STATE OF MICHIGAN
DEPARTMENT OF HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

MAURA D. CORRIGAN
DIRECTOR

February 28, 2011

The Honorable Bruce Caswell, Chair
Senate Appropriations Subcommittee on DHS
Michigan State Senate
Lansing, MI 48933

The Honorable David Agema, Chair
House Appropriations Subcommittee on DHS
Michigan House of Representatives
Lansing, MI 48933

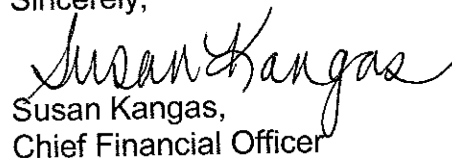
Dear Senator Caswell and Representative Agema:

Section 273(1) of 2010 Public Act No. 190 requires the Department of Human Services (DHS) to report policy changes made to implement provisions of enacted legislation including the DHS budget act. I have attached the report for policy released in the first quarter of Fiscal Year 2011.

The report contains the bulletin number of the policy release as well as the effective date, subject and summary of the policy.

If you have any questions about the attached material, please contact Judith Galant, online manual coordinator, at (517) 241-7084.

Sincerely,



Susan Kangas,
Chief Financial Officer

Attachment
C: Senate and House Appropriations Subcommittees
House Families, Children and Seniors Committee
Senate Families, Seniors and Human Services Committee

CHILDREN'S SERVICES PROGRAMS

ADOPTION

ADB 2010-003 ADOPTION SERVICES POLICY BULLETIN

EFFECTIVE December 1, 2010.

Issued October 27, 2010.

SUBJECT(S)

ADM 210 **Referral to Adoption**

Policy is updated to include details of the case acceptance requirements and describe adoption focused activities that must begin within 7 days of the acceptance of the adoption case transfer. Information about Permanency Planning Conferences (PPC) is added.

ADM 230 **Adoption Services by a Contracted Adoption Agency**

This item is updated to include a policy reference for required monthly caseworker visits and to add the DHS-606, Child Adoption Assessment Addendum, and DHS-612, Adoptive Family Assessment Addendum, to the required assessments. The time frame for providing assessment clarifications or revisions to DHS is changed to 7 days.

ADM 300 **Child Adoption Assessment**

Policy is updated to clarify the requirements of the child adoption assessment and define non-identifying information.

The time frame for completion of the child adoption assessment is changed to 45 calendar days from acceptance of the case.

ADM 400, 410 **Recruitment Efforts, Adoption Orientation**

Policy regarding child-specific recruitment plans is added.

The requirement to provide the DHS Publication 255, Michigan Department of Human Services Adoption Program Statement, to all prospective adoptive families who may be interested in adopting a child from DHS is added.

ADM 440 **Adoption by Agency Associate**

Policy is added that addresses adoption applications by agency board members and former board members.

ADM 521 **Title IV-E Funding Requirements**

PSB 2010-005 **CPS INTERIM: MALTREATMENT IN CARE INTAKE, INVESTIGATION AND DISPOSITION**

EFFECTIVE December 1, 2010.

Issued December 7, 2010.

SUBJECT **Inter-County Complaints**

PSM 712-6

Complaints involving children in court ordered out-of-home placements will be investigated by the CPS-Maltreatment In Care (MIC) units. When a CPS-MIC complaint involves multiple counties, assign the complaint to the county in which the child caring institution or foster family home is located.

In all cases involving multiple counties, requests for courtesy interviews, case records and assistance must be honored. See PSM 713-1, CPS Investigation, Cases Involving Multiple Counties section, for how to document and process requests for courtesy interviews and other activities.

Disputes between counties must be immediately referred for resolution to:

- Urban Field Operations for Genesee, Ingham, Kent, Macomb, Oakland and Wayne counties.
- Outstate operations for all other counties.

Exception 1 will be removed from policy and Exception 2 will be renumbered.

SUBJECT **Special Investigative Situations**

CPS-MIC units are now responsible for investigating child abuse/neglect complaints within all child caring institutions and foster family homes. PSM 716-6 is obsolete.

PSM 712-6

Responsibility to Investigate

The Bureau of Children and Adult Licensing (BCAL) are no longer responsible for the investigation of abuse/neglect of children in the following regulated child care organizations:

- Detention centers.
- Youth homes.
- Shelter homes.
- Residential care facilities.
- Halfway houses.

These investigations are now the responsibility of the CPS-MIC units.

DHS-BCAL Responsibilities

BCAL is responsible for investigating allegations of child abuse and neglect of children who are not the child of the licensee, occurring in the following regulated child care organizations:

- Licensed child care centers.
- Regulated (licensed or registered) child care group and family homes.
- Children's camps.

CPS intake must reject these complaints and refer them to BCAL within 24 hours of receipt of the complaint.

Prosecuting Attorney/Law Enforcement Responsibility

Prosecuting attorney/law enforcement agencies are responsible for the investigation of child abuse and neglect in unregulated institutional settings such as:

- Schools (both public and private), including boarding schools.
- Incidental out-of-home or in-home child care (baby sitting).
- Mental health facilities not subject to PA 116.
- Unregulated (unlicensed or unregistered) child care group and family homes.

CPS intake must reject these complaints and refer to the prosecuting attorney/law enforcement agency within 24 hours of receipt of the complaint.

The Intake Decision Table for Investigation of Child Abuse and Neglect in Child Care Organizations/Relative Care specifies the responsibilities of CPS and the CPS-MIC Units for investigation of child abuse and neglect complaints received by DHS.

INTAKE DECISION TABLE FOR INVESTIGATION OF CA/N IN CHILD CARE ORGANIZATIONS/RELATIVE CARE		
Facility/Placement Type	**Responsible Unit - Department**	
Child caring institution (detention centers; youth homes; shelter homes; residential care facilities, both long and short-term; halfway homes).	**CPS**	**CPS-MIC**
-Allegations against an employee of a CCI for CA/N of a child residing in a CCI.		**X**
-Allegations against a parent for CA/N (for example, during a weekend visit) while the alleged child victim is placed in the CCI.		**X**
-Allegations against an employee of a CCI for CA/N made **after** the child has been returned to a parent's care.		**X**
- Allegations against a licensed/registered provider or an employee of a child care organization of abuse/neglect of their own children.	**X**	
Child foster care-family, unlicensed and relative foster care providers and group homes (DHS, court, private agency, mental health, etc.).	**CPS**	**CPS-MIC**
-Allegations against a foster parent for CA/N while the alleged child victim resides in the foster home.		**X**
- Allegations against a foster parent for CA/N when both biological children and foster children reside in the home.		**X**
-Allegations against a parent for CA/N (for example during a weekend visit) while the alleged child victim is placed in foster care.		**X**
-Allegations against a foster parent for CA/N **after** the alleged child victim has been returned to a parent's care.		**X**
- Allegations against a foster parent for CA/N of biological children when foster children **do not** reside in the home.	**X**	
-Allegations against a parent for CA/N of an alleged child victim prior to going into out-of-home care (but currently in out-of-home placement).	**X**	
Parents caring for children under court jurisdiction (in-home CPS and under DHS supervision following return home from foster care).	**CPS**	**CPS-MIC**
-Allegations against parents for CA/N of children currently in their care.	**X**	
-Allegations against parents for CA/N of a newborn child in the parent's care (not under the court's jurisdiction).	**X**	

Possible Licensing/ Registration Rule Violation

When child abuse and neglect is alleged to have taken place in a licensed CCI, licensed or registered organization or home, or by a licensed or registered provider, BCAL must be notified as soon as possible and no later than 24 hours from the receipt of the complaint. If assigned for CPS investigation, CPS-MIC and the licensing consultant **must coordinate** their investigations or document why not.

Contact the BCAL complaint line at (866) 856-0126 to report the alleged licensing/registration rule violations.

If the CPS complaint is rejected, a copy of the complaint must be forwarded to the responsible licensing unit within 24 hours of receipt of the complaint.

Responsible licensing units may be within the local DHS office, court, private child placing agency or community mental health agency and is the unit responsible for licensing and supervision of the foster home.

BCAL is the responsible licensing unit for complaints involving the following child care organizations and should receive the complaint via FAX at (517) 335-6121.

- Licensed child care centers.
- Regulated (licensed or registered) child care group and family homes.
- Children's camps.
- All child caring institutions (including detention centers, youth homes, shelter homes, residential care facilities (both long and short term) and halfway homes).

See PSM 716-9, New Complaint When Child Is In Foster Care, for more information on handling complaints on licensed foster parents.

BCAL Reporting Responsibilities

If at any time BCAL suspects child abuse and neglect regarding children residing in an alleged perpetrator's home, BCAL must make an immediate complaint to CPS.

Note: The responsibilities for BCAL and CPS during these investigations have been modified.

CPS Responsibilities

When CPS intake receives a complaint regarding **an alleged perpetrator who is a licensed foster parent or employed by a CCI** who has biological/adoptive children or other children residing in their home and the allegations cause concern for the children in that person's home, take the following actions:

- The complaint must be reviewed by a CPS-MIC supervisor.

- The CPS-MIC supervisor will make a determination whether an additional complaint for the alleged perpetrator's children is required.
- Evaluate the complaint in the same manner as any other complaint to determine whether to accept, reject, withdraw or transfer the complaint.
- If a complaint is made by the CPS-MIC supervisor, the complaint will be forwarded to the appropriate county and a local office supervisor will make a decision whether the complaint should be assigned for investigation.
- Document the current concerns which would include allegations of threatened harm in the CPS-MIC investigation which could effect the perpetrator's children based on the allegations and/or findings of the CPS-MIC investigation.

Note: The CPS-MIC supervisor and the local office CPS supervisor must coordinate these complaint investigations.

The policy regarding intake procedures of child abuse and neglect in child caring institutions and foster family homes appears in this bulletin and will be added to PSM 712-6 at the next regular policy release.

INVESTIGATION

PSM 713-8

Policy is revised to require staff in the DHS CPS-MIC units to investigate all assigned complaints of child abuse and neglect occurring in a child caring institution or licensed/unlicensed foster care family home.

Risk and safety assessments and family and child assessments of needs and strengths are still required for all licensed/unlicensed foster home investigations. Risk and safety assessments and family and child assessments of needs and strengths are not required for child caring institution investigations.

Policy includes a requirement for the assigned CPS-MIC worker to have contact with the child caring institution administrator or licensee designee prior to contact with the alleged child victim and prior to completion of the complaint.

Under the Child Protection Law, MCL 722.628(8), DHS has the responsibility for notifying parents or guardians of **any** children interviewed at school or other institution. This notification must occur in all CPS-MIC investigations, except where parental rights have been terminated.

The policy regarding complaint disposition of child abuse and neglect in child caring institutions and foster family homes appears in this bulletin and will be added to PSM 713-9 at the next regular policy release.

DISPOSITION **PSM 713-9**

Completion of a Complaint investigation

A preponderance of evidence finding, regardless of risk level, on a licensed/registered provider or employee of a child caring institution or licensed foster family home, of abuse/neglect against any child(ren), including children in their own home, requires their name to be placed on central registry. For all complaints when a preponderance of evidence finding exists, the CPS-MIC worker must override a low or moderate risk to a high risk level.

The results of a CPS investigation on a licensed/registered provider or an employee of a child caring institution or licensed foster family home of abuse/neglect of their own children **cannot** be shared with their employer.

If a preponderance of evidence finding of abuse/neglect is found to exist in a child caring institution, CPS-MIC must forward (by fax or e-mail) a copy of the Investigation Report (DHS-154) to BCAL within five business days of completion.

BCAL Investigations

When BCAL completes its investigation, CPS must request and obtain a copy of the BCAL report. This information **must** be maintained within the client's file.

SUBJECT **Complaints Involving Child Care Organizations and Institutional Settings**

PSM 716-6

Policy in PSM 716-6 has been revised in this bulletin and will be added to PSM 713-8 at the next policy release. PSM 716-6 is obsolete.

SUBJECT **New Complaints Involving a Foster Child or Foster Parent**

PSM 716-9

Complaints of child abuse and neglect occurring in a licensed foster care home or the home of an unlicensed/unrelated or related caregiver must be investigated by CPS-MIC units. This includes complaints both while the child is placed in the home or after the child has moved from the home.

FOSTER CARE

FOB 2010-004 **ANNUAL TRANSITIONAL MEETING AND 90-DAY DISCHARGE MEETING INTERIM BULLETIN**

EFFECTIVE September 1, 2010.

Issued September 3, 2010.

SUBJECT

ANNUAL TRANSITION MEETING

Beginning at age 16, an annual transition meeting must be held to discuss a youth's permanency goal and identify supportive adults. The DHS-901, Annual Transition Plan Report, must be completed during the meeting. If a youth enters care after his/her 16th birthday, the annual transition meeting must be held within 30 days of entering care. The forms become the youth's transition plan and all progress toward the youth's goals must be documented in the quarterly USP.

In counties with permanency planning conference (PPC) facilitators, the meeting must be facilitated by the PPC facilitator. In counties that do not have PPC facilitators, a children's services worker or supervisor, other than the youth's caseworker, must facilitate. Participants in the meeting should include all persons identified as supportive by the youth. This may include foster parents, biological parents, relatives, the Court Appointed Special Advocate (CASA), therapists, the youth's friends, school staff, employers, or anyone the youth considers to be a support person and wishes to invite.

The meeting must cover all areas identified in the DHS-901: housing, education, employment, transportation, financial management skills, emotional/mental/physical health, substance abuse and other areas that will assist the youth in successfully transitioning from foster care. During the meeting, goals for each area must be identified as well as the supportive adult assisting the youth in achieving each goal. A copy of the DHS-901 must be given to the youth and all individuals responsible for assisting the youth. The original plan must be maintained in the youth's case record. The DHS-901 is a **living document** and should be changed to reflect the defined goals each year.

If a mandatory permanency planning conference is being held, and it is within 30 days of the mandatory annual transition meeting, one meeting may be held to address all issues. However, the DHS-901 must be completed during the meeting and the youth may invite supportive persons to the meeting.

90-DAY DISCHARGE MEETING

As required in the Fostering Connections to Success and Increasing Adoptions Act of 2008 [P.L. 100-351], each foster youth transitioning out of foster care at the age of 18 or older must have a 90-day discharge plan in place. The plan is to be developed during a discharge meeting that must occur no later than 90 days prior to the youth's exit from care. If a case is closed unexpectedly, a discharge meeting must still occur within 30 days of case closure.

The permanency planning conference (PPC) facilitators must facilitate these meetings, or in counties without PPC facilitators, a children's services case worker or supervisor other than the youth's case worker must facilitate.

The discharge plan must be youth-driven. The youth must be involved in every aspect of the process of developing the plan to ensure the plan is personalized to the individual youth. Participants in the meeting may include foster parents, biological parents, relatives, CASA, therapists, the youth's friends, school staff, employers, or anyone the youth considers to be a support person and wishes to invite.

The DHS-902, 90-Day Discharge Plan Report, must be completed during this meeting. A copy is to be given to the youth and any individuals responsible for assisting the youth. The original plan must be maintained in the case file.

The form must be completed to address:

- Housing.
- Health insurance.
- Education.
- Mentors/supportive adults.
- Continuing support services.
- Workforce/employment services.

If an annual transition meeting is held within the 90 days of expected discharge, one meeting may be held to address all issues. However, the DHS-902 must be completed during the meeting.

FOB 2011-004 **FOSTER CARE CASE CLOSING**

EFFECTIVE January 1, 2010.

Issued November 29, 2010.

SUBJECT Annual Transition Meeting and 90-Day Discharge meeting.

FOM 722-15, Foster Care Case Closing

New requirements of Fostering Connections to Success and Increasing Adoptions Act of 2008 [P.L. 110-351] and Dwayne B. v Granholm, et al. state annual transition meetings are to be held, starting at the age of 16, for every youth in foster care. A 90-day discharge meeting is to be held 90 days prior to foster care case closure. Meetings should be youth-driven and identify supportive adults for every youth in foster care.

FOB 2011-002 **INTERIM POLICY BULLETIN: PERMANENCY PLANNING CONFERENCES (PPC) AND INCARCERATED PARENTS**

EFFECTIVE December 1, 2010.

Issued December 22, 2010.

SUBJECT **FOM 722-6B**

Introduction

Permanency Planning Conferences (PPC) represent a family-centered, strength-based and team-guided decision making process designed to produce the optimal decisions concerning a child's safety, placement and permanency. Permanency planning conferences include child welfare staff, parents, caretaker(s), foster parents (of the children in foster care) and may also include extended family, friends, neighbors, community-based service providers, community representatives or other professionals involved with the family. The inclusion of children and youth at PPCs is addressed within this policy; see Children and Youth Participants. The parents and child are encouraged to invite family, friends and/or other people they view as supportive or influential in their lives.

During the PPC, participants work together to create a plan for safety, placement and permanency tailored to the individual needs of each child. This process establishes a forum to share ideas and opinions, embraces the importance of the family's perspective and involvement, stresses full participation of all attendees, encourages honest communication and promotes dignity and respect for all participants.

Events Requiring PPC

PPCs are conducted to make or recommend critical case decisions. PPC referrals are made once a caseworker and the supervisor determine a need. When a need has been determined, the PPC referral must be made immediately. After it is held, the event necessitating the PPC must occur within 45 calendar days or a new one must be held.

Certain circumstances or events and stages of a case progression **mandate** PPCs must occur within the required time frames as outlined below:

Emergency Removal

The CPS worker must make a PPC referral when a child is removed from his/her home. The appropriate staff must schedule it no later than the next business day or prior to the completion of the preliminary hearing.

Considered Removal

The CPS worker must consult with the supervisor whenever the removal of a child from a parent's or guardian's home is in question. If the worker and supervisor are considering removing the child from the home, the PPC referral must be made immediately. PPC staff must schedule the PPC no later than two business days from the referral. It

must be held prior to removal and placement of the child, unless an emergency occurs.

Change of Placement

The supervising agency may immediately change the child's placement if there is reasonable cause to believe the child has suffered sexual abuse or non-accidental physical injury or that there is a substantial risk of harm to the child's emotional well-being within a foster parent's or relative caregiver's home; see FOM 722-3, Reasons for Replacement. The assigned worker must make an **immediate** referral to the PPC staff, who must schedule the PPC meeting no later than the next business day after receipt of the referral.

For any other type of replacement, the assigned worker must make a PPC referral prior to providing the foster parent/relative caregiver with the DHS-30, Foster Parent Notification of Move. In cases where the child is a Michigan Children's Institute (MCI) ward and the caregiver has expressed an interest in adopting, the MCI superintendent must be consulted prior to the change in placement; see FOM 722-3, Reasons for Replacement. The PPC must occur prior to the child's change in placement. If the foster parent/relative caregiver has appealed the intended replacement to the Foster Care Review Board, the child must not be replaced until a final decision is made by the Foster Care Review Board, court or MCI superintendent.

In instances where a foster parent, relative or unrelated caregiver requests that a child be moved from their home, the procedures below must be followed:

- The assigned DHS/placement agency foster care (PAFC) worker must make a referral for a replacement PPC immediately.
- PPC staff must schedule a PPC meeting to occur no later than 3 business days after a verbal or written request for the child to be replaced.
- If the child already has been replaced, the PPC meeting must still occur within 3 business days.

  Note: For mental health hospitalizations, a PPC for change of placement is only required if the plan **does not** involve returning the child to the previous placement. If the decision is not to return the child to the previous placement, the PPC must be held no later than 3 business days after the decision has been made.

Reunification

A PPC referral must be made when the assigned worker decides, in conjunction with the supervisor, to commence consecutive overnight parenting time preceding reunification.

PPC staff must schedule the PPC to occur before the first multiple overnight parenting time begins. If the court orders a child returned home before a PPC can be held, a PPC must be held no later than 2 business days after the date of the court order.

Permanency Goal Change

A referral must be made when the assigned worker decides, in conjunction with the supervisor, during the course of the case that the permanency goal may change. PPC staff must schedule the PPC to occur before the next court hearing and preferably within five business days of the receipt of the request, unless the family would prefer a later date. The PPC must be held prior to any change in goal and must be held before the assigned worker asks the court to approve the new goal.

Note: A PPC for a permanency goal change may be combined with a child in care for nine months conference.

Child Returns from Absent Without Legal Permission (AWOLP) Status

A PPC must be held as soon as possible, but no later than 2 business days after a child returns to placement after being AWOLP.

Child in Care for Nine Months

A PPC referral must be made by the assigned worker when a child has been in care for nine months with a goal of reunification, and sufficient progress has not been achieved to ensure reunification within 12 months. The PPC must be held as soon as possible after the nine-month mark, but no later than 30 business days after this date.

Note: A child in care for nine months PPC may be combined with a permanency goal change conference.

Child Legally Free for Adoption

A PPC referral must be made by the assigned foster care worker when a child has been legally free for adoption for three months, but does not have a permanent placement identified. The meeting must be held within 30 business days after three months have elapsed since termination of all parental rights. A pending appeal does not alter these time requirements.

Note: Children with identified adoptive placements do not require a PPC. These children will be tracked through entry into the MARE module in SWSS.

Other

PPCs or case conferences may be held at other times during an open case, as dictated by circumstances and departmental policy.

Requesting a Permanency Planning Conference

Once the assigned caseworker and supervisor determine a need for a PPC, a written request shall be made to the PPC facilitator or other designated staff person by completing section A of the DHS-969, PPC Referral Report. When multiple agencies are providing services to the family and child or children, the agency required to conduct the PPC is the following:

Emergency Removal

The agency that will remove and/or place the child.

Considered Removal

The agency that will remove and/or place the child.

Child Replacement

The agency that has responsibility for the child.

Reunification

The agency that has responsibility for the family.

Permanency Goal Change

The agency that has responsibility for the family.

Child Returns from Absent Without Legal Permission status

The agency that has responsibility for the child.

Child in Care Nine Months

The agency that has responsibility for the family.

Child Legally Free for Adoption

The agency that has responsibility for the child.

The PPC facilitator or other designated staff person will:

- Log the date, time and name of the requestor.
- Discuss with the requestor the reason for the meeting.

- Request contact information of participants invited to the meeting.
- Determine with the requestor any special accommodations and needs of the participants.

Location of a PPC Meeting

PPCs must occur at a location which is best for parents and children. They must be held at the local DHS or private agency office when safety concerns arise or a participant's special needs must be accommodated.

Scheduling

Prior to scheduling the PPC, every effort must be made to consider the family's availability prior to determining the meeting time.

In scheduling the PPC, the PPC facilitator or other agency staff involved in the scheduling process shall not discuss specific case information with participants prior to or after the PPC except the information necessary to schedule it.

PPC Facilitator Responsibilities Prior to PPC

The PPC facilitator must complete the following activities in scheduling the meeting:

- Setting up the date and time as mandated in policy.
- Arranging an appropriate meeting site. This includes arranging for any special accommodations or safety needs.
- Discussing with the assigned caseworker additional participants that may be needed (such as, service providers, foster family, community representatives, tribal representatives).
- Coordinating efforts with the assigned caseworker to notify all participants of the scheduled time, place and date.
- Coordinating efforts with the assigned caseworker to contact birth parents to ensure they are aware that they may invite others for support to the PPC.

Caseworker Responsibilities Prior to PPC

Prior to a PPC, the assigned caseworker must:

- Request the conference after a case conference with the supervisor. A PPC is considered to be requested on the date the DHS-969, PPC Referral Report, is turned in to the facilitator or designated staff with section A, Caseworker Section, completed.
- Make diligent efforts to notify participants and others of its date, time, and place.
- Provide verbal information about the meeting process to participants and others invited to attend.
- Encourage parents and children to identify and invite support persons they would like to attend.

- Identify and resolve any barriers to participants attendance at the PPC, such as transportation, work schedules and issues surrounding daycare; see Special Needs/Reasonable Accommodations in this item.

Special Needs/ Reasonable Accommodations

In order to promote the safety, well-being, and successful participation of all participants, reasonable accommodations must be provided when inviting an individual with a special need. A participant's special need may include, but is not limited to:

Transportation

The caseworker must explore transportation options with families who identify this as a barrier.

Child Care

The caseworker must explore available child care options with the family in order to ensure all primary caretakers are able to attend the PPC. The caseworker must ensure that child care is arranged prior to the meeting.

Adaptations

The caseworker must explore available options when a family member needs additional assistance in order to participate. These could include a foreign language interpreter, interpreter for the hearing-impaired, wheelchair access, or phone access for an incarcerated parent.

Note: For more information about securing a foreign language interpreter; see AHJ 1021, Bilingual Interpreter Services. See AHJ 1314, Effective Communication for Persons Who are Deaf and Hard of Hearing, for information on interpreters for the deaf or hearing impaired.

Inviting and Notifying Participants

Once scheduled, the assigned caseworker, PPC facilitator and clerical support staff must coordinate efforts to invite participants and invitees to the meeting. Notification of the date, time and place of the meeting can be provided by any reasonable method including mail, telephone, verbal notification.

PPC Notification Guidelines

Participants are identified people that must be invited to all mandated PPCs. Participants include:

- Parents, if parental rights have not been terminated.
- Foster parents and/or relative (licensed or unlicensed) caregivers.
- Children, if of an age to participate.
- Family members, friends or other supports identified by the parents and the children.

- Tribal representatives, for Indian children.
- Service providers as appropriate.
- Caseworker(s) including, but not limited to, FIS/ES, CPS, foster care, adoption, licensing, placement agency foster care and DHS monitor involved with the family.
- Assigned caseworker's supervisor.
- If a case is supervised by a placement agency foster care worker, the DHS monitor should attend. If unable to participate in person, the monitor, supervisor, or other DHS designee must make arrangements to be available by conference call.
- In all cases, and regardless of who is initiating the conference, all agency caseworkers involved with a family must be invited to attend all PPCs. Reasonable efforts must be taken by the caseworker initiating the meeting to locate and contact all other caseworkers.
- All PPCs held for children eligible for adoption must include notification to and involvement of the adoption worker.
- A child's lawyer-guardian ad litem must be invited to attend all PPCs. A PPC should not be delayed due to the unavailability of the lawyer-guardian ad litem to attend the meeting.
- The assigned caseworker, facilitator, or clerical staff should also invite community and tribal representatives, service providers, extended family members, school personnel and any and all other individuals who may have knowledge of or be able to provide support to the family.
- If requested by the parents, their attorney must be allowed to attend. The parent must be advised to notify his/her attorney of a scheduled PPC. As these meetings are not a legal venue or proceeding, they cannot be used as a method of executing legal documents (including but not limited to affidavits, personal protection orders, agreements to divorce, guardianships, etc.).
- If the caseworker has made reasonable efforts to notify a participant, a PPC may be held without the attendance of a participant, except that a parent must attend a reunification PPC. If a parent does not attend a scheduled reunification PPC, it **must** be postponed to secure the parent's attendance.

Incarcerated Parents and PPCs

Foster caseworkers must provide prior notice to an incarcerated parent for the following PPCs only:

- Considered removal.
- Change in permanency goal.
- Child in care for nine months with goal of reunification.

Note: If circumstances permit, agencies may arrange for an incarcerated parent's participation in other types of PPCs.

The caseworker must provide and document notice to the incarcerated parent by mail or telephone. The caseworker must contact the facility and ask that the parent be allowed to participate in the PPC by phone. If time allows, the caseworker must send a copy of the DHS-968, Permanency Planning Conference Attendance Report, and ask the parent to sign and return it. The caseworker must also notify the parent's attorney of the meeting, and the attorney must be allowed to attend.

The caseworker must ensure the incarcerated parent receives copies of the DHS-969, Permanency Planning Conference Referral Report, the DHS-971, Permanency Planning Conference Activity Report, and the DHS-968, Permanency Planning Conference Attendance Report, following each PPC.

Children and Youth Participants

All children age 11 or older must be invited and allowed to attend. The caseworker must evaluate, on a case-by-case basis, whether attendance would be harmful to a child's safety or well-being. For a child younger than age 11, the caseworker and their supervisor may determine if it is appropriate for the child to attend all or a portion of the PPC. If the child, age 11 or older is not invited, the reasons must be documented in the narrative section of the DHS-969 and the case service plan.

Security

The caseworker and facilitator must discuss any security needs and safety concerns prior to the PPC in order to ensure adequate security at the meeting site. Family members may be excluded if they pose a credible safety threat to the group or if attendance would violate a personal protection order, no contact-bond, probation, parole, or other court order. In some of these cases, a telephone conference must be explored.

All participants must be provided with security information whenever a PPC will include the attendance of a family member with a history of violent or threatening behavior.

Domestic Violence Cases

In domestic violence cases, if the batterer is present, arrangements must be made to ensure the non-offending parent's and child's safe arrival and departure from the meeting location. If a personal protection order mandates that the parties must not come in contact, the possibility of a telephone conference must be explored, if not in violation of the court order. The caseworker and his/her supervisor must carefully evaluate a decision to exclude a parent and discuss that decision with the

facilitator. Additionally, the caseworker and supervisor should evaluate the child's attendance based on safety.

Confidentiality

The confidentiality of information shared at the PPC must be addressed. Privacy and respect are emphasized, but parents must be informed that information from the meeting may be used for case planning, in subsequent court proceedings if necessary, and in the investigation of a new allegation of abuse or neglect should such information arise.

Confidentiality Statement

At the time of the PPC, the facilitator must explain the meeting process and read the DHS-966, PPC Information Sheet, and DHS-967, Ground Rules. The parents are requested to sign a confidentiality statement which is included on the DHS-968, Permanency Planning Conference Attendance Report. The facilitator must explain confidentiality as it pertains to the PPC.

The confidentiality statement allows the parent(s) to give permission for specific information regarding their case to be discussed for the purpose of the PPC. If a parent refuses to sign, the meeting will continue. Staff must be fully aware that specific information as outlined in SRM 131, Confidentiality, is not open for discussion unless the parent reveals the confidential information.

PPC Process

The PPC process consists of the following steps provided by the facilitator:

Introduction

- Welcome.
- Provide each participant with a copy of the DHS-966, PPC Information Sheet. The facilitator will read the information sheet aloud to ensure all participants understand the purpose of the PPC.
- Ensure all participants sign-in on the DHS-968, PPC Attendance Report, with the parents signing the confidentiality statement.
- Introductions.
- Statement encouraging participation and desire to work together to develop best possible plan for family and child(ren).
- Statement that all options will be heard and considered.

Ground rules

The facilitator must provide each participant with a copy of the DHS-967, PPC Meeting Ground Rules, and read the ground rules aloud to the participants. The facilitator will:

- Ask the participants to agree to the ground rules.
- Ask for questions.
- Acknowledge any issues that cannot be addressed in the PPC.
- Ensure an understanding of limitations of confidentiality and privacy.
- Facilitate an atmosphere to encourage openness and honesty and allowance for all participants to be heard.

Issue identification

During this phase of the meeting, the issues and/or concerns placing the child(ren) at risk must be discussed.

- The facilitator must ask the parents if they wish to initiate the discussion by sharing information about their family or their understanding of the current situation.
- The assigned caseworker may introduce the structured decision-making tools (safety and/or risk assessments for CPS and reunification and/or safety assessments and permanency planning tree for foster care). The assessment tools identify issues that place the child(ren) at risk and strengths upon which the team may build.
- Issues identified will lead the team discussion.
- The caseworker may present services that have been provided and the family's progress with the services.
- The facilitator may find the need to paraphrase, ask open-ended questions, remind people of the ground rules, allow expression of feelings, summarize, and use other techniques to promote and support the meeting process.
- The facilitator must maintain the focus on the issues of safety and protection of the child(ren) and ensure the assigned worker has had ample opportunity to present all the issues that place the child(ren) at risk.

Brainstorming

During the brainstorming phase, all participants and invitees offer ideas toward possible solutions to the issues placing the child(ren) at risk. The assigned worker must take the approach that all ideas warrant consideration during the brainstorming phase. The facilitator may need to clarify thoughts, encourage innovation and creativity, summarize ideas, etc. Ideas discussed during the brainstorming phase may be listed (on easel, chalkboard) for all participants to view.

Decision

After all ideas for possible solutions have been presented, the facilitator must ensure each idea has been considered and move the team towards consensus by setting a positive tone and identifying the expectation that the group is capable of reaching a consensus.

The assigned worker assists the group by:

- Considering the merit of each idea.
- Exploring consequences and reality testing for each option.
- Determining if the idea provides safety and protection for the child(ren).

The facilitator must explain that while consensus is the goal, DHS must make a decision if a consensus cannot be reached. If a consensus cannot be reached, the applicable DHS agency representative discusses the reasoning for the decision by providing the specific rationale. During the process, the facilitator establishes the agreement is based on the safety and protection of the child(ren) in the least intrusive and least restrictive manner.

Consensus does not imply unanimity, but the facilitator must demonstrate that a quality decision has been reached. The decision reached during the PPC must comply with state and federal laws, DHS policy and licensing rules. If a consensus cannot be reached, the DHS representative makes the decision regarding placement related issues at hand.

Placement

If the decision is to remove the child(ren) from the home, the facilitator must open the discussion of alternative out-of-home placement options. Various options must be given thoughtful consideration along with the child(ren)'s wishes. In considering placement options, special attention must be given to issues such as:

- Sexually acting out, violent or assaultive behaviors.
- Separation issues.
- Mental health concerns.
- Medical needs.
- Continuity of relationships, family, school.
- Any other special needs identified.

Note: The placement selection criteria detailed in FOM 722-3 must be considered when making placement decisions.

Once the out-of-home placement has been decided, the facilitator must reconfirm this conclusion with the group and document it on the PPC Activity Report. Recommendations made for placement are contingent

upon court authorization, home study and appropriate clearances. The facilitator must make the group aware of these contingencies.

Safety plan/action steps

Upon reaching a decision, the safety plan/action steps must be specified. The facilitator must clearly and specifically identify the safety plan/ action steps for each participant. The purpose of a safety plan is to ensure the safety and well-being of children where there is a risk of abuse or neglect. The safety plan/action steps must be documented on the DHS-971, PPC Activity Report. Guidelines for formulating a quality safety plan may include:

- Parents and caregivers having the prominent role in the development of the safety plan.
- Time limited (within a 30-day time frame) and measurable action steps.
- Specific statements regarding caseworker's action steps to reduce risk factors and monitor the safety plan.
- Face-to-face contacts and home visits must correlate with policy and SDM assessment levels that indicate the frequency of contact with family and child(ren).
- Specific, identified services that are accessible within the family's community.
- Action steps addressing parenting time as outlined in policy; see FOM 722-6.
- If placement or replacement with a relative is the safety plan, an appropriate home study must be completed; see FOM 722-3, Placement with a relative. Action steps must include the person responsible for the home study and time frame for completion.
- If reunification is the decision, see FOM 722-7 Reunification.
- Participants identified with a role in the safety plan must complete the action steps within the specified time frame.
- The safety plan must reflect the decision of the team at the time of the PPC.
- Supervisory follow-up, for service referrals designated to the assigned worker, is required within thirty calendar days. The follow-up must also be documented in the PPC database.

Recap/closing

At the close of the meeting, the safety plan/action steps must be used to confirm the decision of the team. The facilitator must:

- Reiterate the team's decision.
- State the safety plan/action steps for each participant.
- Outline the criteria for measuring success.
- Acknowledge all participants' roles.
- Identify tasks requiring supervisory follow-up by checking the appropriate boxes indicating assigned worker tasks on the PPC Activity Report.
- Provide a copy of the DHS-971, Permanency Planning Conference Activity Report, to each participant and the assigned caseworker's supervisor.
- Ensure that the emotional needs of the family are sufficiently addressed with assistance from the assigned caseworker.

Throughout the meeting, the facilitator is responsible for conducting the PPC according to training guidelines and policy. The facilitator must:

- Ensure every participant signs in on the DHS-968, PPC Attendance Report, explains confidentiality to the group, and introduces themselves to the group prior to commencement of the PPC.
- Provide each participant with a written copy of the DHS-966, PPC Information Sheet, DHS-967, PPC Ground Rules, and DHS-965, PPC Satisfaction Survey.
- Document the family strengths and needs.
- Complete the DHS-971, PPC Activity Report, documenting the team's decision, safety plan, action steps, time frame for completion and person responsible for the task.
- Ensure each participant is provided with a copy of the PPC Activity Report.
- Ensure concurrent permanency planning is discussed during the PPC and any plans are clearly documented on the DHS-971, PPC Activity Report.
- Request each participant complete the DHS-965, PPC Satisfaction Survey, at the conclusion of the meeting.

- Provide recap of the meeting and closing comments.

Caseworker PPC Responsibilities

During a PPC, the caseworker shall:

- Present agency recommendations, including any recommendations based on child and family needs, safety assessments and permanency assessments.
- Clearly and respectfully identify risks to the child.
- At a considered removal or emergency removal PPC, explain any concurrent permanency planning considerations to the parents.
- Remain open to participants' and others' ideas about permanency alternatives and safety planning.

Note: If a parent does not attend, the caseworker must advise the parent as soon as possible of the outcome and provide a copy of each document which includes the DHS-969, DHS-971, and DHS-968.

Post-PPC Process (PPC Activity Report Requirements)

Following the PPC, the facilitator is responsible for completing the DHS-969, PPC Referral Report, checking it for accuracy and recording the outcome data. The facilitator must document in the narrative section of the PPC database, the information regarding safety concerns and planning as documented in the DHS-971. A copy of the DHS-971, PPC Activity Report, must be provided to all participants (in person and by phone). The original of each completed document which includes the DHS-969, DHS-971, and DHS-968, must be given to the caseworker requesting the PPC. A copy of each document must be provided to the legal parents. These documents must also be filed in the foster care and/or the child protective services case record(s) under the narrative section.

Data Entry and Self-Evaluation

The PPC database allows for the collection of information about the PPC meetings throughout the state. It includes the data necessary to evaluate both state and local progress in achieving goals. It does not duplicate the information stored on other child welfare case management systems. The facilitator (or designated staff person) must enter the PPC Facilitator Referral and Activity Report information into the database following the PPC or within seven business days. The PPC Web Database User Guide used for instructions on entering the information is located in the juvenile justice data system (JJOLT).

The DHS-965, PPC Satisfaction Survey, must be given to PPC participants to gather voluntary information about the quality of the PPC and/or satisfaction of the participants. This information is used by staff to self-monitor the process.

Information Shared after a PPC

Participants in the PPC must contact the facilitator and/or caseworker immediately if information that could affect the decision becomes avail-

able afterward. All relevant parties must receive the additional information and the caseworker, in consultation with their supervisor, must make a decision to:

- Continue with the current case plan.
- Implement an alternative plan.
- Request a new permanency planning conference.
- Request an administrative review.

Administrative Review

Any DHS or placement agency foster care staff person who participates in a PPC may request an administrative review if a clear safety or policy violation is identified.

A written request for administrative review identifying the reason for the request must be sent to the local office director or services section manager. An administrative review must be conducted as soon as possible, but no later than 1 business day after the request is received. All PPC participants must be notified of, and invited to, the administrative review. A decision reached at the PPC must be suspended until the administrative review is completed. If necessary, an interim safety plan must be implemented.

During the administrative review, the person who requested the review provides a PPC summary and the reason for the administrative review. The review administrator (appointed by DHS) may request additional information in order to clarify the situation. The review administrator makes the final decision to either affirm or overturn the caseworker's decision. The review administrator may also determine alternative safety or permanency plans. During the process, the review administrator completes the DHS-963, Administrative Review Activity Report. At the conclusion of the administrative review, the caseworker must notify all participants of the decision. The decision of the administrative review is final.

SUBJECT

GLOSSARY OF PPC TERMS

Absent Without Legal Permission

A child or youth under court or department jurisdiction who has left his/her placement without legal permission or has failed to return to placement when required.

Caseworker

The supervising agency worker with direct case service responsibilities. The individual may be a Children's Protective Services, foster care, or adoption worker.

Community Partners

Agencies that are providing professional services to the family or have expertise regarding an issue to be addressed at a PPC.

Community Representatives

Knowledgeable members of the family's community that serve as support and offer non-traditional resources.

Concurrent Permanency Planning: The process of working towards the goal of reunification, while at the same time, developing an alternative permanency plan for the child should reunification efforts fail. Concurrent permanency planning involves considering all reasonable options for permanency at the earliest possible point following the child's entry into foster care and concurrently pursuing those that will best serve the child's needs.

Consensus

Agreement with or support of a decision by all participants. If consensus is not achieved, the department maintains the legal responsibility and authority to make the decision.

Considered Removal

A removal which may become necessary and placement of child(ren) in out-of-home care if an adequate safety plan cannot be implemented.

Domestic Violence

The occurrence of any of the following acts by a person that is not an act of self-defense: causing or attempting to cause physical or mental harm to a family or household member; placing a family or household member in fear of physical or mental harm; causing or attempting to cause a family or household member to engage in involuntary sexual activity by force, threat of force, or duress; and/or engaging in activity toward a family or household member that would cause a reasonable person to feel terrorized, frightened, intimidated, harassed, or molested.

Emergency Removal

A removal in which a child or children are placed in out-of-home care on an emergency basis, including after hours or on-call situations.

Facilitator

A trained DHS or placement agency foster care child welfare supervisor or services specialist who manages the PPC process. A facilitator must possess a bachelor's degree and a minimum of 2 years of experience in front line child welfare work.

Invitee

A person who is invited to the PPC but is not required to attend, such as attorneys, community partners/community or tribal representatives, etc.

Lawyer-Guardian ad Litem

An attorney appointed by the court to represent a child.

Placement Agency Foster Care

A private agency contracted by the department to provide direct foster care services.

Participant

Persons who must be notified of and allowed to participate in all required PPCs. Participants are the parent(s) (if parental rights have not been terminated); foster parents or relative caregivers; children, if of an age to participate; family members, friends, tribal members or other supports identified by parents and children; service providers, as appropriate; the caseworker; and the caseworker's supervisor.

Permanency Planning Conference (PPC)

A family-centered meeting conducted to produce the optimal decisions concerning a child's safety, placement and permanence. The meeting includes the parent(s)/caretakers, extended family, friends, neighbors, foster parents, service providers, community representatives, and/or other professionals involved with the family. PPCs are designed to encourage participants to share information about the family, relating to the protection and safety of the child or children and to the overall functioning of the family as it pertains to placement and permanence. They are held to make or recommend critical case decisions. The meetings are used on a mandatory basis for consistency and accountability to create safety, placement and permanency plans for the following circumstances and stages of a case:

- Prior to placement, or by the next working day after an emergency placement.
- Prior to the replacement of a child in foster care to a different placement setting, or by the next working day after an emergency replacement.
- Prior to reunification.
- Prior to a change in the permanency goal.
- When a child returns from absent without legal permission status.

- When a child has been in care for nine months with a goal of reunification, and sufficient progress has not been achieved to ensure reunification within 12 months.
- When a child has been legally free for adoption for three months but does not have a permanent placement identified.
- PPCs may be held at other times during an open case, as dictated by circumstances and departmental policy.

Permanency Planning Conference Activity Report (DHS-971) and Permanency Planning Conference Referral Report (DHS-969)

Documents used to record all necessary information relating to the PPC.

Removal

Requirement of out-of-home placement for the child or children for safety and protection. Removals fall within two categories: emergency or considered.

Reunification

A process that begins the preparation for the return of the child or children to the parent(s)/caretaker from which the removal occurred.

Unrelated Caregiver

An adult who is not related to a child by blood or marriage who has a psychological/emotional bond with the child and is identified as family as a result of their active role in the functioning of the nuclear family.

SUBJECT **ENGAGING INCARCERATED PARENTS IN THE SERVICE PLAN**

FOM 722-6 Foster Care-Developing the Service Plan

Incarcerated Parents

The foster care worker must make reasonable efforts to identify and locate an incarcerated parent. An incarcerated parent may provide important information about the child and any available relatives that may be able to provide placement and support for the child.

Resources

The foster care worker must use, but is not limited to, the following resources to locate an incarcerated parent and identify services available at a jail or prison:

- For parents under the jurisdiction of the Michigan Department of Corrections, http://www.michigan.gov/corrections.

- For parents in federal prisons, http://www.bop.gov/.
- For parents in out-of-state facilities, http://www.vinelink.com or by contacting the facility.

For parents in county jails, contact the county facilities directly.

Verifications

Once an incarcerated parent is located, the foster care worker must confirm the incarcerated parent's charge or conviction offense, prison or jail number, parole or release eligibility, and earliest release date. In cases where reunification is the permanency goal, the foster care worker must engage the parent in the service plan regardless of how long that parent will be incarcerated.

Required Contact & Service Plans

The foster care worker must make monthly contact with the incarcerated parent face-to-face, if at all possible, or through letter and phone contact. The foster care worker must send a letter to the incarcerated parent with the parent's prisoner number on the envelope. The letter must:

- Ask the parent whether he or she wishes to remain a parent to the child, and to identify any relatives who may be interested in placement.
- Explain the purpose of the service plan.
- Solicit the parent's views of his/her needs and strengths.
- Note the services and work opportunities available within the facility to the parent.
- Ask the parent to describe his or her plan to provide care and custody of the child upon release from incarceration.
- Ask the parent to add the foster care worker to his or her call list so that the parent and worker may communicate via telephone.

The foster care worker must assess the incarcerated parent's needs and strengths and document them in the DHS-145, Family Assessment of Needs and Strengths.

The foster care worker must determine the services and work opportunities available within the facility in which the parent is incarcerated. Once the foster care worker determines what services are available, the appropriateness of these services will be assessed in relation to the parent's identified needs.The services available, if they appropriately meet the parent's identified needs, must be documented in the DHS-67, Parent-Agency Treatment Plan and Service Agreement (PATP). Foster care workers are not required to arrange for service providers outside of

the facility to deliver services within the facility but may utilize such services if they are currently available within the facility.

Once the DHS-67, Parent-Agency Treatment Plan is completed, the parent must be given an opportunity to review and sign the plan. The foster care worker must send two copies of the plan to the incarcerated parent. An accompanying letter must clearly request that the parent sign one copy and return it to the foster care worker and keep the other copy for the parent's reference. In addition, the foster care worker must enclose a DHS-1555-CS, Authorization to Release Confidential Information, and request the parent to sign and return the form. This will allow the worker to verify the parent's compliance with the service plan through contact with service providers and prison records.The foster care worker must evaluate an incarcerated parent's compliance with, and benefit from, services in the same manner as non-incarcerated parents. Workers must obtain proof of a parent's compliance with, and benefit from, services from the parent and service providers.

If the parent has been paroled or released from incarceration, or will likely be paroled in the near future, the foster care worker must identify any additional services the parent needs prior to reunification with the child, and update the service plan accordingly. If the incarcerated parent has been convicted of or substantiated for criminal sexual conduct against a child, see FOM 722-12, Expenditure of State Funds in Substantiated Sexual Abuse Cases, before proceeding with efforts to reunify a child with the parent after his or her release from incarceration. A court order may be required.

Unless parenting time or contact would be harmful to the child or there is a no-contact order in place, the foster care worker must arrange for regular visits or contact between an incarcerated parent and the child. Alternatives to regular visitation at a jail or prison facility may be contact via letters sent through the worker or phone contact.

FOM 722-7 Foster Care- Permanency Planning

MCR 2.004 requires the petitioner in a child protection proceeding to notify the court that a party to the proceeding is incarcerated by the Michigan Department of Corrections (MDOC). When a foster care worker or the department's legal representative files a supplemental petition requesting termination of parental rights in a case involving a parent incarcerated by the MDOC, the petition must contain a clause stating "A telephonic hearing is required pursuant to MCR 2.004." The clause must also contain the parent's prisoner number and location. If a parent is incarcerated in a county jail or a prison or jail in another state, the court may determine how the parent will participate in the hearing, but the supervising agency is not required to raise the issue in the petition.

FOM 722-8 Foster Care- Initial Service Plan

Policy revisions include instructions to refer back to FOM 722-6 regarding information about engaging incarcerated parents. Incarceration is no longer a reason for a parent's non-participation in service planning.

FOM 722-8A Foster Care- Family (Re)Assessment of Needs and Strengths

Policy revisions include instructions to refer back to FOM 722-6 regarding information about engaging incarcerated parents. Any mention of incarceration as being a reason for non-participation in service planning has been removed.

Reason: Foster care program office recommendation and court ruling.

FOM 722-8C Foster Care- Parent-Agency Treatment Plan and Service Agreement

Policy revisions include instructions to refer back to FOM 722-6 regarding information about engaging incarcerated parents.

FOM 722-9 Foster Care-Updated Service Plan

Policy revisions include instructions to refer back to FOM 722-6 regarding information about engaging incarcerated parents. Any mention of incarceration as being a reason for non-participation in service planning has been removed.

JUVENILE JUSTICE RESIDENTIAL

JRB 2011-001 Volunteer Programs, Education, Incident Reports, Employment Screening, Restraints.

EFFECTIVE January 1, 2011.

Issued November 29, 2010.

SUBJECT **JR5 530, INCIDENT REPORTS**

Item revised to implement review, staffing, and technology portions of the 2009 draft National Prison Rape Elimination Commission policy standards related to incident reporting. Emphasizes the current Bureau of Juvenile Justice practice of entering incident reports into the Juvenile Justice Information System within 72 hours of the incident and the relationship of incident reports to facility logs.

FINANCIAL ASSISTANCE PROGRAMS

BRIDGES

BPB 2010-016 **BRIDGES POLICY BULLETIN**

EFFECTIVE October 1,2010.

Issued September 1. 2010.

SUBJECT(S)

CHILD SUPPORT INTERFACE

BEM 255

Bridges makes referrals to the Office of Child Support (OCS) for all types of assistance (TOA) that require referral in place of the DHS 1201 used for TOA other than FIP and MA. In addition good cause status, noncooperation and cooperation data is exchanged between Bridges and OCS in the nightly batch process and may prompt Eligibility Determination Benefit Calculation (EDBC). See this item for complete details of the impact to applications and ongoing TOA.

BEM 518

Bridges interface with the Michigan's Support Disbursement Unit (MiSDU) will create unearned income records when there is certified child support. Each month Bridges will conduct the Grant in Jeopardy process to determine if the active cash grant should be closed when the certified support exceeds that grant by $50 or more.

CDC UPDATES

BAM 110, Application Filing and Registration

Registering Applications

Faxed applications/filing forms are acceptable and must be registered if they include the required minimum information. If the faxed application is complete and all the necessary verifications are provided, a paper copy of the application is not required in order to determine eligibility and authorize benefits.

Applicant

Policy added that if it is determined that the wrong applicant applies for CDC, a new application must be mailed or given to the correct applicant. If the signed, completed application is returned within 10 calendar days of the date the specialist requests the application, the original application date is the receipt date. The original application must be filed and kept in the correct applicant's case record.

CDC Joint Custody

Policy removed that required specialists to coordinate authorizations for joint custody cases. Policy added that the client's statement of joint custody is acceptable.

BEM 704, CDC Providers

Aide/Relative Provider Enrollment Process

1) Aide and relative care providers who are also licensed or registered by the Bureau of Children and Adult Licensing (BCAL) as family or group homes, should be paid as family or group child care homes, not as aide or relative providers.

2) A Bridges address inquiry must be completed on a provider's address prior to enrollment. All adult household members found to be living at the address must have background clearances completed.

3) Background clearances must be completed whenever DHS becomes aware that a new adult household member, age 18 and over, has moved into the enrolled provider's home or when information is provided that an adult household member, age 18 and over, is on central registry as a perpetrator, has a criminal conviction or pending criminal charge.

4) Note added that providers are not eligible for any payments for care provided prior to the pay period that holds the training completion date.

Denial/Termination of Aide/Relative Enrollment

Aide and relative care providers are not eligible for care to be authorized for any period that enrollment was ended as a result of a failure to meet program requirements.

BPB 2010-017 **BRIDGES INTERIM POLICY BULLETIN BEM 230A LONG-TERM INCAPACITY**

EFFECTIVE Immediately upon release.

Issued September 1, 2010.

SUBJECT

LONG TERM INCAPACITY

At intake, redetermination or anytime during an ongoing benefit period, when an individual claims to be disabled or indicates an inability to participate in work or JET for more than 90 days because of a mental or physical condition, the client should be deferred in Bridges. Conditions include medical problems such as mental or physical injury, illness, impairment or learning disabilities. This may include those who have applied for RSDI/SSI.

Require the person to provide a DHS-49, Medical Examination Report from their doctor.

MRT determines whether long term disability exists, which may be shown by:

- Cognitive disabilities (such as low intellectual capacity) or learning disabilities that impede comprehension and prevent success in

acquiring basic reading, writing, and math skills, including, but not limited to, an individual with an IQ less than 80.

- Documented chronic mental health problems that cannot be controlled through treatment or medication.
- Physical limitations on ability to perform routine manual labor tasks, including, but not limited to, bending or lifting, combined with intellectual capacity or learning disabilities.

Note: Deferral/participation reason in Bridges is *Incapacitated more than 90 days* while awaiting verification. Potentially disabled individuals are not sent to JET while waiting for the verification of disability.

A person with a condition or impairment that is pregnancy-related must be deferred for a problem pregnancy. These individuals should not be referred to the Medical Review Team (MRT) or to an SSI Advocate if the **only** conditions or impairments are due to pregnancy.

When a person claims they are visually impaired, require the person to provide verification from an ophthalmologist or optometrist; a DHS-49-I, Eye Examination Report may be used; see Visual Impairment in this item.

Individuals with visual impairments should be referred to the Michigan Commission for the Blind (MCB) which offers vocational rehabilitation services, see Visual Impairment in this item.

Verification Returned

When the medical documents indicates a disability will last 90 days or less; see Short Term Incapacity in this item.

When the medical documents indicates the disability will last longer than 90 days:

- Deferral/participation reason in Bridges remains *Incapacitated more than 90 days.*
- Request a utilization report (UT) from the program office; see Requesting a Utilization Report in this item
- Have the person sign a DHS-1555-E, Release of Information.
- On the DHS-49-A, Medical-Social Eligibility Certification, under program, check JET.
- Complete the DHS-49-A-E, Medical Assessment For JET Participation Project and attach to the top of the medical packet.
- Obtain a medical determination from the MRT; see BAM 815, Medical Determination and Obtaining Medical Evidence.

  - •• Some conditions may be verified by other test results or evaluations, such as school, therapist, or other professional records.

- Manually set a reminder in Bridges for a three-month follow up.

Visual impairment

Request a consultation from the MCB. The FIS will:

- Complete Section I on the DHS-517, Consultation Request form.
- Attach all medical and vocational documentation available in the case record.
- Check SOLQ and complete the information on status of RSDI/SSI claim (if any).
- Attach a copy of the DHS-1555-E.

Note: Use locally established procedures for the referral to the MCB that serves your local office.

The MCB consultation must be requested before FIP can be certified at application or redetermination. Once the consultation is requested FIP can be certified. The FIS must follow up on the consultation request and take appropriate action when the response is received.

Individuals with a visual impairment will receive an appointment to talk to a counselor from the MCB, which they will be required to attend instead of going to JET.

Consultation Response

Within 45 days of the request the MCB will:

- Schedule an appointment with the client.
- Complete a consultation.
- Complete Section II of the DHS-517 and send back to the FIS with its recommendation.

DHS Action on Returned DHS-517

When the DHS-517 is returned, take action depending on the response as indicated below:

1. **Individual did not appear for appointment.**

   - Follow Noncompliance with Employment and/or Self-Sufficiency-Related Activities in BEM 233A.

2. **Individual was provided information on employment services.**

   - The *yes* box is checked when the MCB has had the opportunity to talk with the client regarding employment opportuni-

ties, accommodations, etc. which would facilitate the client obtaining and maintaining employment and the client agrees they are work ready, **refer to JET**.

3. **The individual states they are employable.**

   - The *yes* box is checked, **refer to JET**.
   - The *no* box is checked when the client is not responsive to employment information and gave no indication that employment was an option for them. If this box is checked follow step 5 below.

4. **Individual wants to apply for rehabilitation services.**

   - Deferral/participation reason remains *incapacitated more than 90 days*.
   - The MCB will keep the client as a referral.
   - Continued participation is verified at each redetermination.

Note: If an individual does not participate as required, the MCB will contact DHS to schedule a triage meeting for noncompliance; see Noncompliance with Employment and/or Self-Sufficiency Related Activities in BEM 233A.

5. **The Individual does not feel they are capable of employment at this time. Do all the following:**

   - Deferral/participation reason in Bridges remains *Incapacitated more than 90 days.*
   - Request a utilization report (UT) from the program office; see Requesting a Utilization Report in this item.
   - Manually set a reminder in Bridges for a three-month follow up.
   - On the DHS-49-A, Medical-Social Eligibility Certification, under program, check JET.
   - Complete the DHS-49-A-E, Medical Assessment For JET Participation Project and attach to the top of the medical packet.
   - Obtain a medical determination from MRT; see BAM 815, Medical Determination and Obtaining Medical Evidence.

MRT DECISION

Take action below that pertains to the decision rendered by the MRT.

All decisions:

Review the decision and information provided by MRT to determine what accommodations the client needs to participate in the JET program. The person must pursue employment and/or self sufficiency-related activities. Follow the procedure for accommodating disabilities in **Reasonable Accommodation** section in this item.

Note: Add case notes in Bridges including the participation reason code.

Disabled-Potentially eligible for RSD/SSI

Verify the client's status with Legal Services Association of Michigan (LSAM) and the Social Security Administration (SSA); see LSAM later in this item.

- Deferral/participation reason remains *Incapacitated* **more than 90 days.**
- The individual **must** apply for RSDI/SSI if they have not already. Make a referral to the SSA using the DHS-1552, Verification of Application or Appeal For SSI/RSDI form.

Note: When there is an application pending with the SSA and the client is not active with LSAM, the FIS must monitor the RSDI/SSI claim by entering a *Disability Review Date* in three month intervals on the *Disability Determination-MRT* screen in Bridges.

Work Ready

- Set deferral/participation reason to *MWA activity or JET.*
- Refer to JET.

Work ready with limitations (WF,CM,PL,LI)

Do not require the person to apply for RSDI/SSI.

- Set deferral/participation reason to *MWA activity or JET.*
- Refer to JET

Note: Identify the client's limitations using additional information and the case notes section in Bridges on the *JET referral screen* when the referral is made to JET.

Individuals served by the Department of Human Services

DHS must serve individuals who are determined work ready or work ready with limitations by the MRT when the individual cannot be served by the MWA. Using the appropriate code from the MRT decision on the DHS-49-A-E, assign self-sufficiency activities up to the medically permissible limit of the individual.

The MWA should be asked to provide any test results or other documentation about the client's limitations at the time the client is referred back to DHS.

Does the current MRT decision state one of the following three deferral reasons? When the MRT has determined an individual meets

one of the following participation code reasons but is not served by the MWA, the case must be coded in Bridges appropriately:

1. **Chronic Mental Health (CM)**

   MRT identifies eligibility for this deferral on the DHS-49-A-E.

   As a condition of eligibility, an individual must participate in both of the following:

   - Participate in a treatment plan recommended by their medical provider and must be reviewed at redetermination.
   - Participate in FSSP-approved activities (that may include use of the state-wide counseling contract).

2. **Low Intellectual Capacity or Learning Disability (LI)**

   MRT identifies eligibility, for this deferral on the DHS-49-A-E.

   As a condition of eligibility, an individual must actively participate in both of the following:

   - School attendance or community-based literacy program or tutoring provided using Direct Support Services (DSS), if available locally.
   - Participate in FSSP-approved activities (that may include use of the state-wide counseling contracts).

3. **Physical Limitation to Perform Routine Manual Labor Tasks (PL)**

   MRT identifies eligibility for this deferral on the DHS-49-A-E

   As a condition of eligibility, an individual must actively participate in **both** of the following:

   - All medical treatment plans as prescribed by their MD or DO.
   - Participate in FSSP-approved activities (that may include use of the state-wide counseling contracts).

   Note: Individuals who qualify for any of the three deferral reasons above are included in the state's work participation rate.

When to Request a New MRT Decision

When a MRT decision has been completed and the client states they have additional medical evidence or a new condition, gather new verification and send for an updated MRT decision.

The FIS must assign and maintain FSSP activities to ensure continued pursuit of self-sufficiency while gathering verification or assisting clients

with obtaining medical verification or testing. If testing assistance is necessary; see BEM 232, Medical Exams, Immunizations and Tests for instructions.

When an individual presents a doctor's note after the MRT decision but does not have new medical evidence or a new condition, send the DHS-518 to the doctor and request supporting medical evidence.

If new medical evidence is not provided, do not send the case back to the MRT. The previous MRT decision stands.

Requesting a Utilization Report (UT)

Each time a individual utilizes their Medicaid card the service is listed on a UT report. These reports have proven to be a valuable tool to DHS when creating a medical packet for the MRT. Each report contains 12 months of medical history including medications and the name and address of each medical provider.

Note: When developing a medical packet, the FIS should request all medical documentation from each provider on this report. It is not necessary to request documentation from labs or x-rays as they are usually included in the doctor's documentation.

When requesting a UT report, provide the following information:

- Individual name.
- Recipient ID number.
- Case number.
- Name of FIS/ES and phone number.
- County, district and worker number.

The request can be made by e-mail to Policy-Utilization-Report-DHS-Policy@michigan.gov **or** fax a request to 517-335-7771.

LEGAL SERVICES ASSOCIATION OF MICHIGAN (LSAM)

There is no charge to an individual for advocacy services provided by LSAM. When a individual presents verification that a disability lasted or is expected to last 12 months or longer, or expected to result in death, the client is screened to determine if they would be an appropriate referral. **To be appropriate the individual must**:

- Agree to the referral.
- Sign a DHS-1555, Authorization to Release Protected Health Information (a DHS-1555-E can be used).
- Not currently have legal representation.

If appropriate for a referral, complete a DHS-538, Referral to LSAM for SSI Advocacy Services, and attach it to the top of the medical packet along with the following documentation:

- DHS-1555 or DHS-1555-E and all medical and vocational information on an individual.
- A copy of the DHS-538 must be faxed to the Office of Program Policy at (517) 335-7771.

NONCOMPLIANCE

When a client that is determined by MRT to be Work Ready or Work Ready with Limitations becomes noncompliant with the JET program, schedule a planning triage which includes all of the following:

- Review the medical packet including the limitations identified by MRT on the DHS-49A-E.
- If necessary, revise the FSSP using the limitations identified on the DHS-49- A-E. Assign medically permissible activities.
- Enter good cause reason *Client unfit* in Bridges on the *Noncooperation details screen*

If an individual becomes noncompliant with their FSSP assigned activities, follow instructions outlined in BEM 233A.

BPB 2010-018 **BRIDGES POLICY BULLETIN**

EFFECTIVE October 1, 2010.

Issued September 29, 2010.

SUBJECT(S)

BAM 220 **Case Actions**

Medicaid

An ex parte review (see glossary) must begin at least 90 days (when possible) prior to the close of any Medicaid type of assistance.

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, 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.

BEM 230A

Employment And/or Self-sufficiency Related Activities

FIP/RAP Cash

Disability has been revised to include when to use participation codes Low Intellectual capacity (LI), Chronic Mental health (CM) and Physical Limitations (PL).

Annual Federal Cost-of-Living Changes

FAP

RFT 250, 255, 260

Bridges is updated to support the annual cost-of-living update for Food Assistance Program (FAP) standards. The update will appear in budgets with an effective date of October 1, 2010.

The Food and Nutrition Service (FNS) has determined the income limits and benefit issuances will remain the same as last year. Additionally, all utility standards are staying the same or are increased with the exception of the non-heat electric standard which is decreasing by $1. The shelter maximum is decreased from $459 to $458 month.

BPB 2010-0019 **BRIDGES INTERIM POLICY BULLETIN FOR DISASTER ASSISTANCE**

EFFECTIVE October 1, 2010.

Issued October 18, 2010.

SUBJECT

Diaster Assistance

Disaster assistance benefits are designed to provide disaster cash and disaster food assistance to households affected by federally declared disasters/mandatory evacuations including but not limited to tornadoes, floods, storms, chemical spills etc. Eligibility for cash, the Disaster Relief Program (DRP), and Disaster Food Assistance Program (DFAP) is not limited to households that are typically eligible for Financial Independence Program (FIP) and Food Assistance Program (FAP).

For individual assistance, follow Disaster Assistance policy once a disaster is federally declared. Clients who come to Michigan as a result of a federally declared disaster in another state may apply for DRP. DFAP applies to Michigan residents who are victims of a federally declared disaster.

Federally declared disasters are listed at www.fema.gov/news/disasters.fema.

DISASTER RELIEF PROGRAM (DRP)

The Disaster Relief Program is a lump sum, non-recurring benefit paid to families who have been evacuated from their homes due to a natural

or technological disaster. The federal government must issue a major disaster declaration for the area that includes their normal residence.

Program Benefits

The intent of issuing disaster relief payments is to do the following:

- Provide short term, non-recurring payments to families recovering from a disaster to prevent the need to apply for ongoing FIP.
- Provide financial support to families affected by a disaster that will not count toward their federal 60-month time limit to receive cash assistance.
- Provide financial support to families affected by a disaster in a way that will not impact Michigan’s work participation rate.
- Involve less work than processing ongoing FIP.
- Focus Jobs, Education and Training (JET) employment resources on long-term FIP recipients.
- Issue disaster relief payments in lieu of State Emergency Relief (SER), saving state funds.

DISASTER FOOD ASSISTANCE PROGRAM (DFAP)

This one-time food assistance payment is for households that lived in the disaster area at the time of the disaster. These households **must** plan on purchasing food during the disaster period.

Note: Active FAP recipients residing in the declared disaster area will receive an automatic replacement of their FAP benefits through a Bridges mass update.

Eligibility Criteria

Households **must** have experienced at least **one** of the following to qualify for benefits:

- Food lost due to disaster.
- Damage to or destruction of their home.
- Lost or inaccessible income including reduction or termination of income, or a delay in receipt of income for a substantial part of the benefit period.
- Inaccessible liquid assets for a substantial portion of the benefit period.
- Out-of-pocket disaster-related expenses not expected to be reimbursed during the benefit period.

APPLICATION

DRP, DFAP

A DHS-3220, Application for Disaster Cash and Food Assistance, must be completed to request disaster benefits for Michigan residents. A request for disaster benefits may be in person or by an authorized representative applying in person for the client.

The date of application is the date the local office receives the required minimum information on the application. An application must have the client's name, address (permanent or mailing), and a signature to be considered complete for registration.

DRP

Clients from another state, who are applying for an out-of-state disaster, must complete the DHS-1171, Assistance Application, and the DRP addendum, Out-of-State Disaster Cash Assistance Application, to be considered for disaster assistance.

Application Period

DRP, DFAP

Clients may apply for disaster assistance during the **seven** calendar days after the federal government declares the geographical areas of the disaster. The disaster will be defined in Bridges to complete the registration process. If simultaneous disasters occur, Bridges will identify each disaster separately. Choose the correct disaster for which the client is applying. If a DHS-3220 is received after the seventh day, treat the DHS-3220 as a request for assistance and provide the client a DHS-1171, Assistance Application, and/or DHS-1514, State Emergency Relief Application.

Note: In rare instances, the federal government may extend or shorten the application period. If Michigan determines a longer application period is needed due to high demand for disaster assistance, an extension period will be requested from the federal government.

DRP

Clients from another state may apply for disaster assistance in Michigan up to **30** calendar days after the federal government declares an out-of-state disaster.

Where to Apply

DRP, DFAP

Clients may apply for disaster assistance at any local office or predetermined temporary location.

Authorized Representatives

The client may choose to designate an authorized representative (AR) for disaster assistance who may file the application for the head of household (HOH). This AR, or a different AR chosen by the client, may

receive the Bridge card and/or utilize the benefits on behalf of the client. All AR's must be designated in writing. The HOH will need to call the toll-free number on the back of the new Bridge card for a personal identification number (PIN).

STANDARD OF PROMPTNESS (SOP)

DRP

The SOP is seven calendar days starting with the application date.

DFAP

The SOP is three calendar days starting with the application date.

INTERVIEW REQUIREMENTS

DRP, DFAP

Conduct an in-person interview at application before determining eligibility.

DRP

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

Deny DRP on the 30th day if the client has not participated in an interview.

DFAP

For DFAP only, conduct an interview before denying the application for assistance even if it is clear from the application or other sources that the group is ineligible.

Deny DFAP on the 7th day if the client has not participated in an interview.

DRP, DFAP

If the group is ineligible **or** refuses to cooperate in the application process, certify the denial of the appropriate program and Bridges will generate a DHS-82, Disaster Benefits Eligibility Notice.

BENEFIT PERIOD

The benefit period for disaster benefits is 30 days from the date of the federally declared disaster or the date of any mandatory evacuation preceding the declared disaster. During this 30-day period, the following are used to determine eligibility:

- The household's income received or expected to be received.
- The household's accessible liquid assets.

- The household's unreimbursed disaster expenses.

Multiple Disasters

A client can receive only one disaster payment per declared disaster. If there are multiple disasters in a 30-day period, each disaster must be federally declared and identified on Bridges separately.

DFAP

Households cannot receive more than one DFAP allotment in any benefit period. If there are multiple federally declared disasters in the same disaster area in the same 30-day period, the household may participate only in one automatic replacement in the benefit period. If the second disaster destroys the original replacement, the client can request a second replacement by completing a DHS-601, Food Replacement Affidavit.

APPLICATION PROCESSING

DRP, DFAP

A new case number is given to each disaster application in Bridges, even if the HOH already has an existing case. The disaster application takes priority over any pending applications that the client may already have.

Example: Client has a pending FIP/FAP application in May. A disaster is federally declared in June and the client is eligible for DRP/DFAP. DRP/DFAP benefits are issued for June. FIP/FAP eligibility is determined for May, July and forward.

Do **not** delay processing the disaster application for the return of verifications that are not mandatory.

Note: For DFAP only, identity is the only required verification.

Give the verification checklist (VCL) to the client at the time of the interview. In rare circumstances, if a VCL must be sent to a client, use local mail by choosing *Local Print* in Bridges. The VCL is mailed to the address reported on the DHS-3220.

A report will be generated to notify specialists of potential changes for ongoing cases as a result of income, assets and shelter expenses reported on a DHS-3220.

NON-FINANCIAL ELIGIBILITY FACTORS

Identity

The identity of the HOH **must** be verified. If an authorized representative is applying on behalf of the HOH, the identity of the AR must also be verified.

Verification Sources

Verification of identity includes but is not limited to:

DRP and DFAP

- Driver's license.
- State-issued ID.
- Military ID.
- School-issued identity card.
- Social Security Administration cross match in Bridges.

DFAP Only

The affidavit language in the certification section of the DHS-3220 may serve as verification of identity for the client and AR, if applicable.

Residence

DRP, DFAP

For disasters that occur in Michigan, the client's geographical location must be in a federally declared disaster area. The client must have lived in the disaster area at the time of the disaster.

Clients that are coded as homeless in Bridges at the time the disaster occurred and state they resided in the geographical disaster location are potentially eligible for disaster assistance. Applicants who are staying in a shelter, regardless of their length of stay, are potentially eligible.

Note: The mailing address of a homeless client does not have to be in the declared geographical disaster location.

Overrides

If the client does not have a ZIP code or the ZIP code from Postal Soft is incorrect, a manager must approve the override by initialing the DHS-3220. A daily report will indicate the cases that required a manual override.

DRP

Applicants must have been evacuated from their home or forced to relocate in order to receive a payment. The family cannot be residing in the home where the disaster occurred at the time of application.

For clients coming to Michigan from out-of-state federally declared disasters, the out-of-state address must be in the declared area (usually by county or parish). The client must have moved to Michigan due to the disaster and apply for disaster assistance within 30 days of the disaster being declared. Federally declared disasters are listed at www.fema.gov/news/disasters.fema.

A client does not have to intend to remain in Michigan to receive DRP.

Verification

DRP, DFAP

Verify residence if possible.

Verification Sources

Verification of residence includes but is not limited to:

- Driver's License.
- Other ID with address.
- Utility bills.
- Tax bills.

Accept client statement if verification is unavailable.

Food Loss

Food loss due to a disaster.

Verification

Verify only if questionable.

Verification Sources

- Check if residence is within the disaster area.
- Check with power company.

Group Composition

DRP

The group must contain at least one dependent child and a caretaker and/or a pregnant woman.

A dependent child is an unemancipated child, including a child who receives SSI, who lives with a caretaker and is one of the following:

- Under age 18.
- Age 18, attending high school/equivalent at the time of the disaster.

A caretaker is a legal parent, stepparent or specified relative who acts as a parent to a dependent child.

A specified relative must be at least age 18 and legally related to the child by blood, marriage or adoption. Specified relative includes:

- Grandparent (including great or great-great).
- Aunt or uncle (including great or great-great).
- Sibling (including half-sibling).
- Niece or nephew.
- First cousin or first cousin once removed.
- Spouse of any of the above, even if the marriage ended due to death or divorce.
- The parent of a child's putative father.

- A child's legal guardian.
- An adult at least age 21 whose petition for legal guardianship of the child is pending.

All other aspects of group composition (mandatory/optional members) are the same as FIP; see BEM 210.

Note: Do not include members of the household with whom applicants are temporarily staying during the disaster.

DFAP

All members of the household that are living and eating together at the time of the disaster are mandatory group members.

Note: Do not include members of the household with whom applicants are temporarily staying during the disaster.

Group Composition Corrections

DRP, DFAP

After program certification, any corrections needed for group composition, including member adds, must be done by central office.

Verification

Verify members of the household if questionable.

Verification Sources

Ask the applicant to orally list the names, ages and birth dates of all household members.

DRP

Pregnancy Verification

Verify pregnancy only if questionable **and** when DRP eligibility is based solely on the pregnancy.

Pregnancy Verification Sources

Use a statement, including expected date of delivery, from one of the following:

- Doctor of medicine (MD)
- Doctor of osteopathy (DO)
- Physician's assistant (PA)
- Ob-gyn nurse practitioner (NP)
- Ob-gyn clinical nurse specialist (NS)
- Certified nurse-midwife
- Form DHS-49, Medical Examination Report, DHS-54A, Medical Needs or other written statement may be used.

Disqualified Group Members

DRP, DFAP

Disqualified clients are potentially eligible for disaster benefits unless they are disqualified in an active EDG.

Example: Pete is currently disqualified on an active FIP and FAP EDG for failing to provide his Social Security number. He is not eligible for disaster benefits. However, if the EDG is closed, Pete would be potentially eligible for disaster benefits.

Social Security Number

DRP Only

A Social Security number (SSN) must be provided or the client must cooperate in obtaining a Social Security number for each group member.

Verification

Client statement is acceptable.

DFAP Only

An SSN is not a requirement. Do not deny/disqualify a client if they refuse or are unable to provide an SSN.

Citizenship/Alien Status

DRP Only

Individuals must meet citizenship/alien status requirements; see BEM 225.

Verification

Client statement is acceptable.

DFAP Only

Citizenship and alien status is not a requirement.

School Attendance and Student Status

DRP Only

Clients who are 18 years old and **not** the head of household must be attending high school/equivalent full time at the time of the disaster to be eligible for DRP benefit. If the disaster is during a vacation, the 18-year old must be returning to school after break.

Verification

Client statement is acceptable.

DFAP Only

School attendance and student status determination is not a requirement.

Concurrent Receipt of Benefits

DRP, DFAP

The eligibility determination month (EDM) for disaster benefits will be the month in which the disaster occurred or the month of the mandatory evacuation date, whichever is earlier.

Example: Mandatory evacuation date is 6/29. Disaster occurred 7/1. Benefits issued 7/3. EDM is June. Benefit period will be 6/29 to 7/29. Client is potentially eligible for regular FIP/FAP benefits in July.

DRP

A client is not eligible for FIP benefits the same month as a DRP benefit.

Send a DHS-3782, Out-of-State Inquiry, for clients who come to Michigan from out-of-state. Do **not** delay processing while waiting for a response. Advise clients if they receive duplicate benefits that they must return any assistance they receive from another state for the same period. Failure to return benefits from another state for the same period could result in a 10-year federal disqualification for cash, food, SSI **and** MA.

DFAP

A client is not eligible for FAP benefits the same month as a disaster benefit.

Ongoing FAP Recipients

Active FAP recipients residing in the declared disaster area will receive an automatic replacement of their FAP benefits through a Bridges mass update.

Assets

DRP, DFAP

There is no asset limit for disaster benefits. However, accessible liquid assets are used to determine eligibility; see Budgeting Income, Assets and Expenses in this item.

Pursuit of Benefits

The client is not required to pursue any potential benefit; see BEM 270.

Child Support

Child support is not a condition of eligibility; see BEM 255.

Employment Related Activities

Disaster assistance does not have any employment and training requirements as in the BEM 230 series.

BUDGETING INCOME, ASSETS AND EXPENSES

DRP, DFAP

Budget income, accessible liquid assets and disaster-related expenses the household expects to receive/have during the 30-day disaster benefit period. Only budget disaster expenses not expected to be reimbursed during the 30-day disaster benefit period.

Income

Prospect the **net** earnings the household received or expects to receive in the 30-day benefit period. All income of all household members

regardless of age and type of income is countable. **Net** pay is defined as:

- Wages a household receives after taxes and all other payroll withholding such as child support payments, 401K deductions, garnishments, etc. are deducted.
- Self-employment income minus the expenses.
- Unearned income such as RSDI/SSI, unemployment compensation, FIP, worker's compensation, etc. (after all deductions).

Exception: DRP income is **not** budgeted as unearned income in the DFAP budget.

Note: The DRP payment is excluded as income for FAP, CDC and MA. For SER, it is excluded income but any amount of the DRP in the client's possession at the time of SER is a cash asset.

Verification

Verify if possible. Accept client's statement if verification is unavailable.

Assets

Budget all accessible liquid assets. Liquid assets include only:

- Cash on hand.
- Accessible checking and savings account balances.

Note: Remember, with ATM cards and electronic transmission, few liquid assets are truly inaccessible.

Verification

Verify if possible. Accept client's statement if verification is unavailable.

Disaster-Related Expenses

Allow the deduction of disaster-related expenses paid or anticipated to be paid **out-of-pocket** by the household during the disaster benefit period. If the household receives or anticipates receiving a reimbursement for these expenses during the disaster period, only the net expense is deductible (do **not** allow the reimbursable expense).

Note: If the household pays disaster-related expenses using a credit card and will pay their credit card bill after the disaster benefit period, that expense is **not** considered out-of-pocket and is not deductible.

No other expenses are considered in determining eligibility for disaster benefits.

Example: If a client pays voluntary child support, it is not considered a disaster expense and is not allowable.

Examples of deductible disaster-related expenses:

- Home repairs.

- Temporary shelter expenses.
- Evacuation expenses.
- Disaster-related personal injury expenses.
- Disaster-related funeral expenses.
- Disaster-related pet boarding fees.
- Expenses related to replacing necessary personal and household items such as clothing, appliances, tools, and educational materials.
- Clean-up items.
- Disaster-damaged vehicle expenses.
- Disaster-related moving and storage expenses.

Note: Do not mistakenly equate a household's total disaster losses with disaster expenses. For example, a family might report the destruction of their $80,000 home. However, only that household's out-of-pocket expenses that were not reimbursed or are **not** expected to be reimbursed during that benefit period would be considered for determination of eligibility, not the entire value of their destroyed home.

Verification

Verify disaster-related expenses only if questionable.

Benefit Calculation

DRP, DFAP

The household's net (take-home) income received or expected to be received during the benefit period **plus** its accessible liquid assets **minus** unreimbursed disaster-related expenses equals the countable disaster income. Bridges compares this amount to the disaster income limits based on group size. If the household's disaster income is less than or equal to the disaster income limit, the household is eligible for DRP and /or DFAP; see Income Eligibility and Allotment Tables in this item.

BENEFIT ISSUANCE

Disaster assistance is issued through the normal electronic benefit transfer (EBT) process; see BAM 401E, Electronic Benefit Transfer Issuance System.

Semi-Annual contacts/mid-certifications/ redeterminations

FIP, FAP, CDC

EDG's that are active and due for review in the month the disaster occurred will have their review date extended by two months in Bridges. The FAP end date will also be extended in Bridges. This allows work-

load relief so redeterminations, semi-annual contacts and mid-certifications are not handled during the disaster.

HEARINGS

DRP, DFAP

Who May Request

Any household that applied for disaster assistance benefits and was denied benefits may request a fair hearing.

Who May Not Request

Households that never applied for disaster assistance for any reason do not have a right to a fair hearing. This includes households that were unaware of the DRP/DFAP programs or were not able to apply during the application period.

Denials

Clients do **not** have the right to reopen their denied case in order to have their eligibility recalculated because their personal circumstances have changed during or after the application period.

Supervisory Review

A household which has requested a fair hearing is entitled to an immediate expedited supervisory review which in no way shall interfere with the applicant's right to a fair hearing.

Withdrawal of Request

If a head of household wants to withdraw its request for a fair hearing, it may be done verbally or in writing. Send a written confirmation of the withdrawal when the client verbally withdraws their fair hearing request.

Hearing Decisions

If an administrative law judge finds in favor of the client, and the client is due a benefit issuance, central office will issue the benefit through a manual process.

RECOUPMENT

Recoupment for DRP and DFAP will be a manual process. The DRP and DFAP agency error, client error and suspected intentional program violation (IPV) must be a priority for recoupment specialists. Recoupment must be started within six months after the disaster. The recoupment procedures will follow current processes in place for each type of error excluding the exceptions listed below.

An IPV committed in DRP/DFAP will increase the number of IPV's a client has. The IPV will be served on regular cash and/or FAP.

Exceptions

Overissuance Processing

When the specialist discovers a potential overpayment (OP) regarding the disaster, make a referral to the recoupment specialist (RS) within **30 days** of suspecting an OP has occurred using the DHS-4701, Overissuance Referral.

The RS must make disaster OPs their first priority. Within **30 days** of receiving the referral, the RS must establish the claim or refer the suspected intentional program violation (IPV) to Office of Inspector General (OIG).

Suspected IPVs must be a priority with OIG and within **30 days** an agent must have determined if the overissuance is an agency or client error or OIG continues on with the investigation for IPV. Within **120 days** of receiving the referral, OIG must determine if the case is an IPV and return to the RS for entering the claim on Bridges.

Overissuance Period

The benefit period for DFAP will be one month. DRP will be three months of benefits for each disaster.

Benefit Collections

Disaster benefits will automatically be recouped from all respective ongoing benefits. Automated recoupment will never be deducted from disaster benefits.

Collections of disaster benefits will follow the current processes.

INCOME ELIGIBILITY AND ALLOTMENT TABLES

DRP Payment Standard

Group Size	DRP Payment
1	$918
2	$1,209
3	$1,476
4	$1,791
5	$2,082
6	$2,484
7	$2,715
8 or more	Add $240 for each additional person

DRP Monthly Income Limit

Group Size	Monthly Income Limit
1	$1,805
2	$2,428
3	$3,052
4	$3,675
5	$4,298
6	$4,922
7	$5,545
8 or more	Add $623 for each additional person

DFAP Maximum Allotment

Group Size	Maximum Benefit
1	$200
2	$367
3	$526
4	$668
5	$793
6	$952
7	$1,052
8	$1,202
Each Additional Member	+ $150

DFAP Monthly Income Limit

Group Size	Income Limit
1	$1,503
2	$1,815
3	$2,126
4	$2,450
5	$2,788
6	$3,125
7	$3,437
8	$3,749
Each Additional Member	+ $312

BPB 2010-021 **BRIDGES POLICY BULLETIN**

EFFECTIVE November 1, 2010.

Issued November 15, 2010.

SUBJECT **Client Error Over Issuance Thresholds**

FIP, SDA, CDC and FAP

BAM 700, BAM 715

Client error over issuances will no longer be recouped if the amount is under $125 regardless of case status. This change follows agency error thresholds and allows for consistency among error types.

BPB 2010-020 **BRIDGES POLICY BULLETIN**

EFFECTIVE November 1, 2010.

Issued November 15, 2010.

SUBJECT Long Term Care (LTC) Medicaid.

An long term care applicant's patient pay amount may be adjusted by the Department of Community Health to allow the applicant to pay some types of medical expenses incurred before application for Medicaid.

BEM 164, Extended-Care

Patient Pay Offsets If an long term care applicant requests an offset of their patient pay to cover old medical bills. Assist the applicant by forwarding their unpaid bills to:

Medical Services Administration
Michigan Department of Community Health
P.O. Box 30479
Lansing, MI 48909-9634
Attn: PEME

DCH will determine whether an offset is allowable.

Offsets will be applied to the months following an approval. In general, the allowable expenses are the same as allowed for a group 2 deductible case. In addition, the medical expense(s) must be:

- Unpaid, and an obligation still exists to pay.
- Cannot be from a month where Medicaid eligibility existed.
- Cannot be covered by a third party source (public or private).
- Cannot be from a month in which a divestment penalty has been imposed.

- Cannot have been used previously as a pre-eligibility medical expense to offset a patient pay amount.
- Can include cost of room and board for Medicaid long term care facilities, remedial care, and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.
- Must be reported prior to the first Medicaid redetermination following the initial eligibility.
- DCH will terminate offsets if there is a failure to pay the medical provider with the funds.

BEM 546, Post-eligibility Patient-pay Amounts

PATIENT-PAY AMOUNT

The post-eligibility post-eligibility patient pay amounts total income minus total need.

Total income is the client's countable unearned income plus his remaining earned income; see Countable Income in this item.

Total need is the sum of the following when allowed by later sections of this item:

- Patient allowance.
- Community spouse income allowance.
- Family allowance.
- Children's allowance.
- Health insurance premiums.
- Guardianship/conservator expenses.

COUNTABLE INCOME

For all persons in this item, determine countable income as follows:

- RSDI, Railroad Retirement and U.S. Civil Service and Federal Employee Retirement System.
- Non-SSI income for SSI recipients

Use countable income per BEM 500 and 530. Deduct Medicare premiums actually withheld by:

- Including the long term care/hostipal patient's premium along with other health insurance premiums, and
- Subtracting the premium for others (example, the community spouse) from their unearned income.

Exception: Do **not** use the following special exclusion policies regarding RSDI. These policies only apply to eligibility, **not** post-eligibility patient-pay amounts.

- BEM 155, 503 COUNTABLE RSDI.
- BEM 156, COUNTABLE RSDI.
- BEM 157, COUNTABLE RSDI.
- BEM 158, COUNTABLE RSDI.

Note: The checks of clients on buy-in increase about three months after buy-in is initiated. Recompute the PPA when the client's check actually changes. BAM 810 has information about buy-in.

- **Earned and Other Unearned Income.**

  Use BEM 500 and 530. For clients, use FIP- or SSI-related policy as appropriate. Use SSI-related policies for all other persons.

  For the **client only**, disregard $65 + 1/2 of his countable earned income. Use reference table 295 to determine the disregard. Earned income minus the disregard is **remaining earned income**.

PATIENT ALLOWANCE

The patient allowance for clients who are in, or are expected to be in, long term care and/or a hospital the entire long term care/hostipal month is:

- $60 if the month being tested is November 1999 or later.
- $30 if the month being tested is before November 1999.

Exception: Use $90 for any month a patient's VA pension is reduced to $90 per month.

Use the appropriate protected income level for one from RFT 240 for clients who enter long term care and/or a hospital but are not expected to remain the entire long term care/hostipal month. Reminder: The PPA is not reduced or eliminated in the month the person leaves the facility.

COMMUNITY SPOUSE INCOME ALLOWANCE

Long term care/hostipal patients can divert income to meet the needs of their community spouse. The **community spouse income allowance** is the maximum amount they can divert. However, long term care/hostipal patients can choose to contribute less. Divert the **lower** of:

- The community spouse income allowance.
- The long term care/hostipal patient's intended contribution; see Intent to Contribute in this item.

Compute the community spouse income allowance using steps one through five below.

1. **Shelter Expenses**

   Allow shelter expenses for the couple's principal residence as long as the obligation to pay them exists in either the long term care/ hostipal patient's or community spouse's name.

   Include expenses for that residence even when the community spouse is away (for example, in an adult foster care home). An adult foster care home or home for the aged is **not** considered a principal residence.

   Shelter expenses are the total of the following monthly costs:

   - Land contract or mortgage payment, including principal and interest.
   - Home equity line of credit or second mortgage.
   - Rent.
   - Property taxes.
   - Assessments.
   - Homeowner's insurance.
   - Renter's insurance.
   - Maintenance charge for condominium or cooperative.

Also add the appropriate heat and utility allowance if there is an obligation to pay for heat and/or utilities. The heat and utility allowance for a month is:

   - $529 starting January 2008.
   - $550 starting January 2009.

Convert all expenses to a monthly amount for budgeting purposes.

2. **Excess shelter allowance.**

   Subtract the appropriate shelter standard from the shelter expenses determined in step one. The shelter standard for a month is:

   - $525 starting January 2008.
   - $547 starting July 2009.

   The result is the **excess shelter allowance**.

3. **Total allowance.**

Add the excess shelter allowance to the appropriate basic allowance. The basic allowance for a month is:

- $1750 starting April 2008.
- $1822 starting July 2009.

The result, up to the appropriate maximum, is the **total allowance**. The maximum allowance for a month is:

- $2610 starting January 2008.
- $2739 starting January 2009.

Exception: In hearings, administrative law judges can **increase** the total allowance to divert more income to an long term care/ hostipal patient's community spouse; see BAM 600.

4. **Countable income.**

Determine the community spouse's countable income; see COUNTABLE INCOME in BEM 546.

5. **Community spouse income allowance.**

Subtract the community spouse's countable income from the total allowance. The result is the **community spouse income allowance**.

Exception: Use court-ordered support as the community spouse income allowance if both:

- The long term care/hostipal patient was ordered by the court to pay support to the community spouse.
- The court-ordered amount is **greater** than the result of step five.

Intent to Contribute

DHS-4592, Intent to Contribute Income:

- Determines the amount of income an long term care/hostipal patient intends to contribute to his community spouse
- Instructs the long term care/hostipal patient to report how much income he intends to make available
- Should be returned within 10 days

If the DHS-4592 is **not** returned within 10 days:

- Do **not** delay case actions, and

- Budget the entire community spouse income allowance.

Budget the entire allowance **until** the DHS-4592 is returned indicating the long term care/hostipal patient intends to contribute **less**.

When the DHS-4592 indicating an intent to contribute **less** income is received:

- **Decrease** the income diverted to the community spouse to the indicated amount.
- Do **not increase** the income diverted to the community spouse without a new DHS-4592.
- **Decrease** the income diverted if:
  - The community spouse's circumstances change.
  - The change reduces the community spouse income allowance **below** the amount indicated on the DHS-4592.
- Use timely negative action procedures to increase the patient-pay amount.

Do **not** use amounts from previous DHS-4592s when diverting income again after stopping a diversion for one of these reasons:

- A long term care/hostipal patient is discharged to a non-long term care/hostipal setting for 30 or more days.
- A long term care/hostipal patient's ongoing MA case (including active deductible) terminates.
- A long term care/hostipal patient's spouse is hospitalized or in long term care for 30 or more consecutive days.

Start the diversion process from the beginning.

FAMILY ALLOWANCE

An long term care/hostipal patient's income is diverted to meet the needs of certain family members. The amount diverted is called the **family allowance**.

Family members must**:**

Live with the community spouse, **and** be **either** spouse's:

- Married and unmarried children under age 21.
- Married and unmarried children age 21 and over if they are claimed as dependents on either spouse's federal tax return.

- Siblings and parents if they are claimed as dependents on either spouse's federal tax return.

The **basic allowance** for each dependent is the monthly amount **minus** the dependent's countable income, divided by 3. The monthly amount is:

- $1750 starting April, 2008.
- $1822 starting July, 2009.

The **family allowance** is the sum of the dependents' basic allowances.

CHILDREN'S ALLOWANCE

Long term care/hostipal patients without a community spouse can divert income to their unmarried children at home who are under age 18 **and** do **not** receive FIP or SSI.

The amount diverted is called the **children's allowance**. It is the children's protected income level from RFT 240 **minus** their net income. **Net income** is 80 percent of countable earned income per RFT 295, **plus** countable unearned income.

Do **not** divert income if information concerning the children's income is **not** provided.

HEALTH INSURANCE PREMIUMS

Include as a need item the cost of any health insurance (see PRG) premiums (including vision and dental insurance) the long term care/hostipal patient pays, regardless of who the coverage is for. This includes Medicare premiums that a client pays.

Example: long term care/hostipal patient pays health insurance premiums for two (self and spouse). Allow health insurance premiums for two.

Do **not** include premiums paid by someone other than the long term care/hostipal patient as a need item.

Convert the cost of all premiums to a monthly amount for budgeting purposes.

Note: Allow the $5 deduction paid by General Motors retirees which includes long term care insurance coverage as an insurance expense deduction.

GUARDIANSHIP/ CONSERVATOR EXPENSES

Allow $60 per month when an long term care/hostipal patient pays for his court-appointed guardian and/or conservator. Guardianship/conservator expenses must be verified and include:

- Basic fee.
- Mileage.
- Other costs of performing guardianship/conservator duties.

DHS-3227, TENTATIVE PATIENT-PAY AMOUNT NOTICE

Send a DHS-3227, Tentative Patient-Pay Amount Notice, within five working days of application when the applicant is in long term care, **and** a final determination will **not** be made within five working days from date of application.

Send the DHS-3227 to the client and the long term care facility.

NOTIFICATION

Notify both long term care/hostipal patients and their community spouses **in writing** of:

- Their hearing rights, **and** the amount of and method for computing the community spouse income allowance **and** family allowance.

Provide notice when:

- First calculating community spouse income or family allowance.
- The amount of either allowance changes.
- Long term care/hostipal patients, their community spouses, or representatives of either spouse request it.

Use the following forms to provide notice:

- DHS-4587, Community Spouse and Family Income Allowance Notice.

- DHS-4584, Community Spouse and Family Income Allowance Record.

Send a DHS-4592, Intent to Contribute Income, when the community spouse income allowance is greater than zero.

PATIENT PAY OFFSETS

Long-term care (LTC) facilities may deduct the following from a person's patient pay amount (PPA):

- The cost of certain medically necessary services **not** covered by MA such as chiropractic, podiatry, dental (other than emergency dental and oral surgery) and hearing aid dealers, and
- The MA co-payments for covered services.

The remainder of the PPA is then applied to the cost of care provided by the LTC facility. Department of Community Health determines whether an offset is allowable.

PPAs are **not** offset by local office staff.

Note: If an LTC applicant requests an offset of the patient pay to cover old medical bills. Assist the applicant by forwarding their unpaid bills to:

Medical Services Administration
Michigan Department of Community Health
P.O. Box 30479
Lansing, MI 48909-9634
Attn: PEME

DCH will determine whether an offset is allowable.

Offsets will be applied to the months following an approval. In general the allowable expenses are the same as allowed for a group 2 deductible case. In addition the medical expense(s) must be:

- Unpaid, and an obligation still exists to pay.
- Cannot be from a month where Medicaid eligibility existed.
- Cannot be covered by a third party source (public or private).
- Cannot be from a month in which a divestment penalty has been imposed.
- Cannot have been used previously as a pre-eligibility medical expense to offset a patient pay amount.
- Can include cost of room and board for Medicaid LTC facilities, remedial care, and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.
- Must be reported prior to the first Medicaid redetermination following the initial eligibility.
- DCH will terminate offsets if there is a failure to pay the medical provider with the funds.

EXHIBIT - VA NOTICE

This is a portion of an April 1991 letter announcing reduced VA benefits. Key wording is bolded.

You have been **a patient in a Medicaid-approved nursing home and covered by a Medicaid** plan for services since (Date). **Because you have no dependents and are receiving Improved Pension, the law requires that we limit your pension to $90.00 monthly** while you are receiving this type of care.

For that reason, we propose to reduce your benefits from (Date). No overpayment will be created.

This $90.00 monthly payment is for your incidental needs, such as toilet articles, snacks, etc. and **no part of this payment should be used by Medicaid to cover your medical expenses.** You should notify your state Medicaid office that your Improved Pension is being reduced.

BPB 2011-001 **BRIDGES POLICY BULLETIN**

EFFECTIVE December 1, 2010.

Issued December 1, 2010.

SUBJECT **BAM 825**

FIP, SSI and MA

Medicaid Non-Emergency Medical Transportation (NEMT) Brokerage Contract in Wayne, Oakland and Macomb Counties

The Michigan Department of Community Health has contracted with LogistiCare Solutions, L.L. C. to administer non-emergency medical transportation in Wayne, Oakland and Macomb counties for dates of service on and after January 1,2011.

Effective for dates of service on and after January 1, 2011, Wayne, Oakland and Macomb County DHS offices will no longer be reimbursed for Medicaid non-emergency medical transportation.

All beneficiaries residing in Wayne, Oakland, and Macomb will be receiving a letter informing them of this change.

Beneficiaries who are currently receiving or need to request NEMT in the future should be referred to LogistiCare. LogistiCare may be reached at (866) 569-1902.

BAM 210

CDC

The sentence was removed regarding the need for a telephone interview for Child Development and Care (CDC) as telephone interviews are only required at initial application not at redeterminations.

BAM 700, 705 and 715; BEM 221, 223, 230B, 232, 500, 501, 502, 705, 706, 710 and 711

CDC

It is no longer considered a client error when clients do not use funds sent to them to pay their aide for care provided and billed by the aide Aides and relatives are now considered unlicensed self-employed providers and will receive direct pay.

BEM 704

CDC

This item is now called unlicensed provider enrollment process.

Acceptable verifications to verify proof of identity for unlicensed providers have been added.

Proof of residence is now required when enrolling an unlicensed provider. Acceptable verifications have been added.

All required verifications to enroll an unlicensed provider must match the provider’s name as listed on the application. Verifications must be copied and maintained in the provider file.

A note was added that the DHS-4025, Child Care Provider Verification is not required prior to enrolling an unlicensed provider. The completed form is required prior to assigning the provider to a particular child in Bridges.

Local offices now have 10 days to complete the address inquiry, background clearances and enrollment process for an unlicensed provider after the provider submits a DHS-220.

Process to enroll an unlicensed provider has been revised.

- Newly enrolled providers who have not completed the training are not eligible for any payment until the pay period containing the training completion date. No back payments will be issued.

Bridges will send the DHS-4807, Notice of Child Development and Care Provider Eligibility, when a provider is denied. Local offices are required

to manually generate the DHS-4807-C, Client Notice of Child Development and Care Provider Eligibility, from Bridges, and mail to the client when the provider is denied.

Service Begin Date (Effective Date of Enrollment)

If approved, the service begin date for an unlicensed provider who is 18 years of age or older, is the date of the client or provider application, whichever is received first.

If a service begin date for a provider needs to be modified, the local office should fax the client and provider application, along with a cover sheet with the specialist's name and phone number, to CDC Policy at 517-241-8679.

If an unlicensed provider has been denied as a result of a household member and the member leaves the home, the service begin date cannot be before the date the new DHS-220 is received.

Background Clearances

If a provider or household member has an out of state ID, a central registry clearance should be requested from the state where the ID was issued.

BPB 2011-002 **BRIDGES POLICY BULLETIN**

EFFECTIVE February 1, 2011.

Issued December 28, 2010.

SUBJECT Long Term Care (LTC) Medicaid.

Bridges Interim Policy Bulletin for long term care (LTC); BPB 2010-021 has been added to BEM 164 and 546 and the Bridges Glossary.

BPB 2011-003 **BRIDGES POLICY INTERIM BULLETIN**

EFFECTIVE January 1, 2011.

Issued December 28, 2010.

SUBJECT **DHS-1046, Semi-Annual Contact Report**

BAM 210 and RFF 1046

FAP

Clients are no longer required to supply verification of the last 30 days of earnings when returning the DHS-1046 if their income has not changed by more than $100 since their last report. This change is effective with the January, 2011 mailing of the DHS-1046. Section 4, Household Income, on the DHS-1046 is revised to reflect this change. The client's gross earned income from their most current budget will now be pre-filled on the form.

Additionally, a new question is added for the client to indicate if their gross earned income changed by more than $100 from the pre-filled amount. Clients will need only to return verification of their past 30 days of earnings if they answer yes to this question.

If the client indicates their 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 eligibility determination benefit calculation (EDBC) run if a client checks no to the question, but supplies proof of income. The DHS-1046 **must** be recorded as complete and EDBC run so Bridges recognizes the DHS-1046 has been processed. Failure to do so will result in FAP closure.

MID-CERTIFICATION/ SEMI-ANNUAL CONTACT

BAM 210

FAP

Bridges sends a DHS-2240-A, Mid-Certification Contact Notice, for groups assigned a 24-month benefit period during the eleventh 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 you discover 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. A complete DHS-1046 must be submitted by groups with countable earnings and a 12-month benefit period; see BAM 115, Benefit Periods.

The DHS-1046 and DHS-2240-A may be completed by the client, or 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 filing 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 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 twelfth month after receipt of a completed DHS-2240-A and all required verifications.

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 contact is met by receipt of a completed DHS-1046 and required verifications. 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 effect benefits no later than the seventh month.

The client's gross earned income from their 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, they must return verification of their past 30 days of earnings with their completed DHS-1046.

If the client indicates their gross earned income has **not** changed by more than $100, verification of the past 30 days is not required. Run EDBC so Bridges will recognize the DHS-1046 has been processed. However, income must be budgeted and EDBC run if a client checks no to the questions, but supplies proof of income.

DHS-1046, SEMI-ANNUAL CONTACT REPORT

RFF 1046

Introduction

The DHS-1046, Semi-Annual Contact Report, is available as a Bridges-generated document. All groups who are assigned to simplified reporting by the last day of the fourth month of the benefit period will automatically receive a DHS-1046. Bridges sends the report in the beginning of the fifth month of the benefit period. The completed DHS-1046 is due back from the client or authorized representative on the first day of the 6th month in the benefit period.

Manually send from Bridges and track the DHS-1046 if you discover a case was not correctly assigned as a simplified reporter by the last day of the fourth month of the benefit period.

See BAM 210 for policy describing the semi-annual contact requirements.

Bridges prints the following case-specific information on the notice:

- Due date for return of the notice.

- FAP end date (last day of the 6th month) if the form is not returned.
- Local county/district office address.
- Active FAP recipients on the case.
- Child support expenses used in the last budget in Bridges.
- Gross earned income used in the last budget in Bridges.

A return envelope is provided for the client's convenience in returning the completed notice.

Item Instructions

The form is available in Bridges manual correspondence. If the form is sent manually, pre-fill the form with case-specific data listed above. If the client requests a replacement, send a duplicate from correspondence in Bridges.

STATE EMERGENCY RELIEF PROGRAM

ERB 2010-003 **EMERGENCY NEEDS PAYMENT LIMITS INTERIM BULLETIN**

Issued **10/18/2010.**

EFFECTIVE October 1, 2010.

SUBJECT

Energy Caps

Due to a potential decrease in LIHEAP funding for the upcoming fiscal year, the energy caps must be lowered. Therefore, effective October 1, 2010, the caps for energy services provided by State Emergency Relief will be decreased as follows:

Natural gas, wood and other fuel types except fuel oil, propane (LP gas) and coal: decrease from $850 to $350.

Deliverable Fuel - fuel oil, propane (LP gas) and coal - decrease from $850 to $650.

All electric household - decrease from $1700 to $700.

Electricity - decrease from $850 to $350.

The LIHEAP block grant for fiscal year (FY) 2011 has not yet been approved but we do have carryover funds from FY 2010 to use in the interim. Because of the limited funding available, exceptions will not be granted until further notice.

CHILD SUPPORT

Excerpt from OCS Memorandum 2010-018 introducing revisions to the following Michigan IV-D Child Support Manual sections:

2.05, 2.15, 2.20, 2.85, 3.03, 3.55, 3.85, 4.85, 5.15, 5.40, 5.70 and 5.85

MEMORANDUM 2010-018

EFFECTIVE November 11, 2010.

SUBJECT Implementation of the Michigan Child Support Enforcement System (MiCSES)/Bridges Interface.

Changes to the Table of Contents for the Michigan IV-D Child Support Manual.

PURPOSE This IV-D Memorandum explains changes in child support policy related to the MiCSES 7.0 Release (November 11, 2010), which implements the MiCSES/Bridges two-way interface.

This memorandum announces the publication of 12 sections of the Michigan IV-D Child Support Manual. Some of the manual sections are previously published sections that have been revised to reflect changes in child support policy due to the release. In these manual sections, significant changes since the previous publication are indicated with a change bar in the right margin. Other manual sections are new sections that incorporate content from previously published Action Transmittals (ATs) as well as new policy information introduced by the release.

This memorandum also explains numbering and section title changes in the table of contents for the Michigan IV-D Child Support Manual, which is located on mi-support.

MEMORANDUM 2010-018

These manual sections and their updates related to the release are discussed below.

Section 2.05, “Referrals and Applications”

This new manual section combines existing policy regarding applications for IV-D services using the IV-D Child Support Services Application/Referral (DHS-1201) with new policy material regarding automated referrals from Bridges.

Section 2.05 describes the new receipt of automated referrals for IV-D services for Food Assistance Program (FAP) and Child Development Care (CDC) assistance. It also details new information about the referred family and non-custodial parents (NCPs) that Bridges sends with all automated referrals. (The previous information MiCSES received about referred families lacked any information about the NCP.)

This manual section describes the appropriate steps taken either when a case is referred or when a parent or eligible caretaker applies for IV-D services. These steps include:

- Determining case roles;
- Identifying individuals;
- Maintaining assistance records;
- Identifying IV-D cases;
- Notifying IV-D partners; and
- Initiating workflow.

Automated referral processing and responsive action on the part of support specialist and FOC staff are described within this section. All IV-D staff benefit from understanding the conditions that cause a referral for IV-D services and the process by which a referred assistance case initiates one or more new IV-D cases.

Section 2.15, “Cooperation/Noncooperation/Good Cause”

This new manual section includes new policy that provides both support specialists and PA IV-D staff the authority to determine cooperation and noncooperation with the child support program.

Federal law permits cooperation and noncooperation decisions be made by any IV-D staff designated by the state’s IV-D program; there is no federal requirement that such a decision be made by State of Michigan employees only. To quicken necessary IV-D case progress and limit the number of IV-D staff engaged in this step, PA IV-D staff and support specialists will each have this authority for cases assigned to them. This manual section establishes the policy that will guide IV-D professionals in the difficult decision to enact this powerful tool – a decision that will be reserved for the most difficult of cases.

The cooperation and noncooperation process will be automated beginning with the implementation of the MiCSES/Bridges interface. Information about cooperation, noncooperation and good cause decisions will be exchanged automatically between the two systems:

- Cooperation and noncooperation decisions will be transmitted with status codes and informational alerts;
- Support disqualifications (public assistance sanctions) due to noncooperation will be initiated through the system interface; and
- Good cause claims and determinations will be transmitted with status codes and informational alerts.

This manual section also incorporates existing policy from different sources such as the Combined IV-D Policy Manual and ATs.

Note: All PA and support specialist staff must read this manual section before coding a IV-D public assistance family as noncooperative.

Section 2.20, “Court Action Referrals (CARs)”

This new manual section incorporates policy from different sources such as the Combined IV-D Policy Manual and ATs.

Due to new policy related to the cooperation and noncooperation decision process, CARs will no longer be rejected when noncooperation is determined. The case will remain in the functional area (either with the support specialist or the PA) until the custodial party (CP) cooperates with the child support program.

Section 3.03, “Case Updates and Member Demographics”

Section 3.03 is a new manual section. The former Section 3.25, “Demographics for Members” has been renumbered as Section 3.03 and renamed “Case Updates and Member Demographics.”

This manual section discusses:

- How ongoing changes to assistance cases cause necessary reactions by MiCSES and IV-D staff:
  - Changes to assistance history may cause the IV-D case type to change, initiate a financial reaction, or require that the CP be notified of the option to close the IV-D case when all assistance ends;
  - IV-D workers may need to initiate support order modifications when the case composition changes due to dependents, CPs, or NCPs leaving or returning home; and
  - IV-D staff may need to react to changes in demographic information first reported to family independence specialists/eligibility specialists and communicated to MiCSES, including addresses, identifying and physically descriptive information, and notification of a participant’s death.

- How assistance affects IV-D cases:
  - MiCSES will now track assistance by each individual, rather than by the individual within each IV-D case;
  - Assistance received by individuals or on behalf of dependents will automatically apply, or have relevance to, IV-D cases. This manual section describes the detail that Bridges uses to describe individuals' receipt of assistance and their participation in assistance programs, and how those details combine to show that CPs receive benefits themselves or on behalf of children in their care; and
  - Two new MiCSES roles, the IV-A / IV-D Matchmaker and Assistance Adjuster, will allow IV-D staff to adjust the MiCSES record of assistance or change associations between Bridges and MiCSES individuals. This manual section describes when to make changes as well as the necessary steps to obtain these new roles.

Section 3.55, "Hearings"

This new manual section incorporates policy from the Prosecuting Attorney Handbook and the Child Support Manual.

Recipients of assistance have the right to an administrative hearing to contest the denial, reduction or termination of assistance by the Department of Human Services (DHS). This includes those denials, reductions, or terminations resulting from IV-D determinations of noncooperation. This manual section explains recipients' rights in the hearing process, proper notification to recipients, local DHS staff responsibilities, and IV-D staff participation and responsibilities in the hearing process.

Because PA staff are now granted the authority to determine noncooperation (Ref: the Section 2.15 discussion above), those PA staff will participate in administrative hearings to explain the IV-D program's noncooperation decision.

Note: All PA and support specialist staff must read this manual section before coding a IV-D public assistance family as noncooperative.

Section 5.15, "Assignment of Support (Certification/Decertification)"

Section 5.15 has been revised to reflect updated rules on assignment of support due to the receipt of additional information from assistance programs via the implementation of the two-way interface between MiCSES and Bridges. This publication of Section 5.15 addresses the following:

- Medicaid no longer being a benefit that families automatically receive when they receive Family Independence Program (FIP) assistance; consequently, the family will no longer assign medical support if they receive FIP without Medicaid;
- The FIP budget month and its use and impact on the assignment of support;
- Clarification of assignment dates due to the receipt of new information from the assistance programs;
- Updated assignment examples to include budget month and new automatic assistance relevance rules;
- A limited discussion of changes to the FIA Interface Log (FERR) screen; and
- A limited discussion of revisions to the Member Assistance History (MAHI) screen (formerly known as the Member Program History [MHIS] screen).

Since the last publication of this manual section, the detailed foster care assignment discussion has been removed due to the publication of Section 5.85, “Foster Care – Financial.”

Section 5.40, “Public Assistance Impacts: Unreimbursed Grant, Linking, and Pass-Through (Client Participation Payment)”

Since its last publication, the title of Section 5.40 has been changed from “IV-A Impacts: Unreimbursed Grant, Linking, and Pass-Through (Client Participation Payment)” to “Public Assistance Impacts: Unreimbursed Grant, Linking, and Pass-Through (Client Participation Payment).” In addition, Section 5.40 has been revised with updated information regarding the interaction of IV-A and IV-D financial-related data due to the implementation of the two-way interface between MiCSES and Bridges. This includes a discussion of the following:

- Daily processing of the IV-A grant file and its impact on:
  - Ensuring that child support distributions will occur using the most up-to-date grant information; and
  - More efficient processing of excess grant collections so excess unreimbursed grant money will be sent to families in a timely manner.
- Child support collection information provided to assistance programs, including discussions of:
  - Collection terms used by IV-A and IV-D;

- •• The assistance programs' use of support collections; and
- •• The IV-D/IV-A Translation and Collections Matrix.

- The IV-A program's use of child support collections in the newly automated Grant in Jeopardy process. This process determines if families will remain on FIP or may benefit more by leaving assistance to receive child support collections directly.

- Updates to processing assistance discrepancies via new or updated alerts on the Alert Detail (ALRT) screen for support specialists and FOC staff that provide notice of possible missing decertifications or certifications.

- Information regarding new grant file information received, which includes:
  - •• The budget month and its impact on the assignment of support;
  - •• The grant funding source; and
  - •• Types of grant payments.

- Linking/Unlinking IV-A cases, information previously published in ATs. The linking policy has not changed, but some minor system restrictions have been introduced as a result of the MiCSES 7.0 Release.

- The Assigned Support Statement. There are no changes to the Assigned Support Statement or to related policy as a result of the MiCSES 7.0 Release or Bridges. Section 5.40 solely incorporates existing policy as provided in previously published AT 2009-001, REVISED: Assigned Support Statement (DHS-511/FEN852).

Section 5.70, "Fees (SF/PF, OSR and FFEE)"

This is a new manual section that contains new, existing and modified information regarding mandated fees, including:

- Processing fees and service fees, with no new policy information;
- Previously unpublished policy regarding out-of-state (OOS) recovery fees; and
- The $25 federal annual fee (FED fee) and the changes affecting assessment and retention of the federal fee due to the receipt of additional assistance programs such as CDC and FAP.

Note: Before October 1, 2010, the Michigan Legislature directed the Michigan child support program to retain the FED fee from the individ-

ual (the CP) receiving a child support collection. Beginning with fiscal year 2011 on October 1, 2010, the budget for DHS includes money for payment of assessed FED fees. The Michigan Legislature removed the directive to retain the FED fee from the CP.

To accommodate this change, beginning October 1, 2010, MiCSES will not retain the FED fee from any CP.

However, updates to FED fee documentation, such as OCS policy, MiCSES system documents, and training materials regarding this change are forthcoming.

Foster Care Sections of the Michigan IV-D Child Support Manual, which include:

- Section 2.85, “Foster Care – Case Initiation”
- Section 3.85, “Foster Care – Case Management”
- Section 4.85, “Foster Care – Establishment”
- Section 5.85, “Foster Care – Financial”

These new manual sections incorporate content from previous publications of child support policy. There are no substantive policy changes within the foster care referral process due to the MiCSES 7.0 Release. However, there are some minor changes in language and format, which include:

- Changing references from the MHIS screen to the MAHI screen to reflect the revision and renaming of this screen;
- Introduction of the new Resolve Referral (RESR) screen, which will handle most assistance referrals (FAP, FIP, CDC, Medicaid) (however, foster care referrals will continue to be processed according to current system documentation);
- Details of the direct referral interface between the Services Worker Support System Foster Care, Adoption, and Juvenile Justice (SWSS FAJ) and MiCSES;
- Exclusion of language that pertains to “Central VAX” in the MiCSES foster care referral process;
- Exclusion of Simulate-CIMS language as it pertains to the foster care referral process;
- Reducing the amount of technical language from the manual sections because it already appears in MiCSES Customer Information Guides, MiCSES Quick Reference Guides, or frequently asked questions (FAQs); and

- Separating the foster care referral process policy and guidance into four distinct manual sections, effectively dividing them into IV-D functional areas.

Additionally, federal and state regulations, and Office of Child Support Enforcement (OCSE)/IV-D policy references were verified and updated.

Excerpt from OCS Memorandum 2010-019 introducing revisions to Michigan IV-D Child Support Manual 5.75

MEMORANDUM 2010-019.

EFFECTIVE January 1, 2011.

SUBJECT Surcharge.

PURPOSE This memorandum announces revisions to Section 5.75, “Surcharge” of the Michigan IV-D Child Support Manual.

In addition, this memorandum announces updates to the following inter-agency forms to be published with the Michigan Child Support Enforcement System (MiCSES) 7.1 Release (December 10, 2010):

- Notice of Rights and Responsibilities (FEN003).
- Tax Administrative Review Pre-Populated (FEN178).
- Financial Institution Notice of Lien and Levy and Disclosure (FEN321).

Additional forms owned by the FOC or PA forms groups with surcharge language requiring revisions will be published beginning on January 1, 2011.