

ATTACHMENT

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WITH LIBERTY AND ACCESS FOR ALL

Michigan's Assistive Technology Program

Device Demonstrations

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What are Device Demonstrations?

The purpose of a device demonstration is to help people compare and contrast the features and benefits of a variety of devices in order to make an informed buying decision.

Device demonstrations can include one device, multiple devices (such as comparing four different electronic enlarging devices), single category of participants and multiple categories of participants (a student with a vision disability, their special education teacher and parents, for example). Device demonstrations can be direct or indirect.

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Device Demonstrations in Michigan: An Overview

The goals of the Michigan's Plan for AT include increasing access to AT by targeted individuals and entities in the areas of education, employment, community living and information technology/ telecommunications. Michigan has targeted priority to first un-served then to under served geographic areas of the state for this funding. The priority for services is to people who are not eligible to receive services or have assistive technology services paid for through other agencies or organizations. The program is also identifying opportunities to leverage collaborative advocacy efforts by providing demonstrations within specific systems and or focus areas.

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Community Connections of SW Michigan

133 E. Napier, Suite 2

Benton Harbor , MI 49022
Voice 800 578-4245 (269) 925-6422
Fax: 269 925-7141

Community Connections is a Center for Independent Living, serving rural Berrien, Cass and western portion of Van Buren counties. Community Connections has partnered with Michigan State University, through its Assistive Technology Specialist at the **Resource Center for Persons with Disabilities (RCPD)** to provide device demonstrations. They will train volunteers who have disabilities and use AT to provide demonstrations in response to the needs of people who call the center (number above) and request and demonstration.

Assistive Technology Coordinators will help determine individual or group presentation preference, location, time/date of demo, type, etc. Assistance will be provided by Community Connections in linking people with needed transportation to a site if needed.

Community Connections and it's partners are also exploring the possibility of taping some of the demonstrations in preparation for a future indirect device demonstration service via web cast. The partners will be exploring the possibility of offering this service during this initial subcontract.

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Superior Alliance for Independent Living:

129 W, Baraga, Suite H
Marquette, MI 49855
(906) 228-5744
(800) 379-7245

The **Superior Alliance for Independent Living Center (SAIL)** has received a subcontract to provide device demonstrations to residents of the fifteen counties of the Upper Peninsula to explore the benefits of AT and make informed decisions. Michigan 's Upper Peninsula is a remote, rural part of the state that is historically undeserved.

To request device demonstration, call SAIL (numbers above).

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Hearing Assistive Technology Demonstrations

The program has subcontracted with the Hearing Loss Association of Michigan to provide device demonstrations to un-served people with hearing loss disabilities. Through previous funding from Michigan's Assistive Technology Program, this organization started the **Hearing Technology Resource Specialist(HTR Specialists)** program. HLA-MI has trained over 30 volunteers across the state to educate their local communities about hearing assistive technology.

HTR Specialists use customized equipment kits containing various types of devices that can help you hear better in daily living situations. This program recently expanded the devices in their kits to be able to offer Assistive Technology Demonstrations.

To schedule a demonstration, please write to:
htrs@hearingloss-mi.org. The following people have been trained to provide demonstrations:

- Vic Eichler - Portage
- Sheila Bisaha - Flint
- Allan Feldt - Ann Arbor
- Carol Rose - Mohawk
- Margie Gillean - Flint
- Janet Haines - Vassar
- Liz Kobylak - Troy
- Marilyn Knol - Grand Rapids
- Ann Liming - Lansing
- Twyla Neidfeldt - Lansing Area
- Cindy Shapiro - Traverse City
- Cliff Tallman - Kalamazoo
- Juanita Wikman - Muskegon

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Assistive Technology and Long Term Care

The program expanded and updated the "small changes, Big Differences" assistive technology training and kits. 4 kits have been developed to be placed at organizations throughout the state with a focus of training people involved with the **Single Points of Entry for long term care** locations. These sites will provide both training and device demonstrations using the kit. Sites are:

Superior Alliance for Independent Living

129 W, Baraga, Suite H
Marquette, MI 49855
(906) 228-5744
(800) 379-7245

Community Connections

133 E. Napier, Suite #2
Benton Harbor, MI 49022
(269) 925-7141
(800) 578-4245

Disability Network/Southwest MI

517 E. Crosstown Parkway
Kalamazoo, MI 49001
(269) 345-1516 voice
(269) 345-5925 tty
(800) 394-7450

Michigan Disability Rights Coalition

contact Aimee Sterk
(800) 760-4600 ext 329

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Wayne, Oakland and Macomb County Focus Group

The program has contracted with Cathy McAdam and UCP of Metro Detroit to develop training and device demonstrations based on the recommendations of a focus group held last year. Training has been developed and will begin over the Summer and Fall of 2008 with demonstrations to follow. The topic of the training is devices for communication in emergency situations people with a variety of disability characteristics.

Cathy McAdam
(313) 563-1412

<http://www.diverseability.com/mcatherinemcadamlc.htm>

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ATTACHMENT

FIVE

RECIPIENT RIGHTS COMPLAINT

For Office Use Only

Case #:

Category:

If you believe that your rights have been violated, you (or someone else on your behalf) may use this form to make a rights complaint.

Keep the last copy and return this form to the Rights Office:

Complainant's Name: [REDACTED] /

Recipient's Name: [REDACTED]

Address: [REDACTED]

Address: [REDACTED]

Phone Number: [REDACTED]

Phone Number: [REDACTED]

Where did it happen? Ongoing

When did it happen? (Date and Time)

1. Describe What Happened: (Attach additional sheets if necessary)

Consumer (mother) was told by [REDACTED] that he could not move into a living arrangement on April 19. This move in date was denied because mother would not sign a financial agreement. The agreement requested \$5,000 per year and specific contract language would be added to the family's trust and will documents as supplied by [REDACTED]. [REDACTED] had negotiated a per diem rate for the living situation and was prepared to authorize the funding. This contract rate follows Medicaid guidelines as "payment in full".

2. What right(s) do you feel was violated?

If substantiated this would be a violation of:
 Person Centered Planning.
 Dignity and Respect

3. What resolution do you seek?

To move into the [REDACTED] setting right away without a written agreement signed by parents of consumer. The rate authorized by [REDACTED] is payment in full. If consumer is unable to move into this setting, his will remain in his family home and reconvene a PCP planning meeting to identify other living arrangements with assistance of [REDACTED] support coordinator.

Complainant's Signature

Date

Person Assisting Complainant,

Date

8/9

5-1-06

[REDACTED] AUTHORITY RECIPIENT RIGHTS COMPLAINT

For Office Use Only
COMPLAINT #: 13221

If you believe that your rights have been violated, you (or someone else on your behalf) may use this form to make a rights complaint.

Keep the last copy and return this form to the Rights Office:

[REDACTED]

Complainant's Name: [REDACTED]

Recipient's Name: [REDACTED]

Address: [REDACTED]
[REDACTED]

Address: [REDACTED]
[REDACTED]

Phone Number: [REDACTED]

Phone Number: [REDACTED]

Where did it happen?
[REDACTED] Office

When did it happen? (Date and Time)
Ongoing.

1. Describe What Happened: (Attach additional sheets if necessary)

On 5-1-06 the rights office received a written complaint that a consumer was set going to be placed at a [REDACTED] home. Before this process could begin, the move was denied based on the consumer's mother /guardian refusing to sign [REDACTED]'s contract. The refusal to sign was based on a portion of the contract which states that [REDACTED] wanted a "voluntary contribution", which would cover and all services that Medicaid and SSI won't cover. The contract agreement requested \$5000.00 per year and specific contract language would be added to the family's trust and will documents as supplied by [REDACTED]. The contract also stated that [REDACTED] can reassess the requested rate and reserve the right to increase the yearly payments if they so choose by providing the family with a written notice. [REDACTED] negotiated a per diem rate for the living situation and was prepared to authorize funding. This contract rate follows the Medicaid guidelines as "payment in full." Because of this issue, the consumer will not be placed in a group home.

2. What right(s) do you feel was violated?

Dignity & Respect

3. What resolution do you seek?

Investigate. If substantiated, discipline accordingly.

Complainants Signature

Date

Person Assisting Complainant

Date

**MENTAL HEALTH AUTHORITY
OFFICE OF RECIPIENT RIGHTS**

SUMMARY REPORT

Complaint #: 13221

<u>Recipient's Name</u> [REDACTED]	<u>Service Site</u> [REDACTED] - Admin Office	<u>Network Provider</u> [REDACTED]	<u>Core Agency</u> [REDACTED]
<u>Complainant's Name</u> [REDACTED]	<u>Relationship to Recipient</u> [REDACTED]	<u>Violation Category</u> Civil Rights: Discrimination, Ability to pay, Treatment Suited to Condition & Confidentiality	
Substantiated <input checked="" type="checkbox"/> Civil Rights & Treatment Suited to Condition Not Substantiated <input type="checkbox"/> Confidentiality	<u>Date Case Opened</u> 5/1/2006	<u>Date of Report</u> 8-24-06	Final: <input checked="" type="checkbox"/> Amended: <input type="checkbox"/>

I. ALLEGED RIGHTS VIOLATION

On 5-1-06 the Office of Recipient Rights (ORR) received a written complaint that a consumer was denied residential placement services based on the consumer's mother refusing to sign [REDACTED]'s the Licensed or Transition Home Fee Agreement. The refusal to sign was based on a portion of the agreement which states that [REDACTED] wanted a "voluntary contribution", which would cover the cost of all services that Medicaid and SSI won't cover. The agreement requested \$5000.00 per year. The agreement also stated that [REDACTED] can reassess the requested rate and reserve the right to increase the yearly payments if they so choose by providing the family with a written notice. [REDACTED] negotiated a per diem rate for the living situation and was prepared to authorize funding. This contract rate follows the Medicaid guidelines as "payment in full." Because of this issue, the consumer will not be placed in a group home. It was also alleged that [REDACTED] used the placement of the recipient in the home as leverage to "blackmail" or pressure the recipient's mother into signing the agreement.

During the course of this investigation, it was also discovered that the consumer did not sign a release for any representative from [REDACTED] to speak with the recipient's mother regarding the move to Berlin.

II. CITATIONS

The following legal and regulatory provisions are applicable to this case:

MCL 330.1206(1a-h), "which states "(1a-h) The purpose of a community mental health services program shall be to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an **individual's ability to pay**. The array of mental health services shall include, at minimum, all of the following: ..."

MCL 330.1208 (4), which states, "**An individual shall not be denied services because an individual who is financially liable is unable to pay for service.**"

MCL 330.1704 (1,2), which states, "(1) In addition to the rights, benefits, and privileges guaranteed by other provisions of law, the state constitution of 1963, and the constitution of the United States, a recipient of mental health services shall have the rights guaranteed by this chapter unless otherwise restricted by law." "(2) The rights enumerated in this chapter shall not be construed to replace or limit any other rights, benefits, or privileges of a recipient of services including the right to treatment by spiritual means if requested by the recipient, parent, or guardian."

MCL 330.1804 (3), which states, "The department or community mental health services program shall waive payment of that part of a charge determined under section (2) **that exceeds financial liability**. The department or community mental health services program shall not impose charges in excess of ability to pay."

ADMIN Rule R330.2067 (1a, d& h), which states," A community Mental Health services board shall do all of the following. (a) Ensure that a person is not denied service on the basis of race, color, nationality, religious or political belief, sex, age, handicap, county of residence, or **ability to pay**. This policy shall be stated in the program statements of the community mental health board and in contractual agreements."

"(d) Require agencies which provide services by contract or agreement with the board and which receive state aid to furnish the board with an accounting of fee revenue received from patients or from persons paying on behalf of patients."

ADMIN Rule R330.8008, which states, "Financial liability for services approved for state financial support by the department and provided by the department or community mental health services programs directly or under contract shall be determined pursuant to these rules and stated in the department's and community mental health services programs' written policies and procedures."

MCL 330.1808 (1), which states, "The total combined financial liability of the responsible parties shall not exceed the cost of the services."

MCL 330.1810, which states, "An individual shall not be denied services because of the inability of

responsible parties to pay for the services.”

An individual is defined as “The individual, minor or adult, who receives services from the department or a community mental health services program or from a provider under contract with the department or a community mental health services program.”

MCL 330.1817, which states, “For an individual who receives inpatient or residential services on a voluntary or involuntary basis, the department or community mental health services program shall determine the responsible parties’ insurance coverage and ability to pay as soon as practical after the individual is admitted.”

MCL 330.1828, which states, “The department or community mental health services program shall annually determine the insurance coverage and ability to pay of each individual who continues to receive services and of each additional responsible party, if applicable. The department or community mental health services program shall also complete a new determination of insurance coverage and ability to pay if informed of a significant change in a responsible party’s ability to pay.”

MCL 330.1842, which states, “The department shall develop and promulgate rules, pursuant to Act. No. 306 of the Public Acts of 1969, as amended, which shall implement the provisions of this chapter. Such rules shall include particularized procedures for determining ability to pay, and such procedures shall be applied uniformly throughout the state.”

ADMN Rules, 330.8021, which states, “An individual receiving services, his spouse, or his parent may appeal the amount of financial liability by notifying the director of the facility or county community mental health services board in writing or on a form provided by the department, within 30 days of obtaining a new determination.”

ADMN Rules, 330.8239 (2), which states, “A responsible party who has been determined under the medical assistance program or its successor to be Medicaid eligible shall be deemed to have a \$0.00 ability to pay from the schedule specified in this rule.

MCL 330.1708 (1), which states, “A recipient shall receive mental health services suited to his or her condition.”

MDCH Medicaid Provider Manual **section 7.4, -Nondiscrimination**, states, “Providers must render covered services to a beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of Medicaid, providers shall not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political beliefs, or source of payment.”

MDCH Medicaid Provider Manual **Section 12 – Reimbursement, section 12.1 - PAYMENT IN FULL**, states “Providers must accept Medicaid's payment as payment in full for services rendered, except when authorized by Medicaid (e.g., co-payments, patient-pay amounts, other cost sharing arrangements authorized by the State). Providers must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so. This

policy also applies to payments made by MHPs, CHPs, and PIHPs/CMHSPs/CAs for their Medicaid enrollees. Contractors or nursing facility (including ICF/MR) operators must not seek nor accept additional or supplemental payment beyond the patient-pay or MDCH ability-to-pay amount.

MDCH Medicaid Provider Manual, section 13- Targeted case Management, states, “Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessments, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.”

MCL 330.1748 (1-6), which states, “ Information in the record of a recipient, and other information acquired in the course of providing mental health services to a recipient, shall be kept confidential and shall not be open to public inspection. The information may be disclosed outside the department, community mental health services program, licensed facility, or contract provider, whichever is the holder of the record, only in the circumstances and under the conditions set forth in this section.

(2) If information made confidential by this section is disclosed, the identity of the individual to whom it pertains shall be protected and shall not be disclosed unless it is germane to the authorized purpose for which disclosure was sought; and, when practicable, no other information shall be disclosed unless it is germane to the authorized purpose for which disclosure was sought.

(4) For case record entries made subsequent to March 28, 1996, information made confidential by this section shall be disclosed to an adult recipient, upon the recipient's request, if the recipient does not have a guardian and has not been adjudicated legally incompetent. The holder of the record shall comply with the adult recipient's request for disclosure as expeditiously as possible but in no event later than the earlier of 30 days after receipt of the request or, if the recipient is receiving treatment from the holder of the record, before the recipient is released from treatment.

(5) Except as otherwise provided in subsection (4), (6), (7), or (9), when requested, information made confidential by this section shall be disclosed only under 1 or more of the following circumstances:

(6) Except as otherwise provided in subsection (4), if consent is obtained from the recipient, the recipient's guardian with authority to consent, the parent with legal custody of a minor recipient, or the court-appointed personal representative or executor of the estate of a deceased recipient, information made confidential by this section may be disclosed to all of the following:

(a) Providers of mental health services to the recipient.

(b) The recipient or his or her guardian or the parent of a minor recipient or any other individual or agency unless in the written judgment of the holder the disclosure would be detrimental to the recipient or others.

III. ISSUES

1. Is the consumer a Medicaid recipient?
2. Did [REDACTED] agree with [REDACTED] to receive Medicaid funding to provide services for the consumer?
3. Are the additional services that would be provided Medicaid covered services?
4. If so, will the family member be charged for these additional services?
5. If so, are these additional services paid on a voluntary basis?
6. Are these additional services based on the consumer's ability to pay?
7. Did [REDACTED] inform the consumer's mother prior to signing the contract that if the additional services are not agreed to then none of the identified services would be provided?
8. Did [REDACTED] discriminate against the recipient by refusing services based on the recipient's /mother's ability to pay?
9. If so, did [REDACTED] refuse to provide services identified in the consumer's Individual Plan of Service (IPOS) based on a family member's choice not to sign the Licensed or Transitional Home Fee Agreement?
10. Did this result in a delay/denial of services identified in the IPOS?
11. If so, did this constitute a violation of the recipient's right to receive Treatment Suited to Condition?
12. Did [REDACTED] obtain a Release of Information from the recipient, which would have allowed [REDACTED] to negotiate placement with the parent?

IV. SUMMARY OF INVESTIGATIVE FINDINGS

1. Is the consumer a Medicaid recipient? YES.

According to the Oakland County Eligibility Database, it confirms that the consumer is currently a Medicaid recipient.

2. Did [REDACTED] agree with [REDACTED] to receive Medicaid funding to provide services for the consumer? YES.

- a. The complainant, W#1, S#1, S#5, S#6 & S#7 all stated that [REDACTED] and [REDACTED] agreed to a per diem rate to cover 24 hour staffing and transportation.

3. Are the additional services that would be provided Medicaid covered services? YES.

- a. In review of the [REDACTED] Family Financial Commitment form and grid it states that such additional services are services that are non Medicaid services or not funded through SSI. The services and expenses which [REDACTED] provides that are not funded through SSI or Medicaid help to defray the costs of these additional services.
- b. An interview with S#5 on 7-17-06 revealed that in her review of the non-Medicaid covered services listed on the [REDACTED] Family Financial Commitment Form/Grid on the surface are worded to appear to be non-Medicaid services; however, in S#5's opinion, some of the services could be construed as actually Medicaid covered services.
- c. An interview with S#6 revealed that many of the additional services are Medicaid billable services and are services that can easily be identified in the consumer's IPOS. Also, S#6 stated that some of the "additional services" are services that the Provider must implement anyway. Also the "additional services are services that S#5 implements as well. Services authorized in the consumer's plan of service are required to be provided.
- d. In review of the Medicaid Provider Manual dated April 1, 2006, section 13- **Targeted case Management**, on 7-30-06 it states, "**Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessments, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process.** Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes."
- e. In an interview with S#7 she stated that she had several conversations with S#1 in regards to the consumer's placement despite the fact that [REDACTED] has a procedure which dictates that one must sign a contract agreement prior to placement. S#7 said that she reviewed the additional services that [REDACTED] offers and charges for. In S#7's opinion, she said that she feels that some of the additional services are Medicaid covered services and feels that the services can be implemented based on the consumer's IPOS without charging extra.

- f. In review of the consumer's IPOS, it revealed that many of the goals and wishes of the consumer, which were identified on the IPOS, would encompass utilizing the "non-Medicaid services" that [REDACTED] provides. This would indicate that if there are goals in the IPOS that relate to the "non-Medicaid services" that [REDACTED] provides, the caregiver has no choice but to implement what is identified in the IPOS without an additional charge. Also the financial agreement between [REDACTED] and [REDACTED] for the per diem rate would cover those non-Medicaid services.

4. If so, will the family member be charged for these additional services? YES.

- a. W#1 stated that she had questions regarding some points in the family financial commitment contract/agreement. W#1 stated that the additional fees pertain to the additional services that [REDACTED] provides to those who live in licensed homes. W#1 stated that she did not have an issue with paying the additional fee, but had reservation about having this in the contract/agreement as a life long binding requirement. W#1 asked if that could not be placed in the contract and [REDACTED] was unwilling to do so. The decision was made not to sign the contract/agreement. W#1 stated that [REDACTED] encouraged her to have the consumer get to know everyone at the Berlin home only to have the consumer not be placed there in the end.
- b. S#1 stated that the additional services are non Medicaid/SSI services that [REDACTED] offers and that the fees incurred from the additional services are legal. S#1 stated that they have to approach the family first and have them to agree to pay for the additional services.
- c. In review of the [REDACTED] contract it does not address the issue of the additional services and fees that [REDACTED] claims are not Medicaid covered services nor does the [REDACTED] contract state that Medicaid reimbursement that a Provider accepts will be accepted as "payment in full" for services identified in the IPOS. The contract only covers responsibilities the provider has in regard to Medicaid covered services. There were no other additional documents or policies that addressed [REDACTED]'s position to the additional services and fees for the "additional services". There is no direct language in the contract between [REDACTED] and [REDACTED] that states that providing / charging for these additional services is prohibited.
- d. S#7 stated that S#1 was very clear that the additional services were non Medicaid and is not covered so anyone who wants to live in one of [REDACTED]'s homes will be charged.
- e. In review of an e-mail communication to W#1 dated 4-6-06 it clearly stated that the additional funds were "required" and that the issue was "non negotiable."

5. If so, are these additional services paid on a voluntary basis? NO.

- a. The complainant stated that the family is being charged for services that [REDACTED] provides; however, the [REDACTED] Family Financial Commitment question & Answer packet leads the reader to think that the additional costs would be paid on a voluntary basis.

- b. W#1 stated that the additional fees were fees for the additional services and that [REDACTED] does **expect** for the family to pay the additional fees. W#1 also stated that from the beginning she was put under the impression that paying the additional fees was voluntary. It was not until W#1 had reservations about the contract, that at that point [REDACTED]'s position was that the fees were required.
- c. In review of the Family Financial Commitment Question and Answer form (Q&A Form) it states "Each family served by [REDACTED] makes a Family Financial Commitment toward the cost of providing the highest quality services. In some cases, this commitment is a fee for specific services. In other cases, where [REDACTED] is providing comprehensive funding, the commitment is a **voluntary contribution**. Some times, it is a combination of the two. Voluntary contributions will be discussed with families annually, and [REDACTED] expects that each family will make the most generous commitment possible. It would be improper for [REDACTED] to seek support from the community without first ensuring that all families are participating to the very best of their ability."
- d. S#1 stated that the portion in the Q&A form speak to the mailings that are sent out to all of the families giving information on other fundraisers that [REDACTED] participates in. Theses fundraisers are not related to the additional services that are provided. The family can or cannot choose to participate in [REDACTED]'s fundraising activities, but the additional fees are not voluntary and have to be agreed upon.
- e. In review of the [REDACTED] The agreement/**Contract**, it specifically states, "This agreement outlines the parents joint and several **financial obligations to [REDACTED]** in payment for services as described in the Residential Care Agreement and **as explained in the Questions & Answers about [REDACTED]'S Family Financial Commitment**, which states that in some cases where [REDACTED] is providing comprehensive funding, the commitment is a voluntary contribution.
- f. S#3 stated that, the contract between [REDACTED] and [REDACTED] do not touch upon the "additional services" or the additional fees that [REDACTED] provides and requires and there are no [REDACTED] policies that address this issue as well with any of their contracted providers. [REDACTED] does not get involved with any other services outside the realm of Medicaid covered services. [REDACTED] did agree to a per Diem rate for the Medicaid covered services.
- g. In review of an e-mail communication to W#1 from S#2 dated 4-6-06 it specifically stated that the additional fees were required and the issue was non negotiable.
- h. In review of the Family Financial Commitment Form/Grid it shows in this case where [REDACTED] had agreed to pay [REDACTED] for staffing and transportation only, in a licensed group home a \$5000.00 fee per year for "list A" expenses plus a voluntary contribution and the same fee goes for an unlicensed group home as well. **Also on this same form states at the top of the page, "These fees are over and above the ability-to-pay assessed to the individual receiving services."**

6. Are these additional services based on the consumer's ability to pay? NO.

- a. The complainant was not aware as to how the figure is determined for the additional services or what the procedure is in terms of the ability to pay.
- b. S#1 stated that if the family is unable to handle the \$5000.00 fee then they can request a financial re-determination and ask to have the fees reduced. This, according to S#1, is based on the ability to pay.
- c. In review of the [REDACTED] County Medicaid Eligibility database, it conforms that the consumer is a Medicaid Recipient. The consumer's ability to pay is \$0.00.
- d. In review of the Family Financial Commitment Q&A form it appears that the financial commitment is done based on the families ability to pay and not the consumer. The Q&A also outlines [REDACTED]'s own process for financial re-determination, and does not use [REDACTED]'s process for financial re-determination. Please note that [REDACTED]'s procedure for a financial re determination is based on the family's (W#1) ability to pay and the consumer's ability to pay.
- e. S#4, S#5, S#6 and S#7 all stated that the consumer's ability to pay is \$0.00 and that when an individual is receiving public funding the consumer's ability to pay is zero. The consumer cannot be charged above and beyond his/her ability to pay. All four staff also stated that [REDACTED] does not have the authority to go after the family and obligate them to pay for any additional fees and services that the consumer has not requested.
- f. According to the Medicaid Provider Manual dated July 1, 2005 and July 1, 2006 **Section 12 – Reimbursement, section 12.1 - PAYMENT IN FULL**, states **"Providers must accept Medicaid's payment as payment in full for services rendered, except when authorized by Medicaid (e.g., co-payments, patient-pay amounts, other cost sharing arrangements authorized by the State). Providers must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so. This policy also applies to payments made by MHPs, CHPs, and PIHPs/CMHSPs/CAs for their Medicaid enrollees. Contractors or nursing facility (including ICF/MR) operators must not seek nor accept additional or supplemental payment beyond the patient-pay or MDCH ability-to-pay amount."**

7. Did [REDACTED] inform the consumer's mother prior to signing the contract that if the additional services are not agreed to then none of the identified services would be provided? YES.

- a. S#1 denied that W#1 was ever given the impression that if the agreement/contract is not

signed then the consumer would not be accepted. S#1 stated that a packet is given upon intake with [REDACTED] and everything including the family's financial responsibilities is explained. S#1 stated that W#1 has known about the additional services and fees for 6-8 months prior to deciding not to sign the contract/agreement.

- b. W#1 stated when she had questions about the fees pursuant to the Family financial commitment Q&A form then there were problems. W#1 stated that she was put under the impression from the beginning that the fees were voluntary. W#1 stated that it was when she had questions and did not want to sign it, and then it was [REDACTED] who decided that they were not the appropriate placement for the consumer and ultimately the consumer was not placed in the home. W#1 said that she was willing to pay the set amount, (\$10,000.00 cash) but did not want it to be iron clad in the agreement/contract. W#1 stated that she feels that S#1 did make her feel "pressured and blackmailed" to feel that if she did not sign the agreement then her son would not be accepted.
- c. In review of an e-mail sent to W#1 from S#2 dated 4-6-06 it clearly states that the issue of the additional fees were **"required and was non negotiable"** and that if **"the family chooses not to sign the agreement, the [REDACTED] can choose not to accept the consumer."**

8. Did [REDACTED] discriminate against the recipient by refusing services based on the recipient's /mother's ability to pay? YES.

- a. W#1 felt that S#1 made attempts to "blackmail" W#1 into signing the contract/agreement by making her feel as if the consumer would not be placed unless the agreement/contract was signed. W#1 felt that since she did not sign the contract and [REDACTED] did not place the consumer in the Berlin home, her son was discriminated against. W#1 feels that if a parent does not agree and pay for the additional services that [REDACTED] provides, then they have no room for you in their organization. W#1 stated that she was willing to pay \$10,000 dollars as a good faith effort, but was unwilling to sign the agreement. W#1 stated that because she refused to sign the agreement, [REDACTED] decided that her son would not be placed in the Berlin Home.
- b. S#1 denied blackmailing W#1 into signing the contract/agreement. S#1 stated that she explained that this was what [REDACTED] has been doing and is the same procedure for everyone. S#1 stated that [REDACTED] does not make special provisions in the agreement for individuals. S#1 stated to W#1 that she had choices and that W#1 could choose not to go with [REDACTED] if she wanted, but denied using the fact that they would not accept the consumer because W#1 refused to sign the agreement as a way to blackmail W#1 into signing the contract/agreement.
- c. Prior to the move in date of 4-21-06, an e-mail communication was sent to W#1 from S#2 on 4-6-06. The e-mail communication clearly stated that if a family chooses not to agree,

sign the contract, the [REDACTED] can choose not to accept that individual. The e-mail communication goes on the state, "We do need you to sign the agreement for (C#1) to move into Berlin."

- d. In review of the Family Financial Commitment Q&A form makes statements such as, "Your Family Financial Commitment is critical to ensure that [REDACTED] can continue to provide the high level of service you wish for your family member." And "Voluntary contributions will be discussed with families annually, and [REDACTED] expects that each family will make the most generous commitment possible. It would be improper for [REDACTED] to seek support from the community without first ensuring that all families are participating to the very best of their ability."
- e. Pursuant to "b" in issue question #8 above, the e-mail communication from S#2 to W#1 clearly states that if W#1 does not sign the agreement, then her son will not be accepted at [REDACTED].
- f. Pursuant to "c" in issue question #8 above, the e-mail response from W#2 clearly states that if W#1 did not sign the agreement, then [REDACTED] was well within their rights to refuse their services.
- g. Lastly, the end result is that W#1 refused to agree to the [REDACTED] contract and as a result, the consumer was not placed in the Berlin Home to date.

9. If so, did [REDACTED] refuse to provide services identified in the consumer's Individual Plan of Service (IPOS) based on a family member's choice not to sign the Licensed or Transitional Home Fee Agreement? YES.

- a. According to the Medicaid Provider Manual on July 1, 2006 pg. 12, section 7.4,- Nondiscrimination. states, "Providers must render covered services to a beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of Medicaid, providers shall not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political beliefs, or source of payment." X
- b. In review of an e-mail sent to W#1 from S#2 dated 4-6-06 it clearly states that the issue of the additional fees were "required and was non negotiable" and that if "the family chooses not to sign the agreement, the [REDACTED] can choose not to accept the consumer."
- c. In review of an e-mail response from W#2 ([REDACTED]'s legal counsel) regarding [REDACTED]'s legal position pursuant to this investigation states that "The Berlin Home is an unlicensed home and is under no direct contract with [REDACTED] and [REDACTED] nor Medicaid dollars pay for the operation of the home itself. " "The costs of operating the Berlin home are considerable. [REDACTED]'s or Medicaid's payment of some staff time, and for certain transportation reimbursement, does not cover all the expenses of housing,

meals, recreation, education, entertainment, or such services and supports as home management, insurance, advocacy and the like. Nor does SSI payment.” “ In the [REDACTED] financial commitment material, there is a breakdown of the uncovered services on page 6, referenced as “B Unlicensed Group Home Settings Non-Medicaid/SSI covered services. Additionally, Page 6 also includes a description of the amount that families are required to pay towards these costs.” “**These are real costs, and must be met in order for the home to remain available for residents. In sum, SSI and Medicaid do not cover many costs in a transitional home, such as the Berlin home. Therefore, all prospective residents and/or their families are required to sign an agreement regarding support obligations are tied into family’s ability to pay, and – as most families are not in a position to pay for the actual costs of such care—the majority of the expenses of the Berlin home in fact are covered by [REDACTED] fundraising from the community. In the instant case, (W#1) refused to sign the financial support agreement. She was within her rights to do so, but I believe that so was [REDACTED] within its rights in refusing to place her son without a signed agreement. All other residents in the home with living parents or with trusts have signed agreements. [REDACTED] cannot credibly go out to the community and ask the community to support (the consumer) if his own family will not do so. As the financial commitment form indicates, the family support that is requested is based on income, is subject to review, and is kept in confidence. If (W#1) was unable to contribute towards her son’s care, as determined under the financial determination process, then a reduced family contribution would have been sought. However, she (W#1) indicated she was financially able to pay the fee and did not request an adjustment.”**

10. Did this result in a delay/denial of services identified in the IPOS? YES.

- a. Testimony from W#1, S#1, S#2, S#5 and S#6 all stated that [REDACTED] accepted the consumer. Also S#6 indicated that not only did [REDACTED] accept the consumer, but had a move in date of 4-22-06.
- b. In review of an e-mail sent to W#1 from S#2 dated 4-6-06 it clearly states that the issue of the additional fees were “**required and was non negotiable**” and that if “**the family chooses not to sign the agreement, the [REDACTED] can choose not to accept the consumer.**”
- c. W#1 declined from signing the Licensed or Transitional Home Fee Agreement/contract. As a result, the consumer was not placed at Berlin Home.

11. If so, did this constitute a violation of the recipient’s right to receive Treatment Suited to Condition? YES.

Pursuant to the evidence presented above in issue questions #8, #9 and #10 There was a preponderance of evidence to support the allegation that by [REDACTED] refusing to provide services as a result of W#1 refusing to sign the agreement was a denial of all services

including the services that were agreed upon between [REDACTED] and [REDACTED], which results in a violation of the consumer's right to receive Treatment Suited to Condition.

12. Did [REDACTED] fail obtain a release of information form from the consumer, thus violating the consumer's right to confidentiality? NO.

- a. W#1 stated that she has power of attorney and can make decisions for treatment and placement. W#1 has been a part of the consumer's person-centered planning process and has participated in the consumer's treatment planning meetings. Also the consumer identifies W#1 in the IPOS as a person who he wants to be a part of the person-centered process.
- b. S#6 stated that W#1 is the consumer's power of attorney and can make treatment and placement decisions pursuant to the parameters within the power of attorney. S#6 also stated that W#1 is a participant in the consumer's person-centered planning process and has worked within the planning process to obtain placement including placement through [REDACTED].

In conclusion, it was determined that in this investigation that [REDACTED] did not accept the recipient for residential placement due to W#1 refusing to sign the agreement. It was established that the consumer is a Medicaid recipient as well as a recipient of mental health services. The "additional services" that [REDACTED] provides should have been based on the **consumer's ability to pay**, which is \$0.00 and **not the family's ability to pay** because they are mental health services covered by Chapter 8 in the Mental Health Code or services for which consent is required as a condition for receiving the services identified in the recipient's IPOS. Some or all of the "additional services" are Medicaid covered services for which Medicaid payment must be accepted by the Provider ([REDACTED]) as "payment in full." Medicaid prohibits a provider from billing recipients for the difference between what the Medicaid program pays for a service and the charges a provider would bill for services. This is clearly cited in the Medicaid Provider Manual, **section 12 under "Reimbursement-Payment in Full"** dated 7-1-2006.

* In this case, it was discovered that [REDACTED] does require additional funding, which is the sole responsibility of the family (even after death of the family member), for additional services that would have been provided if the consumer would have moved into the Berlin Home. In review of the consumer's IPOS, there were goals identified in the IPOS that would relate to the "additional non Medicaid" services that [REDACTED] provides. Communication sent on 4-6-2006 by a [REDACTED] employee/representative to W#1 indicating that the additional fees for the additional services "were required" and that the issue was "non negotiable." The communication explicitly stated that "if a family chooses not to agree and sign the form, then [REDACTED] can choose not to accept the person at [REDACTED]" [REDACTED]'s position, based on the communication, is that the admission process applies to "everyone" who is interested in [REDACTED]'s services. This would be inclusive of any [REDACTED] consumer receiving [REDACTED] / public funding and who is a Medicaid recipient. The e-mail communication urged W#1 to sign the agreement so that the consumer can move into the home. The communication states that if W#1 cannot afford the fee then

W#1 can request a "financial re-determination", which is done through [REDACTED]'s re-determination process, which violates provisions of Chapter 8 of the Mental Health Code.

An e-mailed, written response received 7-31-06 from [REDACTED]'s legal counsel stated, "These are real costs, and must be met in order for the home to remain available for residents. In sum, SSI and Medicaid do not cover many costs in a transitional home, such as the Berlin home. Therefore, all prospective residents and/or their families are required to sign an agreement regarding support obligations are tied into family's ability to pay, and – as most families are not in a position to pay for the actual costs of such care—the majority of the expenses of the Berlin home in fact are covered by [REDACTED] fundraising from the community. In the instant case, (W#1) refused to sign the financial support agreement. She was within her rights to do so, but I believe that so was [REDACTED] within its rights in refusing to place her son without a signed agreement. All other residents in the home with living parents or with trusts have signed agreements. [REDACTED] cannot credibly go out to the community and ask the community to support (the consumer) if his own family will not do so."

The [REDACTED] Family Financial Commitment Q&A form appears to lead to the conclusion that the each family must make a financial commitment for services. According to the [REDACTED] Family Financial Commitment Q&A packet states, "Services that have a fee where MORC is providing comprehensive funding are a voluntary contribution." This leads the reader to think that the fees are voluntary. The Q&A is very specific and states that [REDACTED] expects that every family will make a voluntary contribution followed up by saying that the families have to make an effort to contribute first before approaching other contributors. If a family member agrees to the terms of not only the Resident Care Agreement, but with the terms of the [REDACTED] Family Financial Commitment Q&A form, then they sign an agreement/Contract. This contract legally binds the family member to the terms of the [REDACTED] Family Financial Commitment Q&A form, which states that the fees for the specific services where [REDACTED] is providing funding is a voluntary commitment. It appears as if the family has to commit and sign a legally binding contract to make a voluntary commitment to [REDACTED] which is not negotiable.

The end result was that the consumer did not move into the Berlin Home pursuant to W#1 not agreeing to sign the agreement/Contract.

The claim by [REDACTED] that the financial contributions are "voluntary donations" from an individual (the consumer's mother) who is not a Medicaid recipient is not persuasive since the receipt of services are contingent on signing a legally binding contract to make the donations during the life of the recipient. [REDACTED]'s assertion that they are not requiring additional payments for Medicaid covered services because the payments are a donation is also not persuasive since the donations are a mandatory pre-condition of services. The claim by [REDACTED] that the financial contribution required of the family member is compensation for at least some of the costs for the "additional services," which are not Medicaid covered services is unpersuasive on two counts. First, the recipient may not receive the Medicaid services without the family member also consenting to sign the Licensed or Transitional Home Fee Agreement and agreeing to pay for the "additional services." Secondly, it appears that some of the identified "additional services" are in essence Medicaid covered services

given a slightly different title. Since the consumer is entitled to receive the services authorized in the written IPOS and is not able to receive those services without consenting to the "additional services," then the standards and regulations which apply to the Medicaid and Mental Health services also apply to the "additional services". Thus a refusal to provide any services based on the family member's unwillingness to sign an agreement binding them make a mandatory financial contribution is a denial of Medicaid and mental health services to this consumer. Even if one accepts the argument that the "additional services" are not Medicaid services, it is not permissible for a provider of Medicaid services to require a recipient or family member to consent to receiving the "additional services" as a precondition for the receipt of Medicaid services or mental health code-required mental health services, and then require a financial contribution from the family in addition to Medicaid reimbursement or the recipient's ability to pay as defined in Chapter 8 of the Mental Health Code. Denying Medicaid and mental health services to a consumer because a family member declined to sign the agreement to pay a fee for "additional services" constitutes a discriminatory denial of services to the recipient based on the ability to pay for services. This denial prevented the recipient from receiving services authorized in the IPOS. In turn resulted in a violation of this recipient's right to receive treatment suited to his condition.

V. CONCLUSIONS

1. Therefore, the consumer is a Medicaid recipient.
2. Therefore, [REDACTED] and [REDACTED] did agree upon a per diem fee for Medicaid covered services.
3. Therefore, the additional services are Medicaid covered services.
4. Therefore, the additional services will be the financial responsibility of the family.
5. Therefore, the additional fees are not paid on a voluntary basis.
6. Therefore, the decision is that the additional fees are not based on the consumer's ability to pay.
7. [REDACTED] did inform the consumer's mother prior to signing the contract that if the additional services are not agreed upon then no services would be provided.
8. Therefore, [REDACTED] did discriminate against the recipient by refusing services based on the recipient's /mother's ability to pay.
9. Based on the evidence presented above in issue questions 1-9, the decision is this case, is that there is a preponderance of evidence to substantiate the violation of Civil Rights; Discrimination based on the ability to pay against [REDACTED]
10. Therefore, the decision in this case is that [REDACTED] did deny services identified in the IPOS.

11. Therefore, the decision in this case is that there is a preponderance of evidence to substantiate the violation of Treatment Suited to Condition against [REDACTED].

12. Therefore, the decision in this case is that there is not a preponderance of evidence to substantiate the violation of Confidentiality against [REDACTED].

VI. RECOMMENDATIONS

As this case was substantiated for the violation of Civil Rights: Discrimination: Based on Ability to Pay and Treatment Suited to Condition the [REDACTED] Office of Recipient Rights recommends the following:

1. [REDACTED] immediately stop the practice of requiring the financial agreements described in this report be signed by the family of the consumer as a precondition to receiving services.
2. [REDACTED] immediately terminate any other such existing agreements and take other measures deemed necessary to ensure and document that family members of [REDACTED] / Authority consumers and family members understand that Medicaid and mental health services cannot be conditioned on the agreement of family members to make financial contributions for "additional services" as described in this report.
3. Any future agreements such as the agreement described in this report must receive prior approval from [REDACTED] and the Authority.
4. [REDACTED] should work with this consumer and his mother who has power of attorney to arrange and implement an individualized plan of service including immediate placement in a [REDACTED] residential setting if desired by the consumer and his mother with power of attorney.
5. [REDACTED] take necessary measures to ensure that recommended and necessary remedial actions are implemented and that any future agreements or mechanisms such as or similar to the arrangement described in this report require the prior review and agreement of [REDACTED] and the Authority.

VII. ACTION TAKEN

The following action was taken by [REDACTED]

1. The consumer's mother has declined at this time to further pursue placement with [REDACTED]. The consumer's mother has been informed that the option is open.

2. [REDACTED] will continue to monitor and ensure completion of remedial action by [REDACTED]

The following action was taken by [REDACTED]

1. [REDACTED] is no longer seeking financial agreements from families.
2. [REDACTED] terminated all agreements with the families.
3. As of 8-28-06 [REDACTED] has notified the families impacted.
4. [REDACTED] will be working with the families to clarify voluntary agreements that are in existence.
5. Any and all future agreements will not be implemented without the prior approval from [REDACTED] and [REDACTED].
6. There are no current vacancies available within the [REDACTED] homes; however, [REDACTED] is willing to serve the consumer in an individualized living situation, provided reasonable agreements between the family, [REDACTED] and [REDACTED].

[REDACTED]
Executive Director

Date

[REDACTED]
Office of Recipient Rights
[REDACTED]

10/31/2007

Complaint #: [REDACTED]

[REDACTED]
RE: [REDACTED]

Dear [REDACTED]

Enclosed please find a Report of Investigative Findings on a Complaint received in the Rights Office regarding an issue at your corporation. This Report reflects the investigation completed and the decision of the Rights Office in this matter.

[X] The Rights Office has determined that this complaint **was substantiated for Civil Rights: Discrimination based on Ability to Pay & Treatment Suited to Condition.** Please review the Decision (Part IV) and Recommendation (Part V) sections carefully for issues or recommendations which may be offered by the Rights Office. Appropriate remedial action is required for this violation by the Mental Health Code and by your contract with the [REDACTED] or one of its Core Providers. Appropriate remedial action must meet the following requirements:

1. Corrects or provides a remedy for the rights violations. Disciplinary action for staff must be based upon your written personnel policies.
2. Is implemented in a timely manner.
3. Attempts to prevent a recurrence of the rights violation.

Your remedial action, as required by the report, is expected to be submitted to my attention and to The Office of Recipient Rights no later than the Response Due date. Failure to do so will result in the Rights Office initiating its delinquent remedial action procedures.

RESPONSE DUE: _____

• *The following demographic information on all substantiated perpetrators needs to be included in the written documentation of the Remedial Action: 1) their full legal name, 2) all previous names, 3) their date of birth[Month and Day only] and 4) the last four digits of their social security number.*

[X] The Rights Office has determined that this complaint **was not substantiated for Confidentiality**. Please review the Decision (Part IV) and Recommendation (Part V) sections carefully for issues or recommendations which may be offered by the Rights Office.

If you have any questions, please contact myself or [REDACTED] Director of Rights and Advocacy.

Sincerely,

[REDACTED]

Enclosure: Investigative Findings Report

Cc: [REDACTED]
[REDACTED]

OFFICE OF RECIPIENT RIGHTS

☒ Report of Investigative Findings

☐ Intervention Action Request

☐ Intervention Summary

Complaint #: [REDACTED]

<u>Recipient's Name</u> [REDACTED]	<u>Service Site</u> [REDACTED]	<u>Network Provider</u> [REDACTED]	<u>Core Agency</u> [REDACTED]
<u>Complainant's Name</u> [REDACTED]	<u>Relationship to Recipient</u> [REDACTED]	<u>Violation Category</u> Civil Rights: Discrimination, Ability to pay, Treatment Suited to Condition & Confidentiality	
Substantiated <input checked="" type="checkbox"/> Civil Rights & Treatment Suited to Condition Not Substantiated <input checked="" type="checkbox"/> Confidentiality	<u>Date Received</u> 5/1/2006	<u>Date of Report</u> 8/8/06	Final: <input checked="" type="checkbox"/> Amended: <input type="checkbox"/>

I. ALLEGED RIGHTS VIOLATION

On 5-1-06 the Office of Recipient Rights (ORR) received a written complaint that a consumer was denied residential placement services based on the consumer's mother's refusal to sign [REDACTED]'s Licensed or Transition Home Fee Agreement. The refusal to sign was based on a portion of the agreement which states that [REDACTED] wanted a "voluntary contribution", which would cover the cost of all services that Medicaid and SSI won't cover. The agreement requested \$5000.00 per year. The agreement also stated that [REDACTED] can reassess the requested rate and reserve the right to increase the yearly payments if they so choose by providing the family with a written notice. [REDACTED] negotiated a per diem rate for the living situation and was prepared to authorize funding. This contract rate follows the Medicaid guidelines as "payment in full." Because of this issue, the consumer will not be placed in a group home. It was also alleged that [REDACTED] used the placement of the recipient in the home as leverage to "blackmail" or pressure the recipient's mother into signing the agreement.

During the course of this investigation, it was also discovered that the consumer did not sign a release for any representative from [REDACTED] to speak with the recipient's mother regarding the move to Berlin.

II. CITATIONS

The following legal and regulatory provisions are applicable to this case:

MCL 330.1206(1a-h), "which states "(1a-h) The purpose of a community mental health services

program shall be to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an **individual's ability to pay**. The array of mental health services shall include, at minimum, all of the following: ..."

MCL 330.1208 (4), which states, "**An individual shall not be denied services because an individual who is financially liable is unable to pay for service.**"

MCL 330.1704 (1,2), which states, "**(1)** In addition to the rights, benefits, and privileges guaranteed by other provisions of law, the state constitution of 1963, and the constitution of the United States, a recipient of mental health services shall have the rights guaranteed by this chapter unless otherwise restricted by law." "**(2)** The rights enumerated in this chapter shall not be construed to replace or limit any other rights, benefits, or privileges of a recipient of services..."

MCL 330.1804 (3), which states, "The department or community mental health services program shall waive payment of that part of a charge determined under section **(2) that exceeds financial liability**. The department or community mental health services program shall not impose charges in excess of ability to pay."

ADMIN Rule R330.2067 (1a, d& h), which states, "A [REDACTED] services board shall do all of the following. (a) Ensure that a person is not denied service on the basis of race, color, nationality, religious or political belief, sex, age, handicap, county of residence, or **ability to pay**. This policy shall be stated in the program statements of the community mental health board and in contractual agreements."

"(d) Require agencies which provide services by contract or agreement with the board and which receive state aid to furnish the board with an accounting of fee revenue received from patients or from persons paying on behalf of patients."

ADMIN Rule R330.8008, which states, "Financial liability for services approved for state financial support by the department and provided by the department or community mental health services programs directly or under contract shall be determined pursuant to these rules and stated in the department's and community mental health services programs' written policies and procedures."

MCL 330.1808 (1), which states, "The total combined financial liability of the responsible parties shall not exceed the cost of the services."

MCL 330.1810, which states, "An individual shall not be denied services because of the inability of responsible parties to pay for the services."

An individual is defined as "The individual, minor or adult, who receives services from the department or a [REDACTED] program or from a provider under contract with the department or a [REDACTED] services program."

MCL 330.1817, which states, "For an individual who receives inpatient or residential services on a voluntary or involuntary basis, the department or community mental health services program shall

determine the responsible parties' insurance coverage and **ability to pay** as soon as practical after the individual is admitted."

MCL 330.1828, which states, "The department or community mental health services program shall annually determine the insurance coverage and ability to pay of each individual who continues to receive services and of each additional responsible party, if applicable. The department or community mental health services program shall also complete a new determination of insurance coverage and ability to pay if informed of a significant change in a responsible party's ability to pay."

MCL 330.1842, which states, "The department shall develop and promulgate rules, pursuant to Act. No. 306 of the Public Acts of 1969, as amended, which shall implement the provisions of this chapter. Such rules shall include particularized procedures for determining ability to pay, and such procedures shall be applied uniformly throughout the state."

ADMN Rules, 330.8021, which states, "An individual receiving services, his spouse, or his parent may appeal the amount of financial liability by notifying the director of the facility or county community mental health services board in writing or on a form provided by the department, within 30 days of obtaining a new determination."

ADMN Rules, 330.8239 (2), which states, "A responsible party who has been determined under the medical assistance program or its successor to be **Medicaid eligible shall be deemed to have a \$0.00 ability to pay** from the schedule specified in this rule."

MCL 330.1708 (1), which states, "A recipient shall receive mental health services suited to his or her condition."

MDCH Medicaid Provider Regulations **section 7.4, -Nondiscrimination**, states, "Providers must render covered services to a beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of Medicaid, providers shall not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political beliefs, or source of payment."

MDCH Medicaid Provider Regulations **Section 12 – Reimbursement, section 12.1 - PAYMENT IN FULL**, states "Providers must accept Medicaid's payment as payment in full for services rendered, except when authorized by Medicaid (e.g., co-payments, patient-pay amounts, other cost sharing arrangements authorized by the State). Providers must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so. This policy also applies to payments made by MHPs, CHPs, and PIHPs/CMHSPs/CAs for their Medicaid enrollees. Contractors or nursing facility (including ICF/MR) operators must not seek nor accept additional or supplemental payment beyond the patient-pay or MDCH ability-to-pay amount."

MDCH Medicaid Provider Regulations, **section 13- Targeted case Management**, states, "Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessments, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning

process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.”

MCL 330.1748 (1-6), which states, “ Information in the record of a recipient, and other information acquired in the course of providing mental health services to a recipient, shall be kept confidential and shall not be open to public inspection. The information may be disclosed outside the department, community mental health services program, licensed facility, or contract provider, whichever is the holder of the record, only in the circumstances and under the conditions set forth in this section.

(2) If information made confidential by this section is disclosed, the identity of the individual to whom it pertains shall be protected and shall not be disclosed unless it is germane to the authorized purpose for which disclosure was sought; and, when practicable, no other information shall be disclosed unless it is germane to the authorized purpose for which disclosure was sought.

(4) For case record entries made subsequent to March 28, 1996, information made confidential by this section shall be disclosed to an adult recipient, upon the recipient's request, if the recipient does not have a guardian and has not been adjudicated legally incompetent. The holder of the record shall comply with the adult recipient's request for disclosure as expeditiously as possible but in no event later than the earlier of 30 days after receipt of the request or, if the recipient is receiving treatment from the holder of the record, before the recipient is released from treatment.

(5) Except as otherwise provided in subsection (4), (6), (7), or (9), when requested, information made confidential by this section shall be disclosed only under 1 or more of the following circumstances:

(6) Except as otherwise provided in subsection (4), if consent is obtained from the recipient, the recipient's guardian with authority to consent, the parent with legal custody of a minor recipient, or the court-appointed personal representative or executor of the estate of a deceased recipient, information made confidential by this section may be disclosed to all of the following:

(a) Providers of mental health services to the recipient.

(b) The recipient or his or her guardian or the parent of a minor recipient or any other individual or agency unless in the written judgment of the holder the disclosure would be detrimental to the recipient or others.


III. ISSUES

1. Is the consumer a Medicaid recipient?
2. Did [REDACTED] agree with [REDACTED] to receive Medicaid funding to provide services for the consumer?
3. Are the additional services that would be provided Medicaid covered services?
4. If so, will the family member be charged for these additional services?
5. If so, are these additional services paid on a voluntary basis?

6. Are these additional services based on the consumer's ability to pay?
7. Did [REDACTED] inform the consumer's mother prior to signing the contract that if the additional services are not agreed to then none of the identified services would be provided?
8. Did [REDACTED] discriminate against the recipient by refusing services based on the recipient's /mother's ability to pay?
9. If so, did [REDACTED] refuse to provide services identified in the consumer's Individual Plan of Service (IPOS) based on a family member's choice not to sign the Licensed or Transitional Home Fee Agreement?
10. Did this result in a delay/denial of services identified in the IPOS?
11. If so, did this constitute a violation of the recipient's right to receive Treatment Suited to Condition?
12. Did [REDACTED] obtain a Release of Information from the recipient, which would have allowed JARC to negotiate placement with the parent?

IV. FINDINGS

1. **5-1-06 interviewed the complainant. The facts are as follows.**
 - a. The complainant stated on 5-1-06 that he received a call from [REDACTED] indicating that a consumer was not able to move into a [REDACTED] home because the recipient's mother decided not to sign a contract agreeing to pay a fee for additional services that [REDACTED] provides. The complainant stated that the contract appears as if the additional fees are based on paying on a voluntary basis; however, if this is stated in a contract, then the additional fees are not paid on a voluntary basis. The complainant stated that [REDACTED] is a Medicaid provider and they made an agreement with [REDACTED] for a fee for services and neither the consumer nor any family member should be charged for any other services.
 - b. The complainant was not aware of the procedure for determining the financial contribution for the additional services.
2. **5-4-06 interviewed W#1. The facts are as follows.**
 - a. W#1 stated on 5-4-06 that she decided that she wanted her son to move into a home supervised by [REDACTED]. [REDACTED] and [REDACTED] agreed to a per diem for services that [REDACTED] would provide while the consumer lived at the Berlin Home. She felt that the placement to the Berlin Home would be best for her son. She stated that she knew that she wanted her son to be placed, but was hesitant to tell him anything just in case the placement didn't work out. She stated that people from [REDACTED] encouraged her to allow her son to go to the perspective site and get acquainted with the other consumers and with the staff in the home so that the transition would be easy. W#1 stated that no one from [REDACTED] instructed her that she would need to get a release of information form signed by her son so that [REDACTED] can speak with W#1 about the consumer's placement. W#1

stated that the only thing that anyone from [REDACTED] was concerned with was her signing the Licensed or Transitional Home Fee Agreement. W#1 said that everything was worked out except some issues with transportation, but once those issues were resolved then the move could take place. Approximately two days before the move in date, W#1 had some questions regarding the contract. As a result, W#1 hesitated to sign the contract until the issues were settled. W#1 stated that the end result was [REDACTED] informing W#1 that if she did not chose to sign the contract then [REDACTED] can chose to refuse not to accept her son at [REDACTED]. W#1 reported that this was put in an e-mail and [REDACTED] was quite clear as to what there position was on the matter and that because of that statement, W#1 felt that this was a form of coercion to get her to sign the contract. W#1 reported that she did not have a problem paying the fee for the additional services in fact, she offered to pay more than what was specified; however, she was concerned with the fact that this agreement would be in the contact forever and that she does not have the right to go back and renegotiate the contract and that [REDACTED] can change the fee amount and increase it without W#1 having a say in it so she decided not to sign the contract. W#1 stated that she did not agree with the way [REDACTED] did business with her and she felt as if the whole process was a let down to her and especially to her son who went to the Berlin home, got to know staff and the other consumers and now cannot reside in that home. W#1 was at a loss as to what and when to inform her son that he would not be moving. W#1 also stated that throughout the process S#1 told her that the fee for the additional services was voluntary until W#1 had questions about the financial obligations for the additional services. At that point when the financial issues came up and there were questions about the contract, then there was a problem with accepting the consumer at [REDACTED]. W#1 felt as if her son was being discriminated against because of this situation. W#1 stated that throughout the process [REDACTED] stated to W#1 that the consumer was accepted. Everything was worked out and there was a move in date. Then two days before the consumer was supposed to move in, everything went awry because W#1 did not feel comfortable with the terms of the contract. W#1 stated that she feels that [REDACTED]'s main goal is not the people, but finances and making money. 

- b. W#1 stated that she has power of attorney and can make decisions for treatment and placement. W#1 has been a part of the consumer's person- centered planning process and has participated in the consumer's treatment planning meetings. Also the consumer identifies W#1 as a person who he wants to be a part of the person-centered process.

3. ****This writer did not interview the consumer.**

- a. On 5-4-06 W#1 was very upset and tearful due to the consumer not being placed in the home. W#1 stated during her interviews that she to this date has not told the consumer that he will not be going to the Berlin Home and asked if this writer would not interview the consumer because it may upset him.
- b. Spoke with W#1 again on 7-27-06 and requested that this writer interview the consumer. W#1 again stated that she does not want this writer to interview the consumer because it may upset him.

4. **On 6-5-06 interviewed S#1. The facts are as follows.**

- a. S#1 denied on 6-5-06 that she coerced or blackmailed W#1 into signing the contract.

S#1 also denied that she blackmailed the recipient's mother into thinking that if she did not sign the contract, then the recipient could not live at the Berlin home. S#1 stated that at the point of intake there is a packet provided for the family, which outlines the additional financial obligations for which the family is responsible in regard to some additional services that [REDACTED] provides outside of the Medicaid covered services. S#1 said that these services have to be paid for and [REDACTED] cannot approach outside individuals who donate money without first approaching the family members and having them to commit to paying for the additional services. S#1 said that [REDACTED] is paying for a small number of staffing hours and 36 cents per mile for transportation only for the consumer. The additional services are outlined on the Family Financial Commitment for Residential Services Form as well as an explanation of the family's financial commitment on the [REDACTED]'S Family Financial Commitment question and answer packet. S#1 said that these services are provided and required. They are a package deal and that the consumer or the family member cannot pick and choose what services they receive. S#1 reported that although the cost of the additional services is far more than \$5000.00, it was only an arbitrary figure. If the family is unable to handle that amount then they can appeal (financial re-determination) and request a rate reduction. According to the [REDACTED] **Family Financial Commitment Q&A** the appeal is sent to an "outside Fee Adjustment Consultant" and then there is a financial re-determination done and a new figure is presented. If the family is able to pay that fee then payment arrangements are made based on the re-determined fee. S#1 said that this is the process, which is fairly new, that is used to determine the family's ability to pay. S#1 also stated that the family must also set up an estate plan. All fees will be deducted from the estate. This plan will also cover the consumer's fees upon the family member's death and fees that are incurred up to the date that the consumer passed away or decided to leave the home will be deducted from the estate as well.

- b. S#1 stated that [REDACTED] sends out a letter if the \$5000.00 fee is changed by [REDACTED] in any way throughout the time that the consumer is with [REDACTED]. The family member can go through the appeal process each time. Please note that this appeal process is done through an "Outside Fee Adjustment Consultant" and not through [REDACTED] or the Authority. S#1 stated that the appeal is sent to an outside company and the re-determination or financial reduction is done there. S#1 stated that W#1 was made aware of this all along the way and that the information was included in the packet that she received in the question and answer portion of the packet.
- c. S#1 said that the language that speaks about voluntary contributions deal with something separate. S#1 stated that they also mail out to every family member written information on different types of fundraising that [REDACTED] participates in, which is not related to the additional services that [REDACTED] provides for the consumer in the residential settings. S#1 said that the written information that the families receive via mail is information that [REDACTED] has always sent out ever since [REDACTED] has been in existence and the family can choose not to participate in any fundraising. S#1 reported that the portion related to fundraising is **voluntary**. What is **not voluntary** are the **additional services that [REDACTED] provides for an arbitrary fee of \$5000.00**. S#1 reported that the Home Fee Agreement **only speaks to** the family agreeing to financial obligations to [REDACTED] in payment for services as described in the Family Financial Commitment Question and Answer form. S#1 stated that it does not make a difference whether or not the consumer is covered

through Medicaid or not. The additional services are services that are not covered through Medicaid, but are additional services that [REDACTED] provides. [REDACTED] provides each consumer's family with a packet containing information regarding financial arrangements for licensed homes and unlicensed homes as applicable. Whether the consumer will reside in a licensed home or an unlicensed home, the family must sign the agreement. S#1 stated that the reason why the contract was not signed was because W#1 was agreeable to pay the \$5000.00 fee; however, W#1 was unwilling to enter into a binding contract. W#1 would pay the fee without having it in writing that she will agree to pay the fee. S#1 also stated that W#1 had private insurance and because the consumer would no longer be living in his private home, she wanted [REDACTED] to still have the consumer's address at her home and not the Berlin Home's address. S#1 said that W#1 told her that she would be in charge of the medication pick-up and dealing with the insurance company for all prescriptions. S#1 reported that she was not agreeable to those terms and S#1 told W#1 that [REDACTED] needs to pick-up the medications and work with the physician and with the insurance company regarding any medical issues. S#1 finally stated that she tried to answer all of W#1's concerns, but felt that W#1 was unhappy with the answers. S#1 felt that [REDACTED] was not the place for her son and that according to S#1 she encouraged W#1 to think some more before making a final decision. S#1 said that at the last minute it was W#1 who decided that she did not want to sign the contract. S#1 stated that there are other providers that may be more suitable for W#1 and that she can choose to go to any other provider that she wants. Per S#1, [REDACTED]'s position is that the additional services that they offer the consumer are services that they can offer and they can have a contract asking the family to be committed to paying for these additional services. S#1 said that they have consulted with [REDACTED]'s attorney, who is well versed in Medicaid Law and the Mental Health Code, and he stated that the additional services/fees that [REDACTED] requires are legal. This writer requested the laws and regulations that were referenced when making his decision to be forwarded to this office. Information was provided on 7-31-06, see #20 in the Investigative Findings section.

5. 6-5-06 interviewed S#2. The facts are as follows.

- a. S#2 stated on 6-5-06 that the consumer has been in [REDACTED]'S database system for approximately 9 years. S#2 met with the family at intake. She stated that the fees, programs and services were discussed. S#2 stated that she had been talking with W#1 for a period of two years. W#1 wanted the consumer to be placed in a transitional home and S#2 felt that the consumer was a good candidate. S#2 reported that [REDACTED] agreed to pay for the consumer's Medicaid covered services, but there are additional services that [REDACTED] provides that are not covered through Medicaid. Payments for these additional services are done through an estate plan set up by the family. S#2 stated that W#1 had known about that process for a period of 6-8 months. S#2 stated that this was not something that was discussed until the day that W#1 decided not to sign. S#2 said that from her understanding W#1 did not have a problem with paying the fee for the additional services, but did not like the fact that the agreement would be a binding contract. W#1 would pay the fee, but did not want to commit to it in the Licensed and Transition Home Fee Agreement.

6. 6-9-06 interviewed S#3. The facts are as follows.

- a. S#3 was requested to review information provided too [REDACTED] by [REDACTED] and determine whether or not any provisions of [REDACTED]'s contract with [REDACTED] addressed the "additional services", "additional fees" or the agreement. S#3 stated on 6-9-06 that the contract between [REDACTED] and [REDACTED] do not touch upon the "additional services" or the additional fees that [REDACTED] provides and requires and there are no [REDACTED] policies that address this issue. [REDACTED] does not get involved with any other services outside the realm of Medicaid covered services. [REDACTED] did agree to a per Diem rate for the Medicaid covered services.
7. 7-13-06 interviewed S#4. The facts are as follows.
- a. S#4 stated on 7-13-06 that she reviewed the [REDACTED] Family Financial Commitment Form and the Family Financial Commitment for Residential Services grid/Form and does not agree with what was outlined in the documentation. S#4 stated that the Michigan Mental Health Code and the Administrative Rules are very clear in regards to the consumer's ability to pay. S#4 stated that an individual who is a Medicaid recipient should not be charged above and beyond what has been agreed upon to provide services. In this consumer's case, [REDACTED] and [REDACTED] agreed to a per diem rate to provide services. The consumer's ability to pay is "\$0.00." S#4 stated that in review of the documentation it does not appear as if the fees are voluntary, but mandatory. S#4 stated that it should not be mandatory to pay the additional fee.
8. 7-17-06 interviewed S#5. The facts are as follows.
- a. S#5 reviewed the additional services identified in the Family Financial Commitment for Residential Services Grid/form. S#5 stated that in review of the additional services, some of the services listed, such as Program and enhanced service coordination may be construed as Medicaid covered services. S#5 also stated that some of the services listed are services that could be identified in the consumer's Individual Plan of Service (IPOS). Lastly, S#5 stated that services such as medical and dental service coordination is a service that any Provider agency can provide at a home without charging an additional fee.
9. 7-18-06 interviewed S#6. The facts are as follows.
- a. S#6 reported that she only went to one meeting back in November of 2005 and they only met with the Home Manager from Berlin. S#6 said that there was no discussion about fees because the home manager would not have been privy to that information. S#6 said that they met with the home manager and made arrangements for the consumer to come over and get to know everyone. S#6 said that [REDACTED] encouraged W#1 to allow her son to go over to the home and get to know everyone and even had a move in date set for 4-21-06. S#6 said that at no time did W#1 call her prior to her having questions about the contract and state that she was informed about the additional fees that [REDACTED] requires. S#6 said that she was not made aware that the placement was not approved until W#1 spoke to the complainant and then W#1 called and told S#6. S#6 stated that the explanation that she was given was that [REDACTED] and W#1 just didn't make a good fit and [REDACTED] was not the organization for W#1 and the consumer. Then S#6 was told that it was because W#1 wanted too much control over the consumer's medical needs. S#6

stated that she felt as if "[REDACTED] pulled the rug from up under W#1." S#6 said that "The arrangements were already made and the consumer was ready to move in and not until W#1 had questions concerning the information from the [REDACTED] Family Financial Commitment question and answer packet, then all of a sudden, the consumer could not move into the home." S#6 stated that [REDACTED] has been charging families for these additional services for 25 years. S#6 stated that it is very clear that [REDACTED] is looking at W#1's ability to pay and not the consumer. The consumer's ability to pay is zero (0) and [REDACTED] cannot charge above and beyond the consumer's ability to pay.

- b. S#6 reviewed the additional services that would have been provided if the consumer would have moved into the Berlin Home. **S#6 stated that some of these services are Medicaid billable services as well as services that she, as the case manager, provides.** S#6 stated that this is a Medicaid issue along with some ethical issues as well. S#6 stated that [REDACTED] provides excellent care to all that they serve, but the business end has a lot to be desired. Additionally, S#6 also stated that some of the services can be easily identified on the IPOS. S#6 said that medical/dental coordination is something that she has done and has personally attended doctor's appointments with the consumer. S#6 also stated that every home has the responsibility to make appointments and transport the consumer to their appointments. [REDACTED] and [REDACTED] already agreed to a per diem rate for [REDACTED] staffing and transportation, which would assist the home with the medical and dental coordination services. As far as program and enhanced service coordination, S#6 said that the consumer has a treatment plan that has to be implemented. S#6 asked, "Why would [REDACTED] charge you for something that they have to implement per the IPOS anyway?" Within that treatment plan there are **program goals** that the consumer wants to accomplish such as learning how to cook, clean, work, do certain chores etc. All of this is identified in the consumer's IPOS already, per S#6 so staff, per the IPOS has to implement program services anyway. In regards to enhanced service coordination, if the consumer's condition changes such as changes in the consumer's medical needs, then [REDACTED] **would make the changes** in the IPOS, arrange for a nurse to come to the home and supply any medical equipment needed. S#6 stated that **program and enhanced coordination would be her job to arrange.** The same can be said for therapeutic recreation services, volunteer services and coordination, and going to [REDACTED] S Labes Vacation Home. S#6 reported that this is all inclusive in the consumer's IPOS, which identifies **community inclusion.** Again, [REDACTED] agreed to pay a per diem rate for [REDACTED] staffing, which would include funding staff to accompany the consumer on the activity. In the consumer's IPOS it also talks about the consumer wanting to go out into the community and participate in community activities. S#6 reported again that many of the services are services that she handles as the case manager and are services that every home is supposed to do for the consumer not just as a normal function for staff to do, but also because the services are identified in the consumer's IPOS and those "additional services" have to be implemented anyway. S#6 stated that she could not understand why [REDACTED] is charging for services that she did not consider being "additional service." S#6 also stated that the consumer has never stated to her or to the treatment team that he had a desire to use the internet or wanted to use the computer at all and as far as assistance with income tax filling, S#6 stated that the consumer identifies the need to learn to budget his money. The consumer could also request that he would like to learn how to prepare and file **his own taxes.** Per S#6, "This can easily be identified as an additional goal for the consumer, why should [REDACTED] charge

him for that goal?" S#6 said that she has a list of free places that her consumers can go to have their taxes prepared and filed. S#6 reported that she has referred many of her consumer's to the free tax places within the county. S#6 said that "[REDACTED] does not need to navigate that." S#6 stated that as the case manager, she would assist the consumer with that. Lastly, [REDACTED] states that they will provide public benefits coordination and payeeship services. Again, S#6 clearly stated that she takes care of that function making sure that the Medicaid does not lapse and if the consumer had a payee/guardian, she makes sure that whatever [REDACTED] is supposed to receive from [REDACTED], she makes sure that it gets taken care of. S#6 said that [REDACTED] does not need to charge for this service as well. S#6 said that if things appear to be more costly than anticipated, then [REDACTED] needs to come back to the table with [REDACTED] and re-negotiate the per diem rate, not charge the families and make them responsible for the services out of pocket.

- c. S#6 stated that at no time did any employee/representative from [REDACTED] contact her and request that she obtain a release of information from the consumer before they speak to W#1 about placement. To this staff person's knowledge, the consumer was not included in any meetings or with the negotiation process between W#1 and [REDACTED] at all; however, W#1 is the consumer's power of attorney and can make treatment and placement decisions pursuant to the parameters within the power of attorney. S#6 also stated that W#1 is a participant in the consumer's person-centered planning process and has worked within the planning process to obtain placement including placement through [REDACTED].

10. 7-19-06 interviewed S#7. The facts are as follows.

- a. S#7 stated on that in late January W#1 spoke with S#7 and told her that W#1 was having a meeting with [REDACTED] regarding the additional fees and that [REDACTED] was urging her to sign the agreement/contract. W#1 wanted to know if she had to sign the agreement/contract. S#7 stated that she requested a copy of the documentation from [REDACTED] and let her supervisor review the documentation. S#7 said that her supervisor told her that W#1 did not have to sign the agreement if she chose not to. W#1 was advised of this. S#7 also stated that she contacted the complainant and forwarded over the documentation and asked if what [REDACTED] was doing was appropriate and if W#1 have to sign the agreement/contract. S#7 stated that the complainant advised as well for W#1 not to sign the agreement/contract if she chose not to. S#7 reported that W#1 did not have an issue with paying the \$5000.00, W#1 was concerned with the fact that the **commitment** to pay a fee yearly was placed in an agreement/contract that was not negotiable and W#1 could not go back and renegotiate when needed. W#1 also had an issue with the fact that the fees could be increased with just a written notice. Lastly, W#1 had an issue with the fact that when the estate plan is set up, [REDACTED] wanted W#1 to make [REDACTED] the beneficiary of the estate.
- b. S#7 stated that she had several conversations regarding this issue and S#1 was very adamant about the additional services and the additional fees. S#7 also stated that she told S#1 that [REDACTED] has to look at the consumer's ability to pay and not the family's ability to pay. S#7 said that S#1 told her that they [REDACTED] had consulted their attorney and were advised that the services that [REDACTED] offers are non Medicaid covered services and they can provide the services and charge individuals for those services. S#7 asked

S#1 to help her to explain how the non-Medicaid services were not in fact Medicaid covered services. S#7 stated that S#1 danced all around the question and kept referring to the staffing hours and transportation. S#7 stated that she has spoken to S#1 several times about the per diem rate that [REDACTED] agreed to as payment in full in addition to not charging the consumer above and beyond the ability to pay. S#7 reported that S#1 stood her ground and still insisted that what [REDACTED] provides are services that are not covered through Medicaid and that those services go above and beyond what other providers are offering.

- c. S#7 stated that in review of the Family Financial Commitment Grid/form she could not distinguish between the "non- Medicaid" services and Medicaid services. S#7 said that some of the additional services in "List A expenses" and "List B expenses" are in fact Medicaid covered services in addition to the fact that some of those "additional services" can be done by the case manger as well. S#7 also said that services such as public benefits coordination and payeeship services can be done by the case manager and is also the responsibility of the provider. Lastly, S#7 stated that the additional services are services that staff would have implemented anyway based on this consumer's treatment plan.
- d. S#7 reported that in her conversations with S#1 it was clear that if families do not agree to sign the agreement/contract then [REDACTED] can choose not to accept the consumer.

11. 7-13-06 reviewed the [REDACTED] Medicaid Eligibility Database. The facts are as follows.

- a. according to the database, the consumer is a current Medicaid recipient.

12. 7-7-06 reviewed an e-mail written by S#2 and dated 4-6-06 was sent to W#1. The facts are as follows.

- a. The e-mail dated 4-6-2006 stated that S#2 spoke with S#1 and the decision was final. [REDACTED]'s position was that the budget that [REDACTED] agreed upon is separate from the additional services and fees that [REDACTED] provides. The e-mail states that "I did speak with (S#1) about your question about us accepting someone based on the [REDACTED] budget but then we require an additional fee. The [REDACTED] funding is only part of the equation and we do require the additional funds. It is not negotiable, so if a family chooses not to pay or agree to pay (sign the form) then we can choose not to accept that person at [REDACTED]. I am not sure that there is an easy way to say this (and it sounds worse written) but, we need you to sign the agreement for (C#1) to move into Berlin. It is important that we use the same admission procedure for everyone served at [REDACTED]. We understand that circumstances change and if in the future you can't pay the fee. You can go through a financial re-determination and ask for a reduced rate. I am sorry if there was something I said that misled you or was confusing. We want to serve (C#1); everyone is very excited about his moving in. You can sign the RCA and financial agreement and send it in to me or (S#1)."

13. 7-20-06 reviewed an e-mail communication from S#7 dated 4-25-06. The facts are as follows.

- a. In review of the e-mail communication from S#7 it states that S#7 has had conversations with S#1 about the consumer moving into the Berlin Home despite [REDACTED]'S requirement to have the agreement Contract signed. The e-mail states that S#1 was "quite clear and confident that the consumer is not going in and is ready to proceed with other referrals to that opening." In the e-mail communication S#7 spoke with S#1 about the Medicaid funding that [REDACTED] agreed to accept from [REDACTED] as "paid in full". S#1's response was that [REDACTED] will accept the funding as paid in full for the staffing hours and transportation/mileage; however, [REDACTED] is offering the "deluxe package with many extras that are not funded through Medicaid. S#7 asked S#1 what where the extras that [REDACTED] provides, S#1 went back to the 24 staffing hours and the additional transportation several times. S#7 stated to S#1 that she was having "difficulty discriminating between the extras and Medicaid covered services." Lastly, the e-mail states that in S#7's opinion S#1 feels that because the Berlin Home is an unlicensed home then the rules do not apply.

14. 7-18-06 reviewed the consumer's current IPOS. The facts are as follows.

- a. In review of the IPOS on 7-18-06 it identifies goals, which can be related to many of the "additional services" that [REDACTED] provides and charges separately for. They are as follows:

***Please note that according to S#1, the consumer cannot choose which service from "List A" or "List B" that they want to pay for. When a consumer moves into a Licensed Group Home, they must accept the entire "List A" package. If a consumer moves into an Unlicensed Group Home then they must accept the entire "List B" package. This is whether or not the consumer wishes to participate or whether or not these services are identified in the IPOS. The consumer would have had the "List B" package because the Berlin Home is a SIP home.**

-Religious services and coordination- The IPOS states that the consumer "does not attend church on a regular basis." [REDACTED] provides "Religious services and coordination. There was nothing in the IPOS that stated that the consumer would like to go to church more and would need assistance with getting linked with church services; however, the "List B" package for Unlicensed Group Home Setting dictates that the **required additional fees** includes an additional service for religious service and coordination.

-Therapeutic recreation services, volunteer services/coordination, going to [REDACTED]'s Labes Vacation Home, caregivers food and activity expense- The IPOS states that the consumer **wants to participate in community activities** such as the "Special Olympics, bowling, social dances, dinner outings, and other community events of interest." The IPOS also specifically states, "(C#1) must be **closely supervised** in the community due to his lack of safety skills and cognitive skills." Staff has to be present with the consumer while he is out in the community, so part of the per diem rate that [REDACTED] agreed to from [REDACTED] would include covering any expense for the direct care giver & materials. *** S#6 stated in the above interview that if the per diem rate is not enough to cover, then [REDACTED] can re-negotiate with [REDACTED] for an increased per diem rate.**

-Public benefits coordination and payeeship services- According to the IPOS, S#6 takes care of the public benefits/ payeeship coordination portion. The IPOS states that S#6 works with the consumer, W#1 and the consumer's DHS worker to keep current with the consumer's benefits.

-Program/enhanced service coordination- The IPOS states that the consumer wants to learn how to cook, clean, work, budget his money (he has a job), etc. These are things that staff would have to coordinate pursuant to the IPOS in concert with the consumer and assist the consumer with implementing the program goals set fourth for the benefit of the consumer.

-Medical/dental service coordination- Per the IPOS, it specifically states that the consumer has "access to a private physician in the community with assistance from his **mother for ALL his medical needs.**" Also please note that both W#1 and S#6 stated that they are very involved with the "coordination" of the consumer's medical and dental services.

-Internet service, Computer services/support & Income tax filing- There is no mention in the consumer's IPOS that would indicate that he has interest in using the computer/ internet services or learning how to use the computer/internet services. The IPOS states that the consumer wants to learn how to budget his money. Even though the IPOS does not mention the desire to learn how to prepare and file taxes, this would be something that can easily be identified in the IPOS as a goal.

15. 7-7-06 reviewed the agreement Contract. The facts are as follows.

- a. The agreement states that it is an agreement between [REDACTED] and the family member of the person who is receiving services. **The agreement outlines the families "financial obligations to [REDACTED] in payment for services as described in the Question & Answer packet about [REDACTED]'s Family Financial Commitment.** The contract leaves room for the fee amount and check boxes as to whether the family will pay annually, semi-annually or quarterly. Rates are subject to change on an annual basis with a 30 day notice of that change. Will and trust provisions are required for payment of services (additional services) after death of the family member, via amenities trust acceptable to [REDACTED]. Evidence of trust arrangements is required within 45 days of placement. [REDACTED] may request additional information on trust arrangements at any time. The contract/agreement does not specifically state that if the fees are not agreed upon, then [REDACTED] reserves the right to refuse placement for the consumer.

16. 7-7-06 reviewed the Question & Answer [REDACTED] Family Financial Commitment packet. The facts are as follows.

- a. In review of the Q&A packet it states the following:
 - (1) "The long term needs of the consumer that [REDACTED] serves cannot be met solely by the

community or public funding process. Each family served by [REDACTED] makes a family financial commitment toward the cost of providing the highest service quality services." The Q&A goes on to state that "The Family Financial Commitment helps defray the cost of services and other expenses which [REDACTED] provides that are not funded by SSI or Medicaid. These services may differ based on a person's living situation. They provide a quality of life and quality of care far exceeding the basic services covered by SSI or Medicaid. As such, your **Family Financial Commitment is critical to ensure that [REDACTED] can continue to provide the high level of service you wish for your family member.**"

(2) The Q&A goes on to state that "Each family served by [REDACTED] makes a Family Financial Commitment toward the cost of providing the highest quality services. **In some cases, this commitment is a fee for specific services. In other cases, where [REDACTED] is providing comprehensive funding, the commitment is a voluntary contribution.** Some times, it is a combination of the two. Voluntary contributions will be discussed with families annually, and [REDACTED] **expects that each family will make the most generous commitment possible. It would be improper for [REDACTED] to seek support from the community without first ensuring that all families are participating to the very best of their ability.**"

(3) The Q&A states that families are required to pay out of pocket for services such as occupational therapy, physical therapy, speech therapy etc. that are not covered through their insurance. If the family cannot afford the additional fees for services not covered then they can request a fee adjustment. The Executive Director of [REDACTED] is contacted for an application. Then the family has to set up an appointment directly with the Fee Adjustment Consultant. Prior to meeting with the consultant, the application has to be fully completed and submitted to the consultant. The family member has to then bring to the meeting the completed copy of the application, which was already submitted to the consultant prior to the meeting. The family member also has to have documentation which reflects two years of 1040 federal tax returns with W-2's and/or 1099 tax forms, dividend and/or interest income statements, a copy of income tax returns for any trusts, a copy of the most recent pay stub. Additional documentation may be required depending on the situation. The consultant will review all of the documentation and take into account any special circumstances and determine an appropriate fee. The new fee can be appealed in writing. An independent appeal committee will review the appeal. **The decision from the Appeal Committee is final.** If the family member who do not agree to pay the full fee nor wish to provide sufficient financial information for a fee adjustment may designate an acceptable third party who agrees formally to pay the full fee amount. If the third party person agrees to pay, then a fee adjustment is done; however, the third party person will not be entitled to request a fee adjustment. This is because the third party person will be acting in a capacity similar to an absolute guarantor of the payments. **The fee adjustment process relates only to the family member's ability to pay and not the third party person.**

(4) An amenities trust shall be established for the benefit of the consumer and funded with a principal amount adequate to fund the present fee with adequate adjustments for future fees. This trust is created for the benefit of a person with a disability and exists along side governmental benefits, particularly SSI and Medicaid, to provide everything other than food and shelter. The trust does not jeopardize public entitlements. The amount required in the trust will be reviewed annually and if necessary will be amended to reflect an **increased projected cost**. An annual certification letter may be required to verify that a proper

amenities trust exists and that sufficient assets are available to fund the trust. Families are advised that additional trust assets will be necessary to provide for other discretionary purchases such as trips, TV's therapy, etc. Upon the death of the resident, the principal will be disbursed as instructed in the trust document.

(5) Estate plan arrangements are required at the time of placement. The Estate plans are to "assure continued, provision of services, a parent's responsibility extends for as long as the adult child is served, not for as long as the parent's are alive." Estate planning is necessary to protect the adult child as well as [REDACTED]'s ability to provide services." "The trust will be billed for Family Financial Commitment fees based on the trust's ability to pay, determined by a mechanism similar to adjustments to current fees. The unpaid portion of fees will accrue as a deferred fee. The deferred fee and any fee deferred accumulated during the parent's lifetime will accrue and no later than the disabled individual's death, be paid from the trust assets. After the reimbursement is made to [REDACTED], the remainder of the trust assets will be distributed as required by the trust document (to family, [REDACTED] or whomever.) If the disabled individual leaves [REDACTED]'s care permanently during his/her lifetime, any deferred balance will be a claim against the estate of the last surviving parent and the amenities trust for the child."

17. 7-7-06 reviewed the Family Financial Commitment for Residential Services Grid/Form. The facts are as follows.

- a. In review of the Family Financial Commitment for Residential Services Grid/Form. Please note that the grid/form at the top of the page states, **"The fees are over and above the ability to pay assessed to the individual receiving services."**
- b. The grid/form states the following: (1) **Licensed Group Home when [REDACTED] funds staffing and transportation only.** (BOX #2) states, "\$5000.00 fee per year for List "A" expenses (plus voluntary contribution). List "A" expenses are religious services and coordination, therapeutic recreation services, volunteer services and coordination, computer services and support, internet service, Labes vacation home, public benefits coordination and payee ship services, income tax filing, program and enhanced services coordination medical and dental services coordination, caregiver activity expense and activity materials. **These services are a package deal and consumers nor can their family members pick and choose which services they choose to partake in.** The entire package must be accepted. (2) **Unlicencensed Group Home Setting, (BOX #2)** states, \$5000.00 fee per year for List B expenses (plus voluntary contribution). List "B" expenses cover the same services as List "A" with additional services such as, "Non-food grocery items, Insurance, Furnishings and equipment Repairs/maintenance, Lawn/snow removal, Basic telephone service, Vehicle expense, Caregiver food and activity expense, and Activity materials."
- c. If there is **NO [REDACTED] funding** in the **licensed home** then the family is committed to paying out of pocket \$5000.00 fee per year for staffing if required beyond basic supervision; and \$5000.00 fee per year for List "A" expenses. For an **unlicensed home** is \$5000.00 fee per year for staffing; and \$5000.00 fee per year for List "B" expenses.

18. 7-7-06 reviewed the [REDACTED] contract. The facts are as follows.

- a. In review of the [REDACTED] contract agreement, there are no provisions, limitations or stipulations regarding the additional services that [REDACTED] provides outside of the Medicaid covered services. [REDACTED] does not have any contract anything regarding fundraisers as well. [REDACTED]'s concern is with the Medicaid covered services. The contract does not have provisions that state that [REDACTED] must abide by state and federal law and accepting Medicaid reimbursement is considered to be "payment in full."

19. 7-27-07 reviewed the Medicaid Provider Manual. The facts are as follows.

- a. Reviewed the Medicaid Provider Manual on 7-30-06. According to the Medicaid Provider Manual dated July 1, 2006 pg. 12, section 7.4, -Nondiscrimination-, states, "Providers must render covered services to a beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of Medicaid, providers shall not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political beliefs, or source of payment."
- b. According to the Medicaid Provider Manual dated July 1, 2005 and July 1, 2006 Section 12 - Reimbursement, section 12.1 - PAYMENT IN FULL, states "Providers must accept Medicaid's payment as payment in full for services rendered, except when authorized by Medicaid (e.g., co-payments, patient-pay amounts, other cost sharing arrangements authorized by the State). Providers must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so. This policy also applies to payments made by MHPs, CHPs, and PIHPs/CMHSPs/CAs for their Medicaid enrollees. Contractors or nursing facility (including ICF/MR) operators must not seek nor accept additional or supplemental payment beyond the patient-pay or MDCH ability-to-pay amount."
- c. According to the Medicaid Provider Manual dated April 1, 2006, section 13- Targeted case Management, states, "Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessments, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes."

20. 7-31-06 reviewed written response dated 7-31-06 from W#2, [REDACTED]'s legal counsel, which was e-mailed to this writer. The facts are as follows.

- a. In review of an e-mail response from W#2 ([REDACTED]'s attorney) regarding JARC's legal position pursuant to this investigation states that "The Berlin Home is an unlicensed home and is under no direct contract with [REDACTED] and [REDACTED] nor Medicaid dollars pay for the operation of the home itself." "The costs of operating the Berlin home are considerable. [REDACTED]s or Medicaid's payment of some staff time, and for

certain transportation reimbursement, does not cover all the expenses of housing, meals, recreation, education, entertainment, or such services and supports as home management, insurance, advocacy and the like. Nor does SSI payment." "In the [REDACTED] financial commitment material, there is a breakdown of the uncovered services on page 6, referenced as "B Unlicensed Group Home Settings Non-Medicaid/SSI covered services. Additionally, Page 6 also includes a description of the amount that families are required to pay towards these costs." "These are real costs, and must be met in order for the home to remain available for residents. In sum, SSI and Medicaid do not cover many costs in a transitional home, such as the Berlin home. Therefore, all prospective residents and/or their families are required to sign an agreement regarding support obligations are tied into family's ability to pay, and – as most families are not in a position to pay for the actual costs of such care—the majority of the expenses of the Berlin home in fact are covered by [REDACTED] fundraising from the community. In the instant case, (W#1) refused to sign the financial support agreement. She was within her rights to do so, but I believe that so was [REDACTED] within its rights in refusing to place her son without a signed agreement. All other residents in the home with living parents or with trusts have signed agreements. [REDACTED] cannot credibly go out to the community and ask the community to support (the consumer) if his own family will not do so. As the financial commitment form indicates, the family support that is requested is based on income, is subject to review, and is kept in confidence. If (W#1) was unable to contribute towards her son's care, as determined under the financial determination process, then a reduced family contribution would have been sought. However, she (W#1) indicated she was financially able to pay the fee and did not request an adjustment." Received the original copy of the e-mail correspondence on 8-1-06.

V. CONCLUSIONS

1. Is the consumer a Medicaid recipient? YES.

According to the [REDACTED] Eligibility Database, it confirms that the consumer is currently a Medicaid recipient.

Therefore, the consumer is a Medicaid recipient.

2. Did [REDACTED] agree with [REDACTED] to receive Medicaid funding to provide services for the consumer? YES.

- a. The complainant, W#1, S#1, S#5, S#6 & S#7 all stated that [REDACTED] and [REDACTED] agreed to a per diem rate to cover 24 hour staffing and transportation.

Therefore, [REDACTED] and [REDACTED] did agree upon a per diem fee for Medicaid

covered services.

3. Are the additional services that would be provided Medicaid covered services? YES.

- a. In review of the [REDACTED] Family Financial Commitment form and grid it states that such additional services are services that are non-Medicaid services or not funded through SSI. The services and expenses which [REDACTED] provides that are not funded through SSI or Medicaid help to defray the costs of these additional services.
- b. An interview with S#5 on 7-17-06 revealed that in her review of the non-Medicaid covered services listed on the [REDACTED] Family Financial Commitment Form/Grid on the surface are worded to appear to be non-Medicaid services; however, in S#5's opinion, some of the services could be construed as actually Medicaid covered services.
- c. An interview with S#6 revealed that many of the additional services are Medicaid billable services and are services that can easily be identified in the consumer's IPOS. Also, S#6 stated that some of the "additional services" are services that the Provider must implement anyway. Also the "additional services are services that S#5 implements as well. Services authorized in the consumer's plan of service are required to be provided.
- d. In review of the Medicaid Provider Manual dated April 1, 2006, section 13- **Targeted case Management**, on 7-30-06 it states, "**Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessments, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process.** Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes."
- e. In an interview with S#7 she stated that she had several conversations with S#1 in regards to the consumer's placement despite the fact that [REDACTED] has a procedure which dictates that one must sign a contract agreement prior to placement. S#7 said that she reviewed the additional services that [REDACTED] offers and charges for. In S#7's opinion, she said that she feels that some of the additional services are Medicaid covered services and feels that the services can be implemented based on the consumer's IPOS without charging extra.
- f. In review of the consumer's IPOS, it revealed that many of the goals and wishes of the consumer, which were identified on the IPOS, would encompass utilizing the "non-Medicaid services" that [REDACTED] provides. This would indicate that if there are goals in the IPOS that relate to the "non-Medicaid services" that [REDACTED] provides, the caregiver has no choice but to implement what is identified in the IPOS without an additional charge. Also the financial agreement between [REDACTED] and [REDACTED] for the per diem rate would cover those non-Medicaid

services.

Therefore, the additional services are Medicaid covered services.

4. If so, will the family member be charged for these additional services? YES.

- a. W#1 stated that she had questions regarding some points in the family financial commitment contract/agreement. W#1 stated that the additional fees pertain to the additional services that [REDACTED] provides to those who live in licensed homes. W#1 stated that she did not have an issue with paying the additional fee, but had reservation about having this in the contract/agreement as a life long binding requirement. W#1 asked if that could not be placed in the contract and [REDACTED] was unwilling to do so. The decision was made not to sign the contract/agreement. W#1 stated that [REDACTED] encouraged her to have the consumer get to know everyone at the Berlin home only to have the consumer not be placed there in the end.
- b. S#1 stated that the additional services are non Medicaid/SSI services that [REDACTED] offers and that the fees incurred from the additional services are legal. S#1 stated that they have to approach the family first and have them to agree to pay for the additional services.
- c. In review of the [REDACTED] contract it does not address the issue of the additional services and fees that [REDACTED] claims are not Medicaid covered services nor does the [REDACTED] contract state that Medicaid reimbursement that a Provider accepts will be accepted as "payment in full" for services identified in the IPOS. The contract only covers responsibilities the provider has in regard to Medicaid covered services. There were no other additional documents or policies that addressed [REDACTED]'s position to the additional services and fees for the "additional services". There is no direct language in the contract between [REDACTED] and [REDACTED] that states that providing / charging for these additional services is prohibited.
- d. S#7 stated that S#1 was very clear that the additional services were non Medicaid and is not covered so anyone who wants to live in one of [REDACTED]'s homes will be charged.
- e. In review of an e-mail communication to W#1 dated 4-6-06 it clearly stated that the additional funds were "required" and that the issue was "non negotiable."

Therefore, the additional services will be the financial responsibility of the family.

5. If so, are these additional services paid on a voluntary basis? NO.

- a. The complainant stated that the family is being charged for services that [REDACTED] provides; however, the [REDACTED] Family Financial Commitment question & Answer packet leads the reader to think that the additional costs would be paid on a voluntary basis.
- b. W#1 stated that the additional fees were fees for the additional services and that [REDACTED] does expect for the family to pay the additional fees. W#1 also stated that from the beginning she

was put under the impression that paying the additional fees was voluntary. It was not until W#1 had reservations about the contract, that at that point [REDACTED]'s position was that the fees were required.

- c. In review of the Family Financial Commitment Question and Answer form (Q&A Form) it states "Each family served by [REDACTED] makes a Family Financial Commitment toward the cost of providing the highest quality services. In some cases, this commitment is a fee for specific services. In other cases, where [REDACTED] is providing comprehensive funding, the commitment is a voluntary contribution. Some times, it is a combination of the two. Voluntary contributions will be discussed with families annually, and [REDACTED] expects that each family will make the most generous commitment possible. It would be improper for [REDACTED] to seek support from the community without first ensuring that all families are participating to the very best of their ability."
- d. S#1 stated that the portion in the Q&A form speak to the mailings that are sent out to all of the families giving information on other fundraisers that [REDACTED] participates in. These fundraisers are not related to the additional services that are provided. The family can or cannot choose to participate in [REDACTED]'s fundraising activities, but the additional fees are not voluntary and have to be agreed upon.
- e. In review of the [REDACTED] The agreement/Contract, it specifically states, "This agreement outlines the parents joint and several financial obligations to [REDACTED] in payment for services as described in the Residential Care Agreement and as explained in the Questions & Answers about [REDACTED]'S Family Financial Commitment, which states that in some cases where [REDACTED] is providing comprehensive funding, the commitment is a voluntary contribution.
- f. S#3 stated that, the contract between [REDACTED] and [REDACTED] do not touch upon the "additional services" or the additional fees that [REDACTED] provides and requires and there are no [REDACTED] policies that address this issue as well with any of their contracted providers. [REDACTED] does not get involved with any other services outside the realm of Medicaid covered services. [REDACTED] did agree to a per Diem rate for the Medicaid covered services.
- g. In review of an e-mail communication to W#1 from S#2 dated 4-6-06 it specifically stated that the additional fees were required and the issue was non negotiable.
- h. In review of the Family Financial Commitment Form/Grid it shows in this case where [REDACTED] had agreed to pay [REDACTED] for staffing and transportation only, in a licensed group home a \$5000.00 fee per year for "list A" expenses plus a voluntary contribution and the same fee goes for an unlicensed group home as well. Also on this same form states at the top of the page, "These fees are over and above the ability-to-pay assessed to the individual receiving services."

Therefore, the additional fees are not paid on a voluntary basis.

6. Are these additional services based on the consumer's ability to pay? NO.

- a. The complainant was not aware as to how the figure is determined for the additional services or what the procedure is in terms of the ability to pay.
- b. S#1 stated that if the family is unable to handle the \$5000.00 fee then they can request a financial re-determination and ask to have the fees reduced. This, according to S#1, is based on the ability to pay.
- c. In review of the [REDACTED] Medicaid Eligibility database, it conforms that the consumer is a Medicaid Recipient. The consumer's ability to pay is \$0.00.
- d. In review of the Family Financial Commitment Q&A form it appears that the financial commitment is done based on the families ability to pay and not the consumer. The Q&A also outlines [REDACTED]'s own process for financial re-determination, and does not use [REDACTED]'s process for financial re-determination. Please note that [REDACTED]'s procedure for a financial re determination is based on the family's (W#1) ability to pay and the consumer's ability to pay.
- e. S#4, S#5, S#6 and S#7 all stated that the consumer's ability to pay is \$0.00 and that when an individual is receiving public funding the consumer's ability to pay is zero. The consumer cannot be charged above and beyond his/her ability to pay. All four staff also stated that [REDACTED] does not have the authority to go after the family and obligate them to pay for any additional fees and services that the consumer has not requested.
- f. According to the Medicaid Provider Manual dated July 1, 2005 and July 1, 2006 Section 12 – **Reimbursement, section 12.1 - PAYMENT IN FULL**, states "Providers must accept Medicaid's payment as payment in full for services rendered, except when authorized by Medicaid (e.g., co-payments, patient-pay amounts, other cost sharing arrangements authorized by the State). Providers must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so. This policy also applies to payments made by MHPs, CHPs, and PIHPs/CMHSPs/CAs for their Medicaid enrollees. Contractors or nursing facility (including ICF/MR) operators **must not seek nor accept additional or supplemental payment beyond the patient-pay or MDCH ability-to-pay amount.**"

Therefore, the decision is that the additional fees are not based on the consumer's ability to pay.

7. Did [REDACTED] inform the consumer's mother prior to signing the contract that if the additional services are not agreed to then none of the identified services would be provided? YES.

- a. S#1 denied that W#1 was ever given the impression that if the agreement/contract is not signed then the consumer would not be accepted. S#1 stated that a packet is given upon intake with [REDACTED] and everything including the family's financial responsibilities is explained. S#1 stated that W#1 has known about the additional services and fees for 6-8 months prior to deciding not to sign the contract/agreement.

- b. W#1 stated when she had questions about the fees pursuant to the Family financial commitment Q&A form then there were problems. W#1 stated that she was put under the impression from the beginning that the fees were voluntary. W#1 stated that it was when she had questions and did not want to sign it, and then it was [REDACTED] who decided that they were not the appropriate placement for the consumer and ultimately the consumer was not placed in the home. W#1 said that she was willing to pay the set amount, (\$10,000.00 cash) but did not want it to be iron clad in the agreement/contract. W#1 stated that she feels that S#1 did make her feel "pressured and blackmailed" to feel that if she did not sign the agreement then her son would not be accepted.
- c. In review of an e-mail sent to W#1 from S#2 dated 4-6-06 it clearly states that the issue of the additional fees were "required and was non negotiable" and that if "the family chooses not to sign the agreement, the [REDACTED] can choose not to accept the consumer."

[REDACTED] did inform the consumer's mother prior to signing the contract that if the additional services are not agreed upon then any services would be provided.

8. Did [REDACTED] discriminate against the recipient by refusing services based on the recipient's /mother's ability to pay? YES.

- a. W#1 felt that S#1 made attempts to "blackmail" W#1 into signing the contract/agreement by making her feel as if the consumer would not be placed unless the agreement/contract was signed. W#1 felt that since she did not sign the contract and [REDACTED] did not place the consumer in the Berlin home, her son was discriminated against. W#1 feels that if a parent does not agree and pay for the additional services that [REDACTED] provides, then they have no room for you in their organization. W#1 stated that she was willing to pay \$10,000 dollars as a good faith effort, but was unwilling to sign the agreement. W#1 stated that because she refused to sign the agreement, [REDACTED] decided that her son would not be placed in the Berlin Home.
- b. S#1 denied blackmailing W#1 into signing the contract/agreement. S#1 stated that she explained that this was what [REDACTED] has been doing and is the same procedure for everyone. S#1 stated that [REDACTED] does not make special provisions in the agreement for individuals. S#1 stated to W#1 that she had choices and that W#1 could choose not to go with [REDACTED] if she wanted, but denied using the fact that they would not accept the consumer because W#1 refused to sign the agreement as a way to blackmail W#1 into signing the contract/agreement.
- c. Prior to the move in date of 4-21-06, an e-mail communication was sent to W#1 from S#2 on 4-6-06. The e-mail communication clearly stated that if a family chooses not to agree, sign the contract, the [REDACTED] can choose not to accept that individual. The e-mail communication goes on the state, "We do need you to sign the agreement for (C#1) to move into Berlin."
- d. In review of the Family Financial Commitment Q&A form makes statements such as, "Your Family Financial Commitment is critical to ensure that [REDACTED] can continue to provide the high level of service you wish for your family member." And "Voluntary contributions will be discussed with families annually, and [REDACTED] expects that each family will make the most

generous commitment possible. It would be improper for [REDACTED] to seek support from the community without first ensuring that all families are participating to the very best of their ability."

- e. Pursuant to "b" in issue question #8 above, the e-mail communication from S#2 to W#1 clearly states that if W#1 does not sign the agreement, then her son will not be accepted at [REDACTED]
- f. Pursuant to "c" in issue question #8 above, the e-mail response from W#2 clearly states that if W#1 did not sign the agreement, then [REDACTED] was well within their rights to refuse their services.
- g. Lastly, the end result is that W#1 refused to agree to the [REDACTED] contract and as a result, the consumer was not placed in the Berlin Home to date.

Therefore, [REDACTED] did discriminate against the recipient by refusing services based on the recipient's /mother's ability to pay.

9. If so, did [REDACTED] refuse to provide services identified in the consumer's Individual Plan of Service (IPOS) based on a family member's choice not to sign the Licensed or Transitional Home Fee Agreement? YES.

- a. According to the Medicaid Provider Manual on July 1, 2006 pg. 12, section 7.4,- Nondiscrimination, states, "Providers must render covered services to a beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of Medicaid, providers shall not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political beliefs, or source of payment."
- b. In review of an e-mail sent to W#1 from S#2 dated 4-6-06 it clearly states that the issue of the additional fees were "required and was non negotiable" and that if "the family chooses not to sign the agreement, the [REDACTED] can choose not to accept the consumer."
- c. In review of an e-mail response from W#2 ([REDACTED]'s legal counsel) regarding [REDACTED]'s legal position pursuant to this investigation states that " **The Berlin Home is an unlicensed home and is under no direct contract with [REDACTED] and [REDACTED] nor Medicaid dollars pay for the operation of the home itself.** " "The costs of operating the Berlin home are considerable. [REDACTED]'s or Medicaid's payment of some staff time, and for certain transportation reimbursement, does not cover all the expenses of housing, meals, recreation, education, entertainment, or such services and supports as home management, insurance, advocacy and the like. Nor does SSI payment." " In the [REDACTED] financial commitment material, there is a breakdown of the uncovered services on page 6, referenced as "B Unlicensed Group Home Settings Non-Medicaid/SSI covered services. Additionally, Page 6 also includes a description of the amount that families are required to pay towards these costs." "**These are real costs, and must be met in order for the home to remain available for residents. In sum, SSI and Medicaid do not cover many costs in a transitional home, such as the Berlin home.** Therefore, all prospective residents and/or their families are required to sign an

agreement regarding support obligations are tied into family's ability to pay, and – as most families are not in a position to pay for the actual costs of such care—the majority of the expenses of the Berlin home in fact are covered by [REDACTED] fundraising from the community. In the instant case, (W#1) refused to sign the financial support agreement. She was within her rights to do so, but I believe that so was [REDACTED] within its rights in refusing to place her son without a signed agreement. All other residents in the home with living parents or with trusts have signed agreements. [REDACTED] cannot credibly go out to the community and ask the community to support (the consumer) if his own family will not do so. As the financial commitment form indicates, the family support that is requested is based on income, is subject to review, and is kept in confidence. If (W#1) was unable to contribute towards her son's care, as determined under the financial determination process, then a reduced family contribution would have been sought. However, she (W#1) indicated she was financially able to pay the fee and did not request an adjustment."

Based on the evidence presented above in issue questions 1-9, the decision is this case, is that there is a preponderance of evidence to substantiate the violation of Civil Rights; Discrimination based on the ability to pay against [REDACTED].

10. Did this result in a delay/denial of services identified in the IPOS? YES.

- a. Testimony from W#1, S#1, S#2, S#5 and S#6 all stated that [REDACTED] accepted the consumer. Also S#6 indicated that not only did [REDACTED] accept the consumer, but had a move in date of 4-22-06.
- b. In review of an e-mail sent to W#1 from S#2 dated 4-6-06 it clearly states that the issue of the additional fees were "required and was non negotiable" and that if "the family chooses not to sign the agreement, the [REDACTED] can choose not to accept the consumer."
- c. W#1 declined from signing the Licensed or Transitional Home Fee Agreement/contract. As a result, the consumer was not placed at Berlin Home.

Therefore, the decision in this case is that [REDACTED] did deny services identified in the IPOS.

11. If so, did this constitute a violation of the recipient's right to receive Treatment Suited to Condition? YES.

Pursuant to the evidence presented above in issue questions #8, #9 and #10 There was a preponderance of evidence to support the allegation that by [REDACTED] refusing to provide services as a result of W#1 refusing to sign the agreement was a denial of all services including the services that were agreed upon between [REDACTED] and [REDACTED], which results in a violation of the consumer's right to receive Treatment Suited to Condition.

Therefore, the decision in this case is that there is a preponderance of evidence to

substantiate the violation of Treatment Suited to Condition against [REDACTED]

12. Did [REDACTED] fail obtain a release of information form from the consumer, thus violating the consumer's right to confidentiality? NO.

- a. W#1 stated that she has power of attorney and can make decisions for treatment and placement. W#1 has been a part of the consumer's person-centered planning process and has participated in the consumer's treatment planning meetings. Also the consumer identifies W#1 in the IPOS as a person who he wants to be a part of the person-centered process.
- b. S#6 stated that W#1 is the consumer's power of attorney and can make treatment and placement decisions pursuant to the parameters within the power of attorney. S#6 also stated that W#1 is a participant in the consumer's person-centered planning process and has worked within the planning process to obtain placement including placement through [REDACTED].

Therefore, the decision in this case is that **there is not** a preponderance of evidence to substantiate the violation of Confidentiality against [REDACTED]

In conclusion, it was determined that in this investigation that [REDACTED] did not accept the recipient for residential placement due to W#1 refusing to sign the agreement. It was established that the consumer is a Medicaid recipient as well as a recipient of mental health services. The "additional services" that [REDACTED] provides should have been based on the **consumer's ability to pay**, which is \$0.00 and **not the family's ability to pay** because they are mental health services covered by Chapter 8 in the Mental Health Code or services for which consent is required as a condition for receiving the services identified in the recipient's IPOS. Some or all of the "additional services" are Medicaid covered services for which Medicaid payment must be accepted by the Provider [REDACTED] as "payment in full." Medicaid prohibits a provider from billing recipients for the difference between what the Medicaid program pays for a service and the charges a provider would bill for services. This is clearly cited in the Medicaid Provider Manual, section 12 under **"Reimbursement- Payment in Full"** dated 7-1-2006.

In this case, it was discovered that [REDACTED] does require additional funding, which is the **sole responsibility** of the family (even after death of the family member), for additional services that would have been provided if the consumer would have moved into the Berlin Home. In review of the consumer's IPOS, there were goals identified in the IPOS that would relate to the "additional non Medicaid" services that [REDACTED] provides. Communication sent on 4-6-2006 by a [REDACTED] employee/representative to W#1 indicating that the additional fees for the additional services **"were required"** and that the issue was **"non negotiable."** The communication explicitly stated that **"if a family chooses not to agree and sign the form, then [REDACTED] can choose not to accept the person at [REDACTED]"** [REDACTED]'s position, based on the communication, is that the **admission process** applies to **"everyone"** who is interested in [REDACTED]'s services. This would be inclusive of any [REDACTED] consumer receiving [REDACTED] public funding and who is a Medicaid recipient. The e-mail communication urged W#1 to sign the agreement so that the consumer can move into the home. The communication states that if W#1 cannot afford the fee then W#1 can request a "financial re-determination", which is done through [REDACTED]'s re-determination process, which

violates provisions of Chapter 8 of the Mental Health Code.

An e-mailed, written response received 7-31-06 from [REDACTED]'s legal counsel stated, "These are real costs, and must be met in order for the home to remain available for residents. In sum, SSI and Medicaid do not cover many costs in a transitional home, such as the Berlin home. Therefore, all prospective residents and/or their families are required to sign an agreement regarding support obligations are tied into family's ability to pay, and – as most families are not in a position to pay for the actual costs of such care—the majority of the expenses of the Berlin home in fact are covered by [REDACTED] fundraising from the community. In the instant case, (W#1) refused to sign the financial support agreement. She was within her rights to do so, but I believe that so was [REDACTED] within its rights in refusing to place her son without a signed agreement. All other residents in the home with living parents or with trusts have signed agreements. [REDACTED] cannot credibly go out to the community and ask the community to support (the consumer) if his own family will not do so."

The [REDACTED] Family Financial Commitment Q&A form appears to lead to the conclusion that the each family **must make a financial commitment for services**. According to the [REDACTED] Family Financial Commitment Q&A packet states, "Services that have a fee where [REDACTED] is providing comprehensive funding are a voluntary contribution." This leads the reader to think that the fees are voluntary. The Q&A is very specific and states that [REDACTED] expects that every family will make a voluntary contribution followed up by saying that the families have to make an effort to contribute first before approaching other contributors. If a family member agrees to the terms of not only the Resident Care Agreement, but with the terms of the [REDACTED] Family Financial Commitment Q&A form, then they sign a The agreement/Contract. This contract legally binds the family member to the terms of the [REDACTED] Family Financial Commitment Q&A form, which states that the fees for the specific services where MORC is providing funding is a voluntary commitment. It appears as if the family has to commit and sign a legally binding contract to make a voluntary commitment to [REDACTED] which is not negotiable.

The end result was that the consumer did not move into the Berlin Home pursuant to W#1 not agreeing to sign the agreement/Contract.

The claim by [REDACTED] that the financial contributions are "voluntary donations" from an individual (the consumer's mother) who is not a Medicaid recipient is not persuasive since the receipt of services are contingent on signing a legally binding contract to make the donations during the life of the recipient. [REDACTED]'s assertion that they are not requiring additional payments for Medicaid covered services because the payments are a donation is also not persuasive since the donations are a mandatory pre-condition of services. The claim by [REDACTED] that the financial contribution required of the family member is compensation for at least some of the costs for the "additional services," which are not Medicaid covered services is unpersuasive on two counts. First, the recipient may not receive the Medicaid services without the family member also consenting to sign the Licensed or Transitional Home Fee Agreement and agreeing to pay for the "additional services." Secondly, it appears that some of the identified "additional services" are in essence Medicaid covered services given a slightly different title. Since the consumer is entitled to receive the services authorized in the written IPOS and is not able to receive those services without consenting to the "additional services," then the standards and regulations which apply to the Medicaid and Mental Health services also apply to the "additional services". Thus a refusal to provide any services based on the family member's unwillingness to sign

an agreement binding them make a mandatory financial contribution is a denial of Medicaid and mental health services to this consumer. Even if one accepts the argument that the "additional services" are not Medicaid services, it is not permissible for a provider of Medicaid services to require a recipient or family member to consent to receiving the "additional services" as a precondition for the receipt of Medicaid services or mental health code-required mental health services, and then require a financial contribution from the family in addition to Medicaid reimbursement or the recipient's ability to pay as defined in Chapter 8 of the Mental Health Code. Denying Medicaid and mental health services to a consumer because a family member declined to sign the agreement to pay a fee for "additional services" constitutes a discriminatory denial of services to the recipient based on the ability to pay for services. This denial prevented the recipient from receiving services authorized in the IPOS. In turn resulted in a violation of this recipient's right to receive treatment suited to his condition.

VI. RECOMMENDATIONS

MCL 330.1722 states, "(2) The department, each community mental health services program, each licensed hospital, and each service provider under contract with the department, community mental health services program, or licensed hospital, shall ensure that appropriate disciplinary action is taken against those who have engaged in abuse or neglect. (3) A recipient of mental health services who is abused or neglected has a right to pursue injunctive and other appropriate civil relief."

MCL 330.1780 states, "(1) If it has been determined through investigation that a right has been violated, the respondent shall take appropriate remedial action that meets all of the following requirements: (a) Corrects or provides a remedy for the rights violation. (b) Is implemented in a timely manner. (c) Attempts to prevent a recurrence of the rights violation. (2) The action shall be documented and made part of the record maintained by the office."

As this case was substantiated for the violation of Civil Rights: Discrimination: Based on Ability to Pay and Treatment Suited to Condition the [REDACTED]

[REDACTED] recommends that [REDACTED] review the Family Financial Agreement for compliance with their contract with Authority and their contract with [REDACTED] as well as all other applicable legal and regulatory standards. [REDACTED] should establish appropriate mechanisms in contract or policy to ensure that recipients are not denied services based on their ability to pay and also not denied services suited to their condition as identified in the consumers Individual Plan of Service (IPOS).

ATTACHMENT

SIX

JOINDER AGREEMENT

This is a legal document. You are encouraged to seek independent, professional advice before signing.

The undersigned hereby enrolls in and adopts the Declaration of Trust of Springhill Housing Corporation, a Non-Profit Housing Corporation, dated May 8, 1997, as subsequently amended by Orders of the Macomb County Probate Court dated the 17th day of June, 1998 and the 25th day of October, 1999, which is incorporated herein by reference.

- A. Trust sub-account number: _____
- B. Grantor's name: _____
- C. Grantor's Social Security No.: _____
- D. Address: _____
- E. Telephone: _____
- F. Grantor's birthdate: _____
- G. Relationship to Beneficiary: _____
- H. Beneficiary's name: _____
- I. Beneficiary's Social Security No.: _____
- J. Address: _____
- K. Telephone: _____
- L. Beneficiary's birthdate: _____
- M. If the Beneficiary has a legal representative (e.g., legal guardian, conservator, representative payee, or agent), what is the name, address, and relationship of such person to the Beneficiary:
 - Name: _____
 - Address: _____
 - Relationship: _____

- N. Does Beneficiary receive Supplemental Security Income? _____ If so, how much per month? _____
- O. Does Beneficiary receive Social Security? _____ If so, how much per month? _____
- P. If the Beneficiary receives Medicaid, what is the Medicaid card number? _____
- Q. list all other forms of government assistance that the Beneficiary receives: _____
- R. If the Beneficiary is covered under any policy of health insurance, what is the insurer's name and address, and what is the policy number?
Insurer: _____
Address: _____
Policy No.: _____
- S. Is the Beneficiary covered under any prepaid funeral or burial insurance plan? _____ If so, what is the insurer's name and address, and what is the policy number?
Insurer: _____
Address: _____
Policy No.: _____
- T. What is the nature of the Beneficiary's disability? _____

- U. If the Beneficiary's condition has been medically diagnosed, what is the diagnosis?

- V. What is the prognosis at this time? _____

- W. Distributions upon the Beneficiary's death: If, upon the Beneficiary's death, funds remain in his or her separate Trust sub-account, such funds shall be deemed to be surplus Trust property, such funds shall be _____

retained by the Trust and, in the Trustee's sole discretion, used (a) for the benefit of other Beneficiaries of the Trust, (b) to aide persons who are indigent and disabled, as defined in 42 U.S.C. sec. 1382c(a)(3), or (c) to provide persons who are indigent and disabled, as defined in 42 U.S.C. sec. 1382c(a) (3), with housing or supplemental support services deemed suitable for such persons by the Trustee. To the extent that any amounts remaining in the Beneficiary's account upon the death of the Beneficiary are not retained by the Trust, as required under 42 U.S.C.

1396p(d)(4)(C), or any regulations promulgated thereunder, or the corresponding provisions of any subsequent Federal law, the Trustee shall pay from such remaining amounts in the account to any state an amount equal to the total amount of medical assistance paid on behalf of the Beneficiary under the State's plan under 42 U.S.C. 1396(a) *et seq.*

- X. The Beneficiary specifically directs the Trustee to give priority in expending funds retained in Trust on behalf of any members of the Beneficiary's family who are indigent and disabled as defined in 42 U.S.C. §1382c(a)(3). Further, if there are no family members of the Beneficiary who qualify as disabled then the Trustee shall use the funds retained on behalf of a person with a disability who is indigent, who receives services through (name an agency for the Trustee to work with if you prefer):
-
-

- Y. The Trust sub-account will be administered solely for the benefit of the Beneficiary.
- Z. Any non-support items that are required for maintaining a Beneficiary's health, safety and welfare may be provided for the benefit of the Beneficiary when, in the discretion of the Trustee, such requirements are not being provided by any public agency, or are not otherwise being provided by any other source of income available to that Beneficiary.
- AA. The Grantor recognizes that all distributions are at the Trustee's sole discretion. With this in mind, the Grantor expresses the following desires as to how funds in the Trust sub-account might be used:

1. Specific Supplemental Needs requested for the beneficiary:

2. General Supplemental Needs to be on going:

BB. Additional supplemental needs, including items of a similar nature to those specified above that are specified in an individualized supplemental needs plan established for the Beneficiary and updated from time to time, may be provided if approved by _____ and _____

CC. At any time, the Grantor may, in a non-fiduciary capacity, reacquire the funds in the Grantor's sub-account by substituting other property of an equivalent value. If the Grantor elects to substitute property, the determination of value is to be made by an independent appraiser.

DD. Trustee fees will be charged in accordance with reasonable costs incurred by the Trustee.

EE. Miscellaneous:

1. The provisions of this Joinder Agreement, as entered into on this _____ day of _____, 2007, may be amended as the Grantor and _____ may jointly agree, so long as any such amendment is consistent with the Declaration of Trust, and the then applicable law.

2. Taxes:

- a. The Grantor acknowledges that Springhill Housing Corporation has made no representation to the Grantor that contributions to the Trust are deductible as charitable gifts, or otherwise.

- b. Trust sub-account income, whether paid in cash or distributed in other property, may be taxable to the Beneficiary subject to applicable exemptions and deductions. Professional tax advice is recommended.
 - c. Trust sub-account income may be taxable to the Trust, and when this is the case, such taxes shall be payable from the Trust sub-account.
- 3. If the Grantor intends to enroll more than one Beneficiary under one Trust sub-account, an additional agreement is required between the Grantor and the Trustee.
- 4. The Trust administered by Springhill Housing Corporation is a pooled accounts trust, governed by the laws of the State of Michigan, in conformity with the provisions of 42 U.S.C. § 1396p, amended August 10, 1993, by the Revenue Reconciliation Act of 1993. To the extent there is conflict between the terms of this Trust and the governing law as from time to time amended, the law and regulations shall control.
- 5. Disclosure and Waiver of Potential Conflicts of Interest:
 - a. Individuals executing the Joinder Agreement are aware of the following potential conflicts of interest that are connected with Trustee's administration of the Trust:
 - 1. The Trustee may appoint persons to assist in the carrying out of its Trustee duties who are associated with Springhill Housing Corporation, MORC, Inc., or Community Housing Network such as staff, board members, volunteers, etc. Additionally, Springhill Housing Corporation, MORC, Inc., or Community Housing Network may provide services and supports to individual sub-account Beneficiaries.
 - 2. The Trustee may appoint Patricia E. Kefalas Dudek as its agent to assist in the carrying out of its Trustee duties. Additionally, Patricia E. Kefalas Dudek and other attorneys by and through Hafeli Staran Hallahan Christ & Dudek, P.C. may act as legal counsel for sub-account Grantors and/or Beneficiaries.

3. The Trustee is the remainder beneficiary of the sub-accounts created hereunder.
- b. Any grantor executing a Joinder Agreement to this Trust hereby waives any and all claims against the Trustee on account of self-dealing, the above-listed conflicts of interest, or other conflicts of interest. The Trustee shall not be liable to any party for any self-dealing or conflicts of interest herein disclosed.

IN WITNESS WHEREOF, the undersigned Grantor has reviewed and signed this Joinder Agreement, understands it, and agrees to be bound by its terms, and has accepted and signed this Joinder Agreement this _____ day of _____, 2008.

Grantor:

Witnessed:

STATE OF MICHIGAN)
COUNTY OF _____)

On the ____ day of _____, 2008, _____
appeared before me, signed, acknowledged, and delivered the above Agreement.

Notary Public, _____ County, Michigan
Acting in _____ County, Michigan
My Commission Expires:

DECLARATION OF TRUST

This DECLARATION OF TRUST is made this 8th day of May, 1997 by Springhill, Inc.

ARTICLE I

NAME OF THE TRUST

The name of the Trust established under this instrument is The Pooled Accounts Trust of Springhill, Inc. (herein referred to as the "Trust"). This Trust is intended to be a pooled accounts trust established under 42 U.S.C. § 1396p(d)(4)(C). All provisions of this trust shall be interpreted to qualify this Trust under 42 U.S.C. § 1396p(d)(4)(C). Any provision of this Trust which prevents this Trust from qualifying under 42 U.S.C. § 1396p(d)(4)(C) shall be null and void.

ARTICLE II

DEFINITIONS

1. "Beneficiary" shall mean a disabled person, as defined in Section 1614(a)(3) of the Social Security Act (42 U.S.C. § 1396p, amended August 10, 1993, by the Revenue Reconciliation Act of 1993), to be a recipient of services and benefits under this Trust. If the Social Security Administration or any authorized governmental entity has not made a determination that the Beneficiary is a disabled person, the Trustee is authorized to accept such Beneficiary within its discretion if it has made a determination that the Beneficiary is a disabled person, as defined in 42 U.S.C. § 1382c(a)(3).

2. "Government assistance" shall mean all services, benefits and financial assistance that may be provided by any state or federal agency to or on behalf of a Beneficiary. Such benefits

include, but are not limited to, the Supplemental Security Income (SSI) program, the Old Age Survivor and Disability Insurance (OASDI) program, the Supplemental Security Disability Income (SSDI) program and the Medicaid program, together with any additional, similar, or successor public programs.

3. "Grantor" shall mean a parent, grandparent, agent acting under a power of attorney, or guardian of a Beneficiary, a Beneficiary himself or herself, or any court. The term "Grantor" shall also include any person or entity that contributes his, her, or its own assets or property to the Trust for the benefit of a Beneficiary, by gift, will, contract, or agreement.

4. "Guardian" shall mean a legal guardian, conservator, agent acting under a durable power of attorney, trustee, representative payee, or other legal representative or fiduciary of a Beneficiary.

5. Payments for "supplemental needs" or for "supplemental care" shall mean non-support disbursements. It is not the Grantor's intention to displace public and private financial assistance that may otherwise be available to any Trust Beneficiary. It is the intention of the Grantor to limit the Trustee's contribution to a Beneficiary's supplemental needs only. The following illustrates the kinds of supplemental, non-support disbursements that are appropriate for the Trustee to make from this Trust to or for the benefit of a Trust Beneficiary. The following examples are not exclusive. Non-covered medical, dental and diagnostic work and treatment for which there are no private or public funds, and medical procedures that are desirable in the Trustee's discretion, even though they may not be medically necessary or life saving may be paid by the Trustee. Differentials in cost between housing and shelter

for shared and private rooms may be paid by the Trustee in its discretion for Beneficiaries of the Trust. Care appropriate for a Beneficiary that assistance programs may not or do not otherwise provide may be paid by the Trustee, as well. Expenditures for recreation, social, travel, companionship, cultural experiences, and expenses in bringing a Beneficiary's siblings and others for visitation with him or her are appropriate expenditures. Supplemental care needs shall also include items of a similar nature specified in a Joinder Agreement if approved by the Trustee.

6. "Trustee" shall mean Springhill, Inc., a non-profit organization, its successor or successors and shall include any Co-Trustee or Co-Trustees. "Co-Trustee" shall mean a person or entity, or both, selected by the Trust to assist with the management, administration, allocation, and disbursement of Trust assets and property.

ARTICLE III

ESTABLISHMENT OF SUPPLEMENTAL NEEDS TRUST

1. It is the intention of Springhill, Inc. to establish a supplemental fund pursuant to 42 U.S.C. § 1396p, as amended August 10, 1993 by the Revenue Reconciliation Act of 1993, for the benefit of Beneficiaries under this Trust. This Trust shall not be reduced in value by the Beneficiaries' creditors. Their public and private assistance benefits shall not be made unavailable to them or be terminated because of this Trust. Assets held in this Trust and sub-accounts are not for the Beneficiaries' primary support. They are to supplement their care needs only. There is no obligation of support owing to the Beneficiaries by the Grantor nor by the Trustee; the Beneficiaries have no entitlement to the income or corpus of this Trust, except as the Trustee, in its complete and

unfettered discretion, elects to disburse, and the Trustee may act unreasonably in exercising discretion. The Trustee's judgment should not be substituted for the judgment of any other person or entity.

2. The Trustee shall pay or apply for the supplemental needs of each Beneficiary, such amounts from the principal or income, or both, of the Trust sub-account maintained for such Beneficiary, up to the whole thereof, as the Trustee, in its sole discretion, may from time to time deem necessary or advisable for the satisfaction of that Beneficiary's supplemental care needs, if any. Any income not distributed shall be added annually to the principal in the Trust sub-account maintained for the respective Beneficiary.

3. Disbursements from this Trust should not be made to or for the benefit of a Beneficiary if the effect of such distribution replaces government assistance benefits of any kind. The Trust corpus and income are not available to any Beneficiary except to the extent of distributions made by the Trustee to a Beneficiary. No distributions should be made by the Trustee to or for the benefit of a Beneficiary in excess of resource and income limitations of any public benefit program to which the Beneficiary is entitled. The Beneficiary's future needs may be considered by the Trustee in connection with disbursements made. The interests of the remainder Beneficiary is of only secondary importance.

4. The Trustee should refuse any request for payments from this Trust for services that any public or private agency has the obligation to provide to Beneficiaries who otherwise qualify for such assistance. The Trustee may not be familiar

with the federal, state and local agencies that have been created to assist persons financially such as the Trust Beneficiaries, and the Trustee should seek assistance in identifying public and private programs that are or may be available to the Trust's Beneficiaries so that the Trustee may better serve them.

5. No part of this Trust, principal or income, shall be subject to anticipation or assignment by the Beneficiaries nor shall it be subject to attachment or control by any public or private creditor of the Beneficiaries; nor may it be taken by any legal or equitable process by any voluntary or involuntary creditor, including those that have provided for the Beneficiary's support and maintenance. Further, under no circumstances may any Beneficiary compel a distribution from a Beneficiary's sub-account.

ARTICLE IV

TRUST FUNDING

Springhill, Inc. shall initially fund this Trust with a lump-sum payment of Fifty Dollars and No Cents (\$50.00). The Trust estate shall consist of this initial contribution and any additional contributions in cash or property made to the Trust estate at any time by any Grantor in accordance with the provisions of Article V. By execution hereof, Springhill, Inc. assigns, conveys, transfers and delivers the above-described funds to the Trust on the date of this instrument.

ARTICLE V

GRANTORS' CONTRIBUTIONS

1. The Trust shall be effective as to any Beneficiary upon execution of a Joinder Agreement by a Grantor, or by court order, subject to the

approval of the Trustee. Upon delivery to and acceptance by the Trustee of property acceptable to the Trustee, the Trust, as to the Grantor of such property and the designation of the respective Beneficiary, shall be irrevocable and the contributed property shall not be refundable, except as is otherwise provided in Article XI Paragraph (3)

2. Property or interests in property can be designated for future transfer by a Grantor as a contribution. Such designation may be revocable and can be revoked by the Grantor as to such property at any time during that Grantor's life and continued competence, upon prior written notice from the Grantor to the Trustee. Examples of such contributions include a policy of life insurance on a Grantor's life in which the Trust is designated as a beneficiary, or the Trust being named as a beneficiary of any future interest in property, such as that which would pass by way of a Grantor's Last Will.

ARTICLE VI ADMINISTRATIVE PROVISIONS

1. A separate Trust sub-account shall be maintained for each Beneficiary, but, for purposes of investments and management of funds, the Trust shall pool these Trust sub-accounts. The Trustee, or its authorized agents, shall maintain records for each Trust sub-account in the name of, and showing the property contributed for, each Beneficiary.

2. The Trustee shall report, at least annually, to each Beneficiary (or to his or her guardian), who is eligible to receive discretionary distributions of the net income or principal from a Trust sub-account maintained for such Beneficiary, all of the

receipts, disbursements and distributions to or from such Trust sub-account occurring during the reporting period. In addition, a complete statement of the Trust sub-account resources shall be furnished. Further, the Trustee shall furnish, at least annually, to each Beneficiary or to his or her guardian, a financial statement concerning the Trust.

3. The Trust sub-account records of the Trustee, along with all Trust sub-account documentation, shall be available and open at all reasonable times for the inspection of the Beneficiary, or his or her guardian, or both.

4. The Trustee shall not be required to furnish Trust records or documentation to any individual, corporation, or other entity who is not a Beneficiary, or does not have the express written approval of the Beneficiary to receive such information, or who is not the fiduciary of the Beneficiary.

5. Except as otherwise provided in this instrument, and so long as the Trustee is prudent in administering the Trust, the Trustee may serve without bond, and may exercise all powers contained in Article VIII.

6. The Trustee, in its sole discretion, may make any payment under the Trust (a) directly to a Beneficiary, (b) in any form allowed by law, (c) to any person deemed suitable by Trustee, or (d) by direct payment of a Beneficiary's expenses.

7. No authority described in this instrument or available to trustees pursuant to applicable law shall be construed to enable the Trustee to purchase, exchange or otherwise deal with or dispose of the principal or income of any Trust

sub-account for less than an adequate or full consideration in money or money's worth, or to enable any person to borrow the principal or income of any Trust sub-account, directly or indirectly, without adequate interest or security.

8. Costs and expenses of defending the Trust from any claim, demand, legal or equitable action, suit, or proceeding may, in the sole discretion of the directors of Springhill, Inc. either (a) be apportioned on a pro rata basis to all Trust sub-accounts, or (b) be charged only against the Trust sub-account as to the affected Beneficiary.

ARTICLE VII

DESIGNATION OF CO-TRUSTEES

The Trustee may designate a Co-Trustee or Co-Trustees to serve at its pleasure.

ARTICLE VIII

POWERS AND AUTHORITY OF TRUSTEE

Subject to the restrictions contained in Article III and Article VI, the Trustee has the following continuing, absolute, and discretionary powers to deal with any property, real or personal, held in the Trust. Trustee may exercise these powers independently and without the approval of any court or judicial authority. No person dealing with Trustee need inquire into the propriety of any of its actions or in to the application of any funds or other property. Trustee shall, however, exercise all powers in a fiduciary capacity for the best interest of any Beneficiary of this Trust Agreement. Without in any way limiting the generality of the foregoing, Trustee is given the following specific powers in addition to any other powers conferred by law:

1. Except as otherwise provided to the contrary, to hold funds uninvested in amounts that Trustee deems appropriate, and to invest in any assets Trustee deems advisable even though they are not technically recognized as legal investments for fiduciaries, without responsibility for depreciation or loss on account of those investments, or because those investments are nonproductive.
2. To retain the original assets it receives for as long as it deems best, and to dispose of those assets as and when it deems advisable.
3. If no personal representative of Grantors' estates is then serving, and to the extent permitted by law, to perform in a fiduciary capacity any act and make any and all decisions or elections under state law.
4. To expend whatever funds it deems proper for the preservation, maintenance, or improvement of assets. In its absolute discretion, Trustee may pay premiums on all insurance policies that it holds, and may elect any options or settlements or exercise any rights under those policies. However, no Trustee who is the insured of any insurance policy that is subject to the terms of this Agreement may exercise any rights or have any incidents of ownership with respect to the policy, including the power to change the beneficiary, to surrender or cancel the policy, to assign the policy, to revoke any assignment, to pledge the policy for a loan, or to obtain from the insurer a loan against the surrender value of the policy.
5. To employ and compensate attorneys, accountants, managers, agents, assistants, and advisors without liability for any act of those

persons, so long as they are selected and retained with reasonable care.

6. To execute deeds, leases, contracts, bills of sale, notes, and other written instruments.

7. To make distributions, whether of principal or income, to any minor child or incompetent person according to the terms of this Trust Agreement by making distributions directly to that person whether or not that person has a guardian; to the parent, guardian, or spouse of that person; to a custodial account established for that person under an applicable Uniform Transfers to Minors Act; to any adult who resides in the same household with that person or who is otherwise responsible for the care and well-being of that person; or by applying any distribution for the benefit of that person in any manner Trustee deems proper. The receipt of the person to whom payment is made will constitute full discharge of Trustee with respect to that payment.

8. To make any division or distribution in money or in kind, or both, without allocating the same kind of property to all shares or distributees, and specifically without regard to the income tax basis of the property. Any division will be binding and conclusive on all parties. Trustee is excused from any duty of impartiality with respect to any division or distribution.

9. To borrow money from any source (including Trustee in its non-fiduciary capacity) for the benefit of any trust created by this Agreement, and to secure the loan by mortgage or other collateral.

10. To compromise, arbitrate, or otherwise adjust claims in favor of or against any trust created by this Agreement and to agree to any rescission or modification of any contract or Agreement.

11. To participate in any type of liquidation or reorganization of any enterprise.
12. To vote and exercise all rights and options, or empower another to vote and exercise those rights and options, concerning any corporate stock, securities or other assets or to delegate those rights to an agent, and to enter into voting trusts and other Agreements or subscriptions that Trustee deems advisable.
13. To buy, sell, exchange, or lease any real or personal property, publicly or privately, for cash or credit, without order of court and upon the terms and conditions that Trustee deems advisable. Any lease so made will be valid and binding for its full term even though it extends beyond the duration of any trust. Specifically, the Trustee may invest the Trust principal in residential real estate suitable for occupancy by a Beneficiary, and may permit occupancy or use without charge in such manner as, in the opinion of the Trustee, best serves the Trust's interest without the necessity of turning such property (whether complete or a shared interest with others) into cash or gaining an income therefrom. Furthermore, the Trustee is authorized to pay out of the income or principal of this Trust the taxes, insurance and maintenance expenses to keep the residential or replacement property in suitable repair, or any portion thereof as the Trustee deems proper.
14. To exercise all its powers by this Agreement, even though it may also be acting individually, or on behalf of any other person or entity interested in the same matters. Trustee, however, shall exercise these powers at all times in a fiduciary capacity, primarily in the interest of the beneficiaries of any trust created by this Trust Agreement.

15. To treat premiums and discounts on bonds and other obligations for the payment of money in accordance with generally accepted accounting principles and to hold nonproductive assets without allocating any portion of the Trust principal to income, notwithstanding the provisions of any applicable principal and income.

16. To incorporate any business or venture forming a part of the Trust estate and to continue any incorporated business throughout the term of the Trust.

17. To employ any investment management service, financial institution, or similar organization to advise it, handle all Trust investments, and render all accounting of funds held on its behalf under custodial, agency, or other Agreements and if no Trustee is corporate, to pay the costs of those services as an expense of administration in addition to fees and commissions.

18. To hold, manage, and develop real estate. To grant easements and make dedications as it deems advisable. To retain unproductive property, as determined appropriate by the Trustee.

19. To buy, sell, and trade in securities of any nature, including short sales, on margin or otherwise. To maintain and operate margin accounts with brokers, and to pledge any securities held or purchased by Trustee with such brokers as security or loans or advances made to Trustee.

20. To disclaim any assets otherwise passing or any fiduciary powers pertaining to any Trust created thereunder, by execution of an instrument of disclaimer meeting the requirements of applicable law generally imposed upon individuals executing disclaimers. No notice to, or consent of, any

beneficiary, other interested person, or any court is required for any such disclaimer, and Trustee is to be held harmless for any decision to make or not make such a disclaimer.

21. To transfer the situs of any Trust property to any other jurisdiction as often as Trustee deems it advantageous to the Trust, appointing a substitute Trustee to act with respect to that property. Trustee may delegate to the substitute Trustee any or all of the powers given to Trustee; may elect to act as advisor to the substitute Trustee and shall receive reasonable compensation for so acting; and may remove any acting substitute Trustee and appoint another, or reappoint itself, at will.

22. The Trustee, its agents, employees, successors, assigns, attorneys or any other representatives, shall be indemnified and held harmless, up to and including any amount held by this Trust, for any costs or expenses, including but not limited to identification, maintenance, administration, remediation, or litigation associated with any property, facility, vessel or other identifiable unit that is subject to environmental claims under the laws of this State or the laws of the United States.

23. To establish accounts of all kinds, including checking and savings, in the name of this Trust, with financial institutions of any kind, including but not limited to banks and thrift institutions; to modify, terminate, make deposits to and write checks on or make withdrawals from and grant security interests in all accounts in the Trust's name; to negotiate, endorse or transfer any checks or other instruments with respect to any such accounts; to contract for any services rendered by any bank or financial institution;

24. To contract with any institution for the maintenance of a safe-deposit box in the name of this Trust.

ARTICLE IX INDEMNIFICATION

The Trustee and each of its agents and employees, as well as its agents' and employees' heirs, successors, assigns and personal representatives, are indemnified by the Trust and the Trust property against all claims, liabilities, fines, or penalties and against all costs and expenses (including attorney's fees and disbursements and the cost of reasonable settlements) imposed upon, asserted against or reasonably incurred thereby in connection with or arising out of any claim, demand, action, suit, or proceeding in which he, she, or it may be involved by reason of being or having been a Trustee or Advisor, whether or not he, she, or it shall have continued to serve as such at the time of incurring such claims, liabilities, fines, penalties, costs, or expenses or at the time of being subjected to the same. However, the Trustee and its agents and employees (and their heirs or personal representatives) shall not be indemnified with respect to matters as to which he, she, or it shall be finally determined to have been guilty of willful misconduct in the performance of any duty as such, by a court of competent jurisdiction. This right of indemnification shall not be exclusive of, or prejudicial to, other rights to which the Trustee, its agents or employees may be entitled as a matter of law or otherwise.

ARTICLE X AMENDMENT OF TRUST

This Declaration of Trust shall be irrevocable,

except that it may be amended from time to time to conform to Article III to effectuate the terms of this instrument. In addition, the Trustee may amend this instrument with the approval of any court of competent jurisdiction in the State of Michigan, so that it conforms with any rules or regulations that are approved by any governing body or agency relating to 42 U.S.C. § 1396p or related statutes, including state statutes and regulations that are consistent with the provisions and purposes of the Revenue Reconciliation Act of 1993. Amendments may be made and approved by any court of competent jurisdiction in this state, by notice of such request for amendment to the Family Independence Agency, or its successor agency, of the State of Michigan.

ARTICLE XI

TERMINATION OF TRUST

1. Every reasonable attempt will be made to continue the Trust for the purposes for which it is established. However, it is recognized that the Trustee does not and cannot know how future developments in the law, including administrative agency and judicial decisions, may affect the Trust or any Trust sub-account. If the Trustee has reasonable cause to believe that the income or principal in a Trust sub-account maintained for any Beneficiary is or will become liable for basic maintenance, support, or care for that Beneficiary which has been or would otherwise be provided by local, state, or federal government, or an agency or department thereof, the Trustee, in its sole discretion, may (a) terminate the Trust sub-account as to the affected Beneficiary as though he or she had died, and the Trustee shall then treat the property in the Trust sub-account according to the provisions of Article XI Paragraph (2), (b) determine that the Trust has become impossible to

implement for the affected Beneficiary, and the Trustee shall then treat the property in the Trust sub-account according to the provisions of Article XI Paragraph (3), or (c) continue to administer the Trust sub-account under separate arrangement with the affected Beneficiary or his or her guardian. Before making any distribution of amounts retained in any Trust sub-account, the Trustee should consider the tax and Medicaid and other public benefit consequences to the Beneficiary of any particular distribution.

2. Upon the death of a Beneficiary, any amounts remaining in the Beneficiary's Trust sub-account shall be deemed to be surplus Trust property and shall be retained by the Trust and, in the Trustee's sole discretion, used (a) for the benefit of other Beneficiaries, (b) to aide persons who are indigent and disabled, as defined in 42 U.S.C. § 1382c(a)(3), or (c) to provide persons who are indigent and disabled, as defined in 42 U.S.C. § 1382c(a)(3), with housing or supplemental support services deemed suitable for such persons by the Trustee. Gifts or devises to the Trust shall be similarly treated unless the purpose for which the gift is made is specified by the donor.

3. The Trustee, in its sole discretion, may refund all or any portion of the property in a Trust sub-account to a Grantor (excluding any court) if it becomes impossible to fulfill the conditions of the Trust with regard to the respective Beneficiary for reasons other than the death of the Beneficiary. In the event such Grantor is not living at the time a refund is to be made, payment may be made to the estate of the Grantor.

4. If it becomes impossible, or impracticable, to carry out the Trust's purposes with respect to all Beneficiaries, the Trustee may terminate the Trust

and distribute the Trust property as set forth in Article XI Paragraph (2), provided, however, that if Springhill, Inc. has ceased to exist or has been dissolved, then any property remaining in the Trust shall be applied and paid over to such other organization or organizations as the Trustee, in its sole discretion, may determine then to be serving the interests and needs of people with disabilities in a manner consistent with the purposes of this Trust. Before action is taken under this Article XI Paragraph (4), a final accounting along with an application seeking approval of the action to be taken shall be filed in a court of competent jurisdiction in this state.

ARTICLE XII

RESIGNATION OF TRUSTEE

The Trustee may resign only with the approval of a court of competent jurisdiction in this state. A successor Trustee shall be selected and appointed by the court. Any successor Trustee shall act as such without any liability for the acts or omissions of any predecessor Trustee.

ARTICLE XIII

GENERAL MATTERS AND INSTRUCTIONS WITH REGARD TO THE TRUSTEESHIP

1. The Trustee shall not be required to furnish any bond for the faithful performance of the Trustee's duties. If bond is required by any law or court of competent jurisdiction, no surety shall be required on such bond.

2. The Trust established under this instrument shall be administered free from the active supervision of any court. Any proceedings to seek judicial instructions or a judicial determination may be initiated by the Trustee in any court having

jurisdiction of these matters relating to the construction and administration of the Trust.

3. The Trustee shall be entitled to reasonable compensation, commensurate with the services actually performed, and to reimbursement of costs and expenses properly incurred.

4. The validity of this Trust shall be determined by the laws, including valid regulations, of the United States and the State of Michigan. Questions of construction and administration of this Trust shall be determined by the laws of the situs of administration.

IN WITNESS WHEREOF, the undersigned hereby subscribes to the above Declaration of Trust on the date and year first above written. This Agreement extends to and is binding upon the personal representatives, successors, and assigns of the Trustee.

SIGNED:

James B. Harp, President of
Springhill, Inc.

WITNESSED:

James M. Brown
Dawn H. Calnen

STATE OF MICHIGAN)
OAKLAND COUNTY)

On the 8th day of May, 1997, James B. Haefner,
President of Springhill, Inc., appeared
before me, signed, acknowledged, and delivered the
above Agreement.

Patricia E. Kefalas Dudek
Notary Public
Oakland County, Michigan
My commission expires:

PATRICIA E. KEFALAS DUDEK
Notary Public, Oakland County, MI
My Commission Expires Jan. 30, 2000

**STATE OF MICHIGAN
MACOMB COUNTY PROBATE COURT**

In the Matter of SPRINGHILL, INC. POOLED
ACCOUNTS TRUST F/B/O
[REDACTED]

File Numbers: [REDACTED]

SPRINGHILL, INC., Petitioner

Honorable: James F. Nowicki

PATRICIA E. KEFALAS DUDEK (P46408)
Attorney for Petitioner, SPRINGHILL, INC.
P.O. Box 721249
Berkley, Michigan 48072-1249
(248) 586-9820

**ORDER TO AMEND THE SPRINGHILL, INC.
POOLED ACCOUNTS TRUST AND JOINDER AGREEMENT**

At a session of said Court, held in the City of
Mt. Clemens, County of Macomb, State of Michigan,
on the 17th day of May, 1999

Present: JAMES F. NOWICKI
PROBATE COURT JUDGE

THIS MATTER having come before the Court upon petition of SPRINGHILL, INC., Trustee of the SPRINGHILL INC., POOLED ACCOUNTS TRUST dated May 8, 1997, and the Court having determined that all interested parties have been notified; IT IS HEREBY ORDERED THAT the SPRINGHILL, INC. POOLED ACCOUNTS TRUST shall be amended in the following manner:

1. Delete Article II, Paragraph 5 and substitute the following in its place:

Payments for "supplemental needs" or for "supplemental care" shall mean non-support disbursements. It is not the Grantor's intention to displace public and private financial assistance that may otherwise be available to any Trust Beneficiary. It is the intention of the Grantor to limit the Trustee's contribution to a Beneficiary's supplemental needs only. The following illustrates the kinds of supplemental, non-support disbursements that are appropriate for the Trustee to make from this Trust to or for the benefit of a Trust Beneficiary. The following examples are not exclusive: non-covered medical, dental and diagnostic work and treatment for which there are no private or public funds and medical procedures that are desirable in the Trustee's discretion, even though they may not be medically necessary or life saving may be paid by the Trustee; differentials in cost between housing and shelter for shared and private

rooms may be paid by the Trustee in its discretion for Beneficiaries of the Trust; care appropriate for a Beneficiary that assistance programs may not or do not otherwise provide; expenditures for dry-cleaning, laundry services, recreation, social, travel, cultural experiences and sporting events. Supplemental care needs shall also include items of a similar nature specified in a Joinder Agreement if approved by the Trustee.

2. Delete Article V, Paragraph 1 and substitute the following in its place:

1. The Trust shall be effective as to any Beneficiary upon execution of a Joinder Agreement by a Grantor, or by court order, subject to the approval of the Trustee. Upon delivery to and acceptance by the Trustee of property acceptable to the Trustee, the Trust, as to the Grantor of such property and the designation of the respective Beneficiary, shall be irrevocable and the contributed property shall not be refundable.

3. Delete Article XI, Paragraph 1(b) in its entirety.

4. Delete Article XI, Paragraph 3 in its entirety.

5. Delete Article XI, Paragraph 4 and substitute the following in its place:

3. If it becomes impossible, or impracticable, to carry out the Trust's purposes with respect to all Beneficiaries, the Trustee may terminate the Trust and distribute the Trust property as set forth in Article XI Paragraph (2), provided, however, that if Springhill, Inc. has ceased to exist or has been dissolved, then any property remaining in the Trust shall be applied and paid over to such other organization or organizations as the Trustee, in its sole discretion, may determine then to be serving the interests and needs of people with disabilities in a manner consistent with the purposes of this Trust. Before action is taken under this Article XI Paragraph (3), a final accounting along with an application seeking approval of the action to be taken shall be filed in a court of competent jurisdiction in this state.

Date: MAY 17 1999

JAMES F. NOWICKI

PROBATE COURT JUDGE

PATRICIA E. KEFALAS DUDEK
Attorney for Petitioner, SPRINGHILL, INC.
P.O. Box 721249
Berkley, Michigan 48072-1249
(248) 586-9820

A TRUE COPY
Barbara P. Canacci
Probate Court

**STATE OF MICHIGAN
MACOMB COUNTY PROBATE COURT**

In the matter of SPRINGHILL, INC. POOLED
ACCOUNTS TRST

File No.: [REDACTED]

SPRINGHILL HOUSING CORPORATION,
A NONPROFIT HOUSING
CORPORATION, Petitioner

Honorable: James F. Nowicki

PATRICIA E. KEFALAS DUDEK (P46408)
Attorney for Petitioner, SPRINGHILL HOUSING
CORPORATION, A NONPROFIT
HOUSING CORPORATION
P.O. Box 721249
Berkley, Michigan 48072-1249
(248)586-9820

**ORDER TO AMEND THE SPRINGHILL, INC. POOLED
ACCOUNTS TRUST DATED MAY 8, 1997**

At a session of said Court, held in the City of
Mount Clemens, County of Macomb, State of Michigan,
on the 25th day of October, 1999

Present: JAMES F. NOWICKI
PROBATE COURT JUDGE

THIS MATTER having come before the Court upon petition of SPRINGHILL HOUSING CORPORATION, A NONPROFIT HOUSING CORPORATION, Trustee of the SPRINGHILL, INC. POOLED ACCOUNTS TRUST, dated May 8, 1997, and the Court having determined that all interested parties have been notified;
IT IS HEREBY ORDERED THAT the SPRINGHILL, INC. POOLED ACCOUNTS TRUST dated May 8, 1997 be amended in the following manner:

1. Change the Declaration of Trust to read "This DECLARATION OF TRUST is made this 8th day of May, 1997 by Springhill Housing Corporation, a Nonprofit Housing Corporation"
2. Article I shall be deleted and the following substituted in its place:

The name of the Trust established under this instrument is The Pooled Accounts Trust of Springhill Housing Corporation, a Nonprofit Housing Corporation, also known as The Pooled Accounts Trust of Springhill, Inc. (hereinafter referred to as the "Trust"). This Trust is intended to be a pooled accounts trust established under 42 U.S.C. §1396p(d)(4)(C). All provisions of this Trust shall be interpreted to qualify this Trust under 42 U.S.C. §1396p(d)(4)(C). Any provision of this Trust which prevents this Trust from qualifying under 42 U.S.C. §1396p(d)(4)(C) shall be null and void.

3. Article II, Paragraph 6 shall be deleted and the following substituted in its place:

6. "Trustee" shall mean Springhill Housing Corporation, a Nonprofit Housing Corporation, also known as Springhill, Inc., a non-profit organization, its successor or successors and shall include any Co-Trustee or Co-Trustees. "Co-Trustee" shall mean a person or entity, or both, selected by the Trust to assist with the management, administration, allocation, and disbursement of Trust assets and property.

4. Article III, Paragraph 1 shall be deleted and the following substituted in its place:

1. It is the intention of Springhill Housing Corporation, a Nonprofit Housing Corporation, to establish a supplemental fund pursuant to 42 U.S.C. §1396p, as amended August 10, 1993 by the Revenue Reconciliation Act of 1993, for the benefit of Beneficiaries under this Trust. This Trust shall not be reduced in value by the Beneficiaries' primary support. They are to supplement their care needs only. There is no obligation of support owing to the Beneficiaries by the Grantor nor by the Trustee; the Beneficiaries have no entitlement to the income or corpus of this Trust, except as the Trustee, in its complete and unfettered discretion, elects to disburse, and the Trustee may act unreasonably in exercising discretion. The Trustee's judgment should not be substituted for the judgment of any other person or entity.

5. Article VI, Paragraph 8 shall be deleted and the following substituted in its place:

8. Costs and expenses of defending the Trust from any claim, demand, legal or equitable action, suit, or proceeding may, in the sole discretion of the directors of Springhill Housing Corporation, a Nonprofit Housing Corporation, either (a) be apportioned on a pro rata basis to all Trust sub-accounts, or (b) be charged only against the Trust sub-account as to the affected Beneficiary.

6. Article IV shall be deleted and the following substituted in its place:

Springhill Housing Corporation, a Nonprofit Housing Corporation, shall initially fund this Trust with a lump-sum payment of Fifty Dollars and No Cents (\$50.00). The Trust estate shall consist of this initial contribution and any additional contributions in cash or property made to the Trust

estate at any time by any Grantor in accordance with the provisions of Article V. By execution hereof, Springhill Housing Corporation, a Nonprofit Housing Corporation, assigns, conveys, transfers and delivers the above-described funds to the Trust on the date of this instrument.

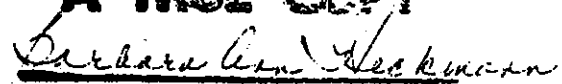
7. Article XI, Paragraph 3 shall be deleted and the following substituted in its place:

If it becomes impossible or impracticable, to carry out the Trust's purposes with respect to all Beneficiaries, the Trustee may terminate the Trust and distribute the Trust property as set forth in Article XI Paragraph (2), provided, however, that if Springhill Housing Corporation, a Nonprofit Housing Corporation, has ceased to exist or has been dissolved, then any property remaining in the Trust shall be applied and paid over to such other organization or organizations as the Trustee, in its sole discretion, may determine then to be serving the interests and needs of people with disabilities in a manner consistent with the purposes of this Trust. Before action is taken under this Article XI Paragraph (3), a final accounting along with an application seeking approval of the action to be taken shall be filed in a court of competent jurisdiction in this state.

Date: OCT 25 1999


PROBATE COURT JUDGE

PATRICIA E. KEFALAS DUDEK
Attorney for Petitioner, SPRINGHILL HOUSING
CORPORATION, A NONPROFIT HOUSING
CORPORATION
P.O. Box 721249
Berkley, Michigan 48072-1249
(248)586-9820

A TRUE COPY

BARBARA ANN HECKMANN
DEPUTY PROBATE REGISTER

**Exception B,
Pooled Trust**

A trust is **not** a Medicaid trust if it meets all of the following conditions:

- The trust must be unchangeable with regard to the provisions that make it an Exception B, Pooled Trust. This is necessary to ensure that a trust initially meeting the other conditions still meets those conditions when the person dies.
- The trust contains the resources of a person who is disabled (not blind) per PEM 260.
- The trust is established and managed by a nonprofit association.
- A separate account is maintained for each beneficiary of the trust, but for purposes of investment and management of funds, the trust pools these accounts.
- Accounts in the trust are established for the benefit of persons who are disabled (not blind) per PEM 260. This means the trust must ensure that none of the principal or income attributable to a person's account can be used for someone else during the person's lifetime, except for "Trustee Fees" per PEM 405.
- Accounts in the trust are established by courts or by disabled persons':
 - Parents.
 - Grandparents.
 - Legal guardians/conservators.
- The trust says that if any funds are distributed from the trust after the person's death, the trustee has an automatic duty to repay Medicaid.

When a person has lived in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the individual received Medicaid, based on the state's proportionate share of the total amount of Medicaid benefits paid by all of the states on the person's behalf.

Examples of circumstances under which a trust **fails** this repay condition are:

- Requiring a trustee to reimburse Medicaid only if Medicaid first submits a claim.
- Failing to provide that repaying Medicaid has priority over all debts and expenses except those given higher priority by law.

**Transfers to
Exception B Trust**

Treat assets and income transferred into an **"Exception B, Pooled Trust"** as part of the trust for the entire month of transfer.

Transfers to an **"Exception B, Pooled Trust"** by a person age 65 or older might be divestment. Do a complete divestment determination if the person is in a "Penalty Situation" per PEM 405.

**Countable
Exception B
Payments**

Count as a person's unearned income any payment received from the trust.

**Multiple
Contributors**

When someone other than the person or the person's spouse has contributed to the principal of a trust, do not count as the person's assets or transferred assets an amount proportional to that other person's contributions to the principal.

Example: The Lang family contributed assets to the Lang Trust as follows:

John (MA applicant)	\$50,000
Sally (John's daughter)	\$10,000
Total Contributions	\$60,000

Sally has contributed 1/6 of the total contributions. The value of the entire principal is currently \$102,000. Therefore, \$17,000.00 (one-sixth) of the current value cannot be counted as John's assets. Do not count the contributors share as an asset.

**REPAYMENT
INQUIRIES**

Refer trustees seeking to repay Medicaid to the following:

Michigan Department of Community Health
Court Originated Liability Section
PO Box 30479
Lansing, Michigan 48909

**COUNTABLE
ASSETS FROM
MEDICAID TRUSTS**

How much of the principal of a trust is a countable asset depends on:

- The terms of the trust, and
- Whether any of the principal consists of "Countable Assets" or "Countable Income."

Countable Assets

The following are countable assets.

- Assets that are countable using SSI-related MA policy in PEM 400. Do not consider an asset unavailable because it is owned by the trust rather than the person.



W. ENGLER, Governor

MEDICAL SERVICES ADMINISTRATION

400 SOUTH PINE
PO BOX 30479
LANSING MI 48909-7979

August 17, 1999

Ms. Patricia Kefalas Dudek
P.O. Box 721249
Berkley, Michigan 48072-1249

Dear Ms. Kefalas Dudek:

Thank you for your recent letter in follow-up to our meeting of July 22, 1999. My staff expects to convene a workgroup in the near future to develop prototype trust documents.

Since our meeting, my staff has advised the Family Independence Agency (FIA) that the Exception B trust documents for your clients, [REDACTED] and [REDACTED] are acceptable and that the Medicaid applications filed on or about June 1, 1999, should now be processed. Since the Assistant Attorney General Morris Klau has advised that the issue of retroactivity is not yet resolved, the effective dates for their eligibility will be the first day of the month of application, if they otherwise qualify. Once the retroactivity issue is resolved the eligibility begin dates will be changed, if appropriate.

Should you establish additional Exception B trust documents that are identical in wording to those of the above three individuals, the documents should be submitted with the Medicaid application to the local FIA office, as has always been the instruction. The local FIA office staff will continue to refer the documents to their central office for review and approval. The central office staff has been instructed to quickly review and approve such documents.

I trust that this information will be of assistance to you and appreciate your continued interest in the Medicaid Program.

Cordially,


Robert M. Smedes
Deputy Director for
Medical Services Administration

cc: Mr. Morris Klau



SOCIAL SECURITY

MEMORANDUM

Date: November 27, 2001

Refer To: S2D5G6
SI-2-1-3

To: District Manager
Sterling Heights, MI

From: Assistant Regional Commissioner
Management and Operations Support

Subject: SSI-Michigan--Review of the Pooled Trust, (Your Faxed Request
Dated May 11, 2001)--REPLY

We have reviewed the above named trust, and have determined that as written, the Pooled Accounts Trust of Springfield Housing Corporation, a Nonprofit Corporation, also known as The Pooled Accounts Trust of Springfield, Inc., would not be considered a resource under the SSI regulations in place prior to January 1, 2000 or as amended beginning January 1, 2000. While a specific claimant's trusts was submitted for review, this determination may be applied to all Pooled Accounts Trust of Springfield, Inc.

Background

Within the Pooled Accounts Trust of Springfield, Inc., individual trust sub-accounts are maintained for each disabled beneficiary who chooses to adopt the trust. However, the funds from each of these sub-accounts will be pooled for investment and management.

An individual establishes a sub-account and becomes a "Primary Beneficiary" by entering into a "Joinder Agreement," whereby the individual enrolls in and adopts the Pooled Trust Agreement. A disabled individual can use their own funds to establish a sub-account for themselves. Other individuals could also place funds or assets into trust for the disabled beneficiary.

The purpose of the trust is to provide for each beneficiary's supplemental care, and not to provide for a beneficiary's basic support and maintenance. The trustee has sole discretion to make payments or distributions to or for the benefit of a beneficiary. The trust documents state that the pooled trust and each sub-account are irrevocable, and a spendthrift provision provides that, to the extent permitted by law, a beneficiary cannot assign or transfer their interest in the trust. The trustee may terminate the trust if it becomes impossible or impracticable to carry out the trust's purposes.

The sub-account will terminate upon the death of the Primary Beneficiary. Any assets remaining in the sub-account after payment of certain expenses shall remain part of the Master Trust to be used for the benefit of the primary beneficiaries of other sub-accounts that are established under the Pooled Trust Agreement. To the extent that any funds remain in the sub-account, they would be available to repay the State for any assistance that had been provided to the Primary Beneficiary.

The Pooled Trust Agreement provides that the grantors or other contributors to the trust cannot revoke any trust established by virtue of the Joinder Agreement. The grantors also do not have the right or power to amend, reform, or revoke the Pooled Trust or any sub-accounts.

Status

Until January 1, 2000, the Social Security Act did not separately describe the resource Treatment, for SSI purposes, of property held in trust. Property is a resource if the individual owns and can convert it to cash to be used for their support and maintenance. Property that could not be liquidated was not a resource. SSA reviewed state property law to decide whether an individual owns the property and whether they had the right, authority, or power to liquidate the property.

Effective January 1, 2000, the Social Security Act as amended directs how to count property held in trust as a resource for SSI purposes. According to the Act as amended, most assets held in trust for individuals are generally going to be countable resources, even if state property law might otherwise exclude them, if any portion of the trust property could be used for the benefit of the eligible individual or his or her spouse. (P.L. 106-169 § 205, 113 Stat. 1822, 1833 (to be codified at 42 U.S.C. § 1382b(e))). The amended Act, however, further provides that property held in trust does not count as a resource if it is excluded from being a countable resource for Medicaid purposes. The amended Act provides that a revocable trust shall be a resource to the individual and an irrevocable trust will be a resource to the extent that a portion of the trust could be used for the benefit of the individual. However, this subsection shall not apply to a trust that is excluded from being counted as resources for the Medicaid program. Thus, trusts satisfying the requirements of section 1917(d) (4) (42 U.S.C. § 1396p(d) (4)) are excluded as resources to the individual for SSI purposes. These amendments apply to trusts established on or after January 1, 2000. This pooled trust is excluded from being a countable resource for the Medicaid program under 1396p(d) (4) (C); therefore, it is excluded from being counted as a resource for SSI purposes.

Section 1917(d) (4) (C) of the Act, 42 U.S.C. § 1396p(d) (4) (C), excludes certain pooled trusts from being counted as resources to a Medicaid recipient. In order to be excluded, the trust must contain assets belonging to a disabled individual and must satisfy certain conditions. It must be established and managed by a nonprofit organization. A separate account must be maintained for each beneficiary of the trust, but for purposes of investment and management of funds, the trust may pool these accounts. Accounts in the

trust must be established solely for the benefit of the disabled individual by the individual or a parent, grandparent, legal guardian, or court. Finally, the trust must provide that amounts remaining in the beneficiary's account at death, if not retained by the trust, will be used to reimburse the State for expenditures made during the beneficiary's lifetime

The Pooled Accounts Trust of Springfield, Inc. satisfies the foregoing criteria. The trust is established and managed by a nonprofit organization. The trust provides for separate sub-accounts for each disabled beneficiary of the trust, but for purposes of investment and management of funds, the trust pools these accounts. The trust provides that sub-accounts will be established by the Primary Beneficiary or a parent, grandparent, legal guardian or court. The trust is established solely for the benefit of the disabled individual. Finally, the trust provides that amounts remaining in the beneficiary's account at death, if not retained by the trust, will be used to reimburse the State for expenditures made during the beneficiary's lifetime

Accordingly, under the new amendments to 42 U.S.C. § 1382b, funds in the Pooled Accounts Trust of Springfield, Inc. will not count as a resource to the disabled beneficiaries who adopt the trust agreement.

Summary

We have determined that the Pooled Accounts Trust of Springfield, Inc. should not be considered a resource to the individual beneficiaries. The trust satisfies the conditions of 42 U.S.C. § 1396p(d) (4) (C) and recent amendments to Title XVI indicates that such trusts are exempt from being counted as resources for SSI purposes.

When a trust is not a resource, income received from the trust may be unearned income to the SSI recipient, depending on the nature of the disbursements. Therefore, any disbursements made directly to a claimant/recipient would be countable as cash income, while disbursements that provide in-kind support and maintenance (ISM) would be countable subject to the presumed maximum value of ISM. In-kind income includes food, clothing, and shelter. Other disbursements, such as payments for medical care, are not ISM, and would not be income.

Questions/concerns regarding this response may be directed to John H. Williams, Program Expert, CRSI/SSI, at (312) 575-4015.


Donna Y. Mukogawa

cc: Area Director, Area III



Patricia E. Kefalas Dudek

fax (248) 731-3081
pdudek@hshcdlaw.com
www.hshcdlaw.com

HAFELI STARAN HALLAHAN
CHRIST & DUDEK, P.C.

Attorneys at Law

4190 Telegraph Road, Suite 3000
Bloomfield Hills, Michigan 48302-2082
(248) 731-3080

L. Rider Brice, III
P. Daniel Christ
Patricia E. Kefalas Dudek
Mark W. Hafeli
Laura M. Hallahan
John D. Staran
Ann D. Christ, Of Counsel

June 30, 2006

VIA UPS

Macomb County
Department of Human Services
44600 Delco Boulevard
Sterling Heights, MI 48313

Re: *Springhill Housing Corporation Pooled Accounts Trust f/b/o* [REDACTED]
Social Security No. [REDACTED]

Dear Sir or Madam:

The purpose of this letter is to notify you that a pooled accounts trust has been created for the benefit of [REDACTED]. This trust is NOT a "Medicaid Trust" as defined by the Michigan Family Independence Agency's Program Eligibility Manual, Item 401 pp. 4-5 of 13, a copy of which is enclosed for your reference, along with a copy of the trust agreement, the Joinder Agreement and a copy of a previous determination that this type of Trust complies with the applicable provisions of FIA policy and federal law. In order to be considered a "Medicaid Trust", five criteria must be satisfied. In this case, the fifth criteria is not satisfied, as the trust is an "Exception B, Pooled Trust" as defined on page 6 of 13 in item 401, a copy of which is also enclosed for your reference.

If you have any questions regarding this notice or require further information about the *Springhill Housing Corporation Pooled Accounts Trust f/b/o* [REDACTED] please let us know.

Very truly yours,

HAFELI STARAN HALLAHAN
CHRIST & DUDEK, P.C.

Patricia E. Kefalas Dudek

PKD/jsd
Enclosures

ATTACHMENT

SEVEN

STATE OF MICHIGAN
WAYNE COUNTY PROBATE COURT

IN THE MATTER OF [REDACTED]
Irrevocable Trust

PATRICIA B. KEFALAS DUDEK,
Trustee & Petitioner

Case No. [REDACTED]
Honorable Milton Mack

v.

[REDACTED],
Former Co-Trustee

HARLEY D. MANELA (P40453)
MALL MALISOW & COONEY, P.C.
Attorney for Petitioner
30445 Northwestern Highway, Ste 250
Farmington Hills, Michigan 48334
(248) 538-1800

[REDACTED]
Guardian ad Litem
[REDACTED] W. Big Beaver Road, Ste 600
Troy, Michigan 48064

[REDACTED]
[REDACTED] Northwestern Highway, Ste. 200
Southfield, Michigan 48075

PETITIONER'S BRIEF IN SUPPORT OF THE CONTINUATION
OF THE SPECIAL NEEDS TRUST F/B/O [REDACTED]

I. FACTUAL BACKGROUND

██████████ (hereinafter ██████████) is a twenty-four year-old person (date of birth October 15, 1982) with several disabilities, including cerebral palsy; permanent and extensive brain damage; mild retardation and developmental delay.¹ His disabilities stem from medical malpractice. He is currently living at ██████████ Murray Crescent Drive, ██████████, Michigan 48076.

The ██████████ Irrevocable Trust dated October 8, 1998 (hereinafter "Trust") was set up for his benefit on October 8, 1998, with ██████████ (hereinafter "██████████") acting as Co-Trustee and attorney.² As stated on pages four (4), six (6), seven (7), eight (8), twelve (12), and eighteen (18) of the Trust agreement, the sole purpose of the Trust is to protect proceeds from the Wayne County Circuit Court settlement of a lawsuit stemming from the accident which caused some of ██████████'s disabilities (Case No. 96-██████████), to qualify ██████████ for government benefits, and to protect ██████████ *Exhibit B*.

As a result of an annual 're-determination of benefits' form not being returned to the Family Independence Agency, and the denial of benefits from the Social Security Administration, ██████████ stopped receiving government benefits during 1999 and did not receive any from 1999 until just recently *Exhibit C*, when Petitioner Dudek assisted ██████████ with obtaining such benefits. *Exhibit D*. Bobrin, as former Co-Trustee, did not assist ██████████ in applying for Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Food Stamps, Mental Health Services, or Medicaid.

As documented on the Annual Accounts submitted by ██████████, ██████████ incurred medical expenses in excess of \$250,000.00. *Exhibits E thru M*. Those medical expenses should not have been paid from the Trust. Had ██████████ been eligible for Medicaid and Mental Health Services, public benefits would have paid these expenses.

Trust assets were needlessly lost also, in connection with obtaining housing for ██████████. At some point between October 1999 and October 2000, the trust paid \$20,000 towards the

¹ see *Exhibit A* of Petitioner's Brief in Support of Supplemental & Amended Objection to Attorney Fees and all Accounts Including Final Account

² see *Exhibit B* of Petitioner's Brief in Support of Supplemental & Amended Objection to Attorney Fees and all Accounts Including Final Account.

purchase of a home, located in Detroit, Michigan, for [REDACTED]'s benefit.³ [REDACTED] failed to secure and protect the \$20,000 distribution from the trust and the assets and trust payment were lost in a subsequent foreclosure sale. In December of 2001, [REDACTED] as Trustee of the trust contributed \$200,000.00 towards the purchase of a second home located in Southfield, Michigan, for the benefit of [REDACTED].⁴ For reasons unknown to Dudek, the house was transferred to [REDACTED]'s mother, [REDACTED] (former Co-Trustee of the trust, hereinafter referred to as [REDACTED]). In 2006, when Dudek was hired by [REDACTED] and appointed Co-Trustee of a revised Exception A Special Needs Trust drafted and requested by Dudek and discovered the transfer to [REDACTED] and the failure of the Trust-owned house to abide by the "sole-benefit" requirements of the Trust, Dudek required the title of the property to be transferred back to the trust.⁵

As Co-Trustee, [REDACTED] paid a \$1,000 monthly stipend to be paid to [REDACTED] for Co-Trustee fees and for the "care" of [REDACTED].⁶ The income was used to make house payments for the Southfield house and to support [REDACTED] Mr. [REDACTED], Co-Trustee [REDACTED] and other family members in violation of one sole benefit rule. This trust has been under the Supervision of this Honorable Court since January 19, 1999.⁷ On November 8, 2001, this Court appointed [REDACTED] as *Guardian ad Litem* for [REDACTED].⁸ Since 1998, the trust has disbursed monies in excess of \$23,000.00 to [REDACTED] for her services, which included drafting, obtaining court approval for, and giving advice to a trust that failed to ever be used for its intended purpose. Over thirty hearings have been held regarding the administration of this trust. *Exhibit V.*

Due to Dudek's diligence, Petitions for Guardianship and Conservatorship were filed on February 23, 2007, in the Oakland County Probate Court and transferred to and granted by this Honorable Court. *Exhibit W.* Additionally, several government benefit applications have been filed and, only very recently approved in August 2007.

³ see Exhibits N and O of Petitioner's Brief in Support of Supplemental & Amended Objection to Attorney Fees and all Accounts Including Final Account.

⁴ see Exhibits P and Q of Petitioner's Brief in Support of Supplemental & Amended Objection to Attorney Fees and all Accounts Including Final Account.

⁵ see Exhibit R of Petitioner's Brief in Support of Supplemental & Amended Objection to Attorney Fees and all Accounts Including Final Account.

⁶ see Exhibit S of Petitioner's Brief in Support of Supplemental & Amended Objection to Attorney Fees and all Accounts Including Final Account.

⁷ see Exhibit T of Petitioner's Brief in Support of Supplemental & Amended Objection to Attorney Fees and all Accounts Including Final Account.

⁸ see Exhibit U of Petitioner's Brief in Support of Supplemental & Amended Objection to Attorney Fees and all Accounts Including Final Account.

II. ISSUE

Does the benefit of continuing the Special Needs Trust for the benefit of [REDACTED] outweigh the cost of administration?

III. ANALYSIS

a. Previous and Current Costs of Administration, including Legal Fees

[REDACTED] charged a total of \$26,504.70 for attorney services between 1999 and 2006. She did not differentiate between Co-Trustee and Attorney charges. Specifically, for the first accounting, she charged \$2,035.00 (Exhibit B); for the second accounting she charged \$2,931.50 (Exhibit F); for the third accounting she charged \$2,810.00 (Exhibit G); for the fourth accounting she charged \$5,876.00 (Exhibit H); for the fifth accounting she charged \$4,565.00 (Exhibit I); for the sixth accounting she charged \$2,134.00 (Exhibit J); for the seventh accounting she charged \$2,828.20 (Exhibit K); for the final (withdrawn) accounting she charged \$2,447.50 (Exhibit L); and for the actual final accounting she charged \$2,447.50 (Exhibit M).

The total guardian ad litem costs for years 2000 through 2006 were \$6,886.25. Specifically, for the second accounting the GAL charged \$975.00 (Exhibit F); for the third accounting the GAL charged \$481.25 (Exhibit G); for the fourth accounting the GAL charged \$2,510.00 (Exhibit H); for the fifth accounting the GAL charged \$900.00 (Exhibit I); for the seventh accounting the GAL charged \$1,120.00 (Exhibit K); and for the final accounting the GAL charged \$900.00 (Exhibit M).

In 2006, the current Trustee (Dudek), and Mall Malisow & Cooney, P.C., charged a combined total of \$7,364.72 for services rendered as Trustee (the sum of \$7,117.22 and \$247.50, their respective charges (Exhibits X and Y)). In 2007, the current Trustee has charged \$20,193.42 for services rendered as Trustee (Exhibit AA). Please note that the total charges for Trustee services in 2006-2007 exceed ordinary annual trustee fees due to the charges associated with setting up a guardianship and obtaining government benefits. Based on past experience, Petitioner assures this Honorable Court that once benefits are obtained and the guardianship is finalized, Trust administration costs will be significantly lower.

An additional \$3,620.75 has been charged in 2006, and \$28,128.74 in 2007, for costs associated with the action against [REDACTED] (the sum of the charge for Dudek's services (\$6,355.48, Exhibit Z and BB) and the charge for Mall Malisow & Cooney services (\$21,773.26, Exhibits Y and CC)).

b. Potential Benefits of a Properly Administered Special Needs Trust, and Losses to the Trust Resulting from Failures in Prior Trust Administration

As a person with a developmental disability, with a properly administered Special Needs Trust and diligence on the part of all the parties involved, Andrew will have no problem

becoming eligible for community based mental health services, Medicaid insurance, Social Security Income, and Food Assistance Program benefits.

Community-based services are support services that are provided for people with disabilities, like [REDACTED], who live in their own homes and communities. Community-based services provide help for all aspects of a person's life and may include the following:

- ◊ Residential services and facilities, including supervised apartments or group homes.
- ◊ Personal assistance services, including assistive technology.
- ◊ Care planning, case management, and a comprehensive individualized plan, that includes a case manager, the person in need of services, and other people that support the individual.
- ◊ Day programs, including placement in activity centers and adult skills programs.
- ◊ Vocational services, including supported employment programs, job training and placement, and job coaching.
- ◊ Other quality of life services, such as recreation, leisure, and transportation.

According to a recent report published by the Kaiser Commission on Medicaid and the Uninsured, and the Urban Institute, per enrollee Medicaid spending for community based services for persons with disabilities is \$34,930.00 annually.⁹ In addition to the community based services, the average Medicaid medical spending per "disabled" enrollee in Michigan is estimated as being \$10,629.00 per year. *Exhibit DD*.¹⁰ Furthermore, a person similarly situated with Andrew would receive a total of \$50,268.00 in Social Security Income disbursements for years 1999 through 2006. *Exhibit EE*.

Using these very conservative numbers and assuming that [REDACTED] would have been eligible for services since 1999, over the past seven years he could have received approximately \$65,847.00 in Medicaid medical benefits, \$279,440.00 in community based services, and \$50,268.00 in SSI benefits. *see chart, next page*. The total amount of potential benefits, \$395,555.00, combined with \$61,905.68 in expenses incurred by the Trust for covered services and expenses such as medical bills, prescriptions, and tutoring, combined with the loss the Trust suffered as a result of the Detroit house expenditure, results in a total loss of \$457,460.68. This significant loss could have been avoided had Andrew's eligibility for government assistance been sustained. This Honorable Court must not permit a discontinuation of the Trust which will result in continued loss of Trust assets which could be used for [REDACTED] benefit.

⁹ The Urban Institute & Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Long-Term Care Beneficiaries: An Analysis of Spending Patterns*, published November 2006
< <http://www.kff.org/medicaid/upload/7576.pdf> > (accessed April 16, 2007).

¹⁰ According to the Kaiser Family Foundation's "Medicaid and the Uninsured" datasheet for fiscal year 2002, the average Medicaid payment, per "disabled" enrollee, in Michigan, was estimated as being \$6,234.00. *see Exhibit T*. Without being able to find additional information on Michigan per-enrollee spending for the years 1999-2001, and 2003, 2005, and 2006, the annual increases in spending listed in the Table for those years are estimates. The per-year difference used to estimate the per-enrollee spending for the years 2003, 2005, and 2006 is \$2,197.50 (the difference between the 2004 value of \$10,629.00 and the 2002 value of \$6,234.00, divided by two). For the years of 1999, 2000, and 2001, the 2002 rate of \$6,234.00 was reduced by one-thousand per year.

Applying the current Medicaid, SSI, and community based service estimates to future years, with a properly administered Trust, [REDACTED] would be eligible for approximately \$56,741.00 in government benefits annually. As of 2006, [REDACTED]'s monthly income is \$2,951.70, resulting in an annual income of \$35,420.40. With a properly administered Trust, many of [REDACTED]'s expenses (such as food, medical expenses, tutoring, psychological services, and any of the community services listed *supra*) would be paid for by the government; allowing the Trust's corpus to grow and better provide for [REDACTED]'s supplemental needs. Instead of [REDACTED] spending his monthly income of \$2,952.70 on items and services that could be paid for by Medicaid, Social Security, or FAP benefits, the money could be spent for his benefit or saved for a crisis situation, like when family is no longer able or willing to take care of him.

	<u>Potential Medicaid Medical Benefits</u>	<u>Potential SSI Benefits</u>	<u>Potential Benefits of Community Based Services</u>		<u>Actual "Covered" Expenses, Incurred by Trust</u>
1999	\$3,234.00	\$3,084.00	\$34,930.00		
2000	\$4,234.00	\$6,312.00	\$34,930.00	Acct 2:	\$20,000.00
2001	\$5,234.00	\$6,533.00	\$34,930.00	Acct 3:	\$4,660.75
2002	\$6,234.00	\$6,708.00	\$34,930.00	Acct 4:	\$4,437.90
2003	\$8,431.50	\$6,792.00	\$34,930.00	Acct 5:	\$6,025.00
2004	\$10,629.00	\$6,936.00	\$34,930.00	Acct 6:	\$4,931.78
2005	\$12,826.50	\$7,116.00	\$34,930.00	Acct 7:	\$19,950.25
2006	\$15,024.00	\$6,787.00	\$34,930.00	Acct 8:	\$1,900.00
<u>SubTotals:</u>	\$65,847.00	\$50,268.00	\$279,440.00		\$61,905.68
<u>Total of Lost Potential Benefits:</u>	\$395,555.00				
<u>Total Loss:</u>	\$457,460.68				

c. *Comparison of Costs of Administration and Benefits of Continuing the Trust*

As this Honorable Court is aware, a claim is pending against former Co-Trustees [REDACTED] for recovery of Trust assets lost as a result of her incompetence. Thus far, the cost of the action against [REDACTED] has been \$31,749.49. Had the Trust been properly administered, and had Medicaid, SSI benefits, food stamps, and community based living services been

obtained, the Trust would have saved \$61,905.68 in covered expenses, and [REDACTED] could have received an estimated \$395,555.00 in government benefits. In addition to requesting a recovery of the benefits and losses associated with [REDACTED] malpractice, Petitioner is requesting reimbursement by [REDACTED] to the Trust for attorney fees paid during her term as Co-Trustee, in the amount of \$26,504.70.

Further, if Petitioner prevails on the action against [REDACTED], Petitioner will request that the court not only reimburses the Trust for the \$457,460.68 in lost benefits/expenses, and [REDACTED]'s fees in the amount of \$26,504.70, but also for the \$31,749.49 in attorney fees associated with the action against [REDACTED]. If Petitioner prevails and this Honorable Court approves the request for fees, then there is no question that the benefit of bringing this action outweighs the cost as the Trust could stand to acquire \$515,714.87. If we prevail and the court does not approve a request for fees, then the benefit of bringing this action could still be as large as \$483,965.38; vastly outweighing the cost of not bringing the action.

If Petitioner does not prevail in the action against [REDACTED], the Trust will have to reimburse the firms for approximately \$31,749.49 in attorney fees. However, even if Petitioner does not prevail in the action against [REDACTED], her diligent actions as Trustee will have led to [REDACTED] being eligible for approximately \$56,741.00 per year in Medicaid, community based services, food stamps, and SSI benefits. Thus, even if the legal action is fruitless, the overall cost will be overshadowed within one year's time by the benefit of the acquired government benefits.

Furthermore, applying the current government benefit estimates to future years, with a properly administered Trust, [REDACTED] could be eligible for an estimated \$56,741.00 in government benefits annually. As stated *supra*, though the 2007 cost of Trust administration is quite high (\$20,193.42), it is expected that once all of [REDACTED]'s government services and benefits are acquired, the annual cost of administration will be greatly reduced. The 2007 costs of administration reflect a highly contentious battle of wills between all the parties involved. If all the parties continue to fail to cooperate in the future, and if the annual cost of administration is still approximately twenty thousand dollars, the fifty-seven thousand dollars in potential annual government benefits will continue to greatly outweigh the price of administration.

d. Maximizing Government Benefits While Maintaining Flexibility

This Honorable Court is rightly concerned with the practicality of providing for [REDACTED]'s needs while the vast majority of his assets are "tied up" in the Trust. This Honorable Court requested an explanation as to how [REDACTED] can maintain a higher standard of living when he is technically living at poverty levels. While it is true that [REDACTED] will not be able to have direct control over his assets, and the Trust cannot "support" him, there are very few short hurdles for him to clear in order to receive distributions for supplemental needs.

If [REDACTED] receives Medicaid, his medical needs will be taken care of by the government. If [REDACTED] receives SSI and FAP benefits, he will be able to afford food and other expenses that the Trust is unable to pay for. If [REDACTED] becomes eligible for community based living services expenses related to his vocational, educational, recreational, and leisure needs could be reduced or completely paid for. Any supplemental needs that [REDACTED] may have, that are not covered by any other source, are permissible distributions under the Trust. Permissible distributions include

dental work not covered by Medicaid, furniture, haircuts, appliances, musical instruments, over the counter medications, snow removal, telephone service, and utility bills. An extensive list of permissible distributions is included as Exhibit PP.

As long as the Trust functions appropriately, with all of his basic needs met by Medicaid, SSI, FAP, and community based living services, and with all of his supplemental needs met by the Trust, there is no need for [REDACTED] to live in poverty. Further, if [REDACTED]'s family members are unable to be gainfully employed due to their extensive efforts in caring for [REDACTED], there is no need for [REDACTED]'s family to live in poverty. Under the terms of the Trust, family members can be reimbursed for the time and effort spent caring for [REDACTED]. If the family paid rent to the Trust, they should be able to continue residing with [REDACTED] and helping him reach his maximum potential. The Trust may pay for [REDACTED]'s utilities and other housing expenses, such as lawn maintenance and furniture, to the extent these are incurred solely for [REDACTED]'s benefit.

If this Honorable Court terminates the Trust, [REDACTED] will suffer. If [REDACTED] and Mr. [REDACTED] have control over the assets, [REDACTED] will be ineligible for all government benefits. Even if this Honorable Court assumes that Mr. [REDACTED] would aid [REDACTED] in properly managing the assets, there is a high likelihood that the funds would be depleted prior to [REDACTED] obtaining a ripe age. If the Trust is discontinued, [REDACTED] will be left facing an uncertain future, with the Trust he has SSI, Medicaid, Medicare (at some point) and mental health services.

If this Honorable Court permits the Trust to continue providing for [REDACTED]'s supplemental needs, thereby ensuring eligibility for government assistance, the only thing that could throw a wrench into the beautiful art of Special Needs Trust administration is if Mr. [REDACTED] continues to thwart Dudek's honest efforts at sheltering for [REDACTED] by failing to communicate [REDACTED]'s needs and by failing to cooperate with the certification and annual recertification process associated with obtaining and continuing government assistance.

IV. RELIEF REQUESTED

ARGUMENT

RELIEF REQUESTED

I declare under the penalties of perjury that this Petition has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

Respectfully submitted,

PATRICIA E. KEFALAS DUDEK
Trustee; Petitioner
4190 Telegraph Rd, Ste 3000
Bloomfield Hills, MI 48302
248-731-3080

HARLEY D. MANELA
Attorney for Petitioner Dudek
30445 Northwestern Highway,
Farmington Hills, Michigan 48334
(248) 538-1800

ATTACHMENT

EIGHT

**STATE OF MICHIGAN
OAKLAND COUNTY PROBATE COURT**

**In the Matter of Irrevocable Special Needs
Trust f/b/o [REDACTED]**

**File No: [REDACTED]
Honorable Eugene Arthur Moore**

**Patricia E. Kefalas Dudek,
Former Co-Trustee**

Petitioner

**Patricia E. Kefalas Dudek (P46408)
Petitioner/Former Co-Trustee
Hafell Staran Hallahan Christ & Dudek, P.C.
4190 Telegraph Road, Suite 3000
Bloomfield Hills, Michigan 48302-2082
(248) 731-3080**

**[REDACTED]
Successor Co-Trustee
[REDACTED]
Telegraph Road, Suite 200
Bingham Farms, Michigan 48025
(248) 594-1919**

**[REDACTED]
Attorney for Co-Trustee [REDACTED]
[REDACTED]
Telegraph Road, Suite 345
Bingham Farms, Michigan 48025
(248) 723-9900**

**PETITIONER'S BRIEF REGARDING APPROVAL OF
CO-TRUSTEE AND ATTORNEY FEES**

Petitioner Patricia E. Kefalas Dudek submits this Brief in support of her Petition requesting that this Honorable Court award and approve Co-Trustee and attorney fees of Petitioner, Dudek and/or her office (collectively referred to herein as "Dudek") for services provided to and for the benefit of the Irrevocable Special Needs Trust f/b/o [REDACTED] and in support thereof states as follows:

PROCEDURAL AND FACTUAL HISTORY

1. Dudek began providing services to [REDACTED] and [REDACTED] (Co-Trustee and mother of [REDACTED]) in 2001 when Dudek was retained to establish a conservatorship for [REDACTED] as a protected individual, coordinate the legal action filed on [REDACTED]'s behalf under the National Childhood Vaccine Injury Act, and the custody dispute between [REDACTED] and her ex-husband [REDACTED] (see Trust Retainer Agreement attached as Exhibit A).
2. Following the settlement of the vaccine injury act suit, Dudek drafted and petitioned the court to create the Irrevocable Special Needs Trust f/b/o [REDACTED] (the "Trust") to be funded with the settlement proceeds (Order attached as Exhibit B).
3. Dudek and [REDACTED] were appointed by the Court to serve as Co-Trustees of the Trust.
4. Over a year into the Trust's administration, the Co-Trustee relationship between Dudek and [REDACTED] proved untenable. [REDACTED] refused to accept Dudek's advice and recommendations on how to manage the Trust for [REDACTED]'s sole benefit.
5. Dudek filed a "Petition for Approval to Withdraw as Co-Trustee; Appointment of New Trustee; Approval of First Annual Accounting of Co-Trustees and Appointment of Guardian ad Litem" on May 3, 2006. (Exhibit H).
6. Over [REDACTED]'s objections, this Honorable Court granted Dudek's Petition and entered an "Order Allowing Withdrawal of Co-Trustee, Patricia E. Kefalas Dudek, Appointment of New Co-Trustee, and Approval of First Annual Accounting of Co-Trustees" on August 15, 2006. (Exhibit I).

7. Dudek filed a "Petition for Approval of Final Account of Co-Trustees for the Period January 1, 2006 Through August 31, 2006, Approval of Legal and Trustee Fees and Discharge Co-Trustee, Patricia B. Kefalas Dudek" on October 17, 2006.
8. A motion for Summary Disposition was filed by Dudek on January 10, 2007.
9. The current Co-Trustees of the Trust, [REDACTED] and [REDACTED] (hereinafter "Co-Trustees") filed a Response to Petitioner's Motion for Summary Disposition on January 29, 2007.
10. Dudek filed an Answer to Co-Trustee's Response to Motion for Summary Disposition on March 5, 2007.
11. A hearing was held on Dudek's Motion for Summary Disposition, during which this Honorable Court denied Dudek's prayer for Summary Disposition, determining that "reasonableness" of fees was a factual inquiry.

ISSUES

1. Did Dudek render Co-Trustee services during the establishment and administration of the Trust, are the fiduciary fees charged by Dudek reasonable, and is she entitled to compensation?
2. Did Dudek render Attorney services during the establishment and administration of the Trust, are the attorney fees charged by Dudek reasonable, and is she entitled to compensation?

ARGUMENT

I. DUDEK RENDERED CO-TRUSTEE SERVICES DURING THE ESTABLISHMENT AND ADMINISTRATION OF THE TRUST, THE FIDUCIARY FEES CHARGED BY DUDEK ARE REASONABLE, AND SHE IS ENTITLED TO COMPENSATION.

The Estate and Protected Individuals Code provides that a Trustee shall receive just and reasonable compensation for services provided to a Trust. In *Comerica Bank v City of Adrian (In re Estate of Fee)*, 179 Mich App 712, 724; 446 NW2d 553 (1989), the Michigan Court of Appeals set forth twelve factors to be considered in determining the reasonableness of a Trustee's fee:

(1) the size of the trust, (2) the responsibility involved, (3) the character of the work involved, (4) the results achieved, (5) the knowledge, skill, and judgment required and used, (6) the time and the services required, (7) the manner and promptness in performing its duties and responsibilities, (8) any unusual skill or experience of the trustee, (9) the fidelity or disloyalty of the trustee, (10) the amount of risk, (11) the custom in the community for allowances, and (12) any estimate of the trustee of the value of his services. *Id.*

When determining which factors are to be given weight, the probate court is required to consider the circumstances of the case. *Id.* The determination of reasonable compensation is within the probate court's discretion. *Id.*

Dudek was hired by [REDACTED] to provide legal services in establishing a conservatorship, with [REDACTED] serving as conservator, for [REDACTED] as a protected individual. Dudek began her representation in May of 2001. The conservatorship was established in late 2002 and was terminated following the creation of the present Special Needs Trust in the fall of 2004. The Trust was established by the Oakland County Probate Court, the Honorable Eugene A. Moore. The Trust was established with a lump sum payment of

\$332,617.26 and funded with continuing payments from an annuity purchased with an additional \$704,776.18 received from the resolution of a National Childhood Vaccine Injury Act claim filed on behalf of [REDACTED]. The Trust was established with Co-Trustees: Dudek and [REDACTED]

During the first year of the establishment of the Trust, Dudek's Co-Trustee duties were extensive. Dudek initially drafted and established the Trust. As Co-Trustee Dudek was responsible to review, advise, and make a determination on disbursement requests from [REDACTED]. Dudek met directly, in writing, and telephonically with [REDACTED] to explain the Trust provisions, and was often required to clarify [REDACTED]'s misconceptions as to the purpose of the Trust and the proper use of Trust funds. Dudek provided numerous funding options to [REDACTED] with regards to the Trust, provided assistance with mortgage options and provided assistance in obtaining a loan for the purchase of a new home.

Dudek established a bank account for the Trust, made arrangements for an investment account, provided payment to numerous creditors that were entitled to reimbursement prior to the establishment of the Trust, and made extensive disbursements in the first year of the Trust. Many of the disbursements were reimbursements to [REDACTED] for items that had previously been purchased, which required verification of the purchase price and substantiation that the purchase was for [REDACTED]'s sole benefit.

As Co-Trustee, Dudek provided [REDACTED] with long-term plans pursuant to the terms of the Trust, but had to repeatedly counter [REDACTED]'s resistance to the proper use of the Trust funds for the sole benefit of [REDACTED]. Understandably, due to [REDACTED]'s unstable personal financial situation, she became dependant on the Trust's income, even though Dudek had arranged for her to be paid as Co-Trustee and Care Coordinator for [REDACTED]. This led to

█████'s attempts to misuse the Trust's funds for improper purchases, which hindered, to a degree, the security and independence afforded to █████. During this time, Dudek had numerous discussions with █████ as to the disbursements made by the Trust account.

For example:

1. █████ argued about mortgage terms, but failed to secure any lender to loan money to the Trust for the purchase of a home. It was solely through a contact of Dudek that a mortgage was secured (see emails attached as Exhibit C);
2. █████ insisted that the Trust pay for a boat and the marina slip fee, notwithstanding it was not for █████'s sole use (see emails attached as Exhibit C);
3. █████ argued about █████'s father being paid for working on the home (see emails attached as Exhibit C) when he has never provided legal child support for █████
4. █████ argued about purchasing █████'s father's house as an investment for the Trust, as well as building and selling houses as an investment and employing █████'s father as the contractor (Exhibit C);
5. █████ argued about the purchase of a treadmill for █████ who uses a wheelchair and, when asked by Dudek, failed to provide a doctor's prescription indicating that this would be for the sole benefit for █████ (Exhibit C);
6. █████ argued about Trustee fees being too high to safeguard █████'s interest, in spite of the fact that the Trust paid █████ a salary to support her living expenses and from which she purchased a Jaguar automobile for herself (Exhibit C); and
7. █████ refused to follow Dudek's advice to invest the Trust money in an investment management program thus failing to provide proper management and security of the Trust assets (Exhibit C).

8. [REDACTED] unilaterally made purchases without the approval or agreement of Dudek, including taking her boyfriend on vacation with her and [REDACTED] at [REDACTED]'s expense.

All of Dudek's actions as Co-Trustee were provided in detailed invoices submitted to [REDACTED] as Co-Trustee on a monthly basis. As detailed in the invoices, the services provided by Dudek were necessary for the efficient administration of the Trust and the resultant fees charged were reasonable (Exhibit D). The time and expenses listed in the invoices, which were previously consented to by [REDACTED] illustrate the reasonableness of Dudek's fiduciary acts and justify the fees for the time, effort, and expense spent in the administration of the Trust.

In accordance with the twelve *Comerica Bank* factors listed *supra*, Dudek's fiduciary fees are reasonable, were for [REDACTED]'s best interests, and she is entitled to compensation. First, the Trust is large: it was established with a lump sum payment of \$332,617.26 and funded with continuing payments from an annuity purchased with an additional \$704,776.18. Second, Dudek was charged with the responsibility of not only protecting the Trust assets from being spent on items not for [REDACTED]'s sole benefit, but Dudek was responsible for complying with the Prudent Investor Rule, and for obtaining government benefits for [REDACTED]. Third, as has been illustrated by the pleadings filed by both parties, the character of the work involved was not only difficult, but was highly contentious. Fourth, during her time as Co-Trustee, Dudek's fiduciary services resulted in the establishment of not only the Trust itself, the purchase and modification of a home for [REDACTED] a bank account, the payment of creditors, the visualization of a long-term plan for the Trust, and protection of the Trust assets from attempts by [REDACTED] to use the assets in

ways that were not for the sole benefit of [REDACTED]. Fifth, the level of knowledge, skill, and judgment required to create and administer a Special Needs Trust, especially when there is an inexperienced Co-Trustee involved, is unquestionably high and time consuming. Sixth, as evidenced by the invoices attached as Exhibit D, a large amount of time and services were required to administer this Trust and protect the assets of the Trust from being used for purposes that were not for [REDACTED]'s sole benefit. Seventh, Dudek provided services to the Trust in a prompt and efficient manner; at times, the most prompt and efficient manner of providing services required the coordination of support staff services. Eighth, as discussed at length below, Dudek is an attorney who possesses an extraordinary amount of skill and expertise and is a nationally recognized leader in the area of estate planning for persons with disabilities and parents of children with disabilities. Ninth, Dudek was never disloyal to the Trust or [REDACTED], and Dudek only motioned this Honorable Court to be removed as Co-Trustee when her discourse with [REDACTED] ceased being beneficial to the Trust and [REDACTED] began to use Trust assets unilaterally. Exhibit H. Tenth, a Trustee of a Special Needs Trust always faces a certain amount of risk due to the extensive tax, Medicaid, and SSI regulations concerning Special Needs Trusts, and coordination of same with the Federal Vaccine Compensation Act. Eleven, it is customary for Co-Trustees to be paid for their services. Lastly, Dudek has estimated the value of the services she rendered as Co-Trustee as being worth \$250 (or more). This estimation is based upon her own experience as well as the expert opinions of other well-known and highly respected attorneys in this field. For example, Attorney Elizabeth Luckenbach Brown, of Jaffe Raitt Heuer & Weiss, P.C., believes that other Trustees of Special Needs Trust charge between \$200.00 and \$300.00 an hour; Attorney Sanford

Mall, of the Mall Malisow Firm, PC, charges \$275.00 per hour when acting as the Trustee of a Special Needs Trust, and believes that other attorneys in this field charge between \$200.00 and \$300.00 an hour; and Attorney Don Rosenberg of Barron Rosenberg Mayoras & Mayoras charges \$250.00 per hour when acting as the Trustee of a Special Needs Trust, and believes that other attorneys in this field charge between \$200.00 and \$300.00 per hour. Exhibit F.

Under the circumstances of this case, the services Dudek provided as Co-Trustee were rendered necessary; and as determined under the *Comertea Bank* factors, *supra*, the Co-Trustee fees charged by Dudek are reasonable. All of Dudek's charged activities were set forth in the first, second, and final accountings prepared by Dudek and provided to [REDACTED]. The services performed were in the best interests of [REDACTED] and the Trust and benefited both the Trust and [REDACTED]. The accountings are true and accurate. There is no wrongdoing on the part of Dudek as Co-Trustee and there is no viable objection to her performance as Co-Trustee or the fees charged for her service. As such, Dudek is entitled to compensation for Trustee fees in the amount \$8,686.71 (\$5,386.70 outstanding) for the period covered by the second and final accounting.

II. DUDEK RENDERED ATTORNEY SERVICES DURING THE ESTABLISHMENT AND ADMINISTRATION OF THE TRUST, THE ATTORNEY FEES CHARGED BY DUDEK ARE REASONABLE, AND SHE IS ENTITLED TO COMPENSATION.

An attorney is entitled to recover reasonable compensation for her services. MCL 700.5413; *In re Estate of Esther Benfer*, Michigan Court of Appeals, per curiam decision, No. 262895 (Nov 21, 2006). "To be chargeable against the estate, the attorney fees must

be for services rendered on behalf and befitting the estate." *In re Prichard Estate*, 164 Mich App 82, 86 (2987).

Michigan Rule of Professional Conduct 1.5(a) states that

A lawyer shall not enter into an agreement for, charge, or collect an illegal or clearly excessive fee. A fee is clearly excessive when, after a review of the facts, a lawyer of ordinary prudence would be left with a definite and firm conviction that the fee is in excess of a reasonable fee. The factors to be considered in determining the reasonableness of a fee include the following:

- (1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;
 - (2) the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;
 - (3) the fee customarily charged in the locality for similar legal services;
 - (4) the amount involved and the results obtained;
 - (5) the time limitations imposed by the client or by the circumstances;
 - (6) the nature and length of the professional relationship with the client;
 - (7) the experience, reputation, and ability of the lawyer or lawyers performing the services; and
 - (8) whether the fee is fixed or contingent.
- emphasis added.*

In addition to the clear statutory authority for this Honorable Court to approve the Co-Trustee and Attorney fees of Dudek, case law supports the application of *quantum meruit*. *Quantum meruit* is literally translated as "as much as he as deserved" and is defined as "a claim or right of action for the reasonable value of services rendered." *Black's Law Dictionary* 1255 (Bryan A. Garner ed., 7th ed, West, 1990). The Court of Appeals in *Reynolds v Polen*, 222 Mich App 20; 564 NW2d 467 (1997) stated "A clear line of authority indicates that when an attorney rightfully withdraws from a matter, recovery of attorney fees on a *quantum meruit* basis is appropriate."

Michigan case law has established a test to determine the reasonableness of challenged attorney's fees. A probate court has broad discretion in determining what

amount constitutes reasonable compensation for attorney services, *In re Estate of L'Esperance*, 131 Mich App 496 (1994); *In re Krueger Estate*, 176 Mich App 241, 248 (1989), and where the amount of attorney's fees is in dispute, each case must be reviewed in light of its own particular facts. *In re Martin*, 205 Mich App 96, 109-110 (1994), rev'd on other grounds, 450 Mich 204 (1995). In making this determination, the probate court has directed that it should adhere to the guidelines for determining "reasonableness" set forth in *Crawley v Schick*, 48 Mich App 728, 737 (1973). *L'Esperance, supra*, at 501.

The Court in *Crawley* stated:

There is no precise formula for computing the reasonableness of an attorney's fee. However, among the facts to be taken into consideration in determining the reasonableness of a fee include, but are not limited to, the following: (1) the professional standing and experience of the attorney; (2) the skill, time and labor involved; (3) the amount in question and the results achieved; (4) the difficulty of the case; (5) the expenses incurred; and (6) the nature and length of the professional relationship with the client.

48 Mich App at 737. The Michigan Supreme Court adopted the *Crawley* standards in *Wood v DAHE*, 413 Mich 573, 588 (1982).

Although there is no universal yardstick which can be used to measure the reasonableness of charges for services of all attorneys, it may be generally stated that among the principal elements or factors to be considered in determining the fair and reasonable value of an attorney's services are the skill and experience called for, the character of the services, the importance of the case, the time spent, the expenses incurred, the difficulty of the case, the professional standing of the attorney, and the results accomplished. A particular charge or allowance for legal services rendered will be sustained if, on a consideration of all the facts and circumstances, in accordance with

the rules stated above, the amount thereof is determined to be sufficient, reasonable, and proper.

In *Crawley*, the Court adopted several of the general standards of the Code of Professional Responsibility and Ethics, Disciplinary Rule 2-106, for determining reasonable attorney fees. Although Disciplinary Rule 2-106(B) relied on in *Crawley* has been repealed, its successor, MRPC 1.5(a), is substantially the same. That rule parrots the *Crawley* factors with the addition of one supplementary relevant factor--that the fee charged is in line with fees customarily charged in the locality for similar legal services. MRPC 1.5(a)(3).

Pursuant to these factors there is no question that the attorney fees Dudek charged for legal services rendered to the Trust are reasonable for the time period in question. Based on the difficulty of the matter, the appropriateness of the time allocated to the services listed in the invoices, the reasonable hourly rate charged, and Dudek's expertise in the administration of special needs trusts, the hourly rate and amount of time expended constitute an appropriate amount of attorney's fees charged. The Trust (and [REDACTED]) was well served and received value and protection from Dudek's legal representation.

First and foremost, the hourly rate charged by Dudek for legal services was reasonable and customary, and was clearly known to [REDACTED]. Pursuant to the Trust Retainer Agreement (Exhibit A) [REDACTED] entered with Dudek in 2002, Dudek initially charged the Trust \$200 per hour for her attorney services.¹ The hourly rate was later increased to \$250 per hour as authorized by the retainer agreement. The Trust Retainer Agreement provides in pertinent part:

¹ It is without question that [REDACTED] was aware and agreed to the initial hourly rate of \$200 per hour. While Dudek maintains that the increased rate of \$250 per hour is reasonable and should be approved, it is clear that the rate amount cannot be below \$200 per hour.

[T]he attorneys shall be paid at the rate of Two Hundred (\$200.00) Dollars per hour....These hourly rats may increase during a lengthy representation and you will be charged accordingly.

* * *

We will send you monthly statements to you detailing the services provided. In addition to the fees, our firm will advance costs as may be needed on your behalf. Typical costs include such items as filing fees for petitions and delivery to the court, express mail charges and any out of pocket costs. ...

* * *

...All accounts not paid in full are subject to seven (7) percent interest annually.

██████ was provided copies of the legal services invoices which clearly reflected the work provided by Dudek, the costs forwarded and the increased \$250 hourly rate. The increase in the hourly rate was clearly detailed in the Trust Retainer Agreement that ██████ agreed to (Exhibit A).

The increase in the hourly rate was not an indiscriminate change, rather it came after Dudek had provided legal services to ██████ and the conservatorship created to manage ██████'s estate. This interaction with ██████ and ██████ predates the creation of and services provided to the Trust. As stated *supra*, Dudek was hired by ██████ to provide legal services in establishing a conservatorship, with ██████ serving as conservator, for ██████ as a protected individual. Dudek began her representation in May of 2001. The conservatorship was established in late 2002 and was terminated following the creation of the present Special Needs Trust in the fall of 2004. During this period Dudek successfully defended against an attempt by ██████'s father to be appointed co-conservator and co-trustee, maintained Supplemental Security Income ("SSI"), Medicaid, and Community Mental Health Services through MORC, Inc.

Dudek charged \$200 per hour for this multitude of services, but because [REDACTED] and [REDACTED]'s conservatorship did not have the assets to pay the legal fees, Dudek's bills were not paid during this three and one half year period. Not until the vaccine injury settlement had been paid to [REDACTED]'s estate did Dudek receive any compensation for services provided and even then Dudek voluntarily waived the imposition of the seven percent interest she was contractually entitled to under the retainer agreement. This Court authorized a payment to Dudek to be made from the Trust (Exhibit B). By that time Dudek's legal services bill had grown to \$10,908.17.

It was only after this extended period of unpaid representation that Dudek increased the hourly rate to \$250--a rate that is reasonable and customary for attorneys of Dudek's experience and expertise. The \$250 hourly rate is within the range of expected and accepted rates charged by attorneys in Southeast Michigan and in particular attorneys that practice in the area of estate planning for persons with disabilities.²

As stated in Dudek's Motion for Summary Disposition, Dudek has practiced in the area of probate and special needs estate planning for over 14 years. She is a nationally recognized leader in the area of estate planning for persons with disabilities and parents of children with disabilities. She is the former chairwoman of the Elder Law and Advocacy Section of the State Bar of Michigan, and a member of the Probate and Estate Planning Section. Dudek is the immediate past chair of the National Academy of Elder Law Attorneys' (NAELA) Trust Special Interest Group. Dudek is a frequent

² By way of comparison, the hourly rate is the same charged by [REDACTED]'s personal attorney, [REDACTED], an attorney with limited to no experience in protecting the rights of people with disabilities or the administration of special needs trusts. [REDACTED]'s fees were paid unilaterally by [REDACTED] to object to supervision of this Trust and the appointment of a GAL to protect [REDACTED]'s best interests. If any fees are unreasonable, Dudek contends they are [REDACTED]'s legal fees.

lecturer on the topic of special needs trusts and is a distinguished presenter and recent key-note speaker at NABLA conferences, and the 2005 NABLA Pawley Award Winner.

The skill, time, and labor required in administering a Special Needs Trust in general is considerable; and this effort was only exacerbated by the difficult interaction with Co-Trustee [REDACTED]. Dudek drafted and established the Special Needs Trust for the benefit of [REDACTED]. Through Dudek's efforts the Trust has been managed to assist [REDACTED]'s financial affairs in order to provide him with the greatest degree of security and independence and serve his best interests. The nature and the length of Dudek's professional relationship with [REDACTED] and the Trust justifies the fees charged by Dudek, and thus the fees are not excessive under MRPC 1.5(a)(6) and the factors enumerated in *Crawley, supra*. Further, the unpaid fees were required for Dudek to act in [REDACTED]'s best interests, to disallow these fees now serves to punish Dudek for Petitioning for Supervision of the Trust and the appointment of a GAL to protect [REDACTED].

Dudek charged \$200-250.00 per hour for her specialized services. Other similarly situated attorneys, who specialize in Probate, Estate, and Trust Administration, in Michigan, charge amounts similar to or higher than Dudek. For example, Attorney Doug Chalgian of Chalgian & Tripp Law Offices, PLLC, Lansing, Michigan, charges \$250.00 per hour, and Attorney Norman Harrison, of Saginaw, Michigan charges \$200.00 to \$250.00 per hour for attorney services. Exhibit E. Attorneys who are similarly situated, and are in Dudek's locality, also charge an hourly rate that is similar to that charged by Dudek. For example, Attorney Josh Ard, J.D., M.B.A., Ph.D., of Williamston, Michigan, charges \$275.00 to \$300.00 per hour when providing attorney services, Attorney Elizabeth Luckenbach Brown of Jaffe Raitt Heuer & Weiss, P.C., Southfield, Michigan,

charges \$225.00 per hour, Professor George A. Cooney of the Law Offices of George A. Cooney, Jr., Farmington Hills, Michigan, charges \$300.00 per hour, Attorney Michele P. Fuller, of Fuller & Stubbs, PLLC, Shelby Township, Michigan, charges \$225.00 per hour, Attorney Sanford Mall, of the Mall Malisow Firm, PC, Farmington Hills, Michigan, charges \$275.00 per hour, and Attorney Don Rosenberg of Barron Rosenberg Mayoras & Mayoras, Troy, Michigan, charges \$250.00 per hour for attorney services. Exhibit F. If other attorneys in the locality charge fees that are approximately the same fees or higher fees for similar legal services, then Dudek's fees are neither excessive or unreasonable under MRPC 1.5(a)(3). [REDACTED] objects to Dudek's fees because she is angry Dudek petitioned for Supervision of the Trust and appointment of a GAL for [REDACTED]. [REDACTED] also threatened Dudek with a malpractice suit.

In the *Response of Co-Trustees to Motion for Summary Disposition of Patricia E. Kefalas Dudek*, Co-Trustees unsoundly relied on outdated surveys from 2000 and 2003 concerning the hourly rates of attorneys specializing in Probate, Estate, and Trust Administration. During the winter of 2006, an extensive survey was conducted by the Probate and Estate Planning Section of the Michigan Bar which led to the publication of the *2006 Desktop Reference on the Economics of Probate and Estate Planning Practice in Michigan*, made available in the Winter 2006 Michigan Probate and Estate Planning Journal. The *2006 Desktop Reference* provides separate tables and reference materials concerning the hourly billing practices for attorneys by office locale, degree of specialization, firm size, classification of services rendered, and number of years in practice. Relevant portions of the *2006 Desktop Reference* are attached as Exhibit G.

According to the *2006 Desktop Reference*, the range of hourly rates for Trust Administration of an office located in Oakland County, south of highway M-59, is between \$100 and \$410. The range of hourly billing rates for an attorney who spends 100% of her time in Probate and Estate practice is \$100 and \$495 per hour, with a mean average of \$224 and the upper quartile charging \$251. A partner in a firm with two to seven partners will typically charge between \$135 and \$300 hourly, with a mean average of \$206 and the upper quartile charging \$228 per hour. Additionally, an attorney who has eleven to fifteen years of experience in this niche of the law will typically charge between \$175 and \$385 per hour, with a mean average of \$203 and the upper quartile charging \$225.

According to the *2006 Desktop Reference*, the highest hourly rates are above \$400, sometimes nearing \$500. Even if this court were to ignore Dudek's uniquely high degree of expertise in the field of special needs estate planning, simply being an attorney who practices in Oakland County, spends 100% of her time specializing in Probate and Estate matters, is a partner in a firm with five partners and has fourteen years of experience, the hourly rates that Dudek charged were in conformance with the hourly rates charged by similarly situated attorneys. Taking her level of expertise into consideration, Dudek's billing practices should be compared to attorneys who are charging the maximum rates. As such, Dudek's rate of \$250 was drastically beneath the reported amounts that reached as high as \$495 for Trust Administration and \$410 for Conservatorships. While Dudek is not petitioning this court to retroactively increase the hourly billing rate charged to the Trust, it is important to note that the fees sought by

Dudek are radically below what the Trust could have been charged. Further, Dudek has been forced to spend considerable time and energy to defend these fees.

Providing legal services to a Special Needs Trust is a cumbersome task, which requires a large amount of skill and experience. [REDACTED] and the Trust benefited from Dudek's fourteen years of experience as a Probate and Estate Planning attorney, and Dudek spent a large amount of time protecting the Trust from [REDACTED]'s attempts to misuse the assets. Considering the lengthy nature of her relationship with [REDACTED] and the Trust, and the statements provided by other highly esteemed attorneys in this field which unanimously support the conclusion that Dudek's fees are reasonable, this Honorable Court should approve the requested attorney fees in the amount of \$9,234.78 (\$6,636.78 outstanding) for the period covered by the second and final accounting of the Trust.

RELIEF REQUESTED

Dudek respectfully requests that this Honorable Court enter an order approving the payment of:

- A. Trustee fees in the amount of \$13,764.86, and attorney fees in the amount \$19,222.54 for the period covered by the first accounting;
- B. Trustee fees in the amount \$8,686.71 (\$5,386.70 outstanding) for the period covered by the second and final accounting;
- C. Attorney fees in the amount \$9,234.78 (\$6,636.78 outstanding) for the period covered by the second and final accounting;
- D. Annual interest in the amount of 7% accrued on the unpaid attorney and co-trustee fees, as agreed to in the written retainer agreement.
- E. All legal and trustee fees incurred by Dudek to transition Trust funds to the new co-trustee; and
- F. Directing the new co-trustee to pay Dudek all unpaid fees immediately.

Respectfully submitted,

**HANELI STARAN HALLAHAN
CHRIST & DUDEK, P.C.**

Date: _____

By: _____
Patricia E. Kofalas Dudek (P46408)
Attorneys for Petitioner
4190 Telegraph Road, Suite 3000
Bloomfield Hills, MI 48302-2082
(248) 731-3080