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

APPEAL NO. 07F-06846

PETITIONER,

Vs.

CASE NO. 1268358185

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 13 Lake
UNIT: 88006

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on January 23, 2008, at 1:48 p.m., in Tavares, Florida. The petitioner was not present but was represented by her daughter , who also testified. Sandra Maxwell, supervisor of Adult Payments in Wildwood, represented the respondent by telephone and testified. Edward Brooks, eligibility worker I, also appeared by phone as a respondent witness. Ralph Coleman, senior eligibility worker, physically appeared as a witness for the respondent.

ISSUE

At issue is the respondent's action of November 29, 2007, to deny the petitioner's application for Institutional Care Program and Medicaid benefits (ICP), for August and September 2007 due to excess assets. The respondent

believes the cash, or cash value of a life insurance policy caused the petitioner to be ineligible in these months. The petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner applied for ICP benefits on August 15, 2007. The petitioner has lived in a nursing facility since July 2007.
2. The petitioner owned a life insurance policy with a cash value of $6,864.93 as of August 6, 2007. The policy is listed in her name. On September 17, 2007, the life insurance company issued the petitioner a check for $6,878.04 for this cash value. The petitioner's representative received this check on September 30, 2007. The funds were deposited into the bank in October 2007.
3. The respondent subtracted a $2,500 burial exclusion amount from the value of the life insurance policy in August 2007. The respondent subtracted this $2,500 exclusion from the cash amount, $6,878.04, in September 2007. The respondent determined the remainders, $4,364.93 or greater, to be a countable asset for ICP. The respondent determines this $4,364.93 counted amount to exceed the ICP asset limit for August and September 2007. The respondent denied ICP benefits for August and September 2007, per notice.
4. The petitioner established an irrevocable trust in October 2007. The respondent determined the petitioner eligible for ICP benefits beginning October 2007.

5. The petitioner does not have funds to pay the nursing home bill for August and September 2007. The petitioner believes the process took time to establish and that she should be eligible for these months.

CONCLUSIONS OF LAW

Florida Administrative Code Rule 65A-1.716(5)(a)1. sets forth a $2,000 countable asset limit in the ICP Program. If the cash, or cash value of the life insurance policy correctly exceeds this asset limit, then the petitioner is ineligible for ICP benefits in August and September 2007.

The respondent's interpretive FLORIDA on-line manual at section 1640.0514 allows a $2,500 burial exclusion policy from countable assets. Findings establish that the respondent correctly subtracted this $2,500 amount from the cash or cash value of the life insurance policy.

The respondent interpretive manual at section 1640.0554 shows that the cash value of a life insurance is considered a countable asset. This manual section states that the cash value of a life insurance is considered available to the petitioner if in the name of the petitioner. Since the cash value of the life insurance policy minus the $2,500 burial exclusion exceeded the $2,000 limit, the petitioner was ineligible for ICP due to excess assets in August 2007.

Likewise, section 1640.0518 shows that cash itself is also included as a countable asset. Since the countable value of this cash exceeded the maximum $2,000 asset limit in September 2007, the respondent is also correct to deny ICP benefits due to excess assets in September 2007.

DECISION

This appeal is denied and the respondent's action affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE AND ORDERED this 26th day of February, 2008,

in Tallahassee, Florida.

Jim Travis
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To:

District 13 ACCESS: Micheal Holder

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

APPEAL NO. 07F-06543

PETITIONER,

Vs.

CASE NO. 1009140728

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 14 Hardee
UNIT: 88581

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned hearing officer on December 12, 2007, at 10:00 a.m., in Wauchula, Florida. The petitioner was not present. She was represented by her treating physician, Dr The respondent was represented by Gail Crews, economic self-sufficiency supervisor.

The respondent was allowed 10 days to return further evidence. No further evidence was received. The record was closed.

ISSUE

At issue is the October 26, 2007 action by the respondent denying the petitioner's application for benefits through the Institutional Care Program and Medicaid on the basis that she did not meet the disability criteria. The burden of proof falls with the petitioner as the applicant for benefits.

FINDINGS OF FACT

1. On September 9, 2007, the petitioner filed a Request for Assistance to apply for Institutional Care Program benefits and Medicaid. Since she was 59 years old, she did not meet the aged criteria and a disability determination was required. On October 19, 2007, the respondent forwarded a request for a disability determination to the District Medical Review Team (DMRT).
2. On October 24, 2007, DMRT determined that the petitioner did not meet the disability criteria. They determined that her medical condition would not prevent her from performing substantial gainful employment for a period of 12 months. On October 26, 2007, the respondent notified the petitioner that her application for benefits through the Institutional Care Program and Medicaid was denied.
3. The petitioner has arthritis, joint pain, fatigue, shortness of breath, and a leaky right heart valve. She fell in September 2007. She developed a large hematoma (hemangioma) that became infected. It is the size of a grapefruit on her right inner thigh. They are trying to drain the hemangioma but there is the risk that she could hemorrhage and lose her leg or life.
4. The petitioner weighs over 300 pounds. She suffers from depression, diabetes, circulatory problems, chronic dermatitis, cellulites, pulmonary hypertension, and has problems regulating her medications. She is

ambulatory with assistance. She needs assistance with all activities of daily living with the exception of eating.

5. The petitioner was initially hospitalized with the fall in September 2007 and was discharged to the nursing facility. She remains in the nursing facility as of the date of the hearing. Dr. t is her treating physician. The prognosis for any improvement is not good. Dr. the opinion that the prospects for medical improvement in the next 12 months are very slim. The medical evidence contains hospital records, medical tests, and nursing home records beginning in September 2007.
6. The petitioner graduated from the 9th grade with no further training. She has not worked in 25 years. Her past work consisted of selling Avon products and waitressing. She is not eligible for benefits through the Social Security Administration due to her spouses' income and her lack of wage credits.

CONCLUSIONS OF LAW

The Florida Administrative Code, Section 65A-1.710 et seq., set forth the rules of eligibility for Elderly and Disabled Individuals Who Have Income of Less Than the Federal Poverty Level. For an individual less than 65 years of age to receive benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. §416.905. The regulations state, in part:

> The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period

> of not less than 12 months. To meet this definition, you must have a severe impairment which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy...

The hearing officer evaluated Ms. C claim of disability using the sequential evaluation as set forth in 20 C.F.R. §416.920. The first step is to determine whether or not the individual is working. Ms. is not working and therefore, meets the first step.

The second step is to determine whether or not an individual has a severe impairment. Since the petitioner's impairment affected work-related functioning and was medically determinable, it was considered severe.

The third step is to determine whether or not the individual's impairment(s) meets or equals a listed impairment in Appendix 1 of the Social Security Act. A review of the listings at 1.00, "Musculoskeletal System, 3.00, "Respiratory System", 4.00, "Cardiovascular System", 9.00, "Endocrine System", and 11.00, "Neurological", 12.00, "Mental Disorders" does not indicate that the petitioner meets a required listing. When the impairments are considered individually or in combination, the evidence does support the meeting of a listed level of an impairment that is medically equivalent to a listing.

The fourth step is to determine whether or not the individual's impairment(s) prevents her from doing past relevant work. The petitioner has not had any past relevant work for 25 years. Therefore, she cannot be evaluated for return to work.

The fifth step is to determine whether or not the individual's impairment prevents her from performing other work. The petitioner has no past relevant work history, she is of advanced age, and a limited education. She does not have the residual functional capacity to perform sedentary work. The vocational grids that apply to the petitioner are at part 404 sub-part P, Appendix 2 of 20 C.F.R., and include the non-exertional considerations. Rule 201.01 calls for a finding of disabled for an individual of advanced age, with a limited education, unskilled or no work experience, and capable of performing sedentary work. Since the petitioner is not capable of even sedentary work, this supports a finding of disabled.

DECISION

This appeal is granted. The respondent should reconsider the petitioner's eligibility for Institutional Care Program benefits and Medicaid accepting that she meets the factor of disability beginning in September 2007.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 22nd day of February 2008,

in Tallahassee, Florida.

Terry Oberhausen
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To:

14 DPOES: Karen Shank

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

APPEAL NO. 07F-06832

PETITIONER,

Vs.

AGENCY FOR HEALTH CARE ADMINISTRATION
DISTRICT: 11 Dade
UNIT: AHCA

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing was convened before the undersigned-hearing officer on February 13, 2008, at 1:45 p.m., in Opa Locka, Florida. The petitioner was not present. , petitioner's father, represented the petitioner. Michelle Knuckle, clinical supervisor, Maxim Healthcare Services, was present on behalf of the petitioner. Sandy Moss, program administrator, Agency for Health Care Administration, represented the agency. Maria Hernandez, operation and management consultant, Agency for Health Care Administration, was present on behalf of the agency. Also present as witnesses for the agency, via the telephone, from Keystone Peer Review Organization (KePRO), were Dr. Robert A. Buzzeo, physician reviewer and Theresa Ashey, RN reviewer. This hearing was originally scheduled for January 9, 2008, but was continued at the request of both parties.

ISSUE

At issue is the agency's action of November 27, 2007, to deny 112 hours of Private Duty Nursing services (PDN) for the period of November 13, 2007 through January 11, 2008, because the medical care as described to them is not medically necessary. Since this was an increase in hours from the previous certification period, the petitioner has the burden of proof.

FINDINGS OF FACT

1. The petitioner, , two years of age, has severe and numerous medical problems related to preterm infancy that require medical services as provided through the Agency for Health Care Administration (AHCA) Medicaid State Plan. AHCA will be further addressed as the agency.

2. On November 8, 2007, Maxim Healthcare Services, as the provider, submitted a request on behalf of the petitioners for 1,128 hours of PDN, 20 hours a day, Monday through Friday, and 24 hours on weekends and days PPEC is closed, for the period of November 13, 2007 through January 11, 2008. This total 1,112 hours. (The provider miscalculated the hours.)

3. The agency has contracted KePRO to determine the number of service hours for PDN. This service is reviewed every 60 days.

4. On November 10, 2007, a board certified pediatric specialty physician consultant reviewed the request. Based on the information provided, the physician consultant determined that the petitioner's father, who works from 5:30 p.m. to 5:30 a.m., Monday through Saturday, can provide coverage on Sunday from 2:00 p.m. to 11:00 p.m.

5. A notice was sent to the petitioner on November 12, 2007. The notice denied 112 hours and approved 1,016 of Private Duty Nursing for the period of November 13, 2007 through January 11, 2008.

6. On December 25, 2007, the request was reviewed by a second board certified pediatric specialty physician consultant who had not issued the initial denial. This physician consultant modified the original denial, approving 16 hours and denying eight hours of PDN services on Sunday, considering that the father has to wake up early on Monday to begin work.

7. The petitioner expressed that he agrees with this determination.

CONCLUSIONS OF LAW

Fla. Admin. Code 59G-1.010 states in part:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:
(a) Meet the following conditions:
1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service...

Fla. Admin. Code 59G-4.290 discusses skilled services, and states in part:

(f) Skilled care recipient. A Medicaid applicant or recipient who requires skilled nursing or skilled rehabilitative services.
(3) Skilled Services Criteria.
(a) To be classified as requiring skilled nursing or skilled rehabilitative services in the community or in a nursing facility, the recipient must require the type of medical, nursing or rehabilitative services specified in this subsection.
(b) Skilled Nursing. To be classified as skilled nursing service, the service must meet all of the following conditions:
1. Ordered by and remain under the supervision of a physician;
2. Sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse.
3. Required to be performed by, or under the direct supervision of, a registered nurse or other health care professionals for safe and effective performance;
4. Required on a daily basis;
5. Reasonable and necessary to the treatment of a specific documented illness or injury;
6. Consistent with the nature and severity of the individual's condition or the disease state or stage...

The Home Health Services Coverage and Limitations Handbook explains on page 2-15 that private duty nursing services are authorized to supplement care provided by parents and caregivers. Parents and caregivers must participate in providing care to the fullest extent possible. Training can be offered to parents and caregivers to enable them to provide care they can safely render.

The agency, through KePRO, took action on November 12, 2007 to deny 112 hours of Private Duty Nursing services for the period of November 13, 2007 through January 11, 2008. The rational for this denial is that the petitioner's father is able to assist

in the care of the petitioner on Sunday, from 2:00 p.m. to 11:00 p.m. This denial was modified during the reconsideration process and only 80 hours were denied. The petitioner stipulated that he agrees with this decision.

After considering the evidence, the Florida Administrative Code Rules and all of the appropriate authorities set forth in the findings above, the hearing officer affirms the agency's action.

DECISION

The appeal is denied as stated in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. 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 agency has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 20th day of February 2008,

in Tallahassee, Florida.

Alfredo Fernandez

Alfredo Fernandez
Hearing Officer
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1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To:

Judith Rosenbaum, Prog. Adm., Medicaid Area 11

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

APPEAL NO. 07F-06485

PETITIONER,

Vs.

CASE NO. 1270433067

FLORIDA DEPT OF CHILDREN AND FAMILIES
DISTRICT: 03 Alachua
UNIT: 88324

RESPONDENT.
_____/

FINAL ORDER

Per notice, a hearing was held before the undersigned hearing officer on December 12, 2007, at 3:45 p.m., in Gainesville, Florida. The petitioner was not present, but was represented by Jonathan Gallington with Hospital Inpatient Services H.I.S. Mr. Gallington also testified. Debra Morgan also with H.I.S., appeared as a witness. The respondent was represented by Louella Teague, supervisor.

ISSUE

1. The first and primary issue is the respondent decision of October 31, 2007 to deny Medicaid coverage under the Emergency Medicaid for Aliens (EMA) program for the months of August 2007 through October 2007. The respondent denied this coverage

based on the assertion that the respondent could not determine eligibility.

2. The second issue is the respondent's decision of the same date to deny Institutional Care Program and Medicaid (ICP) eligibility on the same date. The respondent denied coverage under the Medicaid category based on no eligible members. The petitioner has the burden of proof in both issues.

FINDINGS OF FACT

1. The petitioner is 75 years old with a birth date of May
   The petitioner was admitted to Shands Hospital in Gainesville on August 22, 2007 after being found unconscious behind a dumpster. The petitioner was homeless.
2. The petitioner was hospitalized at Shands Hospital from August 22, 2007 to October 30, 2007. The petitioner had diagnoses of encephalopathy and dehydration during this hospitalization. The hospitalization utilization review determined the petitioner to have an emergency health condition during this total period of hospitalization.
3. On September 13, 2007, H.I.S. submitted an application for EMA and ICP benefits in the petitioner's behalf. The respondent denied ICP benefits because the petitioner was not living in a nursing facility at the time of the decision at issue. H.I.S. seeks ICP eligibility for the petitioner for future placement concerns. The

respondent denied EMA benefits because Medicaid under this category cannot be determined. The parties stipulated to the receipt of notice dated October 31, 2007.

4. The petitioner's medical condition impairs his ability to provide information. The petitioner is a prior citizen of Great Britain. After arrival in the United States (U.S.), the petitioner obtained a Social Security number in 1991 when he then had a valid VISA. It is not known what type of VISA or when the VISA expired. The alien registration number is not known. Both the respondent and H.I.S. have been unable to obtain any other information from the petitioner's relatives.
5. The respondent denied the petitioner's application based on the assertion that eligibility for either EMA or possible regular Medicaid can not be determined. The respondent believes that the petitioner's statement or other proof that the VISA had expired would permit an eligibility determination for EMA. However, there is no testimony or other evidence of the VISA type or status. The respondent also believes that proof of identity is necessary. The H.I.S. representative asserts there is no policy that requires proof that a VISA has expired before EMA eligibility can be determined.

CONCLUSIONS OF LAW

H.I.S. is primarily seeking EMA benefits in the petitioner's behalf for the period of hospitalization for the months of August through October 2007.

However, H.I.S. also seeks ICP for the petitioner for possible future placement concerns. An individual must be a current resident of a nursing facility to be eligible for ICP benefits, per Florida Administrative Code (F.A.C.) Rule 65A-1.711(2)(a) as follows:

> **65A-1.711 SSI-Related Medicaid Non-Financial Eligibility Criteria.**
>
> To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F, with the exception that individuals who are neither aged nor disabled may qualify for breast and cervical cancer treatment, and the following program specific requirements as appropriate:
>
> (2) For ICP benefits, an individual must be:
>
> (a) Living in a licensed nursing facility, or confined to a hospital swing bed or to a hospital-based skilled nursing facility bed, or in an ICF/DD facility that is certified as a Medicaid provider and provides the level of care that the client needs as determined by the department; or living in a Florida state mental hospital and be age 65 or over;...

Since the petitioner was not living in a nursing facility at the time of the denial decision at issue on October 31, 2007, the respondent is correct to deny ICP benefits. In regard to EMA benefits, F.A.C. Rule 65A-1.715 sets forth the following:

> **65A-1.715 Emergency Medical Services for Aliens.**
>
> (1) Aliens who would be eligible for Medicaid but for their immigration status are eligible only for emergency medical services. Section 409.901(9), F.S., defines emergency medical conditions.
> (2) The Utilization Review Committee (URC) or medical provider will determine if the medical condition warrants emergency medical services and, if so, the projected duration of the emergency medical condition. The projected duration of the emergency medical condition will be the eligibility period provided that all other criteria

are continuously satisfied.

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

The petitioner had previous admission to the United States from Great Britain, and had a VISA in 1991. However, it is not known the type of VISA or whether or not the VISA is expired. The F.A.C. Rule above allows for potential EMA eligibility for aliens who would be eligible for Medicaid "but for their immigration status." However, the respondent's interpretive FLORIDA on-line manual at section 1440.0109 gives a list of non-citizens who are excluded for EMA eligibility, in part as follows:

1. Foreign government representatives on official business and their families and servants
2. Visitors for business or pleasure, including exchange visitors,
3. Crewmen on shore leave,
4. Non-citizens in travel status while traveling directly through the U.S.
5. Treaty traders and investors and their families

In the absence of knowledge on the type and expiration of the petitioner's VISA, it cannot be entirely ruled out that the petitioner may still be admitted to the U.S. under one of the above types of non-expired VISA documents. Therefore, the respondent is correct to deny EMA eligibility based on an inability to determine eligibility. Further, if the petitioner were to have a permanent type of registered alien status, he may qualify for other, non-temporary, coverage groups of SSI-Related Medicaid eligibility listed in F.A.C. Rule 65A-1.710. Since the petitioner's

actual alien status is not known, the respondent is correct to determine that the appropriate Medicaid eligibility coverage group can not be determined.

DECISION

The appeal is denied on both issues.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the First District Court of Appeal in Tallahassee, Florida, or with the District Court of Appeal in the district where the party resides. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE AND ORDERED this 4th day of February, 2008, in Tallahassee, Florida.

Jim Travis
Hearing Officer
Building 5, Room 203
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
850-488-1429

Copies Furnished To:
3 DPOES: Theola Henderson

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

APPEAL NO. 07F-07167

PETITIONER,

Vs.

CASE NO. 1179770315

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
DISTRICT: 15 St. Lucie
UNIT: ICP

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, an administrative hearing convened before the undersigned-hearing officer on January 9, 2008, at 11:35 a.m., in Fort Pierce, Florida. The petitioner was not present. His daughte s, represented him. Erika Delgado, ACCESS supervisor, represented the respondent.

ISSUE

At issue is whether the respondent correctly determined that the petitioner is not eligible for Institutional Care Program and Medicaid benefits prior to November 2007 based on excessive income. The petitioner holds the burden.

FINDINGS OF FACT

1. On July 24, 2007, an application for Institutional Care Program (ICP) and Medicaid was submitted to the Department on the petitioner's behalf. ICP was

requested back to May 2007, when the petitioner began residing at the facility. In March 2007, prior to his placement in a nursing facility, his daughter began the eligibility process with the Department.

2. On March 30, 2007, the Department sent a Request for Information requesting additional information in order to determine the petitioner's eligibility. The Respondent's Exhibit 2 highlights the information needed. It shows that the nursing home income limit is $1869. The petitioner's income exceeded that amount, so instructions about executing an irrevocable income trust and funding it with at least $500 was also contained in the request. The information was due on April 12, 2007. Before the information was due, the petitioner's power of attorney, his daughter, requested an extension to the time given to submit verification of his pension and the income trust.

3. On April 17, 2007, the Department sent another Verification List requesting verification of his nursing care level, proof of a qualified trust, and proof of his pension (Respondent's Exhibit 4). The information was due April 27, 2007.

4. On May 17, 2007, the Department sent another Request for Information asking for among other things, proof that the qualified income trust had been executed with an attorney and funded with at least $500, and information concerning a lot in South Carolina (Respondent's Exhibit 5). An Over Income Notice for ICP/HCBS Assistance was attached to the request for information. The information was due May 29, 2007.

5. On July 30, 2007, the Department sent another Verification List asking for the same information concerning the level of care, the pension, the property, and the qualified trust. The information was due August 9, 2007.

6. On August 17, 2007, another Verification List was generated asking for verification of the nursing care level, proof of the qualified trust, proof that the property is for sale, and bank statements showing the funding of the trust from May to August (Respondent's Exhibit 7).

7. The petitioner's income is from Social Security and a pension from United Technologies. In 2007, he received $1315 in Social Security and $778.99 from his pension (Respondent's Exhibit 8). His total income is $2093.99. The ICP income limit is $1869. The amount that needed to be deposited in the trust each month that coverage was requested was $224. This amount was derived by subtracting $1869 from $2093. An income trust was established in May 2007. An opening deposit of $100 was made into the trust account on July 17, 2007. Another $100 deposit was made in August 2007. A deposit of $94 was made on October 4, 2007, and on November 5, 2007, a deposit of $768 was made into the account (Respondent's Exhibit 11).

8. The Department determined that the November 2007 was the first month the petitioner was eligible for ICP because that is the first month the trust account was properly funded thereby bringing the petitioner's income within the Program limits. ICP was denied from May 2007 through October 2007 (Respondent's Exhibit 1).

9. The petitioner's daughter made deposits to the trust account based on information she received from the facility. She had forgotten about the letter the Department sent telling her to deposit $500 a month. Her father accumulated a bill in excess of $23,000 while staying at the facility. The facility expected Medicaid to pick up his balance when he was approved for ICP, but when that did not happen he was

transferred to a different facility. His daughter is already paying $100 a month on a promissory note for another bill.

CONCLUSIONS OF LAW

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

> 1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:
> (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C.
> (f) For hospice services, income cannot exceed 300 percent of the SSI federal benefit rate or income must meet Medically Needy eligibility criteria, including the share of cost requirement. Effective October 1, 1998, institutionalized individuals with income over this limit may qualify for institutional hospice services by establishing an income trust which meets criteria set forth in paragraph 65A-1.702(14)(a), F.A.C.

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

> (15) Trusts. (a) The department applies trust provisions set forth in 42 U.S.C. § 1396p(d).

The Department's Fla. Integrated Pub. Policy Manual, 165-22, Appendix A-9, April 2006, set forth the ICP income limit at $1869 for an individual for the time period at issue.

The Department's Fla. Integrated Pub. Policy Manual, passage1840.0110 Income Trusts (MSSI) states:

> The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and

Community Based Services (HCBS) and PACE. It does NOT apply to Community Hospice.

To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate...If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

1. it is established on or after 10/01/93 for the benefit of the individual;

2. it is irrevocable;

3. it is composed only of the individual's income (Social Security, pensions, or other income sources); and

4. the trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The Economic Self-Sufficiency Specialist MUST forward all income trusts to their District Program Office for review and submission to the District Legal Counsel (DLC) for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A, "Guidance for Reviewing Income Trusts," for instructions on processing income trust cases.

The individual (or their legally authorized representative) must deposit sufficient income into the income trust account in the month in which the income is received to reduce their countable income (the income outside the trust) to within the program income standard. **The individual must make the deposit each month that eligibility is requested.**

The Economic Self-Sufficiency Specialist must advise the individual that they cannot qualify for Medicaid institutional care services or HCBS for any month in which their income is not placed in an executed income trust account in the same month in which the income is received. (This may require the individual to begin funding an executed income trust account prior to its official approval by the District Legal Counsel.)

> Once the District Legal Counsel returns the income trust transmittal through the District Program Office, the Economic Self-Sufficiency Specialist must promptly process the Medicaid application, making sure proper notification of eligibility and patient responsibility is given.

The Department informed the petitioner's representative of the need to establish and fund a qualified income trust, as the petitioner's income exceeded the ICP Program eligibility limits. The above authorities set forth that a sufficient amount of income must be placed in the trust for each month that eligibility is to be determined, in the month that the income is received, to reduce the countable income. The amount of monthly income not placed in the qualified income trust must be compared to ICP income limit.

The findings show that the petitioner had monthly income of $2093.99. The ICP income limit was $1869 for an individual. The findings show that for May 2007 through October 2007, the petitioner had income outside of the Program limits.

The hearing officer finds that since insufficient deposits were made to the trust account in May through October, the Department correctly denied ICP eligibility for those months, and that ICP eligibility began in November 2007.

DECISION

The appeal is denied. The Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The Department has no funds to assist in this review, and any financial obligations incurred will be the petitioner's responsibility.

DONE and ORDERED this 22nd day of February, 2008,

in Tallahassee, Florida.

Margaret Poplin

Margaret Poplin
Hearing Officer
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