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

[redacted]
SARASOTA, FL 34239

APPEAL NO. 18F-06787

PETITIONER,
Vs.

CASE [redacted]

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 27, 2018 at 9:29 a.m. The hearing was reconvened on October 8, 2018 at 10:59 a.m. and October 31, 2018 at 10:36 a.m.

APPEARANCES

For the Petitioner: [redacted]

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

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of not dispositioning Medicaid eligibility for December 2017 and not tracking the medical bills for January 2018.

Petitioner carries the burden of proof to show eligibility by the preponderance of evidence.

PRELIMINARY STATEMENT

The hearing convened on September 27, 2018. Petitioner was present. Neither Petitioner nor his representative received the department's evidence packet. It was mailed to Petitioner's representative on September 21, 2018. The department agreed to provide the evidence to Petitioner's representative by email and to Petitioner by regular mail. Petitioner preferred to have the evidence before going forward with the hearing. It was agreed to reconvene on October 8, 2018. In addition, the department agreed to supplement the record to address why the department did not issue a notice to disposition the request for Medicaid for December 2017; why the department did not issue a notice for bill tracking for December 2017 and January 2018 and if the department correctly enrolled Petitioner in the Medically Needy Program for January 2018 as it appeared Petitioner was over the asset limit. In the absence of a notice, the undersigned determined the appeal was timely filed and accepted jurisdiction.

The hearing reconvened on October 8, 2018. Petitioner was present. [redacted] was present. A notice was issued addressing December 2017 on October 3, 2018 (as it had not been previously issued). A second notice was issued on October 3, 2018 denying Medically Needy coverage for January 2018 due to the value of assets being too high for the program and "Your case was opened in error and has now been closed" (to correct a prior notice). Petitioner submitted a letter to the department on October 8, 2018 in an attempt to show that the counted assets were unavailable. In order for the department

to re-evaluate eligibility for January 2018, additional time was allowed. It was agreed to reconvene on October 31, 2018.

The department submitted evidence pre-hearing, entered as Respondent Exhibits 1 – 5. Petitioner submitted evidence, entered as Petitioner Composite Exhibit 1.

The hearing reconvened on October 31, 2018. Petitioner and his wife, [redacted], were present. The department approved Medicaid for the requested dates of service for January 2018. The only remaining issue is Medicaid eligibility for December 2017. The record was held open through November 7, 2018 for the department to submit notices sent to Petitioner in March 2017 related to the SSI Medicaid denial process. Supplemental evidence was provided and entered as Respondent Composite Exhibit 6. The record closed on November 7, 2018.

FINDINGS OF FACT

1. Petitioner's representative applied for Medicaid with the department on April 5, 2018. There is a potential for retroactive Medicaid coverage for only the three months immediately prior to an application. The April application could include retroactive Medicaid beginning January 2018.

2. On June 5, 2017, Petitioner was approved as a disabled adult for Retirement, Survivors and Disability Insurance (RSDI). It was determined that his onset date for disability was July 18, 2016. (Petitioner's Composite Exhibit 1 at 1)

3. Prior to that, on March 14, 2017, Petitioner was notified by the Social Security Administration that his application for Supplemental Security Income (SSI) filed on February 27, 2017, was denied because the income exceeded the SSI limit. This notice

informed Petitioner to contact “the State of Florida local Office of Health and Rehabilitation Services” to find out about Medicaid eligibility. (Petitioner’s Composite Exhibit 1 at 2-3)

4. Petitioner was an inpatient in the hospital in December 2017 and January 2018. While he was in the hospital, he was advised to contact Respondent and apply for Medicaid.

5. Both Petitioner and his wife testified about making several calls to Respondent that were left unreturned. They both testified about contact with a rude employee in Respondent’s [redacted] office sometime in January 2018 while they were attempting to get an appointment to file for Medicaid. They believe they were told to get out of the office and were prevented from making an appointment. They did not get the employee’s name and did not file a complaint. The department has no record of this contact. The department found a second case Petitioner had been linked to and that record was also void of this contact. Document Imaging was searched by social security number (which reflects all department cases an individual was included in) and no record of this contact was found. The first Medicaid application the department has record of is April 5, 2018.

6. Petitioner believed the Respondent’s recordings at the number he repeatedly called informed to make an appointment to file an application. He also believed he was told he had to wait 24 months after being determined disabled to get Medicaid, which will not be until January 2019, and is why he did not do anything further related to Medicaid coverage.

7. Based on the disputed, relevant fact of when a Medicaid application was filed (or attempted to file), the undersigned must make a finding. Petitioner provided testimony of a contact in a local office in January 2018 where he left without filing an application for Medicaid. Petitioner was given an opportunity to bring any support of this contact with him to the next reconvened hearing. Petitioner brought his wife to testify at the reconvened hearing. Her testimony described an extremely rude employee making very inappropriate statements to Petitioner and his wife including telling them to get out of the office which prevented the filing of an application. While the undersigned could conceive a negative experience with an employee, the undersigned cannot conceive an experience such as the one described without a reasonable person obtaining the employee's name and then filing some type of complaint on this employee; not only for the extremely rude treatment that Petitioner alleges, but also for preventing the filing of an application. The undersigned recognizes Petitioner was recently discharged from the hospital. However, neither he nor his wife took any subsequent action to make application until April 2018. Petitioner also misunderstood prior instruction of waiting 24 months to file for Medicaid; this is not Medicaid policy but is related to Medicare policy. In addition, the department searched its records and found no record of Petitioner's January 2018 visit to an office. The undersigned recognizes the confusion that sometimes occurs with filing for both Medicaid and Medicare. However, this Hearing Officer cannot find that Petitioner attempted and was prevented from filing a Medicaid application in January 2018, which would have provided for the possibility of Medicaid coverage for December 2017.

8. Petitioner's representative was not involved in the case until Petitioner presented to her office in April 2018, at which time she filed the Medicaid application on his behalf.

9. A Medicaid Notice of Case Action was issued on October 3, 2018. The department denied December 2017 on this notice stating, "We did not receive all information needed to determine eligibility." The department explained this was referring to the fact that there was no application filed for which to provide retroactive Medicaid coverage December 2017. (Respondent Composite Exhibit 2 at 5)

10. Petitioner's argument is that an application for SSI is an application for Medicaid. To develop this argument, during the hearing, department transmittal I-05-05-0013 was reviewed. During the hearing, the department representative was able to locate two notices that were issued by the department as a result of Petitioner's SSI denial in 2017. They are dated March 13, 2017 and March 24, 2017. Petitioner confirmed the address on the notices was his correct address at that time, although he does not recall receiving them. The transmittal reviewed includes sample letters informing the individual with the SSI denial that the application for SSI cash payment is also an application for Medicaid and the individual must contact the local Department of Children and Families within 30 days from the date of the notice to follow up on the Medicaid application. (Respondent Exhibit 5 and 6)

11. While the record was held open, the department provided a Notice of Case Action dated October 31, 2018 approving Petitioner's Medicaid coverage from January 1, 2018 through January 31, 2018 under the Medically Needy Program.

12. The supplemental evidence provided while the record was held open also included the department's SSI Notice History Detail screens (CNSS) for a "Notice 1" mailed on

March 13, 2017 showing Petitioner's SSI denial date as March 7, 2017 and a second CNSS screen showing "Notice 2," most likely a denial, was mailed on March 27, 2017.

13. The second relevant disputed fact is receipt of the two notices issued in March 2017 informing Petitioner to come into the office to follow up on Medicaid eligibility. Petitioner does not recall receiving the two notices from the department during March 2017. The department's evidence captured the mailing dates and mailing address. Petitioner admits he misunderstood prior instruction of waiting 24 months to file for Medicare, thinking that was a Medicaid rule. Petitioner admits this caused him to not file an application. Therefore, the undersigned finds that Petitioner did receive the notices from the department in March 2017. He was also informed he needed to contact the State of Florida about Medicaid eligibility in March 2017 when he received the SSI denial letter and did not file an application until a representative filed for him in April 2018.

CONCLUSIONS OF LAW

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

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

16. Petitioner was assigned the burden of proof in accordance with Rule 65-2.060 *Florida Administrative Code.*

17. Rule 65A-1.702, "Special Provisions" states in relevant part:

> (9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.
> (a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services. A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. The individual or his or her representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility. However, Qualified Medicare Beneficiaries (QMB's) are not eligible for retroactive Medicaid benefits under the QMB coverage group as indicated in 42 U.S.C. §1396a(e)(8).

18. The Findings show the only Medicaid application filed with the department was on April 5, 2018. According to the above controlling authority, the only months that could have been considered by the department for retroactive Medicaid coverage were January, February and March 2018. The April 2018 application was not sufficient to have the month of December 2017 addressed as a retroactive month. Therefore, the undersigned concludes that the department's denial action of October 3, 2018 for coverage for December 2017 was correct.

19. Next, December 2017 coverage will be evaluated under the department's process for individuals who are denied SSI cash by the Social Security Administration. This procedure is addressed in the Rule 65A-1.702 *Florida Administrative Code* which states in relevant part:

> (3) Processing Medicaid Applications for SSI Denials.
> (a) On a monthly basis, the department will use the Social Security Administration's (SSA) SDX data to identify individuals who have been denied SSI benefits by the SSA since August 22, 1996. Their date of application for Medicaid eligibility purposes is the date of application for SSI benefits with the SSA.
> (b) The department will identify those individuals for whom the department does not have an open Medicaid assistance case or a pending Medicaid

application at the time the SDX data is processed. These individuals or their SSA payee will be notified by written notice to contact the department's local office to schedule an interview appointment. The notice will be in letter format. It will provide that they must contact the department within 30 days of the written notice. If they fail to do so without good cause, the department will issue them another written notice to provide notice of Medicaid denial for failure to follow through in determining eligibility. This notice will be in letter format.
(c) Good cause includes severe illness of the individual or a family member, an accident involving the individual or a family member, hospitalization of the individual or a family member, death of a family member, natural disaster, being away from home or unexpected closure of the department's offices.
(d) Those individuals whom the department identifies as having an open Medicaid assistance case or a pending Medicaid application at the time the SDX information is processed will not be required to contact the department, unless additional information is needed to complete the application process for Medicaid eligibility. They are not subject to the 30 day time frame for contacting the department.

20. The process is explained in more detail in the department's Policy Transmittal No.: I-05-05-0013 dated May 2, 2005 and titled, "SSI Denials/Padron Letters." The transmittal states in part:

The purpose of this memorandum is to ensure that our staff provide individuals who are denied Supplemental Security Income (SSI) with correct information when they call or visit any of our Economic Self-Sufficiency (ESS) offices.
BACKGROUND:
An application filed for SSI with the Social Security Administration (SSA) is also an application for SSI-related Medicaid. If SSA determines the individual is not eligible for SSI, they notify the person only about ineligibility for a cash payment. Because the client may financially qualify for one of the state's other Medicaid programs, SSA refers the case to the Department of Children and Families (DCF), and it is our responsibility to issue the Medicaid decision notice. These individuals are known as SSI-denials, or as Padron cases after the class action suit that established special procedures for these cases…
The following are ways for staff to identify SSI-denials/Padron individuals:
• The client may have a notice with the heading of "URGENT INFORMATION ABOUT MEDICAID" (see attached). The date above the

> individual's name and address is the date the notice is sent. This is the date from which the 30 days' time frame starts. This is the first notice the FLORIDA System sends to invite the individual to contact us.
> • The client may have a notice that has no heading, but the initial paragraph begins with 'Your application for Medicaid has been denied since you did not contact the Department of Children and Family Services…' (see attached). This is the second notice generated by FLORIDA. This notice will also go out if the client responded to the first notice and was given a verbal denial. This is the reason it is important that staff take action on FLORIDA for all clients who contact DCF concerning receipt of the initial notice.
> • If the client claims to have been denied SSI, but does not have a letter, enter "CNSS" in the PARMS field on FLORIDA and the client's social security number (SSN) in the TRAN field to determine if an SSI denial notice was sent to the client. The screen that comes up will indicate when the client was denied SSI and when DCF sent a notice asking the client to contact the local service center within 30 days. If a denial notice was sent, there will be a second CNSS screen containing the date sent. One of the other forms of identification must be used if the client is not found using CNSS.
> • If the client has a letter from SSA denying the SSI cash payment and there is no record of Medicaid action taken on FLORIDA (including through CNSS) since the date on the SSA letter, ESS staff must assume the client has not been properly notified of the Medicaid decision and determine if the individual is eligible for Medicaid using the FLORIDA system.

21. Petitioner argued that an application for SSI is an application for Medicaid. The undersigned agrees with that argument, thus the above-cited procedure to notify individuals when the SSI cash has been denied to contact the department about a pending Medicaid application (same date as the SSI date of application). However, Petitioner did not file an application for Medicaid until April 2018. The undersigned notes that a March 2017 denial letter from the department, as a result of the SSI denial procedure cited above, is not under her jurisdiction to review for its correctness, as it was not timely appealed. Rule 62-2.046, *Florida Administrative Code* informs of the 90-day time limit to appeal a department action.

22. Petitioner failed to meet his burden of proof by a preponderance of the evidence, that eligibility for Medicaid for December 2017 should have been approved. The department's denial action of October 3, 2018 for December 2017 Medicaid coverage was correct.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

Susan Dixon
Hearing Officer
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Office of Economic Self Sufficiency
[redacted]

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

[redacted]

APPEAL NO. 18F-06835

PETITIONER,

Vs.

CASE NO. [redacted]

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

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative telephonic hearing in the above-referenced matter on November 19, 2018 at 3:11 p.m.

APPEARANCES

For the Petitioner: [redacted] father

For the Respondent: Grace Dillion-Griffith, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the denial of full Medicaid benefits and enrollment in the Medically Needy Program with an estimated share of cost (SOC). The burden of proof is assigned to the petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner provided one exhibit which was accepted into evidence and marked as Petitioner's Exhibit 1.

The respondent presented nine exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 9.

The petitioner was also present at the hearing.

FINDINGS OF FACT

1. On August 3, 2018, the petitioner applied for SSI-Related Medicaid benefits. She is the only household member. The petitioner receives Social Security Disability Income (SSDI) of $1,010 beginning March 24, 2017. She is not a recipient of Medicare benefits. The respondent determined the petitioner was ineligible for full Medicaid benefits as her gross income was over the income limit. The respondent denied full Medicaid benefits and proceeded to determine eligibility in the Medically Needy Program. A $20 unearned income disregard was subtracted from her gross income of $1,010 resulting in the petitioner's countable income of $990. The medically needy income level (MNIL) of $180 was subtracted resulting in a SOC of $810 (Respondent's Exhibits 2, 5 and 7).

2. On August 22, 2016, the respondent mailed a Notice of Case Action to the petitioner informing her that her application dated August 3, 2018 was approved. The notice informed her that she was enrolled in the Medically Needy Program with an estimated SOC of $810 effective August 2018 and ongoing (Respondent's Exhibit 4).

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

4. The petitioner's representative argued that the petitioner's income is not enough to pay her basic living expenses. He asserted that she has monthly expenses for food of $250, clothing of $50, pharmacy/personal items of $20, miscellaneous expenses of $50, gas for her car of $100, auto insurance of $192, electricity of $40, maintenance of $265, condominium insurance of $48, property taxes of $118, cell phone of $50 and recurring medical expenses of $25 (Petitioner's Exhibit 1).

5. The respondent acknowledged the petitioner's expenses but explained that only verified medical expenses can be allowed in the determination of Medicaid benefits.

CONCLUSIONS OF LAW

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

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

8. The Department determined the petitioner's Medicaid benefits under the SSI Related Program.

9. The Department's Program Policy Manual (Policy Manual), CFOP 165-22 at Appendix A-9, shows the income standard for full Medicaid benefits for an individual who is aged or disabled as $891 effective April 2018.

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

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

11. The above authority explains that full Medicaid for an aged or disabled person has an income limit of 88% of the federal poverty level and in addition to meeting that limit, the person must not have Medicare. The petitioner is not receiving Medicare benefits but her income of $1,010 is over the maximum income limit of $891 for an individual who is disabled.

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

13. Fla. Admin. Code R. 65A-1.702 (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.”

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

15. The methods of determining the share of cost for Medically Needy Program benefits is set forth in the Fla. Admin. Code R. 65A-1.713. It states:

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

> (4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical cost. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. **To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions.**
> **Examples of recognized medical expenses include:**
> **1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,**
> **2. Allowable medical services such as the cost of public transportation to obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and personal care services in the home prescribed by a recognized member of the medical community.** [emphasis added]

16. The above authority allows a deduction for allowable medical expenses. The petitioner claims she has $25 in allowable medical expenses, but she has not provided the respondent with those medical bills; therefore, no deduction is allowed.

17. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, states, "Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows: Size 1 Level $180."

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

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

19. The undersigned reviewed the respondent's budget calculations and the petitioner's reported income using the rules cited above and did not find a more favorable outcome other than the SOC assigned by the respondent. Eligibility for full Medicaid is not found.

20. The undersigned concludes the respondent's action to deny full Medicaid benefits and to enroll the petitioner in the Medically Needy Program with the estimated SOC of $810 is within the rules of the Program.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

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

DONE and ORDERED this 17 day of December, 2018,

in Tallahassee, Florida.

Christiana Gopaul Narine

Christiana Gopaul-Narine
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: 07 VOLUSIA
UNIT: 88779

RESPONDENT.
_____/

APPEAL NO. 18F-06925

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on October 17, 2018, at 11:33 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

For the Respondent: Sheila Hunt, DCF Economic Self-sufficiency Specialist II

STATEMENT OF ISSUE

At issue is Respondent's action to deny Petitioner's request for Institutional Care Program (ICP) Medicaid benefits from October 2017 through January 2018. The burden of proof was assigned to Petitioner by a preponderance of evidence.

PRELIMINARY STATEMENT

During the hearing, Petitioner submitted no exhibits at the hearing. Respondent submitted seven (7) exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 7.

The record was left open through October 18, 2018 to allow both parties to submit additional evidence. Respondent's evidence was timely received and marked as Respondent's Exhibits 8 through 12. Petitioner's exhibits were timely received and marked as Petitioner's Exhibits 1 through 7. The record was closed on October18, 2018.

FINDINGS OF FACT

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

1. On June 14, 2013, Petitioner purchased a property in his son's name. Petitioner resided in the home for over three years before moving to another apartment and was eventually admitted to [redacted] in August 2017, *see* Respondent's Exhibit 6.

2. On November 10, 2017, the DR applied for Institutionalized Care Program (ICP) Medicaid benefits on Petitioner's behalf to cover fees for his stay at the facility.

3. As part of the application process, Respondent is required to establish, explore, and verify all factors of eligibility. The applicant or his representative's cooperation in securing such verification(s) is requested if deemed necessary.

4. On December 21, 2017, the application was denied due to failure to disclose assets. The DR was notified via Notice of Case Action (NOCA). The notice explained

that she must request a hearing within 90 days from the mailing date to challenge Respondent's action. She did not request an appeal.

5. On January 31, 2018, the DR reapplied for ICP Medicaid benefits on Petitioner's behalf.

6. In determining eligibility for ICP Medicaid benefits, Respondent must review if disposal or conversion of resources for less than fair market value (FMV) occurred, on or after the look back period. If Respondent determines an improper transfer of assets occurred, a transfer penalty is imposed. The penalty period is applied effective the first month Petitioner would have been eligible for benefits.

7. Case running record comments (CLRC) notes entered on February 2, 2018 indicate during processing, Respondent discovered a total of $43,659.15 was spent from Petitioner's Wells Fargo Checking account ending in [redacted] in April 2013 and June 2013. On February 13, 2018, a pending notice was sent to the DR requesting proof of how funds were spent.

8. On February 14, 2018 and February 24, 2018, the DR submitted separate statements from Petitioner's lawyer and son explaining that the property was purchased and put in son's name because Petitioner was having memory problems and could not manage his own affairs.

9. Respondent reviewed the documents and determined the explanations given for the transfer did not meet the undue hardship required to avoid applying an eligibility penalty. Respondent concluded that money was improperly transferred and denied the application due to "improper transfer of assets."

10. On March 28,2018, Respondent sent a NOCA to the DR informing her that Petitioner gave away, reduced the value of, or sold the following asset(s) or income for less than fair market value. The notice also indicated Petitioner's uncompensated value of the transferred asset was $43,659.15.

11. Additionally, on March 28, 2018, Respondent sent a notice to the DR informing her that the January 2018 application was denied. The notice explained that she must request a hearing within 90 days from the mailing date to challenge Respondent's action, *see* Respondent's Exhibits 8 through 12. The DR did not request an appeal.

12. On May 31, 2018, the DR reapplied for ICP Medicaid benefits on Petitioner's behalf.

13. Respondent determined Petitioner's purchase of a condo in his son's name was an improper transfer of assets; therefore, a penalty period of ineligibility for Petitioner's ICP Medicaid benefits had to be imposed.

14. The formula utilized to calculate the penalty period is the total amount of transferred assets divided by the average monthly private pay nursing home rate. The quotient of the formula is the number of months in the penalty period.

15. Respondent initially calculated the amount of Petitioner's improper transfer of asset as $43,659.15; and calculated Petitioner's penalty period as 4 months and 26 days or $43,659.15 divided by $8,944 = 4.88 months running from September 2017 through January 26, 2018. Respondent approved Petitioner for ICP Medicaid benefits effective February 2018. Respondent explained that Petitioner would have been eligible for ICP Medicaid effective January 27, 2018, but this month was outside of the three months of retroactive period covered by the May 31, 2018 application.

16. On July 3,2018, Respondent mailed the DR a NOCA indicating the May 31, 2018 application for ICP Medicaid was denied due to, “We did not receive all the information requested to determine eligibility. After further consideration, the case was processed and approved.

17. On July 5,2018, Respondent mailed the DR a NOCA indicating the May 31, 2018 application for ICP Medicaid was approved effective February 2018 through April 2019. The notice also states that August 2017 and January 218 were denied due to excess assets, see Petitioner’s Exhibit 2.

18. On July 5, 2018 Respondent sent the DR a separate notice indicating Petitioner “gave away, reduced the value of, or sold the following asset(s) or income for less than fair market value.” The notice also indicated Petitioner’s uncompensated value of the transferred asset was $43,659.15, *see* Petitioner’s Exhibit 7.

19. Respondent explained that Petitioner’s first two ICP applications (November 10, 2017 & January 31, 2018) were denied for different reasons and that notices were sent to the DR. She explained, that the May 31, 2018 application was approved and included three retroactive months, going back to February 2018. She explained that Petitioner was penalized from September 2017 through January 26, 2018 due to the improper transfer of assets. She further explained that Petitioner was not approved from January 27, 2018 due to the month being outside of the retro months covered by the May 31, 2018 application.

20. The DR did not dispute the amount of the uncompensated assets. She argued that transfer was made for reasons other than for Petitioner to become eligible for ICP Medicaid. She explained that the main goal the condo was purchased was to keep

Petitioner in the community as long as possible. She explained that the purchase was made in the son's name only because Petitioner has shown signs of mental decline and was unable to manage his own affairs.

21. She is seeking requesting a reconsideration of the denial of the ICP Medicaid applications as she believed Respondent incorrectly denied Petitioner's ICP application because the Respondent's assumption that the purchase was made with the sole purpose for Petitioner to become eligible for ICP Medicaid benefits. She believes the penalty should be waived and Petitioner should be found eligible for ICP from October 2017 through January 2018 based on the applications she submitted.

CONCLUSIONS OF LAW

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

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

24. The DR is requesting ICP benefits from October 2017 through January 2018. She applied in November 2017 and was notified of the denial via a NOCA issued to her on December 21, 2017. She reapplied in January 2018 and was notified of the denial on March 28, 2018. The notices informed the DR that she had a right to ask for a hearing and that she must request one within 90 days from the mailing date at the top of that notice.

25. The Fla. Admin. Code R. 65-2.046 sets forth the time limits in which to request a hearing as follows:

> (1) **The appellant or authorized representative must exercise the right to appeal within 90 calendar days in all programs.** Additionally, in the Food Stamp Program, a household may request a fair hearing at any time within a certification period to dispute its current level of benefits. The time period begins with the date following: (emphasis added)
> (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.

26. The above authority indicates that any Petitioner who chooses to challenge Respondent's actions must do so within the allotted time. In this case, the notices were sent on December 21, 2017 and March 28, 2018 respectively. The DR did not request this appeal until August 24, 2018. Petitioner acknowledged receiving the notices, but explained she was not aware she could request a hearing.

27. As the DR did not exercise her right to a hearing within the allotted time, the actions taken by the Department with regards to the first two applications at issue and the denial thereof will not be reviewed, as the undersigned lacks jurisdiction to review these matters. Therefore, this portion of the appeal is dismissed as non-jurisdictional.

28. Fla. Admin. Code R 65A-1.712(3), SSI-Related Medicaid Resource Eligibility Criteria, defines the types of transfer of resources and states, in part:

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

> ineligibility for ICP, Institutional Hospice or HCBS Waiver Programs. The Department will mail a Notice of Determination of Assets (or Income) Transfer, CF-ES 2264, 02/2007, incorporated by reference, to individuals who report a transfer for less than fair market value, incorporated herein by reference), advising of the opportunity to rebut the presumption and of the opportunity to request and support a claim of undue hardship per subparagraph (c) 5. below. If the Department determines the individual is eligible for Medicaid on all other factors of eligibility except the transfer, the individual will be approved for general Medicaid (not ICP, Institutional Hospice or HCBS Waiver Programs) and advised of their penalty period using the Medicaid Transfer Disposition Notice, CF-ES 2358, 07/2013, http://www.flrules.org/Gateway/reference.asp?No=Ref-03212, incorporated herein by reference. Transfers of resources or income made prior to January 1, 2010 are subject to 36 month look back period, except in the case of a trust treated as a transfer in which case the look back period is 60 months. **Transfers of resources or income made on or after January 1. 2010 are subject to a 60 month look back period.** (a) The Department follows the policy for transfer of resources in accordance with 42 U.S.C. §§ 1396p and 1396r-5. **Transfer policies apply to the transfer of income and resources**….(emphasis added)

29. 42 U.S.C. § 1396p(c) (1)(A) addresses certain transfers of assets and states:

> In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this title, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i)…

30. Pursuant to the above authority, Respondent must determine if a transfer of assets is valid or invalid. In this instant case, Petitioner did not provide enough verification for Respondent to justify his spend down. Respondent considered the purchase of a condo in the son's name as an act of improper transfer of assets and applied a penalty period effective September 2017.

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

> (3)(c) No penalty or period of ineligibility shall be imposed against an individual for transfers described in 42 U.S.C. § 1396p(c)(2).
> 1. In order for the transfer or trust to be considered to be for the sole benefit of the spouse, the individual's blind or disabled child, or a disabled individual under age 65, the instrument or document must provide that: (a) no individual or entity except the spouse, the individual's disabled child, or disabled individual under age 65 can benefit from the resources transferred in any way, either at the time of the transfer or at any time in the future; and (b) the individual must be able to receive fair compensation or return of the benefit of the trust or transfer during their lifetime.
> 2. If the instrument or document does not allow for fair compensation or return within the lifetime of the individual (using life expectancy tables noted in paragraph (b) above), it is not considered to be established for the sole benefit of the indicated individual and any potential exemption from penalty or consideration for eligibility purposes is void.
> 3. A transfer penalty shall not be imposed if the transfer is a result of a court entering an order against an institutional spouse for the support of the community spouse.
> 4. A transfer penalty shall not be imposed if the individual provides proof that they disposed of the resource or income solely for some purpose unrelated to establishing eligibility.
> 5. A transfer penalty shall not be imposed if the Department determines that the denial of eligibility due to transferred resources or income would work an undue hardship on the individual. Undue hardship exists when imposing a period of ineligibility would deprive an individual of medical care such that their life or health would be endangered. Undue hardship also exists when imposing a period of ineligibility would deprive the individual of food, clothing, shelter or other necessities of life. All efforts to access the resources or income must be exhausted before this exception applies. The facility in which the institutionalized individual is residing may request an undue hardship waiver on behalf of the individual with the consent of the individual or their designated representative.

32. Pursuant to the above authority, a penalty period shall not be imposed if Petitioner meets one of the above-mentioned criteria. The findings show the Petitioner did not meet any of the five criteria.

33. The Department's Program Policy Manual, CFOP 165-22 (Policy Manual), passage 1640.0609.01 Identifying Potential Transfers of Assets or Income (MSSI) states:

> Applicants may declare transfers on the application and unreported transfers may be discovered during application processing or the annual review. At application for ICP, ICP-Hospice, HCBS or PACE, ask all applicants if they (or their spouses if applicable) have transferred any assets within the look-back period preceding the month of application. At review, explore transfers that may have occurred over the course of the year, such as a homestead that was excluded at application.
> The following list indicates the most common clues to potential transfers of assets:
> 1. unidentified withdrawals from bank accounts;
> 2. tax assessor online pages showing change in ownership of property;
> 3. quit claim deed to property with recent signature date;
> 4. unidentified deposits on financial statements;
> 5. data exchange responses for sources not on record;
> 6. purchase of annuities;
> 7. promissory notes and mortgages received in exchange for cash or property;
> 8. formal and informal loans made to others;
> 9. purchase of personal services or care contract;
> 10. purchase life estate interest;
> 11. assets declared at application not included on the Interim Contact Letter; and
> 12. funds placed in a trust.
>
> Evaluate all the above situations and all other transactions that change an asset from potentially countable to excluded, including transfer of ownership interest in a home that was previously excluded as an asset. A homestead is still subject to a transfer of asset penalty, even if it could be/have been excluded prior to the transfer.

34. Fla. Admin. Code R 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, allows an individual an opportunity to rebut the Agency's action and states:

> (3)(e) Each individual shall be given the opportunity to rebut the presumption that a resource or income was transferred for the purpose of qualifying for Medicaid. No period of ineligibility shall be imposed if the individual provides proof that they intended to dispose of the resource or income at fair market value or for other valuable consideration, or provides

> proof that the transfer occurred solely for a reason other than to become Medicaid eligible or if the individual's total countable resources (including the transferred resources) are below the program limits.

35. Pursuant to the above authorities, Petitioner has the burden to prove that the uncompensated transfer of assets was for a purpose other than to become eligible for Medicaid benefits. Additionally, the authorities provide that everyone should be given the opportunity to rebut the presumption that a resource or income was transferred for qualifying for Medicaid. In this instant case, Petitioner's purchase of a condo in his son's name eliminates his ownership or control of such asset. Therefore, Petitioner's transferred asset is invalid and a penalty period must be imposed. Respondent was correct to determine Petitioner made an invalid transfer of assets and to impose a penalty period.

36 Fla. Admin. Code R 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, defines how to calculate the penalty period imposed on individuals who have been found to transfer assets and states, in part:

> (3)(g) For transfers made on or after November 1, 2007 (and within the look back period), periods of ineligibility begin with the later of the following dates: (1) the day the individual is eligible (pursuant to Rules 65A-1.711 through 65A-1.713, F.A.C.) for Medicaid and would be receiving institutional level care services in a nursing home facility, an institution with a level of care equivalent to that of a nursing facility, or home or community based services furnished under a waiver based on an approved application for such care but for the application of the penalty period; or (2) the first day of the month in which the individual transfers the asset; or (3) the first day following the end of an existing penalty period. The Department shall not round down, or otherwise disregard, any fractional period of ineligibility of the penalty period but will calculate the period down to the day. There is no limit on the period of ineligibility. Once the penalty period is imposed, it will continue although the individual may no longer meet all factors of eligibility and may no longer qualify for Medicaid long-term care benefits, unless all assets or income are returned

> to the individual or fair market value compensation is paid for the transferred assets or income. If all transferred assets or income are returned to the individual, the penalty period is eliminated. Eligibility must be evaluated with returned assets included as though the individual had never transferred the assets or income. Returned assets or income must be counted as available when determining eligibility for retroactive months.
> 1. Monthly periods of ineligibility due to transferred resources or income are determined by dividing the total cumulative uncompensated value of all transferred resources or income computed in accordance with paragraph 65A-1.712(3)(f), F.A.C., by the average monthly private pay nursing facility rate at the time of application as determined by the Department (refer to paragraph 65A-1.716(5)(d), F.A.C.).
> …
> c. For transfers on or after November 1, 2007 (and within the look back period), the uncompensated value of all transfers will be added together to arrive at one total value with a penalty period assigned.
> …
> 3. Individuals who are ineligible due solely to the uncompensated value of a transferred resource or income are ineligible for ICP, Institutional Hospice or HCBS Waiver services payment, but are eligible for other Medicaid benefits.

37. Pursuant to the above authority, to determine the penalty period, Respondent must divide the uncompensated value of the transferred assets by the average monthly private pay nursing facility rate.

38. Respondent determined that Petitioner's uncompensated transfer as $43,659.15. The DR did not dispute the value.

39. The Policy Manual at Appendix A-35, indicates the monthly private average pay Nursing Home rate for June 2017 and ongoing as $8,944. Petitioner's penalty period is determined by dividing $43,659.15 by $8,944 = 4.88 months.

40. The Policy Manual at Appendix A-8, indicates that if the penalty period contains a fractional period, Respondent is to multiply the fractional period by 30 to convert the

fraction into days. Petitioner's converted days are .88 x 30 = 26 days, resulting in the actual penalty period to be September 1, 2017 through January 26, 2018.

41. The findings show that the asset transfer did not meet any of the criteria listed in the authority to be considered a valid transfer. Therefore, the transfer is not excluded. Respondent correctly calculated the penalty period.

42. The DR is seeking ICP eligibility from October 2017 through January 2018 based on applications she submitted on November 10, 2017, January 31, 2018 and May 31, 2018 respectively. Petitioner's ICP was approved effective February 2018 as the furthest of the retroactive months covered by the May 31, 2018 application.

43. Fla. Admin. Code R. 65A-1.702 states in part:

> (9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.
> **(a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services.** A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. (emphasis added).

44. The Policy Manual at passage number 0640.0509 addresses Retroactive Medicaid (MSSI) and states in part:

> 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.

45. The above cites dictate Respondent to issue up to three months of retroactive Medicaid from the month of application. In this instant case, the DR's first two applications were denied for various reasons. She reapplied on May 31, 2018 and was eventually approved effective February 2018. Three months prior to the May 31, 2018 application starts in February 2018. The undersigned could not find a more favorable outcome.

46. The DR is requesting that the improper asset transfer penalty period be waived for Petitioner to receive ICP benefits from October 2017 through January 2018 based on the applications she submitted in November 2017, January 2018 and May 2018.

47. In careful review of the cited authorities and evidence, the undersigned concludes Petitioner, through his DR, did not meet the burden of proof in establishing that Respondent incorrectly denied his request for Institutional Care Program Medicaid benefits for the period of October 2017 through January 2018.

DECISION

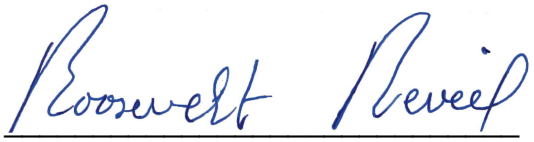
Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED. Respondent's actions are affirmed.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 02 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-06957

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 66292

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 9:38 a.m. on September 24, 2018.

APPEARANCES

For the Petitioner: [redacted], pro se

For the Respondent: Jackie Smalls, ACCESS,
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

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

PRELIMINARY STATEMENT

The petitioner submitted one exhibit, entered as Petitioner Exhibit "1". The respondent submitted seven exhibit, entered as Respondent Exhibits "1" through "7". The record was closed on September 24, 2018.

FINDINGS OF FACT

1. On April 16, 2018, the petitioner (age 41) submitted a Family Medicaid disability application for herself (Respondent Exhibit 1).

2. To be eligible for Family-Related Medicaid, the petitioner must have minor children or be pregnant.

3. The petitioner does not have minor children and is not pregnant. Therefore, the petitioner is not eligible for Family Medicaid.

4. To be eligible for Adult Medicaid, referred to as SSI-Related Medicaid, the petitioner must be age 65 or older or considered blind/disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD). DDD determines Medicaid disability eligibility for the Department.

5. The petitioner is not age 65 or older and has not been considered blind/disabled by the SSA.

6. On April 25, 2018, the Department electronically sent the petitioner's disability documents to the DDD, for an eligibility review (Respondent Exhibit 5).

7. The petitioner applied for disability through the SSA on December 1, 2015. The SSA denied the petitioner disability on March 22, 2016 (Respondent Exhibit 3). The petitioner, through an attorney, appealed the SSA denial decision and is awaiting a hearing date.

8. On May 1, 2018, DDD denied the petitioner disability, due to adopting the SSA denial decision (Respondent Exhibit 5).

9. On May 2, 2018, the Department mailed the petitioner a Notice of Case Action, notifying her April 16, 2018 Medicaid application was denied (Respondent Exhibit 2, page 32).

10. The petitioner said the SSA and her attorney are aware of all her medical conditions.

CONCLUSIONS OF LAW

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

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

13. Medicaid eligibility is based on Federal Regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents, children, and pregnant women, and (2) SSI-Related Medicaid for disabled individuals and adults 65 or older.

14. *Florida Administrative Code* R. 65A-1.703, Family-Related Medicaid Coverage Groups, in part states:

> (1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI

> coverage groups served by the department are stated in each subsection of this rule…
> (5) Medicaid for pregnant women…

15. The evidence submitted establishes the petitioner has no children and is not pregnant. Therefore, she is not eligible for Family-Related Medicaid.

16. *Florida Administrative Code* R. 65A-1.711, SSI-Related Medicaid Non-Financial Eligibility Criteria, in part states, "(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905…"

17. Title 20 of the Code of Federal Regulations § 416.905, Basic definition of disability for adults, in part states:

> (a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.) …

18. In accordance with the above authorities, the petitioner must be age 65 or older or considered disabled to be eligible for SSI-Related Medicaid.

19. Title 42 of the Code of Federal Regulations § 435.541, Determinations of disability, in part states:

> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.
> (b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section—
> (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.
> (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.
> (c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist…
> (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and—
> (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
> (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.
> (iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and—
> (A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
> (B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility…

20. The above authority explains that the SSA determination is binding on the Department.

21. The evidence submitted establishes that the petitioner applied for disability through the SSA on December 1, 2015, and the SSA denied the petitioner disability on March 22, 2016.

22. The petitioner testified that she is appealing the SSA denial, through an attorney, and is awaiting a hearing date.

23. The petitioner testified the SSA and her attorney are aware of all her medical conditions.

24. In accordance with the above authority (#19), the Department denied the petitioner Medicaid disability due to adopting the SSA denial.

25. In careful review of the cited authorities and evidence, the undersigned concludes the Department's action to deny the petitioner Medicaid disability, is proper.

DECISION

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

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this __09__ day of __November_____, 2018,

in Tallahassee, Florida.

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

Copies Furnished To: [redacted]L, 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: 12 DeSoto
UNIT: 88157

RESPONDENT.
_____/

APPEAL NO. 18F-07009, 18F-08533

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on October 31, 2018 at 3:54 p.m.

APPEARANCES

For the Petitioner: [redacted] *pro se*

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

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of September 18, 2018 to deny Qualifying Individual 1 (QI 1) coverage and to enroll her in the Medically Needy Program with a Share of Cost (SOC). Petitioner also appeals her Food Assistance Program (FAP) benefit amount. Petitioner carries the burden of proof by the preponderance of evidence on all issues.

PRELIMINARY STATEMENT

Respondent submitted 43 pages of evidence pre-hearing. These were entered into evidence as Respondent Composite Exhibit 1. Petitioner received the evidence from the department but gave the packet to the police; she did not have it during the hearing to reference.

Petitioner raised a second issue of the amount of her FAP benefits during the hearing. Petitioner also disputed the amount of income used by the department. The record was held open through November 14, 2018 for the department to submit supplemental evidence of how it calculated the FAP benefits and for Petitioner to provide proof of the amount of her income. Instructions were given during the hearing that the record would close on November 14, 2018 unless additional time was requested by either party. Petitioner phoned the undersigned's office on November 14, 2018 and confirmed the fax number. However, no supplemental evidence was provided by Petitioner.

The department submitted its supplemental evidence related to the FAP benefits while the record was held open. The evidence was entered as Respondent Composite Exhibit 2. The record closed on November 14, 2018.

FINDINGS OF FACT

1. Petitioner is 68 years old and is a Medicare recipient. She pays her own Medicare Part B premium.

2. Petitioner pays rent of $550, electric (has air conditioning), phone, water and medical bills.

3. She believes she last had full Medicaid in 2015. Since losing that coverage she has had more medical expenses such as the costs for her prescriptions.

4. Petitioner believes her income "goes up and down." She believes her retirement/Social Security benefits are $1,000 monthly. Petitioner believes she is short every month as her expenses exceed the income she is receiving.

5. Petitioner completed a paper ACCESS Florida Application on September 5, 2018. She checked that she was seeking the following programs: Food Assistance, Medical and Medicaid Waiver/Home & Community Based Services. The department's history screen, run on October 2, 2018, shows Petitioner last received FAP in the month of July 2017. (Respondent Composite Exhibit 1 at 6 – 13 and 24)

6. On page four of the paper application Petitioner answered the question, "Has anyone in your home been convicted on or after 8/22/96 of receiving food assistance, temporary cash assistance or Medicaid in more than one state at the same time?" with, "Unknown = imposter for [redacted] Petitioner indicated on page six of the paper application that her income is retirement/Social Security of $898. She also indicated on page seven of the application that she pays a Medicare premium of $135. (Respondent Composite Exhibit 1 at 9, 11 and 12)

7. The department is required to count gross income for Medicaid and FAP. A data match with Social Security records shows gross Social Security income of $1432 with the net amount at $1298. Petitioner confirmed her social security number matches the one used on this data match. However, Petitioner believes her benefits have been "compromised" due to identity theft. Petitioner indicated at one time she had disability benefits as well as widow's benefits. The data match screen, DES4, also shows a dual

and triple entitlement for both widow and disability benefits on a different claim number with an entitlement date of September 2016 and a "Dual Entitl: Status Code" of 3.[1] The gross payment history shows that Petitioner was receiving $893 in December 2014 and then an increase effective September 2016 to $1,400 as a result of the dual and triple entitlement. The data match next shows an increase to $1,404 for December 2016 and then the increase to $1,432 for December 2017. The data match shows current net monthly payment in the amount of $1,298 for October 2018. (Respondent Composite Exhibit 1 at 14)

8. A data match from Social Security records also shows the Medicare Part B premium is paid by Petitioner in the amount of $134. The undersigned notes Petitioner reported a premium payment of $135; based on the data exchange record from Social Security, a finding is made that her Medicare Part B premium is $134. (Respondent Composite Exhibit 1 at 15)

9. Due to the relevant, disputed fact of how much Petitioner's gross or net monthly income is, the undersigned must make the finding. Petitioner was given the opportunity to furnish evidence of her income to support her assertion that she did not receive even the net amount shown in department records. Nothing was provided by Petitioner to support her argument. Based on the record, the undersigned finds Petitioner's gross income is what the data match with Social Security records shows of $1,432 for 2018 and her net amount is $1,298 for 2018. The difference is the Medicare Part B premium of $134.

[1] The department's State On-line Query (SOLQ) User Guide February 2006 shows status code 3 on the DES4 as "Both benefits eligible for current payment status (checks may be combined or separate)

10. The department issued a Notice of Case Action on September 18, 2018 approving the FAP benefits in the amount of $108[2] for September 2018 and $141 for October 2018 through August 2019. This is a one-year certification. The notice also informed that the request for QI 1 was denied due to income too high to qualify for the program. (Respondent Composite Exhibit 2 at 14 – 16 and 34)

11. Petitioner was enrolled in the Medically Needy Program with a SOC of $1,098. The SOC was determined by deducting the standard $20 deduction and the Medically Needy Income Limit of $180 for one person, from the gross income of $1,432, leaving $1,232. The Medicare Part B premium was then deducted, leaving the remaining SOC at $1,098.

12. The department evaluated Petitioner's eligibility for the QI 1 Program as it has the highest income limit of the three Medicare Part B buy-in programs. The standard $20 deduction was taken from the gross income of $1,432, leaving $1,412. This amount was compared to the current QI 1 income standard of $1,366. Because Petitioner's income exceeded this amount, the department denied the QI 1 coverage. (Respondent Composite Exhibit 1 at 23)

13. The department's records show Petitioner last had Qualified Medicare Beneficiary (QMB) coverage through August 2017. (Respondent Composite Exhibit 1 at 26)

14. Petitioner is in the process of submitting her medical bills to the department to determine when SOC can be met. She previously reported monthly medical expenses of $450 to the department. (Respondent Composite Exhibit 2 at 2).

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[2] The department corrected this amount to $117 for September 2018 and issued a $9 supplement. Respondent Composite Exhibit 2 at 27.

15. To determine Petitioner's FAP ongoing benefit amount, the department used the gross income of $1,432. The standard deduction of $164 was deducted, leaving $1,268. Excess medical expenses of $549 were deducted (total medical costs reported of $450 plus $134 Medicare Part B premium for a total of $584 minus the $35 medical disregard) leaving adjusted income of $719. The rent of $550 was added to the standard utility allowance of $359 for a total of $909. Next, half of the adjusted net income ($719 ÷ 2) of $359.50 was subtracted from the total shelter costs of $909, leaving $549.50; this amount is considered the shelter deduction. The uncapped shelter deduction of $549.50 was then subtracted from the adjusted income of $719, leaving food assistance adjusted income of $169.50. The maximum FAP amount for one person is $192. The food assistance adjusted income of $169.50 was subtracted from the $192, leaving a monthly FAP amount of $141 beginning October 2018.

16. For September 2018 FAP benefits, the same income and expenses were allowed and the same formula was applied as used for October 2018. However, the federal standards were lower for September 2018 as these increase in October[3] of every year. The standard deduction used was $160 and the Standard Utility Allowance used was $347. The maximum FAP amount for one person was $192 (the same for all of the months in this certification period). This calculation resulted in a monthly FAP amount of $135. Because Petitioner applied on September 5, 2018, the September 2018 FAP amount was prorated from that date for the month of application. The remaining calculation involves multiplying the monthly amount of $135 by the proration factor of

[3] Aligned with the Federal Fiscal Year

.867, leaving the September 2018 FAP amount at $117. (Respondent Composite Exhibit 2 at 26)

CONCLUSIONS OF LAW

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

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

19. Petitioner held the burden of proof on all issues in accordance with Rule 65-2.060, *Florida Administrative Code.*

DENIAL OF QI 1 (ONE OF THE THREE MEDICARE PART B BUY-IN PROGRAMS)

20. Rule 65A-1.713, *Florida Administrative Code,* "SSI-Related Medicaid Income Eligibility Criteria" states in relevant part:

> (1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows: …
> (b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C. …
> (g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level…
> (j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid…
> (2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. §416.1100 (2007) (incorporated by reference) et seq., …

> (4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied…(a) For MEDS-AD Demonstration Waiver, Protected Medicaid, Medically Needy, Qualified Working Disabled Individual, QMB, SLMB, QI1, and to compute the community spouse income allocation for spouses of ICP individuals, the following less restrictive methodology for determining gross monthly income is followed…

21. The above authority sets forth the income limits for the three Medicare Part B Buy-in Programs. These are Medicaid coverage groups with income limits based on the Federal Poverty Levels. Of the three programs, QI 1 has the highest income limit, which is equal to or less than 135 percent of the federal poverty level. This authority also informs that the department follows the SSI policy specified in the federal regulations at 20 C.F.R. §416.1100 for all SSI-related coverage groups. In addition, the above authority indicates gross monthly income is determined. This authority explains that QI 1 coverage is limited to payment of the Part B Medicare premium (currently $134 per month) through Medicaid.

22. Title 20 of the Code of Federal Regulations Section 416.1123 “How we count unearned income” states in part, “(2) We also include more than you actually receive if amounts are withheld from unearned income because of a garnishment, or to pay a debt or other legal obligation, or to make any other payment such as payment of your Medicare premiums.”

23. Title 20 of the Code of Federal Regulations Section 416.1124, “Unearned income we do not count” states in part, “(c) (12) The first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need.”

24. The department's Program Policy Manual, CFOP 165-22, Appendix A-9 gives the dollar amounts associated with these percentages of the current Federal Poverty Levels and states in part:

SSI-Related Programs -- Financial Eligibility Standards: October 2018 [4]	
QMB	$1,012
SLMB	$1,214
QI 1	$1,366

25. The department's Program Policy Manual, CFOP 165-22, passage 1840.0901 "Verification of Unearned Income (MSSI, SFP)" informs, "All non-exempt unearned income must be verified at application and review unless otherwise specified. The following sources may be used to verify unearned income: 1. BENDEX or SDX tapes…"

26. The department's Program Policy Manual, CFOP 165-22, Chapter 4600, Glossary, defines BENDEX as, "Beneficiary and Earnings Data Exchange (BENDEX**):** A data exchange source (federal match) that provides benefit information on SSA recipients and updates as changes occur."

27. Based on the above controlling authorities, the undersigned concludes the department correctly counted Petitioner's gross monthly income of $1,432 using its data exchange records from the Social Security Administration. The department then correctly subtracted the $20 standard deduction to compare the result of $1,412 to the

[4] The undersigned notes the income limits based on the Federal Poverty Levels were the same for September 2018 as they are updated only once per year typically in February after the Federal Poverty Levels are updated. (See Respondent Composite Exhibit 1 at 35)

QI 1 income limit for an individual of $1,366. Therefore, the undersigned concludes that the department correctly determined Petitioner's income exceeds the income limit for QI 1 eligibility and properly denied that request.

ENROLLMENT IN THE MEDICALLY NEEDY PROGRAM WITH A SOC

28. Rule 65A-1.701, *Florida Administrative Code* "Definitions" states in part:

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

29. The above authority defines the full coverage Medicaid program, known as MEDS-AD Demonstration Waiver, as a program for individuals who are not receiving Medicare, of if receiving Medicare, the individuals are also eligible for an institutional, hospice or home and community-based Medicaid program. Petitioner receives Medicare; there was no evidence she also receives one of the additional specified Medicaid programs. Therefore, the undersigned concludes Petitioner does not qualify for the full coverage Medicaid program in Florida.

30. Rule 65A-1.710 *Florida Administrative Code* "SSI-Related Medicaid Coverage Groups" defines the Medically Needy Program and states in part, "(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance…"

31. The above authority explains that the Medically Needy Program is for individuals who do not qualify for categorical or full Medicaid.

32. Rule 65A-1.713 *Florida Administrative Code* "SSI-Related Medicaid Income Eligibility Criteria" states in part:

> (1)(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses…
> (4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost," shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:
> 1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,
> 2. Allowable medical services such as the cost of public transportation to obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and personal care services in the home prescribed by a recognized member of the medical community.

33. The above authority sets forth the budgeting methodology for determining the SOC and states the amount of the individual's countable income that exceeds the Medically Needy income level (MNIL) is called the SOC. When countable income exceeds the MNIL, the department will deduct allowable medical expenses in chronological order by

day of service. Allowable ongoing health insurance costs such as Medicare premiums are deducted to reflect the remaining SOC.

34. Rule 65A-1.716 *Florida Administrative Code* "Income and Resource Criteria" sets forth the MNIL for an individual and states in part:

> (2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:
>
> | Family Size | Monthly Income Level |
> |---|---|
> | 1 | $180 |

35. Based on the above controlling authorities, the undersigned concludes the department correctly enrolled Petitioner in the Medically Needy Program and correctly determined her SOC by using the $20 standard deduction, the MNIL of $180 and the Part B Medicare premium of $134, leaving Petitioner's remaining SOC at $1,098.

FAP BENEFIT AMOUNT

36. Title 7 of the Code of Federal Regulations Section 273.2 "Office operations and application processing" states in part:

> (f)(1)(i) *Gross nonexempt income.* Gross nonexempt income shall be verified for all households prior to certification…(7) *State Data Exchange and Beneficiary Data Exchange.* The State agency may verify SSI benefits through the State Data Exchange (SDX), and Social Security benefit information through the Beneficiary Data Exchange (BENDEX), or through verification provided by the household. The State agency may use SDX and BENDEX data to verify other SNAP eligibility criteria. The State agency may access SDX and BENDEX data without release statements from households, provided the State agency makes the appropriate data request to SSA and executes the necessary data exchange agreements with SSA. The household shall be given an opportunity to verify the information from another source if the SDX or BENDEX information is contradictory to the information provided by the household or is unavailable. Determination of the household's eligibility and benefit level

> shall not be delayed past the application processing time standards of paragraph (g) of this section if SDX or BENDEX data is unavailable.

37. The above controlling FAP federal regulation explains that gross income is verified and determined prior to certification. This authority also explains the department's data exchange with the Social Security Administration and instructs that the state agency may verify the Social Security benefit through the beneficiary data exchange or through verification provided by the household.

38. The department's Program Policy Manual, CFOP 165-22, passage 1810.0900 "Benefits (FS)" states:

> The gross benefit amount received or anticipated to be received is considered unearned income. Benefits are owned by the individual for whom they are intended unless the individual is not in the home and the benefits are not redirected. Deductions for optional items such as health insurance and Medicare premiums continue to count as income.

39. The department's FAP policy manual instructs that the gross amount of income is counted, including the Medicare premiums.

40. Title 7 of the Code of Federal Regulations Section 273.9 "Income and deductions" states in relevant part:

> (b)(2) Unearned income shall include, but not be limited to:
> (ii) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits…(d) *Income deductions.* Deductions shall be allowed only for the following household expenses:
> (1) *Standard deduction*—(i) *48 States, District of Columbia, Alaska, Hawaii, and the Virgin Islands.* Effective October 1, 2002, in the 48 States and the District of Columbia, Alaska, Hawaii, and the Virgin Islands, the standard deduction for household sizes one through six shall be equal to 8.31 percent of the monthly net income eligibility standard for each household size established under paragraph (a)(2) of this section rounded

> up to the nearest whole dollar…(3) *Excess medical deduction.* That portion of medical expenses in excess of $35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in §271.2…(6) Shelter costs…(ii) Excess shelter *deduction. Monthly shelter expenses* in excess of 50 percent of the household's income after all other deductions in paragraphs (d)(1) through (d)(5) of this section have been allowed…(iii) *Standard utility allowances.* (A) With FNS approval, a State agency may develop the following standard utility allowances (standards) to be used in place of actual costs in determining a household's excess shelter deduction…

41. The above federal authority instructs the states on what unearned income includes and what deductions are allowed in the FAP. The relevant deductions allowed are a standard deduction; a medical deduction in excess of $35 for a household with an elderly or disabled member; an excess shelter deduction and a standard utility allowance, when eligible.

42. Title 7 of the Code of Federal Regulations Section 273.10 “Determining household eligibility and benefit levels” states in relevant part:

> (a) *Month of application*—(1) *Determination of eligibility and benefit levels.* (i) A household's eligibility shall be determined for the month of application by considering the household's circumstances for the entire month of application. Most households will have the eligibility determination based on circumstances for the entire calendar month in which the household filed its application…(ii) A household's benefit level for the initial months of certification shall be based on the day of the month it applies for benefits and the household shall receive benefits from the date of application to the end of the month unless the applicant household consists of residents of a public institution… As used in this section, the term “initial month” means the first month for which the household is certified for participation in SNAP following any period during which the household was not certified for participation…(A) The State agency shall use a standard 30-day calendar or fiscal month. A household applying on the 31st of a month will be treated as though it applied on the 30th of the month.
> (B) The State agency shall prorate benefits over the exact length of a particular calendar or fiscal month.

(iii) To determine the amount of the prorated allotment, the State agency shall use either the appropriate Food Stamp Allotment Proration Table provided by FNS or whichever of the following formulae is appropriate:
(A) For State agencies which use a standard 30-day calendar or fiscal month the formula is as follows, keeping in mind that the date of application for someone applying on the 31st of a month is the 30th:

$$X = \frac{a \times b}{c}$$

(C) If after using the appropriate formula the result ends in 1 through 99 cents, the State agency shall round the product down to the nearest lower whole dollar. If the computation results in an allotment of less than $10, then no issuance shall be made for the initial month…
(e) *Calculating net income and benefit levels*—(1) *Net monthly income.* (i) To determine a household's net monthly income, the State agency shall:
(A) Add the gross monthly income earned by all household members and the total monthly unearned income of all household members, minus income exclusions, to determine the household's total gross income. Net losses from the self-employment income of a farmer shall be offset in accordance with §273.11(a)(2)(iii).
(B) Multiply the total gross monthly earned income by 20 percent and subtract that amount from the total gross income; or multiply the total gross monthly earned income by 80 percent and add that to the total monthly unearned income, minus income exclusions. If the State agency has chosen to treat legally obligated child support payments as an income exclusion in accordance with §273.9(c)(17), multiply the excluded earnings used to pay child support by 20 percent and subtract that amount from the total gross monthly income.
(C) Subtract the standard deduction.
(D) If the household is entitled to an excess medical deduction as provided in §273.9(d)(3), determine if total medical expenses exceed $35. If so, subtract that portion which exceeds $35…
(H) Total the allowable shelter expenses to determine shelter costs, unless a deduction has been subtracted in accordance with paragraph (e)(1)(i)(G) of this section. Subtract from total shelter costs 50 percent of the household's monthly income after all the above deductions have been subtracted. The remaining amount, if any, is the excess shelter cost. If there is no excess shelter cost, the net monthly income has been determined. If there is excess shelter cost, compute the shelter deduction according to paragraph (e)(1)(i)(I) of this section.
(I) Subtract the excess shelter cost up to the maximum amount allowed for the area (unless the household is entitled to the full amount of its excess shelter expenses) from the household's monthly income after all other applicable deductions. Households not subject to a capped shelter expense shall have the full amount exceeding 50 percent of their net

> income subtracted. The household's net monthly income has been determined…
> (ii)(A) Except as provided in paragraphs (a)(1), (e)(2)(iii) and (e)(2)(vi) of this section, the household's monthly allotment shall be equal to the maximum SNAP allotment for the household's size reduced by 30 percent of the household's net monthly income as calculated in paragraph (e)(1) of this section. If 30 percent of the household's net income ends in cents, the State agency shall round in one of the following ways:
> (*1*) The State agency shall round the 30 percent of net income up to the nearest higher dollar…

43. The federal agency, USDA, Food and Nutrition Services (FNS) explains the above federal regulation in four tables using a four-person household as an example as follows:

Table 2: How to Calculate SNAP Gross Income[5]

Gross Income Calculation	**Example**
Determine household size . . .	4 people with no elderly or disabled members.
Add gross monthly income . . .	$1,500 earned income + $550 social security = $2,050 gross income.
If gross monthly income is less than the limit for household size, determine net income.	$2,050 is less than the $2,720 allowed for a 4-person household, so determine net income.

[5] This example does not have an elderly or disabled member and therefore, some deductions may be capped that are not capped for households with an elderly or disabled member such as Petitioner's.

Table 3: How to Calculate SNAP Net Income

Net Income Calculation	**Example**
Subtract 20% earned income deduction . . .	$2,050 gross income $1,500 earned income x 20% = $300. $2,050 - $300 = $1,750
Subtract standard deduction . . .	$1,750 - $174 standard deduction for a 4-person household = $1,576
Subtract dependent care deduction . . .	$1,576 - $361 dependent care = $1,215
Subtract child support deduction . . .	0
Subtract medical costs over $35 for elderly and disabled . . .	0
Excess shelter deduction . . .	
Determine half of adjusted income . . .	$1,215 adjusted income/2 = $607.50
Determine if shelter costs are more than half of adjusted income . . .	$700 total shelter - $607 (half of income) = $93 excess shelter cost
Subtract excess amount, but not more than the limit, from adjusted income . . .	$1,219 - $93 = $1,126 Net monthly income
Apply the net income test . . .	Since the net monthly income is less than $2,050 allowed for 4-person

Net Income Calculation	Example
	household, the household has met the income test.

How much could I receive in SNAP benefits?
The total amount of SNAP benefits your household gets each month is called an allotment.
Because SNAP households are expected to spend about 30 percent of their own resources on food, your allotment is calculated by multiplying your household's net monthly income by 0.3, and subtracting the result from the maximum monthly allotment for your household size.

Table 4: SNAP Maximum Monthly Allotment Based on Household Size

People in Household	Maximum Monthly Allotment
1	$192
2	$353
3	$505
4	$642

Table 5: Example of SNAP Benefit Calculation

Benefit Calculation	Example
Multiply net income by 30%... (Round up)	$1,126 net monthly income x 0.3 = 337.8 (round up to $338)
Subtract 30% of net income from the maximum allotment for the household size...	$642 maximum allotment for 4-person household - $338 (30% of net

Benefit Calculation	Example
	income) = $304, **SNAP Allotment** for a full month

44. The state agencies are provided the proration factors from the federal agency, USDA FNS. These are published by the department in a "Field Guide Handouts/Proration Factors Chart Cash & FS" dated July 2014. For a date of application on the 5th of the month, the proration factor is shown in this guide as .867.

45. Based on the above controlling authorities, the undersigned concludes the department correctly used Petitioner's gross monthly income and allowed the correct uncapped deductions (for an elderly recipient age 60 and older) to determine her FAP eligibility for October 2018 forward. The department also correctly prorated September 2018 FAP benefits based on the application date of September 5, 2018.

46. In the event Petitioner has verification of her income showing a different gross amount than applied in her Medicaid and FAP budgets, it should be provided to the department for an analysis of how it might impact her benefit levels.

DECISION

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

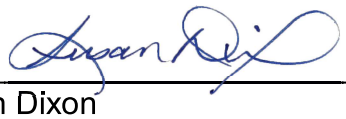
The QI 1 denial and Medically Needy enrollment with SOC of $1,098 appeal is denied.

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 14 day of December, 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-07030

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 66703

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 24th, 2018, at 1:00 p.m.

APPEARANCES

For the Petitioner: [redacted] pro se.

For the Respondent: John Onime, Supervisor for the Economic Self-Sufficiency program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to enroll him in the Medically Needy (NS) program with an estimated share of cost (SOC), instead of full Medicaid. The burden of proof was assigned to the petitioner at the hearing; however, since the Medicaid was terminated, the burden is reassigned to the respondent. The standard of proof in this matter is preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner's friend [redacted] appeared as a participating witness for the petitioner.

Tuesday Steinhilber, Economic Self-Sufficiency Specialist Supervisor appeared as the Spanish language interpreter for the hearing.

The petitioner did not submit any documents for the hearing.

The respondent's exhibits 1 through 7 were admitted into evidence.

The petitioner alleged to have not received the proposed evidence packet issued by the respondent; however, the petitioner did not want to delay the hearing process by requesting a continuance, and decided to proceed. The respondent affirmed that it will reissue the packet on the same day of the hearing.

By way of a Notice of Case Action (NOCA) (Spanish Version) dated June 29th, 2018, the respondent notified the petitioner that his application dated June 26th, 2018 was approved, and he was enrolled in the Medically Needy (NS) program with a monthly Share of Cost (SOC) of $784 effective August 2018. (Respondent's Exhibit 6.)

On August 28th, 2018, the petitioner filed a timely appeal to challenge the respondent's action to enroll him in the Medically Needy program.

FINDINGS OF FACT

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

1. The petitioner applied for SSI-Related Medicaid on June 26th, 2018 for a (1) one-member household, listing just himself. The petitioner reported his only source of income as Social Security Disability Income (SSDI) in the amount of $983. (Respondent's Exhibit 1.)

2. The petitioner is 51 years of age, has no minor children and is not considered as aged since he is not 65 years of age. However, the petitioner was determined disabled by the Social Security Administration (SSA) effective July 6th, 2017. (Respondent's Exhibit 2.)

3. As part of the application process, the respondent obtained verification of his monthly Social Security Disability Income (SSDI) through its Data Exchange (DE) system which shows the petitioner receives $984. (Respondent's Exhibit 2.)

4. The respondent presented a document exhibiting its policy related to SSI-Related Medicaid program including Medically Needy, as well as the financial standards for SSI-Related Programs effective October 2018. The document shows the Medicaid income standard is set at 88% of the Federal Poverty Level (FPL.) Effective October 2018, the Medicaid income standard for an individual is $891, and for a couple it is $1,208. The document shows the Medically Needy Income Level (MNIL) for an individual is $180, and for a couple it is $241. A standard disregard of $20 is deducted from the gross unearned income. (Respondent's Exhibits 4 and 5.)

5. By using the above-mentioned guidelines, the respondent determined SSI-Related Medicaid eligibility for the petitioner. The petitioner's gross monthly unearned income is $984. The respondent applied a $20 unearned income disregard, leaving the petitioner with a countable unearned income of $964. Since the countable income of $964 exceeded the

Medicaid income limit of $891, for the respondent determined that the petitioner was ineligible for Medicaid due to his excess income.

6. The respondent then completed a Medically Needy budget to determine the petitioner's Share of Cost (SOC.) The respondent deducted $20 disregard from the petitioner's unearned SSDI of $984, which left the petitioner with a countable income of $964. The Medically Needy Income Level (MNIL) for an individual is $180. The respondent deducted $180 from the countable income of $964, resulting a Share of Cost (SOC) of $784. (Respondent's Exhibit 3.)

7. On June 29th, 2018, the respondent issued a NOCA (Spanish version) to the petitioner notifying him of its action to enroll him in the Medically Needy program with a SOC of $784. (Respondent's Exhibit 6.)

8. The petitioner argued that prior to the action under appeal, the respondent authorized full Medicaid from February 2018 through July 2018. The petitioner challenged the respondent as to why he is now enrolled in the Medically Needy program instead of full Medicaid since he was already receiving the SSDI of $984 during the above-mentioned period.

9. The respondent confirmed that the petitioner did receive full Medicaid for the period in question; however, it was due to the respondent not budgeting his SSDI income. The respondent did not become aware of the petitioner's income until June 2018. When the respondent processed the petitioner's June 26th, 2018 application, it budgeted the $984 as unearned income, and redetermined eligibility. Based on the income, the petitioner is not

eligible for Medicaid, only for Medically Needy. The Medicaid authorized by the respondent for the above-mentioned period was erroneously authorized without budgeting any income.

10. The petitioner is seeking full Medicaid coverage, and argued that his income is low; therefore, he should receive full Medicaid coverage. The petitioner asserted that currently he does not have Medicare, but would be eligible for it in June 2019. Therefore, Medicaid is the only health insurance he can depend on at this time.

11. The petitioner did not dispute the income budgeted by the respondent; however, he challenged the policy being used. The petitioner contends that he has serious health issues that require constant monitoring by a medical professional. The petitioner argued that most doctors do not accept Medically Needy as Medicaid. The petitioner cannot afford the monthly SOC on a fixed income. The petitioner contends that medical providers refuse to verify his enrollment status in the program, making it difficult for him to get the care he needs.

12. The respondent explained its action to enroll the petitioner in the Medically Needy program with a Share of Cost (SOC,) which is directly dependent on the petitioner's SSDI benefits minus allowable deductions. The respondent also explained how the SOC itself was determined and how it could be met on a monthly basis. The respondent argued that all allowable deductions were afforded to the petitioner in the Medically Needy (NS) budget, and that it was computed correctly.

CONCLUSIONS OF LAW

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

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

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

16. As SSA has determined that the petitioner is disabled, the respondent screened the petitioner for SSI-Related Medicaid program eligibility. The respondent determined that the petitioner would qualify for the SSI-Related Medicaid programs, but only in the Medically Needy program instead of full Medicaid due to his countable income exceeding Medicaid program limit.

17. Federal Regulations at 20 C.F.R. § 416.1121 types of unearned income states:

> Some types of unearned income are—
>
> (a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example, private pensions, **social security benefits**, disability benefits, veteran's benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

18. The above-cited federal authority explains that unearned income, such as Social Security Disability Income (SSDI) is included as income in determining eligibility for the Medicaid programs. The findings establish that the petitioner receives $984 in SSDI. Therefore, the undersigned concludes that the respondent is correct to include the petitioner's Social Security income in its calculations.

19. Federal Regulations 20 C.F.R. § 416.1124 unearned income we do not count states:

> (a) General. While we must know the source and amount of all of your unearned income for SSI, we do not count all of it to determine your eligibility and benefit amount. We first exclude income as authorized by other Federal laws (see paragraph (b) of this section). Then we apply the other exclusions in the order listed in paragraph (c) of this section to the rest of your unearned income in the month. We never reduce your unearned income below zero or apply any unused unearned income exclusion to earned income except for the $20 general exclusion described in paragraph (c)(12) of this section.
>
> (c) *Other unearned income we do not count.* We do not count as unearned income—
> …
> (12) The **first $20 of any unearned income in a month** *[emphasis added]* other than income in the form of in-kind support and maintenance received in the household of another (see §416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility. The $20 exclusion does not apply to a benefit based on need that is totally or partially funded by the Federal government or by a nongovernmental agency. However, assistance which is based on need and funded wholly by a State or one of its political subdivisions is excluded totally from income as described in §416.1124(c)(2). If you have less than $20 of unearned income in a month and you have earned income in that month, we will use the rest of the $20 exclusion to reduce the amount of your countable earned income;

20. The findings establish that the respondent correctly deducted the $20 from the petitioner's gross unearned income of $984 which decreased it to $964.

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

> The Department covers all mandatory coverage groups and the following optional coverage groups:
>
> (1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. §1396a(m).
>
> (5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of

income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

22. Additionally, Fla. Admin. Code R. 65A-1.713 SSI-Related Medicaid Income Eligibility Criteria states:

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

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

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

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

1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,

2. Allowable medical services such as the cost of public transportation to

> obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and personal care services in the home prescribed by a recognized member of the medical community.

23. The above-cited state 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 which is currently $891. The petitioner's income is $984, and after deducting $20, his remaining income is $964, which exceeded the Medicaid program limit of $891. Therefore, the respondent was correct to enroll the petitioner in the Medically Needy program.

24. The Eligibility Standards for SSI-Related programs appear in the respondent's Program Policy Manual CFOP 165-22 (the Policy Manual), at Appendix A-9. Effective October 1st, 2018, the limit for one member household is $891. The respondent determined the petitioner's countable income after all deductions exceeded this standard.

25. The Medically Needy Program provides coverage for individuals who meet the technical requirements for Medicaid but whose income or assets exceed the income limits. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the Medically Needy Income Level (MNIL) for an individual at $180. The above authorities also define the Share of Cost (SOC) represents the amount of recognized medical expenses that Medically Needy enrolled individual or family must incur each month before becoming eligible to receive

Medicaid benefits. The Medically Needy program is available for aged or disabled individuals or eligible couples who do not qualify for the MEDS-AD Program.

26. Since the petitioner was not eligible for full Medicaid, the respondent explored eligibility in other categories of SSI-Related Medicaid such as Medically Needy. The respondent deducted $20 disregard and a $180 MNIL from the petitioner's gross income of $984. After these deductions, the Share of Cost (SOC) was determined to be $784, and the respondent correctly enrolled the petitioner in the Medically Needy program.

27. Based on the evidence, testimony, and the controlling legal authorities, the undersigned concludes that the respondent met its burden of proof in this matter. The respondent correctly terminated the petitioner Medicaid and enrolled him in the Medically Needy program with a SOC of $784. The petitioner's arguments were considered; however, there is nothing in the regulations which would allow a favorable outcome for the petitioner. Therefore, the undersigned affirms the respondent's action to enroll the petitioner in the Medically Needy program with an assigned Share of Cost.

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 19 day of November, 2018,

in Tallahassee, Florida.

Sajan George
Hearing Officer
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency
[redacted]

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

[redacted]

APPEAL NO. 18F-07241

PETITIONER,

Vs.

CASE [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88585

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 22, 2018 at 1:39 p.m.

APPEARANCES

For the Petitioner: [redacted]

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

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to increase her and her husband's share of cost (SOC) at recertification. The respondent carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The respondent submitted five exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 5. The petitioner submitted one exhibit which accepted into evidence and marked as Petitioner's Composite Exhibit 1.

The record was held open until October 30, 2018, for verification of the husband's loss of income and for the respondent to update the budget. The petitioner provided two additional exhibits which were accepted into evidence and marked as Petitioner's Exhibits 2 and 3. The respondent provided one additional exhibit which was accepted into evidence and marked as Respondent's Composite Exhibit 6. The record was closed on October 30, 2018.

Present as witness for the petitioner was [redacted], husband.

Medicaid benefits for the children are not at issue.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner was approved for the Medically Needy program. On June 20, 2018, the petitioner reported her job was ending. The respondent updated the petitioner's case and approved Medically Needy benefits with a SOC of $3,279.

2. On July 31, 2018, the petitioner's certification ended. Her husband was not aware that the his Medically Needy benefits ended.

3. On August 30, 2018, the petitioner submitted an application to recertify for Medicaid benefits. She reported four household members, herself, her husband and their two children. Her husband was employed at [redacted] (Respondent's Exhibit 1).

4. On September 4, 2018, the petitioner requested a hearing to challenge the respondent's action.

5. On September 5, 2018, the respondent mailed the petitioner a Notice of Case Action requesting verification of gross income for her and her husband. The information was due on September 17, 2018.

6. On September 6, 2018, Social Security Administration approved Social Security retirement benefits of $1,700 for the husband beginning October 2018 (Petitioner's Composite Exhibit 1, page 14).

7. On September 12, 2018, the petitioner provided two of her husband's paystubs from August 15, 2018 for $1,932.14 and August 31, 2018 for $1,932.14. The respondent used those paystubs to determine the SOC of $4,979 (Petitioner's Composite Exhibit 1, page 20 and 21 and Respondent's Exhibit 4).

8. On September 14, 2018, the respondent mailed a Notice of Case Action informing the petitioner that her application dated August 30, 2018 was approved and that effective September 2018, the SOC was $4,979 (Respondent's Exhibit 2).

9. On September 17, 2018, the husband resigned (Petitioner's Composite Exhibit 1, page 3).

10. On October 6, 2018, the two children were approved for Social Security benefits (child's benefits) of $854 each, beginning October 2018 (Petitioner's Composite Exhibit 1, pages 5 through 8 and Respondent's Exhibit 3).

11. On October 17, 2018, the respondent mailed another Notice of Case Action informing that petitioner that she needed to provide proof of loss of income and last pay date. The information was due on October 29, 2018 (Petitioner's Exhibit 2).

12. The husband argued that the SOC should be lower as the household income had gone down. The respondent explained that his employment income and Social Security

income are both counted in the Medically Needy budget until he provides verification of loss of income. The petitioner agreed to provide proof of loss of income and the respondent agreed to update the SOC if the petitioner provided verification of loss of income.

13. On October 22, 2018, the husband's loss of income was provided and on October 23, 2018, the respondent mailed a new Notice of Case Action informing that the SOC was $1,115 per month effective October 2018 (Respondent's Composite Exhibit 6, page 3).

14. The new SOC was determined as follows. The Medically Needy Income Limit of $585 for a household size of four was subtracted from the countable net income of $1,700 resulting in $1,115 as the SOC (Respondent's Composite Exhibit 6, pages 8 through 10).

CONCLUSION OF LAW

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

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

17. Fla. Admin. Code R. 65A-1.701 (30) defines Share of Cost (SOC) and states, "Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before

becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month."

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

> (10) Enrollment. The enrollment period under the Medically Needy program begins with the month the individual satisfies the non-financial and resource eligibility criteria, but not earlier than the third month prior to the month of application.
> (13) Determining Share of Cost (SOC). The SOC is determined by deducting the Medically Needy income level from the individual's or family's income.

19. The Department's Transmittal P-15-07-0006 dated July 1, 2015, addresses, Determining When to Count a Child or Tax Dependent's Social Security and Railroad Retirement Income for Family-Related Medicaid states:

> …
> **New Policy**
> Social Security and Railroad Retirement income will no longer be considered when determining if a child or tax dependent meets the threshold to be required to file a tax return. To determine if a child or tax dependent's countable income will be included in the household's income for Family-Related Medicaid, the FLORIDA System will complete an income test. If the countable income, excluding SS/RR, is below the tax filing threshold, none of that individual's countable income (including SS/RR) should be included in the Family-Related budget for themselves or any assistance group in which they are counted.
> Determining When to Count a Child or Tax Dependent's Social Security and Railroad Retirement Income for Family-Related Medicaid Page 2
> 1317 Winewood Boulevard, Tallahassee, Florida 32399-0700 Mission: Protect the Vulnerable, Promote Strong and Economically Self-Sufficient Families, and Advance Personal and Family Recovery and Resiliency If one of the following requirements is met, a child or tax dependent (regardless of age) is not expected to be required to file taxes and all of their income will be excluded from the Family-Related Medicaid budget.
> 1. The child lives with their parent(s) and their earned income or other unearned income (excluding SS/RR income) does not exceed the current year's tax filing thresholds ($6,200 annually for earned income or $1,000 annually for unearned income), **or**
> 2. The tax dependent is claimed by a tax filer and their earned income and other unearned income (excluding SS/RR income) does not exceed the

> current year's tax filing threshold ($6,200 annually for earned income or $1,000 annually for unearned income), **or**
> **3. The child or tax dependent's only source of income is Social Security or Railroad Retirement (without regard to the amount)** (emphasis added)

20. The above authority directs the Department not to consider a child Social Security benefits in the determination of the parent's Family Related program. The respondent did not include the children's Social Security benefits in the Medically Needy SOC.

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

22. The Medically Needy Income Level (MNIL) appears in The Policy Manual at Appendix A-7. Effective April 2018, the MNIL for a household size of four is $585.

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

24. The undersigned carefully reviewed the respondent's determination of the SOC of $1,115 and did not find a more favorable outcome. The respondent subtracted the Medically Needy Income Limit of $585 for a household size of four from the countable net income of $1,700 resulting in $1,115 as the petitioner's SOC. The undersigned concludes that the respondent's calculation of the petitioner's SOC is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal for a lower SOC is denied and the respondent's action is upheld.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 19 day of November, 2018, in Tallahassee, Florida.

Christiana Gopaul Narine

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

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Duval
UNIT: 88369

RESPONDENT.
_____/

APPEAL NO. 18F-07242

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 18, 2018 at 10:48 a.m.

APPEARANCES

For the Petitioner: The petitioner was present and represented himself.

For the Respondent: Sheila Hunt, Economic Self-Sufficiency Specialist II for the Department of Children and Families (DCF).

ISSUE

The petitioner is appealing the Department's action to deny her SSI-Related Medicaid application on August 15, 2018 as she did not meet the disability requirement.

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

PRELIMINARY STATEMENT

Evidence was submitted and entered as the Petitioner's Exhibits 1 and 2, and the Respondent's Exhibits 1 and 2.

The record was closed at the conclusion of the hearing.

FINDINGS OF FACT

1. On July 25, 2018, the petitioner (age 58) applied for SSI-Related Medicaid with the Department as a disabled adult. The petitioner does not have any minor children. On August 6, 2018, the petitioner's application was forwarded to the Division of Disability Determination (DDD). On August 9, 2018, the DDD determined that the petitioner was not disabled on its contention that the petitioner presented to SSA the same health allegations and that she has a pending hearing. The DDD used the denial code of "N32" (Respondent's Exhibit 2, page 16).

2. On August 15, 2018, the Department mailed a Notice of Case Action to inform petitioner that her application for SSI-Related Medicaid was denied due to not meeting the disability requirement. She previously applied for and was denied disability benefits by the Social Security Administration (SSA).

3. The petitioner applied for Social Security disability on November 1, 2015 and was denied in March 2017. The petitioner requested an appeal on June 2, 2017. The appeal is currently in a pending status. The petitioner explained that she has been waiting for an expedited hearing since March 2017. The petitioner explained that she has a hearing in January 2019.

4. The petitioner believes she has been wrongly denied, as she contends that she has been disabled for over 10 years. The petitioner argues that she has paid into the system and that she needs help. The petitioner argues that her issues with her teeth and eyes have caught up with her. The petitioner believes that her evidence is

self-explanatory and believes that it proves her disability. The petitioner lists her disabling conditions as [redacted] The petitioner contends that her medical conditions [redacted] have become aggravated. The petitioner contends that her aforementioned medical conditions have been reviewed by the SSA in its determination. The petitioner contends that she has a new, non-disabling condition of [redacted] in her right ear that came about in February 2018; she considers it to be more irritating than disabling. The petitioner explained that she mentioned it to her primary care physician in August 2018 but that it is not included in any of her medical documentation.

5. The Department's position is that, since the petitioner's medical conditions were the same as the ones reviewed by the SSA, the DDD did not make an independent determination, as her appeal is still pending. The Department contends that while the denial is still under appeal, the SSA denial stands. The Department explained that if the petitioner's condition has worsened or if she has any new medical conditions, she may complete a new application with the SSA since her denial is still under appeal.

CONCLUSIONS OF LAW

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

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

8. Fla. Admin. Code R. 65A-1.710 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, she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

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

9. The findings show that the petitioner is 58 years old. In this case, before Medicaid eligibility can be determined, the petitioner must meet the federal definition of disabled.

10. Additionally, 42 C.F.R. § 435.541 **Determination of Disability**, states:

> (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...
> (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under 435.909.
> (b) *Effect of SSA determinations.*
> (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
> (ii) If the SSA determination is changed, the new determination is also binding on the agency.

> (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except In cases specified in paragraph (c) (4) of this section.
> (c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist…
> (4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-
> (i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or
> (ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirement of the Act, **and** has not applied to SSA for a determination with respect to these allegations…**(emphasis added)**

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

12. The above authorities indicate that the Department must make an independent determination of disability if the individual has applied for Medicaid after 12 months have passed since the SSA has made a disability determination. An exception to this is if the individual has a worsening medical condition or a disabling condition

different from what was considered by SSA in making its determination and there has not been an application for disability with the SSA regarding these conditions. The above authorities also explain that if the SSA denial is under appeal and the individual is not claiming any new medical conditions not previously reviewed by the SSA, the Department does not make a disability determination. In this case, the petitioner applied for Medicaid after 12 months passed since the SSA denial. The findings show that the petitioner has reported her disabling conditions to the SSA and has no new disabling medical conditions. The findings also show that the petitioner's SSA denial is currently under appeal. Therefore, the undersigned concludes that the Department was correct to not make an independent disability determination in this case.

13. The undersigned concludes that the petitioner did not meet her burden of proof to show that the Department's action was incorrect. Based on the above findings and conclusions of law, the undersigned concludes that the Department was correct to adopt the SSA disability denial, which is now under appeal. Until petitioner meets the federal disability criteria (while under age 65) her eligibility for Medicaid cannot be determined.

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 21 day of November, 2018,

in Tallahassee, Florida.

Paula Ali
Hearing Officer
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

PETITIONER,

Vs.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Putnam
UNIT: 88781

RESPONDENT.
_____/

APPEAL NO. 18F-07304

CASE NO. [redacted]

FINAL ORDER

Pursuant to notice, on October 17, 2018, at 1:14 p.m., Hearing Officer Leslie Green convened a telephonic administrative hearing in the above-referenced matter. All parties appeared by telephone from different locations.

APPEARANCES

For the Petitioner: [redacted] pro se

For the Respondent: Viola Dickinson, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is the Respondent's decision to deny the Petitioner's application for the Medically Needy Medicaid Program due to assets in excess of program limits. The Petitioner holds the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

This matter was originally heard by Leslie Green, Hearing Officer. However, on November 30, 2018, Ms. Green passed away unexpectedly. A Notice of Substitution of Hearing Officer, was issued on December 4, 2018. No objections to the substitution were received from the parties. This order is written by the undersigned based on the hearing conducted by Ms. Green and evidence submitted during the hearing and post hearing.

The Respondent submitted four exhibits which were accepted into the record and marked as Respondent's Composite Exhibit "1". The record was held open five (5) days until October 22, 2018 for the Respondent to submit the property appraiser's report for the real estate in question. The exhibit was received in OAH on the same day and entered into the record as Respondent's Exhibit 2.

On October 19, 2018, The Petitioner submitted evidence to corroborate her sworn testimony. The evidence submitted was a copy of an advertisement to sell the property that was placed on Facebook after the appeal hearing. The evidence was accepted into the record and marked as Petitioner's Exhibit 1.

The record was closed on October 22, 2018.

FINDINGS OF FACT

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

1. On August 8, 2018, the Petitioner submitted a paper application requesting SSI-Related Medicaid, *see* Respondent's Composite Exhibit 1, pages 4-6.

2. The Petitioner, [redacted] is 60 years old. Her household consists of herself and her 91-year old mother. Her mother is not seeking assistance, *see* Respondent's Composite Exhibit 1, page7.

3. The Petitioner is not aged or blind. Per CLRC comments dated August 17, 2018, the Petitioner was determined disabled by the Division of Disability Determinations but denied by the Social Security Administration (SSA) and by the Department for being over the asset limit, *see* Respondent's Composite Exhibit 1, page 15.

4. On August 31, 2018, the Department via a Notice of Case Action informed the Petitioner that her application for Medically Needy Medicaid (MN) was denied as the value of her assets were too high for this program, *see* Respondent's Composite Exhibit 1, page 2.

5. On September 7, 2018, a timely appeal of this decision was filed with the Office of Appeal Hearings.

6. The Petitioner is the sole owner of non-homestead property located at [redacted] *see* Respondent's Exhibit 2.

7. The market value of the land including structures is $16,340, *see* Respondent's Exhibit 2.

8. The Petitioner considers the property to be heir property, Petitioner's testimony.

9. The Petitioner has the ability to convert the value of the real estate into liquid resources or cash, Respondent's & Petitioner's testimony.

10. The Petitioner believes that the real estate should be excluded from the resource or asset limit as the house and shed are in disrepair and, in her opinion, are not inhabitable, Petitioner's testimony.

11. The Respondent asserts that she is making a good faith effort to sell the property, Petitioner's testimony.

12. The asset limit for an individual is $5,000, *see* Respondent's Composite Exhibit 1, pages 14, 18, & 20.

13. The Petitioner did not provide any evidence or testimony from a realtor or broker that countered the value of the property as established by the property appraiser's office.

14. The Petitioner states that she is on [redacted] and needs the Medicaid. She believes that the respondent denied the application for Medically Needy benefits in error.

CONCLUSIONS OF LAW

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

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

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

18. Fla. Admin. Code R. 65A-1.710(5) defines a Medically Needy Program as, "A Medicaid coverage group, as allowed by 42 U.S.C. 139a and §1963d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources.

19. In this instant case, the Petitioner was determined disabled by DDD, therefore, eligibility for Medicaid is determined based on income and assets or resources. The Petitioner is potentially eligible for Medically Needy Medicaid based on her income.

20. Federal Regulations at 20 C.F.R. § 416.1201, Resources, general, states in relevant part:

> (a) Resources; defined. For purposes of this subpart L, resources means cash or other liquid assets or **any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance.**
> (1) **If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource.** If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse). **(Emphases mine)**
> …
> (c) Nonliquid resources. (1) Nonliquid resources are property which is not cash and which cannot be converted to cash within 20 days... Examples of resources that are ordinarily nonliquid are loan agreements, household goods, automobiles, trucks, tractors, boats, machinery, livestock, buildings and land. Nonliquid resources are evaluated according to their equity value except as otherwise provided…
> (2) For purposes of this subpart L, the equity value of an item is defined as:
> **(i) The price that item can reasonably be expected to sell for on the open market in the particular geographic area involved; minus**
> **(ii) Any encumbrances. (Emphasis mine)**

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

> (1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C., with the following exceptions:
> (a) For Medicaid for the Aged or Disabled Demonstration Waiver (MEDS-AD), an individual whose income is equal to or below 88 percent of the federal poverty level must not have resources exceeding the current Medically Needy resource limit specified in Rule 65A-1.716, F.A.C.

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

22. According to 65A-1.712 SSI-Related Medicaid Resource Eligibility Criteria (e) For Medically Needy, an individual or couple cannot have resources exceeding the applicable Medically Needy resource limit set forth in subsection 65A-1.716(3), F.A.C.

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

Family Size	Monthly Asset Level
1	$5,000
2	$6,000
3	$6,000
4	$6,500
5	$7,000
6	$7,500
7	$8,000
8	$8,500
9	$9,000
10	$9,500

For each additional person add $500….

23. The above controlling authorities set the asset limit for SSI-Related Medicaid eligibility for a 1-person assistance group at $5,000. The real estate resource in question belongs to the Petitioner and she has the ability to liquify the asset. The Petitioner's total countable real estate gross resource or asset value is $16,340. The value of the Petitioner's asset exceeded the SSI-Related Medicaid asset limit ($16,340 - $5,000 = $11,340).

24. The Fla. Admin. Code R. 65A-1.303, Assets states in pertinent parts:

> (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. **(emphases mine)**

25. Federal Regulations at 20 C.F.R. § 416.1240 "Disposition of resources states in relevant part:

> …
> (c) If an individual fails to dispose of the resources as prescribed in paragraphs (a)(1) and (a)(2) of this section, regardless of the efforts he or she makes to dispose of them, the resources will be counted at their current market value and the individual will be ineligible due to excess resources. We will use the original estimate of current market value unless the individual submits evidence establishing a lower value (e.g., an estimate from a disinterested knowledgeable source).

26. In this instant case, the Respondent submitted the value of the property obtained from the property appraiser's website. The Petitioner submitted a copy of an advertisement submitted to Facebook after the appeal hearing was held. No evidence establishing a lower value from a disinterested knowledgeable source as noted in the authorities above was submitted by the Petitioner. The Facebook advertisement requests less than the market value shown on the property appraiser's website. If the Petitioner is able to sell the property for the lower amount of $12,000, the balance of the sell after subtracting the asset limit of $5,000 would still be in excess of the asset limit ($12,000-$5,000=$7,000).

27. Federal Regulations at 20 C.F.R. § 416.1210 "Exclusions from resources; general" states:

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

28. Federal Regulations at 20 C.F.R. §416.1245 "Exceptions to required disposition of real property" states in pertinent parts.

> (a) Loss of housing for joint owner. Excess real property which would be a resource under §416.1201 is not a countable resource for conditional benefit purposes when: it is jointly owned; and sale of the property by an individual would cause the other owner undue hardship due to loss of housing. Undue hardship would result when the property serves as the

principal place of residence for one (or more) of the other owners, sale of the property would result in loss of that residence, and no other housing would be readily available for the displaced other owner (e.g., the other owner does not own another house that is legally available for occupancy). However, if undue hardship ceases to exist, its value will be included in countable resources as described in §416.1207.

(b) Reasonable efforts to sell. (1) Excess real property is not included in countable resources for so long as the individual's reasonable efforts to sell it have been unsuccessful. The basis for determining whether efforts to sell are reasonable, as well as unsuccessful, will be a 9-month disposal period described in §416.1242. If it is determined that reasonable efforts to sell have been unsuccessful, further SSI payments will not be conditioned on the disposition of the property and only the benefits paid during the 9-month disposal period will be subject to recovery. In order to be eligible for payments after the conditional benefits period, the individual must continue to make reasonable efforts to sell.

(2) A conditional benefits period involving excess real property begins as described at §416.1242(a). The conditional benefits period ends at the earliest of the following times:

(i) Sale of the property;

(ii) Lack of continued reasonable efforts to sell;

(iii) The individual's written request for cancellation of the agreement;

(iv) Countable resources, even without the conditional exclusion, fall below the applicable limit (e.g., liquid resources have been depleted); or

(v) The 9-month disposal period has expired.

(**3) Reasonable efforts to sell property consist of taking all necessary steps to sell it in the geographic area covered by the media serving the area in which the property is located, unless the individual has good cause for not taking these steps. More specifically, making a reasonable effort to sell means that:**

(i) Except for gaps of no more than 1 week, an individual must attempt to sell the property by listing it with a real estate agent or by undertaking to sell it himself;

(ii) Within 30 days of receiving notice that we have accepted the individual's signed written agreement to dispose of the property, and absent good cause for not doing so, the individual must:

(A) List the property with an agent; or

(B) Begin to advertise it in at least one of the appropriate local media, place a "For Sale" sign on the property (if permitted), begin to conduct "open houses" or otherwise show the property to interested parties on a continuous basis, and attempt any other appropriate methods of sale; and

(iii) The individual accepts any reasonable offer to buy and has the burden of demonstrating that an offer was rejected because it was not reasonable. If the individual receives an offer that is at least two-thirds of

> the latest estimate of current market value, the individual must present evidence to establish that the offer was unreasonable and was rejected. (4) An individual will be found to have "good cause" for failing to make reasonable efforts to sell under paragraph (b)(3) of this section if he or she was prevented by circumstances beyond his or her control from taking the steps specified in paragraph (b)(3) (i) through (ii) of this section. **(Emphases mine)**

29. The above cited authorities establish the criteria under which real estate meets and exception or can be excluded as a resource or asset.

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

> …
>
> (2) Exclusions. The Department follows SSI policy prescribed in 20 C.F.R. §416.1210 and 20 C.F.R. §416.1218 in determining resource exclusions, with the exceptions in paragraphs (a) through (g) below, in accordance with 42 U.S.C. §1396a(r)(2).
>
> …
>
> (f) Property that is essential to the individual's self-support shall be excluded from resources if it is producing income available to the individual which is consistent with its fair market value. This includes real and personal property used in a trade or business; non-business income-producing property; and property used to produce goods or services essential to an individual's daily activities. Liquid resources other than those used as part of a trade or business are not property essential to self-support.

31. In this instant case, the Petitioner does not derive any income from the property and it is not essential to the Petitioner's self-support.

32. The [redacted] property does not meet an exclusion. The authorities also define what constitutes a "good faith effort'. The undersigned concludes that the Petitioner did not provide proof of a good faith effort as outlined in the above cited authorities.

33. Based on the requirements of the above regulations, the asset's ownership has been established as belonging to the Petitioner. The Petitioner has access to the property. The property's net value is above the asset limit. The property does not meet any of the allowable exclusions.

34. In this instant case, the Department maintains that the Petitioner's [redacted]eal estate is valued in excess of the $5,000 limit for an individual.

35. The Department provided the electronic file from the property appraiser's office verifying that the property's value is in excess of the resource limit for a one-person assistance group. The evidence shows that the real estate does not meet the criteria for exclusion as a resource.

36. The Petitioner's [redacted]roperty value exceeds the resource limit for a 1-person assistance group. Based on her sole ownership, the availability of the real estate to be converted to a liquid resource and its value, the undersigned concludes that the Petitioner's real estate property does not meet an exception or exclusion. The undersigned concludes that the Petitioner is not eligible for SSI-Related Medicaid as she has assets over the established limit. The undersigned is unable to find a more favorable outcome for the Petitioner.

DECISION

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

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the

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

DONE and ORDERED this 21 day of December, 2018,

in Tallahassee, Florida.

Ursula Lett-Robinson
Hearing Officer
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [redacted] Petitioner
Office of Economic Self Sufficiency

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

[redacted]

APPEAL NO. 18F-07327

PETITIONER,

Vs.

CASE NO. [redacted]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 ST. LUCIE
UNIT: 88778

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on November 19, 2018 at 10:02 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [redacted]

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

STATEMENT OF ISSUE

At issue is whether Respondent's action denying Petitioner's Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that she did not apply for Medicare is correct. Petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

By a Notice of Case Action (NOCA) dated July 6, 2018, Respondent informed Petitioner that her SSI-Related Medicaid Program benefits were being denied because she did not apply for Medicare with Social Security Administration (SSA). On August 28, 2018, Petitioner timely requested a hearing to challenge Respondent's action. The appeal was continued from October 23, 2018 per Petitioner's request.

Petitioner's evidence was marked as Petitioner's Composite Exhibit 1. Respondent submitted three (3) exhibits which were marked as Respondent's Exhibits 1 through 3.

FINDINGS OF FACT

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

1. Prior to the issue under appeal, Petitioner had been hospitalized at [redacted] from June 14, 2018 through June 18, 2018. During her stay there, she incurred $73,580.19 in medical bills.

2. In June 2018, Petitioner applied for Social Security Income (SSI) disability with SSA alleging she is disabled. SSA denied the application due to excess income (N04) *see* Petitioner's Composite Exhibit 1.

3. The Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid Programs. To be eligible an individual must be blind, disabled, or 65 years or older.

4. Petitioner [redacted] is 81 years old and has been a Lawful Permanent Resident (LPR) since 1993. She meets the age and citizenship criteria for SSI-Related Medicaid benefits. Petitioner must verify her Medicare status as a factor of eligibility.

5. On July 2, 2018, the DR applied for Medicaid benefits through the Department's SSI-Related Medicaid Program on behalf of Petitioner.

6. On July 6, 2018, the Department mailed Petitioner a NOCA denying her application for SSI-Related Medicaid due to not contacting SSA to explore Medicare eligibility, *see* Respondent's Exhibit 1.

7. During a supervisory review of the case, Respondent discovered that it failed to provide a pending notice to Petitioner requesting that she contact SSA.

8. On October 12, 2018, the Department sent a NOCA to the DR requesting that she provides proof of Petitioner's Medicare status by October 22, 2018.

9. Respondent explained that the initial denial was premature. She explained that the case has since been reopened to issue the appropriate notice to the DR. She explained that no information has been provided to this day.

10. The DR acknowledged receiving Respondent's pending notice dated October 12, 2018. She argued that, the Department failed to send her a pending before it denied the July 2, 2018 application. She explained that, after receiving this current pending notice, she tried to contact Petitioner and her family members, but they have not responded. She did not try to secure that information directly from SSA. She is seeking Medicaid eligibility for June 2018 to cover Petitioner's medical bills for her stay at the medical facility.

CONCLUSIONS OF LAW

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

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

13. Medicaid eligibility is based on federal regulations. There are two categories of Medicaid that the Department determines eligibility for: (1) Family-Related Medicaid for parents, children, and pregnant women, and (2) Adult-Related (referred to as SSI-Related Medicaid) for disabled adults and adults 65 or older.

14. Fla. Admin. Code R 65A-1.710 et seq., sets forth the rules of eligibility for aged and disabled adults and states:

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

15. Fla. Admin. Code R. 65A-1.205 further addresses the verification process in part and states:

> (1)(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all

> programs, verifications are due ten calendar days from the date of written request or the interview… 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…
>
> (5) The Department can substantiate, verify or document information provided by the applicant/recipient as part of each determination of eligibility. For any program, when there is a question about the validity of the information provided, the Department will ask for additional documentation or verification as required. The term verification is used generically to represent this process.
>
> (a) Substantiation establishes accuracy of information by obtaining consistent, supporting information from the individual.
>
> (b) Verification confirms the accuracy of information through a source(s) other than the individual. The Department can secure verification electronically, telephonically, in writing, or by personal contact.
>
> (c) Documentation establishes the accuracy of information by obtaining and including in the case record an official document, official paper or a photocopy of such document or paper or electronic source that supports the statement(s) made by the individual.

16. Fla. Admin. Code R. 65A-1.205 addresses Requirement to File for Other Benefits and states

> (a) Documentation that the individual has applied for any annuity, pension, retirement, disability or Medicare benefits to which they may be entitled must be received by the department prior to approval for Medicaid benefits.
>
> (b) After the department notifies an individual that they must apply for the other benefits and if they fail to do so in the absence of a showing of good cause, the individual is not eligible for Medicaid benefits.

17. The above authorities explain that Respondent must request in writing, allowing 10 days for an applicant/recipient to return any requested information. Initially, Respondent denied Petitioner's Medicaid application without requesting verification of her Medicare status.

18. At first, the Department erred when it failed to issue a pending notice to Petitioner. This action has since been remedied when a new notice was sent to the DR requesting that information. The hearing was continued from October 23, 2018 to provide additional time to the DR to secure that information from Petitioner. The DR acknowledged that she did not provide that information.

19. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's most recent action is correct.

DECISION

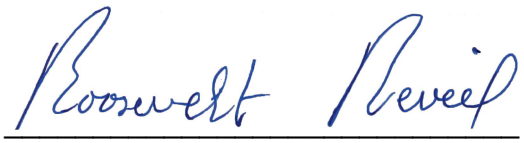
Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

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

DONE and ORDERED this 20 day of November, 2018,

in Tallahassee, Florida.



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