent appropriate evidence to the contrary, the appeal is considered to have been filed timely.

**FINDINGS OF FACT**

1. The petitioner submitted an application on March 15<sup>th</sup>, 2018 for Supplemental Nutrition Assistance Program (SNAP) and for SSI-Related Medicaid.
2. The SNAP benefits were approved, but the Medicaid was denied for failure to contact the respondent for a disability interview and for not providing information that the respondent had allegedly requested in order to complete his application.
3. The petitioner (44 years of age) is a single-person household.
4. On March 19<sup>th</sup>, 2018, the respondent issued a notice requesting a phone interview before March 26<sup>th</sup>, 2018, a completed and signed "Financial Release" form, verification of having applied to the Social Security Administration for Social Security disability and the name and address of any medical doctors that he had seen.

5. The petitioner stated that he had completed an interview and that he had never received any notices requesting information. When the address on the pending notice was reviewed, it showed an incorrect address of [REDACTED] (Respondent's Exhibit 1). The petitioner's witness had noticed the incorrect address on the application and had done a change report to correct the address to [REDACTED] 2018. The respondent confirmed this.

6. The respondent explained that in fact an interview was conducted on April 16<sup>th</sup>, 2018, but that the interview had been for the SNAP program only. The respondent also stated that the petitioner needed to complete another in depth interview for disability Medicaid and provide medical records, and other documents addressed on the March 19<sup>th</sup> NOCA.

7. The petitioner's witness had been helping the petitioner apply for Food Assistance and SSI. She had applied for SSI for him at the Social Security Office, but had not received any response as of yet. She thought she had only applied for SNAP with the department and was not sure if this appeal was for SSI or Medicaid.

8. The respondent explained that on the application received by the department on March 15<sup>th</sup>, 2018, Food Assistance and SSI-Related Medicaid were checked off as benefits being applied for. The respondent stated that if he was determined eligible, then he would be able to receive Medicaid, but that he would have to submit a new application.

9. During the hearing, the respondent checked its system and stated that the SSI application with Social Security was received on June 20<sup>th</sup>, 2018 and the status was still

pending. The respondent also explained that it would adopt the decision from the Social Security Office once it was made.

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

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

12. Federal regulation FAC 65A-1.205 Eligibility Determination Process states in part as follows:

(1)(c) ) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension. The eligibility specialist makes the decision of whether to grant the request for extension...

13. After considering the evidence, testimony, and the appropriate authorities cited above, the hearing officer concludes that the petitioner never received the pending notice, since the NOCA was sent to an incorrect address. Therefore, the petitioner was unable to comply. In addition, the change report correcting the address was done on April 2<sup>nd</sup>, 2018, before the denial on April 19<sup>th</sup>, 2018.

14. Therefore, the case is here remanded to the respondent for corrective action. Within ten calendar days from the date of this order, the respondent will issue written notice to the petitioner allowing him a minimum of ten calendar days to call for his interview and an additional ten calendar days to provide any pending verifications or 30 days if pending for medical information. The respondent must honor the March 15<sup>th</sup>, 2018 application. The petitioner will need to cooperate with this process. This order does not guarantee Medicaid eligibility, but gives the petitioner a second chance to comply with the application process. The respondent must send the application to the Division of Disability Determinations (DDD) for a disability determination. Once the respondent receives the determination from DDD, the respondent will then issue written notice on the outcome of this process, and the notice will include appeal rights should the petitioner disagree with the outcome.

### **DECISION**

Based on the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is hereby partially granted. The case is remanded to the respondent with instructions to initiate corrective action, as described above, within ten calendar days from the date of this order.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 20 day of August, 2018,

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

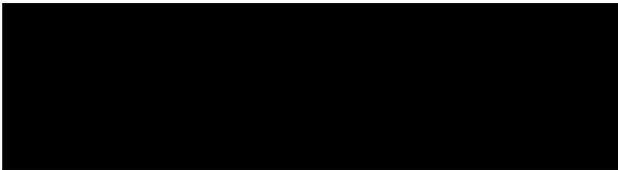
Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

**FILED**

Aug 17, 2018

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 18F-04794

PETITIONER,

Vs.

CASE 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 03 Taylor  
UNIT: 88328

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 17, 2018 at 1:39 p.m.

**APPEARANCES**

For the Petitioner: , Authorized Representative,  
CRS Medical Benefits

For the Respondent: Viola Dickinson, Economic Self-Sufficiency  
Specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of March 13, 2018 denying the petitioner Medicaid eligibility due to a Child Support Enforcement sanction imposed.

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

### **PRELIMINARY STATEMENT**

The petitioner submitted evidence with the hearing request on June 5, 2018.

This was entered as Petitioner's Exhibit 1.

The Department provided the March 13, 2018 Notice of Case Action on July 17, 2018. This was entered as Respondent's Exhibit 1. The Department provided evidence on June 27, 2018 which was entered as Respondent's Exhibit 2.

The record was held open through August 1, 2018 to allow the Department opportunity to review the eligibility for May 2017 and December 2017 and issue a Notice of Case Action on these months of eligibility.

The Department submitted additional information on August 1, 2018 which was entered as Respondent's Exhibit 3. The petitioner submitted no supplemental information to the Office of Appeal Hearings while the record was open.

The record closed on August 1, 2018.

### **FINDINGS OF FACT**

1. The Department imposed a child support enforcement sanction on January 14, 2014 due to the petitioner's failure to comply with Child Support Enforcement. (Respondent's Exhibit 2, page 6)
2. The petitioner's household consists of the petitioner and her minor son.
3. The Department recorded in case notes dated March 12, 2018, that the petitioner's husband (child's father) moved into the household in December 2017. (Respondent's Exhibit 2, page 5)
4. The Department enrolled the petitioner in the Medically Needy program beginning January 2018. The Department issued a Notice of Case Action dated March

29, 2018 informing the petitioner that her Medically Needy Share of Cost was met for the period of January 11, 2018 through January 31, 2018. (Respondent's Exhibit 2, pages 1 through 3)

5. The Department issued a Notice of Case Action on March 13, 2018 enrolling the petitioner in Medically Needy effective February 2018. (Respondent's Exhibit 1)

6. The petitioner is seeking Medically Needy enrollment for May 2017 and December 2017 due to outstanding medical bills.

7. The petitioner provided the Social Security Administration award letter showing the petitioner is disabled as of September 2016. The petitioner began receiving Social Security disability payments effective March 2018 in the amount of \$838 per month. (Petitioner's Exhibit 1, page 27 through 30)

8. The petitioner believes that due to the disability approval her Medicaid eligibility should be determined under SSI-Related Medicaid for all months after March 2016 rather than under Family-Related Medicaid.

9. The petitioner believes that cooperation with child support enforcement is not a requirement for eligibility in the SSI-Related Medicaid program. The petitioner believes the child support enforcement sanction is in error as there was no application for Temporary Cash Assistance for these months.

10. The petitioner explained that she and the husband resided separately between June 2017 and December 2017, but he was back in the home approximately two weeks before Christmas. The petitioner provided a letter stating the same. (Petitioner's Exhibit 1, page 31)

11. The Department provided the case notes for May 2017. The case notes reflect the petitioner's husband was not in the home in the month of May 2017, but provided financial assistance at that time. (Respondent's Exhibit 3, pages 8 and 9)

12. The Department issued a Notice of Case Action July 18, 2018, requesting income verification for the petitioner's husband for the month of December 2017. The information was due no later than July 30, 2018. (Respondent's Exhibit 3, pages 3 through 7)

13. The Department reported non-receipt of information requested in the July 18, 2018 Notice from either the petitioner or the representative. The Department explained the inability for the Department to review eligibility for December 2017 without the necessary information.

14. The Department explained the eligibility for Medicaid for a customer is established under the program (Family-Related or SSI-Related) that will offer the highest benefit (lowest share of cost). The Department explained that the petitioner's share of cost is lower under Medically Needy in the Family Related program rather than in the SSI-Related program.

#### **CONCLUSIONS OF LAW**

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

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

17. Florida Admin. Code R. 65A-1.701, Definitions, states in relevant part:

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

...

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

18. Florida Admin. Code R. 65A-1.703, Family-Related Medicaid Coverage

Groups, states in relevant part:

(1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule.

...

(6) Medically Needy. To be eligible for this coverage group the individual must meet the general requirements prescribed in Rule 65A-1.705, F.A.C.

...

(b) The following provisions apply to Medically Needy.

1. The individual or family must have income equal to or less than the respective Medically Needy income standards prescribed in subsection 65A-1.716(2), F.A.C. If income exceeds the Medically Needy income standards refer to subsection 65A-1.707(2), F.A.C. Refer to Rule 65A-1.713, F.A.C., for additional income criteria applicable to the Medically Needy Program.

2. The individual or family must have assets equal to or less than the respective Medically Needy Resource Standards prescribed in subsection 65A-1.716(3), F.A.C.

19. The findings show the petitioner has a minor son in her home. The findings also show the petitioner is disabled. The undersigned concludes the petitioner's benefits can be determined under either the Family-Related Medicaid

program (due to having a minor child) or the SSI-Related Medicaid program (due to her disability). The undersigned further concludes the Department's determination of eligibility should be under the program which is most advantageous to the petitioner.

20. 42 C.F.R. §433.145, Assignment of rights to benefits – State plan requirements, states in relevant part:

(a) A State plan must provide that, as a condition of eligibility, each legally able applicant or beneficiary is required to:

(1) Assign to the **Medicaid** agency his or her rights, or the rights of any other individual eligible under the plan for whom he or she can legally make an assignment, to medical support and to payment for medical care from any third party;

(2) Cooperate with the agency in establishing the identity of a child's parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in §435.116 of this chapter (pregnant women), who are exempt from cooperating in establishing the identity of a child's parents and obtaining medical support and payments from, or derived from, the non-custodial parent of a child; and

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(b) A State plan must provide that the requirements for assignments, cooperation in establishing paternity and obtaining support, and cooperation in identifying and providing information to assist the State in pursuing any liable third party under §§433.146 through 433.148 are met.

(c) A State plan must provide that the assignment of rights to benefits obtained from an applicant or beneficiary is effective only for services that are reimbursed by Medicaid.

(emphasis added)

21. 42 C.F.R. § 433.148, Denial or termination of eligibility, states in relevant part:

In administering the assignment of rights provision, the agency must:

(a) Deny or terminate eligibility for any applicant or beneficiary who—

(1) Refuses to assign his own rights or those of any other individual for whom he can legally make an assignment; or

(2) In the case of an applicant, does not attest to willingness to cooperate, and in the case of a beneficiary, refuses to cooperate in establishing the identity of a child's parents, obtaining medical child support and pursuing liable third parties, as required under §433.147(a) unless cooperation has been waived;

22. 42 C.F.R. § 435.610, Assignment of rights to benefits, states:

(a) Consistent with §§433.145 through 433.148 of this chapter, as a condition of eligibility, the agency must require legally able applicants and beneficiaries to:

(1) Assign rights to the **Medicaid** agency to medical support and to payment for medical care from any third party;

**(2) In the case of applicants, attest that they will cooperate, and, in the case of beneficiaries, cooperate with the agency in—**

(i) Establishing the identity of a child's parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating or is a pregnant woman described in §435.116; and  
(ii) Identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

**(b) The requirements for assignment of rights must be applied uniformly for all groups covered under the plan.**

(emphasis added)

23. The above controlling authorities are not specific to either Family-Related Medicaid or SSI-Related Medicaid. The authorities do specify that cooperation with child support enforcement and assignment of rights is a requirement to receive Medicaid.

24. The findings show the petitioner was not in compliance with child support enforcement prior to the month of May 2017. The findings also show the petitioner's husband was living outside of the home in the month of May 2017. In the instant case, the petitioner has not shown compliance with Child Support Enforcement for the month

of May 2017. The undersigned concludes the Department appropriately continued the child support enforcement sanction for the month of May 2017. The undersigned concludes denial of Medicaid for the petitioner due to a child support enforcement sanction was appropriate.

25. Florida Admin. Code R. 65A-1.204 Rights and Responsibilities, states in relevant part:

(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.

26. The findings also show the petitioner was pended for information regarding her husband's income for the month of December 2017, when he is reported as residing in the home. The findings show the petitioner has not filed verification of his income by July 30, 2018 as required in the pending notice. The undersigned concludes the Department cannot determine eligibility for Medicaid for the petitioner for the month of December 2017 due to failure on the petitioner's part to verify her husband's residence in her home and his income. The undersigned concludes, in accordance with the above controlling authorities, the child support enforcement sanction should remain enforced for December 2017.

### **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   August  , 2018,

in Tallahassee, Florida.



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

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

**FILED**

Aug 06, 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-04835  
18F-04984

PETITIONER,

Vs.

CASE NO. [REDACTED]

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

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at 9:16 a.m. on July 12, 2018, in [REDACTED] Florida.

**APPEARANCES**

For the Petitioner: [REDACTED] pro se

For the Respondent: Marsha Shearer, ACCESS  
Economic Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

At issue is whether the Respondent's (Department) actions to: (1) approve the petitioner's Medicare Savings Plan (MSP), Qualified Medicare Beneficiary (QMB), effective May 2018 and (2) decrease the petitioner's Supplemental Nutrition Assistance Program (SNAP) benefits, also known as Food Assistance Program, are proper. The petitioner carries the burden of proof by a preponderance of the evidence.

### **PRELIMINARY STATEMENT**

The hearing originally convened, telephonically, on June 27, 2018. The Department was represented by Susan Martin, ACCESS Operations Management Consultant, on June 27, 2018. During the hearing, the petitioner got disconnected, called back and requested that the hearing reconvene in-person, due to telephone issues.

The petitioner submitted three exhibits, entered as Petitioner Exhibits "1" through "3". The respondent submitted 11 exhibits, entered as Respondent Exhibits "1" through "11". The record was closed on July 12, 2018.

### **FINDINGS OF FACT**

1. Prior to the action under appeal, the petitioner received Supplemental Security Income (SSI) through the Social Security Administration (SSA); which included full Medicaid.
2. In 2017, the petitioner turned age 65, the SSA changed the petitioner from SSI to Social Security Retirement, which includes Medicare instead of Medicaid. The SSA also requires a fee for the Medicare premium.
3. Also, prior to the action under appeal, the petitioner received \$76 in SNAP benefits for certification period from January 2018 through December 2018 (Respondent Exhibit 5); for application dated December 1, 2017 (Respondent Exhibit 2).
4. On May 10, 2018, the petitioner, age 66, submitted a web application for SNAP and MSP. The application lists \$848.60 Social Security (SS), expenses include \$194 rent, and utility expenses (Respondent Exhibit 9).

5. The MSP has three types of Buy-In Programs: QMB, Special Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual 1 (QI1). Buy-In Programs, if eligible, pay for the Medicare premium and other medical expenses. QMB pays for the most of the three programs and has the lowest income limit.

6. For the petitioner to be eligible for the MSP, the petitioner's countable household income cannot exceed the following MSP income limits:

\$1,366 QI1  
\$1,214 SLMB  
\$1,012 QMB

7. The Department verified the petitioner receives \$848 SS (Respondent Exhibit 4). Therefore, the petitioner is eligible for QMB.

8. Although the petitioner was approved for QMB, the Department's SNAP calculation for May 2018 included the Medicare premium as a medical expense (Respondent Exhibit 6, pages 24 and 25). The budget is as follows:

Medical Costs	
\$134.00	Medicare premium
-\$ 35.00	medical deduction
<u>\$ 99.00</u>	<u>excess medical expense</u>
\$848.00	SS
-\$160.00	standard deduction
-\$ 99.00	excess medical expense
<u>\$589.00</u>	<u>adjusted income</u>
Shelter Costs	
\$194.00	shelter
+\$347.00	standard utility allowance
<u>\$541.00</u>	<u>shelter/utility costs</u>
-\$294.50	50% adjusted income (\$589/2)
<u>\$246.50</u>	<u>excess shelter/deduction</u>

\$589.00	adjusted income
<u>-\$246.50</u>	<u>excess shelter deduction</u>
\$342.50	adjusted income

\$342.50 X 30% = \$103 (round up) SNAP benefit reduction

9. The \$103 SNAP benefit reduction was subtracted from \$192 (maximum SNAP benefit amount for an individual) to arrive at \$89 in monthly SNAP benefits.

10. On May 11, 2018, the Department mailed the petitioner a Notice of Case Action (NOCA) notifying: (1) \$89 SNAP benefits were approved effective June 2018 through December 2018 and (2) QMB was approved effective May 2018 (Respondent Exhibit 10).

11. Since QMB was approved (the State pays the petitioner's Medicare premium), the petitioner is no longer eligible for the Medicare premium medical deduction in the SNAP calculation. The Department recalculated the petitioner's SNAP budget for June 2018 (Respondent Exhibit 6, pages 26 and 27) to remove the Medicare premium medical deduction. The following is the June 2018 SNAP budget:

\$848.00	SS
<u>-\$160.00</u>	<u>standard deduction</u>
\$688.00	adjusted income
\$194.00	shelter
<u>+\$347.00</u>	<u>standard utility allowance</u>
\$541.00	shelter/utility costs
<u>-\$344.00</u>	<u>50% adjusted income (\$688/2)</u>
\$197.00	excess shelter/deduction
\$688.00	adjusted income
<u>-\$197.00</u>	<u>excess shelter deduction</u>
\$491.00	adjusted income

\$491 X 30% = \$148 (round up) SNAP benefit reduction

12. The \$148 SNAP benefit reduction was subtracted from \$192 (maximum SNAP benefit amount for an individual) to arrive at \$44 in monthly SNAP benefits.

13. On May 15, 2018, the Department mailed the petitioner a NOCA, notifying his SNAP benefits decreased from \$89 to \$44 effective June 2018 through December 2018 (Respondent Exhibit 3).

14. The petitioner reported his rent increased to \$196 during the pre-hearing conference with the respondent's representative. The respondent's representative recalculated the petitioner's SNAP budget (Respondent Exhibit 6, pages 28 and 29).

The following is the July 2018 SNAP budget:

\$848.00	SS
<u>-\$160.00</u>	<u>standard deduction</u>
\$688.00	adjusted income
\$196.00	shelter
<u>+\$347.00</u>	<u>standard utility allowance</u>
\$543.00	shelter/utility costs
<u>-\$344.00</u>	<u>50% adjusted income (\$688/2)</u>
\$199.00	excess shelter/deduction
\$688.00	adjusted income
<u>-\$199.00</u>	<u>excess shelter deduction</u>
\$489.00	adjusted income

\$489 X 30% = \$147 (round up) SNAP benefit reduction

15. The \$147 SNAP benefit reduction was subtracted from \$192 (maximum SNAP benefit amount for an individual) to arrive at \$45 in monthly SNAP benefits.

16. On June 20, 2018, the Department mailed the petitioner a NOCA notifying his SNAP benefits increased to \$45 effective July 2018 through December 2018 (Respondent Exhibit 3, page 15).

17. The petitioner argued he should receive more than one utility allowance because he pays different utilities.

18. The respondent's representative explained the petitioner is only eligible for one utility expense and he is receiving the highest one.

19. The petitioner disagrees with the SNAP amount and believes he is entitled to additional SNAP benefits.

20. The petitioner argued that he "wants" Medicaid because he has always had Medicaid.

21. The respondent's representative explained the petitioner is not eligible for full Medicaid. The respondent's representative explained the petitioner has Medically Needy with a Share of Cost, which will pay once the petitioner's SOC is met and after Medicare pays 80% of the medical expenses.

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

### **MSP QMB ISSUE**

24. *Florida Administrative Code* R. 65A-1.702, Special Provisions, explains the 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.) ...

25. *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...

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

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

Appendix A-9, sets forth for an individual, the following:

\$1,366 QI1  
\$1,214 SLMB  
\$1,012 QMB

27. Title 20 of the Code of Federal Regulations § 416.1121 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...”

28. The evidence submitted establishes the petitioner’s \$848 SS is below the \$1,012 QMB income limit; therefore, the petitioner is eligible for QMB.

29. The evidence submitted establishes the petitioner’s MSP application is dated May 10, 2018; therefore, the petitioner’s QMB is effective May 2018.

SNAP ISSUE

30. Title 7 of the Code of Federal Regulations § 273.9, Income and deductions, in part states:

...

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

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

(i) Annuities; pensions; retirement, veteran's, or disability benefits...

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

(1) Standard deduction...

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

(6) Shelter costs...

(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions...

(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, water, sewerage, well and septic tank installation and maintenance, telephone, and garbage or trash collection. The LUA must include expenses for at least two utilities. However, at its option, the State agency may include the excess heating and cooling costs of public housing residents in the LUA if it wishes to offer the lower standard to such households. The State

agency may use different types of standards but cannot allow households the use of two standards that include the same expense...

31. The petitioner argued he is entitled to additional utility deductions because, he pays several utilities.

32. The above authority (#30) explains SNAP applicants are only eligible for one utility standard.

33. The Department's Program Policy Manual, CFOP 165-22, at Appendix A-1, sets forth; \$192 maximum SNAP benefit amount for a household size of one, \$160 standard deduction and \$347 standard utility allowance.

34. The evidence submitted establishes that the Department allowed the highest standard utility allowance (\$347) in the petitioner's SNAP calculation.

35. Title 7 of the Code of Federal Regulations § 273.10, Determining household eligibility and benefits levels, in part states:

- ...
- (e) Calculating net income and benefit levels — (1) Net monthly income.
    - (i) To determine a household's net monthly income, the State agency shall...
      - (A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members...
      - (C) Subtract the standard deduction...
      - (D) If the household is entitled to an excess medical deduction as provided in §273.9(d)(3), determine if total medical expenses exceed \$35. If so, subtract that portion which exceeds \$35...
      - (H) Total the allowable shelter costs... Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost...
      - (I) Subtract the excess shelter cost...
    - (2) Eligibility and benefits...
      - (ii)(A) ... the household's monthly allotment shall be equal to the maximum SNAP allotment for the household's size reduced by 30 percent of the household's net monthly income...

36. In accordance with the above authorities, the Department included the petitioner's \$848 SS unearned income and subtracted allowable deductions (standard deduction, excess medical deduction (May 2018), SUA and excess shelter cost deduction) in the petitioner's SNAP budget calculations.

37. The evidence submitted establishes the petitioner was approved QMB; therefore, he was no longer eligible for the Medicare premium medical deduction in June 2018 and ongoing.

**HEARING OFFICER'S CONCLUSION**

38. 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 actions to:

- (1) Approve the petitioner QMB, effective May 2018 and,
- (2) Approve the petitioner SNAP benefits: \$89 in May 2018, \$44 in June 2018 and \$45 in July 2018 going forward, are proper.

**DECISION**

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are denied and the respondent's actions are affirmed.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 06 day of August, 2018,

in Tallahassee, Florida.



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

Aug 14, 2018

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 18F-04920

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES (DCF)  
CIRCUIT: 12 Manatee  
UNIT: 88274

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 26, 2018 at 9:15 a.m.

**APPEARANCES**

For the Petitioner:  ro se

For the Respondent: Lorry Beauvais, Economic Services Self-Sufficiency Specialist II

**STATEMENT OF ISSUE**

Petitioner is appealing the Department's action of June 13, 2018 enrolling her in the Medically Needy Program rather than approving full Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

### **PRELIMINARY STATEMENT**

The hearing was originally scheduled for July 12, 2018. Petitioner did not call in at the appointed hearing time; she contacted the undersigned's office shortly after the hearing time. Petitioner submitted an explanation in writing on July 12, 2018 as to why she missed the hearing time. Good cause was found and the hearing was rescheduled for July 26, 2018.

On July 26, 2018, the parties held a pre-hearing conference outside of the undersigned's presence. The hearing convened following this conference.

Petitioner represented herself and gave testimony. No witnesses or exhibits were offered during the hearing. Respondent was represented by Lorry Beauvais who provided testimony and department records. The record closed.

An order to reopen the record was issued on July 26, 2018, giving Petitioner an opportunity to object to any of the documents by August 6, 2018 before entering them into the record, as no evidence was entered during the hearing. Petitioner replied to the order on August 1, 2018 and objected to the exhibits becoming a part of the record on the grounds of believing it would be better for her appeal if the records were not part of the record. Petitioner's objection is overruled and the department's documents are now entered as Respondent Composite Exhibit 1; these documents were reviewed and discussed during the hearing. Petitioner's reply to the order is entered as Petitioner's Exhibit 1. The record closed on August 6, 2018.

### **FINDINGS OF FACT**

1. Petitioner relocated to Florida from Illinois on June 6, 2018. She had full Medicaid coverage in the state of Illinois from December 2004 through June 2018.

2. Petitioner is 46 years old and her date of birth is [REDACTED]. She receives Social Security Disability (SSD) in the gross (and net) monthly amount of \$930. She also receives Medicare.

3. Petitioner has a minor daughter that receives Supplemental Security Income (SSI) in the amount of \$322 and Social Security in the amount of \$288. They are temporarily living with Petitioner's mother and are looking for separate housing.

4. Petitioner believes she should be receiving full Medicaid in Florida due to the low income for her family of two. After her bills are paid, she has \$30 to \$50 left for the rest of the month. She receives \$15 in Food Assistance; a portion of their monthly income is spent on food. A medical bill of even \$150 would be devastating to her budget.

Petitioner is concerned about medical bills affecting her credit and her family becoming homeless.

5. In Florida, the income limit for a disabled adult to achieve full Medicaid eligibility is currently \$891. Petitioner's income exceeds that amount. Her daughter's income is not considered when determining adult-related Medicaid eligibility.

6. Petitioner qualifies for Qualified Medicare Beneficiary (QMB) Medicaid which pays for her Medicare Part B premium. Petitioner has no recurring monthly insurance costs to further reduce her SOC.

7. Florida Medicaid (determined by DCF) has two tracks or broad categories: family and adult-related (also referred to as SSI-related). The department considered both the family and adult-track Medicaid programs to determine which was the most advantageous for Petitioner. The adult-track income policy was more advantageous as

the Share of Cost (SOC) in the family-track would be \$832 (Respondent Composite Exhibit 1 at 35).

8. To determine the SOC in the adult-track, the department deducted the \$20 standard deduction and the \$180 Medically Needy Income Level (MNIL) for one person, from the gross monthly income of \$930. This resulted in a \$730 SOC. Petitioner was enrolled with the \$730 SOC (Respondent Composite Exhibit 1 at 35).

### **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 Rule 65-2.056, *Florida Administrative Code*.

### **Burden of Proof**

11. *Florida Administrative Code* 65-2.060 addresses evidence and states that the party having the burden will establish his or her position by a preponderance of the evidence level. Petitioner held the burden of proof.

### **Affordable Care Act as it relates to Adult-Related Medicaid in Florida**

12. The department's ACCESS Florida staff published a document explaining the impact of the Affordable Care Act (ACA) to Floridians, September 13, 2013, which states in part on page 3<sup>1</sup>:

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<sup>1</sup> <http://eww.dcf.state.fl.us/ess/aca/docs/QuickstartCombined.pdf>

**What is the Effect of MAGI (Modified Adjusted Gross Income) on Medicaid Eligibility?**

Beginning January 1, 2014, when federal law goes into effect, Family Related Medicaid and CHIP eligibility will begin using a new income methodology known as MAGI, which stands for Modified Adjusted Gross Income and is defined in the Federal Tax Code... Eligibility rules will not change for people age 65 or older and the disabled. Florida is not expanding Medicaid to adults who are not pregnant, elderly, or disabled. These individuals may be able to get help with insurance costs through the Federal Marketplace if they have income at or above the federal poverty level.

13. Florida did not elect to expand Medicaid for the aged or disabled population under the ACA. The eligibility rules did not change for this population.

Family-Related Medicaid Rules

14. The Department's Program Policy Manual, CFOP 165-22, passage 2230.0400, Standard Filing Unit (MFAM), states in part:

The SFU is determined for each individual by following one of three rules based on intended tax filing status for the upcoming tax year as reported by the applicant/recipient. Individuals cannot receive Medicaid benefits under more than one assistance group, but can have their income included in more than one assistance group.

Filer Rule: If the individual being tested for eligibility expects to file a tax return for the tax year in which eligibility is being determined and does not expect to be claimed as a tax dependent by someone else, the SFU includes the:

1. individual,
2. individual's spouse, if any, even if the individual and the individual's spouse are living separately and filing a joint tax return, and
3. all claimed tax dependents of the individual living inside or outside of the household...SSI recipients in the household are included in the Standard Filing Unit, but their SSI income is excluded. If the SSI recipient has any other income, it is included, subject to tax rules.

15. Passage 2630.0108, Budget Computation (MFAM), of the department's manual, 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.”

16. The above cited policies for Family-related Medicaid instruct that if the individual being tested for eligibility expects to file a tax return for the tax year in which eligibility is being determined, the Standard Filing Unit must include that individual and her tax dependents. The policy also states the SSI income would not be counted, but other income of the SSI recipient would count. The undersigned concludes the department was correct in its determination that the SOC would be higher in this program, as the child’s non-SSI income of \$288 would also be considered. In this program, the countable income would be at least \$1218 minus the MNIL for two of \$387<sup>2</sup> resulting in the SOC of at least \$831<sup>3</sup>.

Florida Medicaid Programs for aged or disabled individuals

17. The department’s SSI-Related Medicaid Programs Fact Sheet, July 2018, page 4, states in part:

**Medical Assistance:**

Medicaid is a federal and state program that is administered by the state. States are allowed options in the administration of the program. Eligibility requirements and available services may vary from state to state.

Medicaid eligibility is determined by DCF, except for SSI recipients. Individuals who receive SSI are automatically eligible for Medicaid in Florida. Medicaid services are managed by the Agency for Health Care Administration (AHCA). DCF determines eligibility for the following SSI-Related Medicaid Programs:

- **Medicaid programs that have full benefits include:**
- Medicaid for aged and disabled individuals (MEDS-AD)
- Institutional Care Program (ICP)

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<sup>2</sup> The department’s Program Policy Manual 165-22, Appendix A-7 shows the MNIL for two of \$387 for Family-related Medicaid.

<sup>3</sup> The undersigned notes the department indicated a SOC of \$832 in this program, however, the income shown on pages 32 and 33 of Respondent Composite Exhibit 1 totals \$1218; not \$1219.

- Hospice
- Home and Community Based Services (HCBS) Waiver Program
- **Medicaid programs that have limited coverage include:**
  - Medically Needy (MN)
  - Medicare cost-sharing programs:
  - Qualified Medicare Beneficiary (QMB)
  - Special Low-income Medicare Beneficiary (SLMB)
  - Qualifying Individuals 1 (QI-1)

18. The above fact sheet explains that Medicaid is a federal and state program.

Eligibility may vary from state to state. Full Medicaid benefits for an individual in the community is through a Waiver program called Medicaid for aged and disabled individuals (MEDS-AD).

19. Section 409.904, Florida Statutes, sets forth the provisions for optional payments under Medicaid and states in part:

The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(1) Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage.

20. The above-cited statute defines the optional MEDS-AD Waiver program and restricts the eligibility to a certain income and asset level, as well as restricting coverage

for individuals who either **do not** have Medicare or if a Medicare recipient, must also be receiving an institutional or home-bound Medicaid service.

21. *Florida Administrative Code* 65A-1.701 defines the MEDS-AD program, as set forth in the statute, and states in part:

(1) Aged and Disabled Adult Waiver Program/Home and Community-Based Services (ADA/HCBS): A Home and Community-Based Services (HCBS) waiver program for aged and disabled individuals in need of skilled or intermediate nursing care services... (20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services... (30) Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month...

22. Florida limited MEDS-AD coverage for Medicare recipients concurrent with federal Medicare Part D implementation in 2005, effective January 1, 2006. Medicare recipients in the community would now have coverage for prescriptions through Part D along with hospital coverage under Part A and outpatient coverage under Part B.<sup>4</sup>

23. The department's Program Policy Manual, CFOP 165-22, Appendix A-9, July 1, 2018, shows 88% of the federal poverty level for one person at \$891 for MEDS-AD and 100% of the federal poverty level for one person at \$1,012 for QMB<sup>5</sup>.

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<sup>4</sup> This historical information can be found at the CMS "Florida MEDS-AD Waiver 1<sup>st</sup> Quarter Report" page 5 at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/MEDS-AD/fl-fl-meds-ad-qtrly-rpt-jan-mar-2016.pdf>

<sup>5</sup> Even though this chart has a July 1, 2018 effective date, only the spousal impoverishment standards increased for July 2018. The MEDS-AD and QMB income limits were the same in June 2018 as July 2018.

24. The findings show that Petitioner has Medicare as a disabled adult. She lives in the community; there was no evidence of Petitioner receiving a Medicaid institutional or Home and Community-Based service. Because Petitioner has Medicare and lives in the community (as opposed to one of the Medicaid institutional or home-bound Medicaid programs) she is not eligible for the MEDS-AD Waiver Program in Florida. In addition, Petitioner has income that exceeds that program's eligibility. However, her income was below the limit for QMB eligibility.

Medically Needy Program and computation of SOC

25. Section 409.904, Florida Statutes, describes the Medically Needy Program and states in part:

(2) A family, a pregnant woman, a child under age 21, a person age 65 or over, or a blind or disabled person, who would be eligible under any group listed in s. [409.903](#)(1), (2), or (3), except that the income or assets of such family or person exceed established limitations. For a family or person in one of these coverage groups, medical expenses are deductible from income in accordance with federal requirements in order to make a determination of eligibility. A family or person eligible under the coverage known as the 'medically needy,' is eligible to receive the same services as other Medicaid recipients, with the exception of services in skilled nursing facilities and intermediate care facilities for the developmentally disabled.

26. The above statute explains the Medically Needy coverage group that is available for individuals who do not qualify for certain mandatory Medicaid coverage groups in Florida. Medical expenses are deducted from the SOC to determine the day of the month the individual becomes Medicaid eligible.

27. Title 20 of the Code of Federal Regulations Section 416.1124, sets forth the \$20 general exclusion for income (not based on need) in the adult-related Medicaid Programs.

28. *Florida Administrative Code 65A-1.702, Special Provisions, states in part:*

(2) Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement. The date of eligibility includes the three months immediately preceding the month of application (called the retroactive period). Eligibility for Medicaid begins the first day of a month if an individual was eligible any time during the month, with the following exceptions: ...b) Individuals applying for the Medically Needy program become eligible on the date they incurred allowable medical expenses, excluding payments by all third party sources except state or local governments not funded in full by federal funds, equal their share of cost, provided that all other conditions of eligibility are met... (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... (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.

29. This rule explains that Medically Needy recipients become eligible for Medicaid on the day of the month they incurred and allowable medical expenses equal their SOC; the allowable expenses do not include payments by sources such as Medicare. The department must have the balance owed by the recipient after Medicare pays its portion before it can determine if the SOC is met. This rule also explains that the SOC is determined by deducting the MNIL from the income.

30. *Florida Administrative Code 65A-1.716, Income and Resource Criteria, sets forth the income standards used in the Medicaid Programs and states in part, "(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: Family Size...1...Monthly Income Level...\$180."*

31. *Florida Administrative Code 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, informs in part:*

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. §416.1100

(2007) (incorporated by reference) et seq. ... (4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost," shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:

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

32. The above rule instructs the department on allowable medical expenses and the Medically Needy tracking process. It states that if countable income exceeds the MNIL, the department will deduct allowable medical expenses in chronological order, by day of service. In addition, 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. Any other expenses paid by a third party, such as Medicare, are not allowable deductions to help reduce or meet the SOC.

33. The undersigned reviewed the department's calculations to determine the most advantageous SOC for Petitioner and concludes the enrollment in the adult-related Medically Needy Program was correct. The SOC calculation correctly considered the allowable deductions to result in the \$730 SOC. Petitioner's arguments were considered and fully understood. However, there is no more advantageous outcome for Petitioner as she does not qualify for the MEDS-AD Waiver Program. Petitioner will need to submit all out-of-pocket medical expenses to the department on an ongoing basis as eligibility is determined separately each month.

### **DECISION**

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

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

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

FINAL ORDER (Cont.)

18F-04920

PAGE - 13

DONE and ORDERED this 14 day of August, 2018,  
in Tallahassee, Florida.



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

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

**FILED**

Aug 16, 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-05113

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 04 Duval  
UNIT: 88701

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 2, 2018 at 10:49 a.m.

**APPEARANCES**

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

[REDACTED] Patient Advocate and Authorized Representative with [REDACTED]  
[REDACTED]

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

**ISSUE**

At issue is the respondent's action to not approve the petitioner for SSI-Related Medicaid for the retroactive months of March 2018 and April 2018 due to the imposition of a Child Support Enforcement (CSE) sanction.

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

### **PRELIMINARY STATEMENT**

Evidence was received and entered as the Petitioner's Exhibit 1 and the Respondent's Exhibits 1 through 2.

The record was closed at the conclusion of the hearing.

### **FINDINGS OF FACT**

1. On May 1, 2018, the petitioner's representative filed an application, on the petitioner's behalf, for SSI-Related Medicaid. The petitioner's representative listed only the petitioner (age 41) on the application (Respondent's Exhibit 2, pages 11-14).

2. The Department reviewed the application for SSI-Related Medicaid and determined that the petitioner was ineligible for Medicaid due to a CSE sanction that was imposed against her. The Department denied the application on its contention that the petitioner was ineligible due to the CSE sanction that was imposed against her for the Medicaid program. On June 1, 2018, the Department mailed to the petitioner's representative the Notice of Case Action informing her of the denial of the application for SSI-Related Medicaid. The Notice of Case Action states: "You or a member(s) of your household is not eligible due to failure to cooperate with child support enforcement..."

3. The petitioner's representative argues that she indicated on the application for SSI-Related Medicaid, submitted on May 1, 2018, that the petitioner has been deemed disabled (Petitioner's Exhibit 1). The petitioner's representative argues that the Department failed to submit the petitioner's application to the Division of Disability

Determination (DDD) due to the CSE sanction. The petitioner's representative argues that the petitioner has been deemed disabled by her physician; therefore, her application should have been forwarded to the DDD.

4. The Department explained that the petitioner's children, ages 14, 11, 8, and 5, are residing with the petitioner and are receiving Medicaid. The Department explained that, except for CSE cooperation, the petitioner met all other eligibility requirements in order to be eligible for Medicaid; therefore, her application was not forwarded to DDD. The Department's records indicate that the petitioner had been penalized, due to the CSE sanction, since August 2015. The Department explained that the petitioner filed an application for Supplemental Nutrition Assistance Program (SNAP) and Medicaid in February 2018 for herself and her four children and that only her children were determined to be eligible for SNAP and Medicaid benefits (Respondent's Exhibit 1, pages 7 through 8). The Department believes that the petitioner was aware she was penalized due to the CSE sanction in February 2018. The Department explained that the petitioner is now receiving coverage under the Family-Related Medicaid program, as she cooperated with CSE on June 28, 2018; her CSE sanction was lifted, retroactively, to June 1, 2018. The Department further explained that the petitioner's CSE sanction cannot be lifted, retroactively, for the months of March 2018 and April 2018 since she did not cooperate until June 28, 2018.

5. The petitioner's representative does not dispute the correctness of the imposition of the CSE sanction. The petitioner's exhibit does not include any evidence

to show that the petitioner was pregnant or that she had good cause for not cooperating with CSE during the period at issue.

### **CONCLUSIONS OF LAW**

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

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

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

(7) A standard filing unit (SFU) is determined based on the individual for whom assistance is requested. A fully deprived child is one who is not living with either birth parent due to reasons such as death, abandonment or incarceration. The following are illustrations of SFU determinations: ...  
(c) ...For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI.

9. The above controlling authority states that there must be at least one child under age 18 in the household for the parent to be eligible for coverage in the Family-Related Medicaid program. The petitioner's representative argues that the Department did not forward the petitioner's application to the DDD based on her disability. The findings show that the petitioner derived her eligibility for Medicaid from her four children, who are all under the age of 18, and would have been eligible for Family-Related Medicaid during the period at issue if she did not have a CSE sanction. The

undersigned concludes that the petitioner was potentially eligible for Family-Related Medicaid due to meeting the above criteria; therefore, the Department was correct to not forward her application to DDD for a disability determination.

10. Federal Regulations at 42 C.F.R. §433.145 Assignment of rights to benefits—State plan requirements.

(a) A State plan must provide that, as a condition of eligibility, each legally able applicant or beneficiary is required to:

(1) Assign to the Medicaid agency his or her rights, or the rights of any other individual eligible under the plan for whom he or she can legally make an assignment, to medical support and to payment for medical care from any third party;

(2) Cooperate with the agency in establishing the identity of a child's parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in §435.116 of this chapter (pregnant women), who are exempt from cooperating in establishing the identity of a child's parents and obtaining medical support and payments from, or derived from, the non-custodial parent of a child; and

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(b) A State plan must provide that the requirements for assignments, cooperation in establishing paternity and obtaining support, and cooperation in identifying and providing information to assist the State in pursuing any liable third party under §§433.146 through 433.148 are met.

(c) A State plan must provide that the assignment of rights to benefits obtained from an applicant or beneficiary is effective only for services that are reimbursed by Medicaid.

11. Federal Regulations at 42 C.F.R. §433.148 Denial or termination of eligibility.

In administering the assignment of rights provision, the agency must:

(a) Deny or terminate eligibility for any applicant or beneficiary who—

(1) Refuses to assign his own rights or those of any other individual for whom he can legally make an assignment; or

(2) In the case of an applicant, does not attest to willingness to cooperate, and in the case of a beneficiary, refuses to cooperate in establishing the identity of a child's parents, obtaining medical child support and pursuing liable third parties, as required under §433.147(a) unless cooperation has been waived;

(b) Provide Medicaid to any individual who—

(1) Cannot legally assign his own rights; and

(2) Would otherwise be eligible for Medicaid but for the refusal, by a person legally able to assign his rights, to assign his rights or to cooperate as required by this subpart; and

(c) In denying or terminating eligibility, comply with the notice and hearing requirements of part 431, subpart E of this subchapter.

12. Federal Regulations at 42 C.F.R. § 435.610 define the assignment of rights to benefits and states, in part:

(a) Consistent with §§433.145 through 433.148 of this chapter, as a condition of eligibility, the agency must require legally able applicants and beneficiaries to:

(1) Assign rights to the Medicaid agency to medical support and to payment for medical care from any third party;

(2) In the case of applicants, attest that they will cooperate, and, in the case of beneficiaries, cooperate with the agency in—

(i) Establishing the identity of a child's parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating or is a pregnant woman described in §435.116; and

(ii) Identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

**(b) The requirements for assignment of rights must be applied uniformly for all groups covered under the plan (emphasis added).**

13. The Department's Program Policy Manual (Manual), CFOP 165-22, Passage 1440.1700 sets forth that applicants for SSI-Related Medicaid must cooperate with CSE requirements as a condition of eligibility with noted exceptions: Emergency Medicaid for

Aliens, transitional Medicaid, and Child only Medicaid cases. None of these exceptions are applicable in the instant case.

14. On December 9, 2003, the Department issued a policy clearance which addresses CSE cooperation for an applicant who has applied for SSI-Related Medicaid. The clearance explains that applicants for SSI-Related Medicaid are required to assign the rights to third party payments for their children if they are eligible for Medicaid, and that cooperation with child support is not required if the applicant's children are not eligible for Medicaid. The clearance further explains that the applicant must cooperate with CSE if his or her children are eligible for Medicaid. The findings show the petitioner's children were eligible for Medicaid during the period at issue.

15. The above authorities explain that an applicant for SSI-Related Medicaid is required cooperate with child support enforcement as a condition of eligibility. Therefore, the undersigned concludes that the petitioner was required to cooperate with CSE in order to meet the eligibility requirement for the Medicaid program.

16. The Manual, CFOP 165-22, Passage 430.1711 Ending Sanction (MFAM) and the Manual, CFOP 165-22, Passage 1440.1771 Ending Sanction (MSSI) explain that "the effective date for adding a sanctioned individual to the case is retroactive to the first day of the month of compliance." The findings show that the petitioner cooperated with CSE on June 28, 2018 and that her CSE sanction was lifted effective June 1, 2018. Based on the above authority, the undersigned concludes that the Department was correct to not lift the CSE sanction retroactively to March 2018, in order to provide the

months of coverage (March 2018 and April 2018) that the petitioner's representative is seeking.

17. Based on the above findings, conclusions of law, and evidence, the undersigned concludes that the Department is correct in its denial of the petitioner's request for the Department to provide Medicaid coverage, retroactively, for the months of March 2018 and April, since she did not cooperate with CSE until June 28, 2018. The undersigned concludes that the petitioner did not meet the burden of proof in establishing the respondent had incorrectly denied petitioner's request to authorize Medicaid benefits for the months of March 2018 and April 2018.

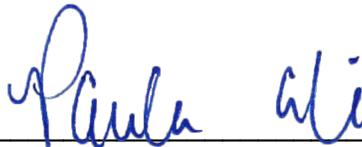
### **DECISION**

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 16 day of August, 2018,  
in Tallahassee, Florida.



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

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

Aug 30, 2018

Office of Appeal Hearings  
Dept. of Children and Families

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



APPEAL NO. 18F-06801

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT  
OF CHILDREN AND FAMILIES  
CIRCUIT: 11 Dade  
UNIT: 88880

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 23<sup>rd</sup>, 2018, at 10:00 a.m.

**APPEARANCES**

For the Petitioner: , pro se.

For the Respondent: Martha Lopez, Operations & Management Consultant for the Economic Self-Sufficiency program.

**STATEMENT OF ISSUE**

The petitioner is appealing the respondent not properly notifying her of the termination of the Medicare Savings Program (MSP) coverage under the Qualifying Individual 1 (Q11), by issuing the March 2<sup>nd</sup>, 2018 Notice of Case Action (NOCA) to the incorrect address.

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

The petitioner is also appealing the Social Security Administration's (SSA) action to collect Medicare premium amounts from her benefit check.

### **PRELIMINARY STATEMENT**

Appearing as an impartial observer was Alma Patino of the Office of Appeal Hearings.

The petitioner's composite exhibit was admitted into evidence.

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

By way of a Notice of Case Action (NOCA) dated March 2<sup>nd</sup>, 2018, the respondent notified the petitioner that, "your Qualifying Individual 1 benefits will end on March 31<sup>st</sup>, 2018. Reason: Ineligible due to the value of undisclosed assets." (Respondent's Exhibit 1.)

On August 17<sup>th</sup>, 2018, the petitioner filed an expedited Medicaid appeal (which was granted) to challenge the respondent's action.

Prior to addressing the merits of the case, it is necessary to determine if the appeal was filed timely.

### **FINDINGS OF FACT**

1. On March 2<sup>nd</sup>, 2018, the respondent issued via the United States Post Office (USPS) a Notice of Case Action (NOCA) to the petitioner informing her that, "your Qualifying Individual 1 benefits will end on March 31<sup>st</sup>, 2018. Reason: Ineligible due to the value of undisclosed assets." (Respondent's Exhibit 1, Page 10.) The notice also informs the petitioner of her right to ask for a fair hearing before a state hearing officer within 90 days from the date of the notice (page 12 of the notice).

2. The above-mentioned Notice of Case Action was issued to [REDACTED], [REDACTED].

3. The notice issued to the address mentioned above was not returned by the United States Postal Service (USPS.) The notice was issued to the address provided by the petitioner on the web application she filed on February 26<sup>th</sup>, 2018. (Respondent's Exhibit 3, Page 3.) Therefore, the respondent contends that the notice was presumably received by the petitioner.

4. The petitioner contends that she did not receive the NOCA issued by the respondent on March 2<sup>nd</sup>, 2018. The petitioner stated that the only notice she received in the mail stated that her food assistance benefits would end on March 31<sup>st</sup>, 2018.

5. The respondent stated that the same NOCA which the petitioner received addresses all programs including the Medicare Savings Program, and pointed out to page 10 of the notice, which shows Qualified Individual 1. (Respondent's Exhibit 1.) Additionally, the petitioner contacted the Department on March 8<sup>th</sup>, 2018, to inquire about the case status and she was informed of the denial. (Respondent's Exhibit 2, Pages 23 and 24.)

6. The petitioner claimed that she did not realize the Qualified Individual 1 program is a Medicare Savings Program, and had she known that, she would have provided all the necessary documents to the Department.

7. The petitioner stated that she moved on March 1<sup>st</sup>, 2018, and informed the Department about her change of address due to the move. Therefore, she contends that the respondent issued the notice to the incorrect address. The petitioner however, did not present

any evidence supporting her argument, and the respondent has no record of such a change ever reported by the petitioner.

8. The petitioner explained that what prompted her to request a hearing in the absence of a notice was that the Social Security Administration began to recoup as well as deduct Medicare premiums from her benefit check. The petitioner contends, that is when she became aware of the fact that the State of Florida stopped paying for her Medicare premiums, hence the appeal.

9. The petitioner contends that the Department must reinstate her MSP benefits, so that the Social Security Administration can reimburse her for the amount it had already collected. The petitioner had already filed an appeal with the Social Security Administration for the same reason, and is pending for a decision.

10. The petitioner argued that the 90-day time limit to request a hearing should not be applicable in her situation due to her limited income, as well as a lack of understanding of the program.

### **CONCLUSIONS OF LAW**

11. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 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 proceeding is a *de novo* proceeding pursuant to Florida Administrative Code R. 65-2.056.

14. Fla. Admin. Code 65-2.046, sets forth time limits in which to request a hearing, and states in part:

(1) The appellant or authorized representative must exercise their right to appeal within **90 calendar days in all programs** [*emphasis added ....*]  
The time period begins with the date following:

(a) The date on the written notification of the decision on an application.

(b) The date on the written notification of reduction or termination of program benefits.

(c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.

(2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.

15. The evidence shows that the respondent properly issued a Notice of Case Action (NOCA) on March 2<sup>nd</sup>, 2018 to the petitioner's address it had on record. This address was provided by the petitioner herself on her application submitted on February 26<sup>th</sup>, 2018, three (3) days prior to the respondent issuing the NOCA. The petitioner confirmed the receipt of a NOCA indicating the termination of her food assistance benefits. The evidence presented by the respondent shows that this NOCA is a six (6) page document, which also addresses the Medically Needy and the Qualified Individual 1 programs on subsequent pages. Additionally, the petitioner admitted that she did not understand that the Qualified Individual 1 program is a

Medicare Savings Program. Had she known, she would have complied with the respondent.

16. Jurisdictional boundaries are clearly defined in quasi-judicial administrative proceedings such as this. The hearing officer is limited by law to not address issues beyond his/her jurisdiction. The undersigned concludes that the respondent properly notified the petitioner of its decision by issuing a Notice of Case Action March 2<sup>nd</sup>, 2018 to the petitioner's address on record. The petitioner confirmed during the hearing that she received the NOCA regarding the food assistance. The respondent established that it is the one and same NOCA, which explained all programs. The notice informed the petitioner of her right to file for a hearing, but that the request must be received within 90 days of the date the notice was issued. The filing date of August 17<sup>th</sup>, 2018, is 168 days after the Notice of Case Action was issued, and is beyond the 90-day time limit to request a hearing on the action. Therefore, the respondent's action to terminate the petitioner's Qualified Individual 1 program is not within the jurisdiction of the undersigned hearing officer. Therefore, that portion of the appeal is hereby denied as non-jurisdictional.

17. Fla. Admin. Code 65-2.044, addresses the right to request a hearing, and states in part:

Any applicant/recipient dissatisfied with the **Department's action** *[emphasis added]* or failure to act has a right to request a hearing. He/she may do so when it is believed that:

- (1) Opportunity to make application has been denied.
- (2) The application has been rejected.
- (3) The application has not been acted upon within a reasonable length of time.
- (4) The benefits have been modified or discontinued.

(5) Reconsideration of the assistance/service benefits is refused or delayed.

(6) Opportunity has not been given to make a choice of service.

(7) **Any other Department action or inaction relating to public assistance eligibility is incorrect.** *[emphasis added]*

18. The above-cited authority grants the hearing officer jurisdiction to address the department's action related to public assistance eligibility. The Social Security Administration is not a state agency/department; therefore, its action cannot be challenged before a state hearing officer. Therefore, the petitioner's claim to have the Social Security Administration reimburse the recouped amount back to her is not within the jurisdiction of the undersigned hearing officer. The proper venue to request such a hearing is with the Social Security Administration itself, and the petitioner confirmed that she had already done that. Therefore, that portion of the appeal is hereby dismissed as non-jurisdictional.

### **DECISION**

Based upon the foregoing Findings of Fact and the Conclusions of Law, the undersigned rules as follows:

A. As to the issue of the respondent issuing the NOCA to the incorrect address, the appeal is denied.

B. As to the issue of Social Security Administration's action to collect Medicare premiums from the petitioner, the appeal is dismissed as non-jurisdictional.

**NOTICE OF RIGHT TO APPEAL**

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

DONE and ORDERED this 30 day of August, 2018,

in Tallahassee, Florida.



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Sajan George  
Hearing Officer  
Building 5, Room 255  
1317 Winewood Boulevard  
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Copies Furnished To: [REDACTED], Petitioner  
Office of Economic Self Sufficiency

Jul 16, 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. [REDACTED]

PETITIONER,

Vs.

ADMINISTRATOR

[REDACTED]

RESPONDENT.

\_\_\_\_\_ /

**FINAL ORDER**

Pursuant to notice, a hearing in the above-referenced matter convened on July 5, 2018 at 9:38 a.m. at the [REDACTED]

**APPEARANCES**

For the Petitioner: The petitioner was present and was represented by his daughter, [REDACTED]

For the Respondent: [REDACTED] Administrator for the facility.

**ISSUE**

At issue is the facility's intent to discharge petitioner due to non-payment of a bill for services; a Nursing Home Transfer and Discharge Notice was issued on April 24, 2018 with an effective date of May 24, 2018.

The respondent carries the burden of proof by clear and convincing evidence.

### **PRELIMINARY STATEMENT**

By notice dated April 24, 2018, the respondent informed the petitioner that the facility was seeking to discharge/transfer him due to nonpayment. On May 22, 2018, the petitioner timely requested a hearing to challenge the discharge/transfer.

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

Appearing as witnesses for the respondent were [REDACTED], Business Office Manager (BOM), and [REDACTED], Social Services Director (SSD).

Evidence was received and entered as the Respondent's Exhibits 1 through 2.

A letter dated June 1, 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.

The record was closed at the end of the hearing.

### **FINDINGS OF FACT**

1. The petitioner, age 67, has been residing in the respondent's facility since November 15, 2017.
2. The BOM contends that the petitioner's representative has not provided the necessary verifications to approve the Medicaid application, nor has she paid the private portion that is due to the facility. The BOM contends that the estimated patient responsibility was \$1191 prior to the change on July 2018. The BOM explained that the estimated patient responsibility, prior to July 2018, was calculated by the petitioner's Social Security income in the amount of \$1296, subtracted by the \$105 in personal needs that was to be kept by the petitioner. The BOM alleges that the petitioner's

daughter has not paid the estimated patient responsibility, as she is using the funds to pay for her personal expenses. The BOM contends that the facility has reported to the state, the misuse of the petitioner's personal funds by the petitioner's daughter.

3. The SSD contends that the facility reached out to the petitioner's daughter for her to submit the verifications to complete the Medicaid application. The SSD contends that the verifications were not received; therefore, the 30- day discharge notice was issued to the petitioner. The SSD contends that the petitioner's daughter was informed of the facility's intent to discharge her father from the facility. The SSD contends that a copy of the discharge notice was also sent to the local Ombudsman's office.

4. The BOM contends that the monthly billing statements are sent to the petitioner's representative at [REDACTED] from its home office. The Respondent's Exhibit 2 includes copies of the billing statements for the following dates: January 1, 2018, with a balance due in the amount of \$15085.94; April 1, 2018, with a balance due in the amount of \$36197.69; and May 1, 2018, with a balance due in the amount of \$49032.74. The BOM contends that the current balance owed to the facility, as of the date of the hearing, is \$57802.32. The BOM contends that the petitioner's Medicaid application is in a denied status.

5. The petitioner's daughter acknowledges that she received the monthly billing statements. The petitioner's representative contends that the petitioner's daughter has made attempts to provide the verifications needed, but is having a difficult time obtaining the award letter because the Social Security Administration will not release it to her since her father did not initiate the request. The petitioner's daughter explained

that she is not her father's power-of-attorney. The petitioner's representatives do not understand why the facility cannot request from SSA the necessary verifications. The petitioner's daughter contends that it was her understanding that once Medicaid was approved, the monies would be deducted from the petitioner's Social Security income, and that she would be getting a bill from the facility to inform her of the monthly amount due. The petitioner's daughter contends that she received bills for \$800 and \$359, which she paid. The petitioner's daughter contends that she did not receive a bill for \$1191. The petitioner's daughter argues that she is not paying her personal expenses with the petitioner's income. The petitioner's daughter contends that when she and the petitioner resided together, he gave his permission for her to use his income to pay the rent and other expenses. The petitioner's daughter argues that she could not cancel the payments that were scheduled to pay the expenses that the petitioner owed and were being paid from his bank account. The petitioner's daughter believes that the petitioner's bank account should include enough funds to pay the facility the estimated patient responsibility and will check his account to verify.

6. The BOM contends that, upon admission, the facility informs its residents' families that they are to pay to the facility the estimated patient responsibility until Medicaid is approved. The BOM explained that the estimated patient responsibility amount is calculated by including the income received by the resident, minus the \$105 set aside for the petitioner for his personal needs. The BOM explained that since the amount is estimated, the amount of the actual patient responsibility may be more or less than the estimated patient responsibility once Medicaid is approved.

7. The SSD contends that the petitioner's health has declined and that he has been signed up for hospice care.

### **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 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

9. Federal Regulations appearing 42 C.F.R. § 483.15, sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

(c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

...

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or...

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. Based on the evidence presented, the undersigned concludes that the nursing facility has established that the petitioner has failed, after reasonable and appropriate notice to pay for a stay at the facility. This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident.

12. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

### **DECISION**

This appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The respondent may proceed with the discharge, as describe in the Conclusions of Law and in accordance with applicable Agency for Health Care Administration requirements.

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

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the 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

FINAL ORDER (Cont.)

18N-00055

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must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 16 day of July, 2018,

in Tallahassee, Florida.



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