STATE OF MICHIGAN

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Bridges Administrative Policy Manuals

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STATE OF MICHIGAN

DEPARTMENT OF HEALTH & HUMAN SERVICES

DEPARTMENT POLICY

All Programs

Clients have rights and responsibilities as specified in this item.

The local office must do **all** of the following:

- Determine eligibility.
- Calculate the level of benefits.
- Protect client rights.

CLIENT RIGHTS

Right to Apply

All Programs

On the **same day** a person comes to the local office, a person has the right to file an application and get local office help to provide the minimum information for filing.

An application **or** filing form, whether faxed, mailed or received from the Internet must be registered with the receipt date, **if** it contains at least the following information:

- Name of the applicant.
- Birth date of the applicant (not required for the Food Assistance Program (FAP) or the Child Development and Care (CDC) program).
- Address of the applicant (unless homeless).
- Signature of the applicant/authorized representative.

An application/filing form with the minimum information listed above must be registered in Bridges using the receipt date as the application date even if it does not contain enough information needed to determine eligibility; see Bridges Administrative Manual (BAM) 110.

If an application/filing form does not contain the minimum information listed above, send it back to the client along with a DHS-330, Notice of Missing Information, informing the client of the missing information.

Note: If an applicant applies for multiple programs which include FAP and/or CDC and the birthday of the applicant is missing, the FAP and/or CDC programs must be registered.

Do not return an application for health care coverage to an applicant. See BAM 115 for when to use the DHS-330, Notice of Missing Information. A DHS-1171-F, filing form is not acceptable for any category of health care coverage.

Family Independence Program (FIP), State Disability Assistance (SDA), Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA)

Treat a faxed or emailed application or filing form as an incomplete application. MDHHS must receive an original signature before benefits are approved.

See **Right to Apply** in the **Client Rights** section of this item.

FAP

A photocopy, facsimile (fax) or an Internet version of a DHS-1171, Assistance Application or the filing form is acceptable. An original signature is not required.

Medicaid (MA)

A photocopy, facsimile (fax) or an electronic version of a DCH-1426, DHS-3243, and DHS- 4574 is acceptable.

The federal application for health coverage is acceptable for any Medicaid category.

Additional information may be required for an SSI-related category. An original signature is not required.

Note: Individuals applying for disability-related MA and/or SDA who have previously been denied by the Disability Determination Service (DDS) must have a new or worsening condition to be referred back to DDS when they submit a subsequent application for these programs; see BAM 815, Medical Determination and Disability Determination Service.

Right to Confidentiality

All Programs

Information concerning individual clients is confidential and protected; see BAM 310, Confidentiality and Public Access to Case Records.

Right to Nondiscrimination

All Programs

Clients have the right to be treated with dignity and respect.

For FAP Complaints alleging discrimination, clients have the right to make complaints to the:

Michigan Department of Health and Human Services
Specialized Action Center
235 S. Grand Avenue
P.O. Box 30037
Lansing, MI 48909
Or call (855) 275-6424 or (855) ASK-MICH.

Complaints that are deemed to be potential Americans with Disabilities Act (ADA) or discrimination claims will be routed directly to the county director. The county director will use the Office of Human Resources (OHR) to properly address all aspects of the allegations. All other complaints that come through the specialized action center will be routed to the customer information specialist in the district/county office for follow-up.

Michigan Department of Civil Rights (MDCR) and/or US Equal Employment Opportunity Commission complaints regarding clients must be routed directly to OHR for review and a coordinated response with the district/county office. Any mediations, settlements or appeals will be directed to the office legal services and policy for further review and coordination with the district/county office.

The Office of Human Resources is responsible for all agency equal opportunity and diversity efforts. For more information, visit this website: http://www.michigan.gov/dhs/0,4562,7-124-5459_7701_7845---,00.html.

Non-Discrimination Statements/Complaints

FIP

US Health and Human Services (HHS) Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (for example, Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the AD-3027, USDA Program Discrimination Complaint Form, found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Submit completed form or letter to USDA either by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410

(2) fax: 202-690-7442.

(3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact

the USDA SNAP Hotline Number at 800-221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by state); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call 202-619-0403 (voice) or 800-537-7697 (TTY).

This institution is an equal opportunity provider.

A client or a client's authorized representative must sign the complaint form. The client is not required to use the complaint form. The client may write a letter instead. If the client writes a letter, it must contain all of the information below and be signed by the client or the client's authorized representative/attorney.

Complaints of alleged discrimination should contain the following:

- Name, address and telephone number or other means of contacting the complainant.
- Name, address and telephone number of client's attorney or authorized representative, if the client is represented.
- Name of the individual(s) or entity the client believes discriminated against the client and the agency or recipient that employs that/those employees.
- Issue of the client's complaint. The issue is a description of what happened, or the action that was taken by the individual(s) or agency that the client believes discriminated against him or her, resulting in some harm.
- Factor(s) in the alleged discrimination. For example, the client may believe that he or she was treated differently because of race, color, national origin, disability, sex (gender), age or religion. (Not all bases apply to all programs.)
- Date(s) that the incident(s) the client is reporting as discrimination occurred.

FAP

US Department of Agriculture (USDA) Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (for example, Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the AD-3027, USDA Program Discrimination Complaint Form, found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit completed form or letter to USDA by:

1. Mail: U.S. Department of Agriculture

   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410;

2. Fax: (202) 690-7442.

3. Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

A client or a client's authorized representative must sign the complaint form. The client is not required to use the complaint form. The client may write a letter instead. If the client writes a letter, it

must contain all of the information below and be signed by the client or the client's authorized representative/attorney.

Complaints of alleged discrimination should contain the following:

- Name, address and telephone number or other means of contacting the complainant.
- Name, address and telephone number of client's attorney or authorized representative, if the client is represented.
- Name of the individual(s) or entity the client believes discriminated against the client and the agency or recipient that employs that/those employees.
- Issue of the client's complaint. The issue is a description of what happened, or the action that was taken by the individual(s) or agency that the client believes discriminated against him or her, resulting in some harm.
- Factor(s) in the alleged discrimination. For example, the client may believe that he or she was treated differently because of race, color, religion, sex, age, national origin, marital status, sexual orientation, familial status, disability, limited English proficiency, or because all or a part of an individual's income is derived from a public assistance program. (Not all bases apply to all programs.)
- Date(s) that the incident(s) the client is reporting as discrimination occurred

Right to Request a Hearing

All Programs

The client has the right to request a hearing for any action, failure to act, or undue delay by MDHHS; see BAM 600.

Exception: For **MA only**, a client and the client's community spouse have the right to request a hearing on an initial asset assessment **only if** an application has actually been filed for the client.

General Complaints

FAP Only

Record general complaints about the FAP program using the Food Assistance Complaint Tracking Database. The database **cannot** be used for discrimination complaints. If a client files a discrimination complaint, the specialist is required to address the issue by following Discrimination Complaints in this item. Examples for when it is appropriate to input general complaints include, but are **not** limited to:

- Overdue FAP applications.
- General FAP complaints.
- Allegations of inappropriate or rude behavior of the MDHHS staff.
- Client complaints of FAP closure due to incomplete or untimely recertifications.
- Allegations the specialist is unresponsive or not acting in a timely manner.

Local offices must continually update any complaints and provide detail regarding their efforts at resolution within the database. When new complaints or information regarding prior complaints is received, local offices **must** make every effort to update the information within 48 hours. Clients may send complaints about the FAP program to any of the offices listed below:

- The appropriate MDHHS local office or Self-Service Processing Center. See the MDHHS directory at MDHHS Internet/Inside MDHHS/County Offices/Map of County Offices for office locations.
- The Specialized Action Center; see address in Right to Nondiscrimination section in this item.
- The Food and Nutrition Service (FNS) regional office:

  U.S. Department of Agriculture
  FNS Midwest Regional Office
  77 W. Jackson Blvd., 20th Floor
  Chicago, Illinois 60604-3507

CLIENT OR AUTHORIZED REPRESENTATIVE RESPONSIBILITIES

Responsibility to Cooperate

All Programs

Clients must cooperate with the local office in determining initial and ongoing eligibility. This includes completion of necessary forms; see Refusal to Cooperate Penalties in this item.

Clients must completely and truthfully answer all questions on forms and in interviews.

The client might be unable to answer a question about himself or another person whose circumstances must be known. Allow the client at least 10 days (or other timeframe specified in policy) to obtain the needed information.

Clients must also cooperate with local and central office staff during quality control (QC) reviews.

FAP Only

Do **not** deny eligibility due to failure to cooperate with a verification request by a person **outside** the group. In applying this policy, a person is considered a group member if residing with the group and is disqualified; see **DISQUALIFIED PERSONS** in BEM 212.

When a lack of QC review cooperation is apparent, the QC auditor notifies the client of the consequences and sends a copy of the letter to the specialist. If contacted by the client regarding the audit request, advise the client to cooperate with the auditor.

Refusal to Cooperate Penalties

All Programs

Clients who are able but refuse to provide necessary information or take a required action are subject to penalties. Specific penalties can be found in the applicable Bridges Eligibility Manual (BEM) and BAM items.

FIP and SDA Only

Begin program closure due to inability to determine continued eligibility when notified by a QC auditor of a group member's failure to cooperate with a QC review.

MA Only

Refusal to provide necessary eligibility information or to cooperate with a QC review results in ineligibility for:

- The person about whom information is refused, **and**
- That person's spouse if living in the home, **and**
- That person's unmarried children under 18 living in the home.

Note: Failure to cooperate with Social Security numbers (BEM 223), Child Support (BEM 255) or Third Party Resource Liability (BEM 257) requirements might disqualify a person but is **not** a refusal of necessary eligibility information.

FAP Only

Close the program when notified by a QC auditor that the group failed to cooperate with a QC review. The auditor recommends closure on a DHS-1599, Quality Control Audit Results Summary, and the specialist receives a copy.

The group is ineligible until after the date shown on the summary attached to the DHS-1599 **or** until the group cooperates with the auditor, whichever occurs first.

Note: The date shown is 95 days from the end of the QC review period in which the program was scheduled for review.

Hearing Request

Delete the closure pending a hearing decision if the group requests a hearing during the pended negative action period to contest the auditor's finding of noncooperation.

Attempt to resolve the issue prior to the hearing; see **LOCAL OFFICE REVIEW** in BAM 600:

- If the group agrees to cooperate with the QC review and withdraws the hearing request, notify the auditor by telephone and follow-up memo.

- If the issue remains unresolved, request the auditor's attendance at the hearing to provide evidence.

Note: The location of QC auditors is available through the Office of Quality Assurance in the central office.

Cooperation During Ineligibility

If the FAP group agrees to cooperate with the QC review during the ineligibility period, notify the auditor by telephone and follow-up memo. Accept and process the group's reapplication when notified of the audit findings.

Application After Ineligibility

If the ineligibility period ends without the FAP group's cooperation in the QC review, the group may reapply. However, **all** eligibility requirements must be verified, including those which are not routinely verified.

Note: This also applies to expedited FAP applications.

Responsibility to Report Changes

FIP, SDA, RCA, MA and FAP

This section applies to all groups **except** most FAP groups with earnings; see BAM 200, **Food Assistance Simplified Reporting**.

Clients must report changes in circumstance that potentially affect eligibility or benefit amount. Changes must be reported within 10 days of receiving the first payment reflecting the change.

Income reporting requirements are limited to the following:

- Earned income:
  - Starting or stopping employment.
  - Changing employers.
  - Change in rate of pay.
  - Change in work hours of more than five hours per week that is expected to continue for more than one month.
- Unearned income:

- Starting or stopping a source of unearned income.
- Change in gross monthly income of more than $50 since the last reported change.

Exception #1: For Medicaid, clients must report a change in gross monthly income of more than $25 since the last reported change.

Exception #2: Only certain changes affect eligibility for Children Under 19 (U19) prior to renewal of benefits.

See BAM 220 for processing reported changes.

Other changes must be reported within 10 days after the client is aware of them. These include, but are **not** limited to, changes in:

- Persons in the home.
- Marital status.
- Address and shelter cost changes that result from the move.
- Vehicles.
- Assets.
- Child support expenses paid.
- Health or hospital coverage and premiums.
- Child care needs or providers.

Exception: For FIP only, a parent or other FIP caretaker must notify the department of a child's absence from the home within **five** days of the date it becomes clear to the caretaker that the child will be absent for 30 days or more and does not meet temporary absence requirements.

For FAP only, see BEM 554, Estimated Medical Expenses, for reporting requirements of medical expenses.

For Time-Limited Food Assistance (TLFA) only, the client must report to the specialist any month the work requirement is not fulfilled.

Explain reporting requirements to all clients at application, redetermination and when discussing changes in circumstances.

Changes may be reported in person, by mail or by telephone. The DHS-2240, Change Report Form, may be used by clients to report changes. However, it is **not** mandatory that changes be reported on the DHS-2240. Changes must be reported timely even if the client does not have a DHS-2240.

Give or send the client a DHS-2240:

- At application (Bridges automatically sends at certification).
- At redetermination (Bridges automatically sends at certification).
- Whenever it seems appropriate given the case circumstances.
- Upon the client's request.
- Whenever a DHS-2240 is returned.

Exception: Do not give or send a DHS-2240, Change Report Form, to FAP groups assigned to simplified reporting, or any MA only client.

CDC Only

Within 10 calendar days of the occurrence, clients are required to report changes in:

- Group composition/death.
- Out of state residency.
- Providers or child care setting.
- When income exceeds the eligibility income scale in RFT 270 for the group size.

Verifications

All Programs

Clients must take actions within their ability to obtain verifications. MDHHS staff must assist when necessary; see BAM 130 and BEM 702.

LOCAL OFFICE RESPONSIBILITIES

All Programs

Ensure client rights described in this item are honored and that client responsibilities are explained in understandable terms. Clients are to be treated with dignity and respect by all MDHHS employees.

Informing the Client

All Programs

Inform people who inquire about:

- The MDHHS programs available, including domestic violence comprehensive services.
- Their right to apply.

Provide specific eligibility information on all programs in which they are interested. The DHS-1171, Assistance Application Information Booklet, contains information about programs, services, rights and responsibilities.

The local office is **not** expected to:

- Provide estate planning advice.
- Provide funeral planning advice.
- Determine the effect on eligibility of proposed financial arrangements such as a proposed trust.

See BEM 100 regarding public access to policy information.

FIP Only

Inform clients of the various options (if applicable) to qualify for FIP and the right to select the most beneficial option. In FIP, this is usually the option that results in the largest cash grant; see BEM 210.

MA Only

The requirement to provide specific eligibility information is satisfied by the eligibility information on the application form.

Clients who qualify under more than one MA category have the right to choose the most beneficial category; see BEM 105.

FAP Only

Local offices must prominently display the following posters:

- DHS Pub. 521, Your Rights and Responsibilities in the Food Assistance Program.
- DHS Pub. 716, Expedited Food Assistance Benefits.

- DHS Pub. 765, Right to Apply.
- Pub. AD475B, And Justice for All.
- DHS Pub. 788, Home Heating Credit Notice.

Note: While not mandatory, many of these posters are also available in other languages. Local offices are expected to display these versions as well as the mandatory English version.

Assisting the Client

All Programs

The local office must assist clients who ask for help in completing forms, gathering verifications, and/or understanding written correspondence sent from the department. Particular sensitivity must be shown to clients who are illiterate, disabled or **not** fluent in English.

Note: If such assistance requires interpreter services and the local office is unable to identify an interpreter service provider please escalate the request to your county's Business Service Center and they will provide guidance on how to assist the client.

The poster, DHS Publication 478, Help Is Available, must be displayed in the local office lobby. A section of the application form has the same title and information. These documents tell clients that MDHHS must help persons fill out the application when requested.

Interpretation

The department will provide appropriate interpreters to persons with limited English proficiency (LEP) to afford such persons an equal opportunity to participate in or benefit from MDHHS programs and services. The department and its contracted service providers will take reasonable steps to provide services and information in appropriate languages to ensure that LEP individuals are effectively informed, notified of their rights and responsibilities and can effectively participate in and benefit from MDHHS programs, services and activities.

The provisions described in this policy apply to all MDHHS programs, contract service providers, and sub-recipients who provide direct services to MDHHS clients. Language interpreters

will be available for use by clients and applicants in each phase of the service delivery process (for example, telephone inquiries, intake interviews, service delivery, complaints, etc.)

Use of Interpreters

The following procedures are to be followed by employees, contracted service providers, and sub-recipients to ensure accessibility of programs and services to clients or applicants with LEP:

- Assess the need for an interpreter and client's preferred language or method of communication from the application, client statement, family members or other representative.
- Interpreters will be provided within two days of a request or as otherwise required. Delaying services may not always be practical or appropriate; therefore, provision will be made when advance notice for an auxiliary aid or interpreter is not given. Client files must be documented to indicate if an interpreter is needed. If so documented, the department or provider will arrange to have the interpreter available for all scheduled appointments. When the department refers a LEP client to a service provider, the department will notify the service provider that an interpreter is needed.
- Record the need for special language accommodations and the applicant’s primary spoken and written language on the Household Information screen in Bridges.

A client who needs a bilingual interpreter must be informed that he may choose one of the following:

- Arrangements for an interpreter by MDHHS, including payment of any costs.
- Use of his or her own adult interpreter.

Note: While MDHHS should honor client preference, MDHHS staff can and should use discretion and evaluate the appropriateness of using the family member or other client selection. MDHHS staff should consider the individual's competency for interpretation, potential conflict of interest, confidentiality, and any potential signs of coercion or control over the client by the individual providing interpretation.

Minor children should never be used as interpreters.

If the client does **not** identify his or her own interpreter, select one of the options, in the following order of preference as available, and inform the client of the selection:

- MDHHS staff person.

  Note: Clients **cannot** decline the use of such an interpreter if they do not select their own.

- Face-to-face community agency staff or other volunteer.
- Telephone interpreter services should be used as a last resort when face-to-face interpretation is not available, or for an infrequently encountered language.

Competency of Interpreters

Certification of interpreters is not required; however, competency requires demonstrated proficiency in both English and the other language, fundamental knowledge in both languages of any specialized terms, or concepts unique to the program or activity being interpreted, sensitivity to the LEP person's culture, and a demonstrated ability to convey information in both languages accurately. Training in ethics of interpretation is preferred, but interpreters should at least demonstrate an understanding of the ethics of interpreting and confidentiality responsibilities.

Note: These competency expectations apply to all potential interpreters, including MDHHS staff members who are utilized as interpreters.

Payment for Interpreters

If a MDHHS staff person is not available to interpret and the client declines the use of a volunteer, select one of the following:

- Contractual provider of interpreter services.
- Interpreter hired on an as-needed basis.

The client or applicant will not be responsible for any costs associated with interpretation or translation. MDHHS or service provider officials, with budget approval, have the responsibility for approving contracted or purchased interpretation and translation services.

Information regarding bilingual interpreter services with payment procedures for non-contractual interpreters can be found in the Administrative Policy Manual for Hostipals/Facilities, APF-113, Interpreter/Trnslator Services, located on the MDHHSs internet Inside MDHHS/Policy and Planning/Policy Manual or on the MDHHS Public site at MDHHS Internet/Inside MDHHS/Legal/Equal Opportunity & Diversity.

Documentation of Interpretation and Translation

Document translation/interpretation assistance provided to a client on the DHS-848, Certification of Translation/Interpretation for Non-English Speaking Applicants or Recipients.

Note: If interpretation is provided over the phone, document this information on the interpreter's signature line of the DHS-848. If both client and interpreter are on the phone, acquire signatures on the DHS-848 via fax or email.

Interpreters for Persons Who are Deaf

Information on obtaining qualified interpreters for people who are deaf is found on the MDHHS Public site at MDHHS Internet/Inside MDHHS/Legal/Equal Opportunity & Diversity.

Determining Eligibility

All Programs

Determine eligibility and benefit amounts for all requested programs. Supplemental Security Income (SSI) recipients, title IV-E recipients, special needs adoption assistance recipients, and department wards are automatically eligible for current MA; see BEM 117 and 150.

Review the effect on eligibility whenever the client reports a change in circumstances. Actions must be completed within the time period specified in BAM 220.

At application and redetermination, thoroughly review all eligibility factors in the case.

At application, redetermination, semi-annual contact and mid-cert contact, check **all** available automated systems matches to see if income has started, stopped, or changed (for example: consolidated inquiry (CI), SOLQ, etc.).

Note: The Work Number is **not** an automated system match which must be checked at application, redetermination, semi-annual or mid-certification contact. The client has primary responsibility for obtaining verification. However, if, for example, verification of income is not available because the employer uses the Work Number and won't provide the employment information, it is appropriate to use the Work Number.

Do not deny or terminate assistance because an employer or other source refuses to verify income; see BAM 130, **VERIFICATION AND COLLATERAL CONTACTS** and BEM 702, **Child Development and Care (CDC) VERIFICATIONS**.

Do not check automated systems matches for the program Children Under 19 (U19). Refer to the MAGI manual for information on any MAGI-related category.

CDC Only

It is required that the Michigan Works! Management Information System, (MIS), be checked for approved hours of participation at application and redetermination.

Application and redeterminations must be completed within the standards of promptness; see BAM 115 and BAM 210.

Bridges records and documents each eligibility determination for which there is a certified approval or denial on the Bridges certification screen. Upon certification, Bridges automatically sends a notice of case action, informing the client of the decision.

Initial Asset Assessment

MA Only

Process the DHS-4574-B, Assets Declaration, for the initial asset assessment. The client must verify the value of the couple's assets. Notify the client and spouse of the initial asset assessment results; see BEM 402.

Case actions must be completed within the standard of promptness; see BAM 115.

Required Actions When Closing FIP/RCA/SDA

FIP, RCA and SDA Only

When FIP, RCA or SDA closes due to ineligibility (other than death or inability to locate), the client might remain eligible for MA and/or FAP.

Bridges automatically determines if MA eligibility exists under any other MA category before terminating MA and displays the results on the eligibility summary screen.

Bridges will **not** cancel FAP benefits or shorten the FAP benefit period **solely** because FIP/RCA/SDA closes due to failure to cooperate in the review process. Unless otherwise ineligible, FAP continues until the benefit period expires; see BAM 210.

LEGAL BASE

FIP

P.A. 280 of 1939, as amended
Mich Admin Code, 1997 AACS
R 400.3101 - R 400.3131

SDA

Mich Admin Code, R 400.3151 - R 400.3180
Annual Appropriations Act

CDC

Child Care and Development Block Grant of 1990, as amended, Public Act 6 of 2015.
45 CFR Parts 98 and 99
Social Security Act, as amended, Titles IV A, IV E, XX
Mich Admin Code, R 400.5001 - 400.5020

MA

42 CFR 431, 435
MCL 400.60(2)

The Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L-111-152).

FAP

7 CFR 271.6(a)
7 CFR 272.6(a), (b)
7 CFR 273.2(d)
7 CFR 275.12(g)
Mich Admin Code, 1997 AACS
R 400.3001 - R 400.3015

RCA

45 CFR 400.65 - 400.69

RMA

45 CFR 400.90 - 400.107

DEPARTMENT POLICY

Request for Assistance

Family Independence Program (FIP), Refugee Cash Assistance (RCA)**, State Disability Assistance (SDA), Child Development and Care (CDC), Medicaid (MA), Food Assistance (FAP)**

A request for assistance may be in person, by mail, telephone, email or online. The requester has the right to receive the appropriate application form:

- DHS-1171, Assistance Application (all programs except Medicaid). The DHS-1171 packet includes an information booklet and the assistance application. A filing form used to preserve the application filing date is available in the DHS-1171 packet and online at www.michigan.gov/dhs-forms.

  Note: A MI Bridges online application is considered the same as the DHS-1171.

- MDE-4583, Child Development and Care (CDC) Program Application.

- DCH-1426, Application for Health Coverage & Help Paying Costs (all Medicaid categories). Brochures are available on the DCH website at www.michigan.gov/mdch. Select MDCH Brochures Available for Download from the Quick Links in the right navigation.

- DHS-4574, Medicaid Application for Nursing Facility Patients, Long Term Care residents only.

- DHS-1514, State Emergency Relief Application.

Note: Local offices must assist clients who need and request help to complete the application forms; see Bridges Administrative Manual (BAM) 115, Application Processing.

Response to Requests

All Programs

For a **request in person**, the local office must do all of the following:

- Give the requester an application the **same day.**
- Explain the right to file the application (or DHS-1171 Filing Form, with the minimum information) **that day** and encourage the client to do so.
- Explain that the application date might affect the amount of benefits.

Encourage the person to complete the entire application that day. Persons who cannot complete the entire application should complete the DHS-1171, Filing Form, to protect their application date. BAM 105 lists the minimum information to file an application. A DHS-1171, Filing Form is not acceptable for Medicaid.

For a **request by letter or telephone,** mail the application by the end of the **next workday**. If the application is **not** returned, the requester must be contacted according to local office procedures.

Applicants must be informed of their option to obtain a DHS-1171, Assistance Application, which includes a filing form, at the following web site: www.michigan.gov/dhs-forms.

Note: Local offices may register requests for assistance on Bridges; see the REQUESTS section in this item. The applicant may withdraw the request for assistance at any time.

CDC Only

For a **request in person**, the local office must:

- Give the client the following forms:
  - A MDE-4583, Child Development and Care (CDC) Program Application, or a DHS-1171, Assistance Application.
  - A DHS-4025, Child Care Provider Verification.

Explain that the application receipt date will affect the effective date of eligibility for CDC and encourage the requestor to file the application that day.

For a **request by letter or telephone**, mail the application and the above forms to the requester by the end of the **next workday**.

Note: If a client has a completed, pending DHS-1171 or MI Bridges application for another program and verbally requests CDC benefits, document the case and send a DHS-3503, Verification Check List, for the additional required verifications. The CDC application date will be the date the CDC program was requested.

Medicaid Only

Receipt of a completed MSA-2565-C, Facility Admission Notice, serves as a **request** for MA for all persons except:

- Automatically eligible newborns; see Bridges Eligibility Manual, (BEM) 145.
- Active MA beneficiaries.
- Pending MA or FIP applicants.

All other requests must be registered and the client must be sent the following:

- DHS-126, Medicaid Application Inquiry.
- The DCH-1426, DHS- 4574 and the DHS- 3243 if necessary.
- MSA Pub. 726, Nursing Facility Eligibility (if LTC admission).

The following publications must be given or sent to MA applicants and other interested parties:

- MDCH Pub. A Guide to Michigan Medicaid Health Plans.
- DCH Pub. 617, Medicaid Deductible Information.
- MSA Pub. 726, Nursing Facility Eligibility.
- MDCH Pub. 769, Medicare Savings Program.

For Medicaid brochures from the Michigan Department of Community Health, select Medicaid and Health Brochures from the list on the DCH website.

APPLICATION

All Programs, except Medicaid

The DHS-1171 is used for most applications and may also be used for redeterminations; see Redeterminations in this item. The assistance application is available on the www.michigan.gov/dhs-forms website.

CDC Only

The MDE-4583, the DHS-1171 or the MI Bridges application may be used to apply for CDC.

Medicaid

The DCH-1426 may be used for all MA categories. In addition, the following application may be used for LTC residents, DHS-4574, Medicaid Application for Nursing Facility Patients.

The following persons are **automatically eligible** without completing an application:

- Department wards; see BEM 117.
- Title IV-E recipients; see BEM 117.
- Special Needs Adoption Assistance Agreement recipients; see BEM 117.
- Newborns of MA beneficiaries; see BEM 145.

Retro MA Applications

Medicaid Only

The DHS-3243, Retroactive Medicaid Application, is used **along with** the DHS-4574 or DCH-1426 for retro MA applications. Only one DHS-3243 is needed to apply for one, two or three retro MA months; see RETRO MA APPLICATIONS in BAM 115.

Who May Apply

All Programs

Any person, regardless of age, or his/her authorized representative (AR) may apply for assistance. For **FAP only**, an AR must apply on

behalf of certain clients; see the **AUTHORIZED REPRESENTATIVES** section below.

Date of Application

All Programs

Paper Applications

The date of application is the date the local office receives the required minimum information on an application or the filing form. Record the date of application on the application or filing form.

The date of application does **not** change for FIP, SDA, MA, or CDC when the application is transferred to another local office.

FAP Only

See the **WHERE TO APPLY/PROCESS APPLICATIONS** section in this item.

Electronically Filed Applications

All Programs

Electronically filed applications include all applications filed online in MI Bridges, faxed, or emailed.

FIP, SDA, RCA, CDC, FAP

If the application is filed electronically after close of business (such as weekends, holidays, or after 5 p.m. EST on business days), the date of application is the following business day.

Medicaid Only

For applications filed electronically, the date of the application is the submission date regardless of the time received.

Date of Application for Member Add

FIP Only

The date of application or online change request for a member add depends on whether the member being added is a mandatory, optional, or disqualified member. See BAM 115, Interview, for when an in-person interview is required.

- **Mandatory Group Members** - The date of application or online change request is the date the person updates or completes the application form to request assistance; see Date of Application in this item. Conduct a telephone or in-person interview with the adult member add. Update, document and answer all questions on the application form to provide the information necessary to determine eligibility. The specialist must ask when the person joined the group and document the date on the application. Have the adult mandatory group member sign the DHS-1173, Cash Assistance Rights and Responsibilities, **and** DHS-1538, Work and Self-Sufficiency Rules. Do **not** approve eligibility until the DHS-1173 **and** DHS-1538 are signed. See BAM 115, Interviews, for when an in-person interview is required.

  Exception: For dependent child member adds, obtain the information needed to determine eligibility and document the case record. The client need not sign the updated application.

- **Optional Group Members** - The date of application or online change request is the date the person updates or completes the application form to request assistance; see Date of Application in this item. If the optional adult group member requests FIP, the DHS-1173 **and** DHS-1538 must be signed **and** returned before eligibility can be approved.

- **Disqualified Group Members** - The date of application or online change request is the date the person meets the eligibility factor or agrees to cooperate, provided they subsequently cooperate with the requirement that caused the disqualification; see Date of Application in this item. A disqualified person remains a member of the applicant group during the disqualification period. Do **not** approve eligibility of the disqualified adult group member until the DHS-1173 **and** DHS-1538 are signed **and** returned.

  Exception: An individual disqualified for alien status does not require a signed DHS-1538.

SDA Only

The date of application or online change request for a member add depends on whether the member being added is a mandatory or disqualified member.

- **Mandatory Group Members** - The date of application or online change request is the date the person updates or completes the application form to request assistance; see Date of Application in this item. Conduct an in-person interview with the adult member add and update and complete the application to provide the information necessary to determine eligibility. Ask when the person joined the group and document the date on the application. Have the adult mandatory group member sign the DHS-1171 **or** DHS-1173. Do **not** approve eligibility until the DHS-1171 **or** the DHS-1173 are signed.

- **Disqualified Group Members** - The date of application or online change request is the date the individual meets the eligibility factor or agrees to cooperate, provided the individual subsequently cooperates with the requirement that caused the disqualification; see **Date of Application** in this item. A disqualified individual remains a member of the applicant group during the disqualification period. Do **not** certify eligibility of the disqualified adult group member until the DHS-1171 **or** DHS-1173 are signed.

CDC Only

See BAM 220 for CDC member adds.

Medicaid Only

The date of application for a member add is either the date the application form is updated and re-signed in the local office, the date the new application form is received by the local office, or the date the online request is submitted.

FAP Only

See BEM 550 for member add policy.

Response to Applications

All Programs

An application or filing form, with the minimum information, must be registered on Bridges **unless** the client is already active for that program(s); see **REGISTERING APPLICATIONS** in this item.

If there is no record on Bridges, the system assigns individual ID number(s) and an application number.

Note: A person may withdraw an application at any time before it is disposed on Bridges; see **WITHDRAWN APPLICATION** in this item.

DHS Pub. 280, Reporting Changes - When To Report - How To Report - What To Report, describes the client reporting responsibilities. This publication must be given to the client at application.

Multiple Applications

FIP, SDA, RCA, CDC and FAP

When an application is pending and additional application(s) are received prior to certification of the initial application, do **not** automatically deny the application(s). Do the following:

- Review the information for impact on eligibility and benefit level.
- Ensure the case record is documented with the additional application(s) received and note the application(s) used to determine eligibility and/or benefit levels.
- Attach the additional application(s) to the initial application.

When the case is already active for program benefits and additional application(s) are received, the specialist **must** review the application for changes in circumstances. Additionally, the specialist **must** either complete a redetermination or deny the programs requested since they are already active.

SDA Only

Do **not** process an SDA application as interim assistance for a client with an application pending for FIP.

FAP Only

The local office must screen applications to identify those requiring expedited service at the time the household requests assistance. Information to identify those cases is provided on the assistance application.

SSI applicants and recipients may apply for FAP benefits at the Social Security Administration district office; see BAM 116. The local office must register the application upon receipt, using the procedures in BAM 116.

AUTHORIZED REPRESENTATIVES

All Programs

An authorized representative (AR) is a person who applies for assistance on behalf of the client and/or otherwise acts on his behalf (for example, to obtain FAP benefits for the group).

Note: An AR is **not** the same as an Authorized Hearings Representative (AHR); see the Bridges Policy Glossary (BPG) for hearings policy definition.

When no one in the group is able to make application for program benefits, any group member capable of understanding AR responsibilities may designate the AR.

The AR assumes all the responsibilities of a client; see BAM 105.

AR's must give their name, address, and title or relationship to the client. To establish the client's eligibility, they must be familiar enough with the circumstances to complete the application, answer interview questions, and collect needed verifications.

Note: For FAP, if an AR applies on the group's behalf, verification of identity is required for both the AR and the head of household.

WHO MAY BE AN AUTHORIZED REPRESENTATIVE (AR)

FIP, CDC and SDA

An AR must be at least age 18. The person is usually a guardian, spouse or relative outside the group.

Severe physical or mental limitations might prevent a client from applying or designating an AR. An unauthorized person who is otherwise qualified to be an AR may then apply for the client.

MDHHS staff may be authorized or unauthorized representatives for FIP-Foster Care clients **only.**

CDC Only

For CDC the authorized representative **cannot** be the child care provider, a department employee or a recruiter.

FAP Only

An AR who applies on the group's behalf and is a group member may be any age. If outside the group, they must be at least age 18.

Age restrictions do not apply for an AR designated by the group to have access to their FAP benefits to buy the group's food and their own Bridge card.

An AR who applies on the group's behalf and/or has access to the group's FAP benefits must be designated in writing by the client, via the DHS-1171, Assistance Application, and/or DHS-247, Request for Food Stamp Authorized Representative. See the exception for substance abuse center (SATC) residents below.

Ensure that the group is informed of the following:

- Clients or their spouses should prepare or review the application, if possible.
- The group is responsible for incorrect information provided by the AR that results in an overissuance.

Exception: When the AR is an SATC or AFC Home, the facility is responsible for such an overissuance.

Medicaid Only

Application may be made on behalf of a client by his spouse, parent, legal guardian, adult child, stepchild, core relative or any other person provided the person is at least age 18 or married. If this person is not a spouse, parent, legal guardian, adult child, stepchild, or core relative, the person must have authorization to act on behalf of the client, by the client, client's spouse, parent(s) or legal guardian.

The application form must be signed by the client or the individual acting as his authorized representative.

When an assistance application is received in the local office without the applicant's signature or without a signed document authorizing someone to act on the applicant's behalf you must do the following:

- Register the application as a request if it contains a signature.

- Send a DHS-330, Notice of Missing Information, to the individual explaining the need for a valid signature. The signature page of the application may be copied and sent to the agency or individual who filled out the application with the notice.

- Allow 10 days for a response. You cannot deny an application due to incompleteness until 10 calendar days from the date of your initial request in writing to the applicant to complete the application form or supply missing information, or until the initial scheduled interview.

- Record the date the application or filing form with the minimum information is received. The application must be registered and disposed of on Bridges, using the receipt date as the application date.

An application received from an agency is acceptable if it is signed by an individual and is accompanied by written documentation from the individual authorizing the agency to act as the authorized representative.

Note: If unrelated adults living in the same home apply for assistance, neither has the authority to act on the other's behalf without written permission from the applicant.

Authorized Representative

Medicaid Only

An authorized representative must be one of the following:

- An adult child or stepchild.
- A core relative.
- Designated in writing by the individual.
- Court appointed.
  A representative of an institution (such as jail or prison) where the individual is in custody.

Persons Providing Medical Care

Medicaid Only

Persons who provide medical care to the client, or their agents, should **not** act for the client when there is a relative, guardian or friend who is willing and able to act. If a court has appointed a

guardian for a client's estate (such as income and assets), the guardian is usually expected to act for the client.

Exception: An application may be made for newborns surrendered under the Safe Delivery Law, (MCL 712.1-712.20) by the provider hospital, child-placing agency, court appointed lawyer-guardian ad litem or prospective adoptive parent.

A department employee may apply on behalf of a member of the employee's family or a child committed to, or placed with, the department by court order.

Note: An authorization to represent is a form of a power of attorney. When a person who gave the authorization dies, the power of attorney ends. After death, the person does not exist as a legal entity, so no one can represent the person. However, if a person dies while the application is pending, the application should be processed.

An estate may be created to handle the remaining business and financial issues that were outstanding at the time of death. Only a probate court can create a decedent's estate. The court will also appoint someone to act as a representative of the estate.

A court, agency or guardian **legally** responsible for a client must be identified as an authorized representative (AR) by Type on Bridges.

AR - SPECIALIZED SITUATIONS

Substance Abuse Treatment Center (SATC)

FAP Only

An SATC resident must be represented by the center. The SATC designates a responsible staff member as the AR.

Residents should assist their AR to complete the application, and **both must sign it**.

Adult Foster Care (AFC) Home

FAP Only

AFC residents with a guardian who has legal control over their finances or protective payee must apply through that person, **unless** the guardian/payee requests in writing that the home act as the AR.

The AFC home determines which other residents are capable of applying on their own. Such a resident may apply individually or as part of a group of residents. The resident may submit the application in one of the following ways:

- Personally/in person**.**
- Through an AR they choose**.**
- Through an AR employed by and designated by the home.

Note: An AFC home may have some residents apply in groups and others as individuals.

Restrictions on AR Appointments

FAP Only

A provider of meals for the homeless **cannot** be authorized to represent them.

A person disqualified due to Intentional Program Violation **cannot** be an AR **unless** there is no responsible group member or anyone else available.

Medical Information Acknowledgment

All Programs

When the AR completes the application, give or send the client a DHS-4609, Medical Information Acknowledgment, to sign. The DHS-4609 tells the client that MDHHS may share medical information for purposes of eligibility determination and program administration.

If clients are unable to sign the DHS-4609 **and** their condition is such that medical information might need to be shared, refer the AR to Adult Services.

Note: If the form remains unsigned, there is no penalty and eligibility determinations must not be delayed.

OTHER AUTHORIZED REPRESENTATIVE FUNCTIONS

FAP Only

An AR may make food purchases from the FAP benefits account using the Bridge card. There is no age requirement for the AR who uses the group's FAP benefits on behalf of the group.

Note: This can be a different person than the AR who applies for benefits on the group's behalf.

Enter on the Alternate Payee/Authorized Representative screen in Bridges the name of the person who is authorized to purchase food for the group and indicate the Type of Authorized Representative. The authorized representative's name will appear on the Bridge card followed by Food Stamp Authorized Representative (FSAR)**.**

DOCUMENTATION AND CONTROL

FAP Only

The name of every AR must be in the group's case file.

Ensure that a person who purchases food for the group is properly designated on the current DHS-1171, Assistance Application. Grantees can call the Automated Response Unit (ARU) to terminate an FSAR's access. However, grantees must contact the Family Independent Specialist/Eligibility Specialist (FIS/ES) to request a new FSAR. Ask the caller a question only the grantee could answer to ensure the request is valid and document the case record.

Enter the new FSAR on the Alternate Payee/Authorized Representative screen in Bridges and mail a DHS-247, Electronic Benefit Transfer (EBT) Food Stamp Authorized Representative form, to the client for completion and return; see BAM 401E.

A person may represent any number of groups. When one person (such as an employer of migrants) represents numerous clients or has access to large amounts of food assistance benefits, use caution to ensure the following:

- The group freely requested the AR.
- The group's circumstances are correctly represented.
- The group is receiving the correct amount of benefits.
- The AR is using the food assistance benefits properly.

DISQUALIFICATION OF AN AUTHORIZED REPRESENTATIVE

FAP Only

The Office of Inspector General (OIG) determines when an authorized representative should be disqualified; see BAM 720. Upon notification from OIG disqualify the AR from that role for up to one year if the AR does one of the following:

- Misrepresents the group's circumstances by giving false information.

- Improperly uses the group's FAP. The disqualification begins 30 days after the client is notified (see below).

Exception: The disqualification does not apply to an SATC or AFC home acting as AR. Report such acts by a facility representative to the Office of Inspector General.

Send a DHS-176, Client Notice, to the group(s) **and** the AR, specifying:

- The proposed action.
- The reason for the proposed action.
- The group's right to request a hearing.
- The name and telephone number of a local office contact person for more information.

WHERE TO APPLY/ PROCESS APPLICATIONS

FIP, SDA, RCA and CDC

A person may request or apply for assistance electronically or in any local office in Michigan. The application must be processed by

a local office serving the county or district where the person lives or is institutionalized.

Exceptions:

- For SDA only, an application received online or in the local office must be processed by the local office.
- For RCA only, an application received online or in the local office must be processed by the local office.
- A person who lives in a county participating in the Transparent County Line project may apply and have his/her application processed by any county that is also participating in the Transparent County Line project.
- For MA only, see BAM 120, MDHHS Coordination.
- For MA only, see Transfers**: Prohibited Transfers and Transfer Guidelines** in BAM 305 for exceptions to transferring cases.
- For MA, applications from incarcerated individuals should be processed and maintained in the local office in which the individual lived prior to the incarceration.
- For an SDA applicant in a special living arrangement (SLA), there are specific processing responsibilities; see DEPARTMENT POLICY in BEM 616.
- In Wayne County, specialized districts process applications for individuals in supervised settings, or living arrangements, including:
  - Adult and children's foster care.
  - Nursing homes.
  - Hospitals.
  - Youth residential placements.

  Separate adult medical districts and child and family districts serve these special client populations.
- In Oakland and Wayne counties, specialized districts process applications for refugee individuals and families.
- An application for a person living in another state must be processed by the local office that receives it.

If a client contacts a local office in error:

- Give or send the client an application and the address and phone number of the correct office.
- If the client chooses to complete the application and turns it in at an office which will not be processing the application, do the following:
  - Accept and register it as an application or request as appropriate.
  - Mail it promptly to the correct office so the transfer-in office may act within the standard of promptness; see BAM 115.

Medicaid Only

A Medicaid application can be processed by the local office serving the client or the authorized representative.

MA applications for incarcerated individuals must be handled by the county of residence prior to incarceration.

Under 19 Medicaid

A person may request or apply for the Under 19 MA categories at:

- Any local MDHHS office in Michigan.
- Any local health department.
- Any other MDHHS authorized contract agencies.

FAP Only

The application must be processed by a local office serving the county or district where the group lives.

Exceptions:

- Clients who apply online may have their FAP application processed by any Self-Service Processing Center regardless of the county in which they live.
- In Oakland and Wayne counties, specialized districts process FAP applications for refugee individuals and families.

For application filing purposes, persons who are county residents when physically present in a county include:

- Students either attending school or living at home during a school break.
- Elderly persons living with others for part of the year.
- Persons who are working or seeking work.

If clients contact local office in error, do the following:

- Give or send them an application and the address and phone number of the correct office.
- Inform them that the processing time begins when the correct office receives the application.
- If they choose to complete the application and turn it in at your office, accept it, and mail it the same day to the correct office.

Exception: Individuals who live in a county participating in the Transparent County Line Project may apply and have their application processed by any county that is also participating in this project.

WITHDRAWN APPLICATION

All Programs

A client/AR may withdraw the application any time before it is disposed on Bridges. However, if clients have an AR, they must first revoke the AR's authorization to represent them before the clients may withdraw the application. The signature of the AR is not required. Document the withdrawal request in Bridges.

To confirm it, Bridges will automatically generate a notice of case action to the client. The client may reapply any time.

REGISTRATION

All Programs

All applications, redeterminations, referrals, initial asset assessments, member adds and program adds must be registered on Bridges.

REQUESTS

All Programs

Requests for assistance may be oral or written. Those containing enough identifying information may be registered.

Medicaid only

A completed MSA-2565-C, Facility Admission Notice, is a request for MA and must be registered.

Exception: Do **not** register the MSA-2565-C as a request if the person is one of the following:

- An automatically eligible newborn; see BEM 145.
- An active MA beneficiary.
- A pending MA or FIP applicant.

INITIAL ASSET ASSESSMENTS

MA Only

Register an initial asset assessment upon receipt of a signed DHS-4574-B, Assets Declaration.

REGISTERING APPLICATIONS

All Programs

Register a signed application or filing form, with the minimum information, within **one workday** for all requested programs.

See Right To Apply in the CLIENT RIGHTS section in BAM 105 for the minimum information necessary to register an application.

All department programs are registered using the registration functions on Bridges including Direct Support Services and SER.

When registering an application with minimum information, use judgment to code race and sex. The assigned specialist must update the coding, if necessary, when the application is completed.

Note: For FAP and CDC only, select **unknown** when the client chooses not to declare his/her ethnicity and/or race. If an in-person interview is held with the client, use judgment to choose an ethnicity/race for the client.

CDC, MA and FAP

A photocopy or fax of an application or the filing form is acceptable.

FIP, SDA, and RCA Only

Treat a fax of an application or filing form as an incomplete application. However, the original signed application must be received by MDHHS before benefits are approved.

FAP Only

Register joint applications received from the Social Security Administration following normal registration procedures; register all programs the client has checked on page 1. Bridges screens for expedited processing of all FAP applications; see BAM 116 for SSI/FAP Joint Application Processing.

REDETERMINATIONS

Record the receipt of a signed DHS-1010, Redetermination Form, in Bridges. The DHS-1010 receipt date is the date the signed form is received in the local office.

FAP Only

If an **untimely** redetermination application (see BAM 210) is the client's fault, record receipt of the redetermination packet as described above and document client fault in Bridges. The standard of promptness is extended 30 days when the household/client is at fault.

A photocopy or fax of a DHS-1171, DHS-1010 or the DHS-1046 is acceptable.

MEMBER ADD

All Programs

All individuals in a household must be identified and included in the household. Complete an *Add Member* case action on Bridges for all individuals who move into a household to add them to the existing household and eligibility determination groups (EDGs).

Use the *Add Member* case action to add a new member to existing EDGs and to request assistance in the appropriate group(s) for the new member.

Example: Joan and son, Todd, receive FIP and FAP. Joan's cousin, Polly, moves in and will be purchasing and preparing food with them.

Process an *Add Member* case action to add Polly. On the Program Request screen, indicate that she is requesting benefits on Joan's FAP EDG but **not** on Joan's FIP EDG.

Bridges will show Polly's Status for the FAP EDG as Requesting and Not Requesting for the FIP EDG.

ADD A PROGRAM

All Programs

All new applications must be registered. However, once an application for any program is pending or active, use the *Add Program* case action in Bridges to add an additional program(s) to the existing case.

Example: The applicant/grantee has a gas shut-off notice and brings it in shortly after the specialist disposed the application. The head of household states they need help with the bill. Use the *Add Program* case action to add SER to the head of household's case.

Bridges records the SER application, using the new application date entered for the program being added.

REINSTATEMENTS

All Programs

Reinstatements are **not** registered in the *Registration* function. Record reinstatements on Bridges using the *Reinstatement* case action if all programs were closed on the case. Use the *Case Change* case action if any program is still active on the case.

An application is **not** required.

REGISTRATION DISPOSITION

All Programs

All denials, including withdrawals, are recorded in Bridges.

An application or initial asset assessment pends in Bridges until eligibility determination and benefit calculation (EDBC) is run and the results are certified. Dispose of applications and initial asset assessments within the standard of promptness (SOP).

BAM 115 has SOP timeframes. Certifying eligibility results automatically disposes an application.

Note: Report MH-132, Worker Registration Report, shows SOP data based on the Bridges application and disposition dates.

Initial Asset Assessments

Medicaid Only

When processing an initial asset assessment, run EDBC and certify results within **one workday** of completing the initial asset assessment.

Applications

All Programs

When a program is withdrawn, enter the reason on the program request screen in Bridges.

Certifying the eligibility results automatically records the approval, denial or pend (such as waiting for FIP client to attend Partnership. Accountability. Training. Hope. [PATH].) Bridges automatically sends the client a notice of case action upon certification and also sends a DHS-198, Child Development and Care (CDC) Provider Notice, to the client's CDC provider when the provider has been authorized to provide care.

SSI Coordination

MA Only

Most SSI approvals are opened automatically by the State Data Exchange (SDX) system. Those that cannot be opened automatically are opened by the SSI Coordination Unit in central office.

Inquiries regarding SSI openings are handled by the SSI Coordination Unit (517-335-3627 or 517-335-3608).

See BEM 150 for details about handling new SSI transfer-ins.

LEGAL BASE

FIP

45 CFR 206.10(a)(1)(i)(ii)(iii)
MCL 400.25
Social Welfare Act, Act 280 of 1939, 400.1 *et seq.*

CDC

Child Care and Development Block Grant of 1990, as amended, Public Act 6 of 2014
45 CFR Parts 98 and 99
Social Security Act, as amended, Title IV A, IV E, XX
Mich Admin Code, R 400.5001 - 400.5020

RCA

45 CFR 400.65 - 400.69

SDA

Current Annual MDHHS Appropriations Act

MA

42 CFR 435.906-908

The Patient Protection and Affordable Care Act(Pub. L. 111-148) and the health Care and Education Reconciliation Act (Pub. L. 111-152).

FAP

7 CFR 273.2
7 CFR 273.2(n)

DEPARTMENT POLICY

All Programs

Clients must complete and sign one of the following application forms:

- DHS-1171, Assistance Application (all programs except Medicaid).

  Note: A MI Bridges online application is considered the same as the DHS-1171 or a DCH-1426.

- MDE-4583, Child Development and Care (CDC) Program Application.

- DHS-4574, Medicaid Application (patient of nursing facility).

- DHS-4574-B, Assets Declaration (for initial asset assessment); see Bridges Eligibility Manual (BEM) 402.

- DCH-1426, Application for Health Coverage & Help Paying Costs.

Note: If the applicant is applying for Child Development and Care (CDC) only, the MDE-4583, DHS-1171 or MI Bridges application may be used.

Any application or the DHS-1171, Filing Form, with the minimum information, must be registered in Bridges; see BAM 110, Response to Applications.

Following registration of the application, do **all** of the following:

- Interview clients when required by policy; see INTERVIEWS in this item.

- Certify eligibility results for each program within the applicable standard of promptness (SOP); see Standards of Promptness and Processing Delays in this item.

- Bridges automatically generates a client notice informing them of the eligibility decision. Bridges Administrative Manual (BAM) 220 explains the use of client notices.

Helping Clients

All Programs

The local office must assist clients who need and request help to complete the application form.

The time limit to respond to requests for help completing the application form depends on the circumstance:

- For clients in the local office, respond within one workday.
- For clients who send a letter, respond by a return letter or phone call within five workdays.
- For clients who telephone, respond by either of the following:
  - Return phone call within one workday.
  - Send letter within five workdays.

When help **cannot** be provided by phone call or letter within specified time frames, complete a home call within five workdays.

The local office must have designated staff to make home calls to help complete applications in all of the following:

- Sufficient help **cannot** be provided by telephone or letter.
- The client is physically unable to come to the office.
- The client has no one else to help or to come to the office on his/her behalf.

Note: The cover page of Michigan Department of Health & Human Services (MDHHS) application forms advises clients of their right to receive help and includes the phone number of the MDHHS Customer Service Unit (855) 275-6424 to report a refusal of help.

Signature Requirement

All Programs

Before the application or DHS-1171, Filing Form, is registered, it must be signed by the client or authorized representative (AR).

Note: The signature(s) establishes both of the following:

- Client and/or AR understand their rights and responsibilities.

- Client and/or AR prepared the application or filing form truthfully under penalty of perjury.

Medicaid

A DHS-1171, Filing Form, is not used to register a request for assistance.

CDC Only

An applicant who is unable to write may sign with an **X**, witnessed by one other person such as a relative, friend, department specialist etc.

If the DHS-1171 is updated by the client to request CDC, it must be re-signed and dated.

Family Independence Program (FIP), State Disability Assistance (SDA), Refugee Cash Assistance (RCA) and Food Assistance Program (FAP) Only

If an in-person interview is required/held, the client and/or AR must sign and date the application in your presence, **even if** it was already signed. Sign and date the application as a witness; see In-Person Interviews in this item.

FAP Only

If the group does **not** have an adult **or** an AR, a minor group member must sign the application.

FIP Only

If an in-person interview is required (see In-Person Interviews in this item), **all** adult mandatory group members in the home must sign the application in the presence of the specialist if physically able.

If a telephone interview is an option for the group (see In-Person Interviews in this item,) the specialist must do all of the following:

- Send the DHS-1173, Cash Assistance Rights and Responsibilities, to **all** adult mandatory group members in the home that have **not** signed the DHS-1171. Do **not** approve eligibility until the DHS-1173 is signed **and** returned by **all** other adult mandatory group members.

Note: If the application is a MI Bridges online application, the head of household has electronically signed the DHS-1171. All other adult mandatory group members in the home have **not** signed the DHS-1171.

- Send the DHS-1538, Work and Self-Sufficiency Rules, to **all** adult mandatory group members in the home. Do **not** approve eligibility until the DHS-1538 is signed **and** returned by **all** adult mandatory group members.

  Note: If the application is a MI Bridges online application, the head of household has electronically signed the DHS-1538. Do not send the head of household on a MI Bridges application a new DHS-1538 unless requested. **All** other adult mandatory group members in the home have **not** signed the DHS-1538.

- If a DHS-1171, DHS-1173 or DHS-1538 is returned to the DHS office with a signature that is questionable, require the client to re-sign the DHS-1171, DHS-1173 or DHS-1538 in the local office and witness the signature on the required form.

SDA and RCA Only

The client's **spouse and other adult mandatory group members** in the home must sign the application in the presence of a specialist if physically able.

SDA Only: If the SDA application is a MI Bridges online application, the head of household has electronically signed the application. Other adult mandatory group members have **not** signed the application. Require **all** other adult mandatory group members in the home to sign the DHS-1173 in your presence if physically able. Do **not** approve eligibility until the DHS-1173 is signed by **all** other adult mandatory group members.

RCA Only: If the RCA application is a MI Bridges online application, the head of household has electronically signed the application and the DHS-1538. Other adult mandatory group members have **not** signed the application and the DHS-1538. Require **all** other adult mandatory group members in the home to sign the DHS-1173 and the DHS-1538. Do **not** approve eligibility until the DHS-1173 and the DHS-1538 are signed by **all** other adult mandatory group members.

Member Add Signature Requirements

FIP Only

All adult mandatory group member adds must sign and return the DHS-1173 and DHS-1538. Do not approve eligibility of the member add until the DHS-1173 **and** DHS-1538 is signed and returned for **each** adult mandatory group member add.

INCOMPLETE APPLICATIONS

All Programs

An incomplete application contains the minimum information required for registering an application. However, it does not contain enough information to determine eligibility because all required questions are not answered for the program(s) for which the client is applying; see BAM 105.

When an incomplete application is filed, retain the application and give or send the client the DHS-3503, Verification Checklist. Inform the client of the:

- Request for contact to complete missing information.
- Due date for missing information**.**
- Interview date, if applicable.

If an interview is necessary, conduct it on the day of the filing, if possible. Otherwise, schedule it for **no later than 10 calendar days** from the application date.

Application Completed Later

All Programs

When incomplete applications become complete, explain the situation in the case notes section of the application form or in case comments in Bridges.

Example: Incomplete application filed October, 3, 2016; became complete October 17, 2016.

When the applicant or the representative completes a previously incomplete application, the application must be re-signed and re-dated on the signature page.

Bridges retains the original registration date, regardless of how or when the application becomes complete.

Failure to Complete the Application Process

All Programs

Do **not** deny an incomplete application until 10 calendar days from the **later** of either the initial:

- Request in writing to the applicant to complete the application form or supply missing information.
- Scheduled interview.

Exception: For FAP, do **not** deny an application if the client has not participated in the **initial interview** until the **30th** day after the application date **even** if he/she has returned all required verifications. When denying cases on the 30th day, navigate to the *Program Request Details* screen and select *Failed to Attend Food Assistance Intake Interview* as the reason for the denial. The initial interview **must** be scheduled as an in-person appointment, phone appointment or home call.

APPLICATION AFTER DENIAL/ TERMINATION

All Programs

The following applies when an application is denied **or** eligibility is terminated before the month of a scheduled redetermination or end date:

- The application on file remains valid through the last day of the month **after** the month of the denial or termination. To reapply during this time, the client/AR must do all of the following:
  - Update the information on the existing application.
  - Initial and date each page next to the page number to show that it was reviewed.
  - Re-sign and re-date the application on the signature page.

- If eligibility exists, the updated application is valid until the originally scheduled redetermination or end date.

Reminder: An application *cannot* be updated or re-signed outside the local office except as part of a home call.

REINSTATEMENT

All Programs

A new application is **not** required to reinstate eligibility; see BAM 205, REINSTATEMENTS.

WHEN TO USE THE DHS-1171

All Programs, except Medicaid

The DHS-1171, Assistance Application, must be completed:

- When applying for program benefits.
- When case management dictates, such as suspicion of unreported income.

Exception: For CDC, the MDE-4583, may be completed instead of the DHS-1171.

Exception: Medicaid (MA) categories use separate application forms; see WHEN TO USE THE DHS-4574 in this item.

At Initial Application

All Programs

A **separate application** is required for **each group**.

Exception: Only one application form is required when MA groups, even with separate case numbers, live together such, as spouses applying for different MA categories. An application may be photocopied or cross referenced for multiple case files.

An application form is generally valid for 12 months from the date eligibility is initially certified in Bridges.

Exception: For FAP, the period might be fewer or more than 12 months; see Benefit Periods under ELIGIBILITY DECISIONS in this item.

MA Only

A separate application is required for anyone **not** in the home, such as one spouse at home and the other in long term care (LTC).

FAP Only

A group might be ineligible in the month of application but eligible for a future month due to changes in circumstance:

- Use the same DHS-1171 to deny eligibility for the application month and to determine eligibility for later months.
- It is not necessary to interview the group again, **but** Bridges will request any additional needed verification.
- Do **not** deny and re-register the application in Bridges. Certifying approval for the next month disposes of the registration.

At Program Transfer

All Programs

When recipients request benefits they are **not** currently receiving, use the DHS-1171 or DCH-1426 on file **if** it was approved within the last 12 months.

- Update the application and data collection to add or change information to transfer among MA only categories. The client does not have to re-sign the application.
- For other transfers, update the application **and** have it re-signed; see WHEN THE DHS-1171 IS NOT NEEDED in this item. Register the new program using the date the application form was re-signed as the application date.

Eligibility for a new program or MA category is limited to the renewal or end date already in Bridges.

Exception: When an ex parte review of a client's current Medicaid eligibility case file shows the recipient indicated or demonstrated a disability (see glossary), continue Medicaid until information needed to proceed with a disability determination has been requested and reviewed. Continue Medicaid coverage until the review of possible

eligibility under other Medicaid categories has been completed; see BAM 210 and BAM 220

MA Only

A recipient losing Medicaid under a category for which a DCH-1426 is not needed may need to complete a DCH-1426 in order to transfer to another MA category if a DCH- 1426 has not been approved for another program within the past 12 months. Always give the recipient a reasonable opportunity to complete the DCH-1426 and to provide the verification of eligibility under other categories **before** termination of MA; see BAM 220, Case Actions.

Exception: Transitional MA eligibility is 12 months from the date of Low-Income Family (LIF) ineligibility; see BEM 111, Transitional MA.

At Redetermination/ Renewal

FIP, SDA, CDC, SSI-Related MA and FAP Only

A new application, MI Bridges redetermination or DHS-1010, Redetermination, must be completed at each redetermination of eligibility.

Exception: When policy requires a benefit period shorter than 12 months, the DHS-1171, DCH-1426 or DHS-1010 on file may be updated and re-signed if **both** of the following apply:

- The application/redetermination was initially certified within the last 12 months.
- The client is interviewed (if required) and provides any needed verification before redetermination.

MAGI Medicaid

MDHHS must use information currently available in State of Michigan systems to renew eligibility. Do not request information from the beneficiary if the information is already available to MDHHS. This includes completing a renewal form. See BAM 210, Redetermination/Ex parte review/Renewal.

FIP

At redetermination, if an adult mandatory group member is added to the group, send the individual the DHS-1173 **and** DHS-1538. Do **not** approve the redetermination until the DHS-1173 **and** DHS-1538 are signed **and** returned. See additional requirements in BAM 210, Member Add at Redetermination.

WHEN THE DHS-1171 IS NOT NEEDED

CDC Only

The DHS-1171 is not needed when the client is only applying for CDC and has completed a MDE-4583.

WHEN TO USE THE MDE-4583

CDC

The MDE-4583, may be used at any time to request CDC and for CDC redeterminations.

MA Only

No DCH-1426 is required to apply or renew Medicaid or in the following instances:

- Transfers to:
  - Transitional MA; see BEM 111.
  - Special N Support; see BEM 113.
  - Refugee Medical Aid; see BEM 630, REFUGEE ASSISTANCE PROGRAMS.
- Transfers between Medicaid categories; see At Program Transfer, in this item.
- Supplemental Security Income (SSI) recipients.
- **Automatically** eligible newborns; see BEM 145, NEWBORNS. Authorize the newborn's MA as soon as the child's birth is reported. Contact the newborn's mother if there is **not** enough information to obtain a beneficiary ID for the child in Bridges.

- Beneficiaries who complete the, DHS-4574, Patient of Nursing Facility.
- Department wards, Title IV-E recipients and special needs adoption assistance recipients; see BEM 117, DEPARTMENT WARDS, TITLE IV-E AND ADOPTION RECIPIENT.
- Individuals who apply through the Federally Facilitated Marketplace (FFM).

MA Only

Instead of the DCH-1426, the DHS-4574, Medicaid Application (Patient of Nursing Facility), for LTC beneficiaries (do not use for waiver beneficiaries) may be used.

An approved application is current for 12 months from the original disposition date.

RETRO MA APPLICATIONS

MA Only

Retro MA coverage is available back to the first day of the third calendar month prior to:

- The current application for FIP and MA applicants and persons applying to be added to the group.
- The most recent application (**not** renewal) for FIP and MA recipients.
- For SSI, entitlement to SSI.
- For department wards; see BEM 117, DEPARTMENT WARDS, TITLE IV-E AND ADOPTION RECIPIENT, the date MDHHS received the court order for a department ward.
- For Title IV-E and special needs adoption assistance recipients; see BEM 117, DEPARTMENT WARDS, TITLE IV-E AND ADOPTION RECIPIENT, entitlement to title IV-E or special needs adoption assistance.

Exception: Full-coverage QMB eligibility **cannot** be retroactive. ALMB **cannot** be authorized for a previous calendar year; see BEM 165.

Exception: A person might be eligible for one, two or all three retro months, **even if not** currently eligible. The DHS-3243, Retroactive Medicaid Application, is used to apply for retro MA. Only one DHS-3243 is needed to apply for one, two or all three retro MA months. See RETRO MA APPLICATIONS in BAM 110.

Do not request a DHS-3243 if the individual is eligible under Children under 19 (U19), Pregnant Women (PW), or MIChild (MCD) Retro MA Eligibility Requirements.

Eligibility must be made for **each** of the three retro months; see BAM 115 Standard retro MA eligibility requirements.

Children Under 19 (U19), Pregnant Women (PW), MIChild (MCD)

Determine eligibility for the application month first. An individual who is eligible for Children under 19 (U19), Pregnant Women (PW), or MIChild (MCD) for the application month is eligible for retro MA when all of the following conditions are met.

This applies **even if** the retro MA question on the application is not answered or is answered no.

1. The client is eligible for Children under 19 (U19), Pregnant Women (PW), or MIChild (MCD) for the application month.

2. For a pregnant woman, the woman was pregnant or under age 19 for the retro MA month.

3. The person was a Michigan resident. Retro MA **cannot** be approved for a month if you know the person was **not** a Michigan resident for the retro MA month. However, assume a person was a Michigan resident unless you have information to the contrary, such as information on the application indicating the person lived in another state.

4. The person is **not** ineligible because of BEM 265, INSTITUTIONAL STATUS. Retro MA **cannot** be approved for a retro MA month if you know the person would be ineligible because of institutional status. However, assume a person was **not** institutionalized unless you have information to the contrary.

5. Any applicable post-eligibility patient-pay amount has been computed. An application month may be a long term care and/or hospital (L/H) month or you may have information

suggesting that a retro MA month is an L/H month (example: MSA-2565-C, Facility Admission Notice). In such situations, decide whether a retro MA month is an L/H month and compute the post-eligibility patient-pay amount. Do **not** approve retro MA coverage for a month until that decision and/or computation is completed.

6. Use the Standard Retro MA Eligibility Requirements below to determine retro MA eligibility if the client is **not** eligible for Children under 19 (U19), Pregnant Women (PW), or MIChild (MCD) for the application month.

Parent/Caretaker (PCR), Healthy Michigan Plan (HMP), Former Foster Care (FFC)

MAGI groups which were automatically approved and certified using federal trusted data sources meet the requirements for retroactive Medicaid with no additional verification.

- Individuals must request and be approved for only the specific months they need coverage for, not automatic coverage as is true for U19, PW, and MIChild.
- Must meet programmatic requirements for requested months.
    - PCR-must have a dependent child during the requested month(s).
    - HMP- retro month must be April 2014 or later. Not a Medicare recipient, at least age 19 and under 65.
    - FFC- not in foster care during retro months.

Standard Retro MA Eligibility Requirements

MA Only

Determine eligibility for **each** retro MA month **separately**.

To be eligible for a retro MA month, the person must:

- Meet all financial and nonfinancial eligibility factors in that month, and
- Have an unpaid medical expense incurred during the month, or

Note: Do **not** consider bills that the person thinks may be paid by insurance as paid bills. It is easier to determine eligibility sooner rather than later.

- Have been entitled to Medicare Part A.

Reminder: There is **no** asset test for MAGI-related Medicaid categories.

Financial eligibility policies might affect a pregnant woman's eligibility for retro months.

When a client is eligible for a retro month that is **also** an L/H month, determine the post-eligibility patient-pay amount; see BEM 546.

UPDATING THE APPLICATION

All Programs

An application is **never** returned to the client or AR to update.

While an application is considered valid, the client may update the current application rather than complete a new one to add or transfer programs or add a member.

Allow updating only if it can be done without obliterating the previous information and there is sufficient room to legibly add the new information. The client must sign and date the application again after updating it.

Exception: For **FIP** dependent child member adds, obtain the information necessary to add the member and document the case record. The client is not required to sign and date the updated application.

Note: For **FAP**, an interview and an updated application can be requested but **cannot** be required to add a member.

Example: Alexis is scheduled for an interview to add her boyfriend to her FAP case. She supplies all requested verifications needed to determine eligibility but fails to attend the interview. Process the member add. Do **not** deny the member add or close the case.

STANDARDS OF PROMPTNESS

All Programs

The standard of promptness (SOP) begins the date the department receives an application/filing form, with minimum required information.

Exception #1: For **FAP**, the SOP begins when the **correct** local office receives it; see BAM 110, WHERE TO APPLY/PROCESS APPLICATIONS, FAP ONLY.

Exception #2*:* For **FAP**, when a person applies for SSI and FAP before being released from a medical institution, the SOP begins on the applicant's date of release.

See BAM 105, for the minimum required information for filing.

Process applications and requests for member adds as quickly as possible, with priority to the earliest application date; see Processing Delays in this item. Requests for member adds must be entered in Bridges.

FIP Only

Upon immediate receipt of the FIP application, the specialist must run the FIP Eligibility Determination Group (EDG) in Bridges to timely generate an automated Partnership. Accountability. Training. Hope. (PATH) referral, as well as the DHS-4785, PATH Appointment Notice, to the client. While the specialist should run the FIP EDG immediately, this must be completed within five days of the application date. Certify FIP program approval or denial of the application within 45 days.

Note: The specialist must review the DHS-1171 for any potential deferral requests prior to running the FIP EDG; see BEM 230A.

SDA, RCA, RMA and MA Only

Certify program approval or denial of the application within 45 days. Bridges automatically generates the client notice.

Exceptions:

- 15 days for all pregnant Medicaid applicants.

- 30 days for Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA) applicants.
- 60 days for SDA applicants.
- 90 days for MA categories in which disability is an eligibility factor.

The SOP can be extended 60 days from the date of deferral by the Medical Review Team.

CDC Only

Certify program approval or denial within 30 days from the receipt of application. Bridges automatically generates the client notice.

MA Only

The SOP for an **initial asset assessment** begins the date the local office receives a signed DHS-4574-B, Assets Declaration. Complete the assessment and mail the client and spouse a notice within 45 days; see BEM 402.

FAP Only

The expedited due date (SOP) is six calendar days after the application date. The regular FAP due date (SOP) is 29 calendar days after the application date.

FAP benefits must be **available** by the seventh day for expedited and the 30th day for regular FAP. Available means clients **must** have a Bridge card and access to their benefits by the seventh day for expedited and the 30th day for regular FAP benefits.

INTERVIEWS

FIP, SDA, RCA, CDC and FAP

The purpose of the interview is to explain program requirements to the applicant and to gather information for determining the group's eligibility.

The interview is an official and confidential discussion. Its scope must be limited to both of the following:

- Collecting information and examining the circumstances directly related to determining the group's eligibility and benefits.

- Offering information on programs and services available through MDHHS or other agencies.

The person interviewed may be any responsible group member **or** AR. For CDC, the AR **cannot** be the child care provider, a department employee, or a recruiter. The client may have any other person present.

Do the following during the interview:

- State the client's rights and responsibilities; see BAM 105.
- Review and update the application.
- Help complete application items **not** completed when it was filed.
- Resolve any unclear or inconsistent information.
    - Note: For FAP, if the clients' expenses exceed their income, have a discussion with them and document the case.
    - Determine the client's expenses and current situation by:
        - Adding all of the client's expenses such as rent, mortgage, utilities, taxes, etc. When determining the utility amount to include in the calculation, do **not** use the heat and utility standards; use the average monthly amount the client is responsible to pay. Verification of their actual bill(s) is not required.
        - Asking if they are behind in their bills. For example, ask if they have a shutoff notice, eviction, foreclosure, defaulted on a medical bill, someone else is paying their expenses, etc. If they are not current on their bills or someone else is paying their bills, a FEE referral may not be needed based on your discussion with the client.
    - If after the expenses vs. income calculation is completed and the client's situation is still questionable, open the case and refer to FEE.
- Request needed verification **not** brought to the interview.
- Advise the client of the SOP for processing.
- Make services referrals if needed.

- Confirm if the client needs a Mihealth card and/or Bridge card.
- Advise cash and/or FAP clients how and when they receive benefits.

FAP and CDC

An interview is required before denying assistance even if it is clear from the application or other sources that the group is ineligible.

FAP Only

Do **not** deny the application if the client has not participated in a scheduled initial interview until the 30th day after the application date **even** if he/she has returned all verifications; see **Scheduling Interviews** for FAP only in this item.

FIP Only

In addition to the above requirements, the following must be reviewed with **all** adult mandatory group members during the FIP interview:

- Work participation requirements. Identify any potential deferrals listed in BEM 230A.
- Direct support service opportunities, including transportation and child care required to attend the PATH orientation; see BEM 229.
- Family Self-Sufficiency Plan (FSSP) requirements listed in BEM 228.
- Penalties for non-compliance; see BEM 233A.
- FIP time limits; see BEM 234.
- Child support requirements; see BEM 255.
- Vendoring payments request; see BAM 425.
- Prohibited use of FIP to purchase lottery tickets, alcohol or tobacco. It is also prohibited for gambling, illegal activities, massage parlors, spas, tattoo shops, bail-bond agencies, adult entertainment, cruise ships or other nonessential items.

The local office may exempt a relative caretaker or unrelated caretaker ineligible grantee and dependent child member adds from the FIP interview requirements.

FIP, SDA, and RCA

An interview is **not** required before denying assistance if it is clear from the application or other sources that the group is ineligible.

MA Only

Do **not** require in-person interviews as a condition of eligibility.

Telephone Interviews

CDC and FAP Only

Conduct a telephone interview at application before approving benefits. However, conduct an in-person interview if one of the following exists:

- The client requests one.
- The specialist determines it is appropriate. For example, it is suspected information in the application is fraudulent.

  Exception: Do not require an in-office interview if the client is experiencing a hardship which prevents an in-office interview. Instead, conduct the in-person interview at the client's home or another agreed-upon location. Hardship conditions include but are not limited to: illness, transportation difficulties, work hours, etc.

- The application is a joint SDA/RCA and FAP application; see Jointly Processed SDA/RCA and FAP applications in this item.

Note: When conducting a telephone interview, ask the caller a question only the head of household could answer (such as last four digits of his/her Social Security number, date of birth, etc.) to ensure the identity of the caller. The best practice is to document the case record with the answer to your question.

CDC Only

If the 1171 or MIBridges is used at application, the client must be asked, during the telephone interview, if the program group has assets that exceed $1 million.

FIP Only

The specialist must conduct a telephone interview at application with **each** adult mandatory group member before approving benefits. However, conduct an in-person interview with **each** adult mandatory group member if one of the following exists:

- The client requests one.
- The specialist determines it is appropriate. For example, the specialist suspects information in the application may be fraudulent or the application signatures are questionable.
- If transportation or child care barriers that prevent the individual(s) from participating in PATH are identified on the DHS-1171, DHS-619, Jobs and Self-Sufficiency Survey, or during the FIP telephone interview.

Note: When conducting a telephone interview, ask the caller a question only the individual being interviewed could answer (such as last four digits of his/her Social Security number, date of birth etc.) to ensure the identity of the caller. Document the case record with the answer to your question. Complete this step for **each** adult mandatory group member.

In-Person Interviews

FIP Only

The specialist must conduct an in-person interview for **each** adult mandatory group member at application before approving benefits if any of the adult mandatory group members:

- Identifies on the DHS-1171, DHS-619 or during the FIP telephone interview a transportation or child care barrier that prevents an individual's ability to attend PATH.
- Requests an in-person interview.
- The specialist determines it is appropriate. For example, the specialist suspects information in the application may be fraudulent or the application signatures are questionable.

SDA and RCA

The specialist must conduct an in-person interview at application before approving benefits. The client/AR must sign and date the application in your presence, **even if** it was already signed. Sign and date the application as a witness.

SDA

Do **not** deny assistance if the applicant is a resident of a juvenile justice facility whose verified expected release date is within two weeks of the date the SDA application was received. Schedule an interview with the applicant to be held within the first five days after release, if possible.

Jointly Processed SDA/RCA and FAP Applications

Conduct an in-person interview at application before approving benefits. The client/AR must sign and date the application in your presence, even if it was already signed. Sign and date the application as a witness.

Exception: For FAP, do not require an in-office interview if the client is experiencing a hardship which prevents an in-office interview. Instead, conduct the FAP interview by telephone, at the client's home or another agreed-upon location. Hardship conditions include but are not limited to: illness, transportation difficulties, work hours, etc.

Home Calls

All Programs

If eligibility factors are questionable, schedule a home call in Bridges; see Helping Clients in this item.

Document the reason for the home call in the case record.

For **FAP only**, some clients who are unable to appoint an AR for the interview may request it be held at their home or other convenient place. These include:

- Groups made up entirely of members age 60 or older or mentally or physically disabled.
- Groups unable to come to the local office due to a specific problem such as illness, care of a group member, rural isolation, prolonged severe weather or work/training hours.

Note: Migrant groups may be interviewed at the work site.

Schedule interviews outside the office in advance and hold them during normal weekday working hours **unless** the client requests another time. When requested, obtain prior supervisory approval. Do **not** enter a home without permission or under false pretenses. Home searches are prohibited.

Single Interview

FIP, SDA, RCA, CDC, and FAP Only

Clients applying for multiple programs such as SDA/RCA and FAP **cannot** be required to attend separate interviews for each. However, waiver of the in-person interview for FAP does **not** waive the requirement for SDA/RCA. For jointly processed SDA/RCA and FAP applications where the client is experiencing a hardship, the FAP interview must be conducted by telephone, at the client's home or another agreed-upon location. Hardship conditions include but are not limited to: illness, transportation difficulties, work hours, etc.

Scheduling Interviews

FIP, SDA, RCA, CDC and FAP

Schedule interviews in Bridges promptly to meet the standard of promptness.

For **FAP only** schedule the interview as a telephone appointment **unless** specific policy directs otherwise. The interview must be held by the **20th** day after the application date to allow the client at least 10 days to provide verifications by the 30th day.

SDA Applicants Exiting Juvenile Justice Facilities

For **SDA** applications received up to two weeks prior to the applicant's expected release date from a juvenile justice facility, schedule the interview to be held within the first five working days after release, if possible, or, if not, as soon as possible.

Missed Interviews

FAP Only

If clients miss an interview appointment, Bridges sends a DHS-254, Notice of Missed Interview, advising them that it is **the clients'**

responsibility to request another interview date. It sends a notice only after the **first** missed interview. If the client calls to reschedule, set the interview prior to the 30th day, if possible. If the client fails to reschedule or misses the rescheduled interview, deny the application on the 30th day. If failure to hold the interview by the 20th day **or** interview rescheduling causes the application to be pending on the 30th day; see Processing Delays in this item.

ELIGIBILITY DECISIONS

Denials

All Programs

If the group is ineligible **or** refuses to cooperate in the application process, certify the denial within the standard of promptness to avoid receiving an overdue task in Bridges.

Bridges sends a DHS-1605, Client Notice, or the DHS-1150, Application Eligibility Notice, with the denial reason(s). Medicaid denials receive a DHS-1606, Health Care Coverage Determination Notice.

FAP Only

An interview is required before denying assistance even if it is clear from the application or other sources that the group is ineligible. For non-expedited FAP, the interview must be scheduled **to occur** by the 20th day to allow the client at least 10 days to provide verifications by the 30th day. Do not deny the application if the client has not participated in the initial interview until the 30th day after the application date even if he/she has returned all verifications.

Subsequent Processing

FAP Only

Proceed as follows when a client completes the application process **after denial** but within 60 days after the application date.

On or before the 30th day:

- Re-register the application, using the **original** application date.
- If the client is eligible, determine whether to prorate benefits according to initial benefits policy in this item.

Between the 31st and 60th days:

- Re-register the application, using the date the client **completed** the process.
- If the client is eligible, prorate benefits from the date the client complied.

Approvals

All Programs

Bridges sends the DHS-1605 detailing the approval at certification of program opening.

Bridges sends the DHS-1606 detailing Medicaid approvals. Send the following publications, as appropriate, if **not** given at application:

- MDCH-201, Your Rights and Responsibility in a Health Plan.
- MDCH-669, Medicaid Fee For Service Handbook.
- MSA Pub. 617, Medicaid Deductible Information.
- MDCH Pub. 726, Nursing Facility Eligibility.
- MDCH Pub. 769, Getting the most out of life by getting the most out of health care.

CDC Notices

Bridges sends the DHS-198, Child Development and Care Provider Notice, to each provider who has been authorized to provide care for eligible children and the DHS-198-C, Child Development and Care Client Notice, to the client. These forms notify the provider and client of the application approval and authorization of care.

Designation of Head of Household

All Programs

A member of the group must be designated as head of household for purposes of case identification and benefit issuance.

Normally, the group chooses the head of household. Designate a member **if either of the following**:

- Policy prohibits the group's choice from acting as head of household**.**

- The group fails to designate a head of household or disagrees about who it should be.

For **CDC**, see BEM 205, APPLICANT; and BAM 110, Who May Apply.

FIP Only

The person designated as head of household must meet the definition of caretaker; see BEM 210.

MAGI-Related MA Only

Designate a core relative as head of household for any case with an unmarried person under age 18 for whom support action is required per BEM 255.

FAP Only

An ineligible or disqualified person can be the head of household **if** he/she is the only adult in the group.

Note: The person is identified as a disqualified EDG member in Bridges.

Initial Benefits

FIP and SDA Only

Provided the group meets all eligibility requirements, begin assistance in the pay period in which the application becomes 30 days old.

If the application becomes 30 days old and the group has **not** met eligibility requirements, begin assistance for the first pay period when it does.

Bridges issues initial benefits as appropriate.

RCA Only

RCA begins the pay period:

- **After** the pay period that includes the application date.
- Provided the group meets all eligibility requirements in that pay period.

Note: Do not delay approval of RCA benefits solely for employment and self-sufficiency activity requirements. Participation in self-sufficiency activities is not a condition of initial eligibility, however it is a condition of continued eligibility.

If the application becomes 30 days old and the group has **not** met eligibility requirements, Bridges begins assistance in the pay period the group meets the requirements.

FIP and SDA Only

For **member adds**, see BEM 515, CHANGES IN NEED, and BAM 110, Date of Application for Member Add.

FAP Only

Bridges prorates benefits for the month of application, beginning with the date of application, when the group is eligible for the application month.

Exception: Migrant/seasonal farmworker groups that were active in the Food Assistance Program the month **before** the date of application are eligible for a full month's benefit. This policy applies whether the entire group (or any migrant member of the group) was last active for FAP in Michigan or another state.

CDC Provider Assignment Effective Date

CDC

The first day that care may be authorized is the latest of the following:

- The CDC application receipt date.
  - ***Exception:*** For foster care only, 21 days prior to the CDC application receipt date.
- The date the child care need begins.
- The date the provider becomes eligible for subsidy payments.
- The date the unlicensed provider completes the basic training requirement.
- 60 days prior to the receipt of a completed DHS-4025.

Benefit Periods

FIP and SDA Only

The group's benefit period continues until it no longer meets the program's eligibility requirements.

MA Only

Benefit periods are discussed in various BEM items. Retro MA Applications are addressed in this item.

MA Only Except ALMB

Certify MA groups for 12 months when:

- **All** group members are senior and/or disabled, **and**
- The group's **only** source of income is SSI and/or RSDI benefits, **and**
- The group is also receiving a 24-month benefit period for FAP.

Note: The FAP Mid-Certification form may be used to perform an ex parte review for a second 12-month Medicaid period.

Exception: ALMB eligibility must be completed before the end of each calendar year. Set the ALMB redetermination date as September, October, November or December, but no more than 12 months.

FAP Only

The group is eligible for a specific benefit period (in calendar months) with a begin and end date.

Begin Date At Application

The FAP **begin date** depends on the group's eligibility **and** whether the 30-day standard of promptness (SOP) has been met; see Subsequent Processing in this item. Use the following criteria:

- When the 30-day SOP is met, **or** it is **not** met but the group is **not** at fault for the delay, the **begin date** is either of the following:
  - The application date **if** the group is eligible for the application month (**even if** proration causes zero benefits).

- The first day of the month **after** the application month **if** that is when the group becomes eligible.

- When the 30-day SOP is **not** met and the group is at fault for the delay, the **begin date** is the date the group meets all application requirements; see FAP Fault Determination in this item.

Exception: See BEM 610 to determine the begin date for migrant/seasonal farmworkers.

Begin Date At Redetermination

The FAP **begin date** is the first day of the first month of the new benefit period.

End Date

The **end date** used at application or redetermination is always the last day of the final benefit month. Eligibility **cannot** continue without a redetermination and authorization of a new benefit period; see BAM 210, Redetermination.

Assigning a Benefit Period

Bridges assigns the **longest** benefit period possible based on the group's circumstances. Certain groups are given a specific **minimum** or **maximum** benefit period. Unless a specific period is required, benefit periods are assigned to accommodate the group's circumstances. The prorated month counts as the first calendar month of the benefit period.

Use the following guidelines and the group's circumstances to establish the group's benefit period.

Benefit Period to Coordinate with Other Programs

Apply the following policy **only** to FAP groups that do **not** have countable earned income. For FAP groups with countable earnings, see 12-Month Benefit Period in this item.

If the FAP program was opened prior to the other program and the client applied for both programs at the same time, either of the following may be done:

- Redetermine eligibility for the other program when the FAP benefits are due to expire (this may result in an 11-month redetermination for the other program).

- Redetermine FAP so the end date is extended to the last day of the other program's redetermination month, **provided** this does **not** exceed 12 months.

Exception: It may not be possible to coordinate FAP benefit periods for groups that qualify for 24-month benefit periods or groups that require a shorter benefit period.

24-Month Benefit Period

Bridges assigns a 24-month benefit period for groups in which **all** group members are senior and/or disabled **and** the group does not have any income or its **only** source of income is SSI and/or RSDI benefits.

Note: The annual mass update in RSDI and SSI benefit amounts does **not** affect this certification.

If a group reports a change in circumstances that affects its benefit period, such as a non-disabled/non-senior person joining the household, Bridges does all of the following:

- Shortens the benefit period according to policy in BAM 220.
- Schedules a redetermination.
- Sets a new (12 months or less) benefit period consistent with the group's circumstances.

Conduct a mid-certification contact with the FAP group once each year. The RD-093, Redetermination Report - Worker Listing, serves as notification that contact is due; see BAM 210.

12-Month Benefit Period

Bridges assigns a maximum 12 months for FAP groups that do **not** qualify for a 24-month benefit period or that do not require a shorter benefit period. For example:

- FIP groups with no earnings.
- Group has unearned income such as unemployment compensation benefit (UCB), child support, etc.

Note: FAP groups with countable earnings must have a 12-month benefit period. Conduct a mid-certification contact with the FAP group once each year. A notice will be sent when a contact is due on the RD-093, Redetermination Report - Worker Listing; see BAM 210.

Three-Month Benefit Period

If a group's circumstances are not stable and do not fit any other benefit period, a three-month benefit period **may** be assigned. Benefit periods for these groups should be determined on a case-by-case basis. Always assign the longest benefit period possible. Three months is the **minimum** benefit period which can be assigned.

Example: Kathy has no income but has a shelter obligation. Assign a three-month benefit period or a 12-month benefit period based on the case circumstances. If based on her case circumstances, it is determined a three-month benefit period is warranted, indicate this on the Unstable Circumstances Details Screen. Document the rationale for choosing the benefit period given.

Example: Kathy has no income and no obligation for rent and utilities because she is living with friends. After discussion with the client, it is determined a 12-month benefit period is appropriate.

Example: Kathy has no income but has a shelter obligation. She has applied for FIP. A 12-month benefit period **may** be given.

Deferred Actions

All Programs

To speed eligibility determinations, defer **completion** of required actions listed below.

FIP, SDA and MA Only

Referral to the prosecutor of spouses or parents of minor head of households living outside the home. The referral must be made within 14 days of the case opening.

MA Only

Receipt of a reply to an interstate inquiry regarding clients who moved to Michigan within 30 days before applying. Make the interstate inquiry **before** approving the application.

FAP Only

When processing expedited service applications both of the following actions are deferred:

- Verifications, other than identity.
- For FIP/SDA/RCA-related Food Assistance groups, actions required for the other program.

See BAM 117.

Follow-Ups

All Programs

Create a manual task in Bridges or other follow-up device when either of the following occur:

- Information indicates a potential change in circumstances.
- An action has been deferred.

Bridges will automatically display the task for follow-up on the date that is specified.

Department Errors

All Programs

As soon as possible, document and correct benefits approved or denied in error by changing Data Collection, running Eligibility Determination Benefit Calculation (EDBC) and certifying the results. Bridges sends the client a timely or adequate notice as appropriate for department error corrections resulting in:

- Program eligibility or ineligibility.
- Increased or decreased need.
- Higher or lower patient-pay amount.

FIP, SDA, RCA and FAP Only

See BAM 405, FIP, RCA AND SDA SUPPLEMENTAL BENEFITS, and 406, SUPPLEMENTAL FOOD ASSISTANCE BENEFITS, regarding supplemental benefits.

See BAM 705, AGENCY ERROR OVERISSUANCES, and BAM 715, CLIENT/CDC PROVIDER OVERISSUANCE, regarding recoupment.

CDC

See BAM 705, AGENCY ERROR OVERISSUANCES, for procedures to be followed when a department error has occurred.

MA Only

The period of erroneous coverage **cannot** be removed from or reduced in Bridges.

Service Referrals

All Programs

Clients may be in need of referrals to Adult Services, Adult Protective Services, Preventive Services For Families, or Children's Protective Services. Be alert to those needs and refer cases when indicated or required. If there is a disclosure of domestic violence, and the client is not receiving services, refer the client to the appropriate community service.

If there is reasonable cause to believe an adult or child has been abused, neglected or exploited, make a referral immediately by calling 1-855-444-3911.

For all other service programs follow local office procedures.

FIP and MA Only

Inform clients under age 21 of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. At an in-person interview, give the client MSA Pub. 491 or 498. Use local office procedures for EPSDT scheduling and/or transportation.

CASE ASSIGNMENT

All Programs

Bridges assigns cases to the next available specialist based on the specialist's Manage Office Resources profile and/or special skills such as language, long-term care etc.

Application assignment does not differentiate between case managers and non-case managers (NCM). If a cash application is assigned to an NCM, and Bridges builds a FIP or RCA Eligibility Determination Group (EDG), reassignment to a case manager must be accomplished manually.

PROCESSING DELAYS

All Programs

If an application is **not** processed by the standard of promptness (SOP) date, document the reason(s) in the case record. Document further delays at 30-day intervals.

Exceeding the SOP **cannot** be the **sole** reason for a denial.

When one program approval/denial will exceed the SOP, certify eligibility results for any others such as FAP within the SOP, if possible.

FAP Fault Determination

FAP Only

For a pended application, determine who is at fault for the delay every 30 days after the application date.

Note: This affects an approval of benefits for the months of delay, but **not** necessarily a denial; see Denials under Eligibility Decisions in this item.

FAP Group at Fault

If the 30-day SOP is **not** met **and** the group is at fault, the following applies:

- Select **yes** for the Extend SOP due to group at fault question on the Program Request Details screen for FAP.
- Bridges sends a DHS-1150-E, Food Assistance Application Notice, to inform the group that the EDG is pended and will be denied on the 60th day unless the needed actions are taken.
- Bridges prorates benefits from the date the group complies with all application requirements.

The group is at fault when you have taken all required actions but the group has **not** complied with either of the following:

- Provided all verifications by the 30th day, despite 10 days or more to provide them**.**

- Participated in the scheduled interview; see Interviews in this item.

Local Office at Fault

If all necessary actions have not been completed **and** the application will pend beyond the 30th day, the following applies:

- Send the group a DHS-5301, Pending Food Assistance Application Notice, to inform them of the pending status.
- Take prompt action to correct the cause of the delay.
- If eligible, the group's benefits begin with the application date.

The local office is at fault if the specialist fails to:

- Request necessary verifications at least 10 days before the 30th day.
- Provide requested help to complete the application process or secure verifications.
- Schedule a timely interview, resulting in less client time than policy requires to take an action; see Interviews in this item.
- Run EDBC and certify results to authorize benefits.

FAP Delays Beyond 60 Days

FAP Only

If the application pends beyond 60 days, obtain missing information, if possible, and process the application. There are three possible consequences:

- **Case information complete**. If the group is eligible **and** the local office was at fault on the 30th day, authorize benefits from the application date. If the group was at fault on the 30th day, benefits begin on the date the group completes the application process.
- **Local office at fault, case information *not* complete.** Request missing information via DHS-1150, Application Eligibility Notice, and verification checklist if appropriate. Give

the group 10 days to provide verifications. Authorize benefits as for complete cases above.

- **FAP Group at fault, case information *not* complete**. This occurs **only if** verification requested between the 30th and 50th day was **not** provided, and the application is still pending. Deny the application by running EDBC and certifying the results immediately.

LEGAL BASE

FIP

MCL 400.25
45 CFR 260.10
Mich Admin Code, R 400.3107, 400.3108, 400.3110, 400.3111, 400.3155, 400.3156

CDC

Child Care and Development Block Grant of 1990, as amended, Public Act 6 of 2014
45 CFR Parts 98 and 99
Social Security Act, as amended
Mich Admin Code, R 400.5001 - 400.5020

SDA

Current Annual Appropriations Act
Mich Admin Code, R 400.3151 - 400.3180

MA

42 CFR 431, 435

The Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152).

FAP

7 CFR 273.2

DEPARTMENT POLICY

This item applies to **FAP only.** FAP groups consisting entirely of SSI applicants or recipients may choose to apply for Food Assistance benefits at the Social Security Administration (SSA) office. This includes clients who apply for SSI and Food Assistance benefits before being released from medical institutions. Whenever an SSI client contacts the SSA office for any business, SSA will advise the client of the right to apply for Food Assistance benefits at the SSA office. SSI clients retain the option of applying for Food Assistance benefits at the local DHS office.

Form DHS-1171, Assistance Application, is used for SSI clients choosing to apply for Food Assistance at the SSA office. SSA screens the DHS-1171 for potential entitlement to expedited service and informs the applicant that he may receive benefits sooner if he applies at the local DHS office.

SSI clients may also complete the redetermination process at the SSA office. All FAP redetermination policies in BAM 210 apply **except** the in-person interview must be waived if requested by an SSI group **and** the group is unable to appoint an authorized representative. SSA will handle the application in the same manner as an initial application but will indicate in red at the top of the DHS-1171 that it is a redetermination.

Client Rights and Responsibilities

SSI groups are entitled to the same rights and have the same responsibilities as any other FAP group.

SSA Responsibilities

When an SSI group chooses to apply for Food Assistance benefits through SSA, SSA will take the following actions:

- Assist the client in completing the FAP application.
- Prescreen each application for entitlement to expedited service and mark “Expedited Processing” on the first page of all applications which seem to require it.
- Interview the applicant.

- Attach a transmittal form to all applications regarding verification(s). (See Verification Provided by SSA in this item for more information.)
- Forward the applications to the designated local office within one working day after receipt.
- Give the applicant the local office pamphlet (or loose materials) which provides basic program information, issuance information, and instructions for obtaining Food Assistance benefits. SSA orders these materials through the local office.
- Give the applicant information on how and where to receive Electronic Benefit Transfer (EBT) training. Food Assistance benefits issued in the form of EBT are accessed using a plastic Bridge Card. Clients must be aware of what is required of them if they don't go into the local office.

Local offices should arrange with their local SSA office for the most convenient and timely method for transmitting applications.

Local Office Responsibilities

Upon receipt of a signed application from SSA, the local office must take the following actions:

- Register the application if the applicant has **not** already applied for or been approved for Food Assistance benefits. Use the date filed at SSA for the application date.
- Process applications according to the appropriate standard of promptness, based on the date they were filed at the SSA office. (See Exception below.)
- Bridges automatically screens **all** applications for expedited service. The expedited service timeliness standard begins on the date the application was received at the correct local office. (See Exception below.)

Exception: Clients may apply for SSI and Food Assistance benefits before being released from medical institutions. The application filing date for these applications is the date of release from the institution. (The expected release date is in section A. Address Information on page 2 of the DHS-1171, Assistance Application).

Example:	Application completed	10/10/08
	Date of Release	10/16/08
	SOP: (expedited FAP)	10/20/08
	(non-expedited)	11/12/08

Interviews

Since SSA conducts the interview, the local office is **not** required to reinterview the applicant. The DHS specialist must **not** contact the group unless:

- The application is improperly completed.
- Mandatory verification is missing.
- Certain information on the application is questionable.

If the specialist contacts the SSI/FAP group for one of the above reasons, the specialist **cannot** require the group to come to the local office or discuss items which are unrelated to the reason for the contact.

Verification Provided by SSA

All mandatory verifications must be obtained prior to approving eligibility. Verification may be provided by SSA via the SSA-4233, Social Security Administration Transmittal for Food Assistance Applications, or through the usual means of verification.

SSA will provide all verification available at application. The transmittal form will indicate one of three things regarding each item requiring mandatory verification.

- **Verified.** The verification or a photocopy will be attached.
- **In SSI File.** The item is verified, but the document was retained in the SSI file. This statement from SSA is acceptable verification for FAP purposes.
- **Not Verified.** Verification was **not** available to SSA and must be obtained by the DHS specialist.

In addition, the SSA worker will indicate areas which are questionable on the back of the transmittal form. The SSA worker will verify these areas if the verification is available at application.

If a group returns needed verification to SSA rather than the local DHS office, SSA will forward it using an SSA-4233 marked "Evidence Only."

Verification **not** provided through SSA must be provided by the group or obtained through automated systems matches. The match from SSA may be used to verify SSI status and benefit amount. If the match indicates earned income, it **cannot** be used to verify the amount of earned income. Also, the FAP group must be given the opportunity to provide verification from another source if the information from SSA contradicts other group information.

Do **not** delay processing the application while waiting for the HR-070 or BENDEX report.

Eligibility Factors

SSI/FAP groups must meet all FAP non-financial and financial eligibility factors listed in the BEM.

Benefit Periods

Assign a benefit period according to the guidelines in BAM 115.

CHANGES

SSI/FAP groups must report changes within 10 days. See BAM 105.

Complete any necessary budget changes in Bridges upon learning of the SSI determination. If the information is discovered and it appears that the FAP group did **not** report receipt of SSI benefits within 10 days of receipt of first payment as required, an overissuance may have occurred. Handle the overissuance according to policy in BAM 700 and 720.

LEGAL BASE

FAP

7 CFR 273.2(k)
7 CFR 273.12
7 CFR 274.2

DEPARTMENT POLICY

The policy in this item applies to Food Assistance Program (FAP) only. The purpose of FAP expedited service is to help the neediest clients quickly. Certain processing requirements and actions (identified in this item) are deferred due to the shortened standard of promptness.

DEFINITIONS

Expedited Service

Expedited Service has a shorter standard of promptness and fewer verification requirements to determine FAP eligibility than are normally required.

Liquid Assets

Liquid Assets include:

- Cash on hand.
- Checking or savings accounts.
- Savings certificates.

EXPEDITED SERVICE CRITERIA

Eligibility factors are the same for expedited as regular FAP benefits.

Applicant groups are entitled to expedited service if one of the following applies:

- They have less than $150 in monthly gross income and $100 or less in liquid assets.
- They are destitute migrant or seasonal farmworkers and have $100 or less in liquid assets; see BEM 610, **MIGRANTS/SEASONAL FARMWORKERS**.
- The group's combined gross income and liquid assets are less than its monthly rent and/or mortgage payments plus the Heat and Utility Standard, or Non-Heat Electric, Water and/or Sewer, Telephone, Cooking Fuel or Trash Removal standards.

FAP groups entitled to expedited service are required to do **all** of the following:

- Complete and submit a DHS-1171, Assistance Application.
- Participate in an interview (for example, in-person, telephone, etc.).
- Cooperate with certain verification requirements; see MINIMUM VERIFICATION in this item.

IDENTIFYING GROUPS ENTITLED TO EXPEDITED SERVICE

Bridges screens all FAP applications to identify those requiring expedited service. Answers to the questions on the DHS-1171, Food Assistance Information section, and the DHS-1171 Filing Form, provide the information needed to identify expedited service cases. This information is input on the Expedited Screening page. The group does **not** have to request expedited service. A group **cannot** waive its right to expedited service.

If the client is unable to complete the entire assistance application, he can complete the filing form to start the standard of promptness and answer questions related to expedited service processing on the back page of that form. The filing form is located in the DHS-1171, Assistance Application packet.

STANDARD OF PROMPTNESS (SOP)

FAP groups entitled to expedited service **must** have a Bridge card and access to their benefits **no** later than the seventh calendar day following the date of application; see BAM 115, **Standard of Promptness, FAP Only**.

EXCEPTIONS TO THE EXPEDITED STANDARD OF PROMPTNESS

Extend the standard of promptness in the following situations:

- A telephone interview is conducted and the application is incomplete. The standard of promptness begins on the day the signed, completed application is received by the local office.

- Entitlement to expedited service is **not** identified during the screening process, but is discovered by the specialist during normal processing. The application **must** then be processed according to expedited service standards. The standard of promptness begins on the date of discovery. The discovery date **must** be documented in the case record.

INTERVIEWS

FAP groups entitled to expedited service must participate in an interview. See BAM 115, **INTERVIEWS** for specific interview policy. If the application is filed in person, the interview **must** be held the same day unless the client requests a postponement. If the client qualifies for an out-of-office or telephone interview, it must be conducted **no** later than the first working day following the application submittal.

If the FAP group applied by mail, fax, through MI Bridges, etc., and/or could **not** be contacted within one day to be interviewed, this fact **must** be documented in the case record. The interview must be conducted **no** later than one working day after contact is made.

Provide any necessary help in completing the application during the interview. If a telephone interview is conducted, and the application is incomplete, complete it and mail a copy to the client for review and signature.

MINIMUM VERIFICATION

In all cases, the applicant's **identity must** be verified (see BEM 221). The data match with Social Security Administration (SSA) is sufficient to verify identity for FAP. Reasonable effort must be made to verify:

- Residency.
- Income or lack of income.
- Assets, and
- All other eligibility factors.

Note: FAP benefits **cannot** be delayed beyond the expedited standard of promptness solely because these eligibility factors (other than **identity**) have **not** been verified.

BUDGETING

Allowable shelter deductions are:

- Rent/Mortgage.
- Heat and utility standard, or
- Non-heat electric standard, and/or
- Water and/or sewer standard, and/or
- Telephone standard, and/or
- Cooking fuel standard, and/or
- Trash removal standard.

FAP FAULT DETERMINATION

For pending FAP expedited service applications, determination of fault must be made at six day intervals after the date of application.

The FAP group is at fault when all required actions have been taken, but the FAP group has **not** taken one or more of the following actions:

- Completed the application form.
- Provided verification of identity.
- Completed the scheduled interview.

If the FAP group is at fault, answer “yes” to the “Extend SOP due to group at fault” question on the Program Request-Details screen. This prevents the registration from being overdue on Worker Registration reports and extends the standard of promptness to 29 days following the date of application.

BENEFITS AND BENEFIT PERIODS

Prorate benefits for the month of application, beginning with the date of application, when the group is eligible for the application month as for other FAP program groups; see BEM 556 and BAM 115.

Exception: Migrant/seasonal farmworker groups that were active in the FAP program the month **before** the date of application are eligible for a full month's benefit. This policy applies whether the group (or any member of the group) was last active in Michigan or another state.

Assign expedited service cases **benefit periods** according to the guidelines in BAM 115.

Note: Groups with unstable circumstances may be assigned a short benefit period; see examples in BAM 115.

SUBSEQUENT BENEFITS

Food Assistance groups that did **not** provide all required verifications will **not** be issued benefits for subsequent months until the FAP group provides the waived verification **or** completes a redetermination.

Groups that apply after the 15th of the month receive a minimum benefit period of two months (month of application and following month).

One of the following standards of promptness must be met based on when verification requirements are met. If they are met:

- Before the end of the application month, issue the second month's benefits on the first working day of the second month.

  Example: Application = September 10
  Expedited Opened = September 12
  SOP = September 16
  Verifications Received = September 25
  Must Issue Second Month = October 1

- In the second month, issue the second month's benefits within five work days.

  Example: Application = September 10
  Expedited Opened = September 12
  SOP = September 16
  Verifications Received = October 2
  Must Issue Second Month = By October 7

  Note: This second example will only occur if the verification is returned within 30 days of the date of application and the application is subject to subsequent processing; see BAM 115 and BAM 130.

If waived verifications/actions are **not** met by the 10th day following the request, take the required actions in Bridges timely to deny the ongoing FAP benefits for the remainder of the benefit period.

LIMITS ON EXPEDITED SERVICE

There is **no** limit to the number of times a group can be approved under expedited procedures. However, prior to the next expedited approval, the FAP group **must** either:

- Complete the verification requirements that were postponed at the last expedited approval (regardless of the amount of time that has expired); **or**
- Be processed under normal application processing standards.

DENIAL OF EXPEDITED SERVICE

Verbally notify the client of the denial if expedited service was registered. Process applications denied for expedited service according to normal application processing standards described in BAM 115. In addition, refer the client to appropriate emergency programs and/or resources for which they may be eligible.

When the client is denied expedited service but appears eligible for food assistance benefits, Bridges will

- Automatically change the application to a regular FAP application using the original application date once you've entered the client's information on the expedited screening page in the Program Request logical unit of work **and**
- Set the due date to 29 days from the original application date.

Advise clients denied expedited service that they can request a supervisory conference and/or a hearing if they disagree with the decision; see BAM 600. Do **not** hold the application pending the result of a hearing. If the client requests a conference, it must be held within two working days of the request, **unless** the client requests that it be scheduled later.

LEGAL BASE

FAP

7 CFR 273.2(i)
7 CFR 273.14(f)

DEPARTMENT POLICY

Medicaid

The Michigan Department of Health and Human Services/Medical Services Administration (MSA) is responsible for the following medical programs in Michigan:

- Medicaid.
- Maternity Outpatient Medical Services (MOMS).
- Breast and Cervical Cancer Prevention and Treatment Program (BCCPTP).

The Michigan Department of Health and Human Services (MDHHS) administers Medicaid under the supervision of MSA. MSA administers the BCCPTP and MOMS programs.

MSA has established a no-wrong-door policy for Medicaid to expand where a person may submit an application for medical assistance.

MSA RESPONSIBILITY

Maternity Outpatient Services

Information about Maternity Outpatient Services (MOMS) is in BEM 657.

- Local office MDHHS staff do not determine eligibility for MOMS.
- Local office MDHHS staff determine Medicaid ESO for pregnant women and enter the correct codes for pregnancy and citizenship, thereby allowing MOMS eligibility.
- MOMS is **not** Medicaid.
- MOMS is **not** on Bridges.

Breast and Cervical Cancer Prevention and Treatment Program

MSA determines eligibility for this MA category. Policy and procedures are in BEM 173.

Policy Exceptions

MSA is responsible for responding to requests for **policy exceptions** for Medicaid. Complete instructions are in BEM 100. Send policy exceptions to:

Michigan Department of Health and Human Services/Medical Services Administration
Bureau of Medicaid Policy and Health System Innovations
Eligibility Policy Section
PO Box 30479
Lansing, MI 48909

MDHHS LOCAL OFFICE RESPONSIBILITY

MDHHS determines eligibility for:

- Medicaid.

  Exception: MSA determines eligibility for BEM 173, Breast and Cervical Cancer Prevention and Treatment Program.

- RAP Medical.

HMO (LC 07) Becomes L/H Client

MSA and MDHHS share responsibility when a recipient in an HMO (Level of Care (LC) code 07) enters a long-term care (LTC) facility.

The provider contacts the Health Maintenance Organization (HMO) to request that the client be disenrolled from the HMO. The HMO submits the request for disenrollment to MSA.

The Quality Improvement Section, Medical Services Administration, reviews the documentation and decides whether to approve the HMO's request for disenrollment.

Do **not** request a change to LC code 07 when a client enters LTC. The HMO is responsible for requesting the disenrollment.

> ***Exception:*** A recipient might be enrolled in managed care after admission to LTC. In such cases, contact MSA at (517) 241-8759 to request removal of LC code 07.

MSA is responsible for:

- Ending LC code 07 on Bridges.
- Adding LC 02 or 08 and the Provider ID on Bridges. The authorization begin date for LC 02 or 08 is the day after the LC 07 end date.
- Forwarding a copy of the DCH-1185, Request to Disenroll from Health Plan to Nursing Facility, to the local DHS.

  Note: All DCH-1185s for recipients in Wayne County will be forwarded to the medical district. That office is responsible for obtaining the case record from the appropriate district office.

If notified that a recipient in managed care has entered LTC before there is notice of the HMO disenrollment, you may begin actions necessary to determine continued eligibility (request verifications). However, not all case actions can be completed until the DCH-1185 is received from MSA.

DHHS is responsible for:

- Determining continuing eligibility. Computing the post-eligibility patient-pay amount.
- Entering the post-eligibility patient-pay amounts after MSA has entered LC 02 or 08 in Bridges.

Use standard negative action procedures to begin the patient-pay amount; see BEM 547.

Newborns

MSA AUTHORIZATIONS in BEM 145, Newborn explains when the Medical Services Administration will authorize MA for a newborn.

LOCAL HEALTH DEPARTMENTS AND MDHHS

Local health departments may participate in outreach and application assistance.

Application assistance means helping clients apply for and obtain verifications for Medicaid. Each local health department chooses whether or not it will participate.

Local health department Responsibilities

For applications submitted through the participating local health department, the local health department is responsible for:

- Ensuring that the application is signed and that all items are completed. Items that do **not** apply are to be marked N/A.
- Obtaining all information needed to make an eligibility determination and supplying copies of all necessary documentation and verification.
- Doing a preliminary income budget to determine if the application should be submitted for a Medicaid determination.
- Attaching documentation of the client's noncooperation with obtaining verifications to the application.

Missing Verification

An application received from a participating local health department should have all the information and verification necessary to determine Medicaid eligibility. If all of the necessary information/verification does **not** accompany the application:

- Contact the local health department and request that the local health department obtain the missing information or verification. Use the DHS-3503, Verification Checklist, or other mutually agreeable written means, to notify the local health department of the missing information or verification.

Do **not** delay a determination of eligibility because an application does **not** specify a family's choice of a health or dental plan.

- Allow the local health department at least 10 days to provide the information or verification.
- Contact the local health department if the requested information is **not** received by the due date. Extend the time limit if there has been a delay in getting the information or verification (BAM 130). Do **not** deny the application as long as the local health department is working to obtain the information or verification.
- If the local health department says that verification **cannot** be obtained despite a reasonable effort, use the best available information. See Obtaining Verification in BAM 130 for details and exceptions.
- If the local health department indicates that the client has **not** cooperated in efforts to obtain verification, review the local health department's documentation relating to the refusal (copies of correspondence, record of telephone contacts). Determine if the client has refused to cooperate. Deny the application, if appropriate. If denial is **not** appropriate (client was not informed of what was needed or client was not given sufficient time), ask the local health department to request the verification again.

MDHHS Application Processing

When an application is submitted through a participating local health department:

- Register the application if it contains at least the applicant's name, the applicant's birth date, the applicant's address, and the applicant's/authorized representative's signature; see BAM 105, Right to Apply. The application date is the date the application is received at MDHHS with the minimum information.
- Determine eligibility for Medicaid.
- Notify the client of the eligibility decision.

Informing local health departments and Confidentiality

Confidentiality is **not** violated when information is provided to local health departments regarding applications and eligibility or ineligibility.

Provide the following information if participating local health departments want to know the disposition of an application:

- Whether a person has been approved for Medicaid.
- Whether coverage is limited to emergency services.
- If denied, the reason for each person's denial.
- Each beneficiary's ID number.
- The begin date of MA coverage, including retro MA coverage.

Changes and Renewals

MDHHS is responsible for:

- Reviewing continued eligibility when changes are reported, including obtaining any necessary verification.

  Exception: Medicaid Under 19 and MIChild eligibility continues until renewal unless the child reaches age19, moves out of state, becomes ineligible due to Institutional Status, dies,. or (MIChild only) is enrolled in other comprehensive health insurance.

- Processing renewals.

EXCEPTIONS UNIT

Certain Bridges transactions must be processed through the Exceptions Unit in MSA. The MA exceptions unit telephone numbers are:

- 1-800-292-9570 (requires security card) - This is a voice-activated enhanced call process with 6 menu items.

- 517-241-8759 - This is a voice-mail line to use to request removal of Level of Care (LC) codes 07 or 88. A series of questions prompts callers to leave the information necessary to remove the LC code. A response will state when the LC code

will be removed. If the LC code cannot be removed or other information is needed, the worker will be contacted.

Call 517-241-8759 directly or 1-800-292-9570 and press 3 to remove these LC codes.

Referrals to MSA Reimbursement Unit

Notify MSA of the potential need for reimbursement of paid medical expenses. Send reimbursement information to:

Michigan Department of Health and Human Services
Medical Services Administration
Att: Venetta Watt
Eligibility Quality Assurance Section/Reimbursement
400 S. Pine St., 5th floor
Lansing, MI 48913
MSA Estate Recovery Unit

Recoveries for Medicaid claims correctly paid are as follows:

- For individuals who received medical assistance at age 55 or older, recovery is made from the individual's estate for all services covered by the Michigan Medicaid program with dates of service on or after July 1, 2010, except Medicaid cost sharing. To be subject to estate recovery, a person over 55 must have begun receiving long-term care services after September 30, 2007. If a beneficiary over the age of 55 began receiving long-term care services prior to September 30, 2007 and there was a break in coverage and a new eligibility period began any time after September 30, 2007, the Medicaid recipient will be deemed to have begun receiving long-term care after September 30, 2007 and therefore be subject to recovery.
- Recovery will only be pursued if it is cost-effective to do so as determined by the department at its sole discretion.

Limitations on Recoveries

The state complies with the requirements of section 1917(b)(2) of the Social Security Act: Recovery of medical assistance will be made only after the death of the individual's surviving spouse, and

only when the individual has no surviving child who is either under age 21, blind, or disabled.

Undue Hardship

Recovery may be waived if a person inheriting property from the estate can prove that recovery would result in an undue hardship. An application for an undue hardship must be requested by the applicant and returned with proper documentation in order for a hardship waiver to be considered. In order to qualify for a hardship exemption, an applicant must file the application with the department not later than 60 days from the date the department sends the Notice of Intent to the personal representative or estate contact. An undue hardship exemption is granted to the applicant only and not the estate generally.

Undue hardship waivers are temporary. Submitted applications will be reviewed by the department or its designee, and the department shall make a written determination on such application.

An undue hardship may exist when one or more of the following are true:

- The estate subject to recovery is the sole-income producing asset of the survivors (where such income is limited), such as a family farm or business.
- The estate subject to recovery is a home of modest value, see definition in this item.
- The state's recovery of decedent's estate would cause a surviving heir to become or remain eligible for Medicaid.

When considering whether to grant an undue hardship, the department shall apply a means test to all applicants to ensure that waivers are not granted in a way that is contrary to the intent of the estate recovery program under federal law.

An applicant for an undue hardship waiver will satisfy the means test only if both of the following are true:

- Total household income of the applicant is less than 200 percent of the poverty level.
- Total household resources of the applicant do not exceed $10,000.

Definitions:

- **Survivor:** An heir who does not predecease the deceased beneficiary under the provisions of MCL 700.2104 or according to the terms of the decedent's will.
- **Home of Modest Value:** A home that is valued at 50 percent or less of the average price of homes in the county where the home is located as of the date of the Medicaid beneficiary's death.
- **Value of Medicaid recipient's home:** The State Equalized Value (SEV) of a Medicaid recipient's home from the year the Medicaid recipient died is used to determine whether that home is a home of modest value. The SEV will be double to find the value of the home.
- **Average Price**: The average price of homes in the county shall be determined from the Equalized Valuation Totals Summary report (L-4023) published by the State Tax Commission. The average price shall be calculated by dividing the total True Cash Value of Residential Real Property in the county by the total Number of Parcels.
- **Resources:** All income, as defined in BEM 500 series, and assets, as defined in BEM 400 an applicant has.
- **Long-Term Care Services**: Means services, including but not limited to, nursing facility services, hospice, home and community based services, adult home help, and home health.

Divestments

When a divestment is discovered, it will be determined if the state was aware of the transfer and whether the transfer was or would have been allowed. If necessary MSA will refer the case to the Office of the Attorney General to have the property put back in the estate.

MSA will not pursue a divestment when any of the following are true:

- The transfer of assets was disclosed as part of the Medicaid eligibility determination process and notwithstanding such transfer, the applicant was determined to be Medicaid eligible.

- The transfer of assets was not disclosed as part of the Medicaid eligibility determination process, but the department determines that if it had been disclosed the applicant would still have been determined to be Medicaid eligible.

- The transfer was disclosed as part of the Medicaid eligibly determination process, and a divestment penalty was assessed, which at the time of the decedent's death was exhausted.

MSA will refer a divestment to the Michigan Department of Health and Human Services Office of Inspector General, or MSA will seek additional recovery from the estate when either of the following are true:

- The transfer of assets was disclosed as part of the Medicaid eligibility determination process, a divestment penalty period was assessed and the assessed penalty period had not been exhausted at the time of the beneficiary's death. MSA will only seek the value of the outstanding penalty period that was assessed under these circumstances.

- The transfer of assets was not disclosed as part of the Medicaid eligibility determination process, and the department determines that if it had been disclosed the applicant would not have been determined to be Medicaid eligible.

Appeals

The Hardship Waiver applicant has the right to contest the department decision of whether an undue hardship exists. The applicant may request a hearing within 60 days of the notice of case action on the application. The request for a hearing must be in writing and will be conducted under the provisions of BAM 600, Hearings.

HEALTHY MICHIGAN PLAN COST-SHARING

All individuals who are eligible for the Healthy Michigan Plan (HMP) and enrolled in a Medicaid health plan will pay most cost-sharing through the MI Health Account. Cost-sharing includes co-pays, and for some beneficiaries, contributions. Point of service co-pays may be required for a limited number of services that are carved out of the health plans, such as certain drugs. HMP co-pay information, including amounts, can be found at the Michigan Department of

Health and Human Services (MDHHS) website for Assistance Programs/Health Care Coverage, or by calling the Beneficiary Help Line at 1-800-642-3195.

Individuals eligible for HMP who are not enrolled in a health plan are only responsible for co-pays when applicable, and will pay those co-pays at the point of service.

Contributions

HMP beneficiaries with incomes above 100 percent of the Federal Poverty Level (FPL) may be charged monthly contributions for their health care coverage. Contribution amounts vary based on income and family size and will not exceed 2 percent of household income. Some individuals may be exempt from contributions.

Exemptions, and any other changes to the contribution amount because of changes in income or other demographic information will be processed by the MI Health Account vendor prospectively.

When a beneficiary is no longer eligible for coverage under HMP, he may be entitled to the remainder of any unused contributions in the MI Health Account. These funds may only be used to purchase private health insurance coverage.

Cost-Sharing Reductions for HMP Beneficiaries

Beneficiaries may earn cost-sharing reductions to co-pays and contributions owed through the MI Health Account.

Offset of State Tax Refunds and Lottery Winnings

Beneficiaries who fail to meet HMP cost-sharing obligations may be subject to offsets of their state tax refunds and lottery winnings. Beneficiaries who meet the criteria established for offsets will be notified of the potential for an offset and of his rights to a review of the referral of his unpaid cost-sharing amounts.

Cost-Sharing Limits

The limit is based on income and applies to most types of health care coverage cost-sharing including HMP.

Beneficiaries in the same household cannot be charged more than 5 percent of the family's income each calendar quarter for cost-sharing. Updates to the cost-sharing limit occur prospectively as income and other changes are received. MDHHS monitors the cost-sharing limit and costs as they are incurred and processes changes each quarter. Beneficiaries are not required to keep track of these costs.

DEPARTMENT POLICY

All Programs

According to federal and state law, the Michigan Department of Health and Human Services (MDHHS) is a designated voter registration agency. Laws require that MDHHS provide voter registration services to MDHHS clients in specific situations. These services include:

- Providing form NSP-938B, Michigan Voter Registration Application at specified times and upon request.
- Assisting clients in completing the NSP-938B.
- Accepting and validating the NSP-938B.
- Forwarding the NSP-938B to the appropriate governmental clerk in a timely manner.

IN PERSON TRANSACTIONS

Individuals are required to present photo identification when registering to vote in person. If an individual does not possess photo identification, he/she is permitted to sign an affidavit form to this effect.

Acceptable photo identification documents include:

- Michigan driver's license or Michigan personal identification card (current or expired).
- Current driver's license or personal identification card issued by another state.
- Current federal or state government-issued photo identification.
- Current U.S. passport.
- Current student identification with photo – from a high school or an accredited institution of higher education.
- Current military identification card with photo.
- Current tribal identification card with photo.

Voter registration applicants that do not possess one of the above-listed photo ID documents may sign the DHS-1185, Affidavit of Voter not in Possession of Picture Identification Form.

The DHS-1185 should be stapled to the voter registration form (NSP-938B or NSP-938B-SP) and sent to the local clerk.

OBTAINING FORMS

The NSP-938B may be obtained from the:

- Department of Technology, Management and Budget (DTMB) warehouse.
- Online from the MDHHS public Web site at: www.michigan.gov/MDHHS-forms. Select the NSP-938B from the Applications category.

The Bureau of Elections prohibits MDHHS from making the NSP-938B form available on MS Word. Photo copies may be used if supplies run short. Individual copies may also be printed from the MDHHS public Web site.

The MDHHS-1185 is available in the MDHHS Forms Library.

ISSUING VOTER REGISTRATION FORMS

Distribute an NSP-938B:

- With an application for assistance, including, but not limited to:
  - DHS-1171, Assistance Application.
  - DCH-0373-D, MIChild and Healthy Kids Application
  - DHS-4575, Medicaid Application (Patient of Nursing Facility).
  - DHS-4574-B, Assets Declaration.
  - DHS-1011, Medicaid Supplemental Application.
- With a redetermination, including, but not limited to:
  - DHS-1010, Redetermination Form.
  - DHS-542, MiCAP Redetermination Form.
- Upon Request.

- When a change of physical address is reported to the local office.

Exception: The only time an NSP-938B is not distributed is when an individual declines in writing by checking the *No* box in Section U of the DHS-1171, Assistance Application, or declines in writing on another MDHHS form that asks whether the individual would like to register to vote. **If this question is unanswered (left blank), distribute an NSP-938B.**

Note: An NSP-938B is automatically generated and mailed when *Yes-out of office transaction* is selected, and when an individual reports a change of physical address.

- When an individual applies for assistance, redetermination or reports a change of physical address in the local office, distribute an NSP-938B in person.

If for any reason, an NSP-938B is not distributed while the individual is in the local office, and the individual has not declined to register to vote, select *Yes-out of office transaction,* so an NSP-938B is automatically mailed.

For forms that do not include the voter registration question, mail an NSP-938B to the individual.

Note: Individuals using MI Bridges to apply for or renew benefits are automatically offered an NSP-98B and the response is pre filled in Bridges.

ASSISTING INDIVIDUALS

Assist individuals in the completion of the NSP-938B when requested. **Do not:**

- Seek to influence an individual's political preference or party.
- Display any political preference or party allegiance.
- Make any statement or take any action to discourage a person from registering to vote.
- Make any statement or take any action which may lead a person to believe that a decision to register to vote or not to register to vote has any bearing on their eligibility for services or benefits.

ACCEPTING VOTER REGISTRATION FORMS

Complete NSP-938B

- Accept a completed NSP-938B.
- Review the form to ensure that it is complete and legible.
- When the *yes* box is checked, the upper-most portion of the form serves as the individual's voter registration receipt.
- Detach and give or mail the receipt to the individual once the form is validated.
- Forward the lower portion of the completed NSP-938B to the local office Voter Registration Services Coordinator ***immediately*** upon receipt, to ensure that forms will be sent to the appropriate governmental clerk in a timely manner; see Timely Forwarding Voter Registration Forms in this item.

Incomplete NSP-938B

If an individual returns an NSP-938B with the *Yes* box checked but it is missing a signature or information forward to the local office voter registration services coordinator ***immediately****.*

Note: Bureau of Elections has a process in place to follow up with a client for missing information.

If an individual returns an NSP-938B with the "*No"* box checked, completion of the remainder of the form is not necessary. Enter the current date and your initials in the upper right corner of the form, and forward to the local office voter registration services coordinator for storage; see Storing Declinations below.

VOTER REGISTRATION SERVICES COORDINATOR RESPONSIBILITIES

Each local office must designate a voter registration services coordinator as well as a back-up coordinator. Coordinator responsibilities include all of the following:

- Answering local office questions regarding voter registration services.
- Ensuring that there is an adequate supply of voter registration applications in both English and Spanish.
- Ensuring that there are voter registration applications available in the local/district office lobby.
- If it is determined or a report is received that an individual was not given the appropriate opportunity to register to vote, ensure that an NSP-938B, along with an explanatory letter, is mailed to the individual. A template for the explanatory letter can be obtained by contacting the central office voter registration coordinator, see Communicating with Central Office Voter Registration Services Coordinator in this item.

  Note: A copy of the letter sent to the individual must be retained in the local office for 24 months.
- Prominently displaying National Voter Registration Act (NVRA) posters in each local/district office lobby and ensuring that posters are available for community partners, as requested.
- Reporting voter registration information; see Reporting and Tracking in this item.
- Forwarding complete and incomplete voter registration forms to the appropriate clerk of the county, city or township in a timely manner; see Timely Forwarding of Voter Registration Forms in this item.
- Communicating with the central office voter registration services coordinator; see Communicating With Central Office Voter Registration Services Coordinator in this item.

Timely Forwarding of Voter Registration Forms

Voter registration services coordinators must forward voter registration forms ***within seven calendar days*** of receipt in the local office. Forms must be forwarded to the clerk of the county, city or township where the client resides.

Exception: During the 7 day period which precedes the registration deadline forms must be forwarded to the clerk of the county, city or township ***within one business day.*** This is required to allow a person who registers close to the close of registration to participate in the election.

Where to Send Voter Registration Forms

Forward the complete NSP-938B as follows:

- If the person who completed the NSP-938B resides within the city limits of one of the twenty-six largest cities in Michigan, forward the completed form to the city clerk. Mailing addresses for city clerks are found on page two of the NSP-938B instructions.
- For all others, forward the completed form to the clerk of the person's county of residence. Mailing addresses for the county clerks are found on page two of the NSP-938B instructions.

If it is unclear where to send the form, forward to:

Department of State
Bureau of Elections
P.O. Box 20126
Lansing, Michigan, 48901-0726

Storing Declinations

An NSP-938B with the *No* box checked is known as a declination. This individual has declined the opportunity to register or update their voter's registration. Declinations must be retained in a designated location in the local office for 24 months.

Communicating with Central Office Voter Registration Services Coordinator

Local office voter registration services coordinators communicate with the central office voter registration services coordinator via email at: DHSVotes@michigan.gov.

Questions regarding this policy may be addressed through this avenue.

Local office voter registration services coordinators must contact the central office voter registration services coordinator for the following:

- Gain access to the NVRA Summary Reporting Tool.
- Request the template for the explanatory letter.
- Provide the name, phone number and email address of the local office voter registration services coordinator and back-up coordinator and the county and/or district they represent.
- When there is a change in the local office voter registration services coordinator or back-up coordinator, the following information must be submitted:
  - Name.
  - Phone and fax numbers.
  - County office.
  - District office, if applicable.

REPORTING AND TRACKING

Each local office voter registration services coordinator must complete the NVRA Summary Web-based Report, available from the MDHHS-Net intranet. The summary report is due by the fifth of each month (or next business day if the fifth falls on a non-work day). Instructions and access to this tool are available from the central office coordinator.

The summary report requires coordinators to report the number of completed voter registration forms received by the local/district office. Keep track of the number of completed registration forms for-

warded to the county/city clerks each week and enter the monthly total on the report.

LEGAL BASE

All Programs

42 U.S.C. 1973gg through 1973gg-10
MCL 168.509v

DEPARTMENT POLICY

All Programs

Verification means documentation or other evidence to establish the accuracy of the client's verbal or written statements.

Obtain verification when:

- Required by policy. Bridges Eligibility Manual (BEM) items specify which factors and under what circumstances verification is required.
- Required as a local office option. The requirement **must** be applied the same for every client. Local requirements may **not** be imposed for Medicaid Assistance (MA).
- Information regarding an eligibility factor is unclear, inconsistent, incomplete or contradictory. The questionable information might be from the client or a third party.

Verification is usually required at application/redetermination **and** for a reported change affecting eligibility or benefit level.

If the individual indicates the existence of a disability that impairs their ability to gather verifications and information necessary to establish eligibility for benefits, offer to assist the individual in the gathering of such information.

Verification is **not** required:

- When the client is clearly ineligible, or
- For excluded income and assets **unless** needed to establish the exclusion.

Types of Verification

All Programs

Use documents, collateral contacts or home calls to verify information.

A **document** is a written form of verification. It may include a photocopy, facsimile or email copy if the source is identifiable.

Permanent documents must be obtained only once, unless they are found to be missing from the case record. **Examples:** birth certifi-

cate, passports, divorce papers, death notice. Copies of these documents should remain in the case record. Nonpermanent documents must be current. **Examples:** driver's license, pay stub, rent receipt, utility bill, DHS-49-F, Medical-Social Questionnaire.

Family Independence Program (FIP), State Disability Assistance (SDA), and Medicaid (MA)

Documents used to verify citizenship and identity may be originals or copies of the original document.

Facsimiles or emails are **not** acceptable documents for citizenship or identity.

Medicaid

Verification of identity is not required.

MAGI MEDICAID

MDHHS must use information currently available in STATE OF MICHIGAN systems to renew eligibility. Do not request information from the beneficiary if the information is already available to MDHHS. This includes completing a renewal form.

Current means the following:

- **Income** documents must correspond to the period used to determine eligibility or benefit amount; see BEM 500, 501, 502, 503 and 504.
- **Medical** documents must correspond to the period set by the Disability Determination Service (DDS) **or** to the date(s) stated on the document **if** DDS approval is not required.
- **Other nonpermanent** documents are generally considered current if dated within 60 days before your eligibility determination. Older documents may be used if available information indicates the document remains current and there have been no changes in circumstances.

A **collateral contact** is a direct contact with a person, organization or agency to verify information from the client. It might be necessary when documentation is not available or when available evidence needs clarification.

The client must name suitable collateral contacts when requested. Assist the client to designate them. The local office is responsible for obtaining the verification. If the contact requires the client's signed release, use the DHS-27, Release of Information, (DHS-20, Verification of Resources, for inquiries to financial institutions), and specify on it what information is requested.

If the information requested could include health information send a DHS-1555 or a DCH-1183, Authorization to Release Protected Health Information, for the individual's signature.

When talking with collateral contacts, disclose only the information necessary to obtain the needed information. Do **not** disclose specific programs for which the household has applied. Do **not** release any information supplied by the household or imply that the household is suspected of any wrongdoing.

Home calls are **not** required but may be used to verify factors; see **INTERVIEWS** section in Bridges Administrative Manual (BAM) 115.

Obtaining Verification

All Programs

Tell the client what verification is required, how to obtain it, and the due date; see **Timeliness of Verifications** in this item. Use the DHS-3503, Verification Checklist (VCL), to request verification.

Exception: For Food Assistance Program (FAP) only, if there is a system-generated due date on the verification form such as a DHS-3688, Shelter Verification, a verification checklist is not required to be sent with the verification form.

Use the DHS-3503C, Verification Checklist for Citizenship/Identity, to request documentation of citizenship or identity for FIP, SDA or MA determinations.

The client must obtain required verification, but the local office must assist if they need and request help.

If neither the client nor the local office can obtain verification despite a reasonable effort, use the best available information. If **no** evidence is available, use your best judgment.

Exception: Alien information, blindness, disability, incapacity, incapability to declare one's residence and, for FIP only, relationship and pregnancy, must be verified.

Citizenship and identity must be verified for clients claiming U.S. citizenship for applicants and recipients of FIP and SDA.

Note:

- When verification is scanned or copied and the information is legible, place a copy in the case file.
- If the verification is totally or partially illegible, place a copy in the case file.
- If partially legible, document the case with actual verification received such as a lease, paystubs. Include additional details such as whether it was reviewed, if it appears to be authentic, and any visible information such as the date of entry into the U.S., shelter expense.

Self-Attestation

MAGI-related Medicaid

Self-attestation is acceptable for most eligibility factors. Citizenship, social security numbers and lawful presence require documentation.

Sources available to the STATE OF MICHIGAN, for example, SSA, SAVE, MDHHS vital records, H79, Redetermination & Renewal Verifications (RRV) Service, must be utilized first before requesting documentation from the individual.

When electronic verification is not successful, documentation may not be requested of an individual for whom documentation does not exist or is not reasonably available at the time of an application or renewal. Such circumstances include, but are not limited to, individuals who are homeless and victims of domestic violence or natural disasters.

Citizenship Verification for Medicaid

When an applicant for Medicaid claims to be a U.S. citizen or to have qualified immigrant status, and all other eligibility factors are

met, certify benefits. Once the case has been open and coverage entered in Bridges, verification of citizenship must be completed.

Attempt to verify citizenship through a data match such as the Social Security Administration or a MDHHS vital records match. MAGI- related applicants will have citizenship and identity verified if the application comes to Michigan Department of Health & Human Services (MDHHS) via the Federally Facilitated Marketplace (FFM) or MAGI rules engine. If there is a discrepancy with the information or it is not available then contact with the beneficiary is necessary; see BEM 221 and 225.

Allow the beneficiary 90 days to provide the required verifications. If no documentation is provided at the end of the 90 days, the beneficiary should be disenrolled from Medicaid within 30 days.

Beneficiaries must be notified of the pending closure and the reason for the closure. If documentation is received prior to the closure date the coverage must continue.

Medicaid

The Michigan Department of Health and Human Services (MDHHS) Program Eligibility Policy Section will evaluate beneficiaries who are unable to provide documentation of citizenship on a case by case basis.

MDHHS will attempt to verify citizenship after all other possibilities have been exhausted by MDHHS and the beneficiary.

These attempts include but are not limited to data matches, state to state written and/or verbal inquiries, interviews with friends and relatives and the use of computerized records.

If you are unable to verify citizenship for a beneficiary send a written request to:

Michigan Department of Health and Human Services
Bureau of Medicaid Policy and Health System Innovation
Eligibility Policy Section
P.O. Box 30479
Lansing, MI 48909

The policy email address is Eligibilitypolicy@michigan.gov

All requests must include:

- Beneficiary's name.
- Case number and beneficiary ID number.
- Specialist name, telephone number and email address.
- A brief description of the situation, specify if assistance is needed in determining citizenship or qualified immigration status.
- What steps the beneficiary has taken in an attempt to provide the verification.
- What steps the specialist has taken in an attempt to verify citizenship or immigration status.
- Include the results of the Social Security Administration match and MDHHS vital records match.

Obtaining Verifications

Never place original documents such as a lease, paystubs, birth certificates in the case file.

Verification Sources

All Programs

Verification Sources of each BEM item lists acceptable verifications for specific eligibility factors. Other, less common sources may be used **if** accurate and reliable.

Use a particular source **if** it is the most reliable (public records, data matches). Otherwise**,** use the one easiest to obtain.

FIP, SDA and Medicaid

Refer to BEM 225 for a list of acceptable documents to use to verify citizenship.

Sources **must** be used in the order listed from most reliable to least reliable, **not** the easiest to obtain.

Timeliness of Verifications

FIP, SDA, Child Development and Care (CDC), FAP

Allow the client 10 calendar days (**or** other time limit specified in policy) to provide the verification that is requested.

CDC Only

If the client cannot provide the verification despite a reasonable effort, extend the time limit at least once.

At redetermination, if a signed DHS-1010 or application is received, generate a VCL and allow 10 calendar days for the client to provide the verifications. If the verifications are not returned or are returned as incomplete, two 10 calendar day extensions must be given, sending VCLs after each verification due date. Clients are not required to request the extensions.

Verifications are considered to be timely if received by the date they are due. For electronically transmitted verifications (fax, email or Mi Bridges document upload), the date of the transmission is the receipt date. Verifications that are submitted after the close of regular business hours through the drop box or by delivery of a MDHHS representative are considered to be received the next business day.

Send a negative action notice when:

- The client indicates refusal to provide a verification, **or**
- The time period given has elapsed and the client has **not** made a reasonable effort to provide it.

Note: For FAP only, if the client contacts the department prior to the due date requesting an extension or assistance in obtaining verifications, assist the client with the verifications but do not grant an extension. Explain to the client they will not be given an extension and their case will be denied once the VCL due date is passed. Also, explain their eligibility will be determined based on their compliance date if they return required verifications. Re-register the application if the client complies within 60 days of the application date; see BAM 115, Subsequent Processing.

Only **adequate** notice is required for an application denial. **Timely** notice is required to reduce or terminate benefits.

Exception: At redetermination, **FAP** clients have until the last day of the redetermination month **or** 10 days, whichever is later, to provide verification; see BAM 210.

Medicaid

Allow the client 10 calendar days (or other time limit specified in policy) to provide the verification requested. Refer to policy in this item for citizenship verifications. If the client cannot provide the verification despite a reasonable effort, extend the time limit up to two times.

At renewal if an individual is required to return a pre-populated renewal form, allow 30 calendar days for the form to be returned.

At application, renewal, ex parte review, or other change, explain to the client/authorized representative the availability of your assistance in obtaining needed information. Extension may be granted when the following exists:

- The customer/authorized representative need to make the request. An extension should not automatically be given.
- The need for the extension and the reasonable efforts taken to obtain the verifications are documented.
- Every effort by the department was made to assist the client in obtaining verifications.

Verifications are considered to be timely if received by the date they are due. For electronically transmitted verifications (fax, email or MI Bridges document upload), the date of the transmission is the receipt date.

Verifications that are submitted after the close of regular business hours through the drop box or by delivery of a MDHHS representative are considered to be received the next business day.

Send a case action notice when:

- The client indicates refusal to provide a verification, **or**
- The time period given has elapsed.

Only **adequate** notice is required for an application denial. **Timely** notice is required to reduce or terminate benefits.

Discrepancies

All Programs

Before determining eligibility, give the client a reasonable opportunity to resolve any discrepancy between his statements and information from another source.

LEGAL BASE

FIP

45 CFR 206.10(a)(2)(ii)
45 CFR 233.10(a)(1)(ii)(B)
MCL 400.37

CDC

Child Care and Development Block Grant of 1990, as amended, Public Act 6 of 2015
Social Security Act, as amended
45 CFR Parts 98 and 99
Mich Admin Code, R 400.5001 - 400.5020

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

MA

42 CFR 435.913(a)
42 CFR 435.916 (a), (b)
MCL 400.37

Pub. L. 109-171

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3.

The Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152).

FAP

7 CFR 273.2(f)

DEPARTMENT POLICY

Food assistance groups with countable earnings, as currently defined in the BEM 500 series, are assigned to the simplified reporting (SR) category. This reporting option increases Food Assistance Program (FAP) participation by employed households and provides workload relief.

REQUIREMENTS

Simplified reporting groups are required to report **only** when the group's actual gross monthly income (**not** converted) exceeds the SR income limit for their group size. **No** other change reporting is required.

If the group has an increase in income, the group must determine their total gross income at the end of that month. If the total gross income exceeds the group's SR income limit; see RFT 250, the group must report this change to their specialist by the 10th day of the following month, or the next business day if the 10th day falls on a weekend or holiday. Once assigned to SR, the group remains in SR throughout the current benefit period unless they report changes at their semi-annual contact or redetermination that make them ineligible for SR.

Note: Changes known to the Department must be acted on even though the client is required to report only if the group's total gross income exceeds the SR income limit for their group size.

SR does not change reporting requirements for any other program.

The group is still assigned to SR if the person with earned income is a disqualified member.

WHO IS NOT ELIGIBLE FOR SR

The following groups are not eligible for SR:

- Migrants/seasonal farmworkers.
- Homeless.
- Groups with only excluded earnings.
- Food assistance groups without countable earned income.

These groups continue to report changes using the standard Food Assistance reporting criteria; see Bridges Administrative Manual (BAM) 105 and Bridges Eligibility Manual (BEM) 610.

DETERMINING THE INCOME LIMIT

The income limit is 130 percent of the poverty level based on group size. To determine the group's SR income limit, all eligible members of the FAP group are counted; see Reference Tables Manual (RFT) **250**.

Disqualified members are **not** included in the group size when determining the income limit. However, their budgetable income is included in the group's total gross income when comparing to the income limit.

NOTIFICATION

Bridges sends information about simplified reporting including the DHS-1045, Simplified Six Month Review, to groups assigned to the SR category at the following times:

- Application.
- Redetermination.
- When assigned to the SR category as an ongoing case.

Bridges sends the simplified reporting information which explains the reporting requirement and provides the gross monthly income reporting requirements for the group based on their circumstances at the time of issuance. The DHS-1605, Notice of Case Action, sent at application and redetermination includes the specific income limit for the group based on the group size. This information should be emphasized during your discussion with the client to ensure their understanding of the SR requirements.

ASSIGNING BENEFIT PERIODS

Applications and Redeterminations

Groups meeting the SR category at application and redetermination are assigned a 12-month benefit period and are required to have a semi-annual contact. For applications and redeterminations, SR begins the first month of eligibility.

Example: On March 19, a group with earned income applies for FAP. The specialist processes the case on April 2. Benefits are approved beginning March 19. Bridges assigns a benefit period of March 19 through February 28. The DHS-1046, Semi-Annual Contact Report is sent out the beginning of the fifth month (July) of the benefit period. It is due back from the client on the first day of the sixth month (August.) Complete the budget to affect no later than the seventh month's benefits. At redetermination, the group's reporting requirements are re-evaluated based on their current circumstances. The specialist completes a redetermination in February for March. The benefit period is March 1 through February 28; see BAM 210.

Changes or Beginning SR During a Benefit Period

Bridges shortens the benefit period for ongoing groups who report starting earned income and have more than 12 months left in their benefit period. Bridges does all of the following:

- Sets the end date to 12 full months from the processing date.
- Issues a DHS-1605 explaining simplified reporting, household income limit and the new shortened benefit period end date.
- Issues a DHS-1045, Simplified Six-Month Review.

For groups whose benefit period has less than 12 months remaining at the time earnings are first reported, Bridges assigns the group to the SR category, but does **not** extend the benefit period. The current end date must be retained even though the end date is less than 12 months. If the group remains SR eligible at redetermination, Bridges assigns a new 12-month benefit period.

Example: On August 7, our client reports her husband returned to the group. The group currently follows standard reporting requirements; they are change reporters. The husband has earned income. The current benefit period end date is May 31. On August 17, the specialist processes the case change, Bridges issues simplified reporting requirements including a DHS-1045 and the end date remains May 31.

Once assigned to the SR category, groups retain their 12-month benefit period regardless of household changes, until the next benefit period is established.

If the group reports they are now homeless or they have stopped earnings, make all appropriate changes in Bridges and run Eligibility Determination Benefit Calculation (EDBC). However, they remain in SR until the semi-annual contact or redetermination. Their report status will change to a change reporter in:

- Month six for changes reported in months one through six of the benefit period (if they are still considered a change reporter).
- Month 12 for changes reported in months 7-12 (if they are still considered a change reporter).

PROCESSING CHANGES AND CASE ACTIONS

Benefit Increases/ Decreases

Timely action (within 10 days or other time frame specified in policy) **must** be taken on **all** reported changes such as applying for another program, regardless of whether the client is required to report the change; see BAM 220.

Processing Changes Reported on a DHS-1046, Semi-Annual Contact Report

When processing the DHS-1046 adequate notice is given for all discovered changes. These include changes such as automated system matches (consolidated inquiry, State On-line Query (SOLQ), reported for other programs and/or reported on the DHS-1046. Complete the budget to affect no later than the 7th month's benefits. Changes reported on the DHS-1046 and discovered through checking the automated system matches must be acted upon for all other programs according to case action policy in BAM 220.

Note: The Work Number is **not** an automated system match which must be checked at application, redetermination, semi-annual or

mid-certification contact. The client has primary responsibility for obtaining verification. However, if for example, verification of income is not available because the employer uses the Work Number and won't provide the employment information, it is appropriate to use the Work Number.

Do not deny or terminate assistance because an employer or other source refuses to verify income; see BAM 130**, VERIFICATION AND COLLATERAL CONTACTS,** and BEM 702, **CDC VERIFICATIONS**.

SPECIAL INCOME CONSIDERATION

Income considered unpredictable such as on-call hours remains budgeted until, based on reporting requirements, the client determines a change should be reported, or the next redetermination/semi-annual contact, whichever occurs first.

Contractual income that is ending prior to the benefit period end date will be considered verified upon initial report. Because the income is averaged over the period it is intended to cover, the end date has already been verified. Post a follow-up to remove the income for the subsequent month.

If the group reports that their gross income exceeds 130 percent of the poverty level but they remain eligible, they will be advised they are not required to report any other changes in income until their next redetermination/semi-annual contact.

LOSS OF EMPLOYMENT

Specialists must investigate the loss of employment at redetermination/semi-annual contact to determine if a voluntary quit has occurred. If the person does **not** meet the work requirement or good cause does **not** exist, a minimum one month disqualification must be served; see BEM 233B.

OVERISSUANCE/ UNDERISSUANCE AND SR

The only client error overissuances related to simplified reporting that can occur for FAP groups in SR are when the group fails to report that income exceeds the group's SR income limit, or the client voluntarily reports inaccurate information. For failure to report

income over the limit, the first month of the overissuance is two months after the actual monthly income exceeded the limit. Groups report if their actual income for a month exceeds 130 percent of poverty level. QC uses the actual income when determining whether a client should have reported; see BAM 715.

Example: The group's income for September exceeded the SR income limit. The group should have reported this by October 10th. The decrease would have been effective in November. November is the first month of the overissuance.

SR does **not** affect client errors that occur at application and redetermination. SR does **not** affect the determination of agency error overissuances.

OQA AND SR

To review a case under simplified reporting rules rather than change reporting rules, the following must be true:

- The case must have had earned income when it was put into SR.
- The case must be an SR eligible group; see **Who is Not Eligible for SR** in this item.
- The benefit period must be properly set; see **Assigning Benefit Periods** in this item.

LEGAL BASE

7 CFR 273.12

DEPARTMENT POLICY

All Programs

The policies in this item apply to:

- All **FIP, SDA** and **CDC** groups.
- **FAP** groups whose benefit period ends after the month of the potential reinstatement.
- **Medicaid** groups whose eligibility ends the month of, or later than, the month of potential reinstatement.

REINSTATEMENT REASONS

All Programs

Reinstatement restores a closed program to active status without completion of a new application. Closed programs may be reinstated for any of the following reasons:

- Closed in error.
- Closed-correct information not entered.
- Timely hearing request.
- Redetermination packet not logged in.
- Hearing decision ordered reinstatement.
- Complied with program requirements before negative action date.
- DHS-1046 manually sent and due date is after the last day of the 6th month.
- Court ordered reinstatement.
- MAGI Medicaid 90 day passive renewals.

STANDARD OF PROMPTNESS

All Programs

Reinstatements due to an agency error must be processed within timeframes outlined in BAM 220 processing case changes. Reinstatements ordered as part of a hearing decision must be processed within timeframes outlined in BAM 600.

FIP, SDA, RCA

Policy regarding the period for which an application form is considered valid is **not** applicable to reinstatements. However, if a redetermination was due or overdue at the time of closing or would have been due during the period the program was closed, complete the redetermination within 30 days of the date of reinstatement.

PROGRAM BENEFITS

All Programs

Bridges will determine eligibility and the amount of program benefits for the month of reinstatement and any months during which the program was closed, as if the program had not been closed. The client must update the application form if any changes occurred.

Initiate reinstatement by entering the date and reason for reinstatement on the Bridges program request screen, under individual information. Enter any changes in data collection before running EDBC and certifying the reinstatement. Once the reinstatement is certified, any and all benefits due to the client will be issued.

The eligibility begin and end dates for each program are determined by the policies indicated below:

- CDC - BAM 115 and 220.
- MA - BAM 210.
- FAP - BAM 400 and BAM 406.

Reinstatements that exceed 12 months must be processed by MDHHS exceptions.

NOTIFICATION

All Programs

Use a DHS-176 to inform the client when a request for reinstatement is denied.

LEGAL BASE

FIP

MCL 400.6,.37,.67

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

CDC

Child Care and Development Block Grant of 1990
45 CFR Parts 98 and 99
Social Security Act, as amended

MA

42 CFR 431.230,.231,.246,.250, 435.916(a)

FAP

7 CFR 273.15(k) and (s),.17(a), (b) and (f)

DEPARTMENT POLICY

All Programs

The Michigan Department of Health & Human Services (MDHHS) must periodically redetermine or renew an individual's eligibility for active programs. The redetermination/renewal process includes thorough review of all eligibility factors.

Redetermination, renewal, semi-annual and mid-certification forms are often used to redetermine eligibility of active programs.

However, the client **must** complete a DHS-1171, Assistance Application, to request a program that is not active at the time of redetermination or a DCH-1426, Application for Health Coverage and Help Paying Costs, to request Medicaid.

Local offices must assist clients who need and request help to complete applications, forms and obtain verifications; see Bridges Administrative Manual (BAM) 130, Obtaining Verification.

Medicaid

A redetermination is an eligibility review based on a reported change.

A renewal is the full review of eligibility factors completed annually.

PASSIVE RENEWAL

MAGI MEDICAID

MDHHS must use information currently available in STATE OF MICHIGAN systems to renew eligibility.

Do not request information from the beneficiary if the information is already available to MDHHS. This includes completing a renewal form.

Individuals must be able to select how many years to opt in to allowing MDHHS to access tax information to determine continuing eligibility, up to a maximum of 5 years.

Individuals must also have the opportunity to opt out of allowing the use of tax information. Do not include individuals in the passive renewal process if this question is not answered on the application.

Only information that has changed or is missing may be requested from the beneficiary. The beneficiary is not required to take any action, such as signing or returning a notice if there has been no change in their circumstances.

If the information is not sufficient to renew eligibility, MDHHS must send a pre-populated renewal form to the beneficiary.

Allow the beneficiary 30 calendar days to respond and return the renewal form.

MDHHS must notify the beneficiary of their eligibility and the basis for the determination.

EX PARTE REVIEW

Medicaid (MA) Only

An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid.

When possible, an ex parte review should begin at least 90 calendar days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

REDETERMINATION/ RENEWAL CYCLE

All Programs

A complete redetermination/renewal is required at least every 12 months. Bridges sets the redetermination/renewal date according to benefit periods; see Eligibility Decisions in BAM 115. Redeterminations/renewals may be scheduled early or are scheduled less than 12 months apart when necessary for:

- Error-prone cases, in response to supervisory case readings, quality assurance data or quality enhancement data.
- **MA only**, newborn cases must be renewed no later than the month of the child's first birthday; see Bridges Eligibility Manual (BEM) 145.

- **Food Assistance Program (FAP)** cases with unstable circumstances assigned a three-month benefit period.

Exception #1: Some MA groups do **not** require a renewal; see No MA Renewal in this item.

Exception #2: Some FAP groups are assigned a 24-month benefit period and **require only** a mid-certification contact in the 12th month; see Mid-Certification Contact in this item. For MA, a companion case for a spouse may also be given the extended benefit period once the mid-certification notice has been received and reviewed. Michigan Combined Application Project (MiCAP) cases are assigned a 36-month benefit period.

FAP Only

Benefits stop at the end of the benefit period **unless** a redetermination is completed **and** a new benefit period is certified. If the client does not begin the redetermination process, allow the benefit period to expire. The redetermination process begins when the client files a DHS-1171, Assistance Application; DHS-1010, Redetermination; DHS-1171, Filing Form; DHS-2063B, Food Assistance Benefits Redetermination Filing Record. See; **Subsequent Processing** in this item.

Child Development and Care (CDC) Only

A redetermination for CDC cannot be completed earlier than the 12 month eligibility period.

Medicaid

Benefits stop at the end of the benefit period **unless** a renewal is completed **and** a new benefit period is certified. Also, the renewal month is 12 months from the **date the most recent complete application was submitted.**

In a Group 2 Persons Under 21 case, if a member will reach age 21 **before** the month the case is scheduled to be renewed, an ex parte review (see glossary) should begin at least 90 days prior to the date the member turns 21; see BAM 220.

In a Special N/Support, Title IV-E or Foster Care TMA case, an ex parte review should begin at least 90 days prior to the date the case is scheduled to close; see BAM 220.

No Medicaid Renewal

Medicaid Only

Do **not** renew the following:

- Special N/Support; see BEM 113.
- Title IV-E recipients; see BEM 117.
- Special needs adoption assistance recipients; see BEM 117.
- Department wards; see BEM 117.
- Supplemental Security Income (SSI) recipients; see BEM 150.

Note: A review must be completed before closing an individual in one of these categories if the closure is for any reason other than total ineligibility for any MA (such as moved out of state or death).The review must consider eligibility in all other MA categories.

INTERVIEW REQUIREMENTS

FIP, State Disability Assistance (SDA), Refugee Cash Assistance (RCA), CDC and FAP

Interview requirements are determined by the program that is being redetermined.

FAP Only

An interview is required before denying a redetermination even if it is clear from the DHS-1010/1171 or other sources that the group is ineligible.

Indicate on the individual interviewed/applicant-details screen in Bridges who was interviewed and how the interview was held, such as by telephone, in person etc.

Medicaid

Do **not** require an in-person interview as a condition of eligibility.

CDC Only

There is no redetermination interview requirement for CDC.

Telephone

FAP Only

The individual interviewed may be the client, the client's spouse, any other responsible member of the group or the client's authorized representative. If the client misses the interview, Bridges sends a DHS-254, Notice of Missed Interview.

Conduct a telephone interview at redetermination before determining ongoing eligibility. However, conduct an in-person interview if one of the following exists:

- The client requests one.
- It is determined appropriate. For example, information on the application is suspected to be fraudulent.

  Exception: Do **not** require an in-office interview if the client is experiencing a hardship which prevents an in-office interview. Instead, conduct the in-person interview at the client's home or another agreed upon location. Hardship conditions include but are **not** limited to: illness, transportation difficulties, work hours.

- The specialist is processing a joint SDA/RCA and FAP redetermination; see Jointly Redetermined SDA/RCA and FAP Cases in this item.

Note: When conducting a telephone interview, ask the caller a question only the head of household could answer (such as last four digits of his/her Social Security number, date of birth, etc.) to ensure the identity of the caller.

In-Person

State Disability Assistance (SDA)

All individuals with a SDA Eligibility Determination Group (EDG) participation status of eligible or disqualified adult who are physically able must be interviewed and must sign and date the DHS-1010 or DHS-1171 in the specialist's presence.

Interviews are usually conducted at the local office but may be held in a group's home if:

- The head of household's physical condition precludes an office interview.
- A home call would result in better information.

FIP Only

The specialist must conduct a telephone interview with the head of household at redetermination before certifying continued eligibility. However, conduct an in-person interview if one of the following exists:

- The client requests one.
- The specialist determines it is appropriate. For example, the specialist suspects information in the DHS-1171 or DHS-1010 is fraudulent or the DHS-1171 or DHS-1010 signatures are questionable.

Note: When conducting a telephone interview, ask the head of household a question only the head of household could answer (such as last four digits of his/her Social Security number, date of birth, etc.) to ensure the identity of the caller. Document the case record with the answer.

Each adult EDG member must sign the DHS-1538, Work and Self-Sufficiency Rules, at redetermination. Send **each** adult EDG member in the home the DHS-1538 at redetermination. **Each** DHS-1538 must be signed **and** returned for **all** adult EDG members **before** FIP redetermination can be approved.

Member Add at Redetermination

FIP Only

At redetermination, if an adult mandatory group member is added to the group, the specialist must do the following:

- Conduct a telephone or in-person interview with the adult mandatory group member; see BAM 115, Telephone Interviews.
- Review the list of FIP requirements; see BAM 115, Interviews.
- Send the new adult mandatory group member the DHS-1173, Cash Assistance Rights and Responsibilities, **and** DHS-1538.

Do **not** approve the redetermination until the DHS-1173 **and** DHS-1538 are signed **and** returned.

Jointly Redetermined SDA/RCA and FAP Cases

SDA/RCA and FAP

Conduct an in-person interview at redetermination before determining ongoing eligibility. The head of household or authorized representative must sign and date the DHS-1010 or DHS-1171 in the presence of a MDHHS specialist even if it was already signed. Sign and date the application as a witness.

Exception: For FAP, do **not** require an in-office interview if the client is experiencing a hardship which prevents an in-office interview. Instead, conduct the in-person interview by telephone or at the client's home or another agreed upon location. Hardship conditions include but are **not** limited to: illness, transportation difficulties, work hours, etc.

SCHEDULING

All Programs

Bridges generates a redetermination packet to the client three days prior to the negative action cut-off date in the month before the redetermination is due. Bridges sends a DHS-2063B, Continuing Your Food Assistance Benefits, to **FAP** clients for whom FIP, SDA, or Medicaid are **not** active. The packet is sent to the mailing address in Bridges. The packet is sent to the physical address when there is no mailing address. The packet is also sent to the MA authorized representative on file.

Redetermination/renewal forms may include:

- DHS-574, Redetermination Telephone Interview (FIP and FAP).
- DHS-1010, Redetermination (all programs).
- DHS-1046, Semi-Annual Contact Report (FAP).
- DHS-1171, Assistance Application (all programs except Medicaid).
- DHS-2240-A, Mid-Certification Contact Notice (MA and FAP).

- DHS-2063-B, Continuing Your Food Assistance Benefits (FAP).
- DCH-1426, Application for Health Coverage and Help Paying Costs.
- DHS-4574, Medicaid Application (Patient of Nursing Facility).

The packet includes the following as determined by the TOA to be redetermined:

- Redetermination/review/renewal form indicated above.
- Notice of review as determined by policy.
- Interview date.
- Interview type.
- Place and time.
- Required verifications.
- Due date.
- Return envelope.

FAP Only

If the DHS-1171 and the DHS-2063-B must be manually sent, mail them **no later** than two workdays before the first day of the redetermination month. If the forms are **not** mailed within that time period, adjust the timely filing date; see FAP Timely And Untimely Filing Date in this item.

Clients may be, but are **not** required to be, interviewed before the timely filing date.

CDC Only

At redetermination, if the 1171, 1010, Renew My Benefits, is used and has not been updated with the CDC asset question, the client will need to be contacted to certify the program group's assets do not exceed $1 million.

Early Redetermination

FIP, SDA, RCA, MA and FAP

Redetermination of an active program may be scheduled up to three months before the review date. Redetermination of active programs may be necessary for one of the following reasons:

- Case is found to be error-prone as a result of supervisory case reading, quality assurance data or quality enhancement data.
- Specialist's schedule requires early redetermination of active program.
- To align dates to simultaneously process redeterminations for multiple programs. Bridges does this automatically for all programs except certain MA programs such as TMA.

Initiate redetermination early by selecting that option from the Bridges left navigation. Enter the case number and select the program(s) to be redetermined early from the list of options that are determined by the case number.

CDC Only

A redetermination for CDC cannot be completed earlier than the 12 month eligibility period.

FAP Only

When a redetermination is scheduled early, FAP benefits cannot be terminated **prior** to the end of the benefit period for failure to complete the redetermination process.

Children Under 19 (U19) and MIChild (MCD)

Do **not** shorten a beneficiary's 12-month eligibility period.

Once eligible for Children Under 19 or MIChild, a beneficiary remains eligible until the next redetermination unless any of the following occurs:

- Reaches age 19.
- Moves out of state.
- Is ineligible due to institutional status; see BEM 265.
- Death.

A member may be added to an existing case even though the redetermination date is less than 12 months in the future.

Note: If eligibility was granted based on incorrect or fraudulent information, continuous eligibility may be interrupted.

Mid-Certification/ Semi-Annual Contact

FAP Only

Bridges sends a DHS-2240-A, Mid-Certification Contact Notice, for groups assigned a 24-month benefit period during the 11th month of their benefit period and a DHS-1046, Semi-Annual Contact Report, the beginning of the fifth month for cases assigned a 12-month benefit period.

Note: Manually send from Bridges and track the DHS-1046 if it is discovered that a case was not correctly assigned as a simplified reporter by the last day of the fourth month of the benefit period.

Groups assigned a 24-month benefit period must submit a complete DHS-2240-A, Mid-Certification Contact Notice. A complete DHS-1046, Semi-Annual Contact Report, must be submitted by groups with countable earnings and a 12-month benefit period; see BAM 115, Benefit Periods.

The DHS-1046 and DHS-2240A may be completed by the client, the client's authorized filing representative or by the specialist (during a telephone call, home call or interview with the client). However, the form must be signed by the client or authorized filing representative.

A report is considered complete when all of the sections (including the signature section) on the DHS-1046 and the DHS 2240-A are answered completely **and** required verifications are returned by the client or client's authorized representative. If an expense has changed and the client does not return proof of the expense, but all of the sections on the report are answered completely, remove the expense from the appropriate data collection screen in Bridges before running eligibility determination and benefit calculation (EDBC).

24-Month Benefit Period

The mid-certification contact notice must be recorded, data collection updated and EDBC results certified in Bridges by the last day of the 12th month after a completed DHS-2240-A and all required verifications are received.

Note: Run EDBC even if the client indicates no changes so Bridges will recognize the DHS-2240-A has been processed.

12-Month Benefit Period

The semi-annual contact report must be recorded, data collection updated and EDBC results certified in Bridges by the last day of the sixth month of the benefit period to affect benefits no later than the seventh month. The contact is met by receipt of a completed DHS-1046 and required verifications.

Processing DHS-1046

The client's gross earned income from his/her most current budget is pre-filled on the DHS-1046. If the client's gross income has changed by more than $100 from the pre-filled amount on the form, he/she must return verification of his/her past 30 days of earnings with his/her completed DHS-1046.

If the client indicates his/her gross earned income has **not** changed by more than $100, verification of the past 30 days is not required. However, income **must** be budgeted and EDBC run if a client checks "No" to the questions, but supplies proof of income.

Note: Run EDBC so Bridges will recognize the DHS-1046 has been processed.

Medicaid only

The DHS 2240-A may be used to complete an ex parte review of MA or certify a second 12-month MA period when the group has a 24-month FAP certification.

REDETERMINATION PACKET RECEIVED

All Programs

A redetermination/review packet is considered complete when all of the sections of the redetermination form including the signature section are completed.

Exception: For FIP, SDA and FAP only, if any section of the redetermination/review packet has not been completed but there is a signature, consider the redetermination/review complete. Complete any missing sections during the interview.

When a complete packet is received, record the receipt in Bridges as soon as administratively possible.

If the redetermination is submitted through MI Bridges, the receipt of the packet will be automatically recorded.

Failure to Record Receipt of Redetermination Packet

CDC Only

When redetermination packets are not logged by the 10th day of the redetermination month, the DHS-5322, Notice of Potential Child Development and Care (CDC) Closure, will be generated by Bridges to the client. This notice informs the client that CDC benefits will end the pay period that holds the last day of the month.

FIP, SDA, and CDC

If the redetermination packet is not logged in by the negative action cut-off date of the redetermination month, Bridges generates a DHS-1605, Notice of Case Action, and automatically closes the EDG.

FAP only

If the redetermination packet is not logged in by the last working day of the redetermination month, Bridges automatically closes the EDG. A DHS-1605 is not generated.

Medicaid only

Benefits are not automatically terminated for failure to record receipt of the renewal packet.

Failure to Record Receipt of the Mid-Certification Contact Notice

FAP Only

If the DHS-2240A is **not** logged in Bridges by the 10th day of the 12th month, Bridges will generate a DHS-2240B, Potential Food Assistance (FAP) Closure, to the client. This reminder notice explains that the client must return the DHS-2240A and all required verifications by the last day of the month, or the case will close.

If the client fails to return a complete DHS-2240A by the last day of the 12th month. Bridges will automatically close the case. If the client reapplies, treat it as a new application and Bridges will prorate the benefits.

If the completed DHS-2240A and verifications are returned by the last day of the 12th month, process the changes to ensure the client's benefits are available no later than 10 days after their normal issuance date in the 13th month of the benefit period.

Failure to Record Receipt of the Semi-Annual Contact Report

If the DHS-1046 is not logged in Bridges by the 10th day of the sixth month, Bridges will generate a DHS-1046A, Potential Food Assistance (FAP) Closure, to the client. This reminder notice explains that the client must return the DHS-1046 and all required verifications by the last day of the month, or the case will close.

If the client fails to return a complete DHS-1046 by the last day of the sixth month. Bridges will automatically close the case. If the client reapplies, treat it as a new application and Bridges will prorate the benefits.

If the completed DHS-1046 and verifications are returned by the last day of the sixth month, process the changes to ensure the client's benefits are available no later than 10 days after their normal issuance date in the seventh month of the benefit period.

Conducting the Interview

FIP, SDA and FAP

- Obtain a complete redetermination/review packet from the client.
- Compare the redetermination/review document to the existing DHS-1171 or previous DHS-1010 and other case data.
  - Reconcile any discrepancies and ensure anything omitted is completed.
- Review the verifications and reconcile discrepancies.

- Verbally cover the rights and responsibilities with the client and refer them to view online, the following sections of the PUB-1010, Important Things About Programs and Services:
  - Things You Must Do.
  - Important Things To Know.
  - Repay Agreements.
  - Information About Your Household That Will Be Shared.

SDA Only

- Have the client re-sign and date the DHS-1010 as part of the in-person interview.

  Exception: For FAP, re-signing the DHS-1010 is required only for jointly processed SDA/FAP cases.

- Sign and date the DHS-1010 as a witness as part of the in-person interview.

FIP Only

- Review the Family Self-Sufficiency Plan (FSSP) for compliance.
- Identify any barriers to the family's self-sufficiency and strategies for client to overcome them.
- Update each FSSP to identify the specific steps the individual will take towards family self-sufficiency.
- Review work participation requirements. Identify any potential deferrals listed in BEM 230A.
- Review direct support service opportunities, including transportation and child care; see BEM 229.
- Review penalties for non-compliance; see BEM 233A.
- Review FIP time limits; see BEM 234.
- Explain the prohibited use of FIP to: purchase lottery tickets, alcohol, tobacco, or for gambling, illegal activities, massage parlors, spas, tattoo shops, bail-bond agencies, adult entertainment, cruise ships, or other nonessential items.

FAP TIMELY AND UNTIMELY FILING DATE

FAP Only

Timely Filing Date

In order to receive uninterrupted benefits (benefits available on his/her scheduled issuance date), the client must file the redetermination through MI Bridges or file either a DHS-1010, Redetermination, DHS-1171, Assistance Application, or a DHS-2063B, Continuing Food Assistance Benefits, by the fifteenth of the redetermination month.

Exception: If the client's redetermination materials are mailed late, the timely filing date is 17 days **after** the materials are mailed.

> **Example:** Madison's FAP redetermination is due in July. The redetermination materials are mailed July 6 with a due date of July 16 on the DHS-3503. Madison returns all necessary items needed to complete her review on July 20. Her filing date is timely because her review materials were mailed late. Her benefits must be available to her on the scheduled issuance date.

When processing a redetermination for FAP and FIP, SDA, or MA, consider the FAP redetermination filed timely if it is filed timely for the other program; see FAP Client Failure to Meet Redetermination Requirements.

Untimely Filing Date

FAP Only

Any FAP redetermination form **not** submitted timely (see above) has the same processing timeframe as an initial application (30 days from the date the redetermination was filed); see FAP Client Failure to Meet Redetermination Requirements in this item.

VERIFICATIONS DEADLINE

FIP, SDA, CDC and MA

Verifications are due the same date as the redetermination/review interview. When an interview is not required, verifications are due the date the packet is due.

Bridges allows clients a full 10 calendar days from the date the verification is requested (date of request is not counted) to provide all documents and information. If the tenth day falls on a weekend or holiday, the verification would not be due until the next business day.

MAGI Medicaid beneficiaries have 30 calendar days to return the pre-populated renewal form.

Bridges gives timely notice of the negative action if the time limit is **not** met.

FAP Only

Verifications must be provided by the end of the current benefit period **or** within 10 days after they are requested, whichever allows more time. If the tenth day falls on a weekend or holiday, the verification will not be due until the next business day.

Note: The DHS-3503, Verification Checklist, should be sent after the redetermination interview for any missing verifications allowing 10 days for their return.

> **Example:** Client returns a complete DHS-1010 on the last day of the benefit period and fails to provide verification of income. Request income verification allowing the client 10 days to return verification.

If verifications are provided by the required deadline but too late for normal benefit issuance, benefits must be issued within five workdays.

Note: If an expense has changed and the client does not return proof of the expense, but all of the sections on the report are answered completely, end-date the expense from the appropriate data collection screen(s) in Bridges before running EDBC.

CDC Only

If the redetermination verifications are not returned by the 10th calendar day or are returned incomplete, two 10-day extensions must be given to the client resending VCL's after each verification due date. The client does not need to request the extensions.

COMPLETING THE REDETERMINATION/ RENEWAL

All Programs

To complete the redetermination/renewal process, do **all** of the following:

- Obtain a DHS-1171, DHS-1010 or other review document.
- Record packet received by selecting that item from the left navigation in Bridges and entering the date received.
- Review, document and verify eligibility factors as required.
- MAGI Medicaid uses the H79, Redetermination & Renewal Verification (RRV) Service to perform income verifications.
- **Except for** Children Under 19 (U19) and MIChild (MCD)**,** check **all** available automated systems matches to see if income has started, stopped or changed, such as consolidated inquiry, State On-line Query (SOLQ), etc.

Note: The Work Number is **not** an automated system match which must be checked at application, redetermination, semi-annual or mid-certification contact. The client has primary responsibility for obtaining verification. However, if for example, verification of income is not available because the employer uses the Work Number and won't provide the employment information, it is appropriate to use the Work Number.

Do not deny or terminate assistance because an employer or other source refuses to verify income; see BAM 130, VERIFICATION AND COLLATERAL CONTACTS and BEM 702, CDC VERIFICATIONS.

- Update data collection by recording changes in circumstances and entering verifications received.

- Run EDBC in Bridges.
- Certify EDBC results if appropriate.
- Review the need for services and other assistance programs.

Bridges generates a verification checklist (VCL) for any missing verifications.

Upon Certification

- Prepare the case record; see BAM 300.
- Send Pub. 280, Reporting Changes - When To Report - How To Report - What To Report.

  Exception: Do not send to FAP groups assigned to simplified reporting.
- Bridges sends a DHS-2240, Change Report Form, as needed.

  Exception: A DHS-2240, Change Report Form, is not sent to FAP groups assigned to Simplified Reporting, Children under 19 (U19).
- Bridges sends a DHS-1605, explaining simplified reporting and household income limit, and a DHS-1045, Simplified Six-Month Review, to FAP groups assigned to simplified reporting.
- Bridges produces and sends a DHS-198C, Child Development and Care (CDC) Client Notice, to the client.
- Bridges produces and sends a DHS-198, Child Development and Care (CDC) Provider Notice, to the provider(s).
- Bridges produces and sends a DHS-1606, Health Care Coverage notice which details the information used to determine eligibility.

STANDARD OF PROMPTNESS

All Programs

Bridges generates a redetermination packet to the client three days prior to the negative action cut-off date in the month before the redetermination is due. This allows time to process the redetermination before the end of the redetermination month.

Reinstatements in Month Prior to Redetermination Month

If an EDG closes and is due for redetermination the following month and is subsequently reinstated at least three days prior to the current month's negative action cut-off date, the redetermination packet will be generated as usual.

If an EDG closes and is due for redetermination the following month and is subsequently reinstated on or after three days prior to the current month's negative action cut-off date, the redetermination packet will be generated at month end.

FAP Only

The FAP redetermination must be completed by the end of the current benefit period so that the client can receive uninterrupted benefits by the normal issuance date.

If timely redetermination procedures are met, but too late to meet the normal issuance date, issue benefits within five workdays.

Bridges will issue a payment for lost benefits if the client is **not** at fault for delayed processing that prevented participation in the first month.

CDC CLIENT FAILURE TO MEET REDETERMINE REQUIRMENTS

CDC Only

A CDC case that closes for failure to meet redetermination requirements will not be eligible for re-entry into the program if the program group's income exceeds the $15 family contribution maximum income in the income eligibility scale in RFT 270.

FAP CLIENT FAILURE TO MEET REDETERMINATION REQUIREMENTS

FAP Only

Delays

The group loses its right to uninterrupted FAP benefits if it fails to do any of the following:

- File the FAP redetermination by the timely filing date.
- Participate in the scheduled interview.
- Submit verifications timely, provided the requested submittal date is **after** the timely filing date.

Any of these reasons can cause a delay in processing the redetermination. When the group is at fault for the delay, the redetermination must be completed within 30 days of the compliance date.

If there is no refusal to cooperate and the group complies by the 30th day, issue benefits within 30 days of the compliance date. Benefits are not prorated.

Subsequent Processing

If a client files an application for redetermination before the end of the benefit period, but fails to take a required action, the case is denied at the end of the benefit period. Proceed as follows if the client takes the required action within 30 days after the end of the benefit period:

- Re-register the redetermination application using the date the client **completed** the process.

- If the client is eligible, prorate benefits from the date the redetermination application was registered.

Example 1:

- On January 5, client returns DHS-1010 for a certification period ending January 31.

- On January 31, redetermination is denied for failure to return verifications.

- On February 10, client returns required verifications.
- Re-register the original redetermination application with the February 10 date and issue prorated benefits from February 10.

Example 2:

- On January 3, client returned DHS-1010 for a certification period ending January 31.
- On January 31, redetermination is denied for failure to return verifications.
- On February 2, client files a new application.
- On February 10, client returns required verifications from January redetermination.
- Use the February 2nd date to process benefits.

Example 3:

- Client has a redetermination due for February with the certification period ending February 28.
- On February 28, case closes for failure to return the DHS-1010.
- On March 10, client returns completed DHS-1010.
- Client must complete a new application for FAP since they returned the completed DHS-1010 after the end of the benefit period.

REPORT OF REDETERMINATIONS

All Programs

RD-093

The monthly RD-093, Redetermination Report - Worker Listing, lists the following:

- FIP, SDA, MA, and CDC cases that are past due more than one month.

- FIP, SDA, MA, and CDC cases that are past due one month.
- FIP, SDA, MA, CDC, and FAP cases that are due this month.
- FIP, SDA, MA, CDC, and FAP cases that are due next month.
- FIP, SDA, MA, CDC, and FAP cases that are due in two months.
- FAP and MA cases that are due for a mid-certification contact.

RD-093, Long Term Care (LTC) Case Identification

MA Only

The LTC-application indicator (4574) on the RD-093 identifies MA LTC cases. Bridges sends the DHS-4574, Medicaid Application (Patient of Nursing Facility), in the redetermination packet for the MA redetermination when a DHS-4574 was filed at application.

RD-093, Deductible Case Identification

MA Only

The deductible indicator (#) identifies active deductible cases. This indicator will be printed when the member of an MA EDG has a deductible amount.

LEGAL BASE

FIP

MCL 400.32, MCL 400.43, MCL 400.55(f)

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

FAP

7 CFR 273.10(g)(2)
7 CFR 273.14
7 U.S.C. 2020

MA

42 CFR 435.916(a)

CDC

Child Care and Development Block Grant of 1990 as amended,
Public Act 6 of 2014
45 CFR Parts 98 and 99
Social Security Act, as amended
Mich Admin Code, R 400.5001 - 400.5020

DEPARTMENT POLICY

Family Independence Program (FIP), Refugee Cash Assistance (RCA), State Disability Assistance (SDA), Child Development and Care (CDC), Medicaid (MA), Food Assistance Program (FAP)

Process the following case actions:

- Initial applications and reapplications; Bridges Administrative Manual (BAM) 115, Application Processing.
- Redeterminations; BAM 210,
- Reinstatements; BAM 205.

Bridges will evaluate each change reported and entered in the system to determine if it affects eligibility.

Exception: For Medicaid only**,** the Michigan Department of Health and Human Services (MDHHS) health services side, shares responsibility for medical services authorization (MSA) and certain related determinations when a recipient in managed care (Level of Care 07) becomes a Long Term Care/Hospital patient; see BAM 120, DCH/ DHS Coordination, for details.

Changes in circumstances may be reported by the client, via computer tape matches, through quality assurance (QA) reviews, or by other means.

A **positive action** is a Michigan Department of Health & Human Services (MDHHS) action to approve an application or increase a benefit.

A **negative action** is a MDHHS action to deny an application or to reduce, suspend or terminate a benefit. This includes an increase in a post-eligibility patient-pay amount for MA or an increase in the client pay for a special living arrangement.

CDC Only

Changes reported by clients may affect eligibility for other programs, but may not affect the current CDC eligibility or benefit. Only changes that would positively affect the client's family contribution or authorized hours, or those listed in CDC EDG Closure Reasons, should be acted on.

Note: See BEM 703, Request for Additional Assistance, for policy pertaining to a request for an additional provider, need reason or need hours for an active client during the 12-month continuous eligibility period.

CDC clients are required to report, within 10 calendar days, changes in:

- Group composition/death.
- Out of state residency.
- Providers or child care setting.
- Assets that exceed $1 million.
- When income exceeds the income eligibility scale for the group size; see RFT 270, CDC Flat-Rate Family Contribution.

NOTICE OF CASE ACTIONS

All Programs

Upon certification of eligibility results, Bridges automatically notifies the client in writing of positive and negative actions by generating the appropriate notice of case action. The notice of case action is printed and mailed centrally from the consolidated print center.

For **FAP Only**, see Actions Not Requiring Notice in this item.

Exception: Written notice is **not** required to implement a hearing decision or policy hearing authority decision.

Refer to policy in BAM 600, Hearings, if a client disputes a case action.

There are two types of written notice: **adequate** and **timely**.

A notice of case action must specify the following:

- The action(s) being taken by the department.
- The reason(s) for the action.
- The specific manual item which cites the legal base for an action or the regulation or law itself.
- An explanation of the right to request a hearing.
- The conditions under which benefits are continued if a hearing is requested.

Adequate Notice

An adequate notice is a written notice sent to the client at the same time an action takes effect (not pended). Adequate notice is given in the following circumstances:

All Programs

- Approval/denial of an application.
- Increase in benefits.

FIP, RCA, SDA, MA, CDC

- A recipient or his legal guardian or authorized representative requests in writing that the case be closed.
- Factual information confirms a recipient's death.
- It is verified that a recipient has been approved for assistance in another state.
- It is verified that an eligible child, **or in MA,** an eligible group member of any age, has been removed from the home as a result of court action.

FIP, SDA, and FAP Only

An intentional program violation (IPV) disqualifies the only eligible member or reduces/terminates other members' benefits. See the DISQUALIFICATION section in BAM 720, Intentional Program Violation, for notice procedures and forms.

FIP and MA Only

Denial of request for medical transportation.

SDA Only

Case closure due to a member's receipt of Supplemental Security Income.

CDC Only

- The client or provider reports, orally or in writing, that a child is no longer in the care of that provider.
- The client or provider reports, orally or in writing, a need for fewer authorized hours.

- It is verified that a child member of the program group was voluntarily placed in foster care.

- Information verifies the provider is no longer eligible to receive payments.

MA Only

- Case opening with a deductible or patient-pay amount.
- Decrease in post-eligibility patient-pay amount.
- Recipient removed due to his eligible status in another case.
- Addition of MA coverage on a deductible case.
- Increase in medical benefits.
  Divestment penalty when level of care (LC) code is blank or 20.

FAP Only

- Negative action results from information on the DL-060, Child Support Information Report.

- The change was reported in writing and signed by an eligible group member **and** the new benefit level or ineligibility can be determined based **solely** on the written information.

  Note: When deleting a member, an application the client files on their own, **or** the updated application of a group they join, is considered a change reported in writing by an eligible member of the former group.

- Reliable information indicates the group will leave the state before the next issuance.

- Changes reported on a DHS-1046, Semi-Annual Contact Report.

Timely Notice

All Programs

Timely notice is given for a **negative action** unless policy specifies adequate notice or no notice. See Adequate Notice and, for CDC and FAP only, Actions Not Requiring Notice, in this item. A timely notice is mailed at least 11 days before the intended negative action takes effect. The action is pended to provide the client a chance to react to the proposed action.

Actions Not Requiring Notice

FAP Only

A notice of case action is **not** sent in the situations below. The action must take effect no later than the month after the change.

- Reliable information indicates the group left the state.
- Reliable information indicates all members died. Reliable sources generally include a newspaper, friends or relatives of the group, or other agencies.
- Supplementation over multiple months to restore lost benefits is completed; see BAM 406, Supplemental Food Assistance Benefits.
- From a joint FIP/SDA and FAP application, the FAP benefit began first **and** the FAP approval letter indicated the benefit might decrease if FIP/SDA were later approved.
- The FAP benefit varies from month to month within the benefit period due to changes anticipated when the case was certified, **and** the group was so notified at that time.
- Benefits are reduced for failure to repay a FAP overissuance that resulted from IPV (BAM 720, Intentional Program Violation) or client error (BAM 715, Client/CDC Provider Violation). See BAM 725, Collection Actions.
- The FAP certification period has expired and redetermination application was not filed.
- The group voluntarily requests closure in writing.

Child Care Provider Authorization

CDC Only

Bridges generates a DHS-198, Child Development and Care (CDC) Provider Notice, to notify CDC providers when:

- An authorization is added.
- There is a change in the authorization period.

- The authorized hours change.
- Closing the CDC eligibility determination groups (EDG).
- The family contribution changes.

A manual DHS-198 must be sent by the specialist when a manual authorization is entered in Bridges.

MASS UPDATES

All Programs

Certain changes result from changes by the federal or state government and involve mass updates of the entire or major portions of the caseload. Central office usually processes most of the affected cases through Bridges mass update and mails notices to client. Local offices are often required to assist in a mass update, as specified in a program policy bulletin.

Mass updates affecting various programs include:

- Annual FAP standards update.
- Retirement and Survivors Disability Insurance updates.
- Periodic changes in program benefit amounts.
- Other changes in eligibility factors based on laws or regulations.

STANDARDS OF PROMPTNESS

All Programs

The standard of promptness (SOP) is the maximum time allowed to complete a required case action. Cases should be processed as quickly as possible. The SOP sometimes varies by program.

Change Reported Via Tape Matches

All Programs

Case actions resulting from changes reported via tape match (BENDEX, SDX, IRS, enumeration, etc.) must be completed within 45 days of receiving the information.

It is a best practice to resolve information obtained from a State New Hires report and/or a National Directory of New Hires report within 21 calendar days from the date the match is reported to the specialist.

All Other Reported Changes

FIP, RCA, SDA, CDC and MA

Act on a change reported by means other than a tape match within 15 workdays after becoming aware of the change.

FAP Only

Act on a change reported by means other than a tape match within 10 days of becoming aware of the change.

Benefit Increases: Changes which result in an increase in the household's benefits must be effective no later than the first allotment issued 10 days after the date the change was reported, provided any necessary verification was returned by the due date. A supplemental issuance may be necessary in some cases. If necessary verification is **not** returned by the due date, take appropriate action based on what type of verification was requested. If verification is returned late, the increase must affect the month after verification is returned.

Example: Rich reports on March 23rd that he now has a shelter expense. Act on the change by April 2nd. May's benefits will be the first month affected because the 10th day after the change is reported falls in the next benefit period. Affect the April issuance if the action can be completed by March 31st.

If verification is required or deemed necessary, allow the household 10 days from the date the change is reported to provide the verification. The change must still affect the correct issuance month. For example, the first benefit month occurring 10 days after the date the change was reported.

Example: Rich reports a shelter change on March 21st. However, verification of his new shelter obligation is requested late on March 23rd. Rich provides the verification on April 2nd. Make the change to affect April's benefits by using a supplemental issuance.

If verification is required or deemed necessary but the client fails to return the verification within 10 days after the change was reported, but does provide the verification at a later date, act on the change within 10 days after the verification is provided.

Example: Using the previous example, Rich does not supply the shelter verification until April 6th. Act on the change by April16th to

affect May's benefits. No supplement is issued for April, due to Rich's failure to return the verification within 10 days.

Benefit Decreases: If the reported change will decrease the benefits or make the household ineligible, action must be taken and a notice issued to the client within 10 days of the reported change.

Example: Debra calls on March 22nd and reports that her husband left the home. Act on the change and issue the negative action notice by April 1st. The change will be effective for May's benefits.

Example: Mary calls on March 19th and reports that her rental expense went from $300 per month to $250 per month. Even though Mary must be allowed 10 days to return verification of her decreased shelter costs, act on this change and issue the negative action notice by March 29th. If the verification is not returned within 10 days, begin a second negative action to remove the expense completely.

EFFECTIVE DATE OF CHANGE

All Programs

Bridges evaluates the following dates entered in data collection to determine positive action dates, negative action dates and effective dates:

- Circumstance start/change date.
- Reported on.
- Verification received on.
- Date client became aware.

FIP, RCA, SDA and FAP Only

See BEM 505, Prospective Budgeting/Income Change Processing, for policy regarding effective dates for income changes.

FIP, RCA and SDA Only

See Bridges Eligibility Manual (BEM) 515 FIP/RCA/SDA Budget, for policy regarding effective dates for member adds.

CDC Only

Act on reported changes as soon as possible, but act within the standard of promptness; see STANDARDS OF PROMPTNESS in this item. The day a reported change is acted on is not always the day the change must take effect.

Example: A client had prior pay periods certified for CDC. The client failed to report an increase in income that exceeded the income eligibility scale for the group size. When the income is updated, eligibility determination and benefit calculation (EDBC) will re-run from when the change occurred. Bridges would then generate zero approved hours or an over-payment. The client would then be denied the pay period after the change occurred for excess income.

Positive Actions can be entered on Bridges to affect current, future, and past CDC pay periods. First determine the positive action date. If the change was reported timely, for example a change in providers, (within 10 calendar days), the positive action date is the day the change occurred or is expected to occur. If the change was reported late, the positive action date is the day the change was reported. Positive actions take effect on the positive action date.

Exception: Family contribution decreases, that are not a result of a provider receiving a higher star rating are positive actions and affect the first CDC pay period that begins on or after the positive action date.

Note: For a new or changed authorization to take effect on the positive action date, begin it the first day of the CDC pay period that contains the positive action date.

Negative Actions: If timely notice is required, the negative action date must be the first workday at least 11 days after the notice was sent, or the date the change is expected to occur if that is later. If adequate or no notice is required, the negative action date is immediate (the day action is taken on the change), but not before the change is expected to occur.

The following negative changes entered on Bridges take effect as follows:

- Family contribution increases are a negative action and take affect the first CDC pay period that starts on or after the negative action date.

- CDC case closures and member removals (for example removing an eligible child) take effect on the negative action date.

Case actions that end an authorization without removing a member or close the CDC eligibility determination group (EDG) are not pended. If the ended authorization is not being replaced, or is being replaced with one for fewer hours, the change affects the first CDC pay period that begins on or after the negative action date. If replacing the authorization with one for more hours, the rules for positive actions are applied.

FAP Only

For non-income changes, complete the FAP eligibility determination and required case actions in time to affect the benefit month that occurs 10 days after the change is reported. See BEM 212, Food Assistance Program Group Composition, and BEM 550, FAP Income Budgeting, for policy regarding effective dates for member adds. The benefit month **cannot** be earlier than the month of the change.

Example: A $30 shelter increase reported on May 15th would increase the household's June allotment. If the same increase were reported on May 28, the household's allotment would have to be increased **by** July. (The 10th day following May 28 would be June 7.) However, the first month we **can** affect is June, provided the action on the shelter change is completed by May 31st.

PROCESSING CHANGES

All Programs

Enter all changes in Bridges by changing the affected data elements. Certify the eligibility results in Bridges for all appropriate benefits and benefit periods.

Negative Actions

A **negative action** is identified in Bridges with notice reason(s) in eligibility results. Negative actions include:

- Decrease in program benefits, including case or EDG closure.
- Special living arrangement client pay increase.

- Inactivation of an eligible group member.
- CDC family contribution increases.
- Change in payment method to restricted payment (no code needed). Termination of a member's medical eligibility (member remains active but **not** medically eligible).
- Medical coverage cancellation or reduction.
- Inactivation resulting in a FAP benefit increase is **not** a FAP negative action.
- Patient-pay amount initiated (**unless** this occurs on the day of case opening).
- Post-eligibility patient-pay amount increase.
- Changing the Level of Care (LC) code from 02 or 08 to LC code 56 (divestment penalty); see BEM 405, MA Divestment.
- Changing CDC eligibility from categorical to income eligible.

FAP Only

Reducing a FAP group's benefits at redetermination is treated as a **positive action** because the change affects the new certification, **not** the current benefit period.

Notice Reasons

All Programs

The notice reason(s) in Bridges indicates the reason for the action.

NEGATIVE ACTION DATE

Bridges automatically calculates the negative action date. The negative action date on Bridges is the day after the timely hearing request date on the Bridges notice of case action.

Timely Hearing Request Date

The timely hearing request date is the last date on which a client can request a hearing and have benefits continued or restored

pending the hearing. It is always the day before the negative action is effective.

Immediate Negative Actions (Adequate Notice)

An immediate negative action occurs when the negative action requires adequate notice based on the eligibility rules in this item. Adequate notice means that the action taken by the department is effective on the date taken.

CDC Only

Adequate notice means that the action taken by the department is effective on the date of the Circumstance Start/Change Date (CSCD).

Pended Negative Actions (Timely Notice)

A pended negative action occurs when a negative action requires timely notice based on the eligibility rules in this item. Timely notice means that the action taken by the department is effective at least 12 calendar days following the date of the department's action.

ACTIONS NOT ALLOWED BY LOCAL OFFICES

Bridges automatically sets all negative action effective dates based on the rules for each program and the date the action is processed in the system. Occasionally there is a need to affect a negative action with less than 12 days' notice (11 days added to the current date). An exception may be requested for the specific program. Follow the procedure for requesting exceptions found in BEM 100, Introduction. The program office will validate the need for the exception and forward the request to the appropriate staff to enter the override in Bridges.

DELETING A NEGATIVE ACTION

All Programs

Negative actions must be deleted from Bridges in some situations.

Hearing Requests

Record the hearing request date and complete all required information on the Hearings Restore Benefits screen in Bridges. Then follow Additional Steps to Delete a Negative Action in this section; see BAM 600, Hearings.

Requirement Met Before Negative Action Effective Date

Enter the information the client provided to meet the requirement that caused the negative action, using the appropriate Bridges screens. Then follow Additional Steps to Delete a Negative Action in this section.

Additional Steps to Delete a Negative Action

Take these additional steps to delete a negative action in Bridges:

- Reactivate the program(s) on the Program Request screen in Bridges.
- Run eligibility and certify the results.

Bridges will automatically recalculate benefits based on the information and dates entered in the system; see EFFECTIVE DATE OF CHANGE in this item.

BENEFIT SUSPENSION

FIP, RCA, SDA and FAP Only

Benefit suspension means stopping program benefits for one month due to temporary ineligibility when allowed by policy. Document the reason(s) in the case record.

To suspend benefits for one month, check the *TempInelig* box on the initial eligibility results screen in Bridges before continuing to the certification screen. Do **not** check the box if ineligibility will continue beyond one month.

This option is not available in Bridges if the previous month's benefits were suspended.

If **timely notice** is required, the date of the first benefit credited must be later than 11 days from the date the DHS-176, Benefit Notice, is sent.

FIP, RCA and SDA Only

If suspending cash assistance benefits, notify any shelter vendor(s) for the case that vendor warrants will not be produced for that month. The client is responsible to pay any vendors directly.

CDC MEMBER ADDS

When a client reports a new person in the home, determine what, if any, actions must be taken. Complete a telephone interview to determine what verifications may be required. A signed application or a DHS-1010, Redetermination, is required when adding an adult group member; however an in-person interview is **not** required. For new members who are mandatory Certified Group members, enter the following additional information in Bridges, at a minimum:

- Care arrangement.
- Age exception, if 13 through 18 years of age.
- Citizenship/alien status.
- Countable income belonging to the new person.
- Absent parent information, if applicable.
- Valid need reason, if applicable.

Adding the new member may result in a positive, negative or no change in benefits; see EFFECTIVE DATE OF CHANGE in this item, Shortening a 24 Month FAP Benefit Period.

SHORTENING A 24-MONTH FAP BENEFIT PERIOD

FAP Only

Bridges will shorten the FAP benefit period for groups assigned a 24-month benefit period when a change is reported which changes the group's status so that it no longer meets the criteria for a 24-month benefit period.

Bridges sends a DHS-2063B, Food Assistance Benefits Redetermination Filing Record, to inform the FAP household of the following:

- The benefit period expiring the month after the DHS-2063B is sent.
- Its timely application date.

See BAM 210, Redetermination/Ex Parte Review.

SHORTENING THE FAP BENEFIT PERIOD DUE TO EARNINGS

FAP Only

For ongoing cases that report starting countable earned income and qualify for FAP simplified reporting, Bridges will do all of the following:

- Shorten the benefit period to 12 months after the change is processed, provided the number of months remaining in the FAP benefit period is more than 12 months.
- Send the client a DHS-265, Shortened Benefit Period, a DHS-266, Food Assistance Simplified Reporting Requirements, and a DHS-1045, Simplified Six-Month Review.

Example: On August 8, 2009, the FAP group reports starting income. The change is processed on August 17th. The current FAP benefit period ends June 30, 2011. Bridges changes the FAP benefit end date to August 31, 2010 and sends the FAP group a DHS-265, DHS-266 and DHS-1045.

SSI CASE ACTIONS

SSI Openings and Changes

FIP, RCA, SDA and MA Only

Bridges generates tasks that provide SSI data reported by the Social Security Administration (SSA) on the State Data Exchange (SDX) system.

Bridges acts on specific HR-070 information to prevent benefit duplication or mispayment.

SDA Only

Take appropriate action based on a Bridges Task that SSI benefits have started or changed.

Enter amounts from the SSI AMOUNT and SSI ELIG SDX interface fields from the SDX interface to recalculate SDA eligibility and benefits.

Note: Whenever the SSI benefit changes, a task will be generated for SDA cases containing SSI recipients.

FIP Only

Persons **cannot** receive FIP **and** SSI at the same time. Also, central office **cannot** open a manual SSI case for an SSI recipient who is a certified group member in a FIP EDG.

Run EDBC to remove the SSI recipient from the FIP certified group.

MA Only

See BEM 150, MA For SSI Recipients.

FAP Only

Enter the ongoing SSI benefits as unearned income.

SSI APPLICATION DENIALS

SSI-Related MA Only

The SDX reports SSI denials and appeals. Exhibit III in BEM 260, MA Disability/Blindness, lists the specific codes needed to identify appeals and disability/blindness denials.

Eligibility for MA based on disability or blindness does **not** exist if the SSA disability determination is **final** as defined in BEM 260, MA Disability/Blindness. Enter appropriate appeal information in Bridges.

If the client is no longer eligible for disability-related MA, Bridges will explore other MA categories. If the client is **not** eligible for any, Bridges will close the MA. If the client qualifies for a category but must meet a deductible, Bridges will close MA based on disability and open an active deductible EDG under the new MA category.

Timely notice of benefit reduction or closure is sent by Bridges.

SSI Terminations

MA Only

Central office closes SSI MA when SDX indicates SSI benefits are terminated. Bridges sets a redetermination date and continues MA eligibility when SSI stops.

Continue the beneficiary's MA coverage until the redetermination is completed. The redetermination does not need to be completed if the beneficiary's SSI is reactivated in a subsequent SDX batch. In most cases this is a local office responsibility; see BEM 150, MA for SSI Recipients.

DEATH NOTIFICATION

All Programs

A reliable source must verify a recipient's death before action is taken on a case. Reliable sources generally include death notices in newspapers, friends and relatives of the client, and other agencies. The verification source is entered in Bridges for the date of death.

CDC Only

Report all deaths of children while in the care of a child care provider; see SRM 172, Child/Ward Death Alert Procedures and Timeframes, for specific reporting instructions.

EX PARTE REVIEW

MA Only

An ex parte review (see glossary) must begin at least 90 days (when possible) prior to the close of any Medicaid Type of Assistance.

- When the ex parte review shows that a recipient does have eligibility for Medicaid under another category, change the coverage.
- When the ex parte review shows that a recipient may have continuing eligibility under another category, but there is not enough information in the case record to determine continued

eligibility, send a verification checklist (including disability determination forms as needed) to proceed with the ex parte review. If the client fails to provide requested verification or if a review of the information provided establishes that the recipient is not eligible under any MA category, send timely notice of Medicaid case closure.

- When the ex parte review suggests there is no potential eligibility under another MA category, send timely notice of Medicaid case closure.

When it is determined that a recipient will no longer meet the eligibility criteria for FIP-related Medicaid, because of an actual or anticipated change, determine whether the recipient has indicated or demonstrated a disability (see glossary) as part of the ex parte review (see glossary).

- If the ex parte review reveals the recipient has already been determined disabled for purposes of qualifying for a disability-based Medicaid eligibility category, by the SSA or the department, and the determination is still valid, continue the recipient's Medicaid eligibility under the disability-based Medicaid category for which the recipient is otherwise eligible.

- If, during the ex parte review it is determined a recipient has indicated or demonstrated a disability, request from the recipient additional information needed to proceed with a disability determination. Pending the determination, continue the recipient's Medicaid.

  - If the recipient fails to provide the information requested after being given a reasonable opportunity to do so, and eligibility under all other categories has been ruled out, send timely notice of Medicaid case closure indicating the person is not eligible for disability based Medicaid as well as FIP related categories.

  - If, following the disability determination process, the recipient is determined to not be disabled for purposes of qualifying for disability-based Medicaid categories and eligibility under all other categories has been ruled out, send timely notice of Medicaid case closure indicating the person is not eligible for disability-based Medicaid as well as FIP-related categories.

- If, following the disability determination process, the recipient is determined disabled for purposes of qualifying for disability-based Medicaid categories, continue the recipient's Medicaid under the disability-based Medicaid category for which the recipient is otherwise eligible

Medicaid coverage will continue until the client no longer meets the eligibility requirements for any other Medicaid TOA.

CASE CLOSURE

All Programs (Except SER)

When a recipient is no longer eligible or requests case closure, do **all** of the following:

- Enter all appropriate information, including verification sources, in Bridges to document ineligibility, or the client's request that the program(s) be closed.
- Run EDBC in Bridges and certify the eligibility results.
- Make appropriate referrals for other programs or services.

CDC EDG CLOSURE REASONS

The following are valid reasons to end CDC benefits:

- Client requests closure.
- Unable to locate.
- Child support non-cooperation or IPV sanction.
- Incarceration.
- Loss of Michigan residency.
- Income exceeds the eligibility scale in RFT 270.
- Only child ages out or leaves the home.
- Minor parent, active on legal guardian's case, turns 18.
- Assets exceed $1 million.

- Failure to return employer statement verifying that income below the income eligiblity scale in RFT 270 will resume within 6 months of the reported excess income.

CASE ACTION NOTICE FORMS

FIP, SDA, RCA, CDC and FAP

Bridges sends the appropriate notice based on the case action taken.

Notices are sent to Spanish or Arabic-speaking clients using a Spanish-Arabic form, if available, and if the client has indicated Spanish or Arabic as the household's written language.

A notice must be generated manually in those situations in which Bridges is not able to generate a notice, as identified in this item.

APPLICATION APPROVALS/ DENIALS

All Programs

The following notices are used to notify the client of an application approval or denial.

The DHS-1150, Application Eligibility Notice, is generated for withdrawals entered on the Program Request screen prior to data collection/intake.

The DHS-1605, Notice of Case Action, is generated by Bridges for automated eligibility determinations.

MA Only

A DHS-114, Deductible Notice, is generated when MA is approved with a deductible.

A DHS-1606, Health Coverage Notice, is generated when Medicaid is approved or denied.

See BEM 402, Special MA Asset Rules, for policy on notices to send regarding asset transfer information and the results of an initial asset assessment.

POSITIVE CHANGES

All Programs

Bridges automatically generates a DHS-1605, Notice of Case Action, to notify the client of the results of the Bridges automated eligibility determination. The results for all programs are included on a combined notice.

NEGATIVE CHANGES AND CASE CLOSURES

All Programs

Bridges generates a combined DHS-1605, Notice of Case Action, for all programs. A DHS-1606, Health Coverage Notice, is generated for Medicaid. Other notices are either generated by Bridges or must be manually completed and sent in the specific circumstances listed below.

FIP, RCA, SDA and FAP Only

Bridges generates the following notices when a claim is created:

- DHS-4357, Client Notice of Disqualification and/or Recoupment.

Note: The DHS-4357 is only generated by the recoupment specialist.

- DHS-4358, Notice of Agency or Client Error Overissuance and Recoupment Action.

FIP and MA Only

Send a DHS-301, Medical Transportation Notice, if a request for medical transportation is denied.

MA EXCEPTIONS UNIT

The MA Exceptions Unit in the Medical Services Administration (MSA) is responsible for the following case actions.

- Deletion of duplicate individual ID numbers.
- SSI case closures for death or moved out-of-state.
- Case number deletions.

- LC codes 07, 14 and 88 changes.
- Addition of LC code 32.
- MA coverage when the MA end date is more than 24 months earlier than the current month and year.

Telephone Numbers

The MA Exceptions Unit may be reached by calling the following:

- 1-800-292-9570 (security card is required when calling this number). This is a voice-activated enhanced call process. Select from the five menu items. The menu items are:
  - 1 - Foster Care, Child Development and Care and Patient-Pay changes.
  - 2 - LC codes 07 or 11 questions and addition of LC code 32.
  - 3 - LC codes 07 and 88 (**Note:** Call either 1-517-241-8759 (described below) directly or 1-800-292-9570 and press 3 to remove these LC codes.).
  - 4 - Responding to a letter about duplicate ID numbers.
  - 5 - All others (including all third-party resource concerns (**except** Medicare) including the non-Medicare portions of OI codes 92-95).
- 1-517-241-8759 - This is a voicemail line to request removal of LC codes 07, 14 or 88. Follow the prompts to leave the information necessary to remove the LC code. You will be told when the LC code will be removed. If the LC code **cannot** be removed or other information is needed, you will be contacted.

LEGAL BASE

FIP

Social Welfare Act, PA 280 of 1939, as amended
Mich Admin Code, R400.902

RCA

45 CFR 400

CDC

Child Care and Development Block Grant of 1990; as amended, PA 6 of 2014
45 CFR Parts 98 and 99
Social Security Act, as amended

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

MA

42 CFR 431.200-.250
42 CFR 435.912-.913, .919

FAP

7 CFR 273.12-.13, .21

DEPARTMENT POLICY

All Programs

The **paper case record** consists of a folder, arranged in packets and identified by a client name, recipient ID or case number, established for a particular client group. The case record contains all forms, documents and other evidence relevant to the group's current and past eligibility.

The **electronic case file (ECF)** consists of scanned documents, arranged by category and identified by a client name, recipient ID or case number, established for a particular client group. The ECF contains all forms, documents and other evidence relevant to the group's current and past eligibility.

Policy in this item explains what must be in the case record (both paper and electronic) and provides guidelines for organizing it.

All local offices must follow a uniform system of records with the minimum content and organization described in this item. This ensures that material is recorded and filed in a manner readily available and understandable to all Michigan Department of Health & Human Services (MDHHS) staff who use it.

Documents (including MDHHS forms), notices and other written correspondence regarding the group's eligibility, benefit status or benefit level that are produced in Bridges can be retained in Bridges and do not need to be copied into the case record.

Electronic documents are routed to Bridges for viewing and storing based on levels. Document levels are divided by case level, individual level, or provider level. Individual level documents will be viewable in all cases associated to the individual.

Documents provided by the client or produced in Bridges that contain pertinent information in determining eligibility must be in the case record.

Examples include:

- Birth registry verification.
- Consolidated inquiry information (CI).
- Child support information.
- Unemployment benefit information (UCB).
- Pay stubs.

- MDHHS forms returned to MDHHS completed with requested information.

For **MA only**, if a single application form and other documents are used for persons with separate case numbers (example: spouses), the local office has the option to maintain separate case records by copying or cross-referencing the materials.

Unless captured in Bridges the case record must document **all** of the following:

- Date of application and, for **MA only**, date of a request for initial asset assessment, if applicable.
- Date and basis for disposition of the application/request.
- Facts essential to the eligibility determination.
- Amount or level of benefits.
- Actions taken by the local office regarding the case.

DEFINITIONS

Active case record: record is pending or open for current benefits.

Case filing: loose documents, verification etc. that need to be placed within a packet in the case record.

Case packet: a group of information placed together for easy reference. The first page of each case packet is a DHS-3524 Bridges, Case Record Packet Cover Sheet that identifies the type of packet (see packet types in this item).

Exception: The first page of the Employment Packet is a DHS-3524 BE, Employment Packet Cover Sheet.

Case Record: documents and information related to a given case (one or more programs) arranged in a series of packets and contained in a folder identified by a case name, grantee ID, or case number.

Closed file area: a place designated by the local office where closed records and denied records are stored.

Note: In many local offices both closed and obsolete records are stored in the same location.

Closed record: complete case record that has no active programs. Case record that is in a holding area (usually called closed files) waiting for either the retention period to expire or for the client to reapply.

Example: When an individual/family loses eligibility for all programs the complete case record is sent to closed files.

Obsolete: case information that is no longer in use and is not essential to support **current eligibility** and benefits. Store in chronological order.

Example: Jane Doe is active for FAP and FIP, she has been active for a number of years. The documentation used for eligibility in previous years is no longer needed, this information can be placed in the obsolete packet. Keep in mind the original DHS-1171, Assistance Application, (from this concurrent benefit period) along with the current DHS-1171should remain in the eligibility packet.

Example: Jane Doe received benefits in Michigan until last year when she moved to Florida. At the time of the move her case was closed and the case record was sent to closed files. Today she moved back to Michigan and applied for assistance. The closed file will be removed from the closed file area and given to the FIS/ES. If she is found eligible for benefits the FIS/ES will send all information not needed for current eligibility to obsolete files.

Confidential Nature of Case Records

Federal and state laws restrict the use and release of client information; see BAM 310, DEPARTMENT POLICY.

Record Retention

Paper, ECF

No case record material can be removed and/or destroyed unless MDHHS policy regarding retention and disposal is met. The Department of Technology, Management and Budget has general instructions for record management at www.michigan.gov/records management. Specific local office requirements are found on the MDHHS-Net under Communications/Inside Michigan/Work Resources/Records Management.

PACKETS/TABS

Paper case records must have information organized into packets. Each case record will have an Eligibility Packet and a Vital Statistics Packet. The other packet types, such as; child development and care, emergency programs, incorrect issuance (recoupment), legal and medical will be required if it pertains to the case record.

The ECF has information organized into tabs. Each record will have an Application tab and a Vitals tab. Other examples of tabs include income, assets, etc. Documents in the ECF are stored chronologically from oldest to newest.

Eligibility Packet

Paper

The first page of each packet is a DHS-3524, Case Record Packet Cover. Fasten packets in the upper left corner. Generally, material is to be filed chronologically, the most recent information at the **back** of the packet.

Use this packet for information related to current eligibility and benefit amount. File certain documents in the vital statistics packet.

Place the following eligibility material (when applicable) in the order listed below:

- The most recent assistance application such as DHS-1171, Filing Form, completed DHS-2063B, Food Assistance Benefits Redetermination Filing Record if returned. These forms must remain in this packet as long as the case is open. If the case closes and reopens, move these forms to the obsolete packet.

- Copies of all materials used at the most recent case opening (**except** vital statistics-related materials). Group these by type (such as: asset-related). Other than income verification, keep these in this packet as long as the case is open. If the case closes and reopens, move any material no longer relevant to the obsolete packet. The application form used in the most recent **redetermination**. File it in the obsolete packet when it is no longer current. Documentation of client contacts from home calls or office visits relating to current eligibility. Move documents no longer related to current eligibility to the obsolete packet.

- Copies of all materials used in the most recent eligibility determination (such as: member add, redetermination) **except** documents filed in the vital statistics packet. Group these by type.
- Copies of all documentation of budgetary needs unless stored in Bridges. Move these to the obsolete packet when no longer current.
- Current income documentation. Move documentation to the obsolete packet when no longer current.
- Place FIP/SDA worksheets showing an ongoing recoupment amount in the obsolete packet when recoupment is complete; see incorrect issuance packet in this section.
- Copies of all documentation regarding audits or correspondence with the office of Quality Assurance.
- All documentation pertaining to direct supportive services.

ECF

The ECF does not contain an Eligibility packet/tab. Documents are stored under the appropriate tab.

Vital Statistics Packet

Paper, ECF

Use this packet for documents expected never to (or only infrequently) change, even after closures and reopenings. Include the following for each group member **unless** an item is more useful in the eligibility packet:

- Adoption records.
- Alien registration card.
- Birth certificate.
- Death certificate.
- Divorce decree.
- Driver's license or other ID card.
- Social Security card.
- DHS-8A, Irrevocable Funeral Contract Certification.
- Marriage certificate.
- Naturalization records.

- Passport.
- Paternity records.
- Power of attorney/guardianship papers.
- Prepaid funeral contract.
- Special MA category verification
- Support order (most recent).
- Americans with Disability Act (ADA) documentation.
- Need for translator or material to be translated; DHS-848, Certification of Translation/Interpretation for Non-English Speaking Applicants or Recipients.

State Emergency Relief (SER) Program Packet

Paper

This packet is required for all State Emergency Relief (SER) requests and approvals; See ERM 405, SER Case Record.

ECF

The ECF does not contain an SER packet/tab. Documents are stored under the appropriate tab.

Medical

Paper, ECF

Use this packet for all medical reports, forms, correspondence, etc., regarding medical eligibility **including** items related to current eligibility or benefits. File all SSI referral and advocacy-related forms in the medical packet. Any client that has an active or pending program that is based on a medical determination, such as: State Disability Assistance (SDA), Medicaid due to disability or blindness, or a Family Independence Program (FIP) case where there is a claim of disability, the medical packet and **all** medical documentation **must** stay in the active case record.

Example 1: If a case closes and the client reapplies for a program that is based on a medical decision the complete medical packet **must** remain in the active case record and all new medical evidence must be added to the medical packet in chronological order.

Example 2: Client is active for a program based on disability and they are approved for Supplemental Security Income (SSI) or

Retirement Survivor Disability Insurance (RSDI) (based on their own disability) the medical packet can be sent to obsolete/closed file area.

Example 3: Client had a case based on a medical determination Example: SDA or Medicaid based on disability or blindness, or a FIP case where there was a claim of disability and the client is no longer active or pending for that program, the medical packet can go to obsolete/closed file area. Examples would include a FAP or Child Development and Care (CDC) only case. However if this client re-applies for any program where a medical determination is necessary, the existing medical packet would need to be placed back into the active case record and the new medical information would be added to the packet in chronological order.

Legal Packet

Paper, ECF

Use this packet for all documents, forms, correspondence, client-signed agreements, etc., regarding legal matters, hearings and Intentional Program Violation (IPV) disqualifications, **including** items related to current eligibility or benefits.

Never obsolete materials in this packet.

Note: All hearing Decision and Orders, court actions, notices of intentional program violation, intentional program violation repayment agreement and all other documents that result in an IPV **must** never be obsoleted. The Michigan Administrative Hearings System (MAHS), courts and the Office of Inspector General (OIG) must have documentation on all past IPVs to impose a sequential disqualification.

Employment Packet

Paper

Use this packet for all information pertaining to the following:

- Direct support service purchases that have a lifetime maximum. Bridges will track all purchases made in Bridges, however all life time purchases made prior to Bridges will need to be maintained in this packet.

- Work participation program information that is **not** maintained in Bridges and information printed from Bridges and entered into evidence at a work participation program related hearing.
- Work participation program penalty tracking information. Administrative law judges (ALJs) will require verification of all prior penalties before giving the next higher penalty.

ECF

The ECF does not contain an Employment packet/tab. Documents are stored under the appropriate tab.

Child Development and Care Packet

Paper

Use this packet for all case information related to provision of CDC services.

CDC case information in this packet may be obsoleted at case review, however the original application and supporting verifications from the most recent case opening must be maintained in the case record. The retention period for CDC case information is **four years** after CDC case closure to conform with federal audit requirements.

ECF

The ECF does not contain a CDC packet/tab. Documents are stored under the appropriate tab.

Child Development and Care Provider File

Effective January 1, 2013, all new unlicensed provider enrollments and the associated files are completed and maintained by the Provider Enrollment Unit (PEU) at the Michigan Department of Education (MDE). Unlicensed provider applications or verifications that are received in the local office should be date stamped, scanned and sent to: CDCproviderenrollment@michigan.gov. Local offices should retain the scanned information for 90 days from the date it was sent. After the 90 day retention period, the information can be destroyed.

Unlicensed provider applications or documents should be retained for three years after the date of inactivity or closure.

Incorrect Issuance Packet

Paper, ECF

Use this packet for documents related to benefit overissuance or underissuance. File all hearing Decision and Orders, court actions, notices of intentional program violation, intentional program violation repayment agreement and all other documents that result in an IPV in the Legal Packet. MAHS, courts and OIG must have documentation on all past IPVs to impose a sequential disqualification.

Never obsolete these records. Cross-reference the legal packet when needed.

Group all material chronologically that relates to the same incorrect issuance. This can include:

- Overissuance (OI):
  - ARS and BRS overissuance history.
  - DHS-234, Release Plan.
  - DHS-1172s, FIP/SDA Worksheet; see Eligibility Packet in this item.
  - DHS-1835C, Fraud Investigation Disposition Report.
  - DHS-2242s, FAP Worksheet, or LOA FAP Worksheet showing the OI amount.
  - DHS-4355, Agreement to Repay Debt.
  - DHS-4357, Intentional Program Violation Client Notice.
  - DHS-4358, Notice of Agency or Client Error Overissuance and Recoupment Action.
  - DHS-4358-A, Notice of Overissuance.
  - DHS-4358-B, Agency and Client Error Information and Repay Agreement.

- DHS-4358-C, Overissuance Summary.
- DHS-4358-D, Hearing Request for Overissuance or Recoupment Action.
- DHS-4701, Overissuance Referral.
- Plain paper with the OI calculation, if needed.
- OI-related hearing decision, withdrawal or note that the client failed to show for the hearing.
- OI-related correspondence and other documents
- Debt collection hearing decision and related documents.

Do not obsolete overissuance documents until four years after the overissuance event is paid off or written off.

Note: Documentation listed above generated by the recoupment specialist or designed staff person must be forwarded to the case record as soon as administratively possible.

- Underissuance:
  - DHS-13, Supplemental Payment Authorization.
  - DHS-521, Notice of Restoration Letter.
  - DHS-1172s, FIP/SDA Worksheet or LOA Worksheet showing the underissuance.
  - DHS-2242s, Food Assistance Program Worksheet or LOA FAP Worksheet showing the underissuance.
  - DHS-3925, Restoration of Lost Food Stamp Benefit, or LOA OI/UI Summary.
  - Plain paper with the underissuance calculation, if needed.
  - Correspondence and other documents related to the supplementation. At local office option, underissuance materials may be placed in the obsolete packet after the client supplement is issued.

Note: The Incorrect Issuance (OI) packet/tab is restricted to recoupment specialists only for entry and deletion.

Obsolete Packet

Paper, ECF

Use this packet for information no longer in use and **not** essential for current eligibility. This includes forms documenting MDHHS actions which are immediately obsolete (such as, retro MA determination).

Place the date the case record became obsolete on the case packet cover sheet prior to sending the material to obsolete files.

Note: A purge anytime on or after date can be added on the cover sheet if known.

Do **not** file evidence of **ongoing** recoupment, legal materials, or Initial Asset Assessment documentation in this packet.

Establish a separate obsolete folder if this packet grows too large for the case record. Identify the folder by client name and/or case number and the word **obsolete**.

Initial Asset Assessment Packet

Paper, ECF

Use this packet for documents and verification related to an initial asset assessment; see BEM 402. Such material includes:

- Verification of the value of the couple's assets.
- DHS-4574-B, Assets Declaration.
- DHS-4585, Initial Asset Assessment and Asset Record.
- DHS-4586, Asset Transfer Notice.
- DHS-4588, Initial Asset Assessment Notice.

Never obsolete materials in this packet.

OTHER CASE RECORDS

Department Wards

Department wards are eligible for MA. Case information is maintained in children's services case records. Retro MA determinations must be filed in those services records; see BEM 117.

SSI Cases

Establish a case record when central office opens SSI Medicaid based on information from SSA. It will not contain an application or eligibility packet; see BEM 150.

Newborns

When a separate case is opened for a newborn (such as, mother on Medicaid based on disability or blindness and newborn on Medicaid for newborn), **cross-reference** the cases. Establish a case record when MSA opens Medicaid for the newborn. File documents in either case record. The newborn's record will **not** contain an application or eligibility packet; see BEM 145, Newborns.

LEGAL BASE

FIP

45 CFR 205.60(a)(1)
MCL 400.55 (g)

CDC

Child Care and Development Block Grant of 1990; as amended, Public Act 6 of 2015
45 CFR Parts 98 and 99
Social Security Act, as amended

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

SER

Mich Admin Code, R 400.7001, et. seq.

MA

42 CFR 431.17(b)

Food Assistance Program

7 CFR 272.1(f)

DEPARTMENT POLICY

All Programs

Local office management resources should be invested in case reading activities.

This includes:

- Selecting the case.
- Completing the review.
- Documenting and communicating the findings.
- Monitoring and following up.
- Planning corrective actions.

Overview

A process analysis approach to case reading focuses on systems, policy and procedures in an effort to prevent errors rather than just correct them.

Case readings collect information to improve the accuracy and efficiency of program management and the delivery of services. First and second-line managers, quality analysts, lead workers and other designated local office staff may conduct the readings.

Case Review

The case review may be either a **general**, **specific** or **targeted** read. A general read is a review of all eligibility factors for the program(s) read. A specific read is a review of a limited number of eligibility factors identified for a predetermined reason. A targeted read is a review of a limited number of eligibility factors identified by central office for a predetermined reason.

The local office determines the need for evaluation and selects the cases for a general or specific read. Process analysis, accuracy of policy implementation, a special project, worker experience, or other reasons may prompt a review.

Selection of Cases

Depending on the reason for the review, cases are selected at random using one of the sources listed below. Cases are selected randomly by allowing each case an equal chance to be selected. For example, if you are selecting four cases from the RD-093 that lists 20 cases, you could pull every fifth case listed on the report.

- computer-generated reports - list cases with certain identifying characteristics
  - AL-030 - earned income, automated recoupment, unearned income, etc.
  - RD-093 - redeterminations.
  - MH-132 - approvals and denials.
  - DL-030 - child support rebates.
  - AA-712 - age and school attendance.
  - UB-120 - wage match.
  - HR-070 - SSI information.
  - ED-030 - RSDI information.
  - UB-141 - Unemployment benefits match.
- Special Run Reports - used for special projects.
- Case Actions - based on the experience of specialists. (See the Personnel and Professional Development (AHP) manual Item 692-0, Guidelines for Performance Evaluation - AP Worker 06, 07, 08 General Information.)

How To Read a Case

A case is reviewed by comparing the actions taken by the specialist to the verification and documentation in the record and determining whether policy was correctly applied in a timely manner.

Use form DHS-4331, Assistance Payments Case Reading, to record and communicate the findings. Check the factors listed on the DHS-4331 to determine that all necessary actions were taken. Use the comment section to inform the specialist of any required action and the reason. Post a follow-up for any action to be completed. The comment section is also used to give positive feedback.

For some actions, oral communication with the specialist promotes better understanding and offers an opportunity to solicit suggestions for improving systems and processes.

Use the Case Reading Guide (EXHIBIT I) with the DHS-4331 for consistency in the way factors are reviewed. The guide asks questions for each factor listed on the DSS-4331. Instructions for the DHS-4331 are in the Reference Forms & Publications (RFF) manual.

Data Evaluation

The information from case reading may be used to identify unmet needs in programs and areas of policy. Local office staff should decide whether policy clarification, policy revision, local office procedural changes or training is appropriate to pursue.

General case reading data may also be compiled, summarized and reported upwards. However, a roll-up of case reading data cannot be assumed to be statistically valid due to issues such as lack of a random sample, managers using different selection criteria, and managers using different case reading methods. Targeted case readings may be designed to avoid these problems, through careful planning.

INTRODUCTION

The case reading guide is intended to help achieve consistency in the way cases are read. The questions are designed to lead the reader to correct case reading results.

The case reading guide, along with the DHS-4331, Assistance Payments Case Reading, is a tool to help identify error-prone areas that might require further attention. It is not intended to cover all specific policy situations and exceptions. Likewise, all questions do not apply to every program.

A secondary use of this guide is as a self-assessment tool. DHS specialists can use the guide to see whether required case actions were taken.

EXHIBIT - INSTRUCTIONS

If the question does not apply to the case/program/case action, skip the question.

If all questions are answered yes or left blank, no action is required.

A “no” answer to any question in the guide means that some action is required. The required action could be documentation, verifica-

tion, correct application of policy, clarification of inconsistencies, correct computation of a budget, etc.

Instructions for completing the DHS-4331, Assistance Payments Case Reading, can be found in the RFF, Reference Forms & Publications Manual.

A. GENERAL FACTORS

1) Registration/ Application/ Identity

BEM 221, BAM 110, BAM 115, RFF REFERENCE FORMS & PUBLICATIONS - DHS-1171

- Is the application signed by the client/representative? Is the application signed by the client's spouse and other adult group members in the home, if physically able?
- Is/Are the signature(s) witnessed?
- Has the identity of the group members been verified?
- Is the application appropriately coded, documented and certified?
- Is the application registered timely with the proper date and program code?
- Were the registered programs appropriately disposed of within the SOP?

2) Expedited Food Assistance

BAM 110, BAM 117

- If the household met one of the four conditions for expedited services, was the application registered correctly?
- If expedited food assistance was issued, did the group provide the minimum verification required (identity)?

- If the household was eligible for expedited food assistance, were the benefits available to the client within seven calendar days after the application date?

3) Authorized Representative

BAM 110

- Is the most recent FAP authorized representative who purchases food for the client currently on CIMS?

4) Client Notification Letter(S)

BAM 115, RFF FORMS & PUBLICATIONS - DHS-176, DHS-1150, DHS-417, DHS-114A, RFF-4598, DSS-4660, LOA2 & CIMS NOTICES, SOCIAL CONTRACT, ETC.

- Were all appropriate notices sent?
- Were the notices completed with manual items, dates, signatures and specific messages where required?

5) CIMS Coding

BEM 164, 165 AND 545 (MA) BAM 903, SIC CODES & SIE EDITS

- Is the coding consistent with the case record information?

6) Receipt of Benefits

BEM 110-156 BEM 222, 547, 554 BAM 110-115, 200, 220, 400, 405, 406, 705, 710, 715, 720, 725

- Were known changes acted on in a timely manner?
- Were reported changes reflected in the budget, supplemented or recouped appropriately?
- Were the initial benefits issued for the correct period?
- Is the MA eligibility begin date correct?
- If MA was authorized for a month prior to the month for which the first FIP payment was made, was an MA-only or MA-FAP-only eligibility determination made?

- Has receipt of benefits from other programs (FIP, FAP and SDA in the same period, out-of-state, etc.) been checked, to avoid concurrent receipt of benefits?
- Are the begin and end dates for the level of care correct?
- Are the begin and end dates for the patient-pay amount correct?
  - If this is an active deductible case, are the begin and end dates for the deductible amount correct?

7) Pursuit of Benefits

BEM 125, 126, 129, 131, 164, 165, 255, 256, 257, BAM 110, 220, 270

- Has the group pursued all potential benefits as required? (RSDI, workers compensation, UCB, etc.)
- If the case indicates another responsible party (absent parent/spouse, insurance company, worker's compensation etc.) has a DCH-1354A been completed? If yes, is CIMS coded for Third Party Liability?
- At FIP closure or denial, was eligibility for other MA programs (TMA, Special N/Support, Healthy Kids and the Newborn Category, etc.) explored?
- If the case contains a pregnant woman or a child, was eligibility under the Healthy Kids categories properly determined?
- If the case contains a pregnant woman and she is not eligible for Healthy Kids For Pregnant Women, (BEM 125) was eligibility under Group 2 Pregnant Women (BEM 126) properly determined?
- For aged, blind and disabled MA applicants or recipients, was eligibility for QMB, limited QMB and Extended Care properly determined?
- If the case contains a disabled, employed person, was eligibility for Freedom to Work properly determined?

B. HOUSEHOLD COMPOSITION

1) Relationship

BEM 215

- If the relationship of each person is not listed on page 3 of the DHS-1171, is it documented elsewhere?
- Were questionable relationships verified?
- Are all FIP eligible children living with a specified relative or the relative's spouse?

2) Living Arrangement

BEM 210, 211, 212, 215, 250

- Was the presence of the FIP eligible child(ren) verified?
- Was the absence of a parent(s) verified?
- Is it verified that a residential facility placement was temporary, if claimed? Were other questionable absences verified as temporary?

3) Group Composition

BEM 210, 211, 212, 213, SIC Codes

- Are all mandatory members included in the applicant group, except those who are disqualified or do not meet a nonfinancial eligibility factor?
- If there is a disqualified member in the home, is the reason documented in the case and the correct coding on CIMS?
- If a disqualification period has ended and the disqualified person has complied with procedural requirements, was the appropriate action taken to add the member to the eligible group?
- Do persons listed on the DHS-1171 who are not included in the FAP group purchase and prepare food separately? (This does not include those who meet the criteria for a senior impaired group.)

- If the household meets the special criteria for separate FAP groups, were the groups determined correctly and the right certification period assigned? (The LO2 FAP group composition software may be used.)
- If all FAP group members are recipients of FIP, SA, and/or SSI, has categorical eligibility been correctly determined and coded on LOA2 and CIMS?

C. NONFINANCIAL FACTORS

1) Age and School Attendance

AGE - BEM 240

- Is the age requirement met for each recipient included in the eligible group?
- Is each 18-year-old child included in the FIP group a full-time high school student expected to graduate by age 19?
- Was MA eligibility pursued for all applicants under 21 and age 65 or older?

School Attendance - BEM 245

- Is each child 16 or over a full-time student or a Work First registrant? (FIP)
- Do all food assistance recipients age 18-49, attending post-secondary education, meet student status criteria?

2) Residence/ Citizenship/ Alien Status

BEM 220, 225, 226

- Are all eligible members residents of Michigan?
- Do all eligible members intend to remain in Michigan? (Does not apply to FAP, migrants and certain MA programs.)
- Does each eligible group member have US citizenship or acceptable alien status?

3) Work Registration/ Participation

BEM 229, 230A, 230B, 230C, 233A, 233B, 233C.

- Do all mandatory clients have the appropriate employment code on ASSIST/CIMS?
- Are all deferrals correctly verified and documented using forms similar to the following:
  - DHS-22, Assessment For a Special Needs Child.
  - DHS-26, Daily Schedule, Special Needs Child/Spouse.
- Were mandatory registrants referred to Work First using the DHS-2439, Work First Referral, or were clients referred to another employment-related contractor?
- Does the case contain the appropriate DHS-4783A and DHS-4783, Personal Responsibility Plan and Family Contract (Parts I and II)?
- If the case contains any act of noncompliance does it contain the following forms:
  - DHS-2444, Notice of Employment-Related Noncompliance.
  - DHS-71, Good Cause Determination.

4) Support (Child And Spouse)

BEM 255, 256

- Have the appropriate referrals been submitted?
- Have any support disqualifications been processed and coded correctly on CIMS?

5) Enumeration

BEM 235

- Does each recipient in the group have a verified SSN on CMS (special attention to newborns added to FIP case)? Before the first redetermination, a current SS-5 or other verification of application for SSN in the case record is sufficient.

- Has every person for whom cooperation with the enumeration process is refused been disqualified?
- If application for a SSN was made at another agency (SSA or a hospital), did the specialist follow up at redetermination?

6) Disability/ Blindness (MA, SDA)

BEM 260, 261, BAM 815

- Has the eligible member's disability been verified?
- Have the proper referrals been made? (e.g., SSA, MRS, etc.)

D. ASSETS

BEM 400, 401, 402, 405, 405(A), 406, RFF Forms & Publications, DHS-1171

- Was the value of reported assets consistent with other case documents, such as DHS-1171, MRS forms, SOS, IRS match? If no, were inconsistencies clarified and documented?
- Was the disposition of any asset documented and was divestment considered?
- Were any lump sum or accumulated benefits, not counted as income, evaluated as assets?
- If there is a responsible relative in the home, was an asset test done?
- If the month being tested is an L/H month, have the special MA asset rules in BEM item 402 been applied, if appropriate?
- Were all assets evaluated, verified, properly counted and within the asset limit?
- Was all asset information recorded on page B of the DHS-1171 or the LOA2 budget?

E. NEEDS/EXPENSES

1) Needs

BEM 515 BAM 825

- Does the current budget include all eligible members?
- If the grantee is an SSI recipient, is the group receiving the correct allowance for the remaining group members?
- Is the program type and/or person class coded correctly?
- If information in the case indicates the client has a need, was medical transportation explored and documented?

2) Expenses

BEM 544, 545, 554, 556

- If the shelter expense includes a housing subsidy, does the food assistance (FAP) budget allow only the client's portion?
- Were the correct shelter expenses allowed in the FAP budget?
- If more than one group lives in the same residence and shares the cost of heat, was the heat and utility standard divided among the number of groups?
- Is the FAP case properly coded to determine the correct excess shelter allowance for a senior/disabled/veteran (SDV) household member?
- For MA, were medical expenses including LTC, personal care, old bills, and current bills used to determine eligibility for past months, the processing month and future months?
- For Group 2 MA, was the correct cost of health insurance and Medicare premiums paid by the medical group added to the protected income level?

3) Deductions (Food Assistance)

BEM 554

- Are allowable medical expenses deducted for SDV household members?
- Are all allowable unreimbursed dependent care expenses being budgeted?

F. INCOME

1) Earned

BEM 500, 517, 518, 530, 535, 540, 541, 545, 549, 550, 552

- Was the reported earned income consistent with other case documents such as DHS-1171, MRS forms, tape matches, DHS-38, pay stubs, etc.? If no, were inconsistencies clarified and documented?
- If there is a responsible relative in the home, was an income test done and was income properly deemed to the group?
- Was all countable earned income verified, and were the correct dates and amounts used?
- Was ONLY countable earned income budgeted, including tips?

2) Unearned

BEM 500, 517, 518, 530, 535, 540, 541, 545, 549, 550, 552

- Was the reported unearned income consistent with case documents, such as DHS-1171, MRS forms, tape matches, DHS-32, award letters, DHS-3994, etc.? If no, were inconsistencies clarified and documented?
- If there is a responsible relative in the home, was an income test done and was income properly deemed to the group?
- Was all the countable unearned income verified, and were the correct dates and amounts used?
- Was ONLY countable unearned income budgeted, including child support rebates, refunds and reimbursements?

- Was the FIP/SDA countable income included in the food assistance budget? (check for automated recoupment)
- If the group had windfall income, was an ineligibility period calculated correctly and the client properly notified?

3) Deductions

BEM 500, 517, 518, 535, 536, 540, 541, 554, BAM 200

- Were child care expenses reported, verified and allowed?
- Are all allowable expenses deducted from self-employment income and rental income?
- Was the child support paid by a group member, up to the monthly court-ordered amount (excluding arrearage), allowed as a deduction?
- If there is a dependent relative in the home, was the income test done and income properly diverted?
- When budgeting child support received by the client, was $50 excluded from each month's support payment (FIP and FIP-related MA only)?

G. MISCELLANEOUS FACTORS

1) Case Record Organization

BAM 300

- Were materials correctly packeted?
- Were obsolete materials obsoleted?

BAM 425, 505

- Is a signed DHS-560 in the eligibility packet?
- If client requested vendoring, was vendoring initiated?
- If warrants were credited, was the provider(s) notified?

3) Overissuance/ Underissuance

BAM 405, 406, 700, 705, 710, 715, 720, 725

- If there was an overissuance or underissuance, was the appropriate recoupment/supplement action taken?
- Was the entire period of misissuance addressed and corrected budgets completed?
- Were the required notices sent to the client?
- Was CIMS appropriately coded for the misissuance?

4) Emergency Assistance

SER Manual

Note: Some of the questions listed below may be addressed under factors A through F of the reading form.

The questions which are unique to SER are addressed here.

- Is there a current signed DHS-1514 and DHS-1171 in the case?
- Was the emergency request registered timely?
- Is the emergency a covered service?
- Were repeat request criteria and required payments correctly determined and documented?
- Will the payment resolve the emergency?
- If the emergency was approved, did the case meet the asset limit?
- Was the need verified and documented?
- Was all projected income for the 30-day budget period used in doing the budget?
- Does the requested need meet the affordability criteria?

- If there was excess income and/or cash assets, did the client make the copayment?
- Were potential resources explored and necessary repay agreements signed?
- Was the amount authorized within the maximum allowed?
- If an exception was granted, is the necessary documentation in the case?
- Was the client sent a DHS-1419?

DEPARTMENT POLICY

All Programs

Assignment, Reassignment and Transfer are automated processes in Bridges.

Assignment is the designation of responsibility for processing an application to a specific workload.

Reassignment is a change in responsibility for the ongoing maintenance of active program groups from one caseload to another caseload.

Transfer is a change in the county or district responsible for processing an application or providing ongoing maintenance.

Bridges automatically assigns and reassigns all related assistance payments cases to the same workload or to a workload in the same unit.

ASSIGNMENT

Automated assignment occurs at the end of the registration process and is based on the local office intake rotation.

Local Office Intake Rotation

Bridges identifies specialist availability and authorization to process the following special group characteristics:

- Groups that have a disabled member.
- Family groups.
- Migrant groups.
- Non-English speaking groups.
- Groups assigned to special policy.
- Groups in Special Living Arrangements (SLA)s.

Local offices can authorize an Eligibility Specialist (ES) or Family Independent Specialist (FIS) as Special Accommodation Assignments Only (SAAO) in one or more of the above group characteristics. Staff authorized as SAAO will be assigned only related cases which contain a group characteristic the person specializes in. Staff authorized for the group characteristic but **not**

marked SAAO will be assigned other types of related groups in addition to those with a special characteristic.

Local offices can also limit the number of assignments to a workload by indicating a partial workload, in increments of 10 percent.

Local Office Assignment Coordinator

Each local office must designate an assignment coordinator to maintain its intake rotation in Bridges.

The assignment coordinator can change an automated assignment upon request from local office management when unforeseen circumstances result in an inappropriate assignment (for example, the client is related to the specialist, the specialist has to leave work suddenly).

REASSIGNMENT

Local office management controls the criteria Bridges uses for automated reassignment by establishing individual profiles on the Manage Office Resources (MOR) Profile screen. This screen identifies ongoing specialist authorizations to maintain specific programs and the following special group characteristics:

- Migrant groups.
- Family groups.
- Non-English-speaking groups.
- Groups in SLAs.
- Error prone groups.
- Groups requiring disability reviews.
- Groups assigned to special policy for demonstration projects.

Local offices can authorize an ongoing specialist as an SAAO in one or more of the above group characteristics.

Staff authorized as an SAAO will be reassigned only related cases which contain a group characteristic the person specializes in. Staff authorized for the group characteristic(s) but **not** marked SAAO will be reassigned other types of related groups in addition to those with a special characteristic.

Local offices can also limit the number of reassignments to a workload by indicating a partial workload, in increments of 10 percent.

The MOR Profile screen also records authorizations by type of program such as the Family Independence Program (FIP), State Emergency Relief (SER), for processing related group intake.

Local Office Reassignment Coordinator

Each local office must designate a local office reassignment coordinator. This may be the case transfer clerk, assignment coordinator or another designated individual. The local office reassignment coordinator:

- Receives the physical case record from the sending workload.
- Completes reassignment transactions for specified cases or workload redistribution.
- Forwards and logs out the physical case record to the receiving workload.

Specialist Reassignment Procedures

When a case is identified for reassignment, the specialist will receive a Bridges reassignment alert/request from his/her supervisor, manager or local office reassignment coordinator.

The specialist needs to complete the following steps:

- Assemble the current physical case record and file all loose documents in the proper packets. Reconstruct the physical record if it cannot be located; see **Lost Physical Case Records** in this item.
- Forward the physical case record to the local office reassignment coordinator.

TRANSFER

A case record is generally transferred to another local office when:

- A group moves within the state to an area served by a different county or district office, **or**
- The case must be serviced in a different county or district office for administrative reasons.

Note: A person who lives in a county participating in the transparent county line project may apply and have his/her application processed by any county that is also participating in the transparent county line project.

See **Transfer Guidelines** in this item.

Transfers are made through the Manage Office Resources Case Transfer screen. The specialist needs to:

- Prepare the electronic and physical case record for transfer, **and**
- Transfer the case within 10 workdays after the later of:
  - The date the transfer is requested, or
  - The actual date the group moves.

Note: The case and EDG numbers do not change when a case is transferred.

Exception: Do **not** transfer out the **physical** case records of migrant groups who receive Food Assistance Program (FAP) benefits only; see BEM 610 Migrants/Seasonal Farmworkers policy. Prepare and transfer the Bridges electronic record only. The transfer-in office must establish a separate, physical case record for the same certified FAP group.

FIP and Medicaid (MA)

When a client moves, it may cause health maintenance organization (HMO) disenrollment. The Department of Community Health's (DCH) enrollment broker, Michigan Enrolls, will contact the client if disenrollment occurs.

Clients who have questions about their HMO care may contact DCH at its toll-free number: 1- (800) 642-3195.

.Prohibited Transfers

MA Only

The local office services unit with primary responsibility for services must maintain the MA case record when the client is a child in foster care or in an institution funded by DHS. This policy also applies to out-of-state placements.

Bridges will prohibit the transfer of a case with pending tasks and reminders. However if necessary, a supervisor can authorize the transferring of a case with pending tasks and reminders.

SDA, MA

Do not transfer the cases of students residing in dormitory housing at the Michigan Career and Technical Institute (MCTI) to the Barry County DHS office. These cases remain in the county of origin. This is a Michigan Rehabilitation Services (MRS) program that is open to statewide participation. The students stay in the dormitories at MCTI during the school year, but return home on weekends and holidays. DHS and MRS services are provided by the student's home county.

Transfer Guidelines

MA Only

MA case records are **not** transferred in the following situations:

- The local offices involved agree that case transfer is **not** in the best interest of a client and/or program administration.

  A single local office should maintain the case records of:

  - All clients in the same fiscal or Low-Income Family (LIF) MA qualified group, **and**
  - A long term hospital (L/H) patient and his dependent(s) when the dependent(s) is an MA recipient who receives money diverted from the L/H patient.

- The client enters a hospital in another service area and the stay is expected to last **less** than 30 days.

Note: Admission to a hospital's long-term care unit can reasonably be expected to last more than 30 days.

Transfer Procedures

All Programs

To prepare a case for transfer, do the following:

1. For electronic data management (EDM) hybrid cases, provide what exists of the paper case file to administrative support with the DHS-709, EDM Transfer-out Notice of Hybrid Case File, attached to the top of the file.

2. When a case file containing only electronic documents (ED) is identified to be transferred, the following steps must be completed by the specialist:

   - View Pending Casework screen.

     - Complete pending work such as all EDs, change reports and task/reminders prior to transfer.

     - If all EDs are not able to be completed for example, Disability Determination Service (DDS) determination pending, health plan change may affect treatment; the manager can elect to transfer the case, similar to transferring cases with outstanding tasks/reminders.

3. Once the case is ready to be transferred, the specialist transfers the case in Bridges by:

   - Locating the case or application on the Case Transfer screen. Then locate the case or application to be transferred using the Case/Application search box.

   - Select the Region and Office the case is being transferred to, or use the magnifying glass to search for the correct office.

   - Click Update.

Specialist Transfer-In Procedures

All Programs

Do the following upon receiving an alert that a case has been transferred to your workload from another local office:

Review the electronic record to determine whether all appropriate actions have been completed. Complete any necessary actions that were not completed.

If an interview is required schedule the interview no later than five workdays from the alert date; see interviews in BAM 115.

Interview the client if required. Complete a **review** of the eligibility factors that might have changed because of the move **or** conduct a full redetermination. However, if the redetermination is due or overdue, it must be completed.

Pending Applications and Initial Asset Assessments

All Programs

Do **not** deny a pending application or MA initial asset assessment **solely** because the group moved to another county or district. Transfer the application and documentary evidence to the new local office so that the original standard of promptness can be used.

If a group requesting assistance already has an application or MA initial asset assessment pending in another local office, request the case record.

Inactive Physical Case Records

All Programs

The new office will request transfer of an inactive physical case record during the registration process if the last county or district of record is not the same as the registering county or district.

The former county or district of record must transfer the inactive physical case record within 10 working days of receipt of the transfer request alert.

Lost Physical Case Records

All Programs

Documentation and information needed to support an eligibility determination may be recorded on the electronic case record. However, signed documents, vital statistics, medical and legal packets, and supportive verification and documentation are stored in the physical case record.

Transfer-Out Offices

When a transfer request is received and the physical case record cannot be located, do **all** of the following:

- Check to see if the case file consists entirely of ED's.
- Notify the new local office that the physical record is lost.
- Reconstruct the record using available documents and other information.
- Follow the **Transfer Procedures** in this item.
- If the lost physical case record includes a pending application, transfer the pending groups to the new local office. This ensures adherence to the established standard of promptness.
- If the physical case record is later found, forward it to the new local office indicated in Bridges. This includes **inactive** cases.

Transfer-In Offices

When the transfer-out office **cannot** locate the physical case record, do the following:

- Have the client sign a new application.
- Obtain sufficient verifications and documentation to support the eligibility determination.

Do **not** close or deny benefits **solely** because the client is unable to re-verify information that has been coded as previously verified in Bridges.

LEGAL BASE

FIP

Public Act 280 of 1939 as amended

SDA

Annual Appropriations Act
Michigan Administrative Code; R 400.3151-400.3180

Child Development and Care

Child Care and Development Block Grant of 1990
45 CFR Parts 98 and 99
Social Security Act, as amended R 400.5001 - 400.5020, MAC

MA

MCL 400.32

FAP

7 CFR 272.3

DEPARTMENT POLICY

All Programs

Information contained in all program case records is confidential and may be released **only** under limited circumstances for five general purposes: program administration, other government officials' access, charitable organization access, general public access, and client access. Policy in this item sets conditions for releasing information for each purpose.

Do **not** discuss with unauthorized persons, either during or after working hours, information about individual clients known through the Michigan Department of Health & Human Services (MDHHS) employment.

Releases for Program Administration

All Programs

Case record information may be released for purposes directly related to administration of the Family Independence Program (FIP), Child Development and Care (CDC), State Disability Assistance (SDA), Medicaid (MA), Food Assistance Program (FAP) and Supplemental Security Income (SSI), Title XX social services, and other means-tested assistance programs.

Exception: Information from **MA** records may be released **only** for purposes directly connected to administering the MA program.

Program administration means any of the following:

1. Establishing eligibility, determining benefits and providing services to clients.

2. Investigation, prosecution, or criminal/civil proceedings related to program administration. This includes cooperation with local, state or federal law enforcement officials and postal inspectors.

   For **FAP only**, the request must be in writing and include the:

   - Identity of the requestor.
   - Authority to request the information.
   - Violation being investigated.

- Identity of the client about whom the information is requested.

3. Administration of other federal or federally assisted programs which provide assistance in cash, in kind, or in service, directly to individuals based on need.

Note: This does **not** apply to the release of MA records; see ***Exception*** in this item.

4. Any audit related to program administration and conducted by a government agency authorized to do so.

Examples of releasing information for purposes directly related to program administration include, but are not limited to:

- Response to a social services agency in another state to confirm a client's eligibility status and benefits received in Michigan.
- Referral to the Social Security Administration (SSA) to determine a client's SSI eligibility.
- Referral to the Michigan Unemployment Insurance Agency (UIA) to verify a client's wage record or eligibility for unemployment benefits (UB).
- Referral to MDHHS Services programs and sharing of information between Family Independence Specialist (FIS)/Eligibility Specialist (ES) and services staff
- Correspondence with a court (including Friend of the Court), the Internal Revenue Service (IRS), or SSA to locate absent parents or obtain support.
- Request to a doctor, hospital or other agency for medical information needed to determine eligibility.
- Referral or response to the MDHHS Office of Inspector General or to MDHHS Children's Services Administration staff for investigative purposes.
- Referral or response to a court or law enforcement official regarding intentional program violation (IPV), paternity or support.

- Release of information necessary for the client's participation in employment-related activities.
- Release of the current status of FAP clients to school authorities regarding the National School Lunch Program.
- Sending notices, or otherwise providing information, to a client's child care provider when:
  - Child care services are authorized.
  - Changes are made in the authorization information previously given to the provider.
  - An authorization ends.
  - A Child Development and Care (CDC) application is denied.
  - A CDC application is withdrawn.
  - A CDC case is closed.

See Bridges Eligibility Manual (BEM) 704, Information to Share with Providers.

The release of any such information must be **necessary for program administration**, **not** solely to meet the needs of a person or agency. Releases are limited to persons or agency representatives who are subject to standards of confidentiality comparable to those of MDHHS.

Obtaining Client Consent

A signed application for assistance provides consent for purposes of program administration. No other written consent is required.

If uncertain whether the requested information is necessary to administer programs, **inform the client** of the request and obtain a **signed consent** before making the information available.

A DHS-27, Release of Information, is the best means to obtain the client's consent. Any consent must contain all of the following:

- Client signature.
- Current date.
- Person/agency to whom the information is released.

- Time period covered.
- Information to be released (either itemizing or stating a general release of any information).

When a serious threat to the family's health or safety exists, prior consent is **not** needed **except** when HIV/AIDS status is requested. Notify the client immediately of the information released.

Access by Government Officials

FIP, CDC and SDA Only

One copy of FIP/CDC/SDA information may be released to the following **if necessary to perform their official duties**:

- Official of a federal or state agency (including law enforcement).
- Official of a city, county or district (including law enforcement).
- Member or committee of the Congress or State Legislature.

Release information requested by an official's **representative if** s/he is so authorized by the official **and** the information is directly related to the official's duties. The official must provide a statement establishing those facts **if** local office staff do **not** know the representative. Place that statement in the case record.

The request may be initiated in person or via correspondence but **must be in writing**. Send the requestor a DHS-63, Request for Information Regarding Person Receiving Cash Assistance, to complete and return. A request in any other form must clearly identify the official and contain sufficient information to identify the client(s).

Exception #1*:* A release in regard to an individual's testing for HIV or AIDS is very limited; see HIV and AIDS Confidentiality in this item.

Exception #2*:* Do **not** release information obtained from the Workers' Compensation Agency (Michigan Department of Licensing and Regulatory Affairs) **unless** subpoenaed by a court **or** requested by the client or his legal representative. This applies **even if** the client provides a signed consent to release it to others.

If the validity of a request is questionable, contact the official/agency to confirm that the information is needed to perform official duties.

Inform the requestor that s/he must safeguard this confidential information and must **not** use it for purposes outside the official's functions or in unlawful ways; see General Public Access to Case Records in this item.

The official or representative may read the entire case record if necessary to perform official duties, but **only** in the local office. **Case records must not be removed from** M**DH**H**S premises.**

Case Record Access by Charitable Organizations

FIP, CDC and SDA Only

L**imited** case record information may be released in response to a request by a charitable organization, **provided** local office staff recognize it as having among its purposes the provision of goods or services to the indigent.

Note: The DHS-1171, Information Booklet, contains a section called “Information About Your Household That Will Be Shared.” By signing the DHS-1171, Assistance Application, clients certify they have received a copy, reviewed and agree with the sections in the assistance application information booklet which permits limited case information to be divulged.

The request may be initiated in person or via correspondence, but **must be in writing**. A DHS-63, Request for Information Regarding Persons Receiving Cash Assistance, may be sent to the requestor to complete.

If the validity of a request is questionable, contact the organization to confirm that the information is needed to provide a charitable benefit.

Explain to the representative that the purpose of the request must be to provide a benefit to clients and that it is illegal to use the information acquired for personal, political, commercial or religious reasons.

A request may be for particular clients or for a list of clients within a geographic area, age range or the like; see Client Lists in this item.

Example: A representative of the Toys for Tots organization might request a list of families in the county with children of pre-school age.

If the above conditions are met respond to the request by releasing **only** the following:

- Grantee name and address.
- First name(s) and age(s) of the child(ren) living with the grantee.

Retain completed requests chronologically in a separate file. Record on the back or attach a sheet to indicate the client(s) identified, resulting benefit(s), other facts concerning the inquiry, and any client action taken as a result. If a list of clients was provided, attach a copy.

General Public Access to Case Records

All Programs

Federal regulations and Michigan law limit general public access to case records.

Information which the client has provided a signed consent to release may be given to members of the general public who request it.

Information required by court order to be released must be given to the person/agency named in the order.

MA and FAP Only

In the absence of the client's signed consent or a court order, release case record information to **only** the client, his or her representative, or the following:

- For **MA**, a person/organization whose request is directly connected to administration of the **MA** program.

- For **FAP**, a person/organization whose request is directly connected to administration of MDHHS programs.

No information may be released to anyone else, even to acknowledge the client is a recipient.

FIP, CDC and SDA Only

The **general public** means anyone **except** the client, his representative, a recognized charitable organization, or a local, state or federal government official whose request is part of official duties.

The request may be initiated in person or via correspondence, but **must be in writing.** The DHS-63 may be used. If the request is in some other form, it must contain the requestor's home address and occupation as well as enough information to identify the correct client.

Limits on Information Provided

When a request meets the above requirements, provide **only the name and amount of monthly assistance** the group is currently receiving or last received. **Do not provide the group's address** or any other case information. Check the case record for a completed DHS-970 prior to releasing **any** information; see VICTIMS OF DOMESTIC VIOLENCE in this item.

Inform the requestor that:

- It is unlawful to utter or publish released information unless IPV or wrongful issuance of benefits is alleged.
- It is unlawful to use the information for political or commercial purposes.
- Violation of confidentiality or improper use of the information can result in a $1,000 fine, two years in prison, or both.

File completed DHS-63s separately and chronologically. Record on the back whether the client was identified, other facts concerning the inquiry, and the information released. Record in the case record any known client service or client action taken as a result.

VICTIMS OF DOMESTIC VIOLENCE

No information can be released, **even** to acknowledge the name and benefit amount, if the client has presented an affidavit attesting that:

- The client was physically and/or emotionally abused by a current or former spouse/companion; **and**
- The client fears that being identified will lead to a recurrence of such abuse.

A completed DHS-970, Affidavit for Withholding Any Information From Disclosure To The General Public, or its equivalent, can be used for this purpose. Confidentiality may be critical to the safety of the client when domestic violence is present. After completion staple it to the inside cover of the case file.

If a release poses a potential risk of physical/emotional harm, but the client has not provided such a sworn affidavit, do the following:

- If possible, contact the client **before** the release, explain the circumstance, and delay the release to allow the client to submit an affidavit.
- If that is **not** possible, after the release inform the client of the release.

Use of the DHS-970 or equivalent prohibits **only** MDHHS from releasing information to the general public. Advise the client that contacting other persons and agencies to request withholding of information is the client's responsibility.

Client Access to Case Records

All Programs

Case materials not separately restricted by law or court order must be available to the client upon request.

Telephone requests are **not** sufficient. Send the client a DHS-63 for completion or return. Correspondence that clearly identifies the client is also acceptable. Before providing any materials requested by mail, contact the client to verify that s/he made the request.

Within **five workdays** after receiving the completed DHS-63 or letter, send one copy of any unrestricted materials requested.

The client may personally inspect the case record during normal business hours in a designated space and in the presence of a staff member. **Case records must not be removed from** M**DH**H**S premises.** Give the person one copy of any unrestricted materials requested.

Client Representatives

A representative acting on the client's behalf may examine the case record or request case materials in writing. They may personally inspect the case record during normal business hours in a designated space and in the presence of a staff member. Case records must not be removed from MDHHS premises. One of the following must verify the person's status as representative:

- Court document or MDHHS administrative hearing authority decision indicating that person is the client's attorney at law, legal guardian or conservator
- For **FIP, CDC, SDA** and **MA**, the client's written statement specifying that person's authority to view or request case record materials

Note: The client's statement might limit what the representative may view (for example, only certain packets or a particular time period within the case history).

- For **FAP only,** the client's written statement designating the person as the **authorized representative** to apply for benefits and address other MDHHS matters on the client's behalf.

Note: The client may designate the same or a different representative to use the food assistance benefits on the client's behalf.

Mental Health Documents

The client or representative may review and copy mental health documents in the case record **except** any portions the department determines would be detrimental to the client or someone else if disclosed.

To be withheld, the document(s) or cover sheet must contain a specific statement by the document holder regarding the potential harm of disclosure. A general notation (such as, “Not for Further Release or Copy”) **cannot** prevent client access.

Note: Holder means the mental health facility or agency from which MDHHS acquired the records. Authority to restrict the release of such documents is contained in Section 748(5)(b) of the Mental Health Code (MCL 330.1748).

If it is questionable whether access to certain information is permitted, contact the holder. Record the response in the case record. The response should include:

- Date of the contact.
- Name and title of the respondent.
- Relationship of the holder to the client.
- Statement as to whether the respondent believes release of the information to the client or representative would be detrimental to the health or safety of the client or others.

Support Specialist Records

Support specialists' records are **not** solely client records and so are **not** totally available to the client or representative. Before releasing case record materials, you must remove all information gathered by the support specialist regarding an absent parent.

If unsure whether to release certain information, contact the support specialist.

Criminal Investigations

Do **not** release to the client or representative any case information related to a criminal investigation, **unless** the investigation and any resulting prosecution are complete.

HIV and AIDS Confidentiality

All Programs

Information identifying a person in regard to the following is confidential:

- Testing for, or infection by, human immunodeficiency virus (HIV).
- Diagnosis of acquired immunodeficiency syndrome (AIDS).

Do **not** disclose such information without prior written consent from the individual, his legal guardian, or a parent when the individual is a minor. **No other person may give consent** for the individual.

The individual consents by signing the application (which contains an acknowledgment regarding release of medical information) or comparable written statement. A legal guardian or parent consents by signing a DHS-4609, Medical Information Acknowledgment, or comparable written statement.

Release such information **only if** it is necessary to do one of the following:

- Administer MDHHS programs.
- Place and/or care for a minor in licensed child care.
- Prepare a report required by child protection law.
- Comply with a court order or subpoena indicating the court has determined that:
  - Other ways of obtaining the information are unavailable or ineffective.
  - Public interest and need for the disclosure outweigh potential injury to the person.

See Court Proceedings in this item.

Important: Unauthorized disclosure of HIV or AIDS information about an individual is a misdemeanor, punishable by up to one year imprisonment and/or $5,000 fine. It is also subject to a civil action and department discipline.

See Employee Handbook Policies (EHP) 410, Request for Public Records Freedom Of Information Act, for more details.

Children's Services Referral Documents All Programs

Access to records of protective and other services provided to children is severely limited. This includes documents in the case

record indicating a referral to services. Remove any document in the case record which mentions such a referral **before** allowing access by any non-MDHHS person. Do **not** copy any such referral to satisfy a request for case materials.

Information for Hearings

All Programs

The client or authorized hearings representative has a right to examine and receive a copy of any documents or other information to be introduced at an administrative hearing or used in the MDHHS decision regarding a hearing. This includes material from another state or federal agency **unless** access is restricted by other law (for example Mental Health Code).

Call the Office of Legal Service and Policy at (517) 373-2082 for help with questionable situations. See also “Client Access to the Case Record” in the “EVIDENCE” section in BAM 600.

Intentional Program Violation

All Programs

Provide case records when requested by an agent of the MDHHS Office of Inspector General.

The agent may **remove** the case record temporarily from the local office. If that is intended, make copies of all pertinent materials for casework purposes until the record is returned.

Court Proceedings

All Programs

Provide case records without subpoena to the Bureau of Legal Affairs or to the department's **legal representative** when MDHHS is the initiator or defendant in a legal action. The representative can be a prosecutor or staff of the attorney general (AG).

The department's legal representative may **remove** the case record temporarily from the local office. If that is intended, make copies of all pertinent materials for casework purposes until the record is returned.

In matters involving legal representation of MDHHS, provide one copy of case record materials when requested or subpoenaed by the client or the client's legal representative.

Subpoenaed Information

If subpoenaed to produce a case record in court or testify as to its contents, proceed as follows:

- Explain to the court (before the hearing, if possible) that case records are confidential by law, and request the court to excuse MDHHS.
- If not excused, read in court the pertinent portions of the statement contained in Exhibit I in this item for the appropriate program(s). Then, if the court orders it, produce the record and/or discuss it.

Reminder: Have available a copy of Exhibits II through V to give to the court if requested.

If subpoenaed by an attorney **other than** the client's attorney to appear or to submit a case record, at a place **other than** a court (for example, copy center or law office), proceed as follows:

- Call the attorney to explain that you are willing to appear but **cannot** produce **or** discuss the case record without the client's signed consent or a court order.
- If the attorney insists, appear at the designated place, read the Exhibit I statement, and withhold the record and discussion of it in the absence of the client's signed consent or a court order.
- If the attorney notifies MDHHS of a scheduled court hearing, appear at the hearing and read the Exhibit I statement. Then comply with any order the court issues.

The above procedures do **not** apply to actions **initiated by MDHHS** (for example, to prosecute for IPV, establish paternity or secure support). Provide the case record to the department's legal representative. If the **opposing** attorney subpoenas the record, contact the MDHHS legal representative for instructions.

If there are questions about a subpoena, contact the Bureau of Legal Affairs in central office through administrative channels.

Court-Ordered HIV/AIDS Information

In response to a **court order**, disclosure about a person who was tested for or infected by HIV, or diagnosed as having AIDS is mandatory. The court is responsible for determining that other ways of obtaining the information are unavailable or ineffective **and** that the public interest and need for disclosure outweigh client confidentiality.

If not stated in the court order, before providing the information, remind the court that its order must ensure the following (MCL 333.5131):

- Disclosure is limited to those parts of the client's record that the court determines essential to fulfill the objective of the order.
- Disclosure is limited to those persons whose need for the information is the basis for the order.
- The court must take other measures it considers necessary to limit disclosure.

See HIV and AIDS Confidentiality in this item.

Legal Representation

The AG represents MDHHS in all litigation. The Bureau of Legal Affairs serves as liaison to the AG. When MDHHS, or an employee as part of official duties, is named as a defendant in a legal action, notify The Bureau of Legal Affairs and forward the complaint or pleading directly to legal immediately. Use a DHS-1216-AP, Request for Attorney General Representation. Follow the instructions on the form. The Bureau of Legal Affairs will provide instructions as needed in handling the court case.

Do not communicate with an opposing attorney or representative on any issue of substance after a court suit is filed. Persons seeking to communicate must be referred to The Bureau of Legal Affairs.

Requests for Research

All Programs

Please complete a DHS-5300, Legal Research Request, form and submit it to the appropriate email box noted on the form.

Client Lists

FIP, CDC and SDA

Without prior written consent, MDHHS may furnish a list of clients or release information about groups of clients only if either:

- It is directly related to the administration of MDHHS programs.
- It is to be used by a charitable organization solely to benefit those clients directly.

See Releases for Program Administration and Case Record Access by Charitable Organizations in this item.

All Programs

Inform any **other** requestor that the information can be released **only** with the clients' prior written consent and that MDHHS will cooperate as follows:

- The local office will prepare a release that includes the requestor's identity, the purpose, and the information requested. The release will be sent to the clients, who may consent or refuse.

- Only information about those who furnish written consent will be provided.

Community Agencies

All Programs

Many communities have social service exchanges or central registration systems where member agencies send and draw information about specific clients. MDHHS may contribute information **only** with the client's written consent.

Freedom of Information Act

All Programs

The Michigan Freedom of Information Act (1976 P 442) requires MDHHS to provide public access to records that are not exempted by a separate law or a specific provision of the FOIA. **Client records are exempt** from this Act, **except** as provided in this item; see Employee Handbook Policies 410.

EXHIBIT I - STATEMENT TO BE READ BY MDHHS STAFF

In response to the subpoena, I must bring to your attention that these records are confidential under Michigan statute.

State law, at MCL 400.35, establishes the confidentiality of FIP, CDC, SDA, MA and FAP records. The MDHHS has promulgated rules for the use of such records, pursuant to Public Act 306 of 1969, as amended.

MCL 400.64 provides exceptions to the restrictions in MCL 400.35. However, those exceptions do not pertain to these records. It further prescribes penalties for violation of the Act.

The MA and FAP statutes comply with pertinent federal laws and regulations:

- For MA, Section 1902(a)(7) of the Social Security Act, as amended; and Section 431.300-.307 of Title 42, Code of Federal Regulations.
- For FAP, Section 11(e)(8) of the Food Nutrition Act of 2008 as amended; and Section 272.1(c) of Title 7, Code of Federal Regulations.

Because the case information is confidential, I must decline to release it unless the Court orders me to do so.

I have available the relevant sections of the above cited federal law, regulations and state statutes for your review.

EXHIBIT II - MICHIGAN SOCIAL WELFARE ACT MCL 400.35 & MCL 400.64

MCL 400.35 Records; confidentiality; rules for use.

Sec. 35. Notwithstanding section 2(6), records relating to categorical assistance, including medical assistance, shall be confidential and shall not be open to inspection except as prescribed in section 64. The state department of social services may promulgate and enforce rules for the use of the records as may be necessary for purposes related to federal, state, or local public assistance, pursuant to Act No. 306 of the Public Acts of 1969, as amended.

MCL 400.64 Applications and records considered public records; inspection; public access; restriction; uttering, publishing, or using names, addresses, or other information; confidentiality; alphabetical index file; inquiry as to name or amount of assistance; making available certain information to public utility or municipality; disclosure of information; violation; penalty; notice of assistance to deserted or abandoned child; documents, reports, or records from another agency or organization.

Sec. 64.

(1) Notwithstanding sections 2(6), 35, 45(6), and 46(6), applications and records concerning an applicant for or recipient of assistance under the terms of this act, except medical assistance, are public records and are open to inspection by persons authorized by the federal or state government, the state department, or the officials of the county, city, or district involved, in connection with their official acts and by the general public as to the names of recipients and the amounts of assistance granted. General public access is restricted to persons who present a signed application containing the name, the address, and the occupation of the persons signing the application. A person shall not utter or publish the names, addresses, or other information regarding applicants or recipients except in cases where fraud is charged or wrongful grant of assistance is alleged. A person shall not use the names, addresses, or other information regarding applicants or recipients for political or commercial purposes.

(2) Records relating to persons applying for, receiving or formerly receiving medical services under the categorical assistance programs of this act are confidential and shall be used only for purposes directly and specifically related to the administration of the medical program.

(3) In each county, the department shall maintain an alphabetical index file in its office of cases receiving assistance through the department. When a citizen makes a personal visit to an office during regular office hours, and makes inquiry as to the name or amount of assistance being received by a person, the requester shall be given the information requested in the manner prescribed by the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(4) Subject to restrictions prescribed by federal regulations governing temporary assistance for needy families or other federal programs, rules of the state department, or otherwise, for preventing the disclosure of confidential information to any person not authorized by law to receive the confidential information, the state department shall make available to a public utility regulated by the Michigan public service commission or a municipality information concerning applicants for, and recipients of, public assistance, the disclosure of which is necessary and the use of which is strictly limited to the purpose of a public utility's administering a program created by statute or by order of the Michigan public service commission and intended to assist applicants for, or recipients of, public assistance in defraying their energy costs.

(5) The state department may disclose information regarding applicants for, and recipients of, assistance under this act in connection with the administration of assistance under this act, including the implementation and administration of section 60a, to the extent that the disclosure in regard to applicants for and recipients of federally funded assistance is in accordance with applicable federal law and regulations regarding disclosure of confidential information concerning applicants for or recipients of federally funded assistance.

(6) Except as prescribed in section 61(2) and 61(3), a person who violates this section is, upon conviction, guilty of a misdemeanor punishable by imprisonment for not more than 2 years or by a fine of not more than $1,000.00, or both. If an employee of the state violates this section, the employee is also subject to dismissal from

state employment subject to rules as established by the civil service commission.

(7) The county department shall give prompt notice to appropriate law enforcement officials of the furnishing of temporary assistance for needy families in each case where a child has been deserted or abandoned by a parent and assistance is being furnished to the child.

(8) Documents, reports, or records authored by or obtained from another agency or organization shall not be released or open for inspection under subsection (1) unless required by other state or federal law, in response to an order issued by a judge, magistrate, or other authorized judicial officer.

EXHIBIT III - 42 CFR, SECTION 431.300-.307

Subpart F—Safeguarding Information on Applicants and Recipients

431.300 Basis and purpose.

(a) Section 1902(a)(7) of the Act requires that a State plan must provide safeguards that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. This subpart specifies State plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and restrictions on the distribution of other information.

(b) Section 1137 of the Act, which requires agencies to exchange information in order to verify the income and eligibility of applicants and recipients (see 435.940ff), requires State agencies to have adequate safeguards to assure that:

(1) Information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving the information, and information received under section 6103(l) of the Internal Revenue Code of 1954 is exchanged only with agencies authorized to receive that information under that section of the Code; and

(2) The information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.

431.301 State plan requirements.

A State plan must provide, under a State statute that imposes legal sanctions, safeguards meeting the requirements of this subpart that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

431.302 Purposes directly related to State plan administration.

Purposes directly related to plan administration include:

(a) Establishing eligibility;
(b) Determining the amount of medical assistance;
(c) Providing services for recipients; and
(d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan.

431.303 State authority for safeguarding information.

The Medicaid agency must have authority to implement and enforce the provisions specified in this subpart for safeguarding information about applicants and recipients.

431.304 Publicizing safeguarding requirements.

(a) The agency must publicize provisions governing the confidential nature of information about applicants and recipients, including the legal sanctions imposed for improper disclosure and use.

(b) The agency must provide copies of these provisions to applicants and recipients and to other persons and agencies to whom information is disclosed.

431.305 Types of information to be safeguarded.

(a) The agency must have criteria that govern the types of information about applicants and recipients that are safeguarded.

(b) This information must include at least—

(1) Names and addresses;

(2) Medical services provided;

(3) Social and economic conditions or circumstances;

(4) Agency evaluation of personal information;

(5) Medical data, including diagnosis and past history of disease or disability; and

(6) Any information received for verifying income eligibility and amount of medical assistance payments (see 435.940ff). Income information received from SSA or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data.

(7) Any information received in connection with the identification of legally liable third party resources under 433.138 of this chapter.

431.306 Release of information.

(a) The agency must have criteria specifying the conditions for release and use of information about applicants and recipients.

(b) Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the agency.

(c) The agency must not publish names of applicants or recipients.

(d) The agency must obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment under section 1137 of this Act and 435.940 through 435.965 of this chapter. If, because of an emergency situation, time does not permit obtaining consent before release, the agency must notify the family or individual immediately after supplying the information.

(e) The agency's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.

(f) If a court issues a subpoena for a case record or for any agency representative to testify concerning an applicant or recipient, the agency must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

(g) Before requesting information from, or releasing information to, other agencies to verify income, eligibility and the amount of assistance under 435.940 through 435.965 of this chapter, the agency must execute data exchange agreements with those agencies, as specified in 435.945(f).

(h) Before requesting information from, or releasing information to, other agencies to identify legally liable third party resources under 433.138(d) of this chapter, the agency must execute data in exchanges agreements, as specified in section 433-138(h)(2) of this chapter.

431.307 Distribution of information materials.

(a) All materials distributed to applicants, recipients, or medical providers must:

(1) Directly relate to the administration of the Medicaid program;

(2) Have no political implications except to the extent required to implement the National Voter Registration Act of 1993 (NVRA) Pub. L. 103–931; for States that are exempt from the requirements of NVRA, voter registration may be a voluntary activity so long as the provisions of section 7(a)(5) of NVRA are observed;

(3) Contain the names only of individuals directly connected with the administration of the plan; and

(4) Identify those individuals only in their official capacity with the State or local agency.

(b) The agency must not distribute materials such as “holiday” greetings, general public announcements, partisan voting information and alien registration notices.

(c) The agency may distribute materials directly related to the health and welfare of applicants and recipients, such as announcements of free medical examinations, availability of surplus food, and consumer protection information.

(d) Under NVRA, the agency must distribute voter information and registration materials as specified in NVRA.

EXHIBIT IV - FOOD AND NUTRITION ACT OF 2008, AS AMENDED

(e)(8) Safeguards which prohibit the use or disclosure of information obtained from applicant households, except that -

(A) the safeguards shall permit -

(i) the disclosure of such information to person directly connected with the administration or enforcement of the provisions of this Act, regulations issued pursuant to this Act, Federal assistance programs, or federally assisted State programs; and

(ii) the subsequent use of the information by persons described in clause (i) only for such administration or enforcement;

(B) the safeguards shall not prevent the use or disclosure of such information to the Comptroller General of the United States for audit and examination authorized by any other provision of law;

(C) notwithstanding any other provision of law, all information obtained under this Act from an applicant household shall be made available, upon request, to local, State or Federal law enforcement officials for the purpose of investigating an alleged violation of this Act or any regulation issued under this Act;-

(D) the safeguards shall not prevent the use by, or disclosure of such information, to agencies of the Federal Government (including the United States Postal Service for purposes of collecting the amount of an overissuance of benefits, as determined under section 13(b) of this Act, from Federal pay (including salaries and pensions) as authorized pursuant to section 5514 of title 5 of the United States Code or a Federal income tax refund as authorized by section 3720A of title 31, United States Code;

(E) not withstanding any other provision of law, the address, social security number, and if available, on request, to any Federal, State, or local law enforcement officer if the officer furnishes if the officer furnishes the State agency with the name of the member and notifies the agency that-

(i) the member--

(I) is fleeing to avoid prosecution, or custody or confinement after conviction, for a crime (or attempt to commit a crime) that, under the law of the place the member is fleeing, is a felony (or, in the case of New Jersey, a high misdemeanor), or is violating a condition of probation or parole imposed under Federal or State law; or

(II) has information that is necessary for the officer to conduct an official duty related to subclause (I);

(ii) locating or apprehending the member is an official duty; and

(iii) the request is being made in the proper exercise of an official duty; and

(E) the safeguards shall not prevent compliance with paragraph (15) or (18)(B) or subsection (u);

EXHIBIT V - 7 CFR SECTION 272.1(c)

(c) Disclosure. (1) Use or disclosure of information obtained from food stamp applicant or recipient households shall be restricted to:

(i) Persons directly connected with the administration or enforcement of the provisions of the Food and Nutrition Act of 2008 as amended, or regulations, other Federal assistance programs, federally assisted State programs providing assistance on a means-tested basis to low income individuals, or general assistance programs which are subject to the joint processing requirements in section 273.2(j)(2).

(ii) Persons directly connected with the administration or enforcement of the programs which are required to participate in the State income and eligibility verification system (IEVS) as specified in section 272.8(a)(2), to the extent the food stamp information is useful in establishing or verifying eligibility or benefit amounts under those programs;

(iii) Persons directly connected with the verification of immigration status of aliens applying for food stamp

benefits, through the Systematic Alien Verification for Entitlements (SAVE) Program, to the extent the information is necessary to identify the individual for verification purposes.

(iv) Persons directly connected with the administration of the Child Support Program under Part D, Title IV of the Social Security Act in order to assist in the administration of that program, and employees of the Secretary of Health and Human Services as necessary to assist in establishing or verifying, eligibility or benefits under Titles II and XVI of the Social Security Act;

(v) Employees of the Comptroller General's Office of the United States for audit examination authorized by any other provision of law; and

(vi) Local, State, or Federal law enforcement officials, upon their written request, for the purpose of investigating an alleged violation of the Food and Nutrition Act of 2008 as amended, or regulation. The written request shall include the identity of the individual requesting the information and his authority to do so, violation being investigated, and the identity of the person on whom the information is requested.

(2) Recipients of information released under paragraph (c)(1) of this section must adequately protect the information against unauthorized disclosure to persons or for purposes not specified in this section. In addition, information received through the IEVS must be protected from unauthorized disclosure as required by regulations established by the information provider. Information released to the State agency pursuant to section 6103(1) of the Internal Revenue Code of 1954 shall be subject to the safeguards established by the Secretary of the Treasury in section 6103(1) of the Internal Revenue Code and implemented by the Internal Revenue Service in its publication, Tax Information and Security Guidelines.

(3) If there is a written request by a responsible member of the household, its currently authorized representative, or a person acting on its behalf to review material and information contained in its case file, the material and information contained in the case file shall be made available for inspection during normal business hours. However, the State agency may withhold confidential information, such as the names of individuals who have disclosed

information about the household without the household's knowledge, or the nature or status of pending criminal prosecutions.

LEGAL BASE

FIP

MCL 400.1 et seq.
MCL 400.35 and MCL 400.64

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

CDC

Child Care and Development Block Grant of 1990.
45 CFR Parts 98 and 99
Social Security Act, as amended
Mich Admin code, R 400.5001 - 400.5020

MA

42 CFR 431.300 - .307

FAP

7 USC 2020(e)(8)
7 CFR 272.1(C)

FOIA

MCL 15. 231 et seq

OVERVIEW

The Child Protection Law (CPL), 1975 PA 238, requires the reporting of child abuse and neglect by certain persons, including certain DHS employees, and permits the reporting of child abuse and neglect by all persons.

All eligibility specialists, family independence specialists and family independence managers are required to report suspected child abuse and neglect.

See the Employee Handbook, Mandated Reporter Child, for information on how to report suspected child abuse and neglect.

LEGAL BASE

Act No. 238, Public Acts of 1975, as amended

MCL 722.621 - 722.638

OVERVIEW

The Social Welfare Act, 1939 PA 280, requires the reporting of abuse, neglect, or exploitation of an adult by certain persons, including all DHS employees, and permits the reporting of abuse, neglect, or exploitation of an adult by all persons.

All DHS employees are required to report suspected adult abuse, neglect, or exploitation.

See the Employee Handbook, Mandated Reporter Adult, for information on how to report suspected adult abuse, neglect, and exploitation.

LEGAL BASE

Social Welfare Act

MCL 400.11 - 400.11f

DEPARTMENT POLICY

Family Independence Program (FIP), Medicaid (MA) and Food Assistance Program (FAP)

The Department of Human Services (DHS) is subject to audits and reviews of its performance. Some of these are internal and some are by external agencies. This item identifies some of these review processes and defines the responsibilities of clients, local offices, central office and the corresponding federal agencies in these processes.

TYPES OF AUDITS

Although many areas of the department are audited, this item addresses audits/reviews regarding financial and medical eligibility and work participation. The following audits (referred to as reviews) are used to monitor DHS performance in these areas:

- Office of Quality Assurance (OQA) Food Assistance Program and Medicaid reviews.
- Office of Quality Assurance (OQA) Family Independence Program (FIP)/Temporary Assistance to Needy Families (TANF) work participation reviews.
- State Management Evaluation Reviews (SME).
- Food Assistance Management Evaluations (FAME).

These audits are described in detail in this item. Included are the scope and purpose of each audit, frequency of review, the review process, and how the findings are used.

OFFICE OF QUALITY ASSURANCE REVIEWS

FIP, MA and FAP

MA and FAP Quality Control Reviews

MA and FAP

Per federal regulations, every state is responsible for conducting MA and FAP Quality Control (QC) reviews.

Scope and Purpose

The purpose of the review is to determine for active cases if the eligibility decision and/or benefit amount for the sample month was correct, or for negative case reviews, if the denial or closure (FAP and MA) or temporary suspension of benefits (FAP only), was correct. QC review findings of active cases determine the incidence and dollar amounts of errors. The objectives of QC reviews are to provide:

- A systematic method of measuring the validity of the eligibility determinations made by the FIS/ES.
- A basis for determining error and misissuance rates.
- A process to improve accuracy by developing prevention strategies and corrective action plans at all levels of the agency.
- The basis for establishing state agency liability and sanctions for misissuance rates that exceed the national standard and state agency eligibility for enhanced funding (FAP only).

Frequency of Reviews and Selection of Cases for Review

Each month a statewide random sample of households is selected from two different categories: active cases and negative cases (households that were denied benefits or whose benefits were terminated (FAP and MA) or temporarily suspended (FAP only).

Request for Case Records

When a case is selected for review, the Office of Quality Assurance reviewer will contact the local office designee to:

- Obtain active and obsolete files (paper and electronic).
- If necessary, assist the reviewer in locating the recipient or enlisting the cooperation of recipients who are not responding to the reviewer's letters or required in-person interviews.

Note: For FAP active cases, reviews that must be dropped because of recipient "non-cooperation/unable to locate" contribute a substantial increase in the Food Assistance misissuance/error rate.

Federal Food Assistance Program reviewers assume that these dropped cases are error cases more than the same number of reviewed cases. Thus, cases that are completed even with an error have less of an impact on the misissuance rate than a dropped audit. Therefore, local office help to avoid dropping an audit is crucial to the state's overall misissuance rate.

DHS-1599, Review Results Findings Summary, Overview

Upon completing the review, the Office of Quality Assurance will electronically provide a DHS-1599, Review Results Findings, summary to the local office with copies to business service center and central office staff. The findings/summary includes:

- Detailed case information indicating that the case is correct or in error.
- Information for local office follow-up when the information is not pertinent to the sample month.
- Report of a dropped review.
- In cases of recipient non-cooperation, a request for case closure and the period of ineligibility; see BAM 105.

The OQA reviewer may write an "Addendum" that is a subsequent review results finding informing the local office that the results of the review have changed. Changes are reported as a result of new collateral information received by the reviewer, or for FAP, a federal second party review by the US Department of Agriculture, Food and Nutrition Service.

Review Results Findings/Summary – Preliminary Error Cases Error Review Committee (ERC)

All preliminary error findings are re-reviewed by the Office of Quality Assurance (OQA) and the Error Review Committee (ERC). The ERC teleconference meeting is facilitated by OAQA and includes representatives from the local office, Field Operations Administration (FOA), Wayne County Operations, Family Program Policy, Office of Workforce Development and Training (OWDT), Department of Community Health (for MA reviews), and OQA.

The goals of the ERC are:

- Determine if there is information or factors that have not been taken into consideration that could possibly change the finding.
- Identify issues that suggest a need to revise or clarify policy.
- Identify training needs or other corrective action.
- Identify the need for systems modifications.
- Develop a better understanding of Bridges.
- Identify error prevention strategies.

A vital part of the ERC review involves the participation of local office management and staff where the QC error was found. The local office has the client's case file, information, and considerable knowledge regarding the reasons for the specialist's actions. Participation in the ERC teleconference meeting also affords the local office the opportunity to contribute directly to recommending changes in policy, procedures, systems and training development. To develop a better understanding of Bridges, it is recommended that local offices have access to Bridges during the ERC meeting discussion.

When a local office receives from OQA electronic notification of Preliminary Case Review Findings that a case is in error, it is mandatory for a Program Manager or First Line Manager in the local office, to participate in the Error Review Committee process. It is the local office's decision to include the FIS/ES case manager or specialist. At least one week in advance of ERC, OQA will contact the County Director and District Manager via email to schedule the meeting and provide the teleconference telephone number and access code for the meeting.

Bias of Review Results

To comply with the federal requirement to avoid bias in the review, no one other than OQA staff is to contact the client or any collateral to discuss case circumstances that led to the error citation. Questionable areas of the review will be discussed at the Error Review Committee teleconference meeting. The Office of Quality Assurance must do any follow-up and resolve any questions, conflicting information or problems. For this reason local office staff is not to act to correct the error until after the results are discussed. Regular work on the case, such as acting on other reported changes or redeterminations, may continue.

Local Office Response To QC Review Error Process

Once the FINAL QC DHS-1599, Review Results Summary, for an error case is received, the local office has 10 work days to submit the DHS-191, Response to Office of Quality Assurance Quality Control Review Error, and any supporting documentation.

- DHS-191 is to be reviewed and signed by the County Director/District Manager.
- Send the DHS-191 electronically to DHSAPSpecialists@michigan.gov. For Urban offices, a copy should also go to the local AP Specialists, as appropriate.
- If a recoupment action is required, a copy of the DHS-4701,Overissuance Referral, must be included with the DHS-191.

Error Prevention Strategies

During the Error Review Committee teleconference meeting, ideas for preventing errors are discussed. Examples of these strategies include changes to local office processes, review or development of new training modules or desk aids, Bridges modifications, and changes to MA and FAP policies. Analysis of errors and error prevention strategies is available on the DHS-Net OQA website.

FIP/TANF Work Participation Reviews

FIP

Purpose and Scope

The purpose of the FIP/TANF review is:

- To determine whether the TANF/FIP group includes a work-eligible individual (WEI), and if so, whether the WEI met the work participation requirements in the sample month. These reviews are federally-mandated to establish Michigan's work participation rate. Federal sanctions are applied if the work participation rate is below the federal target.
- To provide to the federal government demographic information for the FIP/TANF cases reviewed.

Frequency of Reviews and Selection of Cases for Review

Each month a statewide random sample of households is selected from two categories: federally-funded active FIP/TANF cases and federally-funded closed FIP/TANF cases.

Requests for DHS Case Records & MWA Files

When a case is selected for review, the Office of Quality Assurance contacts the local office designee to request the case record. DHS offices have five business days to complete the DHS-572, OQA TANF Case Review Checklist, and provide the checklist and the DHS client case record to OQA. The Workforce Development Agency (WDA) has eight business days to obtain the Michigan Works! Agency (MWA) file and provide it to OQA.

TANF/FIP Case Review

Upon receipt of the records and files, OQA completes the work participation desk review. When OQA has completed its review, the Central Office FIP/TANF Family Program Policy Unit completes a review of the FIP/TANF group's eligibility based on information provided in Bridges. WDA also reviews the work eligible individual's current work participation activities within the One Stop Management Information System (OSMIS).

TANF Work Participation Review Committee (WPRC)

The TANF Work Participation Review Committee (WPRC) is facilitated by OQA and is a partnership between OQA, TANF/FIP Family Program Policy, Field Operations Administration (FOA), WDA, DHS local office representative/PATH Coordinator, and MWAs. To assure accuracy and completeness, case review results and action items for all sampled cases are discussed during weekly TANF Work Participation Review Committee meetings/teleconference calls.

The goals of the WPRC are:

- Assure that federal work participation determinations were accurately made.
- Identify and obtain additional documentation that might not have been provided or available at the time of the review.
- Identify specific reasons that each case did not meet participation requirements.
- Identify and work in partnership to eliminate barriers to meeting work participation requirements.
- Assure that cases that were in the sample are currently being handled correctly, therefore preventing future errors.

DHS-932, Review Results

The DHS-932, OQA, FIP/TANF Program Policy, and WDA Case Review Results, are emailed to DHS offices and MWAs, along with information regarding any follow-up action the local DHS office, MWA and OQA is required to complete.

DHS-584, Response to Review Results

Within twelve work days of receipt of the review results, the local DHS office is required to complete the DHS-584, Response to TANF Work Participation Case Review Results, documenting the completion of action items.

- DHS-584 is to be signed by the county director/district manager.
- Send the DHS-584 and any requested documents to FOA via the DHS-APSpecialists@michigan.gov.

STATE MANAGEMENT EVALUATION REVIEW (ME)

FAP Only

The Food and Nutrition Service (FNS) periodically reviews each state's administration and operation of the Food Assistance Program to determine compliance with federal regulations program requirements.

Scope and Purpose

FNS designates which areas are to be reviewed each year. Typically these reviews include but are not limited to the following areas:

- Application processing.
- Civil rights complaints.
- Benefit issuance.
- Benefit recoupment and collection.
- Reconciliation and reporting.
- State plans for management evaluation (ME) and Quality Control (QC).
- Client complaints.
- Payment accuracy.
- Negative errors.

Frequency of Reviews

The ME is conducted annually.

Central and Local Office Responsibilities

The majority of this audit is conducted in central office using statewide data. However, one or more local offices may be reviewed. The audit begins with an entrance conference which introduces the auditing staff to the state and explains the areas that will be reviewed during the audit.

The actual review typically takes three working days, with one day spent in local offices. Prior to the review, central office selects a local office for review and requests that specific cases be pulled for review. Local offices are usually given time to prepare for the review. Federal auditors are usually assigned to a designated staff

person at each local office to provide information relative to the review.

Once the review is completed at the local office, an exit conference is held in central office.

The results of the review are presented to the department in a written report. The department then has ***60 days*** to respond regarding corrective actions. Local offices are responsible for correcting any errors cited in individual cases.

FOOD ASSISTANCE MANAGEMENT EVALUATION (FAME)

FAP Only

FAME reviews are mandated by FNS and are designed to determine whether local offices are complying with federal regulations and Michigan food assistance policy. FAME reviews do not establish the misissuance rate. Reviews are conducted by consultants from Field Operations Risk Management Unit. The areas reviewed include but are not limited to:

- Certification procedures.
- Issuance services.
- Security/control.
- Reconciliation.
- Record keeping and reporting.

Note: FAME review targets can change each fiscal year according to FNS requirements.

Scope and Purpose

The objectives of FAME reviews are to provide:

- A systematic method of monitoring and assessing program operations;
- A basis for local offices to improve and strengthen program operations by identifying and correcting deficiencies; and
- A working relationship between the local office, central office and FNS to develop solutions to identified problems in policy and/or procedures.

Frequency of Reviews

FAME reviews are conducted annually in large local offices which have over 15,000 cases. Counties aligned under a single director are referred to as management units. Management units of 2,001 to 15,000 cases are reviewed every two years and those with 2,000 cases or less are reviewed once every three years.

FNS may require the State agency to conduct additional on-site reviews when a serious problem is detected in a project area which could result in a substantial dollar or service loss.

FAME Consultants Responsibilities

The FAME consultant contacts the local office to inform them of the date the review is to begin. The consultant:

- Reads cases which have been selected according to random procedures.
- Interviews staff responsible for food assistance activities,
- Reviews records, reports and local procedures.

The review is documented on a worksheet and identifies:

- A description of the deficiency detected.
- The cause(s) of any deficiency detected, if known; and
- The number and identification (case name and number) of casefiles selected and examined.

The consultant forwards the review findings to the county director/district office manager and the director of the Business Service Center (BSC) that the local office is assigned to, listing all deficiencies found during the FAME review. The written report contains a general summary of findings, specific case findings and a request for a corrective action response.

Review worksheets are retained by FAME and Field Operations for three years and are made available to FNS upon request.

Local Office Responsibilities

Local offices must take appropriate corrective action on errors found in the case record within ***15 days*** of receiving the FAME review report. They must then submit a Corrective Action Plan (CAP) to the FAME within ***60 days*** of the FAME report.

The local office CAP must address:

- Each of the program area deficiencies in the FAME report.
- Include the corrective action they will use to correct the deficiency.
- A timetable for meeting the corrective action.

The corrective action may include recommendations for BSC or central office actions which the local office believes would aid in their efforts to correct the deficiency.

Local offices are responsible for developing and completing all necessary follow-up measures to ensure the effectiveness of their corrective actions. Monitoring to fulfill this requirement may take various forms, such as, increased supervisory case readings, special reviews or spot checks, implementing new local office procedures, etc.

DEPARTMENT POLICY

Cash, Food and Medical Assistance

Cash, Food and Medical Benefits are issued to clients based on information entered in Bridges.

This item includes time frames and other instructions to open, change or terminate program benefits.

DEFINITIONS

All Programs

Cut-off Date

The last date in which a change can be made to affect the next benefit issuance.

Cash Assistance Only

Availability Date

The last number of the grantee's recipient identification number identifies the date benefits are available.

Issuance Systems

Benefits are issued using the Electronic Benefit Transfer (EBT) system. Clients have a Michigan Bridge card where their benefits are automatically deposited; see BAM 401E, Electronic Benefit Transfer Issuance System.

Negative Transaction Deadline

The last day for a specialist to send a timely notice of negative action to a client or to generate a DHS-1605, Notice of Case Action, with timely notice to the client, to affect the following month's benefits.

Pay Period (or Payment Period)

The half-month that a warrant/benefit covers. A pay period is either the first through the 15th day **or** the 16th through the last day of the month.

Payment (PA) Effective Date

The first day of the pay period (1st or 16th of the month) for which benefits will be paid.

Single Deadline Date

The last workday of the month. This is the last day the grant amount can be changed to affect the following month's payment amount.

Warrant

The cash benefit paid by the state to eligible groups in the form of a check.

Warrant Date

The date printed on the warrant or the date of the EBT deposit. It is the date the client can expect to receive the warrant or be able to access the EBT deposit.

CASH BENEFITS

Initial, ongoing, supplemental and issuance on closed cash assistance benefits of $1,000 or less are electronically deposited into the eligible group's EBT account.

Benefit authorizations over $1,000, and certain other supplemental benefits are issued as warrants.

Ongoing semi-monthly benefits are issued on a staggered schedule throughout the month, based on the grantee's recipient ID ending digit; see RFS 305, for specific issuance dates.

Openings

At opening, the group is eligible for benefits **no earlier** than the pay period in which the application becomes 30 days old; see BAM 115, Application Processing.

Supplemental Benefits

Bridges issues a supplement when benefits are authorized to correct underissuances.

Immediate Effect Actions

When a change with immediate effect causes a benefit increase or decrease (including closures and transfers to MA), enter the change by the single deadline date to affect the following month's benefit amount.

Negative Actions-Requiring Timely Notice

When providing the client with timely notice of a benefit decrease (including closures and transfers to MA), complete the change by the negative transaction deadline to affect the following month's payment amount.

Benefits Issued at Closure

When Cash programs are closed (including transfers to MA), and the negative action effective date is the second day of the month through the end of a calendar month, both regular benefits for that month will be issued. Closures effective on the first day of the month receive no benefits for that month.

Note: Vendoring stops when the FIP/SDA program closes. The grantee will receive the full monthly amount in any benefits issued after the closure effective date. (Recoupment **will** still be taken from these benefits.)

Address Change

A client or third-party address change must be entered **a** before the issuance date to affect that benefit.

Vendor Payments

BAM 425, Voluntary Vendor Payments, explains entry of vendor payments.

Benefit Issuance

A case payment history can be obtained through the View Benefits screen. By entering up to a 12-month time period and a specific case number, all payments for the case will be displayed on the screen(s).

Make a copy of the screen, if a paper copy of the information is needed. For payment histories not available in Bridges, fax a request to the Specialized Action Center in Central Office at 517-335-6054. Include the case name, case number and the period for which the payment history is needed.

MEDICAL BENEFITS

(Plastic mihealth cards)

MDHHS has contracted with Medifax to produce and issue plastic mihealth cards. Each recipient who is eligible for Medicaid will receive a mihealth card. The mihealth card will be used every month that a client is eligible for Medicaid.

Openings (mihealth cards)

At initial case opening when full or emergency coverage is certified, a mihealth card will be mailed within 48 hours. At initial case opening of a deductible when the deductible is not met, no card is mailed. However, a card is mailed the first time eligibility (full or emergency coverage) is certified.

If the case is being re-opened or reinstated, no card will be issued unless requested by the client. The client must call the beneficiary helpline at 1-800-642-3195 to request a card.

Replacing an mihealth card

Clients must contact the beneficiary helpline at 1-800-642-3195 to request a replacement mihealth card.

Medical History Data Inquiry Transaction

MA Only

Each recipient's medical coverage history is available using the MMIS Preconversion Details or the Medicaid Eligibility screen.

FOOD ASSISTANCE BENEFITS

Issuance Systems

Benefits are issued using the EBT system. Clients have a Michigan Bridge card where their benefits are automatically deposited; see BAM 401E, Electronic Benefit Transfer Issuance System.

Initial Benefits

Bridges authorizes initial benefits for the month a case opens **if** that month is part of the eligibility period. These benefits are issued as initial l benefits; see BAM 406.

Retroactive Benefits

Bridges authorizes retroactive benefits if the group is eligible for a period that is both:

- Prior to the month eligibility was determined.
- Within 60 days of the application date.

If application processing is delayed beyond 60 days from the date of application, Bridges will issue a supplement to correct previous month's benefits which may result in offsetting.

These are supplemental benefits; see BAM 406, Supplemental Food Assistance Benefits.

Regular Benefits

The client’s ongoing benefits are issued based on the last digit of the grantee’s recipient identification number; see RFS 305 for issuance dates.

Supplemental Benefits

Bridges authorizes supplemental benefits when the regular issuance is less than the group is eligible for **or** for periods when the group was eligible but received no benefits; see BAM 406, Supplemental Food Assistance Benefits.

Accessing Benefits

Clients use a Bridge card and personal identification number to access food benefits; see BAM 401E, Electronic Benefit Transfer Issuance System.

Changes and Closures

The cut-off date for a benefit change or case closure is the last workday of the month **before** the month the change/closure takes effect.

Note: Administrative recoupment can reduce benefits to zero. The case remains open and the client must continue to meet eligibility requirements.

Expunged Benefits

FAP benefits which have not been accessed for 365 days will be expunged. Once expunged, the client is no longer entitled to these benefits and the benefits cannot be replaced; see BAM 401E, Electronic Benefit Transfer Issuance System.

Benefit Issuance History

Obtain the client's food assistance benefit history in Bridges.

LEGAL BASE

FIP

42 USC 604-(g)
Social Welfare Act, P.A. 280 of 1939, as amended

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

MA

42 CFR 435.914
Mich Admin Code, R 400.2(4)

FAP

7 USC 2016(a),(j)(1)(A)
7 CFR 273.10(a)(1)(i)(ii)
7 CFR 274.2
7 CFR 274.1(a)(2),(d)(3)
7 CFR 274.7(d)

JOINT POLICY DEVELOPMENT

Medicaid, Transitional Medical Assistance (TMA), and Maternity Outpatient Medical Services (MOMS) policy has been developed jointly by the Department of Community Health (DCH) and the Department of Human Services (DHS).

INTRODUCTION

FIP, SDA, RCA and FAP

Electronic Benefit Transfer (EBT) allows clients who receive cash (FIP, SDA etc.), and food (FAP) to receive their benefits using debit card technology. Benefits are deposited electronically into a cash and/or food account. Clients access their benefits by using their personal identification number (PIN), along with their Bridge card.

EXCESSIVE CARD REPLACEMENT RULE

Issuance of four or more Electronic Benefit Transfer (EBT) cards has been shown to be a potential indicator of fraud and abuse of Food Assistance Program (FAP) benefits. It may also be an indicator of the potential need for a referral to protective services in situations where benefits are suspected of being misused.

In the department's ongoing efforts to combat fraud and abuse, and to comply with new Food and Nutrition Services (FNS) policy, the following procedure will be implemented:

- Xerox will send a card withholding letter to all households when they are at their 4th replacement card within a 12 month period, notifying them that they have reached the number of issued cards threshold, and at their 5th and each subsequent card replacement request their card will not be issued until they have gone into the local office to speak directly to the district manager or county director.
- Upon the client’s request for a 5th card, a second card withholding letter will be sent by Xerox notifying the client that they have exceeded the number of card requests allowed, and that they must contact their local office to schedule an appointment to speak directly to the district manager or county director in order to get another card. Xerox will inform clients calling to request replacements of this requirement.
- The district manager or county director will meet with the client in question and review their situation and explanation. Based on this contact, the county director or district manager will make appropriate referrals and issue a new EBT card under their authority. The situation, referrals, and approval shall be recorded on the DHS-1054, Authorization to Approve Issuance

of Electronic Benefit Transfer (EBT) Card, form. Copies of the authorization document shall be stored in the local office and the case record for seven years either as a hard or scanned copy. Copies will also be forwarded to the appropriate business service center (BSC) director.

- To meet FNS guidelines, EBT replacement cards must be available for pick up or placed in the mail within two business days following notice by the household to the state agency that the card has been lost or stolen. A copy of the authorization form may be used to locally issue an EBT card as appropriate.

BRIDGE CARD ISSUANCE

Head of Household

The EBT vendor, XEROX issues Bridge cards to the program head of household (HOH), unless there is a third-party payee/protective payee for the cash program. The Bridge card is then issued to both the HOH and the third-party payee/protective payee. Bridge cards are automatically mailed by XEROX for:

- Head of Household changes.
- New case openings when a Bridge card has **not** previously been issued for the same recipient identification number.

Note: If a Bridge card has previously been issued for the HOH's recipient identification number and the client no longer has the card, they must contact XEROX to request a replacement card or a local office over-the-counter card can be issued.

Clients will receive the Bridge cards and card mailer with basic information two to five days after the case opening. The, DHS-Pub-322, How to Use Your Michigan Bridge Card, pamphlet will be sent to clients with initial Bridge cards.

Bridge cards will be mailed to the local office for clients who are using the county/district office as their mailing address.

Note: FAP clients must have their Bridge card and access to their benefits to meet the standard of promptness. FAP benefits are not available to the client until the day after the benefits are authorized.

Head of Household Changes

If the HOH on a case changes, remaining benefits in the account do **not** transfer to the new HOH's Bridge card. The previous HOH retains access to the remaining benefits in their account. Any subsequent benefits issued on a case will be added to the new HOH's Bridge card. If the HOH change is due to death or incarceration (prison) see; Deceased or Incarcerated Household Changes in this item.

Deceased or Incarcerated Household Changes

If an individual is either deceased or incarcerated and has **ever** had access to a Bridge card their access, as well as the authorized representative's access, will be terminated once updated accordingly in Bridges.

If the HOH is deceased or incarcerated and there are other members of the household who are entitled to the benefits, a new HOH will need to be determined from one of the remaining adult group members. See BAM 115 Application Processing, Designation of Head of Household.

A DHS-3503, Verification Checklist, will be issued by Bridges to allow the household 10 days to provide their choice of a new HOH. If verification is not received, the EDG will close for failure to verify.

Exception: For FAP only, if a new HOH is not chosen, the EDG will not close. The specialist must choose a new HOH from the remaining group members.

Once designation of a new HOH is received, enter the new HOH into Bridges.

Transfer of Funds

If the HOH is deceased or incarcerated, available benefits may be transferred to another group member who is the new HOH. Benefit transfers must be approved by policy. To request the transfer of the benefits, send an email to the appropriate policy email box; see BEM 100, Policy Interpretations. Include the following information:

- Case name.

- Case number.
- Name and recipient id of old HOH.
- Name and recipient id of new HOH.
- The reason for the transfer.

Authorized Representative

The authorized representative (AR) is chosen by the client and can only access the FAP account. Entering the AR's name in Bridges will automatically generate a Bridge card.

The AR's Bridge card is mailed to the client's address. It contains the HOH's and AR's names. The AR is identified with "ARFS" following the name on the card. It is the client's responsibility to give the Bridge card and the PIN to the AR.

Note: Bridge cards are not issued to the HOH's spouse unless the spouse is designated as the AR.

Clients who no longer want their AR to have access to their FAP benefits may contact XEROX and request them to deactivate or "status" the AR's card, thus ending the AR's access to benefits immediately. Once a card is deactivated it **cannot** be reactivated, even if the same person is requested again as the AR.

Changing the AR in Bridges will deactivate the AR's card, however, not immediately. Advise a client who contacts DHS first, to also contact XEROX to deactivate the AR's card.

If a client wants to change the AR and the person is not listed in the current DHS-1171, Assistance Application, then a DHS-247, EBT Food Stamp Authorized Representative, must be completed: see BAM 110 Authorized Representative.

If the AR performs fraudulent activity involving a client's account, lost or stolen benefits are **not** replaced. If the fraudulent activity was done with the client's knowledge, it may result in criminal charges against the client and/or the client's benefits may be reduced.

Third-Party Payee/ Protective Payee

Third-party payees/protective payees on cash assistance cases are issued a Bridge card and can only access the client's cash benefit account. The Bridge card is mailed to the third-party payee/protec-

tive payee's address on Bridges and will contain only the third-party payee/protective payee's name. When there is a third-party payee/protective payee, the client **cannot** access the cash account. Clients with a third-party payee/protective payee still have access to the FAP account.

If a group has both an AR and a third-party payee/protective payee, it may be the same person or different people. If it is the same person, that person will receive two Bridge cards, one to access the FAP account and the other to access the cash benefits; see BAM 420, Third-Party Payee, for more information.

Cash Third-Party Payee/Protective Payee Changes

The following explains who can access the cash account when there is a change to the third-party payee/protective payee:

- If the third-party payee/protective payee changes, the new third-party payee/protective payee will be able to access any existing benefits in the cash account with their new Bridge card.
- If the third-party payee/protective payee is deleted in Bridges, the third-party payee/protective payee will no longer have access to any benefits. Access will revert to the HOH who will have access to all the benefits in the cash account.

LOCAL OFFICE ISSUED BRIDGE CARD

Local office over-the-counter issued Bridge cards are permanent cards and do not have the client's name printed on the card. Bridge cards may be issued by the local office upon receipt of an email from the eligibility/family independence specialist (ES/FIS). The ES/FIS must list the HOH's name and recipient identification and indicate in the email that an over-the-counter card is to be issued. The clerk must run a case summary and print a copy of the results. Valid photo identification must be presented by the cardholder to receive the card. Never give over-the-counter Bridge cards that belong to the HOH to the AR.

Note: If issuing an over-the-counter to a new HOH that will receive a benefit transfer due to the death or incarceration (prison) of the previous HOH, the policy approval email must accompany the request.

Food Stamp Authorized Representative (AR) Bridge Card

It is **not** advised to issue an AR an over-the-counter Bridge card because of possible disagreements with the client. Issuing a Bridge card to an AR is only suggested in emergency situations (for example, the AR has lost their Bridge card and they need to immediately shop for an individual who is unable to shop).

An AR the over-the-counter Bridge card **cannot** be issued the same day a case is opened in Bridges.

PERSONAL IDENTIFICATION NUMBER (PIN)

The PIN is a four-digit code which identifies the user to the EBT vendor. Anyone with access to both the PIN and Bridge card has access to the recipient's benefits. Clients should be advised to keep their PIN a secret, memorize it, and not write the number on the card. Clients must enter the PIN each time they use an automated teller machine or point-of-sale (POS) device. When the PIN is entered, four stars will show on the screen instead of numbers to prevent anyone from seeing the clients' PIN.

PIN Selection/Change

When clients receive their initial Bridge card from XEROX via the mail, they **must** call the Interactive Voice Response Unit to select a PIN. Recipients may select/change their PIN at any time by calling the Interactive Voice Response Unit at **1(888) 678-8914**. Clients may also use the POS device in the local office.

PIN Lock/Reset

Clients have four consecutive attempts to enter the correct PIN. After the fourth incorrect attempt, clients are locked out and cannot use their Bridge card until 12:01 a.m. the next day. The client's card can be reset prior to 12:01 a.m. by contacting the Customer Service Representative and providing the correct personal information.

INTEGRATED VOICE RESPONSE UNIT

Clients contact the Interactive Voice Response Unit, by calling **1(888) 678-8914** from a touchtone phone. The Interactive Voice Response Unit number is listed on the back of the Bridge card, and is available 24 hours a day, seven days a week. By calling the Interactive Voice Response Unit, the client will be able to:

- Select/change a PIN.
- Obtain account balance(s).
- Hear the last 10 transactions.
- Obtain information on where and how to use their card.
- Obtain benefit(s) availability dates.

Customer Service Representatives

If clients have questions, or difficulties providing the information through the Interactive Voice Response Unit, they are transferred to a Customer Service Representative for further assistance. Examples of services offered by Customer Service Representative include:

- Procedures on how to select, change or reset a PIN.
- Explanations of why a card may not be working.
- Taking reports of lost/stolen/malfunctioning cards, and initiating processes to replace a card.
- Reviewing their account balance.
- Mailing a two-month account history statement to the caller's last known address.
- Deactivation of an AR's card.

Note: DHS staff should **never** call the Integrated Voice Response Unit/Customer Service Representative for the client.

BRIDGE CARD REPLACEMENT

If the Bridge card is lost, stolen or damaged, the client, third-party payee/protective payee and/or the AR **must** immediately notify XEROX by calling the Interactive Voice Response Unit. Any benefit

loss that occurs prior to this notification is the client's responsibility and will **not** be replaced.

Once a Bridge card is reported as lost or stolen, XEROX immediately deactivates the current card and will reissue a new one at the client's request. Replacement cards are mailed in an active status, retain their original PIN and will arrive within two to five calendar days. The HOH or AR's card(s) are mailed to the HOH's address, and third-party payee/protective payee cards are mailed to the third-party payee/protective payee's address.

Note: It is the client's responsibility to change their PIN if they believe the original PIN is compromised.

If cash and/or FAP benefits are accessed after the clients contacts XEROX but before they actually deactivate the old card, the benefit replacement is the responsibility of XEROX and **not** DHS.

DHS only replaces FAP benefits when food is destroyed in a domestic misfortune or disaster; see BAM 502, Food Destroyed in a Domestic Misfortune or Disaster.

Local Office Replacement

Bridge cards can be replaced by the local office. To issue an over-the-counter Bridge card; see Local Office Issued Bridge Card in this item.

Note: The local office will **not** issue a replacement Bridge card to an AR that has a status reason of "statused by primary". This status reason indicates the client no longer wants the AR to have access to their benefits.

Replacement Fee

Clients may receive only one free Bridge card replacement during their lifetime. The client's authorized representatives or third-party/protective payees may only receive one free Bridge card replacement as well.

Clients' available benefits will be reduced to cover the cost of all subsequent replacement cards with no exceptions granted. Even if an error is made with the spelling of an authorized representative or third-party payee/protective payee's name and it is discovered on a future date, there is no way to reverse the charge or reimburse the client.

The available benefit reduction will vary based on whether the card is replaced by the EBT vendor ($3.02) or by the local office ($3.72).

Example: Sally has an authorized representative, named Sam. Sam loses his card and receives the one free replacement authorized representative card. If Sam loses the replacement card or Sally changes her authorized representative, her available benefits will be reduced for any future authorized representative cards.

Note: Sally is still eligible to receive one free replacement card for herself before her available benefits will be reduced to cover the cost of her replacement card.

Benefit Reduction Process

The EBT vendor determines if the entire replacement fee is available. If the entire fee is available in the client's cash account, the fee will be deducted from the available benefits. If not available, they will determine if the entire replacement fee is available in the client's FAP account.

If neither account has the entire replacement fee available, the fee will be deducted the next time an account has the available balance (starting with the cash account).

If the replacement fee is still not available after 365 days, the fee will be expired.

BENEFIT ACCESS

Clients and/or their FSARs access benefits with their Bridge card and PIN at automated teller machines and at POS devices at retailers displaying the **Quest** ® logo or sign. If the case closes, the cash or FAP benefits remaining on the Bridge card are still available to the client. They may continue to access these benefits in the account until they are depleted or expunged.

If the cash account balance contains enough to pay the transaction plus any applicable client fees; see Fees in this item, the account is debited for that amount. An approval message is sent back to the automated teller machine/POS device where either the purchase is completed or cash is dispensed.

If the cash account does not have sufficient funds to cover the transaction, a denial message is sent back to the access device.

Clients can then contact the Interactive Voice Response Unit for information regarding their account.

Cash Benefits and Availability Dates

FIP and SDA clients receive ongoing benefits, early payments (EPs) and supplemental benefits less than $1,000 in their EBT cash account. The ongoing semi-monthly cash assistance EBT deposits are available on the "Warrant Date" shown in the issuance deadline schedule in RFS 305. Supplements and EPs are available the day after authorized. Cash may be obtained only from a client's cash account.

Exception: Benefits on closed cases, EPs over $1000, supplements over $1000 and all replacement benefits are issued as warrants.

Clients can access benefits:

- At any automated teller machine that accepts **Quest**® clients.
- At a check cashier displaying the **Quest**® sign/logo.
- By making a purchase at retailers who accept the Bridge card.
- Through a cash-only POS transaction at a retailer which allows that option.
- As cash back when making a purchase through a POS device located in a retail or merchant establishment that accepts the **Quest**® logo**.**

  Note: The amount of cash back allowed depends on the retailer's policy. The client should ask the retailer before shopping.

Fees

Clients are allowed four cash withdrawals per month from an automated teller machine without transaction fees. However, every automated teller machine transaction in excess of four per month will cost the client $0.85 for each transaction. Such fees will be debited from their cash account balance at the time of the transaction. This will be an automatic debit; clients will **not** be informed of it prior to the transaction.

Note: Clients are **not** assessed a fee for accessing cash benefits with their Bridge card at a POS terminal.

Surcharges

Unlike fees, an automated teller machine/network surcharge is the charge for using a particular bank's automated teller machine. Clients are given the option of paying the surcharge before their withdrawal. A question appears on the screen telling the client the cost of using that automated teller machine. If clients do **not** want to pay the surcharge, they may decline by pressing cancel, and their Bridge card is returned. They can then access another automated teller machine somewhere else with either a lesser surcharge or no surcharge at all.

FAP Benefits and Availability Dates

All FAP benefits are deposited into the client's EBT food account. New openings (including expedited issuances and supplements) are available to clients the day after the client information and benefit authorizations are authorized in Bridges.

Ongoing FAP benefits are available on the dates listed in RFS 305, and available on the same day of the month each month. The date depends on the last digit of the client's recipient ID number.

Clients access their FAP benefits:

- At any Food and Nutrition Service authorized POS retailer.
- Through the use of EBT paper vouchers issued by Food and Nutrition Service authorized merchants and retail establishments for eligible food items when:
  - The Food and Nutrition Service certified merchant or retail establishment does **not** have technical equipment to process the EBT transaction of food benefits.
  - There has been a technical problem that has resulted in the malfunction of the EBT system.

Note: Fees are **not** charged for accessing FAP benefits.

GROUP HOMES

Authorized Retailers

Group homes approved as Food and Nutrition Service-certified retailers are supplied with the necessary POS equipment for processing EBT transactions in the group homes. New group homes requesting to be Food and Nutrition Service-certified must contact Food and Nutrition Service to become an authorized retailer. Provide group homes with the address and phone number for the Food and Nutrition Service Field Office based on their county.

Retailers interested in accepting the Bridge Card for food benefits purchases must be authorized by Food and Nutrition Services (FNS). To become an authorized retailer apply online at www.fns.usda.gov/snap or call the Food Assistance Program at 877-823-4369.

Retailers not authorized by FNS are eligible to participate by accepting the Bridge Card for cash benefits only, and must contact Retailer Operations to receive a survey form and a list of certified third party providers with which they may contract to provide EBT cash benefit services. If you would like this information mailed to you, or if you have questions regarding your contract, call Retailer Operations at 1-888-529-1693.

Group homes acting as Food and Nutrition Service-certified retailers permit clients to exchange their benefit dollars for food by swiping their Bridge card through the home's POS device.

The Bridge card is swiped between the first and the 15th of the month to reduce the client's monthly FAP benefit by half. The group home's account is increased by the amount deducted from the client's account. A second transaction is done between the 16th and the last day of the month for the remaining balance, again debiting the client's account and crediting the group home's account.

Authorized Representatives

Those homes that are **not** approved as authorized retailers may be an authorized representative for the clients in their homes. In these situations, an employee (such as the food buyer) of the group home is identified as the AR for the residents in the home. This person is authorized by the client and the facility to act as an AR, accessing

only the client's FAP benefits at a Food and Nutrition Service retailer location with a POS terminal; see BAM 110, AUTHORIZED REPRESENTATIVES.

LEAVING MICHIGAN

Cash Assistance

EBT clients who move out of state can still access the remaining benefits from their Michigan EBT accounts by using out-of-state ATMs displaying electronic benefit logo or stores displaying a **Quest**® sign/logo.

Food Assistance

FAP clients who move out of state can still access their remaining food benefits at participating food retailers.

Note: If on the last day of the month a FAP case has an out-of-state address on Bridges and the negative action extends into the following month, the system will **not** issue an ongoing monthly issuance for the closure month; see BAM 220, Adequate Notice.

EXPUNGEMENT

Benefits in FAP or cash accounts that have not been accessed for 365 days will be expunged and not available to the client.

Replacing Expunged Benefits

FIP and SDA

See BAM 505, for replacing expunged cash benefits.

Exception: Unaccessed cash benefits which are entirely state funded, for example, SDA benefits and FIP benefits on certain cases will **not** be expunged. Instead, these benefits will be escheated; see BAM 505, Replacing Escheated Benefits.

PROGRAM INTEGRITY

The first line of defense in reducing inappropriate use of Bridge Cards is education. DHS provides client and retailer training. The trainings include guidelines for appropriate use of Bridge Cards as well as fraud and abuse information.

DHS county and district offices also utilize Bridge Card education videos in their lobbies. Michigan offers a toll free phone line (1-888-678-8914) that is available 24 hours a day, Seven days a week. The phone number is located on the back of the Bridge Card. Clients are also provided with written materials when they become eligible for assistance. DHS Pub-322, How to Use Your Bridge Card, includes the following information about appropriate use:

- Misuse of Food Benefits is a violation of state and federal laws.
- **Do not** sell, trade or give away Food Assistance benefits, PIN or Michigan Bridge Card.
- **Do not** allow a retailer to buy food benefits in exchange for cash.
- **Do not** use someone else's food benefits or Bridge Card for households.
- **It is prohibited to use cash assistance to purchase lottery tickets, alcohol, or tobacco. Cash assistance grants cannot be used for gambling, illegal activities, massage parlors, spas, tattoo shops, bail-bond agencies, adult entertainment, or cruise ships.**
- Clients who purchase any beverages, in any type of container with a deposit, who dump the contents out and return the containers for the deposit, may be disqualified from receiving Food Assistance Program (FAP) benefits.
- People who break Food Assistance Program rules may be disqualified from the program, fined, put in prison, or all three; and must repay the food benefits.

EBT authorized retailers are also provided with training and are required to understand and comply with all federal and state guidelines for EBT acceptance. Retailers interested in accepting the Bridge Card for food benefits purchases must be authorized by the federal Food and Nutrition Services (FNS).

Over the Counter Card Reconciliation

A monthly reconciliation of the DHS-3955-EBT and the DHS-3955-A-EBT must be performed by a supervisor or other employee not

involved in the card issuance process. The reconciliation should include a verification of the client/authorized representative signature on the DHS-3955-A-EBT for each card issuance. If an issuance is not supported by a signed DHS-3955-A-EBT, the reconciler must contact the recipient/FSAR to verify the card was received. As part of the reconciliation print the Card Issuance/Replacement (RPT-0114) and the Card Issuance Replacement Detail (RPT-014) in EPPIC to verify the number of cards issued on the DHS-3955-EBT, Bridge Card Issuance Log.

Note: The DHS-4351, Monthly controlled Document Inventory and Reconciliation, provides the format for performing a reconciliation and documents that a reconciliation of the actual inventory with the inventory according to the records of documents used was performed. A DHS-4351 Monthly Controlled Document Inventory and Reconciliation, must be completed monthly and retained for six years.

1. Check status of previous card, if a replacement, using the Electronic Payment Processing and Information Control (EPPIC) Administrative Terminal.

   - If FSAR card is showing a status of Statused by Primary on the Recipient Card Management display, inform the authorized representative. End of procedure.

   - If any other status, go to next step.

2. Pull the next consecutive-numbered card from working supply.

3. Complete DHS-3955-EBT, Bridge Card Issuance Log, and DHS-3955-A-EBT, Bridge Card Issuance Log Attachment.

   - DHS-3955-EBT.

     Enter date in Column 1, Date of Issuance.

     Enter number from card in Column 2, Card Number.

     Enter recipient's name from the HOH Name on the Case-Search/ Summary screen in Bridges in Column 3, Recipient Name. If card is being issued to the FSAR, enter name from AUTH REP field on screen print also.

     Enter HOH's recipient identification number from the Individual # field from the Bridges screen-print in Column 4, Recipient ID/Case Number.

Initial in Column 5, Card Issued By.

- DHS-3955-A-EBT

  Enter number from card on EBT Card Number line.

  Enter recipient's name from the HOH Name on the Case-Search/ Summary screen in Bridges on Client Name line.

  Enter HOH's recipient identification number from the Individual # field from the Bridges screen-print on Recipient ID/Case Number line.

  If card is being issued to FSAR, enter FSAR's name from AUTH REP field on IFSD screen print on Authorized Rep line.

4. Valid photo identification must be presented by the recipient/FSAR. Record identification type and number on ID Description and ID Number lines, respectively, of DHS-3955-A-EBT. In the absence of valid photo identification, collateral contact by a specialist or manager is acceptable.

5. Link card to HOH's recipient identification number using Recip Acct>Acct Maint or OTC Card-New Case on the Administrative Terminal.

   - Enter 16-digit number from card and HOH's recipient identification number.

   - When the card has been successfully replaced message appears, make one print of update screen.

   - If case is inactive in Bridges and is not being reopened, search for HOH's case number.

6. Request recipient/FSAR to sign on Client or Authorized Representative Signature line and enter date on Date line of DHS-3955-A-EBT.

7. Issue new card to recipient/FSAR and request recipient/FSAR to sign and print name on back of card.

   Note: Replacement cards for the recipient are not to be given to the FSAR by local office staff. The FSAR should only receive his/her own card.

8. Assist HOH/FSAR in selecting a personal identification number (PIN) if needed/requested on the POS device.

9. Sign on Issued By Signature line and enter date on Date line of DHS-3955-A-EBT.

10. Attach signed DHS-3955-A-EBT to case search/summary screen and screen print of the card has been successfully replaced screen and retain packet with the Issuance Log.

11. File Issuance Log with attachments in a secured file. The logs and attachments must be retained for a period of four years.

    Note: Access to this file should be limited to the person reconciling Issuance Log to actual inventory and appropriate staff.

RECONCILING DHS-3955-EBT AND DHS-3955-A-EBT

12. Pull DHS-3955-EBT, Bridge Card Issuance Log, with attachments from secured file at least once a month.

13. Verify a DHS-3955-A-EBT, Bridge Card Issuance Log Attachment, is attached for each line on DHS-3955-EBT.

14. Review each DHS-3955-A-EBT for completeness and accuracy.

    - EBT card Number line must be completed.
    - Client Name and Recipient ID/Case Number lines must be completed.
    - Signature of person receiving the EBT-9, Michigan EBT Bridge Card, must be on Client or Authorized Representative Signature line.
    - Signature of person issuing the card must be on Issued By Signature line.
    - Signature on Client or Authorized Representative Signature line must be different from signature on Issued By Signature line.
    - ID Description and ID Number lines must be completed.

- Generate the Card Issuance/Replacement and Card Issuance/Replacement Detail reports in EPPIC. Print only the pages for your specific county using the .pdf version.
- Verify that the number of cards issued on the DHS-3955-EBT log match the EPPIC reports.

If above steps do not check out, resolve problem with Card Issuance Clerk, recipient or FSAR, as appropriate.

Note: It may be necessary to contact the recipient or FSAR to verify that card was received.

If above steps do check out, sign and date DHS-3955-EBT to indicate reconciliation was performed.

4351

Reconciling the DHS-4351, Monthly Controlled Document Inventory and Reconciliation

Each local/district office/ASC must maintain an inventory of controlled documents received and a record of the numbers on the documents; Bridge cards are controlled documents. All controlled documents received and added to the inventory and those distributed from the inventory must be recorded. A monthly physical inventory and a reconciliation of documents distributed must be made with documents recorded in the local office/district office/ASC records. The DHS-4351, Monthly Controlled Document Inventory and Reconciliation, must be used for this purpose and retained for six years.

The DHS-4351, Monthly Controlled Document Inventory and Reconciliation, provides the format for performing a reconciliation and documents that a reconciliation of the actual inventory with the inventory according to the local office records of controlled documents used was performed.

EBT AUTHORIZATION AND SECURITY

To add, change or delete an employee's access to the Xerox EPPIC system, complete the DHS 245, Xerox EPPIC EBT System and either send via e-mail to: DHS_Application_Security@Michigan.gov, or

Fax it to (517) 335-6146. E-mail is the preferred method.

To reset EPPIC, call and create a ticket for the reset at CSC Help Desk at 517-241-9700 or 1-800-968-2644

ID DELETION

Local office management responsible for EBT issuance must submit ID deletion on the DHS-245, Michigan User ID Request Form Xerox EPPIC EBT System, within two business days if the EBT Application or POS Device user either:

- Leaves DHS or the office in which the user requires EBT systems access.
- No longer requires access to the EBT systems as a component of their job function.

Managers must sign and email appropriate forms to DHS Access Security Office in central office.

The DHS-246, EPPIC EBT Program POS User ID Request Form, must also be completed and the user deleted from the POS device. Retain the DHS-246 in the local office security file.

LEGAL BASE

FIP

42 USC 604(g)
2013 PA 41

FAP

7 USC 2016(i)
7 CFR 274.12
Food and Nutrition Act of 2008
2013 PA 41

DEPARTMENT POLICY

Medicaid (MA)

General lists of MA covered services are located at the end of this item; see EXHIBIT I.

In this item MA includes MAGI-related and SSI-related beneficiaries.

CHOICE OF PROVIDERS

MA

The beneficiary is usually free to select a provider or health care plan. However, there are some situations when the recipient may be restricted to certain providers (such as primary care provider, pharmacy, specialist provider). Reimbursement for services rendered is limited to enrolled providers except for emergencies.

HEALTH PLANS

MA

Health plans provide Medicaid-covered health care services for an enrolled group of beneficiaries in a defined service area.

Enrollment

Beneficiaries are given an opportunity to select a health plan. If no selection is made, the beneficiary is automatically enrolled by the state's contracted enrollment broker, Michigan ENROLLS, with a health plan in the beneficiary's county of residence.

Health plan enrollees are identified by Level of Care (LC) code 07 (**HMO ENROLLEE**). Health plan enrollees will also receive an identification card from their health plan.

There are beneficiaries who:

- Must enroll in a health plan.
- May voluntarily enroll in a health plan.
- Are excluded from enrollment in a health plan.

Persons Who Must Enroll In a Health Plan

The following must enroll in a health plan, unless they are **Persons Who May Voluntarily Enroll in a Health Plan** or **Persons Excluded from Enrollment in a Health Plan.**

- Family Independence Program (FIP) recipients.
- Children under 19 (U19) beneficiaries.
- Pregnant women (PW) beneficiaries.
- Group 2 Under 21(G2U) beneficiaries.
- Parent/Caretaker (PCR) and LIF beneficiaries.
- Healthy Michigan Plan (HMP) beneficiaries.
- Supplemental Security Income (SSI) recipients who do not receive Medicare.
- Blind, disabled, and aged MA beneficiaries who do not receive Medicare.
- Persons with full Medicaid coverage and Children Special Health Care Services (CSHCS).

Persons Who May Voluntarily Enroll In a Health Plan

The following may voluntarily enroll in a health plan:

- Migrants.
- Native Americans.
- Persons in the traumatic brain injury program.
- Persons with both Medicare and Medicaid eligibility.
- Persons eligible for QMB; see BEM 165.

Persons Excluded From Enrollment in a Health Plan

- PlusCare recipients.
- Persons limited to emergency MA coverage (ESO).

- Persons enrolled in the Children's Special Health Care Services (CSHCS) program only.
- Persons residing in an ICF/ID (intermediate care facility for individuals with intellectual disability) or a state psychiatric hospital.
- Persons receiving long-term care (custodial care) in a licensed nursing facility.
- Persons receiving MI Choice waiver services for the elderly and disabled (LC code 22); see BEM 106.
- Persons receiving Private Duty Nursing Services.
- Persons with commercial HMO coverage, including Medicare HMO coverage.

  Note: Letters are mailed out each month to Medicaid recipients who have private HMO coverage. This letter informs recipients that they are being disenrolled from their Health Plan; see EXHIBIT IV for further information.
- PACE (Program for All-inclusive Care for the Elderly) recipients.
- Deductible beneficiaries.
- Children in child caring institutions.
- Refugee Assistance Program Medical Aid-only recipients.
- Repatriate Assistance Program Medical-only recipients.

Note: When a person(s) is excluded from health plan enrollment, other members of that person's family may enroll in a health plan.

If a beneficiary enrolled in a health plan enters a long-term care facility for custodial purposes, the health plan may initiate a request for disenrollment from the health plan; see BAM 120. The health plan may request disenrollment by calling:

Michigan Department of Health and Human Services
Managed Care Plan Division
Quality Improvement and Program
517-241-8179

Additional Information about Health Plans

For additional information about health plans, contact:

Michigan Department of Health and Human Services
Comprehensive Health Plan Division
CCC Bldg.
PO Box 30479
Lansing, MI 48909-7979

Michigan Enrolls: 1-888-367-6557

A list of the health plans available in each county is on the Michigan Department of Health and Human Services (MDHHS) website (Medicaid Link). This list is updated monthly. The MDHHS website address is: www.michigan.gov/mdch.

Other Insurance

Health plan enrollees with other insurance should advise their health plan of their insurance coverage.

Covered Services

The health plan is responsible for providing and arranging for all medically necessary services covered by Medicaid with the ***exception*** of:

- Dental care (Services rendered by an oral surgeon are included in the health plan capitation rate).
- Mental health services including inpatient psychiatric services (the health plan is responsible for up to 20 outpatient visits).
- Substance abuse treatment.
- Medical transportation for the three services listed above; see BAM 825.
- Personal care services.
- School-based services.

The health plan is responsible for providing up to 45 days of restorative health care which is intermittent or short-term, restorative or rehabilitative nursing care.

The health plan may also provide services that are not covered by MA.

MICHIGAN PHARMACEUTICAL BEST PRACTICES

MA

MDHHS has contracted with Magellan Medicaid Administration, Inc. to be the pharmacy benefits manager for its fee-for-service health programs and pregnancy-related pharmacy services for Maternity Outpatient Medical Services (MOMS) beneficiaries. The pharmacy benefits manager is responsible for all of the following:

- Prior authorizing certain drugs.
- Processing pharmacy claims.
- Approving payment to pharmacies.
- Other administrative functions to ensure that appropriate payments are being made.

Magellan Medicaid Administration, Inc. does not prior authorize or pay claims for Medicaid contracted health plans.

Prior Authorization

Drugs that require prior authorization appear on the Michigan Pharmaceutical Products List (MPPL). Physicians or other prescribers may request prior authorization by contacting First Health Services.

Magellan Medicaid Administration, Inc.
MAP Department
4300 Cox Road
Glenn Allen, VA 23060
Telephone: 1-877-864-9014
Fax: 1-888-603-7696 or 1-800-250-6950

Hearing Rights

A beneficiary is notified in writing within 10 calendar days of a prior authorization denial. The notice tells the beneficiary how to apply for a MDHHS administrative hearing. The MDHHS hearings application form and a stamped envelope are included with the notice.

HEALTHY KIDS DENTAL

MA

MDHHS has contracted with Delta Dental Plan of Michigan to be the fiscal administrator. Delta Dental Plan administers the Medicaid dental benefit to **all** Medicaid recipients under age 21.

The dental services provided through Delta Dental Plan are the same dental services provided through fee-for-service Medicaid.

Healthy Kids Dental is not limited to persons receiving MA under Children Under 19 (U19). It is for **all** MA beneficiaries under age 21, including FIP recipients, in participating counties.

Beneficiaries must see a dentist that participates with Delta Dental. Beneficiaries may call Delta Dental's customer service with questions at 1-800-482-8915.

Beneficiaries must use their Social Security number (SSN) when calling Delta Dental. If a beneficiary does not have an SSN, a 9 is added to the beginning of the MA beneficiary ID number to resemble an SSN. Beneficiaries may access Customer Service using the modified MA beneficiary ID number as the SSN identifier.

Enrollment

Enrollment in Healthy Kids Dental is automatic based on the beneficiary's county of residence and age. Beneficiaries do not choose a plan.

Enrollment in Delta Dental is done monthly.

ID Cards

In addition to the MI health card, Healthy Kids Dental beneficiaries will receive a Delta Dental card. If the card is lost the beneficiary must call Delta Dental at 1-800-482-8915 to request a replacement card. The beneficiary's SSN is on the card, not the MA beneficiary ID number.

Retroactive Enrollment

Enrollment in Healthy Kids Dental is not retroactive even if MA coverage goes back to the beginning of a month (or earlier). Enrollment is prospective.

If a beneficiary's MA is opened in the middle of the month, the beneficiary's Healthy Kids Dental will begin on the 1st of the month the eligibility transaction is received.

Covered Dental Services

Healthy Kids Dental provides services that are applicable to persons under age 21. These services include:

- X-rays.
- Cavity fillings.
- Extractions.
- Teeth cleanings.
- Root canals.
- Sealants and fluoride treatment.
- Examinations.
- Dentures.

The scope of these services is the same as for fee-for-service MA.

MEDICAID VERIFICATION OF BRIDGES INFORMATION

MA

Sometimes the health plan or Delta Dental Plan may have different information about the recipient than what is in Bridges. In those instances, the health plan or Delta Dental Plan will send a MDCH-2010, Verification of Bridges Information Medicaid Beneficiaries, with the information they have on file for the recipient; see **EXHIBIT V.**

The health plan or Delta Dental will enter the information and indicate what information they have received that is different. They will also indicate how the information was received (that is by: beneficiary, returned mail, provider) and attach supporting documentation, if available.

Review the information from the health plan or Delta Dental Plan, take appropriate action and respond in Section 4 of the MDCH-2010. Return the form to the health plan or Delta Dental Plan address in Section 2.

BENEFIT MONITORING PROGRAM (FEE-FOR- SERVICE)

MA

State and federal regulations require the Medicaid program to conduct benefit utilization reviews to ensure the medically necessary services are being provided to program beneficiaries. The Benefit Monitoring Program (BMP) is in place to monitor program usage and to identify beneficiaries who may be over-utilizing and/or misusing their Medicaid services and benefits.

While in the BMP beneficiaries may be assigned to one or more provider through which they can obtain medical services.

For further information or to make a referral contact:

Michigan Department of Health and Human Services
Benefit Monitoring Program
PO Box 30170
Lansing, MI 48909
Phone: (855) 8085-0312

EPSDT/WELL CHILD PROGRAM

MA

The Early Periodic Screening Diagnosis Treatment Program (EPSDT) Well Child Program consists of well-child visits, immunizations and early detection and treatment of diseases for beneficiaries under age 21. The objective of this preventive health care is early intervention to detect and treat mental or physical disease.

The same components of a well-child visit and the same interval schedule are used regardless of whether the child is in a health plan or is fee-for-service.

MDCH Publication (795), Michigan Free Health Check-ups f*or persons 21 and younger*, explains the well-child visits. http://www.michigan.gov/mdch

ENROLLED PROVIDER BILLING PROCEDURES (FEE-FOR-SERVICE)

MA

Enrolled providers are aware of the covered and excluded services available to MA beneficiaries. Providers must use MA billing procedures to obtain payment for services performed. Billings should be submitted within 12 months from the date of service.

Twelve Month Billing Exceptions

Exceptions to the 12 month billing policy can be made if the delay is caused by agency error or as a result of a court or administrative hearing decision. Agency errors are limited to:

- Delayed Bridges coding, including level of care changes.
- Disability Determination Service (DDS) review.
- Administrative review.
- Delayed eligibility determination.

Exceptions cannot be granted due to provider delays in billing or failure of a recipient or provider to obtain prior authorization.

Form MSA-1038, Request for Exception to the Twelve Month Billing Limitation for Medical Services, is an internal document and must be completed by local office staff to begin the exception process. The completed MSA-1038 should be sent to: **1038@michigan.gov**.

A family independence manager, district manager, or other office designee must be copied on the email. A copy of the hearing decision is no longer required; however, the hearing registration number must be indicated on the MSA-1038.

MDHHS will notify the specialist within 30 days of the decision. If approved DHS will notify providers to bill Medicaid as usual but to enter in the comments section of the claim, “MSA 1038 approval on file”.

MEDICAL SERVICES PROVIDER POLICIES

MA

Local office staff is not expected to be the beneficiary's primary source of information for covered services. The providers of medical services are best equipped to determine medical needs and whether those services are covered by MA as specified in the MA provider manuals.

Some basic guidelines:

- The provider is required to bill all other insurances prior to billing MA.
- Providers must be appropriately licensed and/or certified before entering into an agreement with MDHHS to participate in the MA program.
- Enrolled providers receive direct payment for services rendered but must agree to provide services according to the policies published in the MA provider manuals.
- Certain medical/dental services require the provider to obtain prior approval from MDHHS. Refer to the Medicaid Provider Manual for co-pay information.
- The provider is required to accept payments received from MA as payment in full, ***except*** for patient-pay amounts authorized by MDHHS and co-payments.
- The provider may seek payment from a beneficiary for services not covered if the beneficiary elects to receive the services with the prior knowledge that such services are not covered.
- Institutional and nursing home providers holding a beneficiary's funds in trust are accountable to the beneficiary and may not require the deposit of such funds with the facility. The management of such funds is subject to review by MDHHS.

Local offices may obtain more information on medical/dental care coverage by consulting the MA provider manuals or contacting MDHHS at:

Michigan Department of Health and Human Services
Provider Inquiry

CCC Bldg.
PO Box 30479
Lansing, MI 48909-7979
Phone: 1-800-292-2550

MEDICAL/DENTAL SERVICES IN ANOTHER STATE

MA

A Michigan MA beneficiary may receive medical/dental care outside of Michigan. The areas beyond the Michigan borders are classified as either borderland or beyond borderland. Borderland and beyond borderland providers must comply with applicable Michigan MA policies and procedures, including prior authorization, to be reimbursed for services.

Borderland Areas

The borderland areas are the out-of-Michigan counties which are adjacent to the Michigan border and certain cities beyond these adjacent counties. The specific counties and cities which are borderland areas are:

States, Counties, Cities	
Ohio	**Wisconsin**
• Fulton County • Lucas County • Williams County	• Ashland • Green Bay • Rhinelander
Indiana	**Indiana**
• Elkhart County • Lagrange County • LaPorte County	• St. Joseph County • Steuben County • Fort Wayne

States, Counties, Cities	
Wisconsin	Minnesota
• Florence County • Iron County • Marinette County • Forest County • Vilas County	• Duluth

A beneficiary is covered for medical/dental services rendered in a borderland area to the same extent that such services are covered in Michigan.

Borderland providers are considered to be Michigan providers. They must be enrolled in Michigan Medicaid and adhere to the same policies as Michigan providers.

Beyond Borderland Areas

The beyond borderland areas are all areas of the U.S. outside of Michigan which are not borderland areas.

Beyond borderland medical/dental services received by a Michigan MA beneficiary will be covered only when:

- The beneficiary is temporarily out-of-state and the services are necessary because the individual's health would be endangered if travel to Michigan was required.
- The beneficiary is temporarily out-of-state and the services are necessary because of a medical/dental emergency (as defined by the program).
- The service is prior authorized by MDHHS as more readily available in another state.

Prior Authorization

Certain services provided by **borderland** providers require prior authorization the same as services requiring prior authorization by Michigan providers.

Except in emergencies, the services of a **beyond borderland** provider must be prior authorized. The beneficiary's local physician should submit the following to MDHHS:

- Documentation of the need for beyond borderland services.
- Beneficiary identification.
- Eligibility data.

The address to submit the above information is:

Michigan Department of Health and Human Services
Review and Evaluation Division
400 S. Pine Street
PO Box 30170
Lansing, MI 48909-7979

The beneficiary's physician and the local office may also make telephone inquiries regarding beyond borderland services when it appears that time is of the essence.

Phone: 1-800-622-0276

The Prior Authorization and Review Section may request information from local offices when evaluating the need for beyond borderland services. Prompt assistance from the local offices is appreciated. A copy of the prior authorization decision will be sent to the appropriate local office.

Inquiries

Refer non-enrolled provider questions about borderland or beyond borderland coverage and billings to:

Michigan Department of Health and Human Services
Provider Inquiry
400 S. Pine Street
PO Box 30239
Lansing, MI 48909-7979

Providers may call:

1-800-292-2550

Claims

Medicaid will pay non-enrolled Michigan and borderland providers for:

- Emergency services, and
- Nonemergency services with prior approval.

The following occurs when non-emergency services claims are submitted by a non-enrolled provider:

- The miscellaneous transactions unit will process the claim and send a letter to the provider with a Medical Assistance Provider Enrollment/Trading Partner Agreement form.
- If the provider elects not to complete the Medical Assistance Provider Enrollment/Trading Partner Agreement form, the claim will not be paid.

Reimbursement for services not paid by Medicaid is between the beneficiary and the provider. The provider must notify the beneficiary prior to rendering the service that it is not covered by Medicaid.

Borderland providers who are not enrolled and all beyond borderland providers should submit claims to:

Michigan Department of Health and Human Services
Provider Enrollment
Medicaid Payments
PO Box 30238
Lansing, MI 48909

DHS INQUIRIES

MA

Two telephone numbers are available to contact the Enrollment Services Section in MDHHS:

- 517-241-8759.

  This is a voicemail line to request removal of LC code 07 or 88 in Bridges. A series of questions collects the information necessary to remove the LC code. When the LC code will be removed and instructions for checking Bridges will be given. If the Enrollment Services Section is unable to remove the LC code or has any questions, the specialist will be contacted.

- 800-292-9570.

  MDHHS staff is responsible for adding or ending LC code 16 or 55. However, call the Exception Unit at the above number if information on Bridges needs to be updated or if there are questions about these LC codes.

PROVIDER INQUIRIES

Eligibility Verification System (EVS)

MA

Beneficiary information is available to medical/dental providers through an automated system called the Eligibility Verification System (EVS).

If the beneficiary is eligible, the following information is available:

- Beneficiary name, beneficiary ID number, gender, date of birth.
- Benefit plan ID(s) for the date of service (DOS).
- Level of care information, source provider ID, National Provider Identifier(NPI), provider name, telephone number, address, and the patient pay amount, if applicable.
- Medicaid health plan, primary care physician, including the provider name and telephone number.
- Third party liability, including the payer name, payer ID, coverage type code, group number, policy number, and policyholder ID.
- Pending Medicaid eligibility.

Additional information is not available through EVS.

CHAMPS

Providers may verify beneficiary eligibility using:

- CHAMPS Eligibility Inquiry.
- HIPAA 270/271 (eligibility inquiry/response) transactions.

Refer to the Michigan Medicaid Provider Manual, Beneficiary Eligibility and Directory Appendix Sections for further information.

Providers may contact the MDHHS Provider Inquiry Helpline at 1-800-292-2550 for questions/issues related to the eligibility response.

The Helpline number can also be used by providers without internet access and out-of-state providers.

Providers may also email Provider Support at providersupport@michigan.gov

Health Plans

MA

Refer provider questions about Medicaid Health Plans (MHP) to:

Provider Inquiry: 1-800-292-2550

Covered Services

After consulting the MA provider manuals, providers may call the following number to verify covered services or to receive billing assistance:

Provider Inquiry: 1-800-292-2550.

BENEFICIARY INQUIRIES

Covered Services

MA

Fee-for-Service -Refer beneficiary questions about MA covered services or billing problems to:

Medicaid Beneficiary Helpline:
1-800-642-3195.

Health Plans

MA

Refer beneficiary questions about MA Health Plans, including available providers in their area and enrollment to:

Michigan Enrolls: 1-888-367-6557.

Refer beneficiary complaints and questions about MA providers to:

Medicaid Beneficiary Helpline:
1-800-642-3195.
Michigan Department of Health and Human Services
Enrollment Services Section
CCC Bldg.

PO Box 30470
Lansing, MI 48909-9753

COMPLAINTS ABOUT PROVIDERS

MA

Refer complaints about enrolled providers to:

Michigan Department of Health and Human Services
Comprehensive Health Plan Division
400 S Pine
PO Box 30479
Lansing, MI 48909-7979

Michigan Department of Attorney General
Health Care Fraud Division
PO Box 30218
Lansing, MI 48909

24 hour hotline: 1-855-643-7283 (1-855-MI FRAUD)

Email: hcf@michigan.gov

EXHIBIT I - MA COVERED SERVICES

The following are general categories of MA covered services. This listing should be used for reference purposes only. Some of the services listed are available **only to certain age groups**, may be limited in their scope or may require prior approval.

Local office staff is not expected to be the beneficiary's primary source of information for MA covered services. The beneficiary should be advised to contact the medical services provider directly whenever information is needed regarding MA covered services.

Allergy Testing/Treatment
Ambulance Services
Chiropractic Services
Dental Services
Diabetic Patient Education Program
EPSDT/Well Child Services
Family Planning Services
Hearing Aid Dealers
Hearing & Speech Center Services
Home and Community-Based Waiver Services
Home Health Services
Hospice Services
Hospital Services (Inpatient/Outpatient)
Laboratory and X-Ray Services
Long-Term Care (LTC)
Maternal Infant Health Program
Medical Supplies and Equipment
Mental Health Services
Methadone Maintenance Treatment
Nurse-Midwife and Nurse Practitioner Services
Orthotics, Prosthetics and Special Shoes
Personal Care Services
Pharmacy Services
Physician Services (MD/DO)
Podiatric Services
Psychiatric Care
School-Based Services
Substance Abuse Treatment Services
Therapy (Occupational, Physical, Speech)
Transportation (BAM 825)
Vision Services

For questions regarding a specific service, contact Provider Inquiry at 1-800-292-2550.

EXHIBIT II - NOTICE TO MEDICAID BENEFICIARIES WHO ARE ALSO ELIGIBLE FOR MEDICARE

Michigan Department of
CSDI/ESS
PO Box 30470
Lansing MI 48909

Michigan Department of Community Health
MDCH
Jennifer M. Granholm, Governor
Janet Olszewski, Director

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195. (TTY 1-866-501-5656)
Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono 1-800-642-3195 (TTY 1-866-501-5656)
Arabic: 1-800-642-3195 (TTY 1-866-501-5656)
للحصول على المساعدة لترجمة أو استيعاب ذلك فالرجاء الاتصال برقم

NOTICE TO BENEFICIARIES WHO ARE ALSO *ELIGIBLE** FOR MEDICARE

Our records show that you are *eligible** for Medicare and that you are currently in a health plan. Because you are eligible for Medicare, you will be disenrolled from your health plan. You will still have regular Medicaid or the Adult Benefit Waiver Program (ABW). Talk to your doctor about these changes.

You need to apply for your Medicare benefits. If you are eligible for Medicare and do not apply, Medicaid or the Adult Benefit Waiver Program (ABW), will not pay for any of your medical care. Call your local Social Security Administration Office for help.

Co-payments

When you have regular Medicaid or the Adult Benefit Waiver Program (ABW), you may have more co-payments or higher co-payments than charged by your health plan. Your providers will tell you about any co-payments.

If you do not have a way to get to a doctor or visit and you have regular Medicaid, call your local office of Department of Human Services (DHS). They can help you get a ride. Unless you have an emergency, you must call before you need a ride. The Adult Benefit Waiver Program does not pay for rides.

Remember to take your "mihealth" card and show it to your providers when you go for an appointment.

If you have questions about these changes, call the Beneficiary Help Line at 1-800-642-3195.

* Eligible means that you meet the requirements to be part of this group.

Department of Community Health*PO Box 30470*LANSING, MICHIGAN 48909
www.michigan.gov

EXHIBIT III - NOTICE TO MEDICAID BENEFICIARIES WHO HAVE PRIVATE HMO INSURANCE

Michigan Department of
CSD/ESS
PO Box 30470
Lansing MI 48909

Michigan Department of Community Health
MDCH
Jennifer M. Granholm, Governor
Janet Olszewski, Director

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195. (TTY 1-866-501-5656)
Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono **1-800-642-3195** (TTY 1-866-501-5656)
Arabic: 1-800-642-3195 (TTY 1-866-501-5656)
للحصول على المساعدة لترجمة أو استيعاب ذلك فالرجاء الاتصال برقم

Notice to Beneficiaries Who Have Private HMO Insurance

Our records show that you have private HMO insurance. When you have private HMO insurance, you can not be in a health plan. You will still have regular Medicaid. Your private HMO insurance always pays for medical services first. Medicaid pays after your private HMO has paid their part.

Co-payments

When you have regular Medicaid, you may have more co-payments or higher co-payments than charged by your health plan. Your providers will tell you about any co-payments.

Transportation

If you do not have a way to get to a doctor visit, call your local office of Department of Human Services (DHS). They can help you get a ride. Unless you have an emergency, you must call before you need a ride.

mihealth ID Card

Remember to take your "mihealth" card and your private HMO card to show your providers when you go for an appointment.

Questions

If you have questions about these changes, call the Beneficiary Help Line at 1-800-642-3195.

Department of Community Health*PO Box 30470*LANSING, MICHIGAN 48909
www.michigan.gov

LEGAL BASE

MA

42 CFR 431, Subpart B
42 CFR 431.107
42 CFR, Part 440
42 CFR 441, Subpart B
42 CFR 456.3
MCL 400.109, .110
Social Security Act, Section 1927

DEPARTMENT POLICY

FIP, RCA and SDA Only

Supplemental benefits are issued to correct an underissuance (i.e., the group received less assistance than they were eligible to receive).

Do NOT issue supplements to correct underissuances caused by the client's failure to report.

A supplement correcting an underissuance is offset against an overissuance. The amount of the overissuance is subtracted from the amount of the supplement. This may result in the entire supplement being offset.

Do **not** offset the following overissuances:

- Agency overissuances of under $125.
- Overissuances that have an established claim.

Notify the client of the result of the offset. See the **CLIENT NOTICES** section in this item.

AUTHORIZING SUPPLEMENTAL PAYMENTS

Supplements are authorized in Bridges by certifying eligibility results that include an increased issuance for the benefit month.

Authorize a separate supplement for **each reason** a client is supplemented **and** for **each vendor** supplemented.

Court Orders and Hearing Decisions

When a supplement is required by a court order or an administrative hearing decision, the supplement must be issued within **10 workdays** after the court order/hearing decision is mailed. If you correct data in Bridges to implement the court order or administrative hearing decision, enter the first day of the month that the order or decision indicates the change must begin for the circumstances start/change date, report date, date client became aware and date verified for the data. If that correction returns eligibility results that support the order or decision, Bridges will

automatically calculate the supplement. If not, the supplement must be issued manually. See **MANUAL ISSUANCE SUPPLEMENTS** in this item.

In all other circumstances, process the supplement promptly upon receipt of verification **or** knowledge of the need.

Vendor Supplements

Vendor supplements are processed by central office accounting.

Benefit Inquiry

The *View Benefits* screen under Benefit Issuance in Bridges lists requested supplements immediately after certification. Supplements are shown as pending until the actual benefit/warrant is posted. Bridges displays the case number, grantee/provider name, type of assistance, service type, pay begin date/end date, benefit type, payment amount, recoupment amount (if any), warrant/available date, status and whether a client or vendor is being supplemented. The benefit number is displayed below the case number when the benefit/warrant is posted.

EBT Payments

Supplements for $1,000 or less are deposited into the client's EBT account on the day after authorization.Bridges will display details for these deposits on the first workday after the authorization.

Non-EBT Payments

Supplements for amounts over $1,000 are issued as warrants. These warrants are issued approximately two days after authorization. The payment will be extracted daily and Treasury will mail the warrant on the second business day after the transaction is done.

EDBC on the Same Business Day

If you re-run an eligibility determination and benefit calculation (EDBC) for the same benefit month(s) **on the same business day** that you calculated a benefit resulting in a supplement and the new results do not indicate there is a supplement, the supplement will not be issued.

MANUAL ISSUANCE SUPPLEMENTS

Supplements that must be handled using the manual issuance process in Bridges can be completed in the local office for any months prior to the month the case converted to Bridges including the month of conversion. For all other months, manual issuance supplements must be processed in central office as policy exceptions.

All manually issued supplements require second party review and approval prior to issuance.

REASONS FOR A SUPPLEMENT

Increased Need

Supplements are authorized in the following circumstances:

- A needs increase **cannot** be reflected in the regular benefit. See BEM 515, **Changes in Need**, for effective dates.
- A FIP group that was subject to the immunization penalty reports compliance during the month. A supplement is calculated for the whole month in which immunizations were begun. See BEM 202.

The change causing increased need and the dates when it was reported and verified are recorded in Bridges. This information can be compared with Report SP-270.

Fair Hearing

This is a supplement in the amount ordered in a hearing decision or court order. You must issue the supplement within **10 calendar days** after the decision/order is mailed. If Bridges cannot automatically calculate the supplement (e.g., the amount ordered is not the result of correcting data in the system), you must request a policy exception. Central office will complete the manual issuance in addition to any other policy exceptions that may be required as a result of the decision/order.

Agency Error

Agency errors are underissuances resulting from:

- Computer or data entry errors.
- Inaccurate use or misapplication of policy.
- Failure to process a grant change on time.

Correct the information in Bridges and re-run eligibility to authorize the supplement regardless of whether DHS or the client discovered the error.

Excess Recoupment Payment

This is a supplement to repay assistance when DHS recoups more than the amount of an overissuance. This process is automated in Benefit Recovery in Bridges.

Administrative Decision

Sometimes program policy bulletins require the issuance of supplements. These unique situations are directed at specific client groups to avoid underissuance due to policy or procedural changes. Typically, these supplements will be automatically generated by Bridges. You will receive specific information when these situations occur.

Children's Clothing Allowance

This is a supplement for FIP groups eligible for the children's clothing allowance for a given year when funding becomes available. Bridges will automatically issue a supplement for active FIP groups with children. Supplements are viewable the day following the processing date. When a child is added to an active case, issue a manual supplement.

Note: When funding is available, an Interim Policy Bulletin will be issued stating the effective month.

Conversion

This is a manual issuance supplement you will use when the benefit months that require a supplement are for conversion months and months prior to Bridges conversion. This also includes initial benefits and retroactive payments for pre-Bridges months.

LOCAL OFFICE APPROVALS

Bridges will require a second party/FIM review. This is to ensure compliance with court orders and/or correct application of policy.

CLIENT NOTICES

Clients must be given **adequate** notice that a supplement has been authorized or denied.

Bridges will generate a notice for authorizations that are automatically calculated on the system.

If manual issuance is required, Bridges does not automatically generate a notice. For pre-Bridges or conversion months, use the LOA2 generated notice(s.) For all other months, a policy exception is required and central office will complete a manual notice in Bridges, or if the notice template is not available in Bridges, using an MS Word template.

RECOUPMENT FROM SUPPLEMENTS

EDBC Determined Supplements

Bridges will recoup from an EDBC-determined client supplement when all of the following are true:

- The program has an active claim.
- The recoupment rate is a percentage, not a dollar amount.
- The benefit type is initial or supplemental.

Bridges reduces the supplement or initial issuance amount by the recoupment percent. This reduction is applied to the overissuance balance of the active program.

Manual Issuance Supplements

Recoupment amounts are not automatically calculated or deducted from manual supplements. You are responsible for calculating the recoupment amount when issuing a supplement on a case with an outstanding claim.

Review the claim in Benefit Recovery to determine the correct recoupment percentage to apply. Enter the amount of the supplement less the recoupment into the Benefit Amount field on the Request Cash/FAP/SSP Manual Issuance screen in Bridges.

The recoupment amount must then be posted to the outstanding claim in Bridges Benefit Recovery by the appropriate accounting staff.

LEGAL BASE

FIP

R400.3105

SDA

R400.3170

RCA

45 CFR 400.49

DEPARTMENT POLICY

Supplemental Food Assistance benefit issuances (supplements) **must** be issued:

- When the regular FAP issuance for the current or prior month(s) is less than the group is eligible for, or
- For periods when the group was eligible but received no regular benefits.

Issuance

Supplements are issued through Bridges. The supplemental benefit amount is deposited into the client's EBT food benefit account. The benefit is available the next day.

Bridges will notify the group that a supplement is authorized.

Do NOT issue supplements to correct underissuances caused by the client's failure to report.

Offsetting

Supplements correcting underissuances in previous months may be **"offset"** against overissuances. This means that the amount of the overissuance is subtracted from the amount of the supplement. This might result in the whole supplement being credited.

Offsetting occurs when:

- The benefit recovery system shows an overissuance balance, **and**
- A supplement is authorized to correct a previous month(s) underissuance, **and**
- The supplement was ordered by a court or administrative law judge and the order does **not** specifically prohibit offsetting.

Offsetting is done automatically by Bridges.

INITIAL BENEFITS

Bridges will automatically prorate initial benefits when prorated benefits are required based on the date eligibility begins.

Exception: Migrant/seasonal farmworker groups that were active in the FAP program the month **before** the application date are eligible for a full application month's benefit. This is true whether the entire group or any member of the group was active the month before the FAP application date. Bridges will **not** prorate initial benefits for such groups.

RETROACTIVE BENEFITS

If the application processing is delayed beyond 60 days from the date of application, Bridges will issue a supplement to correct previous months benefits which may result in offsetting (see the **"CORRECTING PRIOR MONTHS BENEFITS"** section in this item).

CORRECTING THE CURRENT MONTH BENEFIT

Bridges will issue a supplement when the current month benefit is less than the group is eligible for.

Such situations include but are **not** limited to the following:

- Due to administrative time frames or agency error, DHS fails to effect any increase of the regular current month benefit as required by policy.

Exception: When current month and prior month(s) underissuances are due to the same agency error, court order, etc., Bridges will consolidate them and issue a supplement under prior months.

- An eligible group requests a hearing within 11 days of the effective date of an immediate negative action affecting current month benefits. Issue the supplement within five days after receiving the hearing request **if** the negative action resulted from a voluntary report by the FAP group. If not, issue the supplement within ten days of receiving the hearing request.

  See BEM 610 for issuing current month supplements for migrant groups.

CORRECTING PRIOR MONTHS' BENEFITS

These supplements are limited to underissuances in the **twelve months** before the month in which the earliest of the following occurred:

- The local office received a request for lost benefits from the eligible group.
- The local office discovered that a loss occurred.
- The group requested a hearing to contest a negative action which resulted in a loss.
- The group initiated court action to obtain lost benefits.

Exception: When a disqualification hearing decision is later reversed by a court, individuals are entitled to lost benefits for all of the months they were disqualified.

Supplement the underissued group whether it is currently active or inactive. If the group's membership changes before the supplement is issued, issue it to the group containing the majority of the original group members. If no such group can be located, issue the supplement to the current group containing the original grantee. When groups requesting a supplement are denied, inform them via DHS-176.

Groups eligible for the supplementation may elect installments.

All prior month supplements are offset against overissuances except those on suspended collection due to an OIG referral. Offsetting is done automatically by Bridges.

Correcting Underissuances Due to Agency Error

A prior month supplement is issued when an agency error in a prior month caused an underissuance. Agency error includes loss of an application by a Social Security Office. Issue the supplement within ten days after discovery.

Corrections Ordered by a Court or ALJ

A prior month supplement is issued for prior months as ordered by a court or ALJ unless the order specifically prohibits offsetting against overissuances. Issue the supplement within the time frames established by the court or BAM 600.

WITHOUT OFFSET

Some supplements for prior month underissuances are **not** appropriate to offset the supplement against overissuances. Such situations include but are **not** necessarily limited to the following:

- A supplement to correct current month's benefits **cannot** be processed until the following month due to administrative time frames or agency error.
- An ALJ or court orders a supplement to correct an underissuance with **no** overissuance offset.

Correcting Excess Recoupment

Bridges will identify and issue a supplement for excess recoupment that has been paid by the client.

Replacement Of Benefits Destroyed

Issue a supplement to replace food that was destroyed through a verified domestic misfortune or disaster through no fault of the client.

Example: Domestic misfortunes or disasters include events which occur such as:

- Fires.
- Floods.
- Electrical outages.

The supplement for the current month cannot exceed the eligible group’s monthly allotment. (see BAM 502).

LEGAL BASE

7 CFR 273.12(C)(1),.17

7 CFR 274.12
7 CFR 274.6(a)(1)(iii)

DEPARTMENT POLICY

FIP and SDA

In some circumstances benefit payments can, or must, be restricted to someone other than the program group. This involves a protective payee or mandatory vendor payments.

A **protective payee** is a person/agency selected to be responsible for receiving and managing the cash assistance on behalf of the group as a third party.

Mandatory vendor payments are shelter payments made by Michigan Department of Health and Human Services (MDHHS), without the client's request, directly to the group's landlord, mortgage or land contract holder. Mandatory vendoring can also include heat and electric payments to a utility company.

Restricted payments are **required** in any of the following circumstances:

- Court-ordered shelter arrearage collection.
- Third-party resource disqualification.
- Minor parent.
- Substance abuse.
- Client convicted of a drug-related felony.
- Money mismanagement.
- A child(ren) receiving FIP has a legal guardian.
- Eviction or threatened eviction.

  Note: Restricted payments apply to only a **current** eviction or threatened eviction. Third-party payments, **not** mandatory vendoring, are required if the local office has been informed that the housing unit fails to meet local housing codes. The protective payee should assist the family to locate housing which meets the codes.

Restricted payments are a local office **option** when the grantee has demonstrated a need for assistance in handling benefit payments but does not meet any of the circumstances above; see “Demonstrated Need For Money Management Assistance” in this item.

Electronic Benefit Transfer (EBT)

EBT allows clients to receive cash benefits (FIP & SDA) electronically. Protective payees are issued a Bridge Card for the client's cash benefits. When there is a protective payee, the client cannot access his/her cash account. Clients still have access to their food assistance benefit account.

Shelter Arrearage

FIP and SDA

Initiate mandatory vendoring when a shelter provider presents a certified copy of a **court judgment** to collect unpaid rent or the cost of damages to rental property from a member of the eligible group. This applies even if the group was not active when the debt was incurred or the person(s) named in the order was not in the group at that time.

Exception: Do **not** initiate or continue mandatory shelter arrearage vendoring when made aware that the rental property has been found to be in violation of local housing codes by the local housing authority.

Assume the court document is valid unless it appears questionable. Send a questionable document to the Office of Legal Services in central office for review.

File clear on the person(s) named in the order and do one of the following:

- If the person is a FIP/SDA applicant or recipient in your county/district, vendor the arrearage.
- If the person has a recipient ID number but is not a current FIP/SDA applicant or recipient, file the order in the case record for possible future action.
- If the person was never issued a recipient ID number, return the order to the provider with that explanation.

Multiple Court Orders

If a **second** court order affects the same eligible group, pend it until the first order is paid in full. Do **not** attempt to implement two court orders at once.

THIRD-PARTY RESOURCE DISQUALIFICATION

FIP

Restrict payments when the grantee is disqualified for failing to identify a third-party resource; see BEM 257. Use a protective payee, if possible.

Exception: The disqualified grantee may continue to receive warrants for the child(ren) as an ineligible grantee **if**:

- No suitable protective payee is found, despite all reasonable efforts; **and**
- Prolonging the search might be detrimental to the child(ren).

Note such a circumstance on the DHS-1171; the DHS-223, Documentation Record; or other appropriate document for placement in the Eligibility Packet of the case record.

Minor Parent Grantee

FIP

Restrict payments (via protective payee, if possible) when the eligible group consists of a **minor parent grantee** and his/her dependent child who live:

- With the minor parent's legal guardian or other adult relative, **or**
- In an adult-supervised living arrangement (for example, foster care).

If possible, the payee should be the responsible adult in the home (such as, relative, legal guardian, or designated staff of the adult-supervised living arrangement).

BEM 201 defines and explains these circumstances.

Money Mismanagement

FIP and SDA

Restrict payments when the grantee endangers his/her own or an eligible child's health or safety by mismanaging benefits.

When money mismanagement might exist (for example, contact from a provider or services specialist), evaluate whether restricted payments are necessary. Complete a DHS-838, Documentation of Money Mismanagement, and file it in the case record.

Evaluate possible money mismanagement when the client:

- Requests SER benefits, and required payments have **not** been made.
- Fails to meet basic obligations (for example, shelter, heat, utilities or health care).
- In **FIP only**, fails to properly feed and clothe a child.
- Incurs debts for **nonessential** items, limiting the ability to pay essential bills.

Restricted payments are appropriate **only if** money mismanagement resulted from the grantee's negligence. This does **not** include the following situations:

- Someone in the group had an emergency which required spending available money.
- Bills for **essential** items exceeded the grant and other income.
- A payment was withheld over a legitimate dispute with the provider (for example, landlord) as to whether the terms of an agreement were met.

Determining the Restricted Payment Type

A decision to use mandatory vendoring **or** send the entire grant to a third party should reflect the seriousness of the money mismanagement. However, use mandatory vendoring if undue time is required to find a payee.

Substance Abuse

SDA

Restrict payments when substance abuse is a contributing factor to the disability; see BEM 261.

Use a protective payee, if possible. If a protective payee cannot be obtained, use vendor payments for shelter, heat, and electric to the extent possible.

Client Convicted of a Drug-Related Felony

FIP

Restrict payments when the grantee has been convicted, for conduct occurring after August 22, 1996, of a felony for the use, possession, or distribution of controlled substances.

Use a protective payee, if possible. If a protective payee cannot be found use vendor payments for shelter to the extent possible.

Eviction or Threatened Eviction

FIP and SDA

Restrict payments when verification indicates the eligible group is being evicted, or threatened with eviction, from its **current** rental unit **for nonpayment of rent**. This applies even if the case was not active when the debt was incurred or the person(s) named was not in the eligible group at that time.

The verification must clearly identify the client. It includes but is not limited to:

- A court order, other court judgment, or court filing document clearly stating that rent is in arrears.
- A notice of intended eviction that cites nonpayment of rent as the reason.
- An application for SER (or in Wayne County, Emergency Services) for a shelter deposit and/or first month's rent by a

homeless shelter resident whose homelessness was caused by nonpayment of rent.

Note: Local offices may grant exceptions to mandatory vendoring in order to address extenuating circumstances (for example, illegal eviction document or unresolved landlord-tenant dispute).

Legal Guardian

FIP

When there is a legal guardian of a child(ren) receiving FIP, the legal guardian must be a protective payee for the FIP.

Demonstrated Need for Money Management Assistance

FIP and SDA

In very limited and compelling circumstances, the local office may assist a grantee in managing money through restricted payments, even though there is no current money mismanagement. Demonstrated reasons may include:

- Developmental disability.
- History of mental disorders.
- Chronic money mismanagement during past periods of assistance.

See Determining the Restricted Payment Type above.

Protective Payee

FIP and SDA

Either a specialist or the client may suggest a third-party manage the group's cash benefits. It may be a relative or friend of the group, a volunteer worker, a member of a private agency that provides protective service or money management counseling or, at the local office director's option, a services worker. The protective payee was formerly referred to as the third-party payee.

Exception: In a minor parent case, the grantee's legal guardian or other supervising adult must be appointed protective payee unless

that person is unable to manage the benefit payments; see BEM 201.

Determine whether the suggested payee is suitable. Ensure that the person is all of the following:

- Concerned with the group's welfare.
- Willing to receive and manage the grant.
- Willing to help the group learn to manage money.
- Able to keep adequate records and receipts of how the grant is spent.

The following **cannot** be a protective payee:

- Members of the eligible group.
- Local office director or management staff.
- FIS/ES determining the group's financial eligibility.
- Anyone handling financial matters of the group.
- Special investigative or resource staff.
- Provider of goods or services to the group (for example, landlord, grocer).

Vendoring in Restricted Cases

FIP and SDA

Mandatory vendor payments are usually authorized when only the shelter, heat or utility obligation is mismanaged **or** when a protective payee **cannot** be found.

Mandatory vendoring is limited to the monthly combined shelter, heat and utility expenses **and** must leave a minimum $2.00 cash grant (such as, grant amount after deducting income, vendor payments and any recoupment amounts).

To receive vendored payments, providers must furnish their federal employer ID number, Michigan temporary ID number or social security number, and enroll as a provider.

In money mismanagement cases, initiate third-party payments to a protective payee (not vendoring) in the following situations:

- The provider refuses to furnish his tax ID number (see above) or enroll as a provider.

- MDHHS is notified by the government agency/unit which enforces the local housing code that:

- The rental unit does **not** meet standards for such housing, **and/or**
- The landlord has **not** followed the community's housing code policies and procedures.

- The landlord, without good cause, refuses to cooperate in available weatherization or conservation programs determined necessary to reduce energy consumption to an acceptable level.

Stop mandatory vendoring when MDHHS learns and verifies that the property reverted to the State of Michigan due to unpaid taxes; see “Reviews” in this item.

Heat and Electric Vendoring

For **FIP**, heat/electric vendoring **cannot** be mandatory. However, urge the client to enroll in voluntary vendoring to help correct money mismanagement; see BAM 425.

For **SDA**, mandatory heat/electric vendoring is a local office option.

Setting Vendor Priorities

FIP and SDA

If the total does **not** allow the minimum $2.00 cash benefit, decide what to vendor to best meet the group's needs. In money mismanagement cases, the following order of priority is suggested:

1. Shelter arrearage.
2. Shelter.
3. 2nd shelter (for example, mobile home lot rental).
4. Heat (or combined heat and electric).
5. Electric.
6. Heat arrearage.
7. Electric arrearage.

Note: Priority vendoring negates certain voluntary vendoring requirements. See the **“VENDOR PAYMENTS”** section in BAM 425.

Notices of Restricted Payments

FIP and SDA

Send the group a DHS-898, Money Management Evaluation Notice, when evaluating the need for restricted payments.

After the evaluation, send another DHS-898 **if** you determine that restricted payments are not necessary.

When starting **or** stopping third-party payments, send:

- A DHS-3797, Protective Payee Appointment Notice, to the payee, **and**
- A DHS-3869, Protective Payee Assignment, to the client.

FIP

Give the group **timely notice** before starting restricted payments. Calculate the pended begin date for third-party payments.

SDA

In SDA, restricted payments are not negative actions. Therefore, give the group **adequate notice**.

Reviews

FIP and SDA

Review restricted payment status when appropriate but **at least at every** determination. Schedule the review with other case reviews when possible. The client, however, has the right to request and be granted a review of the restricted payment status every six months.

Review the status immediately if vendoring must stop because the property reverted to the State of Michigan; see **Vendoring in Restricted Cases** in this item.

For money mismanagement cases, examine the progress of the protective payee and/or client in managing the group's money.

For third-party resource disqualifications, examine the payee's money management ability and the client's willingness to cooperate

in identifying a third-party resource. See the **DISQUALIFICATION** section in BEM 257.

In minor parent cases, examine how the supervising adult has managed the benefit payments.

Resuming Restricted Payments

FIP and SDA

Restricted payments stop automatically at closure and due to certain coding changes.

When reinstating a case or processing such a coding change, resume restricted payments. The following factors apply:

- A new money mismanagement evaluation is not required.
- Reflect the current living situation in the budget.
- Mandatory vendoring documentation in effect at the closure or coding change is sufficient.

Interoffice Transfers

FIP and SDA

Transfer of a case to another local office might result in a new protective payee or provider(s), but it does not affect the requirement for restricted payments. Continuity of the restricted payments must be ensured.

Time Limits

FIP and SDA

In third-party resource disqualifications, continue restricted payments until the person's cooperation is verified. See **Removing a Third-Party Resource Disqualification** in BEM 257.

In minor parent cases, continue restricted payments until the client no longer meets the minor parent definition in BEM 201.

In money mismanagement cases, restrict payments for 24 months (consecutive or otherwise) **or** until the problem is resolved, whichever occurs first. If it appears the problem will last beyond 24

months, notify Services staff to arrange for protection of the children and/or a guardian.

Note: Restricted payments may continue beyond 24 months if the court denies or refuses to accept a guardianship petition.

Hearings

FIP and SDA

The group may request a hearing to dispute a decision to begin or continue restricted payments or to dispute the selection of a protective payee.

Continue restricted payments until the hearing matter is resolved.

LEGAL BASE

FIP

P.A. 280 of 1939, as amended
P.A. 235 of 1995
P.A. 109 of 1997
R 400.3106

SDA

Annual Appropriations Act
Michigan Administrative Code; R 400.3151-400.3180

R300.4151 - 400.3180MAC

DEPARTMENT POLICY

FIP and SDA Only

Voluntary vendoring is a voluntary payment system whereby DHS sends part of the client's FIP/SDA grant directly to the provider(s) of shelter, heat and/or electricity. One-half of the vendored amount(s) is withheld from each semi-monthly warrant.

Cases with ineligible grantees other than SSI recipients, are not eligible for voluntary vendoring.

Clients may request vendoring at any time via the DHS-560, Vendor Payment Request, which **must be completed before vendoring begins**. Vendor payments must be at least $2.00.

All clients with an expense for shelter (rent, mortgage, land contract or other), heat or electricity are expected to complete and sign the DHS-560 to show whether they want vendoring. This applies **even if** the only obligation is a previous unpaid bill.

Reminder: Signing the DHS-560 is **not** a condition of eligibility. Make a note of refusal on the DHS-560 or DHS-1171, Assistance Application.

Have a DHS-560 completed:

- At application, **and**
- When a client wishes to start or stop vendoring, **and**
- When the client moves.

The existing DHS-560 remains in effect until a new one is completed and signed, **even if** the information is changed in Bridges.

Note: Unless a new DHS-560 is obtained after interoffice case transfer, incorrect provider information will remain in the case record.

A new DHS-560 is **not** needed to reinstate a case.

Encourage clients to continue their enrollment in voluntary vendoring. However, stop voluntary vendoring **promptly** when a client makes a **written** request (via DHS-560 or otherwise).

The total vendored amount must leave at least a $2.00 grant. If less than $2.00 remains, see **Setting Vendor Priorities** in the **VENDOR PAYMENTS** section in this item.

VENDOR PAYMENTS

Providers

Shelter providers seeking vendored payments must **first**:

- Furnish their federal employer ID number, Michigan temporary ID number, or social security number; **and**
- Enroll in the Model Payments System (MPS); see BAM 435.

Shelter

The client may specify any monthly amount to be vendored.

Clients in manufactured (mobile or modular) homes may choose to have home purchase and lot rental payments vendored separately.

Rent

To have rent vendored, the client must **first** complete the DHS-560 section indicating he agrees/objects to release of his name and address to the local housing code enforcement authority.

Note: Enforcement authorities include the Michigan Department of Community Health.

Vendor payments are not affected if the client objects to the information release.

In Bridges under Wrap Up, Issuances-Details and answer Yes to vendor assignment. On the Cash Vendor Assignment Details page, select the Vendor Type Shelter and enter the Vendor Amount. The local office is to complete a DHS-4493, Local Agency Code Compliance Referral, attach the CF-090 and forward them to the housing authority.

Vendored Rent NOT Authorized in Certain Situations

Do not authorize vendored rent in the following situations:

- The local housing authority notifies DHS that

- The dwelling fails to meet the housing code, **or**
- The landlord has failed to cooperate with housing code policies and procedures.

- The landlord rejects energy conservation measures offered by DHS or a positive billing company that were determined necessary to reduce consumption to an acceptable level.

- The landlord is delinquent on payment of property taxes.

- Title to the rental property reverts to the State for nonpayment of property taxes.

The housing authority uses an DHS-4494, Housing Code Compliance Notice, to notify DHS that:

- A rental unit does **not** meet the housing code.
- A rental unit previously out of compliance now meets the housing code.

Stop vendoring within five workdays if notified of noncompliance with a housing code **or** an energy conservation program offered by DHS. **Do not** reauthorize vendoring to **that rental unit** (even when another client occupies it) until notified by the housing authority or energy provider that compliance has been established.

Note: The local office is responsible for maintaining a list of rental units out of compliance.

Heat and Electric

The minimum amount vendored is determined by the number of recipients receiving cash benefits; see the Table of Monthly Energy Required Payments in ERM 301.

Clients may choose to vendor more than the required amount for their eligible group size to ensure the minimum required payments are being made based on the household size.

Only one heat provider and one electric provider may be vendored for the case at any one time, **except** for arrearage vendoring. The amount(s) withheld are sent directly to the provider twice a month. (Refer to Wizards in Bridges for an explanation of entries for vendoring.)

Setting Vendor Priorities

Bridges allows up to six vendor situations. However, if the total would leave a grant of under $2.00, assist the client to choose the most important. The following is a suggested order of vendoring priorities:

Note: A shelter judgment arrearage vendor takes priority over **all** other vendors.

1. Shelter arrearage.
2. Shelter.
3. 2nd shelter (such as mobile home lot rental).
4. Heat.
5. Electric.

Supplements and Lost, Stolen, Returned or Replaced Warrants

Vendor supplements are processed by Central Office accounting. To replace a **lost or stolen** single-client vendor warrant (**not** a consolidated vendor warrant) see BAM 500.

To rewrite a **returned** single-client vendor warrant see BAM 505.

Treasury Offsets

The Department of Treasury may withhold, or offset, money from a vendor warrant when the provider has an outstanding debt to the State. A vendor payment which is offset by Treasury against a debt owed by the provider to the State is legally considered to have been paid to the provider.

Refer providers with questions regarding the offsets to the MI Treasury Vendor Offset Program at (517) 636-5270.

Tax ID Number Pended Payments

The Department of Treasury identifies MPS enrolled providers whose tax ID numbers (federal employer or Michigan temporary ID) are incorrect on MPS or not registered with Treasury. DHS holds the vendor payments for 30 days or until the problem is resolved, whichever is earlier.

Note: The provider and client are also notified; see **Provider/Client Notices** in this item.

The Payment Information Unit (PIU) in central office processes incorrect and unregistered tax ID numbers. The provider is requested to furnish the correct number or confirm the information on file within 14 days of the pended payment.

If the problem is **not** resolved timely, a supplement is issued to the client to replace each pended vendor warrant. Money held by DHS beyond the negative action date is issued to the provider, regardless of the reason vendoring stops.

When payment is made, the warrant number and amount, warrant date and payee are also posted.

Providers who contact the local office with a tax ID number problem should be referred to the PIU:

Department of Human Services
Payment Information Unit
P.O. Box 30037
Lansing, MI 48909
(800) 444-5364

PROVIDER/ CLIENT NOTICES

Bridges generates an DHS-4327-M, Vendor Payment Notice, to the provider and/or client for vendoring actions.

Both providers and clients are notified of the following:

- Vendoring begins. The Vendor Action (client request, money mismanagement) determines the DHS-4327-M content.
- The vendored shelter amount changes.
- Vendoring stops and is **not** started again to the same provider the same day.
- Vendor payments are held due to a tax ID problem.

Only clients are notified of the following:

- A change in the eligible group affects the heat/utility allowance.
- Vendoring to a particular provider starts, then stops (or stops, then starts) the same day.

No notice is sent for other corrections in vendor data.

VENDOR WARRANTS

Individual Vendor Warrants

The Department of Treasury issues individual vendor warrants for each client with vendoring. The vendored amount is withheld from the client's regular semimonthly warrant and usually sent to the provider within four days after the regular warrant. Each vendor warrant includes half of the client's monthly vendor payment.

A stub attached to the vendor warrant states:

- Case name.
- Case number.
- FIS/ES workload number.
- Client's address.
- Client's billing account number
- Pay period (for example, Jan. 1st half) the warrant is issued for.
- Message identifying the warrant as a vendor payment.
- $1.00 processing fee deducted (shelter judgments only).

Consolidated Vendor Warrants

Shelter, heat and electric providers with a signed agreement with DHS receive consolidated vendor warrants for multiple clients. The vendored amounts are withheld from the clients' regular semimonthly warrants.

The total heat and electric deductions or shelter payments of all clients with vendoring to the provider are combined into weekly warrants as follows:

- 1st week - First semimonthly payments for clients with case numbers ending in 0-4.

- 2nd week - First semimonthly payments for clients with case numbers ending in 5-9.

- 3rd week - Second semimonthly payments for clients with case numbers ending in 0-4.

- 4th week - Second semimonthly payments for clients with case numbers ending in 5-9.

CAP NOTICE

Client Cap Notice DHS-4327-Y

Clients whose allowances are vendored to the provider will continue to have their allowances vendored to their provider after reaching the fiscal year cap. DHS-849 payments for usage over the cap can only be authorized by exception.

EXHIBIT - SAMPLE LETTER TO SHELTER PROVIDER WHEN A VENDOR WARRANT IS CREDITED

PROVIDER **DATE**

Client

Vendor payments which you have been receiving for shelter on behalf of the above named client will stop for a one month period effective (date) . Payments for this period are the responsibility of the client.

If you have any questions about this letter, contact the specialist whose workload number appears below.

LOCAL OFFICE

LEGAL BASE

FIP

P.A. 280 of 1939, as amended
P.A. 368 of 1996

SDA

Annual Appropriations Act

Michigan Administrative Code; R 400.3151-400.3180

DEPARTMENTAL POLICY

State Disability Assistance (SDA) Only

Special living arrangement (SLA) provider payments for SDA recipients are made in Bridges. The following SLAs are eligible for provider payments:

- Homes for the Aged (HFA).
- Adult Foster Care (AFC) (only if receiving domiciliary or personal care).
- County Infirmaries (CTI) (only if receiving domiciliary or personal care).

Note: AFC and CTI residents not certified for domiciliary or personal care are considered in independent living; see BEM 515.

A type of care determination, which affects the payment rate, must be made before the provider can be paid; see BEM 615. Refer to BEM 616 for client eligibility information.

Liaison With Facility

SLA facilities send notices of admission, extended stay and discharge to the local office where the facility is located. If the client's residence county continues to handle the SDA case, the local office where the facility is located forwards all eligibility and payment information to the residence county.

Payment for SLA Facilities

Bridges requires that:

- The facility is enrolled as a provider.
- There is an active SDA case **or** SDA was active for the period being authorized.
- The SDA/SLA provider has an active assignment on the eligible SDA case. The provider must submit a DHS-768, Invoice/Adjustment Request.

Provider enrollment and payment authorization information are entered in Bridges. Payment is then made to the provider based on

the number of days billed by the provider compared to authorization information;see **Authorizing SDA/SLA Provider Payment** in this item.

The provider payment does not include the client incidentals allowance. Incidentals are placed on the client's Bridge Card by electronic benefits transfer (EBT). Provider payments go directly to the provider.

Authorizing SDA/SLA Provider Payments

After the case has been opened in Bridges, authorize the provider payment. The authorization timeframe is only for the time period the client was in that provider's facility. An invoice (DHS-768) must be sent to the provider for each month in the authorization. The invoice allows the provider to bill for services provided.

Note: It is recommended you send enough invoices (DHS-768) to the provider to cover the authorization period for a year (at least 12) at opening.

Authorizations are entered in Bridges, located in data collection, wrap up, SDA provider assignment. Authorizations are for whole months or portions of months. The authorization must reflect:

- The assigned provider.
- Dates the client resided in the facility. If the end date is unknown it is appropriate to align the authorization date with the redetermination date.
- Service Code based on type of care and provider type.

An authorization can be entered **only** if:

- Bridges shows either that SDA is currently active or that it was active for the period being authorized.
- The authorization begin date is no more than 10 days prior to the date of application (registration).
- The authorization end date is within the previous or next 12 months. If appropriate it should coincide with the redetermination date.

AUTHORIZATION CHANGES

Incorrect Services Codes

In Bridges, if an incorrect service code has been entered or if payment has been made for any portion of the authorization period, enter the correct information and rerun Eligibility. See Underpayments to Providers and Overpayments to Providers in this item for correction procedures.

Change Client Pay

Bridges will determine the client pay amount when the clients income information is entered or changed. The CSCD entered will determine the effective date of the change.A client pay amount can be changed monthly but is **always** effective for a calendar month.

Increases in client pay amount require timely notice and decreases require adequate notice. Authorizations may never be changed retroactively to increase a client pay amount.

Retroactive Adjustments

Authorizations can be changed retroactively if incorrect **and** the change is for a period within the past 12 months. Submit requests for changes older than 12 months through the exception process.

Unpaid Portions

Unpaid portions of authorizations can be changed for any of the following reasons:

- To enter an earlier end date because the client died or moved from the facility.
- Change in the client pay amount.
- Incorrect type of care.
- Incorrect authorization dates.
- Wrong provider authorized.

Paid

The only change that can be made to a paid authorization is to **decrease** the client pay amount or increase the type of care.

DHS-768 Invoice/ Adjustment Request)

To receive payment a provider must complete and submit a DHS-768. Each DHS-768 covers a calendar month, a new DHS-768 must be submitted for each additional month or portion of a month.

Example: If the client is in care from 6/24-7/29 they must provide 2 separate invoices, one for 6/24 to 6/30 and a separate one for 7/1 to 7/29, as care was provided in 2 different calendar months.

The completed DHS-768 should be mailed to:

Michigan Department of Human Services
Field Operations Administration, Suite 1402
P.O. Box 30037
Lansing, MI 48909

Authorization Terminations

End an authorization when the client:

- Is no longer eligible for SDA.
- Is no longer eligible for provider payment due to income (also see **Repayment Agreements** in this item).
- Leaves the facility.

End the authorization by entering an end date

The end date is:

- The date the client is no longer eligible for SDA.
- The date the client is no longer eligible for facility payment.
- The day **before** the client leaves the facility.

If the client enters another facility, complete another authorization. If the client dies, the end date is the date of death.

Bridges will automatically end an authorization when the:

- Address is changed.
- Case is closed.
- End date is reached.

End an authorization when a client remains eligible for SDA, but is no longer eligible for the provider payment paid by the department.

Clients with Budgetable Income

Enter the client income in Bridges and Bridges will deduct the client's net countable income from the provider payment.

Bridges determines if the per diem provider payment exceeds the client pay for that period before authorizing payment. Bridges will **not** authorize provider payment if it is less than the client pay.

Repayment Agreements

Clients who have signed a repayment agreement must repay the department for SDA benefits, including provider payments, when the potential benefit is received ; see BEM 272, SDA Repay Agreements.

Bridges determines if continuing eligibility exists and if not will close the case.Central office or the fiscal unit determines the amount to be recovered based on the monthly provider and incidentals payments. They will check Bridges for provider payments actually made during the repay agreement period and for pending payments which cannot be stopped. These payments will be included in the recovery calculations.

PROVIDER INFORMATION

Bridges Provider Enrollment

Local Office RSS enrolls providers in Bridges Provider Management using Form DHS-2351X, Model Payment Provider Enrollment Request. Providers must be enrolled before an authorization for provider payment can be entered in Bridges. Each facility must be enrolled. After enrollment, Bridges will assign a provider ID number. Bridges Provider Notices

Each time a provider payment authorization is started, stopped or changed in Bridges, the affected provider will be notified. Use SDA Provider Assignment inquiry to resolve any questions about current authorizations or authorization history.

DHS-769, Invoice Error Notice

When the DHS-768 does not contain all required information,payment will not be approved. A DHS-769, Invoice Error Report will be sent to the provider to notify them the reason the payment can not be made. The provider can choose to correct the returned invoice or submit a new one.

SDA/SLA PAYMENT INFORMATION

SDA/SLA Warrants

Provider payments are made through Bridges based on invoices submitted by providers. Payrolls are run weekly. A consolidated warrant is issued for each facility and includes payments for all invoices processed that week.

Invoices may be submitted any time after the pay end date.Each weekend a payroll tape is processed and forwarded to the Department of Treasury for warrant issuance. Mailing is scheduled for the following Thursday. Warrants are usually delayed when a holiday occurs.

SDA/SLA Provider Warrant Rewrite

BAM 500 and BAM 505 include information on requesting a warrant rewrite. Warrant rewrites are included in the weekly payroll. The disposition code is posted the day the rewrite is entered, but the voucher number and location are not assigned until the payroll is run and are therefore not posted until the rewritten warrant is issued.

WARRANT CREDITING AND REDIRECTING

The Reconciliation and Recoupment Section (RRS) in the Bureau of Accounting will request provider warrant intercept and crediting to recover any overpayment. This occurs whenever a provider over-

payment remains unresolved after RRS issues a final overpayment notice to the provider.

OVERPAYMENTS/ RECOUPMENT

Overpayments to Clients

Client overpayment, including provider payment, which is not a result of incorrect facility billing or an error in the type of care authorized, is recouped from the client (see BAM 705). This includes FIP or SDA overpayments resulting from failure to notify the department of changes in living arrangements.

Overpayments to Providers

Overpayments to providers which are a result of incorrect billing for periods for which services were not provided or for incorrect type of care authorizations, are recouped from the provider by the Bureau of Accounting. Contact the facility, inform them of the overpayment and request repayment.

If the facility does not cooperate or refuses, submit a memo to the Reconciliation and Recoupment Section. Include a brief explanation of the overpayment circumstances and **all** of the following information:

- Provider name and ID number.
- Case name(s) and number(s).
- Overpayment amount(s).
- Overpayment period(s).
- Appropriate documentation.
- Account number and cost center.

Refer to the Warrant Crediting and Redirecting section in this item for warrant intercepts resulting from recoupment efforts.

UNDERPAYMENTS/ ADJUSTMENTS

Underpayments to Clients

BAM 405 contains information on authorizing supplements to SDA clients for underpayment of incidentals and special needs.

Underpayments to Providers

If a provider is underpaid for care provided, such as, client pay decreases, or type of care increases, issue a DHS-768 to the provider to rebill for that month. The provider completes the form using the correct information for the entire month. **Inform the provider to identify a changed invoice by placing CORRECTION at the top of the form.**

SLA POLICY EXCEPTION PROCESS

Local Office

Local office directors or district managers may authorize exception requests due to administrative error in the following situation:

The client:

- Made timely application for assistance.
- Cooperated in the interview and verification processes.
- Left the facility before the application could be approved.

A cover memo explaining the situation and requesting exception unit authorization input, may be sent directly to:

Field Operations Administration
Grand Tower Building-Suite 1402
P.O. Box 30037
Lansing, MI 48909

Central Office

A policy exception and authorization exception input request are required for:

- An authorization for provider payment for a period more than ten days prior to the SDA application (registration) date.

Central office will provide notification of decisions made on exception requests. Notify the client of the exception decision.

Problem Resolution

Contact FIP-SDA-RAP@michigan.gov or the local office Field Operations Specialist to resolve SDA/SLA related difficulties.

LEGAL BASE

SDA

Annual Appropriations Act
Michigan Administrative Code; R 400.3151-400.3180

DEPARTMENT POLICY

The policy and procedures in this item apply to FIP, SDA, MA, and SER only; see BEM 704 for CDC.

Providers must be enrolled in Bridges to be paid for services rendered. Bridges will assign a provider ID number when enrolled. The ID number is used when authorizing a payment to the provider. In addition to the Bridges enrollment, providers must complete a vendor registration and file a W-9 through Contract and Payment Express (C&PE) in order to receive payment, by visiting, http://www.michigan.gov/budget/0,4538,7-157-13404_37161---,00.html.

The provider's name, Tax ID Number (TIN), address and Main Mail Code (MMC) assigned to their preferred mailing address in C&PE must correspond with their Bridges enrollment information in order to avoid a payroll error and to prevent a payment from being issued to an incorrect provider or mailed to an incorrect address.

CENTRAL OFFICE PROVIDER ENROLLMENT

The Provider Management Payments Unit (PMPU) is responsible for completing enrollments and making revisions or corrections to all medical service providers, energy-related service providers and non-energy related service providers.

Energy-Related Service Providers

Suppliers of non-heat electricity, natural gas, deliverable fuel and other household fuel types, along with energy-related home repair providers are enrolled as a Low Income Home Energy Assistance Program (LIHEAP) provider.

The provider must complete and submit a DHS-355, Participation Agreement for Michigan's Low Income Home Energy Assistance Program, form to the PMPU in order for a provider to be enrolled as a LIHEAP provider and to receive payment on behalf of a client.

Revisions or corrections to a provider's enrollment must be submitted in writing, by the provider, on a DHS-355 or their business letterhead and sent directly to the PMPU.

Non-Energy Service Providers

To enroll or make changes to the enrollment of non-energy utility providers of water, sewer, burial, home repair, and shelter, (includes home ownership), submit a completed DHS-2351-X, Provider Enrollment/Change Request to PMPU.

Medical Service and Medical Photocopying Service

To enroll or make changes to the enrollment of a Medical Service or Medical Photocopying Service provider, the DHS-94, Medical Services Authorization Provider Enrollment/ Other Change, form and the DHS-93, Examination Authorization/Invoice for Services, form must be sent to PMPU.

After enrollment, PMPU will return the DHS-93 and DHS-94 to the local office, identifying the provider's ID so that payment may be processed.

Provider Management Payments Unit (PMPU)

Use the Search Enrolled Provider inquiry to determine if the provider has already been assigned a provider ID number in Bridges. If an ID number has previously been assigned, please reference that number in the correspondence to PMPU.

Please mail, email or fax provider enrollment or change requests to:

Mailing Address: Financial Services, Accounting Division
Provider Management Payments Unit
235 S. Grand Avenue, Suite 1004
Lansing, MI 48933

Email: MDHHS-Provider-Management@michigan.gov

Fax: (517) 241-7508

LOCAL OFFICE PROVIDER ENROLLMENT

Adult Foster Care, Homes for the Aged, and County Infirmaries receiving payment for care must be enrolled in Bridges by local offices; see BAM 430. Special Living Arrangement (SLA) provider payment cannot be authorized unless the provider is enrolled with

the appropriate eligibility type. SLA provider payment authorizations **cannot** be authorized beyond the eligibility type end date if an end date has been entered.

SERVICE PROVIDERS

Multiple Provider ID Numbers

Some providers may be assigned to more than one provider ID number. This occurs when the company wants to differentiate between several business locations. Multiple provider ID numbers may be assigned to the same business or individual when the provider chooses to be enrolled and paid under a Federal Employer Identification Number (FEIN). Multiple provider ID numbers cannot be assigned when the provider chooses to be enrolled and paid under a Social Security Number (SSN). An individual who would like to obtain a FEIN should contact the Internal Revenue Service or the U.S. Post Office to obtain a Form SS-4, Application for Employer Identification Number. It may take several weeks to obtain a FEIN.

When a provider has been assigned multiple provider ID numbers, local office staff must review the enrolled name, address and tax identification number carefully before authorizing payment, to ensure that the correct provider ID number is used.

Multiple Names and Addresses

A situation may occur where the owner of the business or property requests that the payment be issued to and/or mailed to another individual or business.

For energy and non-energy service providers, payments are issued to the individual or business enrolled in Bridges and mailed to the physical address or the address entered in the mailing address section. The provider's mail code in Bridges must match the mail code provided in C&PE to ensure the payment is mailed to the correct address.

Adding Eligibility Type(s) to Enrolled Providers

If a provider furnishes different services, more than one eligibility type may be added to the provider enrollment. Eligibility type may be added at any time to a provider ID number. The Search Enrolled Provider inquiry menu is used to determine whether a provider is

enrolled and the eligibility types the provider is authorized to furnish.

CHANGES TO PROVIDER ENROLLMENT

Updating Enrollment Information

The provider must request changes to the provider file information (for example, name or address) in writing. The request should include the new information, the provider's tax identification number and the provider ID number.

Changes to the following service provider enrollments may only be completed by PMPU in central office: energy-related, non-energy related, medical and medical photocopying.

A provider ID number may be used to authorize several departmental programs or services (for example, one provider could be authorized for home repair, shelter, and energy-related services). Other local office staff who use the provider ID number may also need to know about the provider enrollment information changes. The eligibility types and the provider documents in the local office provider enrollment file will assist in identifying other staff who use that provider ID number.

PROVIDER ENROLLMENT TERMINATION

Provider Enrollment Terminations - Central Office

Local offices cannot delete or end date the following provider eligibility types:

- Medical service provider.
- Medical photocopying service provider.
- Energy-related service provider.
- Non-Energy related service provider.

When provider enrollment termination is needed, submit the DHS-2351X to PMPU in central office. Energy-related providers must submit the termination request on the DHS-355 or on their company letterhead.

When it is necessary to end date a provider ID number due to multiple provider ID numbers, PMPU will enter the correct provider ID number in the comment section of the Provider Service Details screen of the end-dated provider ID number.

Send a DHS-2351X to PMPU to reactivate any end-dated provider ID number.

Note: Energy-related service providers must complete and submit a DHS-355 in order to have their enrollment re-established.

All Other Providers

SLA Home for the Aged provider enrollments must be terminated by the local office services staff when notification is received from Public Health that the license/certification is terminated.

Computer updates from Adult Foster Care licensing will automatically enter an end date for license closures for SLA, AFC and CI facilities.

PROVIDER ENROLLMENT FILE

Maintain forms used to enroll or change provider information on the provider enrollment file in a secure location. Also include any documents with information upon which a provider enrollment or change is based.

DEPARTMENT POLICY

FIP, RCA, SDA, SSP, CDC, SER, and Medical Services warrants.

Michigan Department of Health and Human Services (MDHHS) replaces warrants reported lost, stolen, not received, or destroyed.

1778 PROCESS

A payee on the warrant claiming it was lost or stolen must complete and sign a 1778, Affidavit Claiming Lost, Destroyed, Not Received or Stolen State Treasurer's Warrant.

Use the MDHHS Forms Library to access a link to the Michigan Department of Treasury (Treasury) form 1778:

1. From the MDHHS-Net click **DHS Forms Library** under Popular Links.
2. Click DHS: Forms 1500 - 1999.
3. Select the **1778, Affidavit Claiming Lost, Destroyed, Not Received or Stolen State Treasurer's Warrant Process** and then click OK.
4. Click the hyperlink to treasury form and complete.

Lost or Stolen Warrant

For stolen warrants, clients must also be encouraged to file a police report. Replacement is made only after recovery of the warrant amount; see Stop Payment and Replacement in this item.

Note: Do **not** complete a 1778 for client or vendor warrants lost or stolen **after endorsement**. These warrants can only be replaced if they are returned to Treasury, or they are canceled by Treasury after 6 months.

Warrant Not Received

Clients and providers sometimes request replacement of warrants never received which they do **not** believe were lost or stolen. Determine in Bridges, Benefit Issuance, whether the warrant was issued.

If the warrant **was** issued, obtain the warrant number, warrant date, amount, and Warrant Status.

- If Bridges indicates it was returned to Treasury; see BAM 505, Returned Benefits.

If the warrant was issued and **not** returned it might be late in mail delivery. Instruct the payee to contact the post office to verify delivery.

- If delivery is verified **but** the payee claims nonreceipt, consider the warrant lost; see Lost or Stolen Warrant in this item.

- If delivery **cannot** be verified, consider the warrant not received. The payee can complete a 1778 on the **day after the fourth mail delivery day following the warrant date**; see Stop Payment and Replacement in this item.

If the warrant was **not** issued, ask a local office designated staff to contact the Michigan Department of Technology, Management and Budget (DTMB) Help Desk (517-241-9700).

Destroyed Warrant

When the local office receives a destroyed or mutilated warrant, the fiscal unit supervisor can complete and sign the 1778 on behalf of the payee and attach the warrant remains. Destroyed warrants do **not** require a police report.

Stop Payment and Replacement

The payee must complete a 1778 to initiate a stop payment and request a replacement warrant. Ask the payee to review the form or, if requested, read and explain the contents. The payee **and** a notary must sign **each** copy of the 1778 **in ink**. Copy signatures are **not** acceptable.

In **limited** circumstances that prevent 1778 completion in the local office (for example, out-of-state provider), forward it to the individual for notarized signature and return.

Exception: Destroyed or mutilated warrants do **not** require payee signatures; see Destroyed Warrant in this item.

After the 1778 is completed, enter the stop payment and replacement request in Bridges (even if the warrant has been **cashed**). Change status to one of the following:

- Stop requested by worker.
- Forgery analysis requested (if it is a paid warrant).

- Promptly send 2 copies to:

  Payment Processing Unit
  Grand Tower Building
  235 S. Grand Avenue, Suite 1015
  Lansing, MI 48909

- File a copy in the case record.
- Send a copy to the local fiscal office.
- Give a copy to the payee.

Original Warrant Found

Remind the payee when completing the 1778, if the original warrant is found, it must be returned to the local office. If one is returned to you, forward it to the local fiscal office to be voided; see BAM 505, Returned Benefits.

Client Requested Warrant Replacement

When the client requests a warrant replacement and the request is processed, the specialist will receive an alert when the stop payment is completed. The specialist is then able to replace the warrant.

Note: Forged warrants are replaced by the Payment Processing unit.

The Payment Processing Unit denies the replacement if it is determined that the payee cashed the warrant or benefited from its cashing. When Payment Processing informs the local office of the denial, notify the client via DHS-176, Benefit Notice.

Vendor Warrant Replacement

A vendor warrant is replaced **only** after recovery of the amount issued, **unless** the warrant was voided or undeliverable; see BAM 505, Returned Benefits. A police report is **not** necessary.

- If the warrant is issued to the same payee for the same amount, the specialist can process the replacement.
- **If the warrant is issued to a different payee but is for the same amount, only central office can process the replacement.**

Note: For SER, if the warrant is issued for a different amount, the specialist can reprocess the warrant (for example, reregister the SER using the original SER date).

1354 PROCESS

Often, a stop payment is requested **after** the original warrant was cashed and paid by Treasury. MDHHS and Treasury are responsible to recover the funds before a replacement warrant is issued. To replace a payment that has been cashed complete a 1354, Affidavit Claiming Forged Endorsement on a State Treasurer's Warrant Process.

- Payment Processing sends a copy of the warrant and a cover memo to the local fiscal office.
- The local fiscal office will complete the 1354, Affidavit Claiming Forged Endorsement on a State Treasurer's Warrant, attach the cover memo, a photocopy of the warrant and forward to the specialist for completion.
- The specialist schedules a local office appointment with the payee to explain the 1354 process and to have the payee view the warrant copy signature.
    - If the payee fails to keep the appointment, or refuses to sign the affidavit, return the 1354 with the memo to the local fiscal office with an explanatory note. The local fiscal office returns the 1354 to the Payment Processing Unit.
    - If the payee admits endorsing the warrant, obtain a signed statement to that effect. Return the 1354 with the memo to the local fiscal office. The local fiscal office returns the 1354 to the Payment Processing Unit.
    - If the payee claims the signature on the warrant copy is forged, both the payee **and** a notary public must sign **each** copy of the 1354 **in ink**. **Only original signatures are acceptable.**

- File a photocopy of the signed 1354 and warrant in the case record, and give the payee a photocopy of **only** the 1354.
- Return the 1354 and warrant copy to the local fiscal office for mailing to the Payment Processing Unit.

Forgery/Recovery

If the client and/or provider disagrees with the decision not to issue a replacement warrant, the client may request a hearing by completing a DHS-18, Request For Hearing.

If it is determined that the warrant **can** be rewritten, Payment Processing replaces the warrant.

Note: Administrative Hearings will deny requests for hearings requested by providers.

CONSOLIDATED VENDOR, MEDICAL SERVICE AND SER HEAT/ELECTRIC WARRANTS

Stop payment/replacement procedures apply to:

- Consolidated vendor warrants issued to cover more than one client's heat/electric vendored amount.
- Medical services warrants.

Determine the status of these warrants in Bridges.

The provider must complete the 1778 to initiate a stop payment and request a replacement warrant. Follow procedures in the Stop Payment and Replacement section of this item. Instead:

- Promptly send 2 copies to:

  Provider Management Payments Unit (PMPU)
  Financial Services, Accounting Division
  Grand Tower Building
  235 S. Grand Avenue, Suite 1004
  Lansing, MI 48909

- File a copy in the case record.

- Send a copy to the local fiscal office.
- Give a copy to the provider.

When the warrant replacement request is processed. The specialist receives an alert when the stop payment is completed. The specialist is then able to replace the warrant.

Before authorizing payment, verify that the provider information in Bridges is correct. If necessary, correct the information; see BAM 435, Provider Management.

If the stop payment cannot be effected because the warrant was cashed, follow procedures in 1354 Process section of this item.

Note: Forged warrants are replaced by the Payment Processing unit.

WARRANT STATUS

When a warrant is reported lost, stolen, not received or destroyed, check the Warrant Status to determine if a warrant was issued:

- If the warrant status shows returned, **do not** proceed with a stop payment.
- If the warrant status shows tax offset, **do not** proceed with a stop payment. This status indicates the warrant was pulled by Treasury; see Warrants Pulled By Treasury in this item.
- If the warrant status is paid, this indicates the warrant has been cashed.
  - If the payee still claims they did not receive and cash the warrant, proceed with the 1778 affidavit; see Stop Payment and Replacement in this item.
  - Once the Forgery Analysis has been requested, follow the 1354, Affidavit Claiming Forged Endorsements On A State Treasurer's Warrant Process in this item.
- If the warrant status was an Electronic Funds Transfer (EFT) and shows as paid, **do not** proceed with a stop payment. This indicates payment was made via an EFT. EFT payments are deposited electronically into an account at a financial institution designated by the provider. If the provider indicates that they did not receive this payment, they must resolve the matter with their financial institution.

Note: An EFT warrant shows in Bridges as a warrant number starting with 0.

- If the warrant status is EFT payment returned, this status indicates that an electronic funds transfer (EFT) was returned to Treasury and rewritten.
- If a warrant is issued and is still outstanding, see 1778 process in this item.

Warrants Pulled By Treasury

Treasury may pull a warrant in order to offset monies owed the state by the provider. Warrants pulled by Treasury will have a warrant status of tax offset in Bridges. Treasury notifies the provider in writing of the reason for this action. Providers who contact the local office regarding a warrant pulled by Treasury should be advised to refer to this letter and contact Treasury at 1-800-950-6227 if they have any questions.

Residual Warrant

If the amount of the warrant pulled was greater than the amount owed to the state, Treasury will issue a new warrant called a residual warrant for the remaining balance to the provider.

Rewrite Or Cancel Residual Warrant Returned To Local Office

Residual warrants do not appear in MDHHS systems. When one of these Treasury warrants needs to be rewritten, canceled or stop payment request initiated, do the following:

- The local fiscal office prepares the DHS-2362, Services Warrant Rewrite/Disposition Request and sends to the specialist.
- The specialist completes the DHS-2362 indicating if the residual warrant is to be rewritten or canceled. The DHS-2362 must be signed by the specialist and a manager and returned back to the local fiscal office to forward to the Payment Processing unit.
- Payment Processing will request that Treasury rewrite or cancel the residual warrant.

Rewrite Or Cancel Residual Warrant Returned To Treasury

To determine if a residual warrant was issued by Treasury, contact the Specialized Action Center at 1-800-444-5364. If issued, request the warrant number and verify if it has been returned.

If a residual warrant was not issued, inform the provider and end procedure.

If a residual warrant was issued and the provider did not receive the benefit, advise the provider to contact Treasury at 1-800-950-6227.

LEGAL BASE

FIP

Social Welfare Act, PA 280 of 1939, as amended
Uniformed Unclaimed Property Act, PA 29 of 1995, as amended
Mich Admin Code, R 400.3104

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

CDC

Child Care and Development Block Grant of 1990
45 CFR Parts 98 and 99
Social Security Act, P.A. 280 of 1939, as amended
Mich Admin Code, R 400.5001 - 400.5020

SSP

20 CFR 416
Social Security Act, §1616 [42 USC 1382e]

DEPARTMENT POLICY

MA only

Requesting a Replacement mihealth card

A new mihealth card may be issued if the client does not receive a card, or if the card is lost, stolen or damaged. The client must call the beneficiary helpline at 1-800-642-3195 to request a replacement card.The replacement card cannot be issued in the local DHS office. Michigan ENROLLS will verify if the addressin Bridges is correct. If the address is incorrect the client will be referred to the local DHS office for an address correction. A new card will not be issued until the address has been updated and the client contacts Michigan ENROLLS again.

Clients must be advised that if they find their original mihealth card after a replacement is received, the previous card must be destroyed.

LEGAL BASE

MA

MCL 400.60(2)

DEPARTMENT POLICY

Food Assistance recipients may be issued a replacement of food that has been destroyed in a domestic misfortune or disaster and reported timely. See BAM 401E for policy regarding replacement of Bridge cards.

Limits

There is **no** limit to the number of replacements for food purchased with food assistance benefits and destroyed in a domestic misfortune or disaster.

Client Responsibilities

Replacements and reauthorizations are processed **only** if the client reports the loss timely. Timely means within 10 days if the loss is due to misfortune or disaster. However, if day 10 falls on a weekend or holiday and it is reported on the next workday, it is still considered timely.

Denial of Replacements

If denying a replacement, send the client a DHS-176, Client Notice, within 10 days of the client's request.

Food Destroyed in a Domestic Misfortune or Disaster

Domestic misfortunes or disasters include events which occur through no fault of the client, such as fires, floods or electrical outages. Verify the circumstances through a collateral contact, a community agency, utility company or a home visit, and note it on the DHS-601, Food Replacement Affidavit.

Discuss with the client the amount of food lost as a result of the misfortune or disaster. Replace the amount the client states they have lost up to the value of the current month’s allotment. The food does **not** have to come from the current month, however the client must complete the DHS-601 describing the loss. Replacement cannot exceed the current month’s benefit.

When replacing food lost, use the **Request Cash/FAP/SSP Manual Issuance** screen in Bridges.

Note: If FNS has declared a disaster, the group may receive either disaster benefits or replacement of food, but **not** both.

EXHIBIT

Replacement Circumstances[a]	When Client Must Request	Limit on Replacements[b]	Specialist Time Period	Forms & Screens	Follow-Up
1. Food of current participant destroyed in a domestic misfortune or disaster.	Within 10 days of the misfortune or disaster. Or the next workday if day 10 falls on a weekend or holiday.	None. Disaster must be verified. Not to exceed eligible group's monthly allotment.	Within 10 days of the request, or within 2 working days of receipt of the signed DHS-601, whichever is later.	Request Cash/ FAP/ SSP Manual Issuance screen.	None. **Note:** Cannot receive both a replacement and FSN-declared disaster allotment.

a. If a circumstance does not fit those described on the chart a replacement is **not** allowed.
b. If a replacement is denied, the group must be informed via the DHS-176, Client Notice.

LEGAL BASE

FAP

7 CFR 274.6

7 CFR 274.12

DEPARTMENT POLICY

This item details procedures for handling FIP, RCA, SDA, State SSI Payment (SSP), CDC, SER, and Medical Services warrants and cash EBT benefits.

WARRANTS

FIP, RCA, SDA, and SSP

Returned and cancelled warrants can be rewritten.

Note: A regular assistance warrant payable to a **deceased** client may be rewritten **only if** the case remains active under another payee. A vendor warrant to a deceased provider (for example, landlord) can be rewritten to either the executor of the provider's estate or to the client.

In some circumstances, the client may not be eligible for the warrant to be rewritten. Initiate closure when any of the following occurs:

- The post office returned a warrant to Treasury as undeliverable.
- The warrant remains uncashed for over 30 days, and there has been no contact from the client.
- The client fails to contact you by the disposition deadline for a warrant returned or delivered to the local office.

Warrants Returned to Treasury

Warrants returned to Treasury are voided. If undeliverable, MDHHS central office will forward the envelope and enclosures and send to the local office for follow up.

Check the View Benefits in Bridges, when a payee requests replacement of a warrant not received, to determine if it was returned.

- Returned warrants are replaced, by using the Rewrite Warrants screen in Bridges; see REPLACING WARRANTS/BENEFITS in this item. File a copy in the case record.

- If the warrant was **not issued**, ask a local office designated staff to contact the Michigan Department of Technology, Management and Budget (DTMB) Help Desk (517-241-9700) to determine why the warrant was not issued.
- If the warrant was issued but **not** returned; see Warrant Not Received in BAM 500.

Warrants Returned to the Local Office

The local fiscal office processes returned warrants. Forward any warrants received to that office.

The local fiscal office notifies the specialist via a DHS-2362, State Treasurer's Warrant Rewrite/Disposition Request, of client and vendor warrants that are returned **or** delivered to the local office. The DHS-2362 authorizes warrant disposition.

Determine whether the warrant should be:

- Voided and returned to Treasury.
- Voided and rewritten.
- Mailed to the client.
- Picked up by the client at the local office.

Note: Representatives picking up a warrant for a client must have the client's signed statement of permission.

Complete the DHS-2362. If the warrant must be voided and rewritten, see below for the correct rewrite procedure. Return the completed DHS-2362 to the local office designee within **10** workdays.

REPLACING WARRANTS/ BENEFITS

Local Office Replacement

Authorize replacement of a warrant/benefit using the DHS-138 or Bridges.

A replacement warrant must be for the exact amount as the original warrant/benefit. The replacement warrant will reflect **current**

Bridges information. Update payee information, if necessary, before replacing the warrant or requesting warrant rewrite.

Note: A warrant returned to the local office must be voided and returned to Treasury by the local office designee **before** it is rewritten. Notify the local office designee of the disposition via DHS-2362. The specialist must wait until the warrant status shows returned before authorizing the rewrite via DHS-2362; see Warrant Returned to the Local Office in this item.

Clients can expect warrants/benefits replaced via Bridges to arrive at the current mailing address in 7-10 days after the replacement is authorized.

Replacing Expunged Benefits

Replace expunged benefits through the Re-Issue Expunged Benefits in Bridges.

Replacing Escheated Benefits

Escheated benefits are replaced by Treasury, **not** by MDHHS. Refer clients who request replacement of escheated benefits to Treasury's Unclaimed Property Division at (517) 636-5320 or online at Michigan's Money Quest under Unclaimed Property on the Michigan Department of Treasury Web site. Escheated benefits are identified in Bridges, Benefit Issuance as Tax Offset.

Inserts and Other Enclosures

When warrants are released or rewritten, be sure clients receive all enclosures (such as, informational inserts) included with the original warrant.

Closure After Uncashed/ Returned Warrant

When a warrant is uncashed for over 60 days, or was sent back to Treasury, the specialist receives the following:

- The envelope and enclosures. Notations on the envelope usually indicate why the warrant was undeliverable or otherwise returned.

- Report PH-280, Uncashed Client Warrants.

Initiate case closure within **two** workdays of receiving the above information if there has been no client contact. Update the case with unable to locate. If the envelope notations indicate ineligibility for **previous** warrants/benefits, begin the recoupment process. If the client contacts the specialist during the timely notice period, stop the case closure and replace the warrant/benefit if requested.

Exception: Do **not** initiate case closure if the warrant sent back to Treasury is an SSP or a vendor warrant. Contact the provider or client to determine the correct address.

Unclaimed Warrant Returned to the Local Office

Close the case when a warrant is returned to the local office and the client fails to contact the specialist by the warrant status due date.

PH-280 Processing

The PH-280 helps document case actions in response to uncashed, undeliverable and voided warrants. Note in the worker action column next to each:

- The date of the case action.
- The disposition of the uncashed warrant.
- Whether the warrant was replaced.
- If **not** replaced, the reason.

Upon receipt of the PH-280, forward the previous month's report to your manager.

MEDICAL SERVICE AND SER OR HEAT/ELECTRIC VENDOR WARRANTS

Special procedures apply when replacing medical service warrants, SER warrants or heat/electric vendor warrants authorized in Bridges.

The Provider Management Unit (PMU) in central office will notify the specialist by memo when a warrant has been returned to Treasury.

Before authorizing a replacement warrant, verify that the provider information in Bridges is correct. Correct the information, if necessary; see BAM 435, Provider Management.

To authorize a replacement warrant:

- Complete the requested information on the memo.
- File a copy in the case record.
- Return original memo with attachments back to PMU.

CHILD DEVELOPMENT AND CARE WARRANTS

A Child Development and Care (CDC) warrant returned to Treasury or the local office can be rewritten, cancelled or released, using a DHS-2362, Services Warrant Rewrite/Disposition Request.

When a warrant includes multiple clients, and multiple specialists, only one DHS-2362 will be issued. The specialist of the first case listed on the warrant is responsible to rewrite or cancel the warrant.

The specialist can only rewrite a CDC warrant to the original payee and for the original amount.

The specialist can rewrite warrants that have been returned to Treasury using the Rewrite Warrant screen.

Central office must rewrite the warrant if the rewrite amount is for less than the original warrant.

Rewrites for a higher amount are not allowed, the provider must rebill for the higher amount.

Rewrites to a different provider are not allowed. If payment was made to the wrong provider, follow the new provider assignment process.

Warrants Received by the Local Office

When a warrant is received in the local office, the local office designee completes the DHS-2362 retains the warrant and forwards the DHS-2362 to the specialist.

The specialist must determine within 10 working days if the warrant is to be rewritten, cancelled or released by completing the DHS-2362 indicating the appropriate action code.

The specialist retains a copy in the case file and forwards the completed DHS-2362 to the local office designee.

Warrants Undeliverable and Returned to Treasury

When a warrant is returned to Treasury, the warrant status on the View Benefits screen will be automatically updated indicating that the warrant has been returned.

A Task and Reminder is generated to the specialist and designated local office designee staff person. The local office designee forwards the DHS-2362 to the specialist.

Within 10 working days the specialist completes the DHS-2362 indicating if the warrant is to be rewritten or never replaced. See instructions for completing the DHS-2362 on the form.

A rewritten warrant will be issued with the next scheduled CDC payroll if entered by the corresponding CDC deadline date; see BEM 711, CDC Payment Schedule.

Note: An EFT payment that is rewritten will be re-issued as a paper warrant.

For a warrant to be rewritten for a lesser amount:

- Complete the DHS-2362 and obtain the manager's signature.
- File a copy of the DHS-2362 in the case record.
- Forward the original to the local office designee.

The local office designee will forward the DHS-2362 to the Reconciliation and Recoupment Section in central office for processing.

For a warrant that is **not to be** rewritten:

- Complete the DHS-2362.
- Forward the DHS-2362 to the local office designee.
- File a copy in the case record.

Note: The local office can rewrite a warrant cancelled in error.

Uncashed Warrants Over 180 Days Old

Warrants that remain uncashed after 180 days will have a warrant status of cancelled on the View Benefits screen. These warrants may be rewritten by the local office using the Rewrite Warrant screen in Bridges.

LEGAL BASE

FIP

Social Welfare Act, P.A. 280 of 1939, as amended
MCL 567.221 et seq.
Mich Admin Code, R 400.3103

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

CDC

Child Care and Development Block Grant of 1990
45 CFR Parts 98 and 99
Social Security Act, P.A. 280 of 1939, as amended
Mich Admin Code, R 400.5001 - 400.5020

SSP

20 CRF 416
Social Security Act, §1616 [42 USC 1382e]

DEPARTMENT POLICY

All Programs

Clients have the right to contest a department decision affecting eligibility or benefit levels whenever they believe the decision is incorrect. The department provides an administrative hearing to review the decision and determine its appropriateness in accordance to policy. This item includes procedures to meet the minimum requirements for a fair hearing.

Efforts to clarify and resolve the client's concerns must start when the hearing request is received and continue through the day of the hearing.

NOTICE REQUIREMENTS

All Programs

The application forms and each written notice of case action must inform clients of their right to a hearing. These include an explanation of how and where to file a hearing request, and the right to be assisted by and represented by anyone the client chooses.

The client must receive a written notice of all case actions affecting eligibility or amount of benefits. When a case action is completed it must specify:

- The action being taken by the department.
- The reason(s) for the action.
- The **specific manual item(s)** that cites the legal base for an action, or the regulation, or law itself; see Bridges Administrative Manual (BAM) 220.

Exception: **Do not** provide a notice of case action when implementing a hearing decision or policy hearing authority decision. The decision serves as notice of the action.

Medicaid (MA) Only

A client and the client's community spouse are each entitled to an explanation of specific factors in the determination. Follow instructions in Bridges Eligibility Manual (BEM) 402.

HEARING REQUESTS

All Programs

All clients have the right to request a hearing. The following people have authority to exercise this right by signing a hearing request:

- An adult member of the eligible group; **or**
- The client's authorized hearing representative (AHR).

Requests for a hearing must be made in writing and signed by one of the persons listed above. The request must bear a signature. Faxes or photocopies of signatures are acceptable. Michigan Administrative Hearings System (MAHS) will deny requests signed by unauthorized persons and requests without signatures.

Exception: For Food Assistance Program (**FAP) only**, a hearing request may be written or oral. If oral, complete the DHS-18, Request for Hearing, note on the DHS-18 the request was oral. Also note on the hearing summary that the request was oral.

A hearing request with a client signature may name an AHR who is authorized to stand in for or represent the client in the rest of the hearing process.

Dissatisfaction with a department action may be expressed, orally or in writing, without specifically requesting a hearing. Determine whether there is actually a desire to request a hearing. If so, ensure that the request is put in writing. The DHS-18, Request for Hearing, available from MDHHS, may be used. Note the date of receipt of the original written request on the form/notice.

All hearing requests **must** be recorded in Bridges, on the Hearing Restore Benefits screen; see Timely Hearing Requests in this item.

Requests Signed by an AHR

All Programs

The appointment of an AHR must be made in writing. An AHR must be authorized or have made application through probate court **before** signing a hearing request for the client.

Verify the AHR's prior authorization unless the AHR is the client's attorney at law, parent or, for **MA only**, spouse. Relationship of the

parent or spouse must be verified only when it is questionable. MAHS will deny a hearing request when the required verification is **not** submitted; see local office and MAHS Time Limits in this item.

The following documents are acceptable verification sources:

- Probate court order or court-issued letters of authority naming the person as guardian or conservator.
- Probate court documentation verifying the person has applied for guardian or conservatorship.
- Authorization signed by the client authorizing this person to represent the client in the hearing process.
- Birth or marriage certificate naming the person as parent or spouse or adult child.

Note any known information about the identity of the person who signed the request (for example, a spouse) on the DHS-3050, Hearing Summary. Attach a copy of any required verification document to the DHS-3050 and forward to MAHS.

Process requests signed by someone whose AHR status is questionable or unverified according to standard hearings procedures, including restoration of benefits, if appropriate. If MAHS denies the request, reimplement the disputed case action and recoup the restored benefits; see Recouping Program Benefits in this item.

When the AHR is an Attorney

All Programs

Within 24 hours of the department receiving notice that a client will be represented by an attorney, a DHS-1216AP, Request for Attorney General Representation, **must** be completed. Requests are to be emailed to the Office Legal Services and Policy (OLSP) at DHS-AGrepresentation-AP@michigan.gov. Once received by the OLSP, the request will be reviewed for appropriateness and completeness, and if approved, OLSP will forward the DHS-1216AP to the Office of the Attorney General to be assigned.

The Attorney General's Office requires a two-week notice prior to the date of the hearing. If there is less than two weeks' notice, a request for adjournment should be made to MAHS for the

purpose of arranging legal representation; see Request for Adjournment in this item. **A hearing date does not have to be received for the request for representation to be made.**

Adjournment is putting off of a scheduled administrative hearing until a later date.

Once an Assistant Attorney General (AAG) is assigned to a case, the department should direct all routine communications to that AAG, not to MAHS. This directive does not pertain to communications that can only be addressed by MAHS. (For example, dismissal of a case when a client requests to withdraw a request subsequent to the meaningful prehearing conference.)

Note: In those cases where it is determined by the department that Attorney General representation would be beneficial (for example: a complex issue in dispute; client representation by a third party organization, etc.), the department **may** request Attorney General representation by following the process above.

Department Requests

All Programs

The department may request a hearing to:

- Establish an intentional program violation and disqualification; see BAM 720, IPV Hearing.
- Establish a collectable debt on closed cases; see BAM 725, Debt Collection Hearing.

Usually Office of Inspector General (OIG), the recoupment specialist or designated staff person makes these requests.

Granting a Hearing

All Programs

MAHS may grant a hearing about any of the following:

- Denial of an application and/or supplemental payments.
- Reduction in the amount of program benefits or service.
- Suspension or termination of program benefits or service.
- Restrictions under which benefits or services are provided.
- Delay of any action beyond standards of promptness.

- For **FAP only**, the current level of benefits or denial of expedited service.

MA Only

MAHS may grant a hearing about any of the following:

- Community spouse income allowance.
- Community spouse's income considered in determining the income allowance.
- Initial asset assessment (but only if an application for MA has actually been filed for the client).
- Determination of the couple's countable assets or protected spousal amount.
- Community spouse resource allowance.

Where to File a Hearing Request

All Programs

Instruct clients or AHR's to deliver, mail, or fax the hearing request to their local MDHHS office labeled, ATTENTION HEARINGS COORDINATOR. The hearings coordinator receives the request on behalf of the department. Route all hearings-related material through the coordinator without regard to whom it is addressed.

All hearings requests received must be date-stamped and forwarded immediately to the hearings coordinator. If the hearing request is received by a local office that is not responsible for the disputed action, date-stamp the request and forward it immediately to the correct local office labeled, ATTENTION HEARINGS COORDINATOR.

Exception: For hearing requests about Medical Services Administration (MSA) determinations, follow procedures in MSA HEARINGS in this item. The administrative tribunal ensures that the request is properly processed.

Deadlines for Requesting a Hearing

All Programs

The client or AHR has 90 calendar days from the date of the written notice of case action to request a hearing. The request must be received in the local office within the 90 days; see Where to File a Hearing Request, found in this item.

Note: Unless otherwise stated elsewhere, computation of time for the purposes of administrative hearings is determined as follows:

- Time is measured in calendar days.
- The computation of time begins on the day after the act, event, or action occurs. (The day on which the act, event, or action occurred is **not** included.)
- The last day of the time period is included, unless it is a Saturday, Sunday, State of Michigan holiday, or day on which the State of Michigan offices are closed. (In such instances, the last day of the time period is the next business day.)
- The last day of the time period runs through the normal close of business.

Example: A notice of case action is issued on August 1st. Under BAM 600, the client has 90 days to request an administrative hearing. In computing this time period, August 1st, the date on which the action was taken, is not counted. The client must file a request for hearing by the close of business on October 30th (unless that day is a weekend, holiday, or non-working day, in which case the request must be filed by the close of the next business day.)

Exception: For **FAP only**, the client or AHR may request a hearing disputing the current level of benefits at any time within the benefit period.

See Timely Hearing Request in this item if a request is received:

- Within the pended negative action period.
- Within 11 days of the effective date of an immediate negative action (such as with adequate notice).

For requests that do **not** meet the definition of a timely hearing request; see Untimely Hearing Request in this item.

Denial of a Hearing Request

All Programs

For hearing requests about MSA determinations; see MSA HEARINGS in this item.

For all inappropriate requests and/or requests filed more than 90 days from the date of the notice of case action, do the following:

- Complete a DHS-3050, Hearing Summary, stating either of the following:
  - State with some specificity why the request should not be heard.
  - The request was received after 90 days from the date of the notice of case action (attach a copy of the notice).
- If there is no resolution at the meaningful prehearing conference, send by US postal mail or ID mail the hearing request and summary to MAHS.

MAHS will inform the client (referred to by administrative hearings as the claimant), the AHR and the hearings coordinator if the request is denied.

MAHS will **not** grant a hearing regarding the issue of a mass update required by state or federal law **unless** the reason for the request is an issue of incorrect computation of program benefits or patient-pay amount. Central office may issue separate instructions regarding deletion of pending negative actions and forwarding of hearing requests to MAHS for disposition.

Supplemental Security Income (SSI)-Related MA Only

MDHHS **cannot** conduct hearings regarding the issue of disability/blindness when the Social Security Administration (SSA) made the determination and that determination is the only issue. These appeals must be filed at SSA. If the request includes other issues that MDHHS must hear, do the following:

- Refer the client to SSA to appeal the SSA disability/blindness determination.
- For all remaining issues, follow standard procedures outlined in this item. Document the referral to SSA on the hearing summary.

STANDARDS OF PROMPTNESS

All Programs

Final action on hearing requests, including implementation of the decision and order (D&O), must be completed within 90 days. The standard of promptness begins on the date the hearing request was first received by any local MDHHS office or MDHHS central office.

For **FAP only**, final action on hearing requests involving only FAP or FAP and any other program (for example, State Disability Assistance (SDA), MA, Child Development and Care (CDC) must be completed within 60 calendar days of receipt of the written or oral request.

Exception: When a hearing request is for Family Independence Program (FIP) and FAP ONLY, the FIP timeliness standard of 90 days may be applied.

Local Office Time Limits

All Programs

Local offices have **21** days from receipt of a hearing request to do all of the following:

- Log the request.
- Obtain and submit to MAHS verification of the AHR's prior authorization, if needed.
- Contact partners 24 hours within receiving DHS-18.
- Schedule a meaningful in-person prehearing conference with a first-line supervisor no later than the 11th calendar day from the receipt of the request for hearing. Include all appropriate staff and partners. (for example, first-line supervisor, Office of Child Support (OCS) or prosecuting attorney's office (PA),

Office of Quality Assurance (OQA) auditors, Partnership. Accountability. Training. Hope. (PATH) representative, Family Independence Specialist/Eligibility Specialist (FIS/ES) or OIG).

Note: When the 11th day falls on a non-workday, the prehearing conference must be scheduled by the next work day. Do not schedule a meaningful prehearing conference for Disability Determination Service (DDS) disputes.

- Determine the nature of the complaint.
- If the issue(s) raised in the request for hearing is not resolved at the meaningful prehearing conference, ID mail or send by US postal mail all of the following to MAHS:
  - DHS-18, Request for Hearing.
  - Any required verification of authority to represent.
  - DHS-3050, Hearing Summary, to include, but not limited to the following:
    - Clear, concise statement of the case action(s) taken, including all programs involved in the case.
    - Chronological summary of events, containing facts that led to the action(s) taken.
    - Identification of any verifications supporting the action(s) taken.
    - Citation of policy that supports the action(s) taken.
    - Correct address of the client and the AHR.
  - Complete hearing packet to include, but not limited to, the following:
    - DHS-1605, Notice of Case Action.
    - A narrative of the meaningful prehearing conference offer and outcome and the DHS-1560, Notice of Prehearing Conference.
    - A copy of all documents the Department intends to offer as exhibits at the hearing.

- Numbering of the hearing packet in the lower right corner of each page.

Note: MAHS must receive the hearing summary and hearing packet by the 21st day.

For hearing requests disputing:

- Determinations made by the DDS.
- Determinations made by MSA; see MSA HEARINGS in this item.
- Determinations made by the OCS or a (PA) office, a copy of the request for hearing **must** be faxed to the office that initiated the adverse action within 24 hours of receipt. The fax cover sheet **must** include:
  - Title "Administrative Hearing-Time Sensitive."
  - Contact information for the hearing coordinator, MDHHS specialist and the Family Independence Manager (FIM)/Assistance Payments (AP) Supervisor.
  - Date and time of the prehearing conference.

The local office has **10** days from the date the decision was mailed from MAHS to complete the DHS-1843, Administrative Hearing Order Certification, which certifies compliance.

MAHS Time Limits

MAHS has 59 days to schedule and conduct a hearing, render a decision and mail it to the local office, the client and the AHR.

Exception #1: For **MA** community spouse resource allowance requests **only,** MAHS has 15 days to schedule and conduct a hearing and 50 days to render and mail a decision.

Exception #2: For **FAP only**, MAHS has 29 days to schedule and conduct a hearing, render a decision and mail it.

Local Controls

All Programs

A DHS-1940, Hearing Request Record, or its equivalent must be maintained by the hearings coordinator. The coordinator is

responsible for tracking the progress of the hearing request from receipt through disposition.

Note: A copy of the Hearing Request Record must be made available to the Business Service Centers or central office upon request.

Expedited Hearings

All Programs

Request an expedited hearing when unusual circumstances exist. A local office supervisor or hearings coordinator may request an expedited hearing by calling the MAHS director or designee.

Do all of the following within **two** workdays of receiving the hearing request:

- Complete the DHS-3050. Include an explanation about why an expedited hearing is needed; see Hearing Summary in this item.
- Write “Expedited Hearing” at the top of the hearing request.
- Forward the hearing request and the summary to MAHS.

Note: The hearing itself is conducted in the same manner as any other hearing.

FAP Only

Request an expedited hearing if a migrant group plans to leave the state within 60 days.

Requests for Adjournment

All Programs

The client, AHR, or local office may request an adjournment of a scheduled hearing. Instruct the client or AHR to call MAHS to request an adjournment. All requests for adjournment should be in writing to MAHS and must include a specific reason for the request unless exception #1 or #2 below applies. **Only** MAHS can grant or deny an adjournment. MAHS will notify the hearings coordinator **if** the adjournment is granted. When the hearing is rescheduled, a

new notice of hearing is mailed to everyone who received the original notice.

If the adjournment is granted at the request of the client or AHR, the standard of promptness is extended for as many days as the hearing is adjourned. However, adjournment of a telephone hearing to schedule an in-person hearing does **not** extend the standard of promptness.

Adjournments requested by the local office and MAHS initiated adjournments do **not** extend the standard of promptness.

Exception #1: For **FAP only**, MAHS **must** grant one adjournment of a scheduled hearing requested by the client or AHR. It **cannot** exceed 30 days unless good cause is shown.

Exception #2: For **FAP-intentional program violation only**, MAHS **must** grant an adjournment of a scheduled hearing **if** the client or AHR makes the request at least 10 days in advance of the hearing. It **cannot** exceed 30 days and MAHS may limit the number of adjournments to one.

COMMUNITY ACTION AGENCY (CAA) AND LIMITED PURPOSE AGENCY (LPA) HEARINGS

CAAs LPAs Only

Community Action Agency (CAA) and Limited Purpose Agency (LPA) administer several programs that are funded through MDHHS. These programs vary depending on locality and funding availability, but generally include weatherization assistance, emergency assistance and programs that promote self-sufficiency.

All CAAs and LPAs have internal appeals processes for clients who receive their services.

If the CAA/LPA internal appeals process has been exhausted and fails to resolve the issue, and the program is a MDHHS-funded program, either the client or the CAA/LPA will forward a hearing request to the MDHHS Bureau of Community Action and Economic Opportunity.

The bureau will review the hearing request, complete a DHS-3050, Hearing Summary, and forward the request to administrative hearings.

Administrative hearings will handle the hearing request according to current procedures.

Role of MDHHS Local Office Staff-CAA and LPA Hearings Only

When the local MDHHS office receives a hearing request disputing services received by a CAA or LPA, the local hearings coordinator does the following:

- Faxes a copy of the hearing request to MDHHS Bureau of Community Action and Economic Opportunity:

  Fax: (517) 335-5042
  Phone: (517) 373-3550

  Be sure that the fax clearly identifies that it is a CAA or LPA hearing request.

- Sends the original hearing request and any supporting materials within three workdays to:

  MDHHS Bureau of Community Action and Economic Opportunity
  235 S. Grand Ave. Ste. 204
  PO Box 30037
  Lansing, MI 48909

The MDHHS Bureau of Community Action and Economic Opportunity will communicate the hearing decisions to the CAA/LPA.

MSA HEARINGS

MA Only

Michigan Administrative Hearings System for the Department of Community Health (MAHS) conducts administrative hearings regarding MSA determinations; see MSA Determinations in this item. The tribunal also conducts hearings regarding the following MSA determinations:

- Medical transportation.
- Level of payment for home help services.
- Denial or reduction of specific home help services related to activities of daily living.

The administrative tribunal has the same authorities and responsibilities MAHS has for MDHHS hearings. These include:

- Granting/denying a hearing request.
- Scheduling/rescheduling the hearing.
- Notifying all parties of the time/place of the hearing.
- Processing requests for in-person hearings.
- Granting/denying requests for adjournments.
- Issuing administrative subpoenas.
- Reimbursing clients for hearings-related expenses.
- Holding the hearing.
- Issuing a decision and order.
- Granting/denying a rehearing/reconsideration request.

MSA Determinations

MA Only

MSA determinations include all of the following:

- Denial of prior authorization.
- Denial of payment for a service, appliance or prosthesis.
- Restricted utilization of the client's mihealth card.
- Determination of level of care (long-term care or MIChoice waiver).
- Enrollment in managed care, including requests for exemption.
- Denial of CHILD's waiver services.
- Reduction of services.
- Authorization of MA for a newborn under BEM 145.

Role of MDHHS Staff

MA Only

When the local MDHHS office receives a hearing request disputing a MSA determination, the local office hearings coordinator does all of the following:

- Logs the hearing request.
- Faxes a copy of the hearing request to the MSA hearings coordinator at (517) 373-4147.
- Sends the original hearing request within three workdays to:

  Department of Health and Human Services
  Administrative Tribunal
  PO Box 30763
  Lansing, MI 48909

MDHHS local office staff will do all of the following:

- Provide a room for the hearing.
- Telephone the administrative tribunal at (877) 833-0870 to begin a telephone hearing.

Exception: See BAM 825 for MDHHS and Medical Services Administration (MSA) responsibilities when MDHHS receives a hearing request on medical transportation.

Role of MDCH Staff

MA Only

MSA policy staff have responsibility to do all of the following:

- Arrange the prehearing conference.
- Complete the hearing summary.
- Notify the client/representative, administrative tribunal, other MSA staff and local MDHHS if all issues raised in a hearing request are resolved prior to the hearing.
- Represent MSA at the hearing.

- Implement D&O of the administrative tribunal and notify the client/representative, other MSA staff and local MDHHS within prescribed time frames.

Michigan Administrative Hearings System for the Department of Health and Human Services (MAHS) staff have responsibility to do all of the following:

- Notify the client/representative, other MSA staff and local MDHHS when a hearing is scheduled.
- Send the decision and order to the client/representative, other MSA staff and local MDHHS.

LOCAL OFFICE REVIEW

All Programs

Resolve disagreements and misunderstandings quickly at the lowest possible level to avoid unnecessary hearings.

On receipt of a hearing request, the hearings coordinator must schedule a meaningful in-person prehearing conference with the client and AHR and a first-line supervisor no later than the 11th calendar day from the receipt of the request for hearing. When the 11th day falls on a non-workday, the prehearing conference must be scheduled by the next work day.

The client or AHR is **not** required to phone or meet with any department staff in order to have a hearing.

Exception: For DDS **disputes**, do **not** schedule a prehearing conference unless the client or AHR requests one.

Supervisory Review

All Programs

Upon receipt of the hearing request from the hearings coordinator, the first-line supervisor:

- Reviews the disputed case action for accuracy according to policy and fact; see Corrected Case Action in this item.

- Determines if the request is timely; see INTERIM PROGRAM BENEFITS PENDING THE HEARING in this item.

Meaningful Prehearing Conference

All Programs

The department must assure that clients receive the services and assistance for which they are eligible. Concerns expressed in the hearing request should be resolved whenever possible through a conference with the client or AHR rather than through a hearing.

The spokesperson for the local office at the prehearing conference may be anyone from the county director to a first-line supervisor. Whoever is assigned this function, however, acts on behalf of the county director or district manager.

A DHS-1560, Prehearing Conference Notice, **must** be generated and mailed to the client and AHR upon receipt of a hearing request, unless the issue in dispute pertains solely to a DDS decision.

A meaningful prehearing conference must be scheduled no later than the 11th day from the date MDHHS receives the request for hearing, unless the client and AHR chooses not to attend the prehearing conference.

Note: When the 11th day falls on a non-workday, the prehearing conference must be scheduled by the next work day.

All appropriate staff and partners (for example, first-line supervisor, support specialist (SS) or PA, PATH representative, FIS/ES or OIG) **must** participate in the prehearing conference.

Exception #1: When the disputed case action involves a MDCH determination, MDCH staff **must** participate in the prehearing conference.

Exception #2: When a meaningful prehearing conference is requested on a DDS dispute, the medical consultant does **not** participate in the conference.

A meaningful prehearing conference includes **at a minimum**, performing **all** of the following:

- Determine why the client or AHR is disputing the MDHHS action.
- Review any documentation the client or AHR has to support his/her allegation.
- Explain the department's position and identify and discuss the differences.

If the dispute cannot be resolved, do all of the following:

- Provide the client and AHR a copy of the DHS-3050, Hearing Summary, and all evidence the department used in making the determination that is in dispute. Complete the DHS-1520, Proof of Service.
- Mention to clients the availability of reimbursement for child care or transportation costs incurred in order to attend the hearing; see Reimbursement for Transportation and Child Care in this item.

State-funded Family Independence Program (FIP) and SDA Only

Contact the local office Interim Assistance Reimbursement (IAR) liaison when the disputed action involves computation by central office payment reconciliation staff of the amount of retroactive SSI benefits recovered from a state-funded FIP or an SDA recipient who signed a repay agreement (Interim Assistance Recovery). The liaison **must**:

- Obtain documentation supporting the calculations from payment reconciliation staff; **and**
- Arrange for payment reconciliation staff to participate in the prehearing conference.

FAP Only

For a denial of **expedited service only**, inform clients or authorized representatives that they may request a prehearing conference if they do **not** agree with the MDHHS decision. The conference must be held within **two** workdays of the expedited request, **unless** the client requests that it be scheduled later. The following persons must attend the conference:

- Specialist's supervisor and/or the local office director or designee.
- Client, authorized representative or AHR.

The specialist is **not** required to attend but may attend at local office option.

Corrected Case Action

All Programs

If the local office determines that the case action needs correction, do the following:

- Update Bridges with the corrected information, including corrected Circumstance Start Change Date (CSCD) dates. Any benefits owed will be issued when Eligibility Determination and Benefit Calculation (EDBC) and certification is completed. This will result in a new Notice of Case Action being generated to the client. Ensure notices are provided to the AHR.
- For **Interim Assistance Recovery disputes**, central office payment reconciliation staff will process corrective payments.
- For **state SSI payments,** central office SSI Payments Unit staff will process corrective payments.
- If the action taken does not resolve the issue include a short summary of the actions the local office took to correct all of the client's concerns on the DHS-3050, Hearing Summary. Include a copy of the Notice of the Meaningful Prehearing Conference.
- At the meaningful prehearing conference, explain the action taken and provide the AHR and the client a copy of the new notice of case action. Be sure to obtain a signature on the DHS-18M.

  Note: Once MAHS receives a request for hearing, a hearing will be scheduled unless the client or AHR signs a written withdrawal (DHS-18A); see Withdrawals Not In-Person in this item.

MA Only

If a MDHHS denial is overturned on appeal by MDHHS, an Administrative Law Judge (ALJ) or a court, send or give the client a DHS-334, Reimbursement Notice.

Hearing Summary

All Programs

Complete a DHS-3050, Hearing Summary, prior to the meaningful prehearing conference. In the event additional space is required to complete the DHS-3050, Hearing Summary, attach a Word document to the DHS-3050 and number the Word document accordingly. All case identifiers and notations on case status must be complete.

The hearing summary must include all of the following:

- A clear statement of the case action, in chronological order, including all programs involved in the case action.
- Facts which led to the action.
- Policy which supported the action.
- Correct address of the client and the AHR.
- Description of the documents the local office intends to offer as exhibits at the hearing.

Number the document copies consecutively in the lower right corner; begin numbering with the hearing summary.

Exception #1: For hearing requests disputing state SSI payments, see STATE SSI PAYMENT in this item.

Exception #2: For hearing requests disputing MDCH determinations, see MDCH HEARINGS in this item.

Exception #3: For DDS ***disputes do all of the following:***

- Complete all identifying information at the top of the DHS-3050.
- Write a brief description of the case action, including all programs involved in the case action.
- Explain the status of any SSI application.

- Conclude with the statement "See attached medical packet."

Number the document copies in the medical packet consecutively in the lower right corner, attach them to the hearing summary and forward to the hearings coordinator.

Exception #4: **For hearing requests disputing OCS/PA actions:**

Attach a supplemental hearing summary completed by OCS/PA detailing actions taken and all evidence provided by the OCS/PA.

State-funded FIP and SDA Only

For **Interim Assistance Recovery (IAR) disputes**, prepare the hearing summary using documents obtained by the local IAR liaison from central office payment reconciliation staff. Attach copies of those and any other supporting documents to the hearing summary and forward to the hearings coordinator.

MA Only

When a hearing request based on a Medicaid denial is received, send or give the client a DHS-333, Retroactive Period/Corrective Action Eligibility Notice. This notice explains the potential for reimbursement of paid medical expenses after a MDHHS denial that is overturned on appeal by MDHHS, an ALJ or a court. To be eligible for reimbursement, the payment must be for a Medicaid-covered care or service that is provided on or after February 2, 2004. If the client is to be notified of an overturned Medicaid eligibility decision, send or give the client a DHS-334, Reimbursement Notice.

A client may be eligible for reimbursement of medical expenses paid to providers for a retroactive eligibility period Medicaid-covered care or service. A medical payment for care or services received in a client's retroactive period may be reimbursable if it is made between a MDHHS denial and 10 days after the date an eligibility determination is issued as a result of the hearing request.

A client may also be eligible for corrective action reimbursement of medical expenses paid to providers for care or services received after the MDHHS application. The corrective action period covers medical expenses paid to providers between the date a MDHHS administrative hearing request is filed and 10 days after the date an eligibility determination is issued as a result of the hearing request. The client must show that the original denial was incorrect for corrective action reimbursements.

Example: A client submits his income and expense information but forgets to include proof of health insurance premiums or child support payments and is denied due to excess income. If the client appeals the MDHHS denial and provides the missing information, this could allow the initial denial, correct when issued, to be overturned. If the care or service for which the client made the medical payment was received after the client's application that resulted in the MDHHS denial, the payment would not be eligible for reimbursement.

Example:

- 2/20/06 application for Medicaid and retroactive Medicaid is received by MDHHS.
- 4/5/06 the application is denied.
- 5/3/06 a hearing request is received in the local MDHHS office.
- 6/7/06 the ALJ overturns the denial and determines the client is eligible for Medicaid.
- 6/14/06 the specialist processes the Medicaid opening.

If the medical payment was for care or services received in the retroactive period, the client is eligible for reimbursement for payments between 4/5/06 (the original denial date) and 6/24/06 (10 days after the second eligibility notice is mailed).

If the medical payment was for care or services after the retroactive period, the corrective action period covers payments made between 5/3/06, (the date the hearing request was received by MDHHS) and 6/24/06, (10 days after the second eligibility notice was mailed).

Hearing Packet

All Programs

A copy of the hearings packet must be ID mailed or sent by US postal mail to:

1. The client, if not presented at the prehearing conference.
2. AHR, if not presented at the prehearing conference.
3. MAHS.

Administrative Review

All Programs

The second-line manager or designee must review all hearing requests which are **not** resolved by the first-line supervisor. The purpose of the review is to assure that local office staff has done the following:

- Applied MDHHS policies and procedures correctly.
- Explained MDHHS policies and procedures to the client and AHR.
- Explored alternatives.
- Offered appropriate referrals to the client.
- Considered requesting a central office policy clarification or policy exception, if appropriate.

By signing box 4 on the DHS-3050, Hearing Summary, the second-line manager must certify:

- The date the DHS-1560, Notice of Prehearing Conference, was sent to the client and AHR, if any.
- The reason the hearing request could not be resolved.
- That eligibility was properly determined for this case.
- That the hearing request cannot be resolved, except through a formal hearing and the reason(s) why.

The managerial certification does not replace the hearing process. The hearing must be held as scheduled unless the hearing request is withdrawn using a DHS-18A, Hearing Request Withdrawal.

The second line manager or designee must evaluate the advisability of a hearing in relation to such factors as intent of policy, type of issue(s) raised, strength of the department's case, and administrative alternative.

MA Only

If, before a pending hearing, the local office overturns a Medicaid denial, see Implementing the Decision and Order in this item.

CONTINUATION OF PROGRAM BENEFITS PENDING `ADMINISTRATIVE HEARING

Denial at Application

All Programs

The client is **not** entitled to benefits pending the hearing when the reason for the hearing request is a denial at application or, for **FAP only**, a denial at redetermination. For **FAP only**, when the hearing request disputes a denial of expedited service, continue to process the application according to normal processing standards.

Timely Hearing Request

All Programs

A **timely hearing request** is a request received by the department within 10 days of the date the notice of case action was issued. When the 10th calendar day is a Saturday, Sunday, holiday, or other non-workday, the request is timely if received by the following workday.

While waiting for the hearing decision, recipients must continue to receive the assistance authorized prior to the notice of negative action when the request was filed timely. Upon receipt of a timely hearing request, reinstate program benefits to the former level for a hearing request filed because of a negative action.

For **FAP only**, these actions apply **only** if the benefit period has **not** expired.

Exception #1: For **all programs**, do **not** restore benefits reduced or terminated due to a mass update required by state or federal law **unless** the issue contested is that the benefits were improperly computed.

Exception #2: For **all programs**, do **not** restore program benefits when the client or AHR specifically states in writing that continued assistance pending the hearing decision is **not** requested.

Exception #3: For **FAP only**, if a client or AHR disputes the computation of supplemental benefits, issue the supplement as originally computed.

Untimely Hearing Request

All Programs

If a client or AHR files an untimely hearing request, program benefits continue at the current level.

Exception: For **FAP only**, benefits must be restored to the former level **if**:

- The delay in filing the request was for good cause (for example, client hospitalized); **or**
- The change was the result of a mass update **and** the issue being contested is that FAP eligibility or benefits were improperly computed **or** that federal law/regulation is being misapplied/misinterpreted.

SSI Disability/ Blindness Denials

SSI-Related MA Only

MA negative actions based on SSI disability/blindness denials **cannot** be deleted if MAHS schedules a hearing regarding other issues raised in the hearing request.

However, if a hearing request is filed at SSA regarding the disability/blindness issue within the pended negative action period, follow the instructions in this item under Timely Hearing Request.

MDHHS can **never** delete the negative action if the SSI disability/blindness denial is final as defined in BEM 260.

When Changes Occur Pending the Hearing

All Programs

Pending the hearing decision, restored benefits must **not** be reduced or terminated **unless**:

- A change **not** related to the hearing issue occurs that affects the recipient's eligibility or benefits; **and**
- The recipient or AHR fails to request a hearing about the change after the subsequent notice of negative action.

Note: For FIP only, the client must continue participation with the Partnership. Accountability. Training. Hope. (PATH) program unless the hearing request was the result of non-cooperation.

FAP Only

Pending the hearing decision, restored benefits must **not** be reduced or terminated **unless**:

- The benefit period expires.

  Note: The client may reapply and be determined eligible for a new benefit period and amount based on a new application.

Recouping Program Benefits

All Programs

If a hearing request is filed timely and program benefits are restored, recoup overissuances if:

- The request is later withdrawn.
- MAHS denies the request.
- The client or AHR fails to appear for the hearing **and** MAHS issues an order of dismissal.
- The hearing decision upholds the department's action.

Calculate the overissuance from the date the negative action would have taken effect until the date the negative action is subsequently implemented.

If an administrative recoupment is processed to recover an overissuance due to a hearing, send a timely notice of case action. In this situation, the client is entitled to a hearing solely on the issue of the recoupment amount.

If a **cash** repayment is sought to recover an overissuance, requests for a hearing will **not** be granted **except** in FAP cases. Complete a

DHS-3050 describing the current facts. Forward the hearing request and the summary to MAHS. MAHS will inform the client and AHR that a hearing will **not** be granted.

WITHDRAWALS

All Programs

When any issue is still in dispute, do **not**:

- Suggest that the client or AHR withdraw the request; **or**
- Mail a withdrawal form to the client or AHR unless it is requested.

When correcting a case action, follow procedures in the Corrected Case Action section of this item. Do **not** ask for a withdrawal based on an action that will be taken in the future; MAHS cannot grant a withdrawal based on an action that has not been completed.

If the client has an AHR, the AHR must sign the withdrawal request. The client may not withdraw the hearing request without first providing the department with a written, signed notice stating they wish to revoke the AHR's authorization to represent the client. The authorization to represent must be revoked by the client before the client signs the hearing request withdrawal.

Withdrawals Requested In-Person at the Meaningful Prehearing Conference

All Programs

At any time during a meaningful prehearing conference the client or AHR may choose to withdraw his/her request for hearing. If the client has an AHR, the AHR must sign the withdrawal request. The client may not withdraw the hearing request without first providing the department with a written, signed and dated notice stating they wish to revoke the AHR's authorization to represent the client. The authorization to represent must be revoked by the client before the client signs the hearing request withdrawal. When such a request is made, complete a DHS-18M, Hearing Request Withdrawal In-Person**,** form.

The DHS-18M, Hearing Request Withdrawal In-Person, form is **only** used when the client or AHR **attends the meaningful prehearing conference in-person** and chooses to withdraw his/her request for hearing **while at the local MDDHS office.**

This form should never be mailed or given to a client to mail back to MDHHS. Do not send the signed DHS-18M form to MAHS.

Once the form has been completed:

- Provide a copy to the client and AHR.
- Keep the original in the case record in the hearings packet.
- Dispose of the request in Bridges.
- Notify the hearings coordinator to dispose of the request on the hearings log.
- Notify any MDHHS partners of the withdrawal and disposition.
- Close out the request for hearing in this matter, and take no further action.

Withdrawals Not In-Person

All Programs

When the client or AHR requests a hearing request withdrawal form outside of the Meaningful Prehearing Conference setting, the DHS-18A, Hearing Request Withdrawal, **must** be used. If the client has an AHR, the AHR must sign the withdrawal request. The client may not withdraw the hearing request without first providing the department with a written, signed and dated notice stating they wish to revoke the AHR's authorization to represent the client. The authorization to represent must be revoked by the client before the client signs the hearing request withdrawal.

DHS-18A, Hearing Request Withdrawal, forms received by MDHHS **must** be faxed to the Michigan Administrative Hearing System (MAHS) for disposition at (517) 335-6088.

1. Withdrawal requests received **prior to** submitting the DHS-3050, Hearing Summary, and hearing packet to MAHS, ID mail or send by US postal mail all of the following to MAHS:

- DHS-1605, Notice of Case Action.
- DHS-18, Request for Hearing (or equivalent).
- Signed DHS-18A, Hearing Request Withdrawal.

2. Withdrawal requests received **after** submitting the DHS-3050, Hearing Summary, and hearing packet to MAHS, ID mail send by US postal mail all of the following to MAHS:

   - Signed DHS-18A, Hearing Request Withdrawal.
   - Copy of the DHS-3050, Hearing Summary, previously submitted. (A copy of the DHS-3050 will allow MAHS to match the withdrawal with the correct request for hearing.)

3. Withdrawal requests received from client by telephone. Ask the caller to promptly mail or drop off a signed written request for withdrawal to the local office. The client may obtain and complete a DHS-18A at the local office or online at: www.michigan.gov/dhs-forms in the other category.

   When the request for withdrawal is received, mail a copy to MAHS. File the original in the case record.

   If the withdrawal is received within seven business days of the scheduled hearing, fax the withdrawal to MAHS.

   MAHS will review the hearing request withdrawal and:

   - If approved, send an Order Dismissing Request for Hearing Pursuant to Withdrawal to all parties.

   - If denied, an administrative hearing will be scheduled.

4. Withdrawal requests received at the time of hearing. When a client comes to the local office for a hearing, and while at the local office, decides to withdraw the request, contact MAHS to advise of the withdrawal request. The assigned ALJ must have an opportunity to discuss the withdrawal request with the client and AHR, or review the signed withdrawal request that may be faxed. **Do Not** send the client away until MAHS has reviewed the withdrawal request and made a determination whether to grant or deny the request. If the withdrawal request is denied, the hearing will take place as scheduled while the client is present in the local office.

5. If a withdrawal fails to dispose of all issues (partial withdrawal), MAHS may accept the DHS-18A on the identified program and a hearing will be conducted on unresolved issues.

STATE SSI PAYMENT (SSP)

SSPs are made for only those months the recipient received a regular monthly federal benefit. This is shown on State On-Line Query (SOLQ) as a recurring payment dated the first of the month. **SSPs are not issued for retroactive or supplemental federal benefits.**

The client or AHR may request a hearing when the client receives a DHS-430, Benefit Reduction Notice, stating that the SSP is being reduced or terminated; see BEM 660.

Handle these hearing requests in the same manner as all other benefit hearing requests.

When a hearing request (usually a DHS-430) is received, do all of the following:

- Log the receipt of the hearing request on Bridges. A timely hearing request will delete the negative action and issue a warrant equal to the previous quarterly payment.

  Note: The cutoff date for entering the receipt of a timely hearing request for the State SSI payment program is the payroll run date for case digit ending in 9; see RFS 106. If a hearing request was received timely but was not entered on Bridges by this date, fax a copy of the hearing request to the State SSI Payment Unit at (517) 335-7771. The State SSI Payment Unit will issue a supplemental payment.

- Request an SOLQ.

- Prepare a DHS-3050, Hearing Summary.

- Introduce the SOLQ pages as evidence at the hearing to verify the action taken.

  Note: Contact the State SSI Payment Unit at (517) 335-3627 for assistance if the SOLQ fails to explain the action taken.

- Represent the department at the hearing.

- If the hearing decision reverses the action taken by the department, issue a supplemental payment.

Prepare for the hearing under the guidance of the SSI Payments Unit staff, as needed. SSI Payments Unit staff will **not** participate in the hearing but are available for consultation regarding:

- Preparation of the hearing summary, and
- Presentation of the case at hearing.

If the SSI Payments Unit determines the disputed case action should be reversed, it will take all actions required. Inform MAHS of the reversal in writing. MAHS will then dismiss the hearing request.

EVIDENCE

Client Access to the Case Record

All Programs

Clients and AHRs have the right to review the case record and obtain copies of needed documents and materials relevant to the hearing. Send a copy of the DHS-3050 and all documents and records to be used by the department at the hearing to the client **and** AHR. DHS-4772, Hearing Summary Letter, may be used for this purpose.

Exception #1: Do **not** disclose the identity of any person who has reported information relating to an alleged program violation.

Exception #2: MDHHS **cannot** provide access to case records restricted by law or specific orders of a court; see BAM 310.

Exception #3: Access to certain mental health records is restricted; see BAM 310.

Subpoenas

All Programs

Request a subpoena if the specialist, the client or AHR requires either of the following:

- A person outside MDHHS to come to a hearing to testify.
- A document from outside MDHHS to be offered as evidence at a hearing.

Send a memo requesting the subpoena to MAHS. Attach a copy of the notice of hearing, (or other indication of date, time and place of hearing) if available. Allow adequate time to mail or hand-deliver the subpoena. The memo must include all of the following:

- Name and address of the person whose testimony is required.
- What document is to be subpoenaed.
- Why the person's presence and/or the document is needed at the hearing.
- How the person's testimony or the document relates to the hearing issue.

The requester is responsible for serving the subpoena and must pay the attending witness $12 per day or $6 per half-day plus the state travel rate per mile from and to the person's residence in Michigan.

MDHHS employees are expected to participate in hearings without a subpoena when their testimony is required; Employee Handbook, **SUBPOENAS ISSUED IN ADMINISTRATIVE MATTERS.**

If the specialist, the client or AHR requests that a MDHHS employee (for example, from another county or central office) participate in the hearing and that participation cannot be arranged, send a memo to MAHS giving all of the following:

- The name and location of the employee.
- Why the employee's participation is needed.
- How the employee's testimony relates to the hearing issue.

MAHS will decide whether to require the employee's participation.

NOTICE OF HEARING

If the case action involved actions taken by MDHHS partners fax or email a copy of the Notice of Hearing to the partner within 24 hours of receipt.

THE HEARING

All Programs

A hearing will take place if the local office and the client or AHR have been unable to resolve the issue(s) which prompted the hearing request.

MAHS must give advance written notice of the time, date and place of the hearing. For **FAP only**, advance notice is specifically defined as the 10 day period preceding the date of the hearing. However, less advance notice may be requested to expedite the hearing.

Clients have the right to all of the following:

- Representation by legal counsel or other person of choice at the client's expense.
- Barrier-free access to the hearing site.
- Interpreters: see BAM 105.
- Child care and transportation costs as necessary to ensure that full participation in the hearing process is possible.

Reimbursement for Transportation and Child Care

All Programs

Clients may request reimbursement of transportation and child care costs at the hearing. Clients must make the request on the hearing record and provide the ALJ the following information:

- Their name and address.
- For **transportation expense reimbursement**, the number of miles traveled round-trip for the hearing.
- For **child care expense reimbursement**, the provider type (for example, child care center) and a signed and dated receipt from the provider showing the full names and ages of all children for whom care was provided.

MAHS will issue the reimbursements when the total combined cost exceeds $3.

Note: Reimbursements are computed using the least costly travel rate.

Telephone Hearings

All Programs

MAHS schedules a telephone hearing for most cases. However, at the request of the client or AHR, MAHS must schedule an in-person hearing. In exceptional circumstances the local office may request an in-person hearing by calling MAHS and explaining the reason for the request.

Telephone hearings are conducted from the assigned ALJ's office. Speaker phones are used to communicate with participants at the local office.

Requests for In-Person Hearings

All Programs

The client or AHR may indicate in the hearing request the desire for an in-person hearing. The notice of hearing also instructs the client and AHR to call MAHS to request an in-person hearing.

In-person hearings are conducted in the local office that serves the client.

Late Arrival for the Hearing

All Programs

Hearings will be held on the scheduled date if the client or AHR arrives within 30 minutes of the scheduled time.

If the client or AHR arrives **more** than 30 minutes late, do **not** send the person away. Immediately call MAHS for direction on how to proceed. Whenever possible, the hearing will be held on the scheduled date if MAHS determines good cause exists for the late arrival.

Failure to Appear for the Hearing

All Programs

Contact MAHS if the client or AHR does **not** appear for the hearing within 30 minutes of the scheduled time. Do **not** take negative action until written authorization from MAHS has been received. If the client or AHR later contacts MDHHS to have the hearing rescheduled, tell the person to do one of the following:

- Write MAHS at P.O. Box 30639, Lansing, MI, 48909-8139.
- Call MAHS at the toll-free number included on the notice of hearing.

Persons at the Hearing

All Programs

An AHR may appear at the hearing with or without the client. Attendance of support person(s) is allowed, unless the ALJ determines that space limitations prohibit multiple persons in attendance.

The local office that initiated the case action that leads to the hearing request must present the case. If the client moved to another county, the county where the client resides must host the client, however, the office that took the action must present the case.

Interim Assistance Recovery

State-funded FIP and SDA Only

For **Interim Assistance Recovery disputes**, the local office IAR liaison must arrange for central office payment reconciliation staff to participate in the hearing by telephone.

Presentation of the Case

All Programs

The local office and client or AHR will each present their position to the ALJ, who will determine whether the actions taken by the local office are correct according to fact, law, policy and procedure. In

most cases, the client or AHR and local office staff will be together in the hearing room and will speak into a speaker telephone. The ALJ will be on the other end of the phone line.

Following the opening statement(s), if any, the ALJ directs the MDHHS case presenter to explain the position of the local office. The hearing summary, or highlights of it, may be read into the record at this time. The hearing summary may be used as a guide in presenting the evidence, witnesses and exhibits that support the department's position. Always include the following in planning the case presentation:

- An explanation of the action(s) taken.
- A summary of the policy or laws used to determine that the action taken was correct.
- Any clarifications by central office staff of the policy or laws used.
- The facts which led to the conclusion that the policy is relevant to the disputed case action.
- The MDHHS procedures ensuring that the client received adequate or timely notice of the proposed action and affording all other rights.

Both the local office and the client or AHR must have adequate opportunity to present the case, bring witnesses, establish all pertinent facts, argue the case, refute any evidence, cross-examine adverse witnesses, and cross-examine the author of a document offered in evidence.

Hearings Facilitator

All Programs

The MDHHS case must be presented by a hearings facilitator or backup facilitator. A hearings facilitator and backup facilitator must be a person familiar with MDHHS programs, policies and systems and is designated to present **all** cases to the ALJ.

The facilitator or backup facilitator must review the case prior to the administrative hearing for correct case action and reasonable fairness.

Individuals in this position will present the department's case and be able to knowledgeably and completely answer the ALJ's program, policy and case-specific questions during the administrative hearing.

Admission of Evidence

All Programs

The ALJ will follow the same evidentiary rules used in circuit court to the extent these rules are practical in the case being heard. The ALJ may admit and give probative effect to evidence of a type commonly relied on by reasonably prudent persons in the conduct of their affairs. The ALJ must ensure that the record is complete, and may do the following:

- Attempt to ensure all necessary information is presented on the record.
- Be more lenient than a circuit court judge in deciding what evidence may be presented.
- Refuse to accept evidence that the ALJ believes is:
  - Unduly repetitious.
  - Immaterial.
  - Irrelevant.
  - Incompetent.

Note: The ALJ may not act as an advocate for either party.

Either party may:

- State on the record its disagreement with the ALJ's decision to exclude evidence and the reason for the disagreement.
- Object to evidence the party believes should **not** be part of the hearing record.

When refusing to admit evidence, the ALJ must state on the record the nature of the evidence and why it was not admitted. The ALJ may allow written documents to be admitted in place of oral testimony if the ALJ decides this is fair to both sides in the case being heard.

SDA and Medicaid Only

When requested evidence is received, the ALJ will review the evidence for completeness and responsiveness and determine whether the evidence is material and relevant.

The client is responsible for providing evidence to support his or her claim. If the client does not provide medical or other evidence the ALJ needs and requests, the ALJ will generally make a decision based on the evidence in record, including evidence the ALJ has obtained directly. To document that the ALJ has made an attempt to fully and fairly develop the record, the ALJ will document all attempts to obtain the evidence as an exhibit(s) in the record.

HEARING DECISIONS

All Programs

The ALJ determines the facts based only on evidence introduced at the hearing, draws a conclusion of law, and determines whether MDHHS policy was appropriately applied. The ALJ issues a final decision **unless**:

- The ALJ believes that the applicable law does **not** support MDHHS policy.
- MDHHS policy is silent on the issue being considered.

In that case, the ALJ recommends a decision and the policy hearing authority makes the final decision.

Exception: For **MA client eligibility only**, if a presiding ALJ believes an MA policy at issue in a given case does **not** conform with federal or state law, all of the following occur:

- The ALJ issues a recommended decision within 20 days of the hearing date.
- Copies of the decision are sent to the client, AHR, MDHHS policy hearing authority, MDHHS local office and chief executive officer (CEO) of MDHHS-MSA, all of whom may file exceptions with the ALJ.
- The recommendation and exceptions are forwarded by the MDHHS Legal Affairs Administration to the MDHHS CEO

through the Michigan Administrative Hearings System for the Department of Community Health.

- The MDHHS CEO makes the final decision regarding all recommended decisions.
- For Medicaid disability determinations, the ALJ will review the evidence for completeness and responsiveness and generally make a decision based on the evidence admitted into the record as to disability, including evidence the ALJ has obtained directly.

MAHS mails the final hearing decision to the client, the AHR and the local office. In most cases, the client has the right to appeal a final decision to circuit court within 30 days after that decision is received.

Community Spouse Income Allowance

MA Only

The ALJ may raise the total allowance used to calculate the community spouse income allowance to an amount greater than provided for in BEM 546 to provide such additional income as is necessary due to exceptional circumstances resulting in significant financial duress.

The fact that a community spouse's expenses for goods and services purchased for day-to-day living exceed the total allowance provided by policy does **not** constitute exceptional circumstance. Goods and services purchased for day-to-day living include:

- Clothing.
- Drugs.
- Food.
- Shelter (for example, mortgage, taxes, insurance, rent, maintenance).
- Telephone.
- Trash pickup.

- Doctor's services.
- Entertainment.
- Heat.
- Utilities.
- Taxes.
- Transportation (for example, car payments, insurance, maintenance, fuel, bus fare).

Employment expenses do **not** constitute exceptional circumstances.

An example of exceptional circumstances is the need for the community spouse to pay for supportive and medical services at home to avoid being institutionalized.

Significant financial duress does **not** exist if the community spouse could meet expenses using their assets. This includes assets protected for the community spouse's needs as the protected spousal amount.

The ALJ may also grant a greater protected spousal amount (BEM 402, Special MA Asset Rules) when necessary to raise the community spouse's income to the total allowance for the community spouse. The community spouse's income for this purpose includes the maximum amount the long term care facility and/or hospital (L/H) client could make available to their community spouse per BEM 546.

When the ALJ grants a greater amount in the above circumstances, the final decision specifies:

- The amount of the protected spousal amount (BEM 402).
- The total allowance (BEM 546) used for the community spouse when determining the community spouse income allowance.
- The assets to be transferred for use by the community spouse.
- When another hearing will be held to review the exceptional circumstances.

If exceptional circumstances no longer exist before the case is due for the follow-up hearing, send the information to MAHS. Be sure to include the register number of the last D&O. MAHS will then decide whether to reschedule that hearing.

Additional Low-Income Medicare Beneficiaries (ALMB)

MA Only

The ALJ cannot order prior months of ALMB eligibility when the prior month(s) is before January of the current calendar year.

Example: A client applies in December 2004 and the specialist determines eligibility in January 2005. The MA begin date is January 2005. There is no eligibility for December 2004 because it is before January of the current year.

Notifying Partners

If a MDHHS partner was involved in the hearing, a copy of the hearing decision **must** be faxed, mailed, or emailed (use their preferred mode of communication) to the partner within 24 hours of receipt.

Implementing the Hearing Decision

All Programs

All hearing decisions **must** be recorded in Bridges, on the Hearing Restore Benefits screen.

Some hearing decisions require implementation by the local office. Implement a decision and order within 10 calendar days of the mailing date on the hearing decision. **Do not provide a notice of case action. The hearing decision serves as notice of the action.** If implementation requires a redetermination, send a notice of case action on the redetermination action.

Implement the hearing decision pending a court appeal unless a circuit court or other court with jurisdiction issues an order requiring a stay.

Note: Specialists will be notified by the Legal Affairs Administration if MDHHS is **not** to implement a hearing decision because of a court stay. If such an order is received from the client, AHR or a court, or if there are any questions, contact Legal Affairs Administration; see Administrative Policy Manual 410, Freedom of Information Act (FOIA).

If unable to determine what action is required, contact the policy clarification mailbox. Policy staff will clarify the situation with the appropriate supervisory ALJ.

If a hearing decision or a local office review results in Medicaid eligibility, send or give the client a DHS-334, Reimbursement Notice. This notice explains the procedure for a client to follow to request reimbursement of paid medical bills from the Michigan Department of Health and Human Services (MDHHS).

Send a DHS-45, DHS to MDCH/MIChild/FTW, transmittal and a copy of the DHS-334, Reimbursement Notice, that was sent to the client to:

Michigan Department of Health and Human Services
Medical Services Administration
Eligibility Quality Assurance Section/Reimbursement
400 S. Pine St., 5th floor
Lansing, MI 48913

The following hearing decisions are **not** implemented by the local office:

- Decisions about MSA determinations are implemented by MSA.
- Decisions about Interim Assistance Recovery disputes are implemented by central office payments reconciliation staff.

Note: See BEM 660 for instructions on implementing decisions about state SSI payments.

Certifying Implementation of the Hearing Decision

All Programs

When a decision requires a case action different from the one originally proposed, a DHS-1843, Administrative Hearing Order Certification, is sent with the hearing decision.

Complete the necessary case actions within 10 calendar days of the mailing date noted on the hearing decision. Complete and mail the DHS-1843 to MAHS to certify implementation and place a copy of the form in the case file.

If it is impossible to implement the hearing decision as written within 10 calendar days, a local office manager or hearings coordinator should call MAHS at (517) 373-0722 and speak with the supervisor of the ALJ who issued the hearing decision. The supervisor will offer advice on how to proceed. A local office manager or hearings coordinator is responsible to follow-up to ensure implementation of the hearing decision is completed.

REHEARING/ RECONSIDERATION

All Programs

A **rehearing** is a full hearing which is granted when either of the following occur:

- The original hearing record is inadequate for purposes of judicial review.
- There is newly discovered evidence **that existed** at the time of the original hearing that could affect the outcome of the original hearing decision.

A **reconsideration** is a paper review of the facts, law and any new evidence or legal arguments. It is granted when the original hearing record is adequate for purposes of judicial review and a rehearing is **not** necessary, but one of the parties believes the ALJ failed to accurately address all the relevant issues **raised in the hearing request**.

Rehearing/ Reconsideration Requests

All Programs

The department, Office of the Attorney General, MDE, client or AHR may file a written request for rehearing/reconsideration. Request a rehearing/reconsideration when one of the following exists:

- Newly discovered evidence that existed at the time of the original hearing that could affect the outcome of the original hearing decision.
- Misapplication of manual policy or law in the hearing decision, which led to a wrong conclusion.
- Typographical, mathematical or other obvious error in the hearing decision that affects the rights of the client.
- Failure of the ALJ to address in the hearing decision relevant issues raised in the hearing request.

The department, the Office of the Attorney General, the client or AHR must specify all reasons for the request.

Local Office Requests

A written request from the local office for a rehearing/reconsideration must be sent to Field Program Policy in central office or to the Michigan Department of Education/CDC Policy for a recommendation. The written request must include all of the following:

- A copy of the decision and order.
- A copy of the hearing summary and all evidence presented at the hearing.
- Explanation of why a rehearing/reconsideration is appropriate.

Send requests to:

Field Program Policy, Central Office
Grand Tower Building, Suite 1402
PO Box 30037

Lansing MI 48909

Fax to:

(517) 241-7570

Or email the appropriate policy email box, per BEM 100.

CDC
Send requests to:

Michigan Department of Education
Child Development and Care
PO Box 30008
Lansing, MI 48909

Email Policy-CDC@michigan.gov.

If the Field Program Policy or CDC Policy supports the local office request, the request shall be made a part of the record. The request will be sent to all parties including: MAHS, the client, AHR, and the requesting local office.

Office of the Attorney General Requests

A written request made by the Office of the Attorney General must be mailed to MAHS as follows:

The written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, MI 48909-07322

The Office of the Attorney General will notify MDHHS field operations and the Legal Affairs Administration, and provide a copy of the request to the client and AHR.

Client or AHR Requests

A written request for Rehearing or Reconsideration must be either faxed or mailed to MAHS as follows:

The written request must be faxed to (517) 335-6088 and labeled as follows:

Attention: MAHS Rehearing/Reconsideration Request

If submitted by mail, the written request must be addressed as follows:

Michigan Administrative Hearings
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, MI 48909-07322

All Requests

MAHS will not review any response filed to any rehearing/reconsideration requests.

A request must be received by MAHS within 30 days of the date the hearing decision is mailed.

Granting a Rehearing/ Reconsideration

All Programs

MAHS will either grant or deny a rehearing/reconsideration request and will send written notice of the decision to all parties to the original hearing.

Exception: MAHS will **not** grant a rehearing involving FAP-IPV.

If MAHS grants a reconsideration, a reconsideration decision will be issued. .

If a rehearing is granted, MAHS will schedule and conduct the hearing in the same manner as the original.

Implementation Pending a Rehearing

All Programs

Pending a rehearing or reconsideration request, implement the original decision and order unless a circuit court or other court with jurisdiction issues an order which requires a delay or stay.

Note: If such an order is received by the client, MAHS, the court or the Legal Affairs Administration and Policy, or if there are questions

about implementing the order, see Employee Handbook, How to Obtain Legal Services.

LEGAL BASE

All Programs

MCL 400.9
MCL 400.37
MCL 24.271through 24.287
Michigan Administrative Code 400.901 et. seq.

FIP

45 CFR 205.10

RCA

45 CFR 400.54

CDC

Child Care and Development Block Grant of 1990.
45 CFR Parts 98 and 99
Social Security Act, as amended,
Michigan Administrative Code R 400.5001 - 400.5020

SDA

Current Annual Appropriations Act
Michigan Administrative Code, R 400.3151 - 400.3180

MA

42 CFR 431.200-.250
42 USC 1396r-5

FAP

7 CFR 273.15

DEPARTMENT POLICY

All Programs

When a client group receives more benefits than it is entitled to receive, the Michigan Department of Health and Human Services (MDHHS) must attempt to recoup the overissuance. This item explains overissuance types and standards of promptness (SOP).

Note: A client or Child Development and Care (CDC) provider may voluntarily repay any program benefits even when there is no overissuance. Refer these situations to the local office.

Definitions

The **Benefit Recovery System (BRS)** is the part of Bridges that tracks all Family Independence Program (FIP), State Disability Assistance (SDA), Child Development and Care (CDC) and Food Assistance Program (FAP) overissuances and payments, issues automated collection notices and triggers automated benefit reductions for active programs.

A **claim** is the resulting debt created by an overissuance of benefits.

The **discovery date** is the date Bridges automatically inserts the date when there is an overissuance and a referral is made to the recoupment specialist (RS) for a client or agency error. The RS determines the discovery date for manual claims and it is the date the overissuance is known to exist and there is evidence available to determine the overissuance type. For an intentional program violation (IPV) the Office of Inspector General (OIG) determines the discovery date. This is the date the referral was sent to the prosecutor or the date that OIG requested an administrative disqualification hearing.

The **establishment date** for an overissuance is the date the DHS-4358A-D, Repay Agreement, is sent to the client and for an IPV the date the DHS-4357 is sent notifying the client when the disqualification and/or recoupment will start.

An **overissuance** is the amount of benefits issued to the client group or CDC provider in excess of what it was eligible to receive. For FAP benefits, an overissuance is also the amount of benefits trafficked (stolen, traded, bought or sold) or attempted to be

trafficked. **Overissuance type** identifies the cause of an overissuance.

Recoupment is a MDHHS action to identify and recover a benefit overissuance.

A **recoupment specialist (RS)** is the specialist assigned to process overissuances and act as liaison with OIG, reconciliation and recoupment section (RRS), and other personnel involved with recoupment and collections.

Trafficking is:

- The buying, selling or stealing of FAP benefits for cash or consideration other than eligible food. Examples would be liquor, exchange of firearms, ammunition, explosives or controlled substances.
- Selling products purchased with FAP benefits for cash or consideration other than eligible food.
- Purchasing containers with deposits, dumping/discarding product and then returning containers to obtain cash refund deposits.
- Attempting to buy, sell or steal FAP benefits for cash or consideration other than eligible food.

PREVENTION OF OVERISSUANCES

All Programs

MDHHS must inform clients of their reporting responsibilities and act on the information reported within the standard of promptness (SOP).

During eligibility determination and while the case is active, clients are repeatedly reminded of reporting responsibilities, including:

- Acknowledgments on the application form.
- Explanation at application/redetermination interviews.
- Client notices and program pamphlets.

MDHHS must prevent overissuances by following Bridges Administrative Manual (BAM) 105 requirements and by informing the client or authorized representative (AR) of the following:

- Applicants and recipients are required by law to give complete and accurate information about their circumstances.
- Applicants and recipients are required by law to promptly notify MDHHS of all non-income changes in circumstances within 10 days. Income related changes must be reported within 10 days of receiving their first payment. FAP Simplified Reporting (SR) groups are required to report only when the group's actual gross monthly income exceeds the SR income limit for their group size.
- Incorrect, late reported or omitted information causing an overissuance can result in cash repayment or benefit reduction.
- A timely hearing request can delete a proposed benefit reduction. The client must repay the overissuance if either:
  - The hearing request is later withdrawn.
  - Michigan Administrative Hearings System (MAHS) denies the hearing request.
  - The client or administrative hearing representative fails to appear for the hearing and MAHS gives MDHHS written instructions to proceed.
  - The hearing decision upholds the department's actions.

  See BAM 600.

Record on the application the client's comments and/or questions about the above responsibilities.

MDHHS may prevent overissuances by referring questionable information to the OIG Front End Eligibility (FEE) agent for investigation.

DISCOVERY OF SUSPECTED OVERISSUANCES

All Programs

An overissuance might be discovered through normal casework or by one of the following:

- Case readings.
- Computer cross matches.
- Quality Control audit findings.
- Welfare Fraud Hotline referrals.
- Non-honored repay agreements.
- Michigan Administrative Hearings System.

FAP Only

If discovered that a FAP household is receiving FAP **and** FDPIR (Food Distribution Program on Indian Reservations), a FAP OI exists **only** if the household received FDPIR prior to its FAP application; see Bridges Eligibility Manual (BEM) 222, Food Distribution Program Benefits.

OVERISSUANCE TYPES

All Programs

The three different types are described below. Further detail is included in BAM 705, 715 and 720.

CDC Only

Information on overissuances as a result of a provider error or provider intentional program violation (IPV) can be found in BEM 707.

Agency Error

All Programs

An agency error is caused by incorrect action (including delayed or no action) by MDHHS staff or department processes. Some examples are:

- Available information was not used or was used incorrectly.
- Policy was misapplied.
- Action by local or central office staff was delayed.
- Computer errors occurred.
- Information was not shared between department divisions such as services staff.

- Data exchange reports were not acted upon timely (wage match, new hires, BENDEX, etc.).

If unable to identify the type, record it as an agency error.

FIP, SDA, CDC and FAP

Agency errors are not pursued if the estimated amount is less than $250 per program.

Exception: There is no threshold limit on CDC **system** errors. Michigan Department of Education (MDE) will recoup these types of overissuances.

Example: If payroll checks or Electronic Funds Transfer (EFTs) for the CDC provider were issued twice, the full amount of the overpayment would be recouped by RRS.

FIP, SDA and FAP

The agency error threshold was raised to $250 from $125 with an effective date of December 1, 2012.

The agency error threshold was lowered to $125 from $500 with a retroactive effective date of August 1, 2008, until November 30, 2012.

Example 1: Jacob Andrew was found to have an agency error for the period of June 2008 through August 2008. Since some of the months fall prior to August 2008, the old $500 threshold applies.

Example 2: Joshua Allen was found to have an agency error for the period of August 2008 through November 2008. Since all months fall after August 2008, the $125 threshold applies.

Note: The past agency error threshold was lowered to $500 from $1,000 effective April 1, 2005, and retroactive to September 1, 2003. If the agency error includes September 2003, the $500 threshold applies. If all months of the error are prior to September 2003, the $1,000 threshold applies.

FIP and SDA

Treat an overissuance due to excess assets as an agency error **unless** IPV caused it.

CDC Only

Note: CDC agency errors and CDC provider agency errors must be pursued beginning October 1, 2006. If the CDC agency error overissuance period included the month of October 2006, include the months previous to October 2006 when determining the amount.

Example: Jacob Andrew was found to have an agency error for the period of March 2006 through December 2006. Since October falls within the error months, CDC agency error **is** pursued for all months.

Note: Agency errors will be assigned to the provider or the client depending on the type of agency error that occurred; see BAM 705.

State Emergency Relief (SER) Only

Follow procedures in the State Emergency Relief Manual (ERM) items for recoupment of SER.

MA and ESS Only

Recoupment of agency errors are not pursued.

Client Error

All Programs

A **client error** occurs when the client received more benefits than they were entitled to because the client gave incorrect or incomplete information to the department.

A client error also exists when the client's timely request for a hearing result in deletion of a MDHHS action, **and any of the following occurred:**

- The hearing request is later withdrawn.
- MAHS denies the hearing request.
- The client or administrative hearing representative fails to appear for the hearing and MAHS gives MDHHS written instructions to proceed.
- The hearing decision upholds the department's actions; see BAM 600.

SDA Only

A client error exists when the client fails to honor an SDA repay agreement after receiving a potential resource. Do not pursue IPV; see BEM 272.

Note: Social Security Income (SSI)-benefit recovery is initiated by RRS in central office. If the client contacts the local office to arrange repayment, have the client sign form DHS-4358B, Agency and Client Error Repayment Agreement. Do **not** enter these debts on ARS unless the client signs a DHS-4358B. Notify the local interim assistance reimbursement (IAR) liaison in the fiscal unit if the client signs a DHS-4358B. The IAR will contact RRS; see BEM 272.

CDC Provider Error

CDC Only

A p**rovider error** is an unintentional or inadvertent error made by the provider who reported incorrect information or failed to report information to the department.

Client Suspected Intentional Program Violation

All Programs

Suspected IPV means an overissuance exists for which all three of the following conditions exist:

- The client intentionally failed to report information **or** intentionally gave incomplete or inaccurate information needed to make a correct benefit determination.
- The client was clearly instructed regarding his or her reporting responsibilities.
- The client has no apparent physical or mental impairment that limits his or her understanding or ability to fulfill his reporting responsibilities.

IPV is suspected when there is clear and convincing evidence that the client has **intentionally** withheld or misrepresented information

for the **purpose** of establishing, maintaining, increasing or preventing reduction of program benefits or eligibility.

CDC Provider Suspected Intentional Program Violation

CDC Only

Note: A suspected provider IPV is an overissuance caused by a provider's intentional act to receive higher reimbursements than he/she is entitled to. See BEM 707 for information on provider IPVs. If care was authorized, provided and paid for but the client was ineligible, this would be considered a CDC client error or agency error.

Intentional Program Violation

FIP, SDA, CDC and FAP

The client/AR is determined to have committed an IPV by:

- A court decision.
- An administrative hearing decision.
- The client/AR signing a DHS-826, Request for Waiver of Disqualification Hearing, or DHS-830 Disqualification Consent Agreement, or other recoupment and disqualification agreement form.

FAP Only

IPV exists when an administrative hearing decision, a repayment and disqualification agreement or court decision determines FAP benefits were trafficked.

MA Only

IPV exists when the client/AR:

- Is found guilty of fraud by a court.
- Signs a DHS-4350 **and** the prosecutor or OIG designee authorizes recoupment in lieu of prosecution.

Multiple Overissuance Types

CDC Only

When an overissuance occurs it may involve more than one overissuance type.

If agency error and another error occurred, follow procedures for the non-agency error overissuance first.

If a hearing-related error occurs, follow policy for CDC client error.

If provider error and CDC client error or CDC client IPV occurred and care was authorized by MDHHS and paid by the Michigan Department of Education (MDE) to the provider but care was not provided, recoup from the provider.

OVERISSUANCE THRESHOLD

FIP, SDA, CDC and FAP

Client and Agency errors are not pursued if the estimated amount is less than $250 per program.

Exception: There is no threshold limit on CDC **system** errors. Michigan Department of Education (MDE) will recoup these types of overissuances.

OVERISSUANCE PROCESSING

All Programs

Specialist Actions

When a potential overissuance is discovered the following actions must be taken:

1. Immediately correct the current benefits; see BAM 220, Case Actions, for change processing requirements.
2. Obtain initial evidence that an overissuance potentially exists.
3. Determine if it was caused by department, provider or client actions.

4. Refer any overissuances needing referral to the RS within **60 days** of suspecting one exists.

Exception: Office of Quality Assurance (OQA) discovered overissuances must be referred to the RS within 7 days of receipt of the OQA findings. OQA has already verified one exists.

FIP, SDA, CDC and FAP

Within **60 days** of suspecting an overissuance exists, complete a DHS-4701, Overissuance Referral, and refer the following overissuances to the RS for your office:

- All client and agency errors over $250.
- All suspected IPV errors.
- All CDC provider errors.

MA Only

Do not pursue recoupment of agency error. Do not refer these to the RS. See BAM 710 for client error and IPV processing.

SER and DSS

Refer SER and DSS overissuances to the RS **only** when IPV is suspected and a FIP, SDA or FAP overissuance also exists for the same period. Follow procedures in the SER manual for recoupment of SER. Follow procedures in BEM 232 for Direct Support Services (DSS) OIs.

RECOUPMENT SPECIALIST REFERRAL

FIP, SDA, CDC and FAP

Bridges refers most overissuances to the RS. Use the DHS-4701, Overissuance Referral, to refer manual overissuances.

Example: Specialists are trained to enter a current circumstance start change date (CSCD) if they do not have past verifications or they do not know the begin date of the change. If the specialist uses a current CSCD and they know an overissuance exists then a manual referral using the DHS-4701 must be made.

Complete **all** sections **and** attach the potential evidence to the DHS-4701 when sending it to the RS for your local office or region.

A recoupment specialist list is on the DHS-Net, under Tools, Directories/Contact Info/Maps. The listing provides RS contact information by county and district.

The DHS-4701 must be sent to the RS within 60 days of suspecting that an overissuance exists.

Exception: OQA discovered overissuances must be referred to the RS within **seven days**. OQA has already verified one exists.

RS Actions

FIP, SDA, CDC and FAP

Within **60** days of receiving the referral, the RS must:

- Determine if an overissuance actually occurred, **and**
- Determine the types.

Within **90** days of determining an overissuance occurred, the RS must:

- Obtain all evidence needed to establish an overissuance.
- Calculate the amount.
- Send a DHS-4358A, B, C & D to the client.
- Enter the programs on BRS.
- Refer all suspected IPV overissuances to OIG for investigation.
- Send a DHS-4701A, Overissuance Referral Disposition, to the specialist explaining the final disposition of the error.

FIP, SDA and FAP

Establish a suspected IPV as a client error.

For OQA discovered overissuances, the RS will have a total of 90 days from the date of receiving the referral to:

- Obtain all evidence needed to establish.
- Calculate the amount.
- Start collection action on agency client and suspected IPV errors as client errors.
- Refer all suspected IPVs to OIG for investigation.

In addition to processing overissuance referrals, RS are responsible for other duties related to recoupment and collections, such as:

- Entering, changing or correcting an overissuance on BRS.
- Transferring overissuances to other case numbers.
- Handling recoupment issues on closed cases.
- Assisting local fiscal units and reconciliation and recoupment staff in central office as needed with collection activities.

OIG Referral

All Programs

Suspected IPV overissuances are referred to OIG on the DHS-834, Fraud Investigation Request, located on the Michigan Inspector General System (MIGS). Evidence for the suspected IPV must be attached to the DHS-834.

Prudent judgment should be used in evaluating an overissuance for suspected IPV. Consider the following questions when reviewing the case:

- Does the record show that department staff advised the client of his rights and responsibilities?
- Does the record show the client's acknowledgment of these rights and responsibilities?
- Did the client neglect to report timely when required to do so?
- Did the client make false or misleading statements?
- Does the client error meet suspected IPV criteria?
- Does the amount meet the OIG threshold found in BAM 720?

FIP, SDA, CDC and FAP

RS must refer all client and CDC provider errors suspected of IPV to OIG when IPV criteria are met. See BAM 720 for the criteria and policy on establishing IPV.

MA, SER and DSS

The ongoing specialist refers these programs directly to OIG when IPV is suspected. Follow directions on the DHS-834. Evidence for

the suspected IPV must be attached to the DHS-834. Provide calculation of the amount and period with the referral.

OVERISSUANCE DISPOSITION

All Programs

When all actions are completed by the RS and OIG, the RS will inform the ongoing specialist of the final disposition on the DHS-4701A.

MA, SER and DSS

These program overissuances are not tracked on BRS. OIG or the RS will inform the local fiscal unit when an account needs to be established for cash collections.

ESTABLISHING OVERISSUANCE CLAIMS

All Programs

Policies and procedures for calculating, establishing and recouping an overissuance are contained in the following manual items:

- BAM 705, Agency Error Overissuances.
- BAM 710, MA Overissuances.
- BAM 715, Client Error Overissuances.
- BAM 720, Intentional Program Violation.
- BAM 725, Collection Actions.
- BEM 232, Direct Support Services.
- ERM 401, Payment.

WELFARE FRAUD HOTLINE REFERRAL PROCEDURES

A toll-free hotline number (1-800-222-8558) is provided to the public for use in filing complaints regarding all programs where possible fraudulent activities may be occurring. The Customer Service Unit (CSU) located in central office receives these calls. An electronic database is now available to refer, monitor and dispose of fraud referrals.

RESPONSIBILITY

ACTION

CSU

1. Receive call.
2. Complete file clearance to determine affected county.
3. Forward referral electronically to the designated fraud coordinator in local office.

Referral Coordinator

4. Forward referral to FIS/ES.

FIS/ES

5. Investigate, take necessary case action and refer to RS if appropriate (within 30 days).
6. Report findings back to designated fraud coordinator.

Referral Coordinator

7. Review findings.
8. Report findings back to central office.

FAP Only

Hotline complaints about FAP clients misusing their EBT food benefits must be handled by the FIS/ES. Dispose of these complaints by advising the client of proper food benefit use and penalties for misuse at the next redetermination. Do not refer these complaints to the Food and Nutrition Service (FNS).

Do refer complaints about retailers to FNS; see RFT 261 for the proper address.

RECOUPMENT SPECIALIST LISTING

A Recoupment Specialist Listing is on the DHS-Net under Tools, ChilDirectories/Contact Info/Maps. The listing provides RS contact information by county and region.

LEGAL BASE

FIP

Personal Responsibility and Work Opportunity Reconciliation Act of 1996., P. L. 104-193 of 1996
MCL 400.60
Mich Admin Code, R 400.329 - 400.331
MCL 400.1 et seq

MA

42 CFR 431.230(b)
MCL 400.60

FAP

7 USC 271.2
7 CFR 272.8
7 USC 2022
Mich Admin Code, R 400.3011

SDA

Annual Appropriations Act

CDC

Child Care and Development Fund, 45 CFR Parts 98 and 99
Social Security Act, as amended 42 USC 301 *et seq*.
Mich Admin Code, R 400.5001 - 400.5020

DEPARTMENT POLICY

All Programs

Recoupment policies and procedures vary by program and over-issuance type. This item explains agency error processing and establishment.

BAM 700 explains overissuance discovery, types and standards of promptness. BAM 715 explains client error, and BAM 720 explains intentional program violations.

Definition

All Programs

An **agency error** is caused by incorrect actions (including delayed or no action) by the Michigan Department of Health and Human Services (MDHHS) staff or department processes. Some examples are:

- Available information was not used or was used incorrectly.
- Policy was misapplied.
- Action by local or central office staff was delayed.
- Computer errors occurred.
- Information was not shared between department divisions such as services staff.
- Data exchange reports were not acted upon timely (Wage Match, New Hires, BENDEX, etc.).

If unable to identify the type of overissuance, record it as an agency error.

AGENCY ERROR EXCEPTIONS

FIP, SDA, CDC and FAP

Agency error overissuances are not pursued if the estimated amount is less than $250 per program.

Exception: There is no threshold limit on CDC **system** errors. MDE will recoup these types of overissuances.

Example: If payroll checks or electronic funds transfer (EFT) for the CDC provider was issued twice, the full amount would be recouped by recoupment and reconciliation specialist (RRS).

FIP, SDA and FAP

The agency error threshold was raised to $250 from $125 with an effective date of December 1, 2012.

The agency error threshold was lowered to $125 from $500 with a retroactive date of August 1, 2008. If the agency error includes some prior months to August 2008 then the $500 threshold applies. If all months of the error fall after August 2008, the $125 threshold applies until November 30, 2012.

Example: Jacob Andrew was found to have an agency error for the period of June 2008 through August 2008. Since some of the months fall prior to August 2008, the old $500 threshold applies.

Example: Joshua Allen was found to have an agency error for the period of August 2008 through November 2008. Since all months fall after August 2008, the $125 threshold applies.

FIP and SDA

Treat an overissuance due to excess assets as an agency error **unless** intentional program violation (IPV) caused it.

FAP Only

Do not recoup overissuances caused by the following agency errors:

- The group was certified in the wrong county.
- The local office failed to have the FAP group sign the application form.

CDC Only

CDC agency errors and CDC provider agency errors must be pursued beginning October 1, 2006. If the CDC agency error included the month of October 2006, include the months previous to October 2006 when determining the amount.

Example: Jacob Andrew was found to have an agency error for the period of March 2006 through December 2006. Since October 2006 falls within the error months CDC agency error is pursued for all months.

SER Only

Follow procedures in the State Emergency Relief Manual (ERM) Items for recoupment of SER.

MA and ESS

Recoupment of agency errors is not pursued.

OVERISSUANCE PROCESSING

FIP, SDA, CDC and FAP

Agency errors (other than CDC **system** errors) are not pursued if the amount is under $250 per program.

FIS/ES Actions

When a potential overissuance is discovered, do all of the following:

1. Take immediate action to correct the current benefits; see BAM 220, Case Actions, for change processing requirements.
2. Obtain initial evidence that it potentially exists.
3. Determine if it was caused by department, provider or client action.
4. Refer agency errors of $250 or more to the Recoupment Specialist (RS) within **60 days** of suspecting an overissuance exists.

OQA Audits

FIP, SDA, CDC and FAP

Overissuances discovered by the Office of Quality Assurance (OQA) must be referred to the RS within **7 calendar days** of receipt of the OQA findings since they verified one exists.

Recoupment Specialist Referral

FIP, SDA, CDC and FAP

Bridges refers most agency errors estimated to be $250 or more to the RS. Use the DHS-4701, Overissuance Referral, to refer manual overissuances.

Complete the DHS-4701 **and** attach the potential evidence. Send to the RS for your local office or region. A recoupment specialist list is on the DHS-Net, Tools under Directories. The listing provides RS contact information by county and district.

The DHS-4701 must be sent to the RS within 60 days of suspecting an overissuance exists.

Recoupment Specialist Actions

FIP, SDA, CDC and FAP

Within **60** days of receiving the referral, the RS must:

- Determine if an overissuance actually occurred.
- Determine the overissuance type.

Within **90** days of determining an overissuance occurred, the RS must:

- Obtain all evidence needed. Calculate the agency error amount**.**
- Establish the discovery date**.**
- Send a DHS-4358A, B, C & D, Notice of Overissuance and Repay Agreement, to the client.
- Enter the FIP, SDA, CDC or FAP overissuance on the Benefit Recovery System (BRS).
- Send a DHS-4701A, Overissuance Referral Disposition, to the ongoing worker explaining the final disposition of the overissuance.

Exception: For O**Q**A**-discovered** overissuance**s**, the RS will have a total of **90** days from the date of receiving the referral to:

- Obtain all evidence needed.
- Calculate the amount.
- Start collection action on agency errors.

CDC Only

There could be agency errors for providers and/or client overissuances. The following are some typical agency errors. Use this list to help determine who is held responsible for the repayment of the overissuance.

Agency Errors Related to the Provider

- Provider not eligible.
- Payments authorized under wrong provider eligibility type.

Agency Errors Related to the Client

- Family Contribution is wrong.
- Child not eligible.
- Child birth date is incorrect, causing a higher agency maximum rate.

OVERISSUANCE PERIOD

All Programs

Begin Date

FIP, SDA, CDC and FAP

The overissuance period begins the first month (or first pay period for CDC) when benefit issuance exceeds the amount allowed by policy, or 12 months before the date the overissuance was referred to the RS, whichever 12 month period is later.

Example: An agency error was referred to the RS in May 2014 for the period of March 2011 through June 2012. The begin date would be July 2011. The period would be July 2011 through June 2012 since this is the latest 12-month period.

To determine the first month of the overissuance period for changes reported timely and not acted on, Bridges allows time for:

- The full standard of promptness (SOP) for change processing, per BAM 220.

- The full negative action suspense period; see BAM 220, EFFECTIVE DATE OF CHANGE.

End Date

The overissuance period ends the month (or pay period for CDC) before the benefit is corrected.

Discovery Date

FIP, SDA, CDC and FAP

Bridges automatically inserts the date when there is an overissuance and a referral is made to the RS. The RS determines the discovery date for manual claims and it is the date that the overissuance is known to exist and there is evidence available to determine the type.

OVERISSUANCE AMOUNT

FIP, SDA, CDC and FAP

The amount of the overissuance is the benefit amount the group actually received minus the amount the group was eligible to receive.

FAP Only

If the agency error involves two or more FAP groups which should have received benefits as one group, determine the error amount by:

- Adding together all the benefits received by the groups that must be combined, and
- Subtracting the correct benefits for the one combined group.

OVERISSUANCE CALCULATION

FIP, SDA, CDC and FAP

Benefits Received

FIP, SDA and CDC

The amount of benefits received in an overissuance calculation include:

- Regular warrants.
- Supplemental warrants.
- Duplicate warrants.
- Vendor payments.
- Administrative recoupment deductions.
- EBT cash issuances.
- EFT payments.
- Replacement warrants (use for the month of the original warrant).

Do not include:

- Warrants that have not been cashed.
- Escheated EBT cash benefits (SDA).

Warrant history is obtained from Bridges under benefit issuance; see RFT 293 and RFT 294.

FAP Only

The amount of EBT benefits received in the calculation is the **gross** (before automated recoupment (AR) deductions) amount issued for the benefit month.

FAP participation is obtained in Bridges under benefit issuance.

If the FAP budgetable income included FIP/SDA benefits, use the grant amount actually received in the month. Use the FIP benefit amount when FIP closed due to a penalty for non-cooperation with employment-related activities or child support.

Determining Budgetable Income

FIP, SDA, CDC and FAP

If improper budgeting of income caused the overissuance, use actual income for the past overissuance month for that income source.

Convert income received weekly or every other week to a monthly amount. Bridges will automatically convert based on answers to on-screen questions.

Exception: For FAP only, income is not converted from a wage match for any type of overissuance.

Any income properly budgeted in the issuance budget remains the same in that month's corrected budget.

Examples:

- Randy and Andi Andrews both started work. Only Randy's income was budgeted. For the corrected calculation, use actual income for Andi and the projected income already budgeted correctly for Randy.
- Minnie and Mickey receive FIP with their five children. Mickey has reported his employment at Disney Corp. Two of the children left five months ago to go live with grandma, but the change was never acted on. The corrected month budgets will use the income already projected properly for Mickey, but remove the children from the household size.

OVERISSUANCE ADJUSTMENTS

Assigned Support

FIP Only

Subtract from the overissuance all or part of any net assigned **current** support collections retained by the state **for the benefit period as follows:**

- If the group was ineligible for FIP during the overissuance period, subtract the net support collections retained.

- If the group was eligible for part of the FIP benefits issued, subtract the portion of the net support collections retained in excess of what the group was eligible for.

Overissuance months prior to October 2011

Example: Subtract $50 from the reported amount before performing the calculations above.

Overissuance Adjustment

Overissuance exists:

	$400	Monthly FIP benefit received by the group.
-	$300	Monthly FIP benefit group should have received.
	$100	One month OI

Reducing the overissuance **when paid support exceeds the FIP benefit:**

	$375	Child support paid per DL-060.
-	$50	Child support rebate sent to group.
	$325	Difference in child support.
-	$300	Actual monthly FIP benefit group was eligible for.
	$25	This amount is subtracted to reduce the OI amount from $100 to $75.

Do not reduce the overissuance **when paid support does not exceed the FIP benefit:**

	$300	Child support paid per DL-060.
-	$50	Child support rebate sent to group.
	$250	Difference in child support.
-	$300	Actual monthly FIP benefit group was eligible for.
	0	Do not subtract anything from the overissuance amount; FIP benefit exceeds the difference in child support.

CLIENT NOTIFICATION

FIP, SDA, CDC and FAP

Unless recouping from the CDC provider, Bridges will notify the client group of the agency error by sending all of the following completed forms:

- DHS-4358A, Notice of Overissuance.
- DHS-4358B, Agency and Client Error Repayment Agreement.
- DHS-4358C, Overissuance Summary.
- DHS-4358D, Hearing Request for Overissuance or Recoupment Action.

An explanation of the reason for overissuance, along with the manual items, must be filled out using the view pending screen in Correspondence.

CDC Provider Agency Error

The provider is not notified of an overissuance by the RS. Send a copy of the issuance summary by ID-mail to:

Fraud and Recoupment Administration
Reconciliation and Recoupment Section
Suite 710, Grand Tower Building

The reconciliation and recoupment section will notify the provider and initiate recoupment.

INITIATE RECOUPMENT

All Programs

Bridges automatically starts the recoupment process. The client is instructed to return the DHS-4358B, Repay Agreement, to the welfare debt unit (WDU) or to the RS if a hearing is requested. The RS must forward a notice to WDU when a hearing is requested.

If the client returned the signed repay agreement it must be entered in Bridges in record repayment agreement.

If the repay is sent to the RS, make a copy for the case record and send the original DHS-4358A, -B, via ID mail to:

Fraud and Recoupment Administration

Reconciliation and Recoupment Section
Welfare Debt Unit
Suite 710, Grand Tower Building

The reconciliation and recoupment section will notify and initiate collection on provider errors.

Active Programs

FIP, SDA, CDC and FAP

Notify the specialist of the final disposition of the overissuance and AR effective date via the DHS-4701A.

HEARING REQUESTED

FIP, SDA, CDC and FAP

Active Cases

A hearing request on a DHS-4358D must be forwarded to the Michigan Administrative Hearings System (MAHS) along with a completed DHS-3050, Hearing Summary, and exhibits, according to normal hearing procedures; see BAM 600.

Received Timely

If the request is received on or before the negative action effective date, update the status field in Claim Adjustment.

- If MDHHS is **not** upheld, use Claim Adjustment to decrease balance to zero with hearing decision for the reason. This will close the claim.
- If MDHHS is upheld, enter standard recoupment for the reason in status field under Claim Adjustment. This will start the recoupment process. Enter the date of the hearing decision in agreement sign date.
- If client withdraws the hearing request or fails to show and the hearing is not rescheduled, enter standard recoupment for the reason in status field under Claim Adjustment.

Received After Effective Date

If the hearing request is received **after** the negative action effective date, continue recoupment until issue resolution. Notify WDU that a hearing was requested.

- If MDHHS is upheld, update the agreement sign date with the date of the hearing decision.
- If MDHHS is **not** upheld, update the adjustment box including entering zero for amount in the Claim Adjustment screen.

Inactive Cases

MDHHS must request the hearing on a closed case. A hearing request on a DHS-4358D for a closed case requires the RS to request a debt collection hearing, regardless of the total overissuance amount.

Complete a DHS-3050 indicating the hearing is for a debt collection issue. Forward the DHS-4358A, -B, -C, and -D, DHS-3050 and all exhibits to MAHS. See BAM 725 regarding evidence and debt collection hearing procedures.

LEGAL BASE

FIP

Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193 of 1996, as amended
1939 PA 280, as amended (Social Welfare Act)
MCL 400.60
Mich Admin Code, R 400.3131

FAP

7 CFR 272.8
7 USC 2022

SDA

Annual Appropriations Act

CDC

Child Care and Development Act, 42 USC 301 *et seq*
45 CFR Parts 98 and 99
Social Security Act, as amended

Mich Admin Code, R 400.5001 - 400.5020

DEPARTMENTAL POLICY

MA Only

Initiate recoupment of an overissuance (OI) due to **client error or intentional program violation** (IPV), **not** when due to **agency error** (see BAM 700 for definitions). Proceed as follows:

- Determine the OI period and amount.
- Determine the OI Type (client error or suspected IPV).
- Initiate recoupment of an OI due to client error.

If IPV is suspected, refer the case to the Office of Inspector General (OIG), if appropriate, by completing a DHS-834, Fraud Investigation Request.

Note: OIs due to IPV are recouped by OIG working directly with the local office fiscal unit.

Exception: Do **not** recoup OIs resulting from hearing decisions upholding MDHHS regarding the level of long-term care.

Reminder: After OI discovery and during recoupment processing, **file certain documents in the Incorrect Issuance Packet** of the case record; see BAM 300.

PROCEDURES

Document decisions and actions on the application form. A manager must review the case record.

MA Payment Information

Complete and email the DHS FIELD REQUESTS-DCH OIG Incoming Data Request Form to OHSIGDataRequests@michigan.gov to obtain a list of MA payments in the OI period.For changes unreported by ongoing recipients, the OI period begins the first day of the month **after** the month in which the standard reporting period **plus** the negative action period would have ended.

Overissuance Determination

When the amount of MA payments is received, determine the OI amount.

For an OI due to unreported income or a change affecting need allowances:

- If there would have been a deductible or larger deductible, the OI amount is the correct deductible (minus any amount already met) **or** the amount of MA payments, whichever is less.
- If there would have been a larger LTC, hospital or post-eligibility patient-pay amount, the OI amount is the difference between the correct and incorrect patient-pay amounts **or** the amount of MA payments, whichever is less.

For an OI due to **any other** reason, the OI amount is the amount of MA payments.

OIG Referral

The **minimum** OI amount for OIG referral is **$500 unless** the local prosecutor sets a lower amount. OIG through regular channels informs affected local offices of lower amounts.

Refer an IPV that is **under** the set minimum **if** the group's actions are repetitious or flagrant. The local office director or designee must approve the referral.

Recoupment

Before recoupment is initiated, a manager or a designee must review the MA case. After review, notify the client (or legal guardian) in writing that:

- MDHHS must seek recoupment, **but**
- Refusal to repay will **not** cause denial of current or future MA if the client is otherwise eligible.

If recoupment is agreed to, complete a DHS-4358B, Recoupment Agreement, have the client/guardian sign it, then forward the original to the local office for collection. If he/she **refuses** to sign it, inform the local office in writing.

A delinquent OI balance can be referred to Treasury for collection **if**:

- The client signed a DHS-4358B, **or**
- Recoupment is court ordered.

LEGAL BASE

MA

42 CFR 431.230(b)
MCL 400.60

DEPARTMENT POLICY

All Programs

Recoupment policies and procedures vary by program and overissuance type. This item explains client error overissuance processing and establishment.

BAM 700 explains overissuance discovery, types and standard of promptness. BAM 705 explains agency error and BAM 720 explains Intentional Program Violations (IPV).

Definitions

All Programs

A provider error overissuance is when the client received more benefits than he/she was entitled to because the client/CDC provider gave incorrect or incomplete information to the department.

A client error exists when the client's timely request for a hearing results in the suspension of a Michigan Department of Health and Human Services (MDHHS) action, and any of:

- The hearing decision upholds the MDHHS action.
- The client withdraws the hearing request.
- The client fails to appear for the hearing which is not rescheduled.
- The Michigan Administrative Hearings System (MAHS) sends written notice to proceed with case actions.

Non-Honored SDA Repay Agreements

SDA Only

A client error exists when the client fails to honor an SDA repay agreement after receiving a potential resource. Do not pursue IPV; see BEM 272.

Note: SSI benefit recovery is initiated by the Reconciliation and Recoupment Section (RRS) in central office. If the client contacts the local office to arrange repayment, issue the client the DHS-4358A, -B, -C and -D, Notice of Overissuance and Repay

Agreement. Have the client sign form DHS-4358B, Agency and Client Error Information and Repayment Agreement. Do **not** enter these debts on Bridges unless the client signs the DHS-4358B. Notify the local Interim Assistance Reimbursement (IAR) liaison in the local office if the client signs a DHS-4358B. The IAR liaison will contact RRS; see BEM 272.

Provider Error

CDC Only

Provider errors are overissuances caused by a provider.

All overissuances established in the local office for CDC providers are sent to RRS in central office.

OVERISSUANCE PROCESSING

All Programs

FIS/ES Actions

When a potential overissuance is discovered, do all of the following:

1. Take immediate action to correct the current benefits; see BAM 220, Case Actions, for change processing requirements.
2. Obtain initial evidence that an overissuance potentially exists.
3. Determine if it was caused by department, provider or client actions.
4. Refer all client errors to the RS within **60 days** of suspecting or if a suspected overissuance exists.

OQA Audits

FIP, SDA, and FAP

Overissuances discovered by the Office of Quality Assurance (OQA) must be referred to the Recoupment Specialist (RS) within seven days of receipt of the OQA findings since they verified one exists.

Recoupment Specialist Referral

FIP, SDA, CDC and FAP

Bridges refers most client errors to the RS. Use the DHS-4701, Overissuance Referral, to refer manual overissuances.

Complete all sections of the DHS-4701 and attach the potential evidence. Send it to the RS for your local office or region. A recoupment specialist list is in DHS-Net, Tools under Directories. The listing provides RS contact information by county and district.

The DHS-4701 must be sent to the RS within 60 days of suspecting an overissuance.

FIP and FAP

Do not refer a client error overissuance to the RS if, at the time it occurred, the group did not include an eligible or disqualified adult.

MA Only

Do not refer MA client errors to the RS; see BAM 710 for client error and suspected IPV processing.

SER and ESS

Refer SER and ESS overissuances to the RS only when IPV is suspected and a FIP, SDA or FAP overissuance also exists for the same period. Follow procedures in the State Emergency Relief Manual (ERM) for recoupment of SER. Follow procedures in BEM 232 for Direct Support Services (DSS).

RECOUPMENT SPECIALIST ACTIONS

FIP, SDA, CDC and FAP

Within **60** days of receiving the referral, the RS must:

- Determine if an overissuance actually occurred.
- Determine the type.

Within **90** days of determining an overissuance occurred, the RS must:

- Obtain all evidence needed to establish it.
- Calculate the amount.
- Establish the discovery date.
- Send a DHS-4358A, B, C & D to the client.
- Enter the FIP, SDA, CDC or FAP overissuance on the Benefit Recovery System (BRS).
- Refer to OIG for investigation if IPV is suspected.
- Send a DHS-4701A, Overissuance Referral Disposition, to the specialist explaining the final disposition.

FIP, SDA and FAP

Establish a suspected IPV as a client error.

For OQA discovered overissuances, the RS will have a total of 90 days from the date of receiving the referral to:

- Obtain all evidence needed to establish it.
- Calculate the amount.
- Start collection action on client and suspected IPV errors as client errors.
- Refer all suspected IPVs to OIG for investigation.

OIG Referral

FIP, SDA, CDC and FAP

RS must refer all client and provider errors suspected as IPV to OIG when IPV criteria are met. See BAM 720 for the criteria and policy on establishing IPV in the local office.

OVERISSUANCE PERIOD

All Programs

Begin Date

FIP, SDA, CDC and FAP

The overissuance period begins the first month (or pay period for CDC) benefit issuance exceeds the amount allowed by policy **or** 72 months before the date it was referred to the RS, whichever is later.

To determine the first month of the overissuance period (for overissuances 11/97 or later) Bridges allows time for:

- The client reporting period, per BAM 105.
- The full standard of promptness (SOP) for change processing, per BAM 220.
- The full negative action suspense period; see BAM 220, Effective Date of Change.

Simplified Reporting

FAP

Bridges determines the first month of the overissuance as two months after the actual monthly income exceeded the simplified reporting (SR) limit. This accounts for the 10 days to report by the client, the 10 days for the specialist to act on the change and the 12-day negative action period; see BAM 200.

Example: The group's income for April exceeded the SR limit. The group should have reported this by May 10, but did not. June is the first month of the overissuance.

If the income falls below the income limit any time during these two months **and** does not exceed the income limit again during the certification period, recoupment is not necessary. If it does exceed the income limit **again** during the certification period and the client does not report, all months that exceeded the limit after the first two months would be recouped.

Example: Bert started a job and called his specialist to report the hours and wages. Bert is put in SR in February and was sent a letter stating his income limit. After a week he gets an increase in hours which puts him over the limit. He does not report. In April the hours were reduced putting him under the income limit. In May Bert is promoted and goes over the income limit and again does not report. The last week of June he is demoted. Bert's overissuance period would be May and June.

End Date

FIP, SDA, CDC and FAP

The overissuance period ends the month (or pay period for CDC) before the benefit is corrected.

Discovery Date

FIP, SDA, CDC and FAP

Bridges automatically inserts the date when there is an overissuance and a referral is made to the RS. The discovery date for manual claims is the date the overissuance is known to exist and there is evidence available to determine the type.

OVERISSUANCE AMOUNT

FIP, SDA, CDC and FAP

The amount of the overissuance is the benefit amount the group or provider actually received minus the amount the group was eligible to receive.

FAP Only

If the overissuance involves two or more FAP groups which should have received benefits as one group, determine the amount by:

- Adding together all benefits received by the groups that must be combined, **and**
- Subtracting the correct benefits for the one combined group.

Overissuance Threshold

FIP, SDA, CDC and FAP

No client overissuance will be established if the amount is less than $250.

OVERISSUANCE CALCULATION

FIP, SDA, CDC and FAP

Benefits Received

FIP, SDA and CDC

The amount of benefits received in an overissuance calculation includes:

- Regular warrants.
- Supplemental warrants.
- Duplicate warrants.
- Vendor payments.
- Administrative recoupment deduction.
- EBT cash issuances.
- EFT payment.
- Replacement warrants (use for the month of the original warrant).

Do **not** include:

- Warrants that have not been cashed.
- Escheated EBT cash benefits (SDA).

Warrant history is obtained from Bridges under Benefit Issuance; see RFT 293 and 294.

FAP Only

The amount of EBT benefits received in the overissuance calculation is the **gross** (before AR deductions) amount **issued** for the benefit month.

If the FAP budgetable income included FIP/SDA benefits, use the grant amount actually received in the overissuance month. Use the FIP benefit amount when FIP closed due to a penalty for non-cooperation in an employment-related activity.

FAP participation is obtained in Bridges under Benefit Issuance.

Determining Budgetable Income

FIP, SDA, CDC and FAP

If improper reporting or budgeting of income caused the overissuance, use actual income for that income source. Bridges converts all income to a monthly amount.

Exception: For FAP only, do not convert the averaged monthly income reported on a wage match.

Any income properly budgeted in the issuance budget remains the same in that month's corrected budget.

Examples:

- Randy and Andi Andrews both started work. They reported Randy's job but did not report Andi's job. For the corrected calculation, use actual income for Andi and the projected income already budgeted correctly for Randy.
- Minnie and Mickey receive FIP with their three children. Mickey has reported his employment at Disney Corp. They failed to report that one of the children left five months ago to go live with his mother, Mickey's ex-wife. The corrected month budgets will use the income already projected properly for Mickey, but remove the child from the household size.

FAP Only

For client error overissuances due, at least in part, to failure to report earnings, do **not** allow the 20 percent earned income deduction on the unreported earnings.

OVERISSUANCE ADJUSTMENTS

FIP Only

Subtract from the overissuance all or part of any net assigned **current** support collections retained by the state **for the benefit period**:

- If the group was ineligible for FIP during the overissuance period, subtract the net support collections retained.

- If the group was eligible for part of the FIP benefits issued, subtract the portion of the net support collections retained in excess of what the group was eligible for.

Overissuance months prior to October 2011

Example: Subtract $50 from reported amount before performing the calculations above.

Overissuance Adjustment

Overissuance exists:

	$400	Monthly FIP benefit received by the group.
-	$300	Monthly FIP benefit group should have received.
	$100	One month OI

Reducing the overissuance **when paid support exceeds the FIP benefit:**

	$375	Child support paid per DL-060.
-	$50	Child support rebate sent to group.
	$325	Difference in child support.
-	$300	Actual monthly FIP benefit group was eligible for.
	$25	This amount is subtracted to reduce the OI amount from $100 to $75.

Do not reduce the overissuance **when paid support does not exceed the FIP benefit:**

	$300	Child support paid per DL-060.
-	$50	Child support rebate sent to group.
	$250	Difference in child support.
-	$300	Actual monthly FIP benefit group was eligible for.
	0	Do not subtract anything from the OI amount, FIP benefit exceeds the difference in child support.

CLIENT NOTIFICATION

FIP, SDA, CDC and FAP

Unless recouping from the CDC provider, Bridges will notify the group of a client error by sending a completed:

- DHS-4358A, Notice of Overissuance.
- DHS-4358B, Agency and Client Error Repayment Agreement.
- DHS-4358C, Overissuance Summary.
- DHS-4358D, Hearing Request for Overissuance or Recoupment Action.

An explanation of the reason for overissuance, along with the manual items, must be filled out using the view pending screen in Correspondence.

CDC Provider Error

The provider is not notified of an overissuance by the RS. Send a copy of the issuance summary by ID-mail to:

Fraud and Recoupment Administration
Reconciliation and Recoupment Section
Suite 710 Grand Tower Building

The reconciliation and recoupment section will notify the provider and initiate recoupment.

INITIATE RECOUPMENT

FIP, SDA, CDC and FAP

Bridges automatically starts the recoupment process. The client is instructed to return the DHS-4358B, Repay Agreement, to the welfare debt unit (WDU) or the RS if a hearing is requested. RS must notify WDU if a hearing was requested.

If the client returned the signed repay it must be entered in Bridges in Record Repayment Agreement.

If the repay is sent to the RS, make a copy for the case record and send the original DHS-4358B via ID mail to:

Fraud and Recoupment Administration

Reconciliation and Recoupment Section
Welfare Debt Unit
Suite 710, Grand Tower Building

The reconciliation and recoupment section will notify and initiate collection on provider errors.

Active Programs

Notify the specialist of the final disposition of the overissuance and administrative recoupment effective date via the DHS-4701A.

HEARING REQUESTED

FIP, SDA, CDC and FAP

Active Cases

A hearing request on a DHS-4358D, Hearing Request for Overissuance or Recoupment Action, must be forwarded to MAHS along with a completed DHS-3050, Hearing Summary, and exhibits according to normal hearing procedures; see BAM 600.

Received Timely

If the request is received within the negative action effective date, update the status field in Claim Adjustment.

- If MDHHS is **not** upheld, use Claim Adjustment to decrease balance to zero with hearing decision for reason. This will close the overissuance.
- If MDHHS is upheld, enter standard recoupment for the reason in status field under Claim Adjustment. This will start the recoupment process. Enter the date of the hearing decision in agreement sign date.
- If client withdraws the hearing request or fails to show and the hearing is not rescheduled, enter standard recoupment for the reason in status field under Claim Adjustment.

Received After Effective Date

If the hearing request is received **after** the negative action effective date, continue recoupment until issue resolution. Notify WDU that a hearing was requested.

- If MDHHS is upheld, update the agreement sign date with the date of the hearing decision.
- If MDHHS is **not** upheld, update the adjustment box, including entering zero for amount in the Claim Adjustment screen.

Inactive Cases

MDHHS requests a debt collection hearing when the grantee of an inactive program requests a hearing after receiving the DHS-4358B, Repayment Agreement, Active recipients are afforded their hearing rights automatically, inactive recipients are not. Complete a DHS-3050 indicating the hearing is for a debt collection issue. Forward the DHS-4358A, -B, -C and -D, DHS-3050 and all exhibits to MAHS. See BAM 725 regarding evidence and debt collection hearing procedures.

LEGAL BASE

FIP

MCL 400.1 et. seq.
MCL 400.60
Mich Admin Code, R 400.3129 - 400.3131
Personal Responsibility and Work Opportunity Reconcilation Act of 1996, P.L. 104-193 of 1996

FAP

7 CFR 272.8
7 USC 2022
Mich Admin Code, R 400.3011

SDA

Annual appropriations Act

MA

42 CFR 431.230(b)
MCL 400.60

CDC

45 CFR Parts 98 and 99
Social Security Act, 42 USC *et seq*, as amended
Mich Admin Code, R 400.5001 - 400.5020

DEPARTMENT POLICY

All Programs

Recoupment policies and procedures vary by program and overissuance type. This item explains Intentional Program Violation (IPV) processing and establishment.

BAM 700 explains the discovery date, types and standards of promptness. BAM 705 explains agency error and BAM 715 explains client error.

DEFINITIONS

All Programs

Suspected IPV

Suspected IPV means an overissuance exists for which all three of the following conditions exist:

- The client **intentionally** failed to report information **or intentionally** gave incomplete or inaccurate information needed to make a correct benefit determination, **and**
- The client was clearly and correctly instructed regarding his or her reporting responsibilities, **and**
- The client has no apparent physical or mental impairment that limits his or her understanding or ability to fulfill their reporting responsibilities.

IPV is suspected when there is clear and convincing evidence that the client or CDC provider has intentionally withheld or misrepresented information for the **purpose** of establishing, maintaining, increasing or preventing reduction of program benefits or eligibility.

FAP Only

IPV is suspected for a client who is alleged to have trafficked FAP benefits.

IPV

FIP, SDA, FAP and CDC

The client/authorized representative (AR) is determined to have committed an IPV by:

- A court decision.
- An administrative hearing decision.
- The client/AR signing a DHS-826, Request for Waiver of Disqualification Hearing, or DHS-830, Disqualification Consent Agreement, or other recoupment and disqualification agreement form.

FIP Only

The Aid to Families with Dependent Children (ADC) program was succeeded by the Family Independence Program (FIP). Treat these programs as interchangeable when applying IPV disqualification policy.

Example: Clients who committed an IPV while receiving ADC are to be disqualified under the FIP program.

FAP Only

IPV exists when an administrative hearing decision, a repayment and disqualification agreement or court decision determines FAP benefits were trafficked.

MA Only

IPV exists when the client/AR or CDC provider:

- Is found guilty by a court, **or**

- Signs a DHS-4350, IPV Repayment Agreement, **and** the prosecutor or the office of inspector general (OIG), authorizes recoupment in lieu of prosecution, **or**

- Is found responsible for the IPV by an administrative law judge conducting an IPV or debt establishment hearing.

OVERISSUANCE PROCESSING

All Programs

FIS/ES Actions

When a potential overissuance is discovered, complete the following steps:

1. Take immediate action to correct the current benefits; see BAM 220, Case Actions, for change processing requirements.
2. Obtain initial evidence that an overissuance potentially exists.
3. Determine if the overissuance was caused by department, provider or client actions.
4. Refer all client or suspected IPV errors to the recoupment specialist (RS) within **60** calendar **days of suspecting an** overissuance **exists.**

OQA Audits

FIP, SDA, CDC and FAP

Overissuances discovered by the Office of Quality Assurance (OQA) must be referred to the RS within **seven days** of receipt of the OQA findings- since they verified one exists.

Recoupment Specialist Referral

FIP, SDA, CDC and FAP

Bridges refers most client and suspected IPV errors to the RS. Use the DHS-4701, Overissuance Referral, to refer manual overissuances.

Complete the DHS-4701 **and** attach the potential evidence. Send it to the RS for your local office or region. A recoupment specialist listing is in the DHS-Net, Tools under Directories. The listing provides RS contact information by county and district.

The DHS-4701 must be sent to the RS within 60 days of suspecting that an overissuance exists.

MA Only

Do not refer MA overissuances to the RS; see BAM 710 for suspected IPV processing.

SER and ESS

Refer SER and ESS overissuances to the RS only when IPV is suspected and a FIP, SDA or FAP overissuance also exists for the same period. Follow procedures in the SER manual for recoupment of SER. Follow procedures in BEM 232 for Direct Support Services (DSS).

RECOUPMENT SPECIALIST ACTIONS

FIP, SDA, CDC and FAP

Within **60** days of receiving the referral, the RS must:

- Determine if an overissuance actually occurred.
- Determine the overissuance type.

Within **90** days of determining an overissuance occurred, the RS must:

- Obtain all evidence needed to establish an overissuance.
- Calculate the amount.
- Establish the discovery date.
- Refer all suspected IPV overissuances to OIG for investigation.
- Enter the FIP, SDA, and FAP suspected IPV errors as client errors on the Bridges Recoupment System (BRS).
- Enter the pending CDC on BRS.

Exception: For OQA **discovered** overissuances, the RS will have a total of **90** days from the date of receiving the referral to:

- Obtain all evidence needed to establish an overissuance.
- Calculate the amount.

- Start collection action on all agency and client errors and suspected IPV errors for FIP, SDA and FAP.
- Refer all suspected IPV overissuances to OIG for investigation.

OIG REFERRAL CRITERIA

All Programs

Prudent judgment should be used in evaluating an overissuance for suspected IPV. Consider the following questions when reviewing the case:

- Does the record show that department staff advised the client of his or her rights and responsibilities?
- Does the record show the client's acknowledgment of these rights and responsibilities?
- Did the client neglect to report timely when required to do so?
- Did the client make false or misleading statements?
- Does the client error meet suspected IPV criteria?
- Does the amount meet the OIG dollar threshold found below?

Suspected IPVs are referred to OIG when:

- From preliminary review, it appears that the overissuance falls within the definition of suspected IPV found in this item, **and**
- The total overissuance amount for all programs combined is $500 or more, **or**
- The total overissuance amount for all programs combined is less than $500, **and**
  - The group has a previous IPV, **or**
  - It involves concurrent receipt of assistance; see BEM 222, **or**
  - The client has had at least two client errors previously, or
  - The alleged fraud is committed by a state government employee.

CDC Provider Error Only

Refer overissuances of $500 or more caused by a provider's intentional false billings or intentional inaccurate statements. Some examples are:

- Failing to bill correctly.
- Receiving CDC payment for care paid by a third party.
- Receiving CDC payment for hours when the child was not in care and the absence was not allowable; see BEM 706.

SER Only

Suspected IPVs can be combined with FIP, SDA, CDC and FAP programs to meet the OIG referral threshold of $500. FIS and ES must calculate the overissuance amount and period before sending to the RS.

OIG REFERRALS

All Programs

Refer all suspected IPVs using the DHS-834, Fraud Investigation Request, located on the Michigan Inspector General System (MIGS). Attach all evidence and verifications supporting the overissuance and suspected IPV to the DHS-834.

Indicate on the DHS-834 whether the client was ever disqualified from the program(s) due to IPV and if so, the number of times per program.

Exception: For FIP, do not refer an overissuance to OIG if at the time it occurred, the group did not include an eligible or disqualified adult.

BRS Entry

FIP, SDA and FAP

When the DHS-834 is sent to OIG, enter the overissuance(s) on BRS for collection as a client error.

OVERISSUANCE PERIOD

Begin Date

FIP, SDA, CDC and FAP

The overissuance period begins the first month (or pay period for CDC) benefit issuance exceeds the amount allowed by policy **or** 72 months (6 years) before the date it was referred to the RS, whichever is later.

To determine the first month of the overissuance period (for overissuances 11/97 or later) Bridges allows time for:

- The client-reporting period, per BAM 105.
- The full standard of promptness (SOP) for change processing, per BAM 220.
- The full negative action suspense period.

Note: For FAP simplified reporting, the household has until the 10th of the following month to report the change timely; see BAM 200.

End Date

FIP, SDA, CDC and FAP

The overissuance period ends the month (or pay period for CDC) before the benefit is corrected.

Discovery Date

FIP, SDA, CDC and FAP

The discovery date for an IPV is the date OIG has verified that an IPV exists. This is the date the referral was sent to the prosecutor or the date that OIG requests an administrative disqualification hearing.

OVERISSUANCE AMOUNT

FIP, SDA, CDC and FAP

The amount of the overissuance is the benefit amount the group or provider actually received minus the amount the group was eligible to receive.

Estimate the overissuance amount pending OIG investigation results **if:**

- IPV is suspected, **and**

There is not enough information to determine the exact amount. Do not enter the estimated IPV as a client error for collection.

FAP Only

When the overissuance involves two or more FAP groups which should have received benefits as one group, determine the amount by:

- Adding together all benefits received by the groups that must be combined, **and**
- Subtracting the correct benefits for the one combined group.

FAP Trafficking

The amount for trafficking-related IPVs is the value of the trafficked benefits (attempted or actually trafficked) as determined by:

- The court decision.
- The individual's admission.
- Documentation used to establish the trafficking determination, such as an affidavit from a store owner or sworn testimony from a federal or state investigator of how much a client could have reasonably trafficked in that store. This can be established through circumstantial evidence.

OVERISSUANCE CALCULATION

FIP, SDA, CDC and FAP

Benefits Received

FIP, SDA and CDC

The amount of benefits received in an overissuance calculation include:

- Regular warrants.
- Supplemental warrants.
- Duplicate warrants.
- Vendor payments.
- Administrative recoupment deductions.
- EBT cash benefits issued.
- EFT payment.
- Replacement warrants (use for the month of the original warrant).

Do not include:

- Warrants that have not been cashed.
- Escheated EBT cash benefits (SDA only).

Warrant history is obtained from Bridges under Benefit Issuance; see RFT 293 and RFT 294.

FAP Only

The amount of EBT benefits received in the calculation is the **gross** (before AR deductions) amount issued for the benefit month.

FAP participation is obtained in Bridges under Benefit Issuance.

If the FAP budgetable income included FIP/SDA benefits, use the grant amount actually received in the overissuance month. Use the FIP benefit amount when FIP closed due to a penalty for non-cooperation in an employment-related activity.

Determining Budgetable Income

FIP, SDA, CDC and FAP

If improper reporting or budgeting of income caused the overissuance, use actual income for the overissuance month for that income source. Bridges converts all income to a monthly amount.

Exception: For FAP only, do not convert the averaged monthly income reported on a wage match.

Any income properly budgeted in the issuance budget remains the same in that month's corrected budget.

Examples:

- Randy and Andi Andrews both started work. They reported Randy's job but did not report Andi's job. For the corrected calculation, use actual income for Andi and the projected income already budgeted correctly for Randy.
- Minnie and Mickey receive FIP with their three children. Mickey has reported his employment at Disney Corp. They failed to report that one of the children left five months ago to go live with his mother, Mickey's ex-wife. The corrected month budgets will use the income already projected properly for Mickey, but remove the child from the household size.

FAP Only

For client error overissuances due, at least in part, to failure to report earnings, do **not** allow the 20 percent earned income deduction on the unreported earnings.

OVERISSUANCE ADJUSTMENTS

Assigned Support

FIP Only

Subtract from the overissuance amount any net assigned **current** support collections (not arrears) retained by the state for the benefit period:

- If the group was ineligible for FIP during the overissuance period, subtract the net support collections retained.
- If the group was eligible for part of the FIP issued, subtract the portion of the net support collections retained in excess of what the group was eligible for.

Overissuance months prior to October 2011

Example: Subtract $50 from reported amount before performing the calculation above.

Overissuance Adjustment

Overissuance **exists:**

	$400	Monthly FIP benefit received by the group.
-	$300	Monthly FIP benefit group should have received.
	$100	One month overissuance

Reducing the overissuance **when paid support exceeds the FIP benefit:**

	$375	Child support paid per DL-060.
-	$50	Child support rebate sent to group.
	$325	Difference in child support.
-	$300	Actual monthly FIP benefit group was eligible for.
	$25	This amount is subtracted to reduce the overissuance amount from $100 to $75.

Do not reduce the overissuance **when paid support does not exceed the FIP benefit:**

	$300	Child support paid per DL-060.
-	$50	Child support rebate sent to group.
	$250	Difference in child support.
-	$300	Actual monthly FIP benefit group was eligible for.
	0	Do not subtract anything from the overissuance amount, FIP benefit exceeds the difference in child support

OIG RESPONSIBILITIES

All Programs

Suspected IPV cases are investigated by OIG. OIG will:

- Refer suspected IPV cases that meet criteria for prosecution to the Prosecuting Attorney.
- Refer suspected IPV cases that meet criteria for IPV administrative hearings to the Michigan Administrative Hearings System (MAHS).
- Return non-IPV cases to the RS.

IPV Hearings

FIP, SDA, CDC, MA and FAP

OIG represents MDHHS and MDE during the hearing process for IPV hearings.

OIG requests IPV hearings when no signed DHS-826 or DHS-830 is obtained, and correspondence to the client is not returned as undeliverable, or a new address is located.

Exception: For FAP only, OIG will pursue an IPV hearing when correspondence was sent using first class mail and is returned as undeliverable.

OIG requests IPV hearing for cases involving:

1. FAP trafficking overissuances that are not forwarded to the prosecutor.
2. Prosecution of welfare fraud or FAP trafficking is declined by the prosecutor for a reason other than lack of evidence, **and**
    - The total amount for the FIP, SDA, CDC, MA and FAP programs combined is $500 or more, **or**
    - The total amount is less than $500, **and**
        - The group has a previous IPV, **or**
        - The alleged IPV involves FAP trafficking, **or**

- The alleged fraud involves concurrent receipt of assistance (see BEM 222), **or**
- The alleged fraud is committed by a state/government employee.

Excluding FAP, OIG will send the OI to the RS to process as a client error when the DHS-826 or DHS-830 is returned as undeliverable and no new address is obtained.

OIG DISPOSITIONS

Referral Rejected

All Programs

OIG may return a DHS-834, Fraud Investigation Request, as inappropriate or with insufficient information to pursue as a result of their initial review and screening of the referral.

FIP, SDA, CDC and FAP

Recoup the overissuance as client or provider error if:

- There is enough information to determine the amount, **and**
- It is not due to agency error.

OIG Closure

All Programs

OIG may return an investigation disposition indicating investigation closure if it determines IPV evidence does not exist.

FIP, SDA, CDC and FAP

Recoup the overissuance as client or provider error if:

- There is enough information to determine the amount, **and**
- It is not due to agency error.

Prosecutor Actions

All Programs

The investigation disposition is completed specifying the prosecuting attorney's office action. If the client signed a DHS-830 and DHS-4350 in lieu of prosecution, see the **IPV ESTABLISHED** section in this item. There is no further administrative appeal after a

DHS-830 and DHS-4350 are signed. The client may appeal to circuit court.

FIP, SDA, CDC and FAP

Recoup the overissuance as client or provider error if:

- Prosecution is declined for lack of IPV evidence, **and**
- OIG did not pursue an IPV hearing, **and**
- There is enough information to determine the OI amount, **and**
- It is not due to agency error.

Court Actions

All Programs

The investigation disposition is completed specifying the action of the court.

If it is determined the client or provider committed an IPV, complete the following steps:

- Initiate recoupment as ordered by the court.
- Recoup the full amount as IPV if the court does not address recoupment.
- If the court-ordered IPV recoupment is less that the overissuance amount, recoup the remainder as client or provider error.
- **For FIP, SDA and FAP** apply the court-ordered disqualification period **or** the standard IPV period specified in this item if the court does not address disqualification.

See IPV ESTABLISHED and DISQUALIFICATION sections of this item.

FIP, SDA CDC and FAP

Recoup the overissuance as client or provider error if:

- The charges were dismissed for lack of evidence.
- There is enough information to determine the amount.
- It is not due to agency error.

Reminder: For OIs originally calculated as suspected IPV that are found to be client error only, the OI period may change and affect the OI amount.

Administrative Action

FIP, SDA, CDC and FAP

The investigation disposition is completed when:

- A DHS-826 and DHS-4350 is obtained from the client.
- For FIP, SDA and FAP, when an IPV hearing decision is issued.

IPV ESTABLISHED

All Programs

OIG will send all dispositions to the recoupment specialist within **14** days of their final disposition. The RS will forward SER and MA overissuances to the ongoing specialist and the local office to initiate recoupment actions.

FIP, SDA and FAP

IPV findings result in a higher repayment amount for recoupment of the overissuance **and** member disqualification for the program in which it occurred.

RS must complete recoupment and disqualification actions within 10 days of receipt of the OIG final disposition or signed DHS-4350 and DHS-830.

Exception: OIG may obtain a DHS-325, Provider Repayment Agreement. The original is sent to the Reconciliation and Recoupment Section (RRS) in central office and a copy is sent to the local office RS and should be filed in the provider file. No further action is required by the RS to initiate provider recoupment.

DISQUALIFICATION

FIP, SDA and FAP

Disqualify an active **or** inactive recipient who:

- Is found by a court or hearing decision to have committed IPV.
- Has signed a DHS-826 or DHS-830.
- Is convicted of concurrent receipt of assistance by a court.

- For FAP, is found by MAHS or a court to have trafficked FAP benefits.

A disqualified recipient remains a member of an active group as long as he lives with them. Other eligible group members may continue to receive benefits.

See BEM 400, BEM 518, and BEM 554 for treatment of the assets and income of disqualified group members.

CDC Providers Only

See BEM 707 for provider disqualifications.

Standard Disqualification Periods

FIP, SDA and FAP

The standard disqualification period is used in all instances except when a **court** orders a different period; see Non-Standard Disqualification Periods in this item.

Apply the following disqualification periods to recipients determined to have committed an IPV:

- One year for the first IPV.
- Two years for the second IPV.
- Lifetime for the third IPV.

FIP and FAP

- Ten-year disqualification for concurrent receipt of benefits if fraudulent statements were made regarding identity or residency; see BEM 203.

CDC Providers Only

See BEM 707 for disqualification periods.

Nonstandard Disqualification Periods

FIP, SDA and FAP

Courts may order nonstandard disqualification periods. Apply the court ordered period.

If the court does not address disqualification in its order, the standard period applies.

Periods Shorter Than Standard

Periods of at least one month, but shorter than the standard period specified are entered on Bridges like the standard period.

When zero disqualification is ordered for a recipient do not enter on Bridges.

Disqualified Grantee

FAP Only

A disqualified member may continue as the grantee **only if** there is no other eligible adult in the group.

When the grantee in a joint FIP/SDA and FAP case is disqualified for FAP, open the group's FAP under a **separate case number if**:

- There is another adult in the FAP case, **and**
- The disqualified member remains the FIP/SDA grantee.
- Continue a joint FIP/SDA and FAP case under a **single case number** after the grantee's FAP disqualification **if** the other adult FAP member becomes the grantee for both groups.

FAP Program Violations

FAP Only

Courts order FAP program disqualifications for misuse of program benefits; see BEM 203 for more information.

Apply disqualification periods when a recipient is convicted by a state or federal court, as follows:

- Two years when the recipient has been convicted of trading FAP to acquire illegal drugs.
- Lifetime period when the recipient has been convicted of:
  - Trading FAP to acquire illegal drugs for a second time.
  - Trading FAP to acquire firearms, ammunition or explosives.
  - Trafficking FAP with a value of $500 or more.
- The standard IPV disqualification periods apply to FAP trafficking convictions less than $500.

The standard IPV disqualification periods apply to FAP trafficking determinations made by MAHS or by the client signing a repay agreement.

CLIENT NOTICE

FIP, SDA and FAP

Notify the client of an IPV recoupment and disqualification actions via the DHS-4357, IPV Client Notice. Recoupment specialists have 10 days after receiving disposition from OIG to initiate recoupment and disqualification actions.

Give adequate notice when initiating recoupment and disqualification as a result of an IPV hearing or when a DHS-826 is signed.

Give the client **timely notice** before initiating recoupment as a result of a court action **unless** the client also signed a DHS-826.

CDC Only

See BEM 708 for sending client notices.

Hearing Request on DHS-4357

FIP, SDA, CDC and FAP

If the DHS-4357 is returned with a hearing requested, send a copy to MAHS (see BAM 600). Attach a copy of the signed DHS-826 or DHS-830 and the DHS-4350, court order or hearing decision establishing the IPV. Only hearing requests challenging the

overissuance benefit reduction or repayment amount (not the overissuance amount) are granted by MAHS.

Note: If the hearing request on a **timely** notice was received **by the** administrative recoupment **effective date**, do **not** initiate administrative recoupment, pending resolution of the hearing issue. Begin administrative recoupment if the request arrived **after** the effective date **or** if no request was filed. You must notify the welfare debt unit that a hearing was requested.

Note: CDC providers do not have hearing rights.

INITIATING RECOUPMENT

FIP, SDA, CDC and FAP

Initiate recoupment on the effective date of the DHS-4357 by entering or changing the overissuance on Bridges Recoupment System (BRS).

Note: If a court or OIG specifies an IPV overissuance amount **less** than the total amount, **and** the difference is **not** due to a calculation error, recoup:

- The court ordered amount as IPV.
- The remaining balance as a client error.

Active programs are subject to administrative recoupment to repay the overissuance. Inactive programs are subject to cash repayment. BRS will automatically send collection notices to inactive cases; see BAM 725.

BRS Entry

FIP, SDA and FAP

To start recoupment and other collections on active and inactive FIP, SDA and FAP programs, make the following changes on Bridges:

- Close the client error claim for the suspected IPV.
- Use the remaining balance of the client error when changing it to an IPV.
- Enter the correct discovery date as determined and documented by OIG.

- Enter the IPV repay notice sent date with current date.

CDC Only

Authorize the pending OIG claim.

INITIATING IPV DISQUALIFICATION

FIP, SDA and FAP

All IPV disqualifications must be served immediately. Begin the disqualification the first month after the notice is sent, unless the action is untimely; see Untimely Disqualification in this item.

If multiple IPV disqualifications occur in the same program, they are served concurrently or with overlapping periods. If other program disqualifications occur during an IPV period, they are served concurrently with the IPV disqualification.

IPV disqualification periods **cannot** be interrupted, **even if** the person becomes otherwise ineligible.

IPV disqualification from a program, for example FIP, is **not** counted when later determining the IPV disqualification period for a **different** program, for example FAP.

Disqualifications take precedence over penalties; therefore, disqualification resulting in penalties (benefit reductions) must be ended in order to impose IPV disqualifications.

Update IPV Sanctions to remove the disqualified member.

CDC Providers Only

MDE CDC Policy Unit will initiate disqualifications. Local offices should continue to complete and submit the DHS-834, Fraud Investigation Request, to OIG when it is discovered a provider may be non-compliant with program requirements; see BEM 707.

Standard of Promptness

FIP, SDA and FAP

Send the client a DHS-4357 within 10 days after the receipt of:

- The investigation disposition indicating IPV was determined.

- The hearing decision that IPV occurred.
- The signed DHS-826 or DHS-830.

Begin the disqualification the first month **after** the notice is sent.

Untimely Disqualification

FIP, SDA and FAP

When a disqualification was **not** imposed according to the standard of promptness (above):

- Impose the disqualification for any remaining months.
- Recoup the benefits issued for the months the person should have been disqualified as an agency error.
- If the agency error amount is over $250, notify the client of this overissuance via the DHS-4358A, B, C and D; see BAM 705.

LEGAL BASE

FIP

MCL 400.60
MCL 400.1 *et seq*.
Mich Admin Code, R 400.3129 - 400.3131
P.L. 104-193 of 1996

FAP

7 CFR 273.16
7 USC 2022
Mich Admin Code, R 400.3011
MCL 400.60

SDA

Annual Appropriations Act

CDC

Child Development and Care, 45 CFR Parts 98 and 99
42 USC 301 *et seq*. Social Security Act, as amended
Mich Admin Code, R 400.5001-400.5020
MCL 400.60

MA

42 CFR 431.230(b)
MCL 400.60

DEPARTMENT POLICY

FIP, SDA, CDC and FAP

When the client group or CDC provider receives more benefits than entitled to receive, Michigan Department of Health and Human Services (MDHHS) or Michigan Department of Education (MDE) must attempt to recoup the overissuance. This item explains repayment responsibility, Benefit Recovery System data management, and the various collection processes used by MDHHS or MDE.

Definitions

The **Benefit Recovery System (BRS)** is the part of Bridges that tracks all FIP, SDA, CDC and FAP overissuances and repayments, issues automated collection notices and triggers automated benefit reductions for active FIP, SDA, CDC and FAP programs.

Administrative Recoupment (AR) is an automated Bridges process that reduces current MDHHS and/or MDE benefits in order to obtain repayment on overissuances for a program.

A **Claim Number** is a unique number assigned to each overissuance when entered on the Benefit Recovery System.

PAYMENT RESPONSIBILITY

All Programs

Repayment of an overissuance is the responsibility of:

- Anyone who was an eligible, disqualified, or other adult in the program group at the time the overissuance occurred.
- A FAP-authorized representative if they had any part in creating the FAP overissuance.

Bridges will collect from all adults who were a member of the case. Administrative recoupment may be deducted on more than one case for a single overissuance.

FIP and FAP

If the overpaid group did not contain an eligible or disqualified adult during the overissuance period, do not initiate recoupment, **unless**

recoupment is established by court order or a repayment agreement is obtained in lieu of prosecution. An adult for recoupment purposes is an individual 18 years old or older.

Note: The Aid to Families with Dependent Children (ADC) program was succeeded by the Family Independence Program (FIP). Treat these programs as interchangeable when applying recoupment/disqualification policy.

Example: Clients who committed an Intentional Program Violation (IPV) while receiving ADC are to be disqualified under the FIP program.

CDC Provider Error

CDC Only

The reconciliation and recoupment section (RRS) is responsible for collecting and recording provider errors. Reconciliation and recoupment section staff enters the overissuance into the automated provider recoupment system. The system produces a notice and overpayment detail and acceptance report, which is mailed to the child care provider. The provider is instructed to review and complete the report and mail it back to the reconciliation and recoupment section.

Note: There is no threshold limit on CDC system errors. MDE will recoup these types of overissuances.

BENEFIT RECOVERY SYSTEM

FIP, SDA, CDC and FAP

Benefit Recovery System (BRS) data is based on recipient identification numbers. Each program overissuance is entered separately. Do not combine program overissuances with different overissuance periods or different overissuance types.

Each overissuance is assigned an overissuance claim number when initially entered on BRS. Review Office of Inspector General dispositions for multiple events that may have been combined or may be deleted.

Case Number Usage

Bridges reviews all persons responsible for the overissuance for current program activity and/or different case numbers.

Active Programs

All cases that contain an adult member from the original overissuance group and are active for the program in which the overissuance occurred are liable for the overissuance and subject to administrative recoupment.

Inactive Programs

Overissuances on inactive programs are recouped through cash repayment processes.

Collection notices are sent to the household on the inactive case. To determine the best case number to use for an inactive case, use this priority:

1. Use the original overissuance case number, when the following apply:
   - The case number has not been purged.
   - The case number is not active for another program.
   - The group includes an eligible or disqualified adult member who was in the program group when the overissuance occurred.

Note: Change the grantee, if necessary, to the person who is responsible for repayment of the overissuance.

2. Use **any** existing case number for inactive person(s) responsible for overissuance repayment when the original case number is not available.

OVERISSUANCE CHANGES

Always do an inquiry before entering, changing or closing an overissuance.

Always document in Bridges case comments the reason for changing or closing an overissuance event in the incorrect issuance packet. Some reasons an overissuance might be changed include:

- An Office of Inspector General or Michigan Administrative Hearings System (MAHS) disposition is received.
- A repayment agreement is received.
- The responsible person has filed for bankruptcy.
- The responsible person has died.
- Duplicate overissuance events are on Benefit Recovery System.
- The overissuance is transferred to another case number.
- A debt collection action has taken place.

Reconciliation and Recoupment Section Changes

Contact the reconciliation and recoupment section (RRS), Welfare Debt Unit, to get changes made to overissuances whenever:

- The overissuance has been suspended by the Welfare Debt Unit.
- The overissuance has a debt referral status type.

Bridges will generate an edit when changes are made to overissuances in any of the above circumstances.

Overissuance Balance Changes

The overissuance balance is calculated by Benefit Recovery System. Changing the original overissuance amount will change the balance for that overissuance and program on Benefit Recovery System records. Do **not** reduce an overissuance balance for any of the following reasons:

- A court released the person from probation and waived restitution.
- A court (probation officer) indicated an amount was worked off (for example, in community service).

Exception: For **FAP only**, reduce an overissuance by the amount the person worked off **after** a court has ordered **and** verified the

activity. Issue supplemental FAP benefits if the total repaid and worked off exceeds the overissuance. **Do not** enter an overissuance payment for the amount worked off.

Payment Consolidation

Changing an overissuance amount or closing an overissuance event will cause Benefit Recovery System to redistribute any payments that were made to the overissuance event.

Overissuance Transfer

Bridges automatically transfers an overissuance to another case number when a liable individual is currently active for the same program in which the overissuance occurred.

COLLECTIONS ON ACTIVE PROGRAMS

Overissuances on active programs are repaid by:

- Lump-sum cash payments.
- Monthly cash payments such as when court-ordered or processed by AG.
- Administrative recoupment (benefit reduction).

Note: For FIP, SDA and FAP the client may repay any part of the overissuance with electronic benefit transfer (EBT) benefits. The electronic benefit transfer benefits cannot cross programs. The client may pay on a FIP overissuance with FIP benefits and/or FAP overissuance with FAP benefits. The local office will accept and provide receipt for payment.

Lump-Sum Cash Payments

Lump-sum cash payments are acceptable on active programs. Payments can be made at the local office or to Cashier's Unit, P.O. Box 30259, Lansing, MI 48909.

Note: When the full overissuance amount is paid in a lump sum prior to the administrative recoupment effective date, the payment must be entered on Benefit Recovery System immediately after the

overissuance is entered in order to prevent administrative recoupment from occurring.

Cash Payments

Monthly cash payments (instead of administrative recoupment) are acceptable on active programs **only** if ordered by a court or processed by the Attorney General office; see **Administrative Recoupment** or Delinquent Cash Payments, in this item.

Note: Clients repaying all or part of an overissuance with a MDHHS issued warrant must be referred to local office to sign the warrant over to the local office. **Do not have the warrant voided and returned to Treasury.**

Administrative Recoupment

FIP, SDA, CDC and FAP

Active programs are subject to Administrative Recoupment (AR) for repayment of overissuances. Active program recipients are allowed to make monthly cash payments (instead of administrative recoupment) **only** when ordered by a court or processed by the AG office; see **Cash Payments** in this item.

Administrative recoupment cannot cross programs. For example; a FIP overissuance cannot be recouped from FAP benefits. An ADC overissuance can be recouped from FIP. A General Assistance (GA) overissuance can be recouped from SDA.

Administrative recoupment continues until program closure or all collectible overissuances are repaid. Administrative recoupment automatically resumes when a program with an overissuance balance reopens.

Administrative recoupment can be deducted from more than one active case for a single overissuance.

See BAM 400, **CASH BENEFITS, Openings**, for FIP and SDA early payment procedures.

AR Amount

FIP, SDA and CDC

FIP and SDA benefits are reduced for recoupment by a percentage of the **payment standard**. The administrative recoupment amount automatically changes when the payment standard changes.

The standard administrative recoupment percentage is always used unless a court has ordered a different percentage or a specific dollar amount.

The standard administrative recoupment percentage for FIP, SDA and CDC is:

- 5 percent for agency error.
- 5 percent for client error.
- 10 percent for intentional program violation.
- 20 percent for CDC provider intentional program violation.

Note: When necessary, the administrative recoupment amount is automatically reduced in order to leave a $2 grant payment to the client.

FAP Only

FAP benefits are reduced for recoupment by a percentage of the **monthly FAP entitlement**. (The entitlement amount is the amount of FAP a group would receive if any intentional program violation-disqualified members were included in the eligible group.)

Administrative recoupment occurs only on current month issuances and automatically changes when the monthly issuance amount changes.

Use the standard administrative recoupment percentage unless a court has ordered a different administrative recoupment percentage or a specific dollar amount. The minimum administrative recoupment amount is $10, unless the final overissuance payment is less than $10.

The standard administrative recoupment percentage for FAP is:

- 10 percent (or $10, whichever is greater) for agency error.
- 10 percent (or $10, whichever is greater) for client error.
- 20 percent (or $20, whichever is greater) for intentional program violation.

Note: In addition to administrative recoupment, FAP supplements to restore lost benefits are automatically **offset** when entered on Bridges to repay FAP overissuances. The restoration supplement is used in part or in whole to repay overissuances.

Delinquent Cash Payments on Active Cases

FIP, SDA and FAP

Active cases failing to make required court-ordered cash payments for 60 days are sent a DHS-1440E, Notice of Payment Due.

All cases sent the DHS-1440E notice informs the client of changing the recoupment method to benefit reduction via Administrative Recoupment (AR).

Thirty days after the DHS-1440E is sent, Bridges changes the recoupment type from cash collection to administrative recoupment, **unless** the client:

- Makes a full payment, **or**
- Seeks to renegotiate the monthly cash payment amount, **and**
- Their financial circumstances warrant a lower monthly payment by the court order.

COLLECTIONS ON INACTIVE PROGRAMS

FIP, SDA, CDC and FAP

Overissuance balances on inactive cases must be repaid by lump-sum or monthly cash payments **unless** collection is suspended; see **SUSPENDED COLLECTION ACTIONS** in this item.

Benefit Recovery System sends a collection notice when programs or cases close and an outstanding overissuance exists; see **AUTOMATED DELINQUENCY NOTICES** in this item.

Cash Payments

All Programs

Lump sum or monthly cash payments are accepted at any local office and in some cases will be routed through the AG office.

FIP, CDC, SDA and FAP

Payments can also be mailed to;

State of Michigan
Cashier's Unit
P.O. Box 30259
Lansing, MI 48909

CDC Providers

State of Michigan
MDE-Child Care-Cashier Unit
P.O. Box 30382
Lansing, MI 48909

MA Fraud

State of Michigan
MDHHS
P.O. Box 30437
Lansing, MI 48909

SER and DSS Fraud

State of Michigan
MDHHS-Reconciliation and Recoupment
P.O. Box 30802
Lansing, MI 48909

Such payments should include the payer's SSN or case number to ensure proper posting of the payment.

Expunged EBT Benefits

FAP Only

Expunged electronic benefit transfer benefits are applied to existing overissuances for the program at the time the expungement occurs.

Probate Claims

All Programs

If a local office becomes aware of an estate of a deceased person with a remaining overissuance balance, it may refer the claim to the Welfare Debt Unit (WDU). WDU and the AG will determine if pursuit

of the estate through probate court claim action is in the best interest of MDHHS or MDE.

DELINQUENCY

FIP, SDA and FAP

Bridges automatically sets delinquency at the claim level and affects all liable individuals attached to the claim. Delinquency is triggered when:

- The client fails to sign and return the DHS-4358C, Department and Client Error Information and Repayment Agreement, within 30 days of the claim establishment date.
- The client fails to make a $50 monthly cash payment within those same 30 days if the case is closed.
- The client on the closed case fails to make full payments each month until the claim is paid off.
- Previously active clients who were being administratively recouped and now have closed did not make the $50 monthly payment within 30 days after the DHS-1440A, Notice of Balance Due, was sent and each month thereafter.

When a claim becomes delinquent, Bridges refers qualifying cash programs to Michigan Treasury and FAP claims referred to the Treasury Offset Program (TOP).

MICHIGAN TREASURY COLLECTIONS

FIP, SDA and CDC

The welfare debt collection process refers cash overissuances to the State Treasury Accounts Receivable System (STARS) at the Michigan Department of Treasury and collects debts through any of the following:

- Garnishment of wages.
- Liens on bank accounts.
- Regular cash payments.
- State income tax offsets.
- Lottery winnings.
- Gaming winnings.

A cash overissuance may be referred to treasury when a full payment has not been received within 30 days after the DHS-1440A was sent.

Once an overissuance is selected for this process, the case will be identified on BRS.

Refer clients to the reconciliation and recoupment section staff (RRS) in central office at 1-800-419-3328, when requesting a review of the collection action.

RSs must assist when contacted by RRS staff in resolving issues such as evidence search, grantee changes, overissuance transfers, etc.

A person's income tax refund might be offset in error when:

- The grantee on a case is not the person responsible for repayment.
- Monthly overissuance payments are made to another department as part of court order and not entered on Benefit Recovery System in a timely manner.

For cases offset in error, recoupment specialists must send a memo explaining the reasons for requesting a refund to:

Reconciliation & Recoupment Section
Welfare Debt Unit
Suite 710, Grand Tower Building

Do **not** delete or modify the overissuance amount to remedy the error.

FEDERAL TREASURY OFFSET PROGRAM

FAP Only

Federal salaries, benefits and tax refunds may be offset to repay **any** collectible FAP overissuance when the claim is delinquent.

Federal payments eligible for offset include:

- Federal income tax returns.
- Federal salary pay, including military pay.
- Federal retirement benefits, including military retirement pay.

- Federal contractor or vendor payments.
- RSDI benefits.
- Railroad Retirement benefits.
- Black Lung (part B) benefits.
- Other federal payments, including certain loans.

Once an overissuance is selected for this process, the case will be identified on Benefit Recovery System. Refer clients to the Reconciliation and Recoupment Section (RRS) in central office to request a review of the collection action. The reconciliation and recoupment section's phone number is 1-800-419-3328.

ATTORNEY GENERAL INITIATIVE

FIP, SDA and FAP

Delinquent claims for inactive programs are eligible for referral to the Department of Attorney General (AG), Revenue and Collections Division. Referrals are issued through WDU. The AG will pursue collections on such claims through voluntary repayments, civil lawsuits, probation violations and seizure/garnishment on civil and criminal restitution orders.

Automated Delinquency Notices

FIP, SDA, CDC and FAP

Benefit Recovery System sends a collection notice when programs close with an outstanding overissuance if the claim is not already set as delinquent.

DHS-1440A

The DHS-1440A, Notice of Balance Due, is sent in the month after:

- A program with an outstanding overissuance balance closes.
- The last active program closes and there is an outstanding overissuance balance in **any** program.

DHS-1440E

The DHS-1440E, Notice of Payment Due, is sent to **active** cases when:

- The overissuance type is due to court-ordered intentional program violation.
- The recoup type is non-standard cash recoupment.
- Required monthly payments not received.

See Delinquent Cash Payments on Active Programs in this item.

DHS-1440-1

The DHS-1440-1, Notice of Default, is sent to inactive cases when the claim is delinquent. All delinquent claims are sent to Michigan Treasury for collection action.

SUSPENDED COLLECTION ACTIONS

FIP, SDA, CDC and FAP

Every overissuance is entered on Benefit Recovery System even when collection action is pending or suspended. Certain status types suspend all or some collection actions:

Used For	Collection Action
OIs pending with OIG	Suspends all collections actions.
OIs pending with AH	Suspends all collection actions.
Bankruptcy	Suspends all collection actions.
Death	Suspends all collection actions.
Suspended	Suspends all collection actions.

Bankruptcy

When a **bankruptcy notice** for a person with an outstanding overissuance balance is received it must be forwarded to the local office's designated fraud coordinator, who will process and track all bankruptcy notices. The coordinator scans the notice to the RSSECT mailbox or sends the document to WDU, WDU will notify MDHHS Legal Affairs and the RS so proper actions will be taken.

MDHHS Legal Affairs reviews and makes recommendations to the Attorney General’s office regarding whether to take legal action to block discharge of the debt. The reconciliation unit suspends debts and retrieves debt if they are in debt collection status. The RS verifies that debts are suspended.

CDC Only

MDE reviews and makes recommendations to the Attorney General's office regarding whether to take legal action to block discharge of the debt. MDE directs the reconciliation unit to suspend debts and retrieves debt if they are in debt collection status. The RS verifies that debts are suspended.

If the client's bankruptcy petition is granted, the court issues a **discharge of debt**. If MDHHS or MDE is listed as a discharged debt on the court document, determine which overissuances were discharged. Update Benefit Recovery System by:

1. The central office document control unit manually writes off overissuances that were discharged by the court:

2. Reinstating recoupment for any intentional program violation overissuances that were not discharged by the court.

   - A notification from MDHHS Legal Affairs will be sent if any intentional program violation overissuances were successfully blocked from discharge.

   - Change the status type to standard recoupment.

If the client withdraws the bankruptcy petition or the court does not grant it, the court issues a **discharge of bankruptcy**. Upon receipt of this document, change the status type back to standard recoupment on each of the affected overissuances to reinstate recoupment.

Keep all bankruptcy documents in the case record's legal packet.

The reconciliation and recoupment section coordinates bankruptcy actions between Treasury and MDHHS. If any claim shows referred to collections contact Reconciliation and Recoupment section at 1-800-419-3328.

Death

Enter the status type of deceased so Bridges will suspend all collection actions on Benefit Recovery System. The overissuance will be written off at the next quarterly Benefit Recovery System write-off.

TERMINATED COLLECTIONS

FIP and SDA

BRS Write-Off

Every quarter, Benefit Recovery System writes off overissuances that are not collectible.

Overissuances are not collectible when:

- The program has been closed six years from the **most recent** of the following dates:
  - Overissuance end date, **or**
  - Establishment date, **or**
  - Last payment date on any overissuances.

RECONCILING GH REPORTS

Bridges generates reports that must be acted on by staff.

Accounting Service Center

Each Accounting Service Center is responsible for reconciling the monthly:

- GH-370, Monthly Cash Reconciliation Report, which lists all cash or FAP benefits made directly to the local office by clients owing MDHHS for overissuances of benefits.
- GH-380, Monthly Write Off Report, contains an audit trail by listing all programs for a client where a write-off occurred.

The Accounting (ACM) Manual 481-5 has detailed instructions on completing these reports.

DRS-100 Report

Recoupment specialists are expected to take action to correct each disqualification record on the report. Depending on the error listed, the RS will correct the decision date, Social Security number, sanction begin date and/or decision date.

COMPROMISED CLAIMS

FAP Only

MDHHS can compromise (reduce or eliminate) an overissuance if it is determined that a household's **economic** circumstances are such that the overissuance cannot be paid within three years.

A request for a policy exception must be made from the RS to the Fraud and Recoupment Administration office outlining the facts of the situation and the client's **financial** hardship. The deputy director of the MDHHS Fraud and Recoupment Administration has final authorization on the determination for all compromised claims.

Send to:

Fraud and Recoupment Administration
Suite 710
235 S. Grand Ave
P.O. Box 30037
Lansing, MI 48909

INTERSTATE CLAIMS

FIP, SDA and FAP

Michigan continues to initiate and collect on claims whether the household remains in the state or not. All requests from other states to transfer a claim to or from Michigan are reviewed by the Fraud and Recoupment Administration; see address above.

FAP Only

When MDHHS learns that a client is serving a current intentional program violation disqualification in another state, the specialist must review the information. Disqualify the client if it is determined the disqualification should continue being served in Michigan.

DEBT COLLECTION HEARINGS

FIP, SDA, CDC, MA and FAP

MDHHS requests a debt collection hearing when the grantee of an **inactive** program requests a hearing after receiving the DHS-4358B, Agency and Client Error Information and Repayment Agree-

ment. Active recipients are afforded their hearing rights automatically, but MDHHS must request hearings when the program is inactive; see BAM 705 or 715, HEARING REQUESTED, Inactive Cases. Do not use the debt collection codes on Benefit Recovery System for these hearings.

FIP

Personal Responsibility and Work Opportunity Reconcilation Act of 1996, PL 104-193 of 1996
1939 PA 280, as amended
Mich Admin Code, R 400.3129 - R 400.3131

FAP

7 CFR 272.8
7 USC 2022
Mich Admin Code, R 400.3011

SDA

Annual appropriations Act

CDC

Child Develoment and Care, 45 CFR Parts 98 and 99
Social Security Act, 42 USC 301, *et seq*. as amended
Mich Admin Code, R 400.5001 - 400.5020

DEPARTMENT POLICY

All Programs

The Michigan Department of Health and Human Services (MDHHS) routinely matches recipient and applicant data with other public and private agencies through computer data exchanges. Information provided with MDHHS/MDE applications (DHS-1010, -1171, -4574, -4574B, 4583 and DCH-373) informs clients of the data exchange process.

Data exchanges assist in the verification of income, assets and other eligibility factors for MDHHS recipients and applicants.

Data exchange information must be reconciled with information contained in MDHHS case records.

DEFINITIONS

BENDEX is the Beneficiary Data Exchange system which is used to exchange information with SSA on recipients of RSDI and Medicare benefits.

M**DOC** is the Michigan Department of Corrections.

M**DE** is the Michigan Department of Education.

eDRS is the Federal Electronic Disqualified Recipient System.

IRS is the Internal Revenue Service.

NDNH is the National Directory of New Hires which is used to receive out of state new hire information.

RSDI is Retirement, Survivors, Disability Insurance, commonly referred to as Social Security benefits.

SDX is the State Data Exchange system which is used to receive information from SSA on applicants and recipients of Supplemental Security Income (SSI).

Social Security Account Number (SSN) is the number shown on a person's social security card.

Social Security Claim Number is the account number under which a person can receive RSDI and/or Medicare benefits. The

claim number might be the person's own account number or that of someone else (such as, spouse, parent).

SSA is the Social Security Administration.

SSI is Supplemental Security Income.

UCB is unemployment compensation benefits.

UIA is the Michigan Unemployment Insurance Agency.

DATA EXCHANGES

Family Independence Program (FIP), State Disability Assistance (SDA), Child Development and Care (CDC), Medicaid (MA) and Food Assistance Program (FAP)

Data is currently exchanged with:

- Social Security Administration (SSA).
- Michigan Unemployment Insurance Agency (UIA).
- Michigan New Hire Operations Center.
- Internal Revenue Services (IRS).
- Michigan Department of Corrections (MDOC).
- Michigan Department of Education (MDE).
- Michigan Lottery.
- Michigan State Police.
- National Directory of New Hires (NDNH).

SSA Data Exchanges

All Programs

Data exchanges from SSA include:

- BENDEX (Beneficiary Data Exchange System).

  This process reports information on recipients of RSDI and Medicare benefits.

- SDX (State Data Exchange).

  This system reports information on applicants and recipients of SSI.

- Enumeration Verification System.

This process matches SSNs entered on Bridges with SSNs on SSA records.

- Deceased Recipient Match.

  This match compares active recipient SSNs to SSA's death records.

- Prisoner Match

  This match identifies pending and active clients in prison or jail.

UIA Data Exchanges

FIP, SDA, CDC, MA and FAP

Data exchanges from UIA include:

- Wage Match.

  This process cross-matches MDHHS recipient data with work history records submitted by Michigan employers.

- Unemployment Compensation.

  This process cross matches MDHHS recipient data with unemployment insurance compensation recipient data.

State New Hire Exchange

FIP, SDA, CDC, MA and FAP

The only data exchange with the Michigan New Hire Operations Center is New Hires. This process cross matches active MDHHS recipients with the New Hire database which is from W-4 tax records or other new hire reporting formats submitted by employers for new employees.

IRS Data Exchange

FIP, MA, and FAP

Data exchanges from IRS include:

- IRS Unearned Income Match.

This process cross matches unearned income data from MDHHS applicant's and recipient's with unearned income reported to IRS.

- IRS Wage and Pension Match.

  This process cross matches income data from MDHHS applicants and recipients with certain income reported to IRS.

Department of Corrections Data Exchange

All Programs

The only data exchange with the Department of Corrections is the automated monthly Incarceration Match. This match identifies all individuals who are active for any program whose current living arrangement is not prison.

Department of Education Data Exchange

FAP Only

The only data exchange with the Michigan Department of Education (MDE) is the School Lunch Program. This process provides MDE with a list of school-age children receiving FAP. This allows students to be certified for free lunches without requiring the student or parent to complete an application.

Students may complete an application form at the local school if they believe they meet the low income requirements and either do not receive FAP or, if they receive FAP, did not appear on the MDHHS match that was distributed to that school district.

Local school districts are required to verify eligibility for a certain percentage of applications for the school lunch program. The verification sampling is for paper applications only, as no further verification is needed from the names provided by the MDHHS. If a FAP recipient's name is on a segment of the MDHHS information that was sent by the MDE to a different school district, the local school district may contact the local office for verification of a school lunch applicant's receipt of FAP. Local offices must cooperate in providing this verification to the local school districts.

eDRS Exchange

FAP Only

The eDRS is an exchange with the Federal Electronic Disqualified Recipient Service for all clients who are applying for FAP or are being added to a FAP case as a new member. This match assists in the identification of potential recipients who may have an intentional program violation in another state.

Lottery Match Data Exchange

FIP, SDA, MA and FAP

The only data exchange with Michigan Lottery is the Lottery Match. This match identifies clients who won $1,000 or more in the previous week.

National Directory of New Hires Exchange

FAP Only

The NDNH is an exchange with the National Directory of New Hires and is required for all FAP recipients and applicants at application and recertification. This match is used to determine current income sources reported from another state.

Data Exchange Reconciliation

FIP, SDA, CDC, MA, and FAP

Information received from any computer data exchange must be reviewed and compared with the recipient's MDHHS record. Any discrepancies must be clarified.

The standard of promptness for resolving information received from most computer matches is 45 calendar days.

Exception:

- It is a best practice to resolve information received from new hires within 21 calendar days.

- The standard of promptness for resolving information received from the SSA Prisoner match is 12 calendar days.

- It is a best practice to send an email to the recoupment specialist as soon as possible to allow the other state to verify the IPV before the standard of promptness to open the case.

Procedures for processing each data exchange vary depending on the information received and the particular data exchange process involved.

Refer to the appropriate item:

- BAM 801, SSA Data Exchanges:
  - BENDEX.
  - SDX.
  - Enumeration.
- BAM 802, Wage Match and UCB:
  - Wage Match.
  - Unemployment Compensation Match.
- BAM 803, IRS Data Exchanges:
  - IRS Unearned Income.
  - IRS Wage and Pension.
- BAM 804, Incarceration Match.
- BAM 807, State New Hires.
- BAM 808, Deceased Recipient Match.
- BAM 809, Lottery Matches.
- BAM 812, Electronic Disqualification Recipient System.
- BAM 813, National Directory New Hires Match.

LEGAL BASE

All Programs

MCL 400.10c

FIP

45 CFR 205.56 -.58
MCL 400.57a(3)
MCL 400.83

MA

MCL 400.10, .83

SDA

Annual Appropriations Act
Michigan Administrative Code; R 400.3151-400.3180

FAP

7 CFR 272
7 CFR 273.2 7
CFR 273.8
7 CFR 273.12
7 CFR 273.16(i)(1),(2),(4)

CDC

Child Care and Development Block Grant of 1990, as amended, Public Act 6 of 2014
45 CFR Parts 98 and 99
Social Security Act, as amended
Mich Admin Code R 400.5001 - 400.5020

DEPARTMENT POLICY

FIP, SDA, MA & FAP

The Michigan Department of Heath & Human Services (MDHHS) regularly matches recipient data with the Social Security Administration (SSA) through computer data exchange processes. Information provided with MDHHS applications (DHS-1010, -1171, -4574, -4574-B and DCH-373) inform clients of the data exchange process.

SSA data exchanges assist in the verification of Social Security numbers (SSNs), Retirement, Survivors and Disability Insurance (RSDI), Supplemental Security Income (SSI) and Medicare benefits.

OVERVIEW

FIP, SDA, MA, FAP & CDC

Data exchanges from SSA and the resulting reports include:

- BENDEX (Beneficiary Data Exchange System) updates Bridges information on recipients of RSDI and Medicare benefits.
- SDX (State Data Exchange) updates Bridges information on SSI recipients.
- Enumeration Verification System matches SSNs entered on Bridges with SSNs on SSA records.
- SOLQ (State Online Query) reports point in time information on RSDI, Medicare, and SSI.

FAP & SDA

40 Qualifying Quarters displays Social Security credits.

BENEFICIARY DATA EXCHANGE (BENDEX)

All Programs

BENDEX is the primary source for RSDI and Medicare benefit information. Each month, a BENDEX inquiry is sent to SSA on all new recipients.

The Social Security Administration response includes any new or changed RSDI and Medicare benefits for that person. After the initial MDHHS inquiry, a BENDEX report is generated whenever RSDI or Medicare begins, changes or stops for active MDHHS recipients.

Note: Black Lung Program data through 1973 is also shown. Later claims were processed by the Department of Labor & Economic Growth and do **not** appear on BENDEX.

How BENDEX Works

For every MDHHS recipient with a Social Security account number **or** claim number on Bridges, BENDEX cross-matches the name, Social Security number and date of birth against Social Security Administration's master beneficiary file. A discrepancy between Bridges and BENDEX information will result in no match.

A match by claim number, if available, is attempted first because it is the most reliable. Therefore, when a MDHHS client is an RSDI recipient, **enter the correct claim number in Bridges.**

WORKER INQUIRIES TO SSA

SOLQ All Programs

Worker inquiries to SSA are requested through Bridges.

Public Assistance Department Information Request

When unable to reconcile discrepant information, send the DHS-3471, DHS/SSA Referral, to the SSA district office serving your area. **Limit its use** to situations in which written and/or automated information sources differ on client benefits. For example:

- To resolve a conflict between BENDEX and SDX or data and other evidence.
- To obtain retroactive and/or historical data unavailable via BENDEX or SDX.
- To refer a person potentially eligible for an SSA program.
- To determine the status of a claim pending with SSA.

STATE DATA EXCHANGE (SDX)

All Programs

The Social Security Administration provides daily SDX data on Michigan's SSI applications, denials, openings, reopenings, closures, addresses and other changes. Central office uses this information to open and update MA program code A, B and E cases on Bridges.

The Social Security Administration provides monthly SDX payroll data on SSI recipients living in Michigan. Central office uses this data to update the state SSI payment file which is used to issue state SSI payment warrants.

ENUMERATION MATCH

All Programs

The ongoing effort to assign Social Security numbers is monitored by the Enumeration Verification System which validates Social Security account numbers entered on Bridges against SSA data. When an SSN is verified there will be a check mark in the Validated by SSA box on the Individual Information screen of Bridges.

LEGAL BASE

FIP

45 CFR 205.56-.58
MCL 400.83

MA

MCL 400.10.,.83

SDA

Annual Appropriations Act
Michigan Administrative Code; R 400.3151-400.3180

FAP

7 CFR 273.2 (f) (1) (r) (a)

DEPARTMENT POLICY

FIP, SDA, CDC, MA, and FAP

The Michigan Department of Health and Human Services (MDHHS) routinely matches recipient employment data with the Michigan Talent Investment Agency and the Unemployment Insurance Agency (UIA) through computer data exchange processes. Information provided with MDHHS/MDE applications (DHS-1010, -1171, -4574, -4574-B, MDE-4583 and DCH-1426) inform clients of the data exchange process.

These data exchanges assist in the identification of potential current and past employment income. Unemployment Compensation Benefits (UCB) are automatically populated in Bridges.

WAGE MATCH

FIP, SDA, CDC, MA, and FAP

MDHHS submits client Social Security Numbers to UIA quarterly to be cross-matched with the work history records submitted by Michigan employers. This information is compared to the client's gross earnings record in Bridges. Specialists receive one task and reminder listing all the matches for the quarter when there is a significant discrepancy between UIA and MDHHS records. The task and reminder is removed when **all** matches have been disposed of for the quarter.

Bridges also compiles the wage match report, identifying overdue and disposed wage matches by county, unit, or other. This report is available under the left navigation inquiry/wage match reports.

Reconciling Discrepancies

FIP, SDA, CDC, MA, and FAP

Reconcile each match on the alert by verifying the client's work history stated on the application or other information in the client's case record. Compare that with the wage match information to resolve the following:

- Is the person reported by UIA the MDHHS client?
- Was the client required to report earnings?

- Were the earnings already reported to MDHHS?
- Is a referral to the recoupment specialist needed to pursue an overissuance?

If there is a discrepancy, request verification from the client.

Verifying Earned Income

Request verification of the wage match earnings by generating a DHS-4638, Wage Match Client Notice, from Bridges. The DHS-4638 automatically gives the client 30 days to provide verification.

Specialist Action

FIP, SDA, CDC, MA, and FAP

Dispose of each recipient identified on the wage match alert.

Case Actions

When income from the wage match is verified and is continuing, make the appropriate changes in Bridges, then run Eligibility Determination Benefit Calculation (EDBC) to reduce or close the benefits.

Exception: For CDC only, do not reduce benefits or close the Eligibility Determination Group (EDG) unless the gross income exceeds the income eligibility scale in RFT 270.

Failure to Provide

FIP, SDA, MA, and FAP

If verifications are not returned by the 30th day, case action will need to be initiated to close the case in Bridges. If the client reapplies, the date the client reapplies determines if the wage match notification must be returned before processing the new application. See the following examples.

Example: Ms. Madison applies for assistance 30 days after case closure was initiated in Bridges. The wage match verification must be returned before processing the application. The case can be opened after verifications are provided. See BAM 117, FAP Expedited Service, for cases meeting expedited criteria.

Example: Ms. Madison applies for assistance 31 days after the case closure was initiated in Bridges. Her case may be opened

without wage matchverification from the date of the new application, if eligible.

CDC Only

Do not close the CDC EDG or reduce benefits if a CDC recipient fails to return Wage Match information.

Standard of Promptness

FIP, SDA, MA, and FAP

Wage match information must be **resolved** within 45 calendar days of receiving the wage match task and reminder. When a match is not disposed of within 45 days, the task and reminder is escalated to the specialist's supervisor.

Recoupment Specialist Action

FIP, SDA, MA, and FAP

If the household fails to provide verification of the earnings, the recoupment specialist is to use the income shown on the wage match report to calculate the overissuance.

Average the income over the time period reported on the task and reminder to determine a monthly income amount. Use the first and last month of the time period as the overissuance begin and end dates.

Notify the household of its right to request a fair hearing or provide actual income verification by checking the box on the DHS-4358C, Overissuance Summary.

If actual verification is provided, recalculate the overissuance.

Recipients with a wage match report indicating the Michigan Department of Health and Human Services (MDHHS) as the employer are adult home help providers. Payment information can be found on Bridges by accessing consolidated inquiry for the recipient.

UNEMPLOYMENT COMPENSATION BENEFITS

FIP, SDA, MA, and FAP

MDHHS receives a weekly file from Michigan UIA containing UCB payments distributed to MDHHS clients. Bridges populates Michigan UCB income automatically. If a file is received for an individual who does not have an existing unearned income record for Michigan UCB in Bridges, one will be created. The circumstance start/change date (CSCD) will be equal to the payment date. The period start date will equal the payment date minus three calendar days, and the pay detail will be entered and marked as yes to include in projections when the payment is for only a two-week period. Mass update will be triggered so the eligibility determination benefit calculation (EDBC) results will then be certified.

Out-of-state UCB income is not automated and must be entered as other unearned income.

A specialist must enter UCB income at application. If the automatic update determines a different UCB amount, Bridges will calculate a new CSCD period start date and enter the new pay detail.

The population of Michigan UCB income in Bridges will automatically stop when **all** extensions are exhausted.

Clients must report if UCB ends before all extensions are exhausted within 10 days. If the client fails to report UCB ending in a timely manner, a supplement cannot be issued.

LEGAL BASE

FIP

45 CFR 205.56-.58
MCL 400.83

MA

MCL 400.10, .83

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

FAP

7 CFR 273.2(f)(9)
7 CFR 272.8
Michigan Claims Plan
MCL 400.10

CDC

45 CFR Parts 98 and 99

DEPARTMENT POLICY

FIP, SDA, MA and FAP

DHS is required to match income information reported by third parties to IRS for all FIP, MA and FAP recipients. The data is compared to earned and unearned income for the recipient. This occurs at application and prior to each redetermination

Information provided with DHS applications (DHS-1010, -1171, - 4574, - 4574B and DCH-0373) inform clients of the data exchange process.

OVERVIEW

FIP, MA, FAP

DHS conducts two data exchange processes with IRS. When a data match occurs, applicants or recipients are sent a notice informing them of the data obtained, the source and further instruction that their specialist will be contacting them.

IRS PENALTIES

FIP, MA, FAP

The Internal Revenue Code contains criminal and civil penalties for unauthorized disclosure of tax return information:

- Per Section 7213(a), unauthorized disclosure of a federal tax return or return information is punishable by a $5,000 fine and/or 5 years imprisonment; see **EXHIBIT I** in this item.
- Per Section 7431, such disclosure is also subject to a lawsuit, including punitive damages if the disclosure is willful or caused by gross neglect; see **EXHIBIT II** in this item.

These criminal and civil penalties apply even after leaving DHS employment.

IRS tape match information is always confidential whether or not the client has signed the release of information and should never be distributed by any means including email or fax for any reason.

UNEARNED INCOME MATCH

FIP, MA, FAP

The IRS Unearned Income Match compares DHS recipient data with unearned income reported to IRS from sources such as bank account interest, lottery winnings and government subsidies. When the data exchange results in a recipient match, the client is sent a DHS-4487A, Unearned Income Notice, for applicants and DHS-4487 for active recipients.

Applicants

FIP, SDA, MA and FAP

The DHS-4487A is mailed to applicants upon receipt of IRS data. Specialists are sent a task/reminder which identifies the applicant who received notices.

Active Recipients

FIP, MA, FAP

The DHS-4487 is mailed during the month prior to the redetermination month for active recipients when a match is found with IRS. Specialists are sent a task/reminder which identifies the client who received notices.

WAGE AND PENSION MATCH

FIP, MA, (except for Healthy Kids), FAP

The IRS Wage and Pension Match compares DHS recipient data with unearned income reported to IRS from sources such as agricultural and military pensions, unemployment compensation, self-employment and annualized out-of-state wages.

When a match is found on the Wage and Pension Match, the client is sent a DHS-4033, Tape Match Income Notice, in the month of August. Specialists are sent a task/reminder which identifies the client who received notice.

CLIENT NOTICE

FIP, MA, FAP

One notice is sent which includes each source of income that is reported for the recipient. The number of pages mailed to the group is shown at the top of each notice (such as page 1 of 3).

Each notice contains the following information:

- Recipient-identifying information.
- Name and address of third-party source reporting the income.
- Type and amount of income reported.
- Tax year for which the income was reported.
- Instructions to submit verification to his/her specialist.

The notice also informs the client that failure to provide the required information may result in benefit denial, reduction or closure.

SPECIALIST PROCESSING OF IRS MATCHES

FIP, MA, FAP

When you receive a task/reminder indicating a match notice was sent, take the following actions:

1. Request the client return all supporting verification.

2. When the client returns the notice, determine if additional verifications are needed. If so, have client sign the DHS-20, Verification of Assets, to allow for release of information from the institution on the notice.

3. If a notice is returned to the local office:

    - Send the form to the Designated Staff Person (DSP) for logging and destruction.

    - Document in the case record any actions taken regarding the notice.

Note: If the specialist, rather than the client, completes the name and/or address of the institution on any document pertaining to the IRS match, it must be sent to the DSP to be logged and destroyed.

4. If the client claims a notice was lost or never received, or if you need a copy, the DSP can reproduce a copy for the client or you; see **OBTAINING IRS NOTICE COPIES** in this item.

5. The client must verify the information on the notice.

   - If the client **cannot** verify the notice information, have the client enter the name and address of the third party source and sign a DHS-20, Verification of Assets, to allow for release of information from the institution listed on the notice.

   - If the client refuses to verify the information, use appropriate BEM and BAM procedures to deny or close the case or reduce benefits.

VERIFICATIONS

FIP, MA, FAP

Information on IRS match notices is **unverified**. Do **not** take a negative action based solely on that information.

Seek verifications from the client or third party which establish factors such as the following:

- Time period involved.
- The asset that generated the income.
- Whether the asset and/or income was available to the client.

When verification is unavailable to both you and the client, use the best available information to determine current eligibility and document in the case record.

Once verification is received, use appropriate BEM and BAM processing procedures to determine past and current eligibility, benefit denial/closure/reduction.

FILING THE CLIENT NOTICE AND THIRD PARTY VERIFICATIONS

All Programs

Do not file the match notice in the case record. It must be treated as confidential and returned to the Designated Staff Person; see **SAFEGUARDING IRS INFORMATION**.

The verification received from the third party is **not** considered IRS confidential information if the client filled out the name and address of the institution and should be filed in the case record. If the specialist fills out the name and/or address of the institution on any document pertaining to the IRS match then it must be sent to the DSP to be logged and destroyed.

SAFEGUARDING IRS INFORMATION

FIP, MA, FAP

The local office or any other office holding these notices must do **all** of the following:

- Appoint a **DSP** to be responsible for the security of notices (safeguarding, release, destruction and log maintenance).
- Keep each notice to be retained in a **locked** place (for example, in a drawer or cabinet). When it is destroyed, destruction must be done by DHS staff **and** only by shredding.
- Keep visitor log to authenticate visitors before authorizing access to the area where the notices are kept. Visitor log shall contain the following information:
    - Name and organization of visitor.
    - Signature of visitor.
    - Form of identification.
    - Date of access.
    - Time of entry and departure.
    - Purpose of visit.
- Develop and follow procedures to ensure notices are not released.

DSP Duties

FIP, MA, FAP

Only the DSP may retain a key to the place housing the notices. The key must be kept in a locked place. Any duplicate key(s) must be kept in the office safe.

The DSP must:

- Print notices for specialist or clients as described in **OBTAINING IRS NOTICE COPIES** in this item.
- Maintain a DHS-4488, Internal Revenue Service Data Control Sheet, to track notice copies released directly to specialists, clients, or mailed to the client.
- Log all notices sent to the DSP (undeliverable, forwarded or returned from specialists) on the DHS-4488 and treat them as confidential. Shred all notices returned and log the method and date of destruction.

The DHS-4488 must be retained for five years after the last notice is logged on it. It may then be destroyed by DHS staff **and** only by shredding.

OBTAINING IRS NOTICE COPIES

FIP, MA, FAP

A copy of the notice may be obtained under certain circumstances from the DSP.

Request for Duplicate IRS Notice

If a client, his representative or a specialist requests a replacement of an IRS notice (for example lost or never received the original); the DSP can reprint through Central Print or Local Print from Bridges correspondence.

When the copy is printed locally, the DSP must:

- Log on DHS-4488.

- **Hand-deliver** it and request ID to ensure the appropriate client or representative or specialist receives the information.

REPORTING UNAUTHORIZED FEDERAL TAX INFORMATION (FTI) ACCESS

Upon discovery of a possible improper inspection or disclosure of federal tax information by a federal employee, a state employee or any other person, the individual making the observation or receiving information should, within 24 hours:

1. Contact the office of the appropriate Special Agent in Charge at the Field Division of Treasury Inspector General for Tax Administration (TIGTA).

Field Division	State Served by Field Division	Telephone
Chicago	Michigan	(312) 554-8751

The mailing address is:

Treasury Inspector General for Tax Administration
PO Box 589, Ben Franklin Station
Washington, DC 20044-0589

2. Take appropriate steps to contain the incident, if still in process. If uncertain what steps need to be taken to contain the incident, go directly to step 3.

3. Contact the DHS Bureau of Technology and Project Services at (517) 335-2742 to report the incident. Ask for the DHS information security officer and identify the purpose of the call as a report of breach of information.

4. Complete form DHS-0097, Breach of Federal Taxpayer Information Incident Report, as fully as possible and email the form to DHS-FTI-Disclosure@michigan.gov.

EXHIBIT I – IRC SEC. 7213 UNAUTHORIZED DISCLOSURE OF INFORMATION

(a) RETURNS AND RETURN INFORMATION.-

(1) FEDERAL EMPLOYEES AND OTHER PERSONS.-It shall be unlawful for any officer or employee of the United States or any person described in section 6103(n) (or an officer or employee of any such person), or any former officer or employee, willfully to disclose to any person, except as authorized in this title, any return or return information [as defined in section 76103(b)]. Any violation of this paragraph shall be a felony punishable upon conviction by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the costs of prosecution, and if such offense is committed by any officer or employee of the United States, he shall, in addition to any other punishment, be dismissed from office or discharged from employment upon conviction for such offense.

(2) STATE AND OTHER EMPLOYEES.-It shall be unlawful for any person [not described in paragraph (1)] willfully to disclose to any person, except as authorized in this title, any return or return information [as defined in section 6103(b)] acquired by him or another person under subsection (d), (i)(3)(B)(i), (1)(6), (7), (8), (9), (10), (12), (15) and (16) or (m)(2), (4), (5), (6), or (7) of section 6103. Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding $4,000, or imprisonment of not more than 5 years, or both, together with the cost of prosecution.

(3) OTHER PERSONS.- It shall be unlawful for any person to whom any return or return information [as defined in section 6103(b)] is disclosed in an manner unauthorized by this title thereafter willfully to print or publish in any manner not provided by law any such return or return information. Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the cost of prosecution.

(4) SOLICITATION.-It shall be unlawful for any person willfully to offer any item of material value in exchange for any return or return information [as defined in 6103(b)] and to receive as a result of such solicitation any such return or return information. Any viola-

tion of this paragraph shall be a felony punishable by a fine in any amount not exceeding $5,000, or imprisonment of not more than 5 years, or both, together with the cost of prosecution.

(5) SHAREHOLDERS.--It shall be unlawful for any person to whom return or return information [as defined in 6103(b)] is disclosed pursuant to the provisions of 6103(e)(1)(D)(iii) willfully to disclose such return or return information in any manner not provided by law. Any violation of this paragraph shall be a felony punishable by a fine in any amount not exceeding $3,000, or imprisonment of nor more than 5 years, or both, together with the cost or prosecution.

SEC. 7213A. UNAUTHORIZED INSPECTION OF RETURNS OR RETURN INFORMATION

(a) PROHIBITIONS.-

(1) FEDERAL EMPLOYEES AND OTHER PERSONS.-It shall be unlawful for-

(A) any officer or employee of the United States, or
(B) any person described in section 6103(n) or an officer willfully to inspect, except as authorized in this title, any return or return information

(2) STATE AND OTHER EMPLOYEES.-It shall be unlawful for any person [not described in paragraph (1)] willfully to inspect, except as authorized by this title, any return information acquired by such person or another person under a provision of section 6103 referred to in section 7213(a)(2).

(b) PENALTY.-

(1) IN GENERAL.-Any violation of subsection (a) shall be punishable upon conviction by a fine of any amount not exceeding $1,000, or imprisonment of not more than 1 year, or both, together with the costs of prosecution.

(2) FEDERAL OFFICERS OR EMPLOYEES.-An officer or employee of the united states who is convicted of any violation of subsection (a) shall, in addition to any other punishment, be dismissed from office or discharged from employment.

(c) DEFINITIONS.-For purposes of this section, the terms “inspect”, “return”, and “return information” have respective earnings given such terms by section 6103(b).

EXHIBIT II - IRC SEC.7431 CIVIL DAMAGES FOR UNAUTHORIZED DISCLOSURE OF RETURNS AND RETURN INFORMATION

(a) IN GENERAL.-

(1) INSPECTION OR DISCLOSURE BY EMPLOYEE OF UNITED STATES.-If any officer or employee of the United States knowingly, or by reason of negligence, inspects or discloses any return or return information with respect to a taxpayer in violation of any provision of section 6103, such taxpayer may bring a civil action for damages against the United States in a district court of the United States.

(2) INSPECTION OR DISCLOSURE BY A PERSON WHO IS NOT AN EMPLOYEE OF UNITED STATES.-If any person who is not an officer or employee of the United States knowingly, or by reason of negligence, inspects or discloses any return or return information with respect to a taxpayer in violation of any provision of section 6103, such taxpayer may bring a civil action for damages against such person in a district court of the United States.

(b) EXCEPTIONS.-No liability shall arise under this section with respect to any inspection or disclosure-

(1) which results from good faith, but erroneous, interpretation of section 6103, or

(2) which is requested by the taxpayer.

(c) DAMAGES.-In any action brought under subsection (a), upon a finding of liability on the part of the defendant, the defendant shall be liable to the plaintiff in an amount equal to the sum of-

(1) the greater of-

(A) $1,000 for each act of unauthorized inspection or disclosure of a return or return information with respect to which such defendant is found liable, or

(B) the sum of-

(i) the actual damages sustained by the plaintiff as a result of such unauthorized inspection or disclosure, plus

(ii) in the case of a willful inspection or disclosure or an inspection or disclosure which is the result of gross negligence, punitive damages, plus

(2) the cost of the action.

(d) PERIOD FOR BRING ACTION.-Not withstanding any other provision of law, an action to enforce any liability created under this section may be brought, without regard to the amount in controversy, at any time within 2 years after the date of discovery by the plaintiff of the unauthorized inspection or disclosure.

(e) NOTIFICATION OF UNLAWFUL INSPECTION AND DISCLOSURE.-If any person is criminally charged by indictment of information with inspection or disclosure of a taxpayer's return or return information in violation of-

(1) paragraph (1) or (2) of section 7213(a),

(2) section 7213A9(a), or

(3) subparagraph (B) of section 1030(a)(2) of title 18, United States Code, the Secretary shall notify such taxpayer as soon as practicable of such inspection or disclosure.

(f) DEFINITIONS.-For purposes of this section, the terms "inspect", "inspection", "return", and "return information" have respective earnings given such terms by section 6103(b).

(g) EXTENSION TO INFORMATION OBTAINED UNDER SECTION 3406.-For purposes of this section-

(1) any information obtained under section 3406 (including information with respect to any payee certification failure under subsection (d) thereof) shall be treated as return information, and

(2) any inspection or use of such information other than for purposes of meeting any requirement under section 3406 or (sub-

ject to the safeguards set forth in 6103) for purposes permitted under section 6103 shall be treated as a violation of section 6103.

For purposes of subsection (b), the reference to section 6103 shall be treated as including a reference to section 3406.

EXHIBIT III - SEC 6103(P)(4) SAFEGUARDS

(4) SAFEGUARDS.-Any federal agency described in subsection (h)(2), (h)(5), (i)(1), (2), (3), or (5), (j)(1), (2), or (5), (k)(8), (1)(1), (2), (3), (5), (10), (11), (13), (14), (15), or (17) or (o)(1), the General Accounting Office, or any agency, body, or commission described in subsection (d), (i)(3) (B)(i) or (1)(6), (7), (8), (9), (12) or (15), or (16), or any other person described in subsection (1)(16) shall, as a condition for receiving returns or return information-

(A) establish and maintain, to the satisfaction of the Secretary, a permanent system of standardized records with respect to any request, the reason for such request, and the date of such request made by or of it and any disclosure of return or return information made by or to it;

(B) establish and maintain, to the satisfaction of the Secretary, a secure area or place in which such returns or return information shall be stored;

(C) restrict, to the satisfaction of the Secretary, access to the returns or return information only to persons whose duties or responsibilities require access and to whom disclosure may be made under the provisions of this title;

(D) provide such other safeguards with the Secretary determines (and which he prescribes in regulations) to be necessary or appropriate to protect the confidentiality of the returns and return information;

(E) furnish a report to the Secretary, at such time and containing such information as the Secretary may prescribe, which describes the procedures established and utilized by such agency, body, or commission or the General Accounting Office for ensuring the confidentiality of returns and return information required by this paragraph; and

(F) upon completion of use of such returns or return information-

(i) in the case of agency, body or commission described in subsection (d), (i)(3)(B)(i), or (1)(6), (7), (8), (9) or (16) or any other person described in subsection (1)(16) return to the Secretary such returns or return information (along with any copies made there from) or make such return information undisclosable in any manner and furnish a written report to the Secretary describing such manner

(ii) in the case of an agency described in subsection (h)(2), (h)(5), (i)(1), (2), (3), or (5), (j)(1), (2), or (5), (1)(1), (2), (3), (5), (10), (11), (12), (13), (14), (15), or (17), or (o)(1), or the General Accounting Office, either-

(1) return to the Secretary such returns or return information (along with any copies made there from)

(2) otherwise make such returns or return information undisclosable, or

(3) to the extent not so returned or made undisclosable, ensure that the conditions of subparagraphs (A), (B), (C), (D), and (E) of this paragraph continue to be met with respect to such returns or return information, and

(iii) in the case of the Department of Health and Human Services for purposes of subsection (m) (6), destroy all such return information upon completion of its use in providing the notification for which the information was obtained, so as to make such information undisclosable;

except that conditions of subparagraph (A), (B), (C), (D), and (E) shall cease to apply with respect to any return or return information if, and to the extent that, such return or return information is disclosed in the course of any judicial or administrative proceedings and made a part of the public record thereof. If the Secretary determines that any such agency, body, or commission including an agency or any other person described in subsection (1)(16) or the General Accounting Office has failed to, or does not, meet requirements of this paragraph, he may, after any proceedings for review established under paragraph (7), take such actions as are necessary to ensure such requirements are met, including refusing to disclose returns, or return information to such agency, body, or commission including an agency or any other person described in subsection (1)(16) or the General Accounting Office until he determines that such requirements have been or will be met. In the case of any agency which receives any mailing address under paragraph

(2), (4), (6) or (7) of subsection (m) and which discloses any such mailing address to any agent, or which receives any information under paragraph (6)(A), 12(B) or 16 of subsection (1) and which discloses any such information to any agent or any person including an agent described in subsection (1)(16) this paragraph shall apply to such agency and each such agent or other person (except that, in the case of an agent, or any person including an agent described in subsection (1)(16), any report to the Secretary or other action with respect to the Secretary shall be made or taken through such agency). For purposes of applying this paragraph in any case to which subsection (m)(6) applies, the term “return information” includes related blood donor records (as defined in section 114(h)(2) of the Social Security Act).

LEGAL BASE

FIP

45 CFR 205.56-.58
MCL 400.83

MA

MCL 400.10,.83

SDA

Annual Appropriations Act
Michigan Administrative Code; R 400.3151-400.3180

FAP

7 CFR 273.2 (f) (1) (r) (a)

DEPARTMENT POLICY

All Programs

A person in a federal, state or local correctional facility for more then 30 days is not eligible to receive FIP, SDA or FAP benefits.

For MA only, a person can remain eligible for MA during a period of incarceration. Coverage is limited to inpatient hospital services only; see BEM 265.

For CDC only, a person in a federal, state or local correctional facility is not eligible to receive benefits.

INCARCERATION MATCH DOC

The automated Incarceration Match is a monthly match between Department of Corrections (DOC) and Bridges. This match runs for all individuals who are active for any program whose current living arrangement is not prison.

If a valid match is found the interface will update living arrangement of the individual to prison and create a mass update trigger for all cases where the client is active. Eligibility will then be re-determined for all programs on the cases where the client is active.

Bad Match Process

A bad match may occasionally occur. If a bad match is suspected a collateral contact with the client must be completed to verify this client is not in prison.

An authorized person from the local office is to call in a help desk ticket indicating a bad incarceration match with the following information:

- Client name.
- Case number.
- Client ID number.
- Program(s) effected.
- The release date from prison if the client was incarcerated.
- The month(s) effected.

The ticket will be assigned and flagged as a bad match and when the report runs for the following month the clients programs will not be effected.

SSA PRISONER MATCH

All Programs

The quarterly prisoner match between the Social Security Administration and Bridges runs for individuals 16 years and older who are pending or active. When a match is found, a task and reminder will be sent to the specialist. Specialists are expected to act on this within 12 days. Be sure to update the living arrangement type, if necessary and run EDBC. If no action is taken within 10 days, it will be escalated to the supervisor.

LOCAL CORRECTIONAL FACILITY

Follow current county procedures for verifying an individual in a local facility using the DHS-48, Verification of Imprisonment, which is a manually generated Bridges form.

Local Facility Verification Returned

When the DHS-48 is returned from the local facility indicating the incarcerated individual is released or on parole, no further action is taken. If the DHS-48 is returned and the individual is still incarcerated change the living arrangement type to jail.

Do not recoup FAP benefits for Simplified Reporters unless the department failed to take timely action.

Local Facility Verification Not Returned

If the DHS-48 is not returned by the local facility verify the whereabouts of the incarcerated individual. Verify the recipient's whereabouts by calling the facility **or** contact the head of household and ask for verification of the prisoner's whereabouts.

LOCATING PRISONERS

Incarcerated individuals in prisons and local jails may be found on various web sites. These web sites can be used to help verify if a client is in prison or jail.

Offender Tracking Information System (OTIS)

Prisoners in DOC facilities are listed on the OTIS file at DOC's web site. Access this list by using DHS-Net, Intranet Links. OTIS provides up-to-date parole and release dates. Information from this site is considered verified.

Federal Bureau of Prisons (BOP)

Prisoners in federal facilities are listed on the BOP site and can be found at www.bop.gov. Information from this site is considered verified.

VINELink

WWW.VINELink.com is a public web site that can be used as a tool to locate prisoners from most jails across Michigan and facilities across the United States.

LEGAL BASE

FIP

45 CFR 205.56-.58
MCL 400.83

SDA

Annual Appropriations Act
Michigan Administrative Code; R 400.3151-400.3180

CDC

45 CFR Part 98 and 99

MA

MCL 400.10,.83

FAP

7 CFR 273.2 (f)(9)

DEPARTMENT POLICY

Family Independence Program (FIP), State Disability Assistance (SDA) and Medicaid (MA) Only

Michigan law allows a person to contract and pay in advance for a funeral. This is called a prepaid funeral contract; see BEM 400.

In this item, **the act** refers to MCL 328.211.

General provisions of the act are as follows:

- The **contract seller** is the person/establishment providing the prepaid funeral contract. The seller may be the funeral provider.
- The **funeral provider** is the person/establishment shown in the prepaid funeral contract as agreeing to furnish specified funeral goods and/or services. The provider need not be a party to the contract.
- Contract sellers and funeral providers must be registered with the Michigan Department of Licensing and Regulatory Affairs (LARA).
- The purchaser, beneficiary, funeral provider and/or contract seller decide what funeral goods and services are contracted for.
- Only a **guaranteed price contract** may be certified **irrevocable**.
- Only the Michigan Department of Health and Human Services (MDHHS) may certify a funeral contract irrevocable by completing a DHS 8-A.
- Amounts paid for contracted funeral goods and services may be reallocated to other funeral goods and services. However, an irrevocable contract cannot be terminated.
- Interest or dividends earned on an irrevocable contract fund are considered part of that fund and may not be given to the purchaser/beneficiary.

- A DHS-8A, Irrevocable Funeral Contract Certification, cannot be used to certify a life insurance funded funeral or annuity funded funeral as irrevocable.
- Transfers of a funeral contract with an 8A must be purchased as a Prepaid Guaranteed Price contract with the funeral provider.

TYPES OF MICHIGAN FUNERAL CONTRACTS

A **guaranteed price contract** fixes the price to be charged for funeral goods and services listed in the contract.

A **non-guaranteed price contract** states clearly that the price of listed goods and services might fluctuate. Actual costs at delivery might be more or less than the amount in the contract fund.

A **revocable contract** can be terminated by the purchaser and the money refunded. The refund might be less than the contract's total value. A contract is revocable **unless** certified irrevocable by DHS using the DHS 8-A.

For program eligibility purposes, an **irrevocable contract** means money in the contract fund, including interest or dividends, is permanently unavailable to the purchaser/beneficiary.

See CONDITIONS TO CERTIFY CONTRACTS IRREVOCABLE in this item.

OUT-OF-STATE FUNERAL CONTRACTS

DHHS can certify as irrevocable a funeral contract with an out-of-state contract seller or funeral provider **only if** the seller **and** provider (if separate) are registered with the Michigan Department of Licensing and Regulatory Affairs. If they are, refer to CONDITIONS TO CERTIFY CONTRACTS IRREVOCABLE in this item.

A prepaid funeral contract with an **unregistered** out-of-state seller or provider is controlled by the other state's laws. The contract funds are unavailable **if** the contract is irrevocable under the other state's law.

Assist clients needing help to determine the status of out-of-state contracts. Inform them that revocable contracts with unregistered individuals may be reestablished using sellers/providers registered with the Michigan Department of Labor and Economic Growth.

Local Office Responsibilities

Tell the applicant/recipient in order to certify a funeral agreement as irrevocable they and their funeral director must complete a DHS 8-A (available on the internet or through the funeral director) and return the completed form to the local office. Tell them they must:

- Complete Section I, **and**
- Have the contract seller complete Section II, **and**
- Give DHS a copy of the contract.

Forward the returned DHS-8A and contract to the **local office director or designee** for certification (completion of Section III). If a disapproval is necessary, it must be explained on that form.

A photocopy, email copy, or facsimile (fax) of a DHS-8A is acceptable.

SSI clients might be referred to DHS to have a contract certified irrevocable. The local office must act on these requests as soon as possible.

Note: Funeral contracts certified irrevocable are treated as unavailable assets for SSI.

CONDITIONS TO CERTIFY CONTRACTS IRREVOCABLE

A prepaid funeral contract(s) must be certified irrevocable, **provided all** of the requirements below are met:

1. The contract purchaser requests via DHS-8A that the contract be certified irrevocable.

2. The contract purchaser is

   - The beneficiary, **and**
   - Alive, **and**
   - A FIP/SDA/MA/SSI applicant or recipient.

Note: Someone else may act as purchaser for a living beneficiary **if** the beneficiary's own money is used. The beneficiary's name must follow the person's signature on the DHS-8A (for example, John Smith for Sara Smith).

3. DHHS has a copy of the contract.

4. The **principal value**(s) (such as amount paid at the time the contract was made, excluding interest or dividends) is not over the Allowable Principal Value explained below.

   - A **revocable** contract(s) with a principal value over the maximum may be ended and a new contract made which can be certified irrevocable. The excess, including interest and/or dividends, is a countable asset.

   - Multiple contracts for a beneficiary may be certified irrevocable **if** the combined principal values are not over the maximum.

   Note: The limit is not affected by the types of goods and services contracted for. For example, the value of burial space items is not deducted to decide if the principal value is within the limit.

5. Sections I and II of the DHS-8A are properly completed. This ensures the following:

   - The purchaser/beneficiary has notice of limits on state liability for additional funeral expenses. Covered expenses are included in ERM 306.

   - The purchaser/beneficiary has notice that an irrevocable contract remains irrevocable even if assistance ends.

   - The contract seller asserts that the contract is a guaranteed price contract and complies with the act.

   - The contract seller is registered with the Michigan Department of Licensing and Regulatory Affairs.

   Note: An employer's registration covers his employees. The employer's registration number may be entered in Section II of the DHS-8A.

   - The contract seller certifies that all funeral providers listed in, or party to, the contract are registered with the

Michigan Department of Licensing and Regulatory Affairs and complying with the act.

6. Ten or more business days have passed since all parties signed the contract. The purchaser may cancel the contract during this period.

The local office director or his designee is authorized to certify agreements irrevocable.

Allowable Principal Value

The allowable principal value for a contract to be certified irrevocable is calculated as follows:

- The absolute maximum; see below.
- **MINUS** the amount already assigned to pay the beneficiary's funeral expenses under either:
  - A life-insurance-funded funeral, or
  - An annuity-funded funeral.

  Note: The DHS-8A asks for this information.

  This deduction applies even if ownership of the life insurance policy or annuity contract has been irrevocably transferred to a funeral director, a trust or another person. This deduction applies regardless of the types of funeral goods and services covered by the assignment.
- **EQUALS** the allowable principal value.

Use the absolute maximum for the date the DHS-8A is received. The absolute maximum is:

- $12,380 effective June 1, 2016.
- $12,240 effective June 1, 2015.
- $12,130 effective June 1, 2014.
- $11,970 effective June 1, 2013.
- $11,775 effective June 1, 2012.
- $11,466 effective June 1, 2011.
- $11,393 effective June 1, 2010.

TRANSFER OF CONTRACTS

Transfer of a funeral contract to another seller or provider is an issue between the purchaser, contract seller and funeral provider. The parties to the contract are responsible for the transfer. A transferred contract remains irrevocable.

LEGAL BASE

MCL 328.229

DEPARTMENT POLICY

All Programs

Michigan Department of Health and Human Services (MDHHS) and the Secretary of State (SOS) cooperate in a statewide on-line clearance system. This allows MDHHS access to the SOS computer database to verify ownership of SOS-titled assets (for example, autos, motorcycles, boats, recreational vehicles, trailers).

The local office ITT installs the SOS software on whichever PC(s) local office management designates. In addition, the local office must designate specific staff members who will have SOS access.

An “SOS Computer Access Request” form must be completed for each designated staff member. Send the completed form to central office to have an SOS password assigned to allow the designated staff person access to SOS. Forms can be obtained by calling the Systems Support Unit in central office at (517) 335-3629.

Local office management establishes requirements and procedures for SOS inquiries. The following are suggested practices to maximize clearance benefits.

PROCEDURES

Submit SOS inquiries to the designated staff via DHS-3614, Request and Registration Control Recorder a local form with pertinent information. If available, include all of the following for each customer the inquiry involves:

- Full name.
- Former name(s).
- Date of birth.
- Michigan Driver's License number.
- Michigan Personal ID Card number.
- Current address.
- Previous addresses in the last year.

Several transactions are used to identify a client. A printout is attached to the inquiry document and returned to you.

Compare the inquiry response to the information on the application form. Contact the client to resolve any discrepancy.

The response might indicate an asset titled to the client which he does **not** actually own. Examples:

- The client's abandoned auto was impounded and sold at auction.
- The purchaser of the client's trailer has failed to transfer the title.
- A motorcycle owned by the client's son is titled to the client for insurance purposes.
- The client sold an auto to a junk dealer (who must record transactions but is **not** required to turn in the title to SOS until the vehicle is totally scrapped).

In these situations, the client may need to obtain additional verification. (See BAM 130).

Note: Do not refer the customer to the Secretary of State as their records reflect the same information obtained by MDHHS in the inquiry response.

If documentation is **not** possible, determine eligibility based on available information and client statements.

SOS training guides available in each local office detail the inquiry and response system. The Systems Support Unit may be contacted at (517)-335-3629 **by** M**D**H**HS staff only and for systems difficulties only, NOT to resolve ownership of an asset.**

DEPARTMENT POLICY

Family Independence Program (FIP), State Disability Assistance (SDA), Child Development and Care (CDC), Medicaid (MA) and Food Assistance Program (FAP)

The Michigan Department of Health and Human Services (MDHHS) routinely matches recipient data with other agencies through automated computer data exchanges. Information provided with MDHHS applications (DHS-1010, -1171, -4574, -4574-B, MDE-4583 and DCH-373) inform clients of the data exchange process.

The State New Hires Match is a daily data exchange of information collected by the Michigan New Hire Operations Center and obtained through the Office of Child Support. State New Hires information is used to determine current income sources for active MDHHS clients.

OVERVIEW

The State New Hire database is established from W-4 tax records (or other new hire reporting formats) submitted by employers to the Michigan New Hire Operations Center. Michigan employers are required to report all new employees within 20 days of the date of hire. The State New Hires process matches the Social Security number (SSN) for all active recipients to the database. If a SSN match is found on Bridges and the State New Hires database, a State New Hires match is created if there is no earned income reflected in Bridges. Specialists receive one task and reminder listing all the matches for the previous week each Monday. The task and reminder is removed when all matches have been disposed.

It is a best practice to resolve information obtained from a State New Hires report within **21 calendar days** from the date the match is reported to the specialist.

Verifying Earned Income

Contact the client immediately if the employment has not been previously reported. Request verification by generating a DHS-4635, New Hire Notice, from Bridges.

When a DHS-4635 is requested, Bridges automatically gives the client 10 calendar days to provide verification from the date the forms were requested.

Case Actions

When income verification is returned, make the appropriate changes in Bridges, then run eligibility determination benefit calculation (EDBC) to reduce or close the benefits.

Exception: For CDC, compare the client's gross income to the eligibility income scale in RFT 270, to determine if the client's income exceeds 85 percent of the state median income (SMI). If income exceeds the SMI for the family size, and is expected to last, initiate closure of CDC benefits.

Failure to Provide

FIP, SDA, MA, and FAP

If verifications are not returned by the tenth day, case action will need to be initiated to close the case in Bridges. If the client reapplies, the date the client reapplies determines if State New Hires verification must be returned before processing the new application. See following examples.

Example: Ms. Madison applies for assistance 30 days after case closure was initiated in Bridges. The State New Hires verification must be returned before processing the application. The case can be opened from the date of the application after verifications are provided.

Example: Ms. Madison applies for assistance 31 days after the case closure was initiated in Bridges. Her case may be opened without State New Hires verification from the date of the new application, if eligible.

CDC Only

Do not close the CDC EDG or reduce benefits for a CDC recipient who fails to return new hire information reports.

Supervisory monitoring reports and management statistical reports are available to any user.

There are different management reports available for State New Hires data. The Summary Listing and Aging Report are

management statistical data roll-up reports. The Pending/Overdue Report and Disposition Reports are supervisory monitoring tools and contain specific case information.

State level reports detail statistics by counties. County level reports detail data by office. Office reports detail data by unit. Unit reports detail data by specialist.

Summary Report

This report provides statistics at the state, county, and office level and contains counts of:

- Number of W-4s reported on New Hires.
- Number of pending matches.
- Number of overdue matches.
- Number of dispositions broken out by disposition code.

Aging Report

This report counts all W-4s on New Hires that have not been disposed of. This report can be requested for state, county, office and unit level.

Pending/Overdue Report

This report can be requested only at the unit level.

Disposition Report

The New Hires Disposition Report may only be requested at the unit level and can be requested for a specific disposition code or for all dispositions.

LEGAL BASE

FIP

MCL 400.83

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

MA

MCL 400.10, .83

FAP

7 CRF 273.2 (f) (9)
MCL 400.10

CDC

45 CFR Parts 98 and 99
Child Care and Development Block Grant of 1990, as amended,
Public Act 6 of 2014

DEPARTMENT POLICY

All Programs

Michigan Department of Health and Human Services (MDHHS) matches recipient data with other public and private agencies through computer data exchanges. Data exchanges assist in the verification of eligibility factors. The acknowledgment section on the MDHHS application informs the clients of the data matching processes.

OVERVIEW

The State Master Death File is received daily and Bridges uses the data from these files to automatically update cases. The Federal Death File is received monthly and Bridges uses the data from these files to automatically update cases on or around the 16th of each month.

DECEASED RECIPIENT MATCH

Bridges will use a matching point system to determine if MDHHS recipients will have full or potential matches.

Full Match

A full match means that Bridges determined there was enough information by using the point system to determine the client is deceased. If a full match is found, Bridges will update the date of death on each recipient and trigger a mass update. No alert will be sent to the specialist.

Potential Match

A potential match means Bridges did not have enough information to update the date of death on the recipient. If a potential match is found, Bridges generates a task/reminder stating Potential Death Match Found and also produce report DM-304, Potential Death Match Report, which contains information about the potential match. Specialists must act on these matches within 45 days. The match will be escalated to the manager if the match is not acted on and disposed.

CASE ACTIONS

The DM-304 cannot be used as verification of death. Determine if the recipient is actually deceased. See the wizard for how to process the deceased recipient match.

If the recipient is deceased, record the date of death in Bridges to determine eligibility. Obtain a copy of the death certificate for the case record, if possible.

LEGAL BASE

FIP

45 CFR 205.55 -205.58

MCL 400.83

MA

MCL 400.10, and 400.83

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

FAP

7 CFR 272.14

CDC

45 CFR Parts 98 and 99
Mich Admin Code, R 400.5001 - 400.5020

DEPARTMENT POLICY

All Programs

The Michigan Department of Health and Human Services (MDHHS) routinely matches recipient data with other agencies through automated computer data exchanges. Information provided with MDHHS applications (DHS-1010, -1171, -4574, -4574-B, and DCH-373) informs clients of the data exchange process.

OVERVIEW

FIP, SDA, MA and FAP

Michigan Bureau of Lottery sends lists of lottery winners from the previous week. In addition, there is a monthly match to allow for any application that was pending during the month that may have become active.

LOTTERY MATCH

FIP, SDA, MA and FAP

The match contains the clients name, recipient ID, date of birth and social security number along with the gross amount of winnings, the net payout and the date winnings were received.

Specialist Action

Depending on the program involved, take appropriate action. If it is found that the match may not be accurate, such as a discrepancy in the winner's information, contact the client.

Use the **gross** winnings when taking action on the case. If winnings are 1 million dollars or more the winner is able to choose a lump sum payout or annuity payments.

Note: Annuity payments are considered unearned income and should be budgeted as such.

Programs

FIP and SDA

- If winnings are $3,000 or less, send a verification request to determine if the client is over the asset level. Follow the Lump Sum/Accumulated Benefits Field Reference Guide for

budgeting located at the Office of Workforce Development and Training website.

- If winnings are over $3,000, take appropriate action to close the case; clients are allowed timely notice.

See BEM 400, Assets, for more information.

MA

Lump sums and accumulated benefits are income in the month received and may be a countable asset for any subsequent months.

See BEM 400 for asset levels of different MA programs.

FAP

Change Reporters and Simplified Reporters.

- If winnings are $5,000 or less, send a verification checklist request to determine if the client is over the asset level. Follow the Lump Sum/Accumulated Benefits Field Reference Guide for budgeting located at the Office of Workforce Development and Training website.

- If winnings are over $5,000, take appropriate action to close the case; clients must be given timely notice.

See BEM 400, Assets.

VERIFICATIONS

Cases showing on the Lottery Match must be documented in the case file. An example of this would be a copy of the Lottery Winnings Spreadsheet with only the client's information shown.

LEGAL BASE

FIP

MCL 400.10e

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180
MCL 400.10e

MA

MCL 400.10e

FAP

7 CFR 273.2(b)(2)
7 CFR 273.8
7 CFR 273.12

DEPARTMENT POLICY

MA Only

Medicare is a federal health insurance program administered by the Social Security Administration (SSA). Medicare has three parts: Part A, hospital insurance (HI), and Part B, supplementary medical insurance (SMI), Part D, prescription drug coverage. A person receiving Medicare may have to pay a monthly premium for his Medicare. A person is also responsible for some of the cost of Medicare-covered services. These costs are called coinsurances and deductibles.

Medicaid coverage includes Medicare cost-sharing benefits. This means Medicaid pays Medicare Part B premiums or Part A and B premiums, coinsurances and deductibles for certain Medicaid recipients. A person who can receive Medicare Part A free of charge is encouraged to apply for it.

The Department of Community Health (DCH) administers the Buy-In programs.

MEDICARE PART A

There are four provisions under which a person can be eligible for Medicare Part A:

- Section 226 of the Social Security Act,
- Section 226A of the Social Security Act,
- Section 1818 of the Social Security Act, and
- Section 1818A of the Social Security Act.

Most persons receive Medicare Part A under section 226 or 226A.

For Medicaid purposes it is important to distinguish only persons receiving under section 1818A from the other three sections.

226/226A Eligibility

A person will usually be eligible for Part A under section 226 or 226A of the Social Security Act if he:

- Is at least age 65 and has sufficient countable work history, or

- Has received RSDI or Railroad Retirement disability/blindness benefits for 24 consecutive months, or

- Has end-stage renal disease treated by a kidney transplant or a regular course of dialysis, or
- Has Amyotrophic Lateral Sclerosis, also known as “Lou Gehrig’s disease”.

There is no monthly Part A premium.

1818 Eligibility

A person is eligible for Part A under section 1818 of the Social Security Act if he meets all of the following criteria:

- He is at least age 65.
- He is a resident of the U.S. and is either:
  - A U.S. citizen, or
  - An alien lawfully admitted for permanent residence who has resided in the U.S. continuously for the 5-year period immediately preceding the month in which he meets all other requirements.
- He is **not** eligible for Medicare Part A without paying a monthly premium.
- He:
  - Is receiving Medicare Part B, supplementary medical insurance (SMI), or
  - Is eligible for and has applied for Medicare Part B during an enrollment period.
- He applies for enrollment during his **“Initial Enrollment Period”** or a **“General Enrollment Period”** (see below).

Exception: The general enrollment period is waived for persons covered by the **“Part A Buy-In Program”** (see below).

The monthly Part A premium must be paid to maintain eligibility.

1818 A Eligibility

A person is usually eligible for Part A under section 1818A of the Social Security Act if he meets all of the following criteria:

- He is under age 65.

- He has been entitled to Medicare Part A based on disability (including child's or widow(er)'s benefits based on disability).
- He continues to have the disabling impairment upon which his Part A eligibility has been based.
- His entitlement to disability-based Part A has ended solely because earnings exceed the dollar limit used to determine whether a person is performing a substantial gainful activity (SGA).
- He is **not** otherwise eligible for Part A.
- He applies for enrollment during his **"Initial Enrollment Period"** or a **"General Enrollment Period"** (see below).

A monthly Part A premium must be paid to maintain eligibility.

Enrollment

A person receiving RSDI or Railroad Retirement benefits is usually enrolled in Part A automatically if he is eligible. Other persons must apply for enrollment at the local SSA office during their **"Initial Enrollment Period"**, a **"General Enrollment Period"** or through the **"Part A Buy-In Program."**

Premiums

Persons receiving Part A under sections 226 and 226A qualify for Part A free of charge. Persons receiving under sections 1818 and 1818A are charged a monthly premium. Medicaid pays the premiums for some persons under the **"Part A Buy-In Program."**

MEDICARE PART B

Eligibility

A person is eligible for Part B if he:

- Is eligible for Part A, or
- Is at least age 65, lives in the U.S., and is either a U.S. citizen or an alien lawfully admitted for permanent residence who has lived in the U.S. five consecutive years.

Note: If a person is age 65 or older and has not lived in the U.S. for five consecutive years, send or FAX a copy of the alien registration card to the Buy-In Unit. The Buy-In Unit must have the

person's date of entry so the other insurance code can be changed to 50 and Medicaid will process claims without Medicare documentation.

Enrollment

Generally, a person who is eligible for Part B and is enrolled in Part A is automatically enrolled in Part B. He may refuse Part B.

A person who is **not** automatically enrolled must apply for enrollment at the local SSA office during his **"Initial Enrollment Period"** or a **"General Enrollment Period"** (see below). The general enrollment period is waived for persons covered by the **"Part B Buy-In Program"** (see below).

Premiums

All persons enrolled in Part B are charged a monthly premium. The premium is determined by SSA. A person who does **not** enroll when first eligible is charged a higher premium. Premiums are automatically deducted from Railroad Retirement, RSDI, and U.S. Civil Service and Federal Employee Retirement checks. Medicaid pays the premiums for some persons under the **"Part B Buy-In Program"** (see below).

MEDICARE PART D

Eligibility

Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. The Department of Community Health (DCH) is the state agency responsible for determining eligibility for the Low-Income Subsidy clients who want a determination made by the State.

Enrollment

A client may contact DCH to request an application at 1-800-642-3195. When a client requests the state agency determine eligibility, rather than have a SSA determination, DCH will mail an application to the client. The completed application should be returned to:

State Medicaid Agency
Medicare D LIS Processing
PO Box 30412
East Lansing, MI 48823

The DCH contractor will review and process the application within 45 days. MDHHS staff are encouraged to assists clients in applying online through the SSA website. The web address is: www.socialsecurity.gov or www.ssa.gov.

Premiums

A monthly premium will be charged and will vary based on the prescription drug plan the client has chosen.

MEDICARE ENROLLMENT PERIODS

The following is a general description of Medicare enrollment periods and begin dates of coverage. Other rules apply to people with end-stage renal disease.

Initial Enrollment Period

For persons eligible under section 1818A the period begins the month they are notified of 1818A eligibility and ends seven months later.

The period for other persons extends for seven calendar months beginning with the third calendar month before the month a person would first be eligible for Medicare. The actual date Medicare coverage begins depends on when the person applies.

- Applies during first three months - coverage begins the month all eligibility requirements are met.
- Applies during fourth month - coverage begins the next month.
- Applies during fifth month - coverage begins the next month.
- Applies during sixth or seventh month - coverage begins the third month after enrollment.

General Enrollment Period

The general enrollment period is for a person who failed to enroll during his initial enrollment period. The general enrollment period is January 1 to March 31 each year. Medicare coverage begins July 1.

The general enrollment period is waived for persons covered by the **"Part A or B Buy In Program."**

Part D Enrollment Period

A client who has Part A and/or Part B coverage can join a prescription drug plan. Information on part D enrollment may be found on the Social Security website. Once enrolled, Medicaid beneficiaries may change plans at any time during the year.

MEDICARE COST-SHARING BENEFITS

Medicaid may pay the following for Medicaid recipients who are entitled to Medicare:

- Medicare Part A premiums.
- Medicare Part B premiums.
- Part of Medicare Part B premiums.
- Medicare deductibles and coinsurances.

The type of Medicare cost-sharing benefits depends on the type of Medicaid eligibility.

Deductibles and Coinsurances

A deductible or coinsurance is the portion of a Medicare-covered expense which Medicare considers the patient's liability. Examples:

- Medicare pays hospital expenses exceeding an annual amount called a deductible.

- Patients receiving Medicare-covered nursing home care are responsible for part of the per diem cost for a certain number of days. This daily amount is called a coinsurance.

Medicaid pays the Medicare deductibles and coinsurances for full-coverage QMB recipients and all other Medicaid recipients. The amount paid is limited by Medicaid's own reimbursement rates for services.

Exception: Medicaid does **not** pay deductibles and coinsurances for:

- SLM-only recipients (BEM 165),
- ALMs (BEM 165), and
- QDWIs (BEM 169).

Part A Buy-In Program

The Part A Buy-In program is used to:

- Pay Part A premiums.
- Enroll persons eligible for, but **not** enrolled in, Medicare Part A.

The Part A Buy-In program covers persons entitled to Part A who are:

- Group 1 MA recipients **except**:
  - BEM 163 (AD-Care) recipients with Program Type (recipient) code 5
  - BEM 164 (Extended Care) recipients with Program Type (case) code 1
- Full-coverage QMB recipients (BEM 165)

Exception: Medicaid pays the Medicare Part A premium for QDWI recipients (BEM 169), but **not** through the Buy-In program.

Part B Buy-In Program

The Part B Buy-In program is used to pay Part B premiums. The program is an agreement between DCH and SSA. The program covers persons who are eligible for both Medicare Part B and are:

- BEM 110, Low Income Families and FIP recipients.
- BEM 150, SSI recipients.
- BEM 155, 503 individuals.
- BEM 156, COBRA widow(er)s.
- BEM 158, DAC recipients.
- BEM 163, AD-Care recipients.
- BEM 164, Extended-Care recipients eligible for QMB.
- QMB, SLMB and ALMB recipients (BEM 165).
- BEM 174, Freedom to Work.
- Group 2 MA recipients (most).

For persons included in the Part B Buy-In program, Medicaid:

- Pays the Medicare premiums; and
- Enrolls persons eligible for, but **not** enrolled in, Medicare Part B if they are enrolled in Medicare Part A or have refused Medicare Part B enrollment.

Generally, the Buy-In program operates automatically based on computer tapes from SSA and central office. Other insurance codes and social security claim numbers may be changed in Bridges by the Buy-In program activities.

Part B Buy-In Effective Date

The Part B buy-in effective date is:

- Determined by SSA for SSI recipients.
- The month QMB or SLMB coverage begins if the only basis for buy-in is Medicare Savings Program eligibility.
- Determined by DCH for ALMB.
- The earliest date the client is both MA and Medicare Part B eligible for all other persons covered by the Buy-In Program, except that buy-in **under** Group 2 MA is **not** retroactive more than two years.

The buy-in is usually processed at the end of the calendar month that a case is opened in Bridges. It takes SSA about 120 days after that to adjust the client's RSDI check. The client will receive a refund for premiums paid while the buy-in was being processed.

Part B Payments for ALMB

Full payment of Medicare Part B premiums is through the Part B Buy-In program provided funding is available. DCH decides whether funding is available.

Claim Numbers

DCH must know a person's health insurance claim number (HICN) for the Buy-In programs to operate. Generally a person's HICN and social security **claim** number are the same. The claim number is **not** the same as the social security account number (SSN). Enter a person's social security claim number (SS-CLAIM-NO) in addition to his SSN (SS-ACT-NO) to facilitate current or future Buy-In. The

Medicare Buy-In Coordinator may contact the local office to obtain an HICN when necessary. A person's HICN is the claim number on his Medicare card.

Note: HICNs do **not** end in HA, DI or P.

Claim Number Letter

DCH sends a letter, DCH-1144, to the clients described below urging them to apply for Medicare Part B in order to get a health insurance claim number. See **"EXHIBIT I"**.

The letter is sent to MA recipients who:

- Are age 65 or older, and
- Have Other Insurance code 90 on Bridges, and
- Do **not** have a Medicare/Social Security claim number in Bridges.

Clients are instructed to call the Medicaid Recipient Hot Line at 1-800-642-3195 if they have questions.

PROBLEMS

Problems arise from time to time. For example, a person may appear Medicare eligible, but is **not**. Direct problems related to Medicare status in Bridges or the Buy-In programs to Buyinunit@michigan.gov.

MEDICARE APPLICATION

The local office can submit a Medicare enrollment form to SSA on behalf of a deceased MDHHS MA client. The purpose is to obtain Medicare coverage of medical bills.

Proceed as follows when you receive such a request:

- Complete form HCFA-40B (**"EXHIBIT II"**) according to the instructions below. The form may be obtained from your local SSA office.
- Provide verification according to the instructions below.
- Mail the completed HCFA-40B to your local SSA office.

HCFA-40B Instructions

Complete the HCFA-40B as follows:

- Print “Deceased Individual” along the top margin of the form above the title.
- Line 1 - If client’s claim number is unknown, enter social security number.
- Line 2 - Leave blank.
- Line 3 - Check yes. Print “Part A and B”.
- Line 4 - Enter client’s name.
- Line 5 - Enter name if appropriate.
- Lines 6 and 7- Enter client’s last address.
- Line 8 - Print “MDHHS” and your telephone number.
- Line 9 - Sign your name with the title “MDHHS Official”.
- Line 10- Enter date.
- Provide verification of:
  - Age, and
  - Citizenship/alien status, and
  - Five years U.S. residency (if **not** U.S. citizen), and
  - Death.

  It is **not** necessary to include copies of documents. Just describe the document used as verification and give the date received in item 14.

Example: Case record contains a copy of a person’s birth certificate that was obtained at interview on 5/11/05. Record: “Birth certificate received by MDHHS 5/11/05.”

Common Verifications

Age:

- Birth certificate established before age five.

- Religious record of birth established before age five.
- Driver's license.
- School or hospital record.

U.S. Citizenship:

- Birth certificate showing birth in U.S.
- U.S. passport.
- USCIS certificate of naturalization.
- I-551.

U.S. Residence:

- U.S. passport.
- The following statement: "MDHHS records show person has been a Michigan resident since (date)."

Death:

- Death certificate.
- Statement from funeral home.

You may want to contact:

- Your local SSA office about other acceptable proofs, and
- Your county clerk about getting death certificates.

EXHIBIT I

You must apply for medical insurance only (Part B) now.

You or your representative should:

- contact your local Social Security office. Please **call** them at 1-800-772-1213 (7:00 am-7:00 pm) to make an appointment.
- tell them you need to apply for medical insurance (Medicare Part B). **Take a copy of this letter to the Social Security Office when you apply.**

Note: You may qualify to have Medicaid pay your Medicare medical insurance premiums through an agreement with the Social Security Administration (SSA).

Your local SSA office may contact Medicaid's Buy-In Unit in Lansing. If you or your representative have any questions about this letter, please call the Medicaid Help Line at 1-800-642-3195.

We sent you this letter because:

- you are an active Medicaid client;
- our records do not show that you have a Medicare Health Insurance claim number, and
- you are age 65 or older or will soon reach age 65. After you reach age 65, ***Medicare must pay medical claims before Medicaid will pay the balance***.

If you have a Medicare Health Insurance Card (a red, white and blue card), or have applied for Medicare within the last three months, please fill out the information requested below. Then return this letter to us in the enclosed return mail envelope.

You, your representative or the local Social Security office should complete the information requested below when you apply for Medicare Part B.

PLEASE RETURN THIS WHOLE COMPLETED PAGE IN THE ENCLOSED ENVELOPE

Medicare Claim Number __ __ __ __ __ __ __ __ __ __

Hospital Insurance (Part A) effective date: _____ Application Date: _____

Medical Insurance (Part B) effective date: _____

Thank You
Medicaid Buy-In Unit

Enclosures

DCH-1144 "The Michigan Department of Community Health is an equal opportunity employer, services and programs provider."

EXHIBIT II (PAGE 1)
EXHIBIT II (PAGE 2)

FORM DOES NOT REQUIRE CLEARANCE OF OFFICE OF MANAGEMENT AND BUDGET

APPLICATION FOR ENROLLMENT IN MEDICARE
THE MEDICAL INSURANCE PROGRAM

TID SMI

1. SOCIAL SECURITY CLAIM NUMBER
CAN ☐☐☐ – ☐☐ – ☐☐☐☐

2. FOR AGENCY USE ONLY
BIC ☐☐☐

3. DO YOU WISH TO ENROLL FOR MEDICAL INSURANCE UNDER MEDICARE?
DEC YES ☐

4. CLAIMANT'S NAME
CLN
Last name First name Middle initial

5. PRINT SOCIAL SECURITY NUMBER HOLDER'S NAME IF DIFFERENT FROM YOURS

6. MAILING ADDRESS (NUMBER AND STREET, P.O. BOX, OR ROUTE)

IF THIS IS A CHANGE OF ADDRESS, CHECK HERE ☐

7. CITY, STATE, AND ZIP CODE

8. TELEPHONE NUMBER

9. WRITTEN SIGNATURE (DO NOT PRINT)
SIGN HERE ➡ _____

10. DATE SIGNED
DOF __ __/__ __/__ __
MONTH DAY YEAR

IF THIS APPLICATION HAS BEEN SIGNED BY MARK (X), A WITNESS WHO KNOWS THE APPLICANT MUST SUPPLY THE INFORMATION REQUESTED BELOW

11. SIGNATURE OF WITNESS

12. DATE SIGNED

13. ADDRESS OF WITNESS

14. REMARKS

TOA 1

TO: (Circle one)

(1) NEPSC	(2) MATPSC	(3) SEPSC	(4) GLPSC	(5) WNPSC	(6) MAMPSC	(7) ODO	(8) DIO

FORM HCFA-40B (1-90)

PRIVACY ACT NOTICE

The Social Security Administration (SSA) is authorized to collect the information on this form under sections 1836, 1840, and 1872 of the Social Security Act, as amended (42 U.S.C. 1395o, 1395s, and 1395ii). The information on this form is needed to enable SSA and the Health Care Financing Administration (HCFA) to determine if you are entitled to supplementary medical insurance benefits. While completing this form is voluntary, failure to provide all or part of this information will result in your not being enrolled for medical insurance under Medicare. You should be aware that the information you furnish can be released by way of "routine uses" published in the Federal Register. Because they are too numerous to list here, SSA can furnish you with additional information upon request. You should also be aware that the information you provide on this form may be verified by way of a computer match (Pub. Law 100-503).

SPECIAL MESSAGE FOR INDIVIDUAL APPLYING FOR MEDICAL INSURANCE UNDER MEDICARE

This form is your application for the medical insurance part of Medicare. It can be used either during your initial enrollment period, during any general enrollment period, or during a special enrollment period to which you **may** be entitled if you are covered under an employer's group health plan.

Your initial enrollment period lasts for 7 months. It begins 3 months before the month you reach age 65 (or 3 months before the 25th month you have received social security disability benefits) and it ends 3 months after you reach age 65 (or 3 months after the 25th month you received social security disability benefits). To have medical insurance start in the month you are 65 (or the 25th month of disability insurance benefits), you must sign up in the first 3 months of your initial enrollment period. If you sign up in any of the remaining 4 months, your medical insurance will start later.

If you do not file during your initial enrollment period, you can file any time after that during a general enrollment period which is the first 3 months of every year. If you sign up in a general enrollment period, your medical insurance begins July 1 of that year. However, when you file in a general enrollment period, your premium may be subject to a penalty increase. For each 12-month period elapsing between the end of your initial enrollment period and the general enrollment period in which you file, your premium will be increased 10 percent.

If you are age 65 or older and employed, or the spouse of an employed person, and are covered under an employer group health plan, you may be eligible to enroll during any of the 7 months after employment is terminated or, if earlier, after your employer group health plan coverage ends for any reason. Also, if you are under age 65, entitled to Medicare based on disability, and are covered under an employer's group health plan based on your own current employment or the current employment of your spouse, or are covered under a large group health plan based on your own current employment or the current employment of any family member, you may be eligible to enroll during a special 7-month enrollment period which begins when the employer group health plan coverage ends or the employment ends, whichever occurs first. Your medical insurance coverage will begin sooner under this special enrollment provision than it will if you delay enrollment until the following general enrollment period. Also, you may be eligible under this special provision for a reduction in the premium surcharge or penalty that usually applies to people who delay their enrollment in medical insurance under Medicare. If you are covered under an employer's group health plan and think that you may be eligible for a special enrollment period, please discuss your enrollment eligibility with a representative at the Social Security office.

*U.S. Government Printing Office: 1995 — 386-892/21210

LEGAL BASE

MA

Social Security Act, Title 18, Section 1902(a)(10)(E), Section 1905(p)
42 CFR 431.625

DEPARTMENT POLICY

The Michigan Department of Human Services (DHS) is required to match all Food Assistance Program (FAP) recipients and applicants with the federal Electronic Disqualified Recipient system (eDRS) at application and when a member is added to an existing case. Information provided with DHS applications (DHS-1010 and DHS-1171) informs clients of the data exchange process.

OVERVIEW

FAP Only

This data exchange assists in the identification of potential recipients that may have an intentional program violation (IPV) in another state.

Process

The eDRS match must be completed by checking consolidated inquiry at application and when a member is added to an existing case. When a specialist completes a consolidated inquiry for an individual, the system will automatically run an eDRS match to check for any IPVs the client may have in another state

If there is a match with the client, Yes will be displayed on the consolidated inquiry search page under FNS eDRS. The specialist must send an email to the recoupment specialist (RS) to verify the IPV with the reported state. The FAP application or the member add cannot be certified until the IPV is verified by the RS. In order to meet the standard of promptness (SOP), email the RS immediately.

The RS will update the IPV information in Bridges, if necessary.

Exception: If FNS eDRS on the consolidated inquiry search page indicates Yes, and the case is expedited FAP, the case can be certified without waiting for the decision from the RS. The specialist must still make an IPV request to the RS. If the RS determines there is an IPV, the RS will enter the IPV information in Bridges and run eligibility to determine if there is an overissuance.

Please refer to Bridges Administrative Manual (BAM) 720, Intentional Program Violation, for further information on IPVs.

LEGAL BASE

FAP

7 CFR 273.16(i)(1),(2),(4)

DEPARTMENT POLICY

The Michigan Department of Human Services (DHS) routinely matches recipient data with other agencies through automated computer data exchanges. Information provided with DHS applications (DHS-1010 and -1171) informs clients of the data exchange process.

OVERVIEW

FAP Only

DHS is required to match all Food Assistance Program (FAP) recipients and applicants with the National Directory of New Hires (NDNH) at application and recertification.

The NDNH is a monthly exchange of information collected from new hire data reported from 54 states and territories and all federal agencies. NDNH information is used to determine current income sources reported from other states for active and pending DHS FAP clients.

It is a best practice to resolve information obtained from a New Hire report within **21 calendars days** from the date the match is reported to the specialist.

Process

This monthly process matches the Social Security number (SSN) for all FAP approved and pending clients from the prior 30 day period and FAP redeterminations that are due two months from the NDNH request month. If a SSN match is found on Bridges and the NDNH, a NDNH match is created. Specialists receive one task and reminder listing all the matches for the month. The task and reminder is automatically removed when all matches have been disposed.

If the client has not previously reported the new job, verification must be requested by generating a DHS-4641, National Directory New Hire Client Notice, from Bridges.

When a DHS-4641 is requested, Bridges automatically gives the client 10 calendar days to provide verification from the date the form was requested.

If income verification is returned, make the appropriate changes in Bridges, then run eligibility determination benefit calculation (EDBC) to reduce or close the benefits.

If verification is not returned by the 10th day, case action will need to be initiated to close the case in Bridges. If the client reapplies, the date the client reapplies determines if national new hire verification must be returned before processing the new application. See the following examples.

Example: Client applies for assistance 30 days after the case closure was initiated. The case must be opened from the date that verifications are provided.

Example: Client applies for assistance 31 days after case closure was initiated. The case may be opened from the date of the new application, if eligible.

Specialist processing of DHS-4641 Cover Letter (Page 1)

1. If the DHS-4641, Cover Letter, (page 1) containing the individuals employment is returned to the local office:
   - Send the form to the designated staff person (DSP) for logging and destruction.
   - Document in the case record any actions taken regarding the notice.
2. If the client claims a notice was lost or never received, or if a copy is needed, the DSP can reproduce it; see OBTAINING DHS-4641 COPIES in this item.

FILING THE CLIENT NOTICE AND THIRD PARTY VERIFICATIONS

Do not file the DHS-4641, Cover Letter, (page 1) in the case record. It must be treated as confidential and returned to the designated staff person; see **SAFEGUARDING NATIONAL NEW HIRE INFORMATION**, in this item.

The second page of the DHS-4641 is not considered confidential information if the client filled out the name and address of the employer and should be filed in the case record. If the specialist fills out the name and/or address of the institution on any document pertaining to the National New Hire match then it must be sent to the DSP to be logged and destroyed.

SAFEGUARDING NATIONAL NEW HIRE INFORMATION

The local office or any other office holding these notices must do all of the following:

- Appoint a DSP to be responsible for the security of notices (safeguarding, release, destruction and log maintenance).
- Keep each notice to be retained in a locked place (for example, in a drawer or cabinet). When it is destroyed, destruction must be done by DHS staff and only by shredding.
- Keep visitor log to authenticate visitors before authorizing access to the area where the notices are kept. Visitor log shall contain the following information:
  - Name and organization of visitor.
  - Signature of visitor.
  - Form of identification.
  - Date of access.
  - Time of entry and departure.
  - Purpose of visit.
- Develop and follow procedures to ensure notices are not released.

DSP DUTIES

Only the DSP may retain a key to the place housing the notices. The key must be kept in a locked place. Any duplicate key(s) must be kept in the office safe.

The DSP must:

- Print notices for specialist or clients as described in **OBTAINING DHS-4641 NOTICE COPIES**, in this item.

- Maintain a separate control sheet designated as a National Directory New Hire to track notice copies released directly to specialists, clients, or mailed to the client by using the DHS-4488, Internal Revenue Service Data Control Sheet.
- Log all notices sent to the DSP (undeliverable, forwarded or returned from specialists) on the DHS-4488 and treat them as confidential. Shred all notices returned and log the method and date of destruction.

The DHS-4488 must be retained for five years after the last notice is logged on it. It may then be destroyed by DHS staff and only by shredding.

OBTAINING DHS-4641 NOTICE COPIES

A copy of the notice may be obtained under certain circumstances from the DSP.

If a client, client's representative, or a specialist requests a replacement of a DHS-4641 notice (for example lost or never received the original); the DSP can reprint through central print or local print from Bridges correspondence.

When the copy is printed locally, the DSP must:

- Log it on the DHS-4488.
- Hand-deliver it and request ID to ensure the appropriate client or representative or specialist receives the information.

LEGAL BASE

FAP

7 U.S.C. 2020(e)(24)

DEPARTMENT POLICY

The Disability Determination Service (DDS) develops and reviews medical evidence for disability and/or blindness and certifies the client's medical eligibility for assistance. DDS does not accept electronic medical records in the form of CDs or DVDs. See Exhibit - DDS AREAS for the phone number of the DDS office which handles each county or district.

FIP, SDA, RCA and MA

This item contains medical determination policy for:

- Establishing medical eligibility for assistance programs.
- Determining whether an institutionalized Medicaid (MA) client is capable of indicating intent to remain a Michigan resident.
- Disability and/or blindness.
- Employment-related activities disability deferrals per BEM 230A and BEM 230C.

AUTHORIZED REPRESENTATIVE

FIP, SDA, RCA and MA

An authorized representative is a person who applies for assistance on behalf of the client and/or otherwise acts on their behalf. The authorized representative assumes all the responsibilities of a client. See BAM 110 for authorized representative requirements.

APPLICATION FOR SSA BENEFITS

FIP and RCA

After a client has verified a disability lasting longer than 90 calendar days, clients must apply for or appeal benefits through the Social Security Administration (SSA). This is a condition of program eligibility; see BEM 270, Pursuit of Benefits.

SDA and MA

At program application or request for disability deferral, clients must apply for or appeal benefits through the SSA if claiming disability

and/or blindness. This is a condition of program eligibility; see BEM 270, Pursuit of Benefits.

SSA DETERMINATION

FIP, SDA, RCA and MA

SSA's final determination that a client is not disabled and/or blind supersedes DDS's certification. See BEM 260 for MA to determine when to proceed with a medical determination for these clients.

INCAPABLE OF INDICATING INTENT

MA Only

A complete medical determination is **not** necessary to determine whether an institutionalized client is incapable of indicating intent to remain a Michigan resident.

Obtain a statement from the health care provider with the client's diagnosis, prognosis and expected length of stay. Attach the statement and any existing medical packet to a DHS-49-F, Medical-Social Questionnaire, and forward to DDS for review.

DDS will respond on the DHS-49-A. Take appropriate action as required by BEM 220.

MEDICAL DETERMINATION PROCEDURES

FIP, SDA, RCA and MA

At application or medical review if requested mandatory forms are not returned, the DDS cannot make a determination on the severity of the disability. Deny the application or place an approved program into negative action for failure to provide required verifications.

Steps for Medical Determination Applications

1. Client claims disability and/or blindness.

   Approve the medical eligibility for FIP/SDA/RCA/MA if one of the following exists:

- If the client is eligible for Retirement, Survivors, Disability Insurance (RSDI) or Supplemental Security Income (SSI) based on disability and/or blindness:
  - Document verification in Bridges.
  - Approve medical eligibility for MA or FIP/SDA/RCA (**Stop here. Medical determination process is complete**).
  - **Note:** If the client reports SSI based on disability and/or blindness was terminated due to financial factors, continue medical eligibility. Documentation would consist of a copy of the Notice of Planned Action letter from SSA to the client or similar, written documentation. The client must meet all financial and non-financial factors for SSI-related MA; see BEM 260. Medical development and DDS certification are not initially required. Schedule the medical review 12 months from the date of SSI termination. At the time of review, go to Steps for Medical Determination Reviews in this item.
- FIP/SDA/RCA clients who are already receiving MA based on their own disability and/or blindness meet the medical eligibility up to the medical review date stated on the DHS-49-A as determined by the DDS 7/1/2015 and after. (**Stop here. The medical determination for FIP/SDA/RCA is complete. A new medical redetermination must be requested from DDS by the medical review date listed on the DHS-49-A).** The client must still meet all financial and non-financial factors for FIP/SDA/RCA.

  Example: Client is active FAP and MA based on disability. The medical review date is 8/1/2016. On 7/15/2015, the client applies for FIP. Approve the client with the FIP employment and training deferral code of incapacitated (IN) until the medical review date of 8/1/2016. Complete the medical determination review for continued potential eligibility of an employment and training deferral.

2. For FIP/SDA/RCA applicants, interview the client per requirements in BAM 115. For MA, no interview is required.

3. The client or authorized representative must complete all sections of the DHS-49-F, Medical-Social Questionnaire. **This form is mandatory**.

   If the client is in a hospital or long-term care facility, the facility may designate a person to complete the DHS-49-F provided the local office, facility and client agree to this option.

4. The client or authorized representative must sign the DHS-1555, Authorization to Release Protected Health Information, to request existing medical records. **This form is mandatory**.

5. For state-funded FIP/SDA only, the client must sign a DHS-3975, Reimbursement Authorization, as a condition of eligibility; see BEM 272, State-Funded FIP and SDA Repay Agreements.

6. Complete a DHS-3503-MRT, Medical Determination Verification Checklist, indicating the following verifications required:

   - DHS-49-F.
   - DHS-1555.
   - DHS-3975, Reimbursement Authorization (for state-funded FIP/SDA only).
   - Verification of SSA application/appeal.

7. Assist the client or representative in completing the DHS-49-F and DHS-1555 if the client or representative is unable to complete the forms. If the client is obviously handicapped (for example, totally blind, paraplegic, quadriplegic, double amputee), enter this information on the DHS-49-F. Document the attempt(s) made to assist the client in Bridges; see BAM 130.

8. Review the DHS-1555 and the DHS-49-F to make sure the appropriate sections are complete.

9. Send the completed DHS-49-F, the completed DHS-1555, and verification of SSA application/appeal, along with any medical evidence provided, to the DDS to begin the medical development process.

Note: The specialist is not required to gather medical evidence. If the client provides medical evidence, forward it to DDS with the DHS-1555 and DHS-49-F.

10. If any additional medical information is received after the completed forms are sent to DDS, forward the additional medical information to the DDS.

    Note: For SDA and MA only, the DDS may put a case on medical hold for further development. A medical hold letter will be sent to the client or authorized representative and a copy will be scanned into Bridges by DDS. Once DDS issues a medical hold, enter the appropriate medical deferral information in Bridges.

Steps for Medical Determination Reviews

1. Complete a DHS-3503-MRT, Medical Determination Verification Checklist, indicating the type of verification requested.

2. The client or authorized representative must complete all sections of the DHS-49-FR, Medical Social Questionnaire Update, at the time of a scheduled medical review. **This form is mandatory**.

   If the client is in a hospital or long-term care facility, the facility may designate a person to complete the DHS-49-FR provided the local office, facility and client agree to this option.

3. The client or authorized representative must sign the DHS-1555, Authorization to Release Protected Health Information, to request existing medical records. **This form is mandatory**.

4. For state-funded FIP/SDA only, if SOLQ indicates that a client has not been automatically coded for repayment, the client must sign a DHS-3975, Reimbursement Authorization, as a condition of eligibility; see BEM 272, State-Funded FIP and SDA Repay Agreements.

5. Complete a DHS-3503-MRT, Medical Determination Verification Checklist, indicating the following verifications required:

   - DHS-49-FR.

- DHS-1555.
- DHS-3975, Reimbursement Authorization (for state-funded FIP/SDA only).
- Verification of SSA application/appeal.

6. Assist the client or representative in completing the DHS-49-FR and DHS-1555 if the client or representative is unable to complete the forms. If the client is obviously handicapped (for example, totally blind, paraplegic, quadriplegic, double amputee), enter this information on the DHS-49-FR. Document the attempt(s) made to assist the client in Bridges; see BAM 130.
7. Review the DHS-1555 and DHS-49-FR, to make sure the appropriate sections are complete.
8. Send the completed DHS-49-FR, the completed DHS-1555, and verification of SSA application/appeal, along with any medical evidence provided, to the DDS to begin the medical development process.

   Note: The specialist is not required to gather medical evidence. If the client provides medical evidence, forward it to DDS with the DHS-1555 and DHS-49-F.
9. If any additional medical information is received after the completed forms are sent to DDS, forward the additional medical information to the DDS.

Steps for DDS

1. Certify the client's disability determination. Record certification on the DHS-49-A.

   Note: The DDS will determine disability and/or blindness for retroactive MA months even if retroactive MA is **not** requested by the client at application. If the client subsequently applies for retroactive MA, refer to the DHS-49-A for the disability determination for those retroactive months.
2. Scan the DHS-49-A and the supporting medical evidence into Bridges.

Steps for the DHS Specialist After DDS Decision

1. Enter the DDS decision into Bridges.
   - If approved, enter the DDS decision and disability review date in Bridges on the *Disability Determination - MRT* screen.
   - If **not** approved:
     - Eligibility for MA based on disability and/or blindness does **not** exist.
     - Eligibility for SDA based on disability and/or blindness does **not** exist, see BEM 261.
     - For FIP, see BEM 230A.
     - For RCA, see BEM 230C.

Previously Denied DDS Medical Determinations

FIP, SDA, RCA and MA

If a client's previous DDS and/or SSA medical determination was not approved, the client has to prove a new or worsening condition in order to start the medical determination process again. Request a DHS-49 for physical conditions and a DHS-49-D/E for mental health conditions. Clinical notes from the treating physician that the condition has worsened may also be used.

If the client verifies a new or worsening condition; see Steps for Medical Determination Applications in this item.

Administrative Hearings

For all administrative hearing procedures see BAM 600.

VERIFICATION REQUIREMENTS

Medical Determination Applications

- DHS-49-F, Medical-Social Questionnaire.
- DHS-1555, Authorization to Release Protected Health Information.
- Verification of SSA application.
- DHS-3975, Reimbursement Authorization (for state-funded FIP/SDA only).

Medical Determination Reviews

- DHS-49-FR, Medical-Social Questionnaire Update.
- DHS-1555, Authorization to Release Protected Health Information.
- Verification of SSA application or appeal.
- DHS-3975, Reimbursement Authorization (for state-funded FIP/SDA only).

VERIFICATION SOURCES

Verification of SSA Application or Appeal

- Single Online Query (SOLQ).
- DHS-1552, Verification of Application for SSI from SSA.
- Correspondence from SSA.

EXHIBIT - DDS COUNTY ASSIGNMENTS

DDS Management

Program Manager, Hirut Mersha-Scarlett (517) 702-5663

Lansing DDS

Clinton
Eaton
Genesee-Clio
Genesee-McCree
Hillsdale
Ingham
Jackson
Lapeer
Livingston
Oakland - Central Administration
Oakland - Madison Heights
Oakland - Prisoner
Oakland - Saginaw
Oakland - Southfield
Oakland - Waterford
Shiawassee
Washtenaw

Lansing DDS Phone: 1-800-366-3404

Lansing DDS Fax: (517) 241-8449

Kalamazoo DDS

Allegan
Barry
Berrien
Branch
Calhoun
Cass
Ionia
Kalamazoo
Kent
Lenawee
Mecosta/Osceola
Newaygo
Oceana
Ottawa
Saint Joseph
Van Buren

Kalamazoo DDS Phone: 1-800-829-7763
Kalamazoo DDS Fax: (269) 337-3090

Traverse City DDS

Alcona	Huron	Oscoda
Alger	Iosco	Otsego
Alpena	Iron	Presque Isle
Antrim	Isabella	Roscommon
Arenac	Kalkaska	Saginaw
Baraga	Keweenaw	Saint Clair
Bay	Lake	Sanilac
Benzie	Leelanau	Schoolcraft
Charlevoix	Luce	Tuscola
Cheboygan	Mackinac	Wexford
Chippewa	Manistee	
Clare	Marquette	
Crawford	Mason	
Delta	Menominee	
Dickenson	Midland	
Emmett	Missaukee	
Gladwin	Montcalm	
Gogebic	Montmorency	
Grand Traverse	Muskegon	
Gratiot	Ogemaw	
Houghton	Ontanogan	

Traverse City DDS Phone: 1-800-632-1097

Detroit DDS

Conner Serv. Ctr.	Inkster
Fort Wayne	Macomb - Mt. Clemens
Glendale/Trumbull	Macomb - Sterling Hts.
Grand River/Warren	Macomb - Warren
Grandmont	Monroe
Gratiot/Seven mile	Redford
Greenfield/Joy	Taylor
Greydale/Grand River	Wayne Adult Medical Services
Hamtramck	

Detroit DDS Phone: 1-800-383-7155

Detroit DDS Fax: (313) 456-6837

LEGAL BASE

FIP

MCL 400.57 *et seq*.

SDA

Mich Admin Code, R 400.3151-400.3180

RCA

45 CFR 400.70 - 400.83

MA

42 CFR 435.531,.540,.541

DEPARTMENT POLICY

Each Michigan Department of Health and Human Services (MDHHS) office must furnish information in writing and orally, as appropriate, to any requesting individual, acknowledging that medical transportation is **ensured** to and from Medicaid (MA) covered services. The Michigan Medicaid Fee-for-Service Handbook may be used to provide written information.

Local MDHHS staff **must** verify client eligibility prior to the authorization of transportation in order to determine who is responsible for reimbursement.

Reimbursement for medical transportation may be authorized only after it has been determined that it is not otherwise available, and then for the least expensive available means suitable to the beneficiary's needs.

Medical transportation is available to:

- Family Independence Program (FIP) recipients.
- MA recipients (including those who also have Children's Special Health Care Services (CSHCS) coverage).
- Supplemental Security Income (SSI) recipients.
- Healthy Michigan Plan (HMP) recipients.

  Note: Unless otherwise indicated, medical transportation coverage for HMP recipients is the same as medical transportation coverage for MA recipients.

MDHHS authorized transportation is limited for clients enrolled in managed care; see **CLIENTS IN MANAGED CARE.**

FRAUD AND ABUSE MONITORING

Any MDHHS employee, volunteer, provider, or beneficiary who suspects Medicaid fraud or abuse is encouraged to report that information to the MDHHS Office of Health Services Inspector General (OHSIG). OHSIG may be contacted by telephone at (855) 643-7283 or by visiting www.michigan.gov/fraud. Information about fraud and abuse reporting requirements is located on the MDHHS website.

COVERED MEDICAL TRANSPORTATION

Medical transportation is available to obtain medical evidence or receive any MA-covered service from any MA-enrolled provider, including:

- Chronic and ongoing treatment.
- Prescriptions.
- Medical supplies.
- Onetime, occasional and ongoing visits for medical care.

Exception: Reimbursement may be made for transportation to U.S. Department of Veteran Affairs hospitals and hospitals which do not charge for care.

MEDICAL TRANSPORTATION NOT COVERED

Do not authorize reimbursement for the following:

- Transportation for non-covered services;
- Waiting time;
- Transportation for medical services that have already been provided;
- Transportation costs for clients residing in a nursing facility. Nursing facilities are expected to provide transportation for services outside their facilities;
- Transportation costs to meet a client's personal choice of provider for routine medical care outside the community when comparable care is available locally. Encourage clients to obtain medical care in their own community unless referred elsewhere by their local physician;
- Transportation services that are billed directly to the Medical Services Administration (MSA); see **BILLED DIRECTLY TO MSA**.

Transportation for a client enrolled in managed care is limited. See **CLIENTS IN MANAGED CARE.**

MEDICAL TRANSPORTATION EVALUATION

Evaluate a client's request for medical transportation to maximize use of existing community resources.

- If a client has resources available to them to provide transportation without reimbursement (for example: personally, or from family or friends) they are expected to utilize them. Local MDHHS staff is encouraged to explore whether such arrangements exist before authorizing transportation. Past circumstances, however, should not determine whether a beneficiary has current or future resources necessary to provide transportation without reimbursement.
- Do not routinely authorize reimbursement for medical transportation. Explore why transportation is needed and all alternatives to reimbursement.
- Do not authorize reimbursement for medical transportation unless first requested by the beneficiary.
- Use referrals to public or nonprofit agencies that provide transportation without reimbursement.
- Utilize free delivery services that may be offered by a beneficiary's pharmacy.
- Use bus tickets or provide for other public transit arrangements.
- Refer to volunteer services or use state vehicles to transport the client if reimbursement for a personal vehicle is not feasible.

VERIFICATION OF MEDICAL NEEDS

Reimbursement of medical transportation requires the annual completion of a DHS-5330, Medical Verification for Transportation, signed by the beneficiary's attending physician, or a physician's assistant or nurse practitioner who is working under the supervision of the attending physician. The local MDHHS office must retain the completed, original DHS-5330 in the beneficiary's file and make it available upon request.

Completion of a DHS-5330 is not required when the transportation is related to determine factors of eligibility, such as employability, incapacity, or disability, or to meet the needs of children for protective services.

MINORS TRAVELING ALONE

The following circumstances apply for minor (under 18 years of age) clients:

- Children under 12 years of age must be escorted to medically necessary appointments by a parent, foster parent, caregiver or legal guardian.
- For children between the ages of 12 and 18 years of age, a consent letter signed by a parent, foster parent, caregiver or legal guardian, is required for a child to be transported without accompaniment unless access to the services do not require parental consent by the Medicaid program.

These requirements do not apply to a beneficiary who has been emancipated, or if they are seeking transportation for health care services that a minor is legally able to consent to (for example, pregnancy-related, sexually transmitted/venereal disease, HIV/AIDS, substance abuse, or outpatient mental health care).

LOCAL OFFICE PROCEDURES

Medical transportation must be administered in an equitable and consistent manner. Local MDHHS offices must have procedures to assure medical transportation eligibility and that reimbursement reflects policy.

Transportation Coordination

It is recommended that local offices institute a transportation coordinator to ensure that all necessary tasks are done. This position would be responsible for establishing local procedures to assure the following:

- All requests for medical transportation are assessed and processed according to MA policy and local office procedures.

- Verification of current or pending MA eligibility on Bridges is available.
- The DHS-5330, Medical Verification for Transportation, form is given to all eligible clients who request transportation.
- Each client's need for transportation and access to resources is appropriately assessed.
- Maximum use is made of existing community transportation resources.

  Note: Many transportation authorities will make tickets/passes available at special rates. The transportation coordinator is encouraged to negotiate with the local transit authority and develop administrative procedures for distribution to clients .

  In some areas it may be cost effective for local offices to contract with local transit providers for all or part of transportation services in the local office, such as Agencies on Aging, Intermediate School Districts, and local Community Mental Health Services Program (CMHSP).
- Alternative transportation means are explored.
- New resources are developed within the community, including the use of social contract participants to act as schedulers, providers or in other supportive roles related to the transportation activities of the local office.
- The MSA program review division (PRD) is contacted for any required prior authorizations.
- MSA-4674s, Medical Transportation Statements, are provided as needed.
- A centralized process for returning completed MSA-4674s is developed and implemented.
- The amount of reimbursement is correct and authorization for is completed, forwarded to the fiscal unit, and processed in a timely manner.
- A local office liaison exists for resolving transportation reimbursement disputes.

LOCAL OFFICE AUTHORIZATION

Travel-Related

Local MDHHS offices may authorize and pay for the following:

- Travel for clients to receive any MA-covered service from any MA-enrolled provider. This includes Early and Periodic Screening Diagnosis and Treatment (EPSDT) and Children's Special Health Care Services (CSHCS) who also have MA coverage.

  Note: CSHCS does not cover transportation assistance for clients that have MA coverage. The same criteria must be applied to authorize medical transportation for dually eligible CSHCS/MA clients as for other MA clients.

  Some local health departments provide reimbursement for transportation to clients for EPSDT screenings or the Maternal Outpatient Support Services (MOMS) program. Check with your local health department prior to authorization to guard against duplicate reimbursements.

- Travel and a fee for an attendant needed to accompany a client requiring special assistance during transport.

- Travel for a parent, relative, guardian or attendant who is accompanying a client who is a minor child.

- Travel for family members of clients who are children in an inpatient hospital treatment program, if the family members are part of a structured treatment or therapy program.

- Travel for one trip for examination and one trip per Disability Determination Service recommendation for clients claiming disability or blindness.

- Travel within or outside the normal service delivery area including borderland outstate travel (local offices have responsibility for defining normal service delivery area).

Meals and Lodging

Local MDHHS offices may authorize and pay for the following:

- Medically necessary overnight stays (inpatient or outpatient, including meals and lodging) for one client, and one parent or escort, for no more than five consecutive nights; See **PRIOR AUTHORIZATION** for stays beyond five nights.
- Medically necessary overnight stays (including meals and lodging) for one child and one parent or escort, admitted at Children's Hospital of Michigan, C.S. Mott Children's Hospital, or Helen DeVos Children's Hospital for up to 14 nights; see **PRIOR AUTHORIZATION** for stays beyond 14 nights.
- Overnight stays if travel is 50 miles (one-way) or more from the beneficiary's home; see **PRIOR AUTHORIZATION** for overnight stays when the distance is less than 50 miles.
- Meal allowance associated with long-term recovery housing for bone marrow transplant operations at U of M or Harper University Hospital (amount determined by MDHHS) and prior authorized through the transplant coordinator. Lodging necessary prior to bone marrow transplant operation is to be paid.
- Meals for trips not involving overnight stays.

REIMBURSEMENT AUTHORIZATION

Authorize reimbursement for medical transportation beginning the month the client reported the need.

At application, do not authorize reimbursement earlier than the MA begin date. If program eligibility is denied, only authorize reimbursement for transportation to obtain medical evidence.

Some transportation services require prior authorization; see **PRIOR AUTHORIZATION** below.

Transportation services for children and families active for child welfare services and required as part of the services care plan is authorized by services staff. See Children's Foster Care Manual FOM 903-9 for policy and procedures. Foster parents that provide medical transportation for a foster child in their care may receive mileage reimbursement at the volunteer driver rate.

REVIEW

Review continued need for medical transportation:

- When indicated on the DHS-5330.
- At redetermination.
- Annually for SSI recipients.

The need for a special allowance must be reviewed yearly; see **Special Allowances.**

The need for transportation must be reviewed even if a client's medical condition is considered lifetime.

CLIENTS IN MANAGED CARE

Medicaid Health Plans (MHPs) are required to ensure that a client's need for transportation necessary to receive MA-covered services is met. This requirement is limited to the MA-covered services the MHP is required to provide, including referrals from specialists and out-of-state providers.

Refer clients to their MHP if the Level of Care code is 07.

For Medicaid clients enrolled in managed care, medical transportation to the following services is the responsibility of the local MDHHS office and not the MHP:

- Dental.
- Substance abuse.
- CMHSP

For HMP clients enrolled in managed care, medical transportation the following services is the responsibility of the local MDHHS office and not the MHP:

- Substance abuse.
- CMHSP.

Transportation to dental services for HMP beneficiaries enrolled in managed care is the responsibility of the MHP.

BILLED DIRECTLY TO MSA

MSA authorizes and pays MA-enrolled providers directly for transportation services for these populations:

- Clients who are enrolled in the MOMS program, unless the beneficiary is enrolled in managed care; see **CLIENTS IN MANAGED CARE**.
- CMHSP clients enrolled in the children's waiver receiving day treatment (as part of its treatment package).
- Emergency ambulance transportation.
- Clients who receive dialysis treatment at dialysis centers that provides transportation.
- Long-term housing related to transplant operations.
- Clients whose eligibility or enrollment status has changed, transportation may be authorized retroactively for these clients, including, but not limited to, the following examples:
    - Clients whose Medicaid eligibility was made retroactive, and client received transportation during the retroactive eligibility time period.
    - Clients enrolled in managed care that were authorized for or received transportation while enrolled in the MHP, and then were dis-enrolled retroactively from the MHP.

Prior Authorization

Prior authorization requests must be submitted before the service is provided and reimbursement is made. Exceptions will only be granted for emergency situations or when extenuating circumstances exist and are clearly documented.

No exceptions will be made for requests submitted 30 days or more after the service is provided.

The following transportation expenses require prior authorization from MSA:

- All outstate travel that is non-borderland; see BAM 402.
- Overnight stays if within 50 miles from client's home (one way).

- Overnight stays beyond five nights (14 nights for Children's Hospital of Michigan, C.S. Mott Children's Hospital, or Helen DeVos Children's Hospital).

- Overnight stays or travel outside the normal service delivery area if expenses for two or more family members are included.

- Attendant(s) in addition to the driver of a wheelchair lift/medivan vehicle.

  Note: Drivers of specialized non-emergency transport vehicles are expected to assist the beneficiary. Attendants should only be requested if the beneficiary verifies that they are, in addition to the driver, medically necessary to assist the beneficiary into and out of the building or that without such assistance it would be impossible or unsafe for the beneficiary to enter or exit the building. Prior authorization should not be requested if the transport is being provided in a private vehicle.

- Mileage and meal expenses for daily long-distance trips.

Prior authorization may be requested for up to 6 months in cases where prolonged treatment requires multiple transports.

For all prior authorizations, send or fax (517) 335-0075 a memo to:

MSA/Ancillary Unit
Attention: Medical Transportation
PO Box 30170
Lansing, MI 48909

The memo must be attached to the DHS-5330 and must include all of the following information:

- Client name.
- Beneficiary ID.
- Case number.
- Client address.
- Reason for requested travel expense(s).
- Effective travel dates (begin and termination).
- Travel origin and destination.
- Diagnosis.
- Specific reason/need for special transportation (if applicable).
- Specialist name and telephone number.

Although it is best to fax or send a memo, local offices can contact the Program Review Division/Ancillary Unit at (800) 622-0276. The Program Review Division will respond to the local MDHHS office with a memo.

REIMBURSABLE EXPENSES

Compute the cost of the client's medical transportation when verification that transportation has been provided is received.

Calculate the total number of round trip miles traveled. Use the distance from the client's home to the medical services destination(s) and back to the client's home. Accept any reasonable client or transporter statement of the mileage. Otherwise, use map miles to determine mileage.

Exception: Volunteer Services drivers can be paid mileage for the distance from their home or office to the client's home and the return trip from the client's home in addition to the round trip mileage for the client's medical services. Volunteer service drivers cannot be paid for mileage when the client either failed to keep the appointment or was not at home.

Missed Appointments or Cancellations

Do not authorize reimbursement to non-emergency transportation providers for missed or cancelled appointments.

Vehicle Rates

The following are reimbursement rates for travel by vehicle:

- Ticket charge per person (one way or round trip) for inter-city bus or public transit.
- Round trip rate of $30 and $0.27 cents per mile for non-emergency medical transport vehicles specially equipped or designed to accommodate non-ambulatory (unable to walk) clients.
- $0.23 per mile for all **personal** vehicles if alternative transportation is not available and mileage reimbursement is necessary. This includes the client, relatives, friends, neighbors, etc.

- $0.27 per mile only for:
  - Commercial non-emergency medical transport vehicles.
  - Nonprofit agencies.
  - Taxis.
  - Vans operated by medical facilities or public entities such as health agencies.
- $0.555 per mile for all registered volunteer service drivers or foster care parents.

Note: A state vehicle may be used to transport clients; see ACM 416, Medical Transportation Payments.

Public Transit

Have a supply of public transit tickets, tokens, passes, etc. available for clients who wish to use public transit for medical transportation.

Note: Public transit tickets, tokens, passes, etc. intended for MA clients must be purchased and tracked separately from those intended for HMP clients; they are not interchangeable.

Fees and Tolls

Necessary travel-related fees and tolls, such as parking, bridge and ferry charges, are reimbursable if verified with original, unaltered receipts.

Meals and Lodging

See Exhibit I, **ESSENTIAL MEDICAL TRANSPORTATION RATE SCHEDULE** for appropriate meal and lodging allowances. Authorized expenses must be verified with original, itemized, unaltered receipts.

Encourage lodging providers to bill the local office directly when overnight accommodations are authorized.

Reflect actual cost of lodging or meals when advance reimbursements are made for less than the maximum table rates.

LOCAL OFFICE AUTHORIZATION describes meals and lodging for stays at certain pediatric hospitals. Attempt to secure lodging at Ronald McDonald House for the parent. Authorize lodging at area motels or the MED-INN only after you have determined that lower cost lodging is not available.

The U of M social work department will not reimburse on behalf of clients or bill MDHHS directly for meals and lodging.

Exceptions to Reimbursement Rates

Exceptions to the maximum reimbursement rate must be prior authorized by MSA PRD.

All exception requests must clearly document at least one of the following:

- No appropriate transportation provider is available within the county.
- No appropriate medical facility is available within the county.
- Mileage (one-way) exceeds 50 miles.
- The quoted rate is the lowest available. Include quotes from a minimum of three providers.
- The provider is the only one available.

Reimbursement Authorization

A completed, original MSA-4674 is necessary to authorize reimbursement for routine travel expenses and to verify that the transportation was provided, unless the expenses require advance reimbursement. An MSA-4674 does not need to be signed by transporters employed by either a city or inter-city mass transit provider.

The local office must receive the MSA-4674 from the transportation provider within 90 calendar days from the date of service to authorize reimbursement. The local office must then approve the MSA-4674 and submit it to the appropriate MDHHS accounting service center within 10 business days of receipt of the form.

DHS-1291

Use the DHS-1291, Local Payment Authorization, for advanced reimbursement for long-distance travel expenses. Attach a DHS-223 to the DHS-1291 to document expenses; see **Expense Documentation**.

Expense Documentation

Documentation of expenses on an MSA-4674 or DHS-223 (attached to the DHS-1291) must include all of the following:

- Clients name and address.
- Case number and Client ID number.
- Transportation provider's name, address, social security number or tax I.D. number.
- Travel or appointment date.
- Medical provider's name, address and signature.
- Number of round trip miles traveled.
- Reimbursement method (client or vendor).

Reimbursement Method

There are two reimbursement methods:

- Direct client reimbursement (client is the payee), or,
- Direct vendor reimbursement (transportation provider is the payee).

The client and transporter must determine who will be the payee. If the transporter is to be payee, the transportation provider completes Section III of the MSA-4674. Make direct client reimbursement if Section III is not completed.

Exception: Always use vendor reimbursement for volunteer services transporters.

Minimum Mileage Reimbursement Amount

The minimum mileage reimbursement for volunteer drivers in personal vehicles is the greater of the following:

- $1.80 per round trip.
- The mileage rate.

Advance Reimbursement for Travel Costs

Authorize advance reimbursements for emergencies and reimbursable expenses prior authorized by MSA PRD with supervisory approval. Use estimates by the client, transportation provider or medical provider to determine the amount of the advance reimbursement.

Use the DHS-1291 and attach **Expense Documentation.** Adjust to reflect actual, verified, reimbursable expenses.

The difference between actual reimbursable expenses and the advance reimbursement will not be paid if documentation is not attached. Also, future advance reimbursement requests may be denied.

DENIAL OF REIMBURSEMENT FOR TRANSPORTATION

A DHS-301, Client Notice (Medical Transportation Denial), **must** be used to notify a client that medical transportation is denied. The notice contains:

- The action being taken.
- The reason(s) for the denial.
- BAM 825 as the legal base.
- The individual's right to request a hearing.

Referrals

The following are referrals not denials:

- Referring the client to the MHP for transportation services covered by the MHP; see **Clients in Managed Care.**
- Referring the client to the CMHSP for transportation covered by their capitation rates; see **CLIENTS in Managed Care**.
- Referring the client to those providers who are able to bill MA directly; see **Billed Directly to MSA**.

Do not issue a DHS-301 when making a referral.

Administrative Hearings

The Michigan Administrative Hearing System (MAHS) is responsible for conducting hearings on medical transportation. The DHS-301 instructs the client to send the hearing request to MAHS.

If MDHHS local office receives a hearing request on a medical transportation denial, the local office hearings coordinator must send the original hearing request, within three workdays of receipt, to:

Michigan Administrative Hearing System
PO Box 30763
Lansing, MI 48909

When a hearing is requested on a medical transportation denial made by MDHHS, the MA Appeals Section will contact the local MDHHS office for case information and relevant documents.

MDHHS staff is responsible for:

- Completing the DCH-0367, Hearing Summary.
- Arranging for and conducting the prehearing conference.
- Scheduling and presenting the case to the administrative law judge.
- Notifying the local office when a representative is needed to attend the telephone prehearing conference and/or serve as a witness at the hearing.

VERIFICATION REQUIREMENTS

Verify the client's:

- Need for chronic and ongoing treatment.
- Need for travel expenses that require prior authorization from MSA PRD.
- Need for travel outside the normal service delivery area.
- Need for overnight stays (including meals and lodging).

- Need for attendant fee if the client needs special assistance; see **Special Allowances** in this item.
- Length of time the need will exist.
- Type of special transportation needed.
- Parking fees and tolls.

Verification is not required in either of the following circumstances:

- The request for special allowances is for Children's Special Health Care Services (CSHCS) or Harper University Hospital.
- Transportation is arranged or authorized for single episodic visits to a medical provider or pharmacy.

Verification Sources

Verify need with the following:

- DHS-5330.
- DHS-49-F, Medical-Social Questionnaire.
- Similar documentation signed by the client's medical provider (or their designee).

Verify fees and tolls, meals, and lodging with receipts.

EXHIBIT I

ESSENTIAL MEDICAL TRANSPORTATION RATE SCHEDULE	
MEALS AND LODGING	**MAXIMUM**
Lodging	$41.25 plus tax
Breakfast must depart prior to 6:00 AM and return after 8:30 AM	$4.50 (includes tax)
Lunch must depart prior to 11:30 AM and return after 2:00 PM	$5.50 (includes tax)
Dinner must depart prior to 6:30 PM and return after 8:00 PM	$11.75 (includes tax)
U of M CHILDREN'S HOSPITAL / OUTPATIENT TREATMENT	**MAXIMUM**
Lodging	
• Any Ronald McDonald House	$12.50 per day
• Other	$41.25 per day

ESSENTIAL MEDICAL TRANSPORTATION RATE SCHEDULE	
Meals • When staying at any Ronald McDonald House • Other	 $7.00 per day $12.00 per day
FEES & TOLLS	**MAXIMUM**
	Actual charge
MILEAGE	**MAXIMUM**
Bus transportation • City bus (one way or round trip) • Inter-city bus (for example, Greyhound) (one way or round trip)	• distributed by local/district office per person • ticket charge per person
Personal vehicle	$.23 per mile, or $1.80 per round trip, whichever is greater regardless of the number of passengers
Volunteer Services drivers and foster care parents	$.555 per mile.
Commercial, nonprofit agencies, medical facilities, local health departments, taxis	$. 27 per mile
SPECIAL TRANSPORTATION ALLOWANCES	**MAXIMUM**
• Wheelchair lift / Medivan non-emergency medical transport vehicle • Attendant	• $30.00 / $.27 per mile • $10.00 per attendant
Meals and lodging expenses allowed for the client and one escort must be prior authorized by MSA for stays longer than 5 nights. See **Meals and Lodging** for stays at Children's Hospital of Michigan, C.S. Mott Children's Hospital, or Helen DeVos Children's Hospital. Rates do not apply for transplant recovery. All travel-related meals, lodging, fees and tolls must be supported by original, itemized (for meals and lodging only), unaltered receipts.	

LEGAL BASE

FIP

P.L. 104-193 of 1996
P.A. 280 of 1939, as amended

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151-400.3180

MA

42 CFR 431.53, and 440.170

FAP

7 USC 2015 (d)(4)(I)(i)(I)

DEPARTMENT POLICY

RCH

Resident County Hospitalization (RCH) pays inpatient medical treatment for persons ineligible for Medicaid (MA). RCH eligibility policy is established for each county by its social services board.

Exception: For **Wayne County only**, RCH applications, eligibility determinations, medical services authorizations, billings and payments are the responsibility of Wayne County Patient Care Management Systems (PlusCare program).

LEGAL BASE

MCL 400.66a

JOINT POLICY DEVELOPMENT

Medicaid, Adult Medical Program (AMP) also known as Adult Benefit Waiver (ABW), Transitional Medical Assistance (TMA/TMA-Plus), and Maternity Outpatient Medical Services (MOMS) policy has been developed jointly by the Department of Community Health (DCH) and the Department of Human Services (DHS).