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

[redacted]

APPEAL NO. 18F-05230

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 11 DADE
UNIT: 88672

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 7, 2018 at 11:30 a.m. and on October 16, 2018 at 10:00 a.m.

APPEARANCES

For the Petitioner: [redacted], pro se

For the Respondent: Rolando Santana, Operations Management Consultant

STATEMENT OF ISSUE

The petitioner is appealing the denial of her application for Medicare Savings Plan (MSP) coverage under the Qualifying Individual 1 (QI-1) program. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted a Department Notice dated November 15, 2017 as evidence for the hearing, which was marked as Petitioner's Exhibit 1.

The respondent submitted a packet of documents as evidence for the hearing, consisting of the following, which were marked as Respondent's Exhibits: Exhibit 1 – Case Information; Exhibit 2 – Running Record Comments (CLRC); Exhibit 3 – Application; and Exhibit 4 – Department Notices.

After the hearing concluded, the record was left open for 15 days for the petitioner to submit additional evidence. However, no additional evidence was received.

FINDINGS OF FACT

1. On June 8, 2018, the petitioner applied for the Medicare Saving Plan benefits. This program pays the Medicare premiums for certain qualifying individuals. A household size of one was listed on the application. The petitioner listed liquid assets of $5,500 in a checking account as well as her Social Security income of $1,434 monthly.

2. On June 12, 2018, the department sent the petitioner a notice informing her that she had been approved for the MSP QI-1 program. However, the Department sent the petitioner another notice on July 25, 2018 informing her that her QI-1 benefits would end on August 31, 2018 for the following reason: "Your household's income is too high to qualify for this program."

3. The petitioner had previously applied for MSP benefits on December 12, 2017 and she had been denied on December 13, 2017 for the same reason – being over the income limit for the program.

4. Using its Data Exchange System with the Social Security Administration (SSA), the Department verified that the petitioner's gross monthly income from SSA is $1,435. The Department obtained additional verification indicating the petitioner also receives a monthly public retirement benefit in the amount of $55.40 from the State of Florida, which is classified as an insurance subsidy. The Department also verified the petitioner's bank account contained $5,500.

5. The Department combined the petitioner's verified income from the two sources and determined the petitioner's monthly gross income as $1,490.40 ($1,435 + $55.40 = $1,490.40). Based on the combined gross income, the respondent determined the petitioner's eligibility for the MSP utilizing the SSI-Related Programs -- Financial Eligibility Standards Chart: April 1, 2018.

6. The chart shows that the 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 (QI-1), 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 QI-1, 135% of the FPL, currently $1,366. The asset limit is the same for all three programs - $7,560.

7. In the petitioner's case, her verified gross monthly income is $1490.40. The only deduction the petitioner is eligible to receive is a standard unearned income disregard of $20; which when deducted from $1,490.40 leaves the petitioner with a

countable income of $1,470.40. Since the petitioner's income exceeds the income standards for all three MSP programs, she failed to qualify for MSP benefits.

8. The Department representative stated the petitioner was denied MSP benefits because she over the asset and income limits. He also explained the petitioner was initially approved in error, which is why the Department's June 8, 2018 notice informed her she was eligible for the program. The benefit was subsequently canceled and denied when the Department discovered the error.

9. The petitioner believed the income and asset limits were different because she was given different information by the organization which assisted her with the application. She also believes the insurance subsidy she receives from the State of Florida retirement system should not be included in the income calculation. She was expecting to receive retroactive MSP benefits because she thought she had been approved for the QI-1 program.

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 Fla. Stat § 409.285.

11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

12. 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.)

13. Fla. Admin. Code R. 65A-1.713(1) further addresses the SSI-Related Medicaid Income Eligibility Criteria as follows:

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

(b) For **QMB**, income must be less than or **equal to the federal poverty level** *[emphasis added]* after application of exclusions specified in subsection 65A-1.713(2), F.A.C.
…
(g) For **SLMB**, income must be greater than 100 percent of the federal poverty level but equal to or **less than 120 percent of the federal poverty level.** *[emphasis added]*
…
(j) For a Qualified Individual 1 (**QI1**), income must be greater than 120 percent of the federal poverty level, but equal to or **less than 135 percent of the federal poverty level**. *[emphasis added]* QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

14. The Department's Program Policy Manual at Appendix A-9, effective April 1, 2018, sets forth the individual income limit for QMB benefits as $1,012; SLMB benefits as $1,214; and QI1 benefits as $1,366. The asset limit is $7,560 for all three programs.

15. The above-cited authority clearly sets forth the financial eligibility criteria to be met in order to qualify for one of the MSP. The Department must follow these guidelines when determining eligibility for the petitioner. The petitioner's total countable income of $1,470.40 exceeds the income standard of $1,366 for the QI-1 program; therefore, the petitioner is not eligible. There are no exceptions found in the regulations which would allow a different outcome for the petitioner. The petitioner would still be over the income limit even if the $55.40 insurance subsidy was excluded from her income. Therefore, the undersigned concludes that the respondent's action to deny the petitioner's request for the MSP based on income being too high is correct.

16. The undersigned notes the Department representative's assertion that the petitioner was also denied due to being over the asset limit appears to be incorrect since her bank account balance of $5,500 is less than the asset limit of $7,560.

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 11 day of December, 2018,

in Tallahassee, Florida.

Rafael Centurion
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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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 18F-05899

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 18, 2018 at 1:00 p.m.

APPEARANCES

For the petitioner: [redacted] and designated representative for the petitioner.

For the respondent: Brian Meola, Esq. Assistant Region Counsel with the Department of Children and Families.

STATEMENT OF ISSUE

The petitioner's representative is appealing the respondent's action to deny petitioner's application for Institutional Care Program (ICP) Medicaid benefits. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for August 21, 2018 at 2:15 p.m. On August 21, 2018, all parties dialed in. The petitioner's representative explained she was not familiar with the case. The previous employee from Family First Firm who requested the hearing was no longer with the agency, the representative requested a continuance to have an opportunity to review the issue at matter in which the respondent did not object. The undersigned granted a continuance and set the hearing on September 18, 2018 at 1:00 p.m.

Jackie Smalls, ACCESS Economic Self-Sufficiency Specialist II, appeared as a witness to the respondent.

During the hearing on September 18, 2018, the respondent's witness addressed the petitioner's power of attorney (petitioner's daughter), giving Family First Firm authorization to represent the petitioner. The respondent's witness position is an organization cannot be assigned as a designated representative, a staff member must be appointed. Therefore, the undersigned reserved ruling on the respondent's motion until the Final Order was issued.

The petitioner's representative did not submit any exhibits at the hearing on September 18, 2018. The respondent submitted three exhibits, which were entered into evidence as Respondent's Exhibits "1" through "3". The record was held open until close of business on September 28, 2018 for submission of additional evidence from the parties. After the hearing, the petitioner's representative submitted one exhibit, which was entered into evidence as Petitioner's Exhibit "1". On September 20, 2018,

the respondent submitted additional information, which was entered into evidence as Respondent's Exhibit "4". The record closed on September 28, 2018.

FINDINGS OF FACT

1. On March 6, 2018, Family First Firm submitted an on-line application for the petitioner (age 75). According to the application, the petitioner was a resident at [redacted] The petitioner's power of attorney (POA) is her daughter. The POA signed a Designated Representative form giving an employee from Family First Firm authorization to act on the petitioner's behalf.

2. On March 7, 2018, as part of the application process, the respondent mailed a Notice of Case Action (NOCA) to the petitioner and the designated representative requesting the following information and submitted by March 19, 2018.

Dear Natividad De Freites,

The following is information about your eligibility.

Once you receive your case number you can go to www.myflorida.com/accessflorida to activate your My ACCESS Account. You will be able to get case status information. You will also be able to print a temporary Medicaid card if you are eligible for Medicaid.

We need the following information by March 19, 2018.

Please complete and sign the Informed Consent Form
Please complete and sign the Affidavit for Designated Representative Form

0PLEASE PROVIDE THE FOLLOWING: Complete and return enclosed forms - Financial Release 2613 signed by you and spouse (client needs to sign the form if able, if not a statement of good cause reason as to why the client cannot sign will need to be provided, if the form is signed by power of attorney or legal guardian, you must return a copy of the power of attorney or legal guardianship papers) and the Designated Representative form , cop of current social security award letter, proof MEDICARE for Natividad, CARE PLUS HEALTH PLAN PREMIUM BILL and bank statements for CHASE 5970, BOA 5674, AND BLANCO POPULAR 1551 account(s)from 072017 to current.

3. The respondent did not receive all the pending information by the due date. On April 6, 2018, the respondent mailed the petitioner and representative a NOCA

informing the March 6, 2018 application was denied. The reason: "We did not receive all information requested to determine eligibility'.

4. The respondent explained it did not receive verification of the financial institution of Chase bank account ending in 5970. The respondent further explained, the application can be reused within 60 days from the date of the application if documentation from Chase bank is submitted. The petitioner had until May 5, 2018 to submit the verification and request to reuse the March 6, 2018 application. The petitioner's representative did not submit a copy of the Chase bank account ending in 5970. The application remained closed.

5. On July 11, 2018, the petitioner's representative requested a hearing to challenge the respondents action to deny the March 6, 2018 application. On this date, the petitioner's representative submitted a new application. The petitioner's POA signed a designated representation form giving Family First Firm to act on the petitioner's behalf.

6. On July 16, 2018, the respondent mailed the petitioner and her representatives a NOCA pending the following information be submitted by July 26, 2018:

Dear Natividad De Freites,

The following is information about your eligibility.

Once you receive your case number you can go to www.myflorida.com/accessflorida to activate your My ACCESS Account. You will be able to get case status information. You will also be able to print a temporary Medicaid card if you are eligible for Medicaid.

We need the following information by July 26, 2018.

Proof of income and assets for each month you are requesting retroactive Medicaid
Other - please see comments below

Case STILL need CHASE monthly statements on account ending in 5970 FROM THREE MONTHS PRIOR TO ADMISSION TO CURRENT, BURIAL EXCLUSION FUNDS AND CARE PLUS health PLAN monthly PREMIUM STATEMENT/BILL.

7. On August 13, 2018, the respondent mailed the petitioner and designated representative a NOCA informing the July 11, 2018 application was denied. The reason; "We did not receive all information requested to determine eligibility'.

8. During the hearing and on record, the petitioner's representative requested to also challenge the respondent's action to deny the July 11, 2018 application.

9. The respondent's witness explained the Chase account ending in 5970 was not provided. The July 11, 2018 application can be reused within 60 days from the date of the application The petitioner had until September 10, 2018 to submit the verification and request to reuse the July 11, 2018 application. The petitioner's representative submitted verifications of the Chase account ending in [redacted] on September 13, 2018. Reuse of the application was denied because verification was provided 63 days after the date of the July 11, 2018 application.

10. The petitioner's representative was encouraged to resubmit a new application.

CONCLUSIONS OF LAW

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

12. This proceeding is a de novo proceeding pursuant to Florida Administrative Code Rule 65- 2.056.

13. Pursuant to Florida Administrative Code Rule 65-2.045 Hearings Request, states in part:

> (3) A request for hearing may be made by the applicant/recipient or someone on his/her behalf. However, if the appeal is filed by someone other than the applicant/recipient, attorney, legal guardian, spouse, next of kin, the grantee relative in cash assistance, or a person allowed by the Department as an authorized representative to participate in the eligibility determination, the person making the appeal must have written authorization of the applicant/recipient. Such written authorization must accompany the hearing request. Should the request be filed without the written authorization, the authorization must be provided in response to a request from the Department or hearing officer, prior to the appeal going forward. Without prior proper written authorization, the Department will treat a request for hearing as being made by someone not authorized to do so. Therefore, the appeal will be dismissed.
> (4) The request shall be in written form when made by someone other than the applicant/recipient.

14. The above authorities explain a fair hearing may be requested by someone other than applicant/ recipients. In this case, the next to kin, petitioner's daughter who is also the petitioner's POA gave a written authorization for Family First Firm to represent the petitioner on her behalf. It is the respondent's positions that an organization cannot be a designated representative.

15. The Code of Federal Regulations 42 C.F.R. 435.923 addresses authorized representatives for Medicaid and states in relevant part:

> (a)(1**) The agency must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency.** (emphasis added) Such a designation must be in accordance with paragraph (f) of this section, including the applicant's signature, and must be permitted at the time of application and at other times.
> (2) Authority for an individual or entity to act on behalf of an applicant or beneficiary accorded under state law, including but not limited to, a court order establishing legal guardianship or a power of attorney, must be treated as a written designation by the applicant or beneficiary of authorized representation.
> (b) Applicants and beneficiaries may authorize their representatives to—
> (1) Sign an application on the applicant's behalf;
> (2) Complete and submit a renewal form;

> (3) Receive copies of the applicant or beneficiary's notices and other communications from the agency;
>
> (4) Act on behalf of the applicant or beneficiary in all other matters with the agency.
> (c) The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on his or her behalf, or the authorized representative informs the agency that he or she no longer is acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based. Such notice must be in accordance with paragraph (f) of this section and should include the applicant or authorized representative's signature as appropriate.
> (d) The authorized representative—
> (1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in paragraph (b)(2) of this section, to the same extent as the individual he or she represents;

16. On February 23, 2018 and July 11, 2018, the POA signed the Department's Appointment of a Designated Representative form. The form includes a signed signature from the Designated representative accepting the appointment and includes the representative's name, address and telephone number. The undersigned finds Family First Firm are the authorized representative to appear on behalf of the petitioner. Therefore, the undersigned will proceed as stipulated.

17. Florida Administrative Code Rule 65A-1.303, Assets, addresses eligibility 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.

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. 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.** (emphasis added) 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…

20. According to the above cited authorities explains, the applicant/recipients and the authorized designated representative have the responsibility to furnish information needed to establish eligibility. If the Department determines that additional information is required to establish eligibility, it must notify the applicant/recipients and the authorized designated representative so that he, or she, can provide the requested information. If the required verifications or information is not provided, the application will be denied. However, if the required verifications or information is provided within 60 days from the date of the application, the application can be reused and the Department can determine eligibility.

21. In this case, the respondent mailed the petitioner and petitioner's designated representative NOCA's informing pending information was needed for applications March 19, 2018 and July 11, 2018 which includes verification needed from Chase bank account ending in [redacted]. The respondent was required to request any assets received in the household in order to determine the petitioner's eligibility. The undersigned concludes the respondent was correct to request the petitioner's Chase bank account ending ir[redacted] The petitioner's representative did not submit the requested verification within the 30 days from the date of the application, of 60 days within the date of application to reconsider the reuse. The applications were denied.

22. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner's representative did not meet the burden of proof. The undersigned concludes the respondent's action denying the petitioner's application for March 6, 2018 and July 11, 2018 for ICP Medicaid were correctly denied, due to failing to provide assets verification (Chase bank).

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 05 day of November, 2018,

in Tallahassee, Florida.

Cassandra Perez
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency
Brian Meola, Esq

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

[redacted]

PETITIONER,

Vs.

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

RESPONDENT.
_____/

APPEAL NO. 18F-05945

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 5, 2018 at 11:11 a.m.

APPEARANCES

For the Petitioner: [redacted] mother of petitioner

For the Respondent: Cecilia Salter-Cassaberry, ACCESS Supervisor

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of May 4, 2018 denying his application for the Medicare Savings Program (MSP). The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

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

The record was held open for additional information from both parties due no later than September 14, 2018. Neither party submitted additional information.

The undersigned determined the information requested from the Department was required in order to have a complete record and be able to address the petitioner's issue fully. An interim order was issued on September 25, 2018. The order allowed the Department through October 5, 2018 to provide the required additional information.

The Department provided additional information on October 3, 2018 which was entered as Respondent's Exhibit 2.

The record closed on October 5, 2018.

FINDINGS OF FACT

1. The Department issued a Notice of Case Action on October 18, 2017 informing the petitioner that he had failed to complete or follow through with his Medicaid renewal. This Notice was issued to the address [redacted] (Respondent's Exhibit 2, pages 14 through 20)

2. The petitioner filed an application for Food Assistance, Cash Assistance, Family Medicaid and Medicare Savings Plan on October 25, 2017. The petitioner listed his address on this application as [redacted] The petitioner is a Medicare recipient. (Respondent's Exhibit 2, pages 41 through 51)

3. The Department issued a Notice of Case Action on October 31, 2017 informing the petitioner of additional information needed no later than November 9, 2017. This Notice was issued to the address [redacted] The Notice informed the petitioner that a telephone interview, proof of loans,

contributions, or gifts, and a "Financial Information Release" form were needed. (Respondent's Exhibit 2, pages 18 through 24)

4. The Department issued a Notice of Case Action on October 31, 2017 informing the petitioner that his Medically Needy and Medicaid on his children would continue. This Notice was issued to the address [redacted] Respondent's Exhibit 2, pages 21 through 24)

5. The Department issued a Notice of Case Action on November 28, 2017 informing the petitioner that his Qualified Medicare Beneficiaries (QMB) Medicaid would end December 31, 2017. This Notice was issued to the address [redacted] The Notice explained the petitioner did not provide all information requested to determine eligibility. The Notice further explained for Medicaid, if the review was completed AND return all information requested by the 90th day after the date the Medicaid ended, the Department would redetermine eligibility and not request a new application. (Respondent's Exhibit 2, pages 31 through 37)

6. The petitioner reported his Social Security check was reduced by about $400. The petitioner explained when this reduction occurred he started talking to both the Social Security and the Department to try to understand why this happened. He does not feel he got a straight answer as to why it happened.

7. The Department explained when the QMB closed effective December 31, 2017, that it took a few months for the information to cross over to Social Security. It appears that Social Security took all of the Medicare premiums from January to March or April out of the April Social Security check.

8. The petitioner filed an application for MSP on April 3, 2018. He listed his address on this application as [redacted] (Respondent's Exhibit 1, pages 3 through 7)

9. The Department issued a Notice of Case Action to the petitioner on April 5, 2018. This Notice was issued to the address [redacted] The notice informed the petitioner that the Department needed proof of his identification. The notice also allowed the petitioner opportunity to call the phone number at the top of the notice to complete the authentication by phone. (Respondent's Exhibit 1, pages 8 through 10)

10. The Department recorded in case notes that this case was processed as a "passive" review. (Respondent's Exhibit 2, page 8)

11. The Department explained that a "passive" review means that no interview is required with the customer. The Department further explained that as the petitioner's QMB was previously closed, he was required to authenticate his identity.

12. The Department issued a Notice of Case Action to the petitioner on May 4, 2018 informing him that his application/review for QMB Medicaid was denied due to failure to provide proof of identity. This Notice was issued to the address [redacted] (Respondent's Exhibit 1, pages 11 through 15)

13. The petitioner filed an application for MSP again on July 6, 2018. He listed his address on this application as [redacted] The petitioner noted on this application he wanted eligibility determined beginning March 2018. (Respondent's Exhibit 2, pages 52 through 56)

14. The Department explained that case notes are entered in the case record at or about the time the action or case processing occurs.

15. The petitioner claimed non-receipt of the Notices issued by the Department until he received the evidence packet. The petitioner cited that the city name of "Panama City" was incorrect and it should be listed as "Panama City Beach".

16. The Department provided the Document History for the petitioner's case. The history does not reflect any returned mail received between October 2017 and July 2018. (Respondent's Exhibit 2, page 12 and 13)

17. The Department explained that when a Notice is mailed to the customer and not returned to the Department, then the Notice is presumed received by the customer.

18. The petitioner did not report problems with receiving mail at his home.

19. Due to the discrepancy of whether or not the petitioner received the Notices in question, the undersigned must make the finding. The Department properly mailed the Notices to the petitioner at the address he provided on his October 25, 2017 application. The Department did not change the city name from Panama City to Panama City Beach in April 2018. The Department has no record of the Notices being returned. The petitioner did not report any other problem receiving mail at his home. The undersigned relied on the presumption that correspondence properly mailed and not returned with no rebuttal evidence to support non-receipt (Brown v. Giffen Industries, Inc., Fla. 1973, 281 So.2d 897, 1973 Fla. SCt 997) to make the finding that the petitioner did receive the Notices at issue.

20. The petitioner did not believe he needed to reapply in April 2018 as he was never notified that his benefits were ending.

21. The petitioner expressed concern that he went into the local office to fill out his application in April 2018, but the Department did not take action to authenticate his identity while he was there.

22. The petitioner filed this appeal on July 20, 2018 following his QMB being reopened effective July 2018.

CONCLUSIONS OF LAW

23. 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.

24. This proceeding is a de novo proceeding pursuant to Rule 65-2.056, Florida Administrative Code.

25. Florida Admin. Code R. 65-2.046, Time Limits in Which to Request a Hearing, states in relevant part:

> (1) The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs except the Road to Independence (RTI) Program under Section 409.1451(4), F.S., and the Adoption Subsidy Program under Sections 120.569 and 120.57, F.S.…. The 90-day time period for all other programs begins with the date following:
> (a) The date on the written notification of the decision on an application.
> (b) The date on the written notification of reduction or termination of program benefits.
> (c) The date of the Department's written notification of denial or a request or other action which aggrieves the petitioner when that denial or action is other than an application decision or a decision to reduce or terminate program benefits.

> (2) The time limitation does not apply when the Department fails to send a required notification, fails to take action of a specific request or denies a request without informing the appellant. If the notice is not mailed on the day it is dated, the time period commences on the date it is mailed.

26. The findings show the petitioner was mailed a Notice of Case Action on November 28, 2017 informing him that his Qualified Medicare Beneficiaries (QMB) Medicaid benefit would close effective December 31, 2017. The findings show the petitioner requested an appeal on his case on July 20, 2018. The above controlling authority allows 90 calendar days following the date of the Notice was issued to file a fair hearing. In the instant case, the 90 days following the Notice issuance expired February 26, 2018. The undersigned concludes that the petitioner's appeal cannot include review of the November 28, 2017 action as more than 90 days following the Notice issuance had passed.

27. The Notice of Case Action regarding the petitioner's application dated April 3, 2018 was dated May 4, 2018. The 90 days following this Notice issuance expired August 2, 2018. The undersigned concludes this portion of the appeal was filed timely. The balance of this order will review the April 3, 2018 denial.

28. 42 C.F.R. § 400.200, General Definitions, states in relevant part:

> Qualified Medicare Beneficiary means an individual who—
>
> (1) Is entitled to Medicare Part A, with or without payment of premiums, but is not entitled solely because he or she is eligible to enroll as a QDWI;
> (2) Has resources, as determined in accordance with SSI methodologies, that do not exceed twice the maximum amount established for SSI eligibility; and
> (3) Has income, as determined in accordance with SSI methodologies, that does not exceed 100 percent of the Federal poverty guidelines.

29. Florida Admin. Code R. 65A-1.711, SSI-Related Medicaid Non-Financial Eligibility Criteria, states in relevant part:

> To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference), with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate. Individuals who are in Florida temporarily may be considered residents of the state on a case-by-case basis, if they indicate an intent to reside in Florida and can verify that they are residing in Florida.
> …
> (5) To be eligible as a QMB or for the SLMB coverage the individual must be entitled to Medicare.

30. Florida Admin. Code R. 65A-1.702, Special Provisions, states in 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.

31. The findings show the petitioner is a Medicare recipient. The undersigned concludes the petitioner meets the Medicare recipient criteria for the QMB program.

32. The Department's Policy Transmittal C-16-04-0005, Revised Customer Authentication Procedures for Applications and Additional Benefit Requests, effective May 1, 2016, states in relevant part:

> This memorandum provides revised procedures for the Customer Authentication process for applications and additional benefit requests.
> Procedural Change
> **Effective May 1, 2016, the Customer Authentication process must be completed for all applications and additional benefit requests, no matter the interview requirement, submitted via an online application or paper application.**
> (emphasis added)

33. The above controlling authority explains that ALL applications or requests for additional benefits must have the Customer Authentication process applied to the

application. The findings show that the petitioner's case remained open for Medicaid or Medically Needy. The undersigned concludes the Department correctly followed the policy by requiring the petitioner to complete the authentication process when he filed the application for the MSP program as this was for an additional benefit to those already open. The undersigned concludes as the petitioner was appropriately pended on April 5, 2018 for authentication to be completed and failed to do so, the Department correctly denied the April 3, 2018 application.

34. 42 C.F.R. § 406.26, Enrollment under State buy-in, states in relevant part:

> (b) Beginning of coverage under buy-in. The coverage period begins with the latest of the following:
> …
> (2) The first month in which the individual is entitled to premium hospital insurance under §406.20(b) and has QMB status.
> …
> (c) End of coverage under buy-in. Buy-in coverage ends with the earlier of the following:
> …
> (2) Loss of QMB status. If the individual loses eligibility for QMB status, coverage ends on the last day of the month in which CMS receives the State's notice of ineligibility.

35. The Department's Program Policy Manual, CFOP 165-22, section 0640.0509, Retroactive Medicaid (MSSI) states in part:

> **This policy does not apply to QMB.**
> Medicaid is available for any one or more of the three calendar months preceding the application month, provided:
> 1. at least one member of the SFU has received Medicaid reimbursable services during the retroactive period, and
> 2. the individual meets all factors of eligibility during the month(s) he requests retroactive Medicaid.
> The applicant may request retroactive Medicaid at any time, as long as the coverage period is for any one of three months prior to any Medicaid or SSI application.
> (emphasis added)

36. The findings show the petitioner requested retroactive Medicaid on his July 2018 application. In accordance with the above controlling authorities, the QMB eligibility begins the first month the individual has Medicare **and** QMB status. The QMB program does not offer coverage for months prior to the month of application. The findings show the petitioner reapplied and was approved for QMB beginning July 2018. The undersigned concludes the Department correctly approved the petitioner for QMB beginning with July 2018 and did not approve any retroactive months.

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 16 day of November, 2018,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Lee
UNIT: 88284

RESPONDENT.
_____/

APPEAL NO. 18F-06078

CASE NO [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 8th, 2018, at 1:00 p.m.

APPEARANCES

For the Petitioner: [redacted]pro se.

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

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to continue to enroll her in the Medically Needy (MN) Program with an estimated share of cost instead of providing her with full Medicaid. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents for the hearing.

Respondents exhibits 1 through 9 were admitted into evidence.

The record was held open until the close of business October 29th, 2018 to allow the respondent to provide additional documents and for the petitioner to receive and review the evidence package. The respondent submitted 22 pages of documents which were admitted into evidence as Respondent's exhibit 10. No contact was received from the petitioner regarding the evidence. All documents were received within the allotted time frame, and the record was then closed.

By way of Notice of Case Action (NOCA) dated August 7th, 2018, the respondent informed the petitioner that her Medically Needy Share of Cost (MN) was decreasing from $1532.00 to $1402.00 as of September 1st, 2018.

FINDINGS OF FACT

1. The petitioner submitted an application on July 23rd, 2018 for SNAP and Medicaid benefits. As part of the process, the respondent is required to explore, and if deemed necessary, re-verify all factors of eligibility which include, but are not limited to all sources of income and allowable expenses.

2. The petitioner's household consists of herself, her 5-year-old daughter, her boyfriend, and his 14-year-old daughter.

3. The petitioner is employed a [redacted] earning $1,691.76 per month and her boyfriend is employed at [redacted], earning $480 a week.

4. The petitioner files taxes and claims her daughter as a tax dependent.

5. Based on the household's income, the petitioner was not eligible for full Medicaid and was re-approved for the MN benefits.

6. By way of Notice of Case Action (NOCA) date August 7th, 2018, the respondent informed the petitioner that her estimated share of cost would decrease from $1,532 to $1,402 per month effective September 1st, 2018. (Respondent's Exhibit 5, page 32).

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 earned income and some income from her boyfriend were considered as the modified gross income (MAGI). The respondent counted two members in the petitioner's standard filing unit (SFU). The total 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. Subsequent to the above-described action, but prior to the hearing a case review was completed by the respondent and corrections were done to the case. The respondent determined that the petitioner's relationship screen was filled out incorrectly causing her boyfriend's income being allocated to her. While reviewing the petitioner's pay, it was also established that the paystub for July 5th, 2018 was non-representative of the petitioner's earnings, and should have not been used in calculating her income. In determining eligibility for Medicaid for the petitioner, the respondent considered the petitioner's last 4 paystubs, as follows: July 5th, 2018 in the gross amount of $643.80 (non-representative since it contained overtime), July 12th, 2018 in the gross amount of

$433.56 (representative), July 19th, 2018 in the gross amount of $350.40 (representative), and July 20th, 2018 in the gross amount of $264.00 (representative). The three representative paystubs were added for a total of $1047.96. The total was then divided by 3 for a weekly average of $349.32 (1047.96 /3 = 349.32). This was then multiplied by 4 to arrive at the monthly modified adjusted gross income (MAGI) of $1397.28 (349.32 X 4 = 1397.28). The household income was then compared to the income limit for an adult with a household size of two ($241). The income still exceeded the maximum limit, resulting in petitioner being found ineligible for full Medicaid benefits.

9. The respondent did not provide a NOCA explaining the new outcome in time for the hearing. The record was held open for this purpose.

10. As the petitioner was determined ineligible for full Medicaid, respondent enrolled her in the Medically Needy Program. To determine the estimated SOC for the petitioner, the Medically Needy Income Level (MNIL) of $387 for a standard filing unit size of two was subtracted from the MAGI ($1397.28), resulting in an estimated SOC of $1,010, *(*Respondent's Exhibit 6). By way of a separate NOCA, dated October 25th, 2018, the respondent informed the petitioner that her SOC was $1010 per month effective July 2018.

11. 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. He explained that the petitioner's SOC amount is directly dependent on her income.

12. Under the Affordable Care Act (ACA), the standard filing unit (SFU) is the tax filing group for the tax year. The petitioner files taxes and claims her daughter as a tax dependent, therefore, a SFU and income of two people were used to determine eligibility.

13. The petitioner did not dispute the income amount or the SFU size used by the respondent in the eligibility process. The petitioner argued that after paying all her household expenses, she has no money left and cannot afford any deductibles. She has serious health issues that require medical attention. The petitioner also stated that at the clinic she attends, she has to pay up-front before she sees the doctor, which she cannot afford. The petitioner also states that she submitted some bills to be tracked and was still receiving bills from the providers. The respondent explained that they had received a bill dated August 10th, 2018, but that she needed to provide an itemized bill before it could be tracked.

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

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

16. 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.

17. 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.

18. 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…"

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

20. 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.

21. 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.

22. 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.

23. 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.

24. 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.

25. 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).

26. 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. (Respondent's Exhibit 8, page 63).

27. 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:

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

> If an individual meets the Medically Needy Program's technical eligibility criteria, he is enrolled into the program. There is no income limit for enrollment. The individual is only eligible (entitled to Medicaid) when he has allowable medical bills that exceed the SOC.
>
> The income for an enrolled assistance group need not be verified. Instead, an estimated SOC is calculated for the assistance group. If after

> bill tracking, it appears the assistance group has met his "estimated" SOC, the unverified income must be verified before the Medicaid can be authorized. An individual is eligible from the day their SOC is met through the end of the month.

29. 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."

30. 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.

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

> The Share of Cost (SOC) refers to the amount of medical bills which an individual enrolled in the Medically Needy Program must incur in any given month before Medicaid coverage may be authorized.
> Eligibility must be determined for Medically Needy any time the assistance group meets all technical factors but the income exceeds the appropriate income limit for Medicaid.
> To calculate the share of cost, compare the countable net income to the Medically Needy Income Level based on the size of the standard filing unit. The difference is the assistance group's share of cost.

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

determined the petitioner's countable household income to be $1397.28. The MNIL of $387 was subtracted from the income to arrive at a SOC of $1,010.28, rounded down to $1,010. . 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 correctly determined that the 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 after the respondent corrected the case. Therefore, the undersigned concludes that the petitioner has failed to meet her burden that she was eligible for full Medicaid or a lower share of cost. The petitioner is encouraged to submit itemized bills to the respondent for bill tracking purposes as requested by the respondent if she wishes the bills to be tracked.

DECISION

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

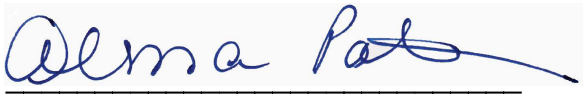
NOTICE OF RIGHT TO APPEAL

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

in Tallahassee, Florida.



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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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Clay
UNIT: 88779

RESPONDENT.
_____/

APPEAL NO. 18F-06116

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 20, 2018 at 3:42 a.m.

APPEARANCES

For the Petitioner: [redacted] attorney

For the Respondent: Jane Almy-Loweinger, Northeast Region Counsel

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of March 5, 2018 denying the petitioner's application for Institutional Care Program Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The case was due to be heard on September 19, 2018. However, the Department counsel was not available on that date. The hearing was rescheduled for September 20, 2018 and convened on that day.

The Department submitted evidence on September 14, 2018 which was entered as Respondent's Exhibit 1. The petitioner submitted evidence on September 17, 2018 which was entered as Petitioner's Exhibit 1.

The parties each submitted documents during hearing. The Department provided the completed form CF-ES 2322, PDF 10/2005 as well as the Qualified Income Trust (QIT) and Plenary Guardian documentation. This filing was entered as Respondent's Exhibit 2.

The document provided by the petitioner is a blank copy of the form CF-ES 2322, PDF 10/2005. As the completed document was provided, this document is unnecessary and was not entered into the record.

The record closed on September 20, 2018.

On September 21, 2018, the Department notified the undersigned of a concession. The Department copied the petitioner's counsel on this notification. The undersigned enters this document as Respondent's Exhibit 3.

The undersigned issued an Order to Reopen and Supplement the Record on September 24, 2018. The Order allowed for updates from the Department and petitioner to be submitted no later than October 8, 2018. The Order also allowed that should the updates resolve the matter, the petitioner could submit a written withdrawal.

The Department submitted additional information on October 2, 2018. This was entered as Respondent's Exhibit 4.

Due to Hurricane Michael, the undersigned was unavailable to review the case between October 9 and 25, 2018 due to office closure.

The Department submitted an additional Notice of Case Action on October 24, 2018. The Department certified that this Notice was shared with the petitioner. This was entered as Respondent's Exhibit 5.

The record closed on October 29, 2018, upon the undersigned's return to the office.

FINDINGS OF FACT

1. The petitioner was admitted to the Nursing Home on October 10, 2017.

2. The petitioner applied for Institutional Care Program (ICP) Medicaid on January 31, 2018.

3. The Department issued a Notice of Case Action on February 2, 2018 requesting additional information to be submitted no later than February 12, 2018. (Respondent's Exhibit 1, pages 4 and 5)

4. The Department issued a Notice of Case Action on March 5, 2018 denying the petitioner's January 31, 2018 application. The reason stated was "We did not receive all information needed to determine eligibility". (Respondent's Exhibit 1, pages 6 through 8)

5. The petitioner elected hospice April 24, 2018.

6. The petitioner filed an application for ICP Medicaid on June 29, 2018.

7. The Department issued a Notice of Case Action on August 3, 2018 denying the petitioner's May 29, 2018 application for ICP Medicaid. (Respondent's Exhibit 1, pages 1 through 3)

8. The petitioner's daughter explained she talked with her mother regarding the need for an income trust so that she would be able to qualify for Medicaid. Her

mother instructed her to set up the trust. The daughter explained she funded the trust each month and paid the facility.

9. The petitioner's daughter executed an Irrevocable Qualified Income Trust (QIT) on November 29, 2017. (Respondent's Exhibit 1, pages 20 through 27)

10. The petitioner had a lifetime contract for personal services with her daughter as well. (Respondent's Exhibit 1, pages 30 through 34)

11. The petitioner's daughter explained the family later determined they needed to establish a guardian for the petitioner. The family members decided the petitioner's son would fill this role. The petitioner's daughter was unaware that they would need to amend the trust that was previously established.

12. The petitioner was appointed a Plenary Guardian, her son, on March 21, 2018. (Respondent's Exhibit 2, pages 10 and 11)

13. The Department legal counsel did not approve the petitioner's QIT. The Department legal identified that all parts of the trust are acceptable with the exception of who established the trust.

14. The Department cited the QIT was executed by the petitioner's daughter and the petitioner's power of attorney was her son. It was the Department's understanding that the QIT is not to be approved if it is not established by a guardian or power of attorney.

15. The Department believed the QIT should be amended so that the trust could be approved.

16. The petitioner cited that the Department's form allows a QIT to be executed by "a person, including court or administrative body, acting at the direction or

upon the request of the individual or individual's spouse". The petitioner believes the Department overlooked this option as there was a legal representative at the time the QIT was reviewed in May 2018.

17. The petitioner cited that federal law also allows for "a person, including a court or administrative body, acting at the direction or upon the request of the individual or individual's spouse to establish a QIT.

18. The petitioner is deceased as of July 9, 2018.

19. The petitioner's family attempted to amend the trust, but were unable to do so as she passed prior to them being able to amend the trust.

20. The Department notified the undersigned and petitioner in writing post hearing of their reconsideration of the law based on oral arguments during the hearing. The Department conceded the fact that a person can act at the direction of an individual to establish a QIT. The Department reversed the denial of the QIT based on the concession. (Respondent's Exhibit 3)

21. The Department issued a Notice of Case Action to the petitioner on October 1, 2018 requesting bank account verification for the QIT for December 2017 through July 2018. The Department also requested additional statement regarding funds paid to the petitioner's daughter was for satisfaction of the personal services contract. The information was due to be returned no later than October 11, 2018. (Respondent's Exhibit 4, pages 3 and 4)

22. The Department provided an updated copy of the Income Trust transmittal CF-ES 2232 with a date of September 21, 2018. The updated form shows that District Legal Counsel concurred that the QIT was valid. (Respondent's Exhibit 4, page 5)

23. The Department submitted a Notice of Case Action dated October 24, 2018. This Notice informed the petitioner that the Medicaid application is approved. The patient responsibility listed for the months of November and December 2017 was $3,579.72. The patient responsibility listed for the months of January 2018 through March 2018 was $3,609.40. The patient responsibility for the months of April 2018 through June 2018 was $3,584.40. The patient responsibility for July 2018 was $3,641.98. The Notice includes the right to appeal within 90 calendar days should the petitioner dispute the amount of the patient responsibility. (Respondent's Exhibit 5)

CONCLUSIONS OF LAW

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

25. This proceeding is a de novo proceeding pursuant to Rule 65-2.056, Florida Administrative Code.

26. 42 U.S.C. § 1396p, Liens, adjustments and recoveries, and transfers of assets, states in relevant part:

> (d) Treatment of trust amounts
> (1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.
> (2)
> (A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:
> (i) The individual.

(ii) The individual's spouse.
(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.
(emphasis added)

27. The findings show the petitioner's Qualified Income Trust (QIT) was established by the petitioner's daughter at the petitioner's direction. In accordance with the above controlling authority, the undersigned concludes the petitioner's income trust was properly established by the petitioner's daughter who was acting at the direction or request of the petitioner. The undersigned further concludes when the trust was established, the petitioner did not have a guardian, power of attorney or any other person with legal authority to establish a trust on her behalf.

28. The findings show the Department reversed the original opinion believing the trust to be improperly established by someone without authority to do so. The findings also show the Department took corrective action to obtain necessary information to determine the petitioner's eligibility. Finally, the findings show the petitioner's eligibility has been established beginning with November 2017. The undersigned concludes the Department has taken all appropriate action based on the updated information to establish the petitioner's eligibility.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19 day of November, 2018,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency
Jane Almy-Loewinger, Esq.
[redacted]

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

[redacted]

APPEAL NO. 18F-06161
18F-06162

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 VOLUSIA
UNIT: 88102

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on September 25, 2018, at 8:33 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

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

STATEMENT OF ISSUE

At issue is whether an unpaid medical bill incurred in January 2017 by Petitioner's son should be paid by the respondent. Petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing was continued from September 5, 2018 per Respondent's request.

Once on the record, the parties informed the undersigned that Petitioner's Medicaid was not an issue and the only remaining issue is the child's unpaid medical bill for January 2017. Since eligibility for Petitioner's Medicaid is no longer an issue, the related Appeal Number 18F-06162 is hereby DISMISSED as moot.

During the hearing, Petitioner submitted an evidence packet which was accepted and marked as Petitioner's Composite Exhibit 1. Respondent submitted four (4) exhibits which were accepted and marked and Respondent's Exhibits 1 through 4. The record was left open through close of business for Respondent to provide additional information. The information was timely received and marked Respondent's Exhibit 5 and the record was closed.

FINDINGS OF FACT

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

1. On [redacted], Petitioner gave birth to a baby boy ("J") and incurred some medical expenses.

2. On January 31, 2017, J was admitted to Orlando Health emergency room. He was discharged on February 2, 2017. During his stay there, he incurred $10,296 on January 31, 2017 and $3,589 from February 1, 2017 through February 2, 201, for a total of $13,885 in medical expenses. Additionally, J was charged $2,677 by [redacted]. for services provided to him on admission date.

3. Petitioner's medical bills for the delivery month were paid by the Department, but her child's bill with [redacted] for January 31, 2017 was not paid.

4. Department's running record comments (CLRC) indicate that Petitioner has made several attempts to address this issue.

5. On February 6, 2017, Department's CLRC notes indicate Respondent received a "2039" for J. No action was taken on it.

6. On March 1, 2017, Respondent received an inquiry from a HCA medical provider about J's Medicaid "pin" number and his eligibility for retroactive Medicaid for January 2017.

7. On May 3, 2017, Petitioner called the [redacted] stating she is still receiving medical bills for J for his stay at the hospital during his month of birth. She was advised to send them to Respondent and request retroactive Medicaid.

8. On May 22, 2017, Respondent received a call from an [redacted] representative requesting Medicaid eligibility for J for January 2017. The Department responded that J's Medicaid was already opened for that month.

9. On October 5, 2017, Respondent received unpaid medical bills related to J's hospitalization from 1/31/ 2017 through 2/2/17. A "passing date" was run and J's Medicaid was approved for January 2017.

10. On October 6, 2017, the Department sent a Notice of Case Action to Petitioner informing her that Medicaid eligibility for January 2017 was approved for J.

11. Medicaid Recipient Information and Department's Individual Eligibility History screens indicate that J's Medicaid coverage started in January 2017, *see* Respondent's Exhibits 2 & 3.

12. On July 17, 2018, [redacted]., a collection agency managed by [redacted] sent a settlement letter to Petitioner indicating they have purchased her account balance of $2,677 from [redacted], LLC., *see* Petitioner's Composite Exhibit 1.

13. Respondent explained that J's Medicaid was approved and eligibility is reflected on the Florida Medicaid Recipients Information system, *see* Respondent's Exhibit 2. She advised Petitioner to contact the provider to explore their billing options. She explained that once eligibility is established, the Department's job is done. The provider is responsible to timely submit all bills to the Agency for Health Care Administration (AHCA) for payments. Respondent has contacted AHCA for advice and it was explained to her that the provider should be notified of the late update, *see* Respondent's Exhibit 5.

14. Petitioner argued as follows: (1) she has been contacting the Department for action for a long time to no avail; (2) that because of the Department's delay in processing Medicaid eligibility for J, his unpaid medical bills from January 2017 were eventually sent to collection. She explained that when she contacted the provider, she was told that the account was already sent to collection and could not be retrieved. She did not recall exactly when the account was referred to collection. When the representative contacted AHCA to inquire as to what to do to remedy this situation, she was told that the time for billing has now elapsed because the bill is over a year.

Petitioner maintains that she should not be liable for any payments for medical services rendered to J in January 2017. She is seeking J's $2,677 account balance that was sent to collection be paid by Respondent.

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. 65-2.042, "Applicant/Recipient Fair Hearings" states in part:

> The Department of Children and Families, hereinafter referred to as Department, is required to provide notice and an opportunity of a hearing to any applicant or recipient when the Department's action, intended action or failure to act would adversely affect the individual's or family's eligibility for an amount or type of financial assistance, medical assistance, social services, Temporary Assistance of Needy Families (TANF), or Supplemental Nutrition Assistance Program (SNAP) benefits, or where action on a claim for such assistance or services is unreasonably delayed.

18. Federal Regulations at CFR §431.220 addresses When a hearing is required and states in pertinent part:

> (a) The State agency must grant an opportunity for a hearing to the following:
> (1) Any individual who requests it because he or she believes the agency has taken an action erroneously, denied his or her claim for eligibility or for covered benefits or services, or issued a determination of an individual's liability, or has not acted upon the claim with reasonable promptness including, if applicable—
> (i) An initial or subsequent decision regarding eligibility;

19. Federal Regulations at CFR §431.221-Definitions states “Action means a termination, suspension, or reduction of Medicaid eligibility or covered services.…”

20. In this instant case, Petitioner requested an appeal because her account was sent to collection for medical services provided to her son for some or all services received from Boundary Peak Emergency Physician, LLC. This issue that does not affect the son’s participation in the Medicaid Program.

21. The findings show, J’s Medicaid for January 2017 was eventually approved. There appears to be no termination, suspension, or reduction of Medicaid coverage. Based on the evidence, testimony, and the controlling authorities, the matter will be dismissed as non-jurisdictional.

22. At the hearing, the petitioner brought up allegations of non-cooperation and obstruction against the Department. The undersigned only has jurisdiction over issues as described in Fla. Admin. Code R. 65-2.056 Basis of Hearings, which in pertinent part states:

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

23. Petitioner has been trying to get Respondent to open her son's Medicaid for January 2017 for months. On October 6, 2017, Respondent sent a notice to Petitioner confirming that the child's Medicaid eligibility for January 2017. The provider was not aware of the approval and referred the bill to collection. Petitioner believes the Department did not act quickly and appropriate enough to determine her son's eligibility for Medicaid for January 2017 and should bear responsibility for the account being sent to collection.

24. The hearing officer has no jurisdiction over customer service issues. You may contact the Northeast Region's Client Relations office at 1- 800-342-9004 to discuss the issues raised regarding customer service if you choose. Additionally, as a Medicaid recipient, Petitioner can file a complaint the Agency for Health Care Administration for nonpayment by email or by phone. To file a complaint by phone, please call the Medicaid Helpline at 1-877-254-1055 or (TDD 1-866-467-4970). Staff are available to assist Monday through Friday, 8am-5pm EST.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeals are decided as follows:

A) Appeal Number 18F-06161 is dismissed as non-jurisdictional.

B) Appeal Number 18F-06162 is dismissed as moot.

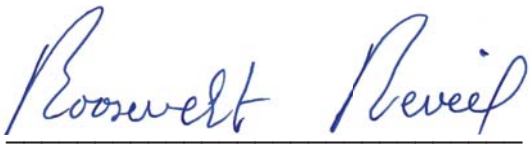
NOTICE OF RIGHT TO APPEAL

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

in Tallahassee, Florida.



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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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 11 DADE
UNIT: 88880

RESPONDENT.
_____/

APPEAL NO. 18F-06545

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 24, 2018, at 10:00 a.m.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: Carolina Maldonado, Operations Management Consultant

STATEMENT OF ISSUE

The petitioner requested an appeal hearing due to the respondent's denial of her application for Medicaid coverage. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted documents as evidence for the hearing consisting of the following, which were marked as Petitioner Composite Exhibit 1: petitioner's letters, physician letters, and medical records. The petitioner also submitted medical bills, which were marked as Petitioner Exhibit 2.

The Department submitted the following documents as evidence for the hearing, which were marked as Respondent exhibits: Exhibit 1 – Work Item Details; Exhibit 2: Department Notice of Case Action; and Exhibit 3 – Medicaid Application.

FINDINGS OF FACT

1. The petitioner is 40 years of age. She is not currently employed and she suffers from morbid obesity. She is not currently pregnant and has no children. She has not been deemed disabled and has not applied for any disability benefits.

2. The petitioner applied for Medicaid benefits or about July 3, 2018. Based on the information contained in the application, the Department issued a Notice of Case Action dated July 9, 2018 denying the Medicaid application. The reason for the denial listed on the Notice was "No household members are eligible for this program." The petitioner filed a timely appeal to dispute the Department's decision.

3. The petitioner explained she is seeking Medicaid coverage because she needs [redacted] surgery. She submitted documents describing her medical conditions as well as her outstanding medical bills.

4. The Department representative explained that the petitioner does not meet any of the eligibility criteria to qualify for Medicaid. The categories of individuals eligible

for Medicaid include the following: aged 65 or over, blind individuals, disabled individuals, pregnant women, and children under age 18.

CONCLUSIONS OF LAW

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

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

7. Florida Administrative Code Rule 65A-1.703 sets forth the coverage groups for Family-Related Medicaid. The coverage groups include children and pregnant women.

8. Florida Administrative Code Rule 65A-1.710 sets forth the SSI-related Medicaid coverage groups. The individuals eligible for this type of Medicaid include the aged (65 or older), blind, or disabled individuals.

9. After considering the testimony and evidence presented, the undersigned concludes the petitioner has not demonstrated the respondent was incorrect in denying her Medicaid explanation. As outlined above, the petitioner does not qualify for Medicaid coverage based on any of the Medicaid coverage groups. Although the petitioner has medical issues and needs health insurance coverage, this is not a qualifying factor to obtain Medicaid coverage based on the applicable eligibility criteria.

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 __05__ day of __November____, 2018, in Tallahassee, Florida.

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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

[redacted]

PETITIONER,

Vs.

APPEAL NO. 18F-06552

CASE NO. [redacted]

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 October 12, 2018, at 11:30 a.m.

APPEARANCES

For the Petitioner: [redacted], pro se

For the Respondent: Carolina Maldonado, Operations Management Consultant

STATEMENT OF ISSUE

The petitioner requested an appeal hearing due to the respondent's denial of his application for Medicaid coverage for himself and his family. The petitioner bears the burden of proof in this matter by a preponderance of the evidence.

PRELIMINARY STATEMENT

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

The Department submitted the following documents as evidence for the hearing, which were marked as Respondent exhibits: Exhibit 1 – Work Item Details; Exhibit 2: June 22, 2018 Medicaid application; Exhibit 3 – June 25, 2018 Department Notice; Exhibit 4 – July 24, 2018 Department Notice; Exhibit 5 – Running Record Comments (CLRC); Exhibit 6 – Medicaid Budget Sheets; Exhibit 7 – Policy Transmittal Memo; and Exhibit 8 – Medicaid Job Aid.

FINDINGS OF FACT

1. The petitioner applied for Family-Related Medicaid benefits on June 22, 2018. He was seeking Medicaid coverage for himself, his wife, and their son, who was 2 years old at that time.

2. The Department issued a Notice of Case Action dated June 25, 2018 requesting that the applicant submit the following additional information: proof of immigration status, proof of income, proof of identification, proof of Florida residency, proof of application for social security number, and copy of the child's birth certificate.

3. The Department issued another Notice of Case Action dated July 24, 2018 denying the Medicaid benefits for all three household members. The reason for the denial was: "We did not receive all the information requested to determine eligibility."

4. The petitioner explained that he and his wife have social security numbers but his son does not. He stated he had been told by the Social Security office that his son could not obtain a social security number because his son was not born in the United

States and because his son was not an employed individual. Regarding the family's immigration status, he stated he has an investor visa which is valid for 5 years and is renewable after that time.

5. The Department representative explained that the petitioner and his wife are not eligible for Medicaid due to their immigration status. However, their son is potentially eligible for Medicaid since he is a child. In order to complete the application process for the son, the family needs to submit the previously requested information such as proof of residency, proof of application for the social security number, and proof of immigration status.

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

7. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code § 65-2.056.

8. Florida Administrative Code Rule 65A-1.705, entitled "Family-Related Medicaid General Eligibility Criteria" states the following concerning residency and citizenship requirements:

> (5) The individual must be a resident of Florida as provided by s. 1902(a) and (b) of the Social Security Act (2007), incorporated by reference. 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.

> (6) The individual must be a citizen of the United States or a qualified alien as defined in 8 USC s. 1641(b) (2000 Ed., Sup. V), incorporated by reference.

9. Florida Administrative Code Rule 65A-1.302, entitled "Social Security Numbers", states the following:

> (1) To be eligible for public assistance, the individual must either provide the social security number (SSN) when known for each person whose needs are included in the assistance group or SFU or, apply for a SSN for each individual who either does not have a number assigned or whose number is unknown. The client's verbal statement is sufficient to verify this information.
> (2) If the SSN is unknown or has never been obtained, the individual must apply for a SSN through the local Department office or Social Security Administration (SSA) office. If the individual chooses to apply for a SSN through the Department Office, the eligibility specialist sends the completed form SS-5, Application for SSN, and original evidence of age, identification and citizenship to the local SSA office. Assistance is not denied, delayed, or discontinued when the individual (or his representative) has applied through the welfare enumeration system for a SSN, pending issuance and/or verification.
> (3) If the individual (or his representative) fails to provide or apply for a SSN on his own behalf or on the behalf of the child(ren) without good cause, the needs of the individual or child, whichever is applicable, must be excluded from the assistance group.

10. As explained in the Department's July 1, 2016 Policy Transmittal Memo (Resp. Ex. 7), non-citizen children who are lawfully residing in the United States are eligible for Medicaid coverage if they meet the technical and financial eligibility requirements. Therefore, the petitioner's son is potentially eligible for Medicaid. However, as explained by the Department's representative, additional documentation needs to be submitted so that the Department can complete its eligibility review for the child's Medicaid coverage.

11. After considering the testimony and evidence presented, the undersigned concludes the petitioner has not demonstrated the respondent was incorrect in denying

the family's Medicaid application at this time. As outlined above, the petitioner may submit to the Department the additional documentation concerning his son so that the Department can re-review the son's eligibility for Medicaid coverage.

DECISION

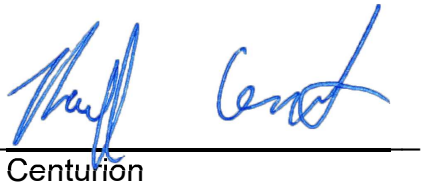
Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

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 __07__ day of ___November____, 2018,

in Tallahassee, Florida.



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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

[redacted]

APPEAL NO. 18F-06648

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 Palm Beach
UNIT: 88262

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 10, 2018 at 1:12 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Janet Turnbull, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for Medicaid at application. The burden of proof was assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The hearing was scheduled for September 12, 2018. Prior to going on record, the petitioner stated he did not receive the department's evidence packet. The petitioner requested a continuance to give time to receive and review the evidence packet. The request was granted, and the hearing was rescheduled for October 10, 2018 at 1:00 p.m.

[redacted] with Language Line Solutions, provided interpreter services for the hearing.

The petitioner submitted a 31-page evidence packet, which was marked and entered as Petitioner's Composite Exhibit "1". The respondent submitted a 22-page evidence packet, which was marked and entered as Respondent's Exhibits "1" through "8". The record was left open through October 17, 2018, for additional information including the Hankerson policy. On October 11, 2018, an additional 9-page evidence packet was received, which was marked and entered as Respondent's Exhibit "9" and "10". The record was closed the same day.

FINDINGS OF FACT

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

2. Prior to the action under appeal, on March 24, 2018, the petitioner (29 years old) was in boating accident. The [redacted], suffered injury to his [redacted], and suffered a [redacted]. (Petitioner's Composite Exhibit 1).

3. On April 13, 2018, the petitioner applied for disability with the Social Security Administration (SSA) (Respondent's Exhibit 7).

4. On June 22, 2018, the petitioner submitted a web application requesting Supplemental Nutrition Assistance Program benefits and SSI-Related Medicaid through a disability determination. Medicaid is the only benefit at issue (Respondent's Exhibit 1).

5. The petitioner is the only household member applying for benefits. He has been living with his uncle since his accident. The petitioner has not worked since his accident.

6. On July 10, 2018, the respondent submitted the petitioner's disability report to DDD citing the [redacted] (Respondent's Exhibit 5).

7. On July 31, 2018, the petitioner's SSA application was denied (Respondent's Exhibit 7).

8. On July 31, 2018, the petitioner's application was denied by DDD, citing Hankerson, using code "N35: Impairment is severe at a time of adjudication but not expected to last twelve months, no visual impairment", primary diagnosis [redacted] – [redacted] and secondary [redacted] (Respondent's Exhibit 4 and 8).

9. On August 1, 2018, the respondent sent the petitioner a Notice of Case Action informing him the request for Medicaid was denied because no household member met the requirements for the program (Respondent's Exhibit 2 and 3).

10. The petitioner timely requested the appeal.

11. The petitioner claims on September 23, 2018, he appealed the SSA decision (Petitioner's Testimony).

12. The petitioner states he needs the medical coverage to complete therapy for his [redacted]. He states he is unable to use the [redacted] therapy.

13. The respondent explained that it denied the petitioner's Medicaid application because SSA has determined that he is not disabled and DDD has adopted the same decision based on its policy. DDD did not complete an independent review of the disability packet. The respondent further explained that once DDD determines 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

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

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

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

17. 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 or older.

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

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

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

20. 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.

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

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

22. The above cited authorities explain the SSA determination made within 12 months of the Medicaid application is binding for the respondent unless the applicant reports a disabling condition not previously reviewed by SSA. In this instant case, SSA has determined the petitioner's condition is severe, however, it is not expected to last more than 12 months.

23. In accordance with the above authorities, the respondent denied the petitioner's Medicaid, as it must adopt the SSA denial decision.

24. The undersigned has explored all other Medicaid groups. The only other Medicaid group was Family-Related Medicaid Program benefits. The petitioner has no minor children residing with him. The Family-Related Medicaid Program benefit rules are set forth in the Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid Program, a dependent child must be living in the home or the applicant must be pregnant. The petitioner does not meet the criteria for Family-Related Medicaid Program benefits.

25. Based on the evidence and cited authorities, the undersigned concludes the respondent's action to deny the petitioner's application for Medicaid Program benefits was within rules of the program. The petitioner has failed to meet his burden that he is eligible for any Medicaid benefits.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19 day of November, 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

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 Lee
UNIT: 883DT

RESPONDENT.
_____/

APPEAL NO. 18F-06683

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on November 16th, 2018, at 1:00 p.m. in [redacted] Florida.

APPEARANCES

For the Petitioner: [redacted] pro se.

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

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to enroll him in the Medically Needy (MN) Program with an estimated share of cost (SOC) instead of providing him with full Medicaid. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any documents for the hearing.

Respondents exhibits 1 through 10 were admitted into evidence.

The petitioner's father, [redacted], appeared as a witness.

By way of Notice of Case Action (NOCA) dated July 3rd, 2018, the respondent informed the petitioner that he was approved for Medically Needy (MN) with an assigned Share of Cost of $659 effective June 2018.

On August 8th, 2018, the petitioner filed a timely appeal to challenge this action.

FINDINGS OF FACT

1. The petitioner submitted an application on June 27th, 2018 for SNAP and Medicaid benefits. As part of the process, the respondent is required to explore, and if deemed necessary, verify all factors of eligibility which include, but are not limited to all sources of income and allowable expenses.

2. The petitioner was 38 years of age at time of application, is disabled and lives by himself.

3. Prior to enrollment in the Medically Needy program, the petitioner had full Medicaid through the Social Security Office. The petitioner received $750 monthly amount from SSI until February 2018 and was covered by full Medicaid through April 2018.

4. The petitioner applied for Social Security disability using his father's social security earned income and began receiving $859 monthly gross amount from Social

Security Disability effective February 2018. This increase in income caused him to lose his Medicaid and SSI benefits.

5. The petitioner applied for Medicaid with the state, but based on the petitioner's income, the petitioner was not eligible for full Medicaid and was enrolled in MN.

6. By way of Notice of Case Action (NOCA) dated July 3rd, 2018, the respondent informed the petitioner that he was enrolled in MN with a share of cost of $659. (Respondent's Exhibit 5)

7. The petitioner states that he had been told by the Social Security Office that his benefits would not change and is seeking full Medicaid.

8. The respondent explained that he was not eligible for Medicaid because his monthly income exceeded the income limit for one person. The respondent then enrolled the petitioner in the Medically Needy program and calculated a Share of Cost (SOC) for the petitioner as follows: $859 (petitioner's gross SSA income) was reduced by a $20 standard income disregard, followed by a $180 Medically Needy Income Level (MNIL) deduction for one person resulting in the final estimated SOC to be $659. No medical expenses were reported. The respondent explained how the SOC was determined and how it could be met.

9. The petitioner did not dispute the income amount used by the respondent in the eligibility process. The petitioner however, stated that he has serious health issues that require constant monitoring. The petitioner also stated that his doctors don't accept SOC as Medicaid, and that his SOC is too high. The petitioner also contends that he cannot afford that much monthly expense on a fixed income. The petitioner argued after

paying for his household expenses, he has no money left and cannot afford any deductibles. He is seeking full Medicaid so that he can get the medical care he needs.

10. The petitioner stated that he has no Medicare insurance and was told by the Social Security Office that he had to wait two years before he was eligible for it. The respondent confirmed this.

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

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

13. The Code of 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.

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

15. 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** *[emphasis added]* or if

> receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services…

16. The above authority explains that the MEDS-AD (full Medicaid for an aged or disabled person) has an income limit of 88% of the federal poverty level ($891 for an individual) for individuals not receiving Medicare.

17. The Code of Federal regulations at 20 C.F.R. § 416.1124, Unearned income we do not count, states, in relative part: "(c) (12). The first $20 of any unearned income in a month…"

18. The above-cited rules explain the budgeting procedure to determine eligibility. The petitioner's SS income of $859 is reduced by a standard deduction ($20) to arrive at $839 as countable income.

19. The Eligibility Standards for SSI-Related Programs appear in the Department's Program Policy Manual CFOP 165-22 (the Policy Manual), at Appendix A-9. Effective July 1st, 2018, the limit for an individual is $891. (Respondent's Exhibit 9). The Department determined Petitioner's countable income after all deductions to be $839 during the application at issue. Petitioner's countable income is under the $891 income limit and since he does not have Medicare he is eligible to receive full Medicaid.

20. Based on the evidence, testimony, and the controlling authorities, the undersigned concludes that the department's action to deny the petitioner full Medicaid and his enrollment in the Medically Needy Program with a SOC of $659 is incorrect.

DECISION

Based on the foregoing Findings of Fact and Conclusion of Law, this appeal is granted. The respondent will, within ten days from the date of this order, make the

necessary correction and provide Medicaid eligibility to the petitioner effective July 2018.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 04 day of December, 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
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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

[redacted]

APPEAL NO. 18F-06778

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 55512

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 18, 2018 at 8:30 a.m.

APPEARANCES

For the petitioner: [redacted], the petitioner's aunt represented the petitioner

For the respondent: Sylma Dekony, ACCESS Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner's representative is appealing the respondent's action to deny the petitioner's application for Adult-Related (SSI) Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Serving as translator telephonically from Language Line Solutions was Amanda, employee number [redacted]

The petitioner did not submit any exhibits. The respondent submitted one exhibit, which was accepted into evidence and entered as Respondent's Exhibit "1". The record was held open until close of business on October 25, 2018 for submission of additional evidence from the respondent. On October 25, 2018, the respondent submitted additional information, which was accepted into evidence and entered as Respondent's Exhibit "2". The record closed on October 25, 2018.

FINDINGS OF FACT

1. The petitioner's aunt filed an application for disability Medicaid on August 3, 2018 for the petitioner (age 23). On the application, the petitioner's aunt reported that the petitioner was disabled. The petitioner is not age 65 or older and does not have any minor children.

2. As part of the application process, the Department reviewed the State of Florida On-Line Query. The State On-Line Recipient Query (SOLQ) indicated the petitioner received Social Security Administration (SSA) benefits through her father's SSA benefits. On June 2014 and on the petitioner's 19th birthday, SSA benefits were terminated. The SOLQ shows the petitioner applied for Supplemental Security Income (SSI) with SSA on August 3, 2018.

3. The Division of Disability Determination (DDD) is responsible for making state disability determinations on behalf of the respondent when an applicant applies for

Medicaid on the basis of disability. The petitioner's application was referred to DDD on August 10, 2018.

4. DDD did not conduct an independent review; instead, it denied the petitioner's disability claim by adopting a previous SSA denial decision. DDD has access to SSA information. The petitioner was denied disability benefits through SSA with a denial code N-32. Code N-32 means "Capacity for substantial gainful activity other work, no visual impairment".

5. The Disability Determination and Transmittal returned from DDD lists the petitioner's primary diagnosis as [redacted] and her secondary diagnosis as Learning disorder. DDD marked the Disability Determination and Transmittal as "Hankerson GI8/18 same allegations" and sent it to the Department on August 16, 2018 (Respondent Exhibit 1, page 21).

6. On August 21, 2018, the respondent mailed the petitioner a Notice of Case Action denying her Medicaid application; due to not meeting the disability requirement (Respondent Exhibit 1, page 7).

7. The petitioner's aunt explained the petitioner needs Medicaid benefits to get her medication, she cannot afford to purchase the medication. She is worried about the petitioner's mental health.

8. The undersigned questioned the respondent regarding DDD's determination that SSA denied the petitioner for disability benefits with a denial code N-32. The record was held open for the respondent to submit documents regarding the petitioner's SSA's denial decision.

9. The respondent submitted a copy of a Fax Request to DDD for SSA Disability Status completed by DDD. The form indicates, on January 18, 2018, the petitioner applied for childhood disability benefits re-entitlement (CDBR) with SSA through her father's social security number and benefits. SSA denied the petitioner's CDBR claim on May 11, 2018. On August 9, 2018, the petitioner requested a reconsideration and on August 14, 2018 a hearing was requested (Respondent Exhibit 2). The petitioner submitted an SSI application under her social security number on August 3, 2018. That application remains pending.

CONCLUSIONS OF LAW

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

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

12. Fla. Admin. Code R. 65A-1.711, sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905, "Basic definition of disability for adults". The regulation states, in part:

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

> that makes you unable to do your past relevant work or any other substantial gainful work that exists in the national economy…

13. The Code of Federal Regulations at 20 C.F.R. § 404.351 addresses "Who may be reentitled to child's benefits?" and states in part:

> If your entitlement to child's benefits has ended, you may be reentitled on the same earnings record if you have not married and if you apply for reentitlement. Your reentitlement may begin with—
> (a) The first month in which you qualify as a full-time student. (See §404.367.)
> **(b) The first month in which you are disabled, if your disability began before you became 22 years old.** (emphasis added)
> **(c) The first month you are under a disability that began before the end of the 84th month following the month in which your benefits had ended because an earlier disability had ended**;(emphasis added)
> or
> (d) With respect to benefits payable for months beginning October 2004, you can be reentitled to childhood disability benefits at anytime if your prior entitlement terminated because you ceased to be under a disability due to the performance of substantial gainful activity and you meet the other requirements for reentitlement. The 84-month time limit in paragraph (c) in this section continues to apply if your previous entitlement to childhood disability benefits terminated because of medical improvement.

14. On January 18, 2018, the petitioner applied, before her 22nd birthday, for CDBR benefits for SSA to determine entitlement through her father's benefits. According to the federal regulation above, a person must have a disability that began before age 22 or have a disability that began before the end of the 84-month period following the month in which the child's most recent entitlement to benefits as a CDBR were terminated because the disability ceased. In this case, the petitioner received child disability insurance benefits through her father's social security number and benefits, SSA terminated these benefits on June 2014. The petitioner applied for CDBR on January 18, 2018 to reestablish disability and determine if she would qualify for disability benefits through her parents' earnings/SSA benefits.

15. The Code of Federal Regulations at 42 C.F.R. § 435.541 addresses determinations of disability and states in part:

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability…
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.
> (b) Effect of SSA determinations.
> (1) Except in the circumstances specified in paragraph (c)(3) of this section—
> **(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.** [emphasis added]
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.
> **(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.** [emphasis added]
> (c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of following circumstances exist:
> …
> (2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid…
> (4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—
> (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
> (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
> (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated

> since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
> (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; 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 federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid disability application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. SSA denied the petitioner's CDBR disability claim through her father's social security number on May 11, 2018 because it determined she was not disabled under its rules. The petitioner appealed the SSA's denial decision on August 9, 2018.

17. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in adopting the SSA disability denial from May 11, 2018. The respondent's action to deny the petitioner's August 3, 2018 Adult-Related (SSI) Medicaid application was correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 06 day of December, 2018,

in Tallahassee, Florida.

Cassandra Perez
Hearing Officer
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