BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

vs.

EASTERN LOS ANGELES REGIONAL CENTER,

Service Agency.

OAH No. 2022050258

DECISION

Irina Tentser, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter on July 11, 2022, by videoconference.

Jacob Romero, Fair Hearing and HIPAA Coordinator, represented Eastern Los Angeles Regional Center (ELARC or Service Agency).

Melissa Amster, Attorney, represented Claimant. Claimant's mother (Mother) was present throughout hearing.

Testimonial and documentary evidence was received. The record closed and the matter was submitted for decision on July 11, 2022.

ISSUE

Should Service Agency fund a total of 40 hours per week of LVN Respite Services for Claimant, with Service Agency funding to be discontinued if Medical agrees to fund the LVN Respite Services at a total of 40 hours per week?

EVIDENCE RELIED UPON

Documents: Service Agency Exhibits 1-24; Claimant Exhibits A-EE.

Testimony: Mayra Santana, ELARC Service Coordinator; Jacob Romero, ELARC Fair Hearing and HIPAA Coordinator; Kenny Ha, Aveanna Healthcare Director of Business Development; and Mother.

FACTUAL FINDINGS

Jurisdictional Matters

1. Claimant is a six-year-old girl who is eligible to receive services from Service Agency based on her diagnoses of cerebral palsy and intellectual disability. Claimant lives at home with her father and Mother. Mother is the primary caregiver. Claimant's paternal grandmother visits the home but does not provide care for Claimant.

Claimant's Background

2. Claimant is diagnosed with Global Developmental Delay 315.8 (ICD: F 88) (Significant adaptive deficits) and Cerebral Palsy; Polymicrogyria; and partial deletion of Chromosome 6. (Exhibit 3.) Claimant is also diagnosed with indeterminate handedness, bilateral frontoparietal, right temporal lobe polymicrogyria, left

parasagittal posterior frontal lobe closed lip schizencephaly, and microcephaly. Claimant also has a history to seizures. (*Ibid.*)

3. Claimant is non-ambulatory and non-verbal. She requires 24-hour support from a caregiver with all self-help skills, toileting, bathing, dressing and feeding. (Exhibit 3.) She requires assistance with mobility, transfers and positioning. Claimant can sit when propped up. She can reach for objects and write her name with hand over hand assistance. She can use her fingers to point to pictures on the iPad. Claimant uses diapers. She is transported via wheelchair. Claimant uses ankle-foot orthoses. She suffers from constipation due to her medication or because she does not move her lower extremities.

4. Claimant had a gastrostomy tube (G-tube) inserted in October 2020. She is fed exclusively by the G-tube and nothing by mouth. She takes PediaSure, prune juice, and medication via the G-tube.

Claimant's Medical Conditions

5. Claimant was hospitalized from October 20, 2020, through November 4, 2020, due to laceration to her neck. A Special Incident Report was generated as a result. Mother was criminally charged with child abuse/aggravated assault. Mother testified at hearing that she was involuntarily committed for three weeks around the time of the incident that led to her arrest. She is in the process of completing a mental health diversion program as of the date of hearing stemming from the incident. Mother testified at hearing that the stress of being the primary caregiver for Claimant without respite assistance from other caregiving sources contributed to the occurrence of the 2020 incident.

6. In 2019, Claimant was diagnosed with hip dysplasia, which complicates her care needs because Claimant requires assistance with all movements and transfers. In October 2019 and April 2021, Claimant underwent hip surgeries on both sides of her body. The procedure put hardware inside the hip areas, followed by a full body cast Claimant had to wear for three to four months because part of the procedure included breaking the femur bone. In addition, Claimant underwent double adductor surgery, and a six-month recovery period followed. Mother reported Claimant cried incessantly at all hours while she was awake for three months straight. Mother further reported that the recovery process was exceedingly difficult for her mentally, as Claimant's primary caregiver, to manage.

7. As of the date of hearing, Claimant has a brace that goes around her waist and down one leg, which requires Mother to physically move Claimant to get her around. Claimant weighs approximately 45 pounds. Claimant's right hip has dislocated again, shifting the joint to one side so that the top of the femur rubs on the hip bone. A third hip surgery is therefore required and is currently scheduled for the first week of August 2022. After the surgery, Claimant is projected to be in the hospital for one week. A body cast brace will be required for a projected minimum of three months following the surgery.

8. Based on Claimant's recovery from her first two hip surgeries, it is likely Claimant will require a similarly prolonged recovery period that will place demands on Mother as her caregiver. Mother reported she is concerned she may be unable to meet the caregiver demands in a manner sufficient to meet Claimant's medical needs.

9. Claimant is authorized to receive 283 hours per month of In-Home Supportive Services (IHSS) from the county. 168 of the 283 hours are for protective supervision of Claimant. Mother is Claimant's IHSS provider. As of August 1, 2021, IHSS

deemed Claimant "can get 41 hours, 59 minutes per week of protective supervision services because a recent assessment showed [Claimant is] non-self-directing, confused, mentally impaired or mentally ill and need 24-hour supervision to safeguard [Claimant] from injury, hazard or accident. During times outside of IHSS authorized protective supervision, supervision must be provided through another agency or person." (Exhibit 4.)

10. Claimant's medical expenses are covered by private insurance and by Medi-Cal through Institutional Deeming. Institutional Deeming provides full scope unrestricted Medi-Cal coverage without a share of cost for developmentally disabled consumers under age 18.

Claimant's Respite Services

11. On January 27, 2020, Service Agency approved 48 hours per month of LVN respite services for Claimant from January 1, 2020, through June 30, 2020. (Exhibit 21.) The 48 hours per month of LVN respite services have subsequently been approved by Service Agency in six-month increments through December 31, 2022.

12. Claimant has not, at any time, received the 48 hours per month of LVN respite services authorized by Service Agency. Initially, in May 2020, the service was postponed by Claimant's family due to COVID-19 safe at home precautions. In October 2020, Mother requested the LVN respite services to be initiated and the authorization was changed to start in October 2020. It is undisputed that despite a diligent search Service Agency has been unable to locate a home health care vendor who can find an LVN to provide Claimant's LVN respite services at the 48 hours per month authorized rate. Claimant maintains that an LVN cannot be found because most LVNs do not accept assignments that are less than 40 hours per week. Service Agency

contends that an LVN cannot be found because of nursing staff shortages. However, Service Agency was advised as of February 25, 2020, that for vendors with medical staff available, "they only accept consumers with 32hrs per week…" (Exhibit CC, p. 5 of 64.)

13. During the two years in which Claimant received no LVN respite services from any provider, the family pursued generic resources to fund an LVN for a total of eight hours per day based on the medical demands of Claimant's care. Their efforts were unsuccessful. On March 4, 2022, Claimant's private insurance, Independence PPO, denied the request on appeal due to a lack of medical necessity:

> "[N]o skilled nursing needs were documented that would require the knowledge, skills and judgment of a trained nurse-only that of a trained caregiver. In addition, services that are solely to provide respite and/or to allow or accommodate the member caregiver's schedule is not medically necessary therefore not covered. Therefore, this is denied as not medically necessary."

(Exhibit E.)

14. In March 2022, one of Service Agency's vendors Claimant had been working with for several months to provide an LVN for Claimant's 48 hours per month of LVN respite, Kenny Ha of Aveanna Healthcare, suggested Claimant request 40 hours per week of LVN respite services for a limited period of two months to be funded by Service Agency, so that an LVN could be provided for Claimant to generate TAR notes as part of an application to be submitted to Medi-Cal to fund the service. A TAR is a

form required to be submitted to Medi-Cal to obtain approval of Claimant's funding request for full-time LVN care at a rate of 40 hours per week.

15. At Claimant's most recent Individual Program Plan (IPP) meeting, on January 19, 2022, an increase in LVN respite hours was discussed with Claimant's former Service Coordinator and the family subsequently requested Service Agency fund 40 hours per week of LVN respite services. By a Notice of Proposed Action (NOPA) dated April 14, 2022, Service Agency notified Claimant the request was denied. The basis for the denial was stated as follows:

> ELARC Registered Nurse assessed the need for gastronomy [*sic*] respite and recommended 48 hours of Nursing Respite per month. Medical insurance has also reviewed the case and found that nursing care is not clinically warranted. Subsequent appeal of the insurance denial upheld the original decision. As a result, there is adequate support from the regional center and generic resources.

(Exhibit 1.)

16. On April 29, 2022, Claimant, through counsel, submitted a Fair Hearing Request (FHR) appealing Service Agency's denial. The basis for requesting a fair hearing was cited as "[D]enial of LVN Nursing Services for 40 hours per week, or until Medi-Cal approves services." (Exhibit 2.)

May 11, 2022, Informal Meeting

17. On May 11, 2022, an informal meeting was held by videoconference between the parties. Claimant's Individualized Education Program (IEP) services,

provided by the school district, were discussed at the meeting. Claimant is attending the Carlson Home Hospital program. The teacher came into Claimant's home prior to COVID-19. Subsequently, all sessions in Occupational Therapy (OT) and Physical Therapy (PT) are through video conference.

18. During the May 11, 2022, informal meeting, at Service Agency's request, Mother described a typical Monday through Friday week for Claimant. Her description was consistent with her hearing testimony.

> Mother noted that [Claimant] wakes up every day at around 5:00 AM, crying. Mother then puts the child in her hip replacement device, changes her diaper. Then, mother prepares the morning G-Tube feeding and medication. Mother will then dress, clean and transfer her for the school, OT video sessions. Then, the child has lunch, and takes her medication. Mother noted that her daughter requires cleaning due to periodic vomiting and that she has to change her diaper between four to five times per day. After lunch and school, Mother works with the child on her exercises with tummy time. After that, she provides prune juice with water in her G-Tube. Thereafter, the child will either rest without incident or vomit. Then, mother prepares for nighttime feeding and medication. According to [Mother], [Claimant] wakes up between three and five times per night.

(Exhibit 19.)

19. As documented by Service Agency at the informal meeting, Claimant's counsel acknowledged she would like Mother to stop serving as the provider of Claimant's IHSS hours. However, Claimant's counsel represented it was not realistic to find an IHSS worker that will change diapers and have a G-tube feeding qualification for $15 per hour. It was also noted that there are about 740 hours in a month (24 hours x 31 days=744 hours/month) and that even if Mother could cease providing all the IHSS hours, it was unlikely that an IHSS worker without G-tube feeding qualifications could legally care for a child that requires G-tube feeding. (Exhibit 19.)

20. At the informal meeting, Service Agency acknowledged that the nurse staffing agency, Aveanna Healthcare, was following up with Medi-Cal and Community Support Services (CSS) and suggested Service Agency refer the case to Coordinated Life Services (CLS) to alleviate the burden of following up for generic resources.

21. At the informal meeting, Claimant's counsel expressed concern about Claimant's upcoming surgery in August 2022, which will require recovery and follow up, bringing Mother and Claimant back to a point where they will require support for the recovery.

22. After the informal meeting, by letter dated May 11, 2022, Service Agency notified Claimant of its decision affirming the denial of Claimant's requested increase in LVN respite services. Service Agency acknowledged Claimant had exhausted the Independent PPO private insurance coverage with a referral and appeal through grievance, but noted Medi-Cal and CCS remained to be explored. Service Agency exercised its discretion under Welfare and Institutions Code section 4659, subdivision (d), to deny or refuse to pay for medical services while Claimant followed up with Medi-Cal and CCS as generic resources.

23. Service Agency also adopted, in essence, the justification of Claimant's private insurance for denying Claimant's request, asserting that Claimant's needs could be meet by a trained caregiver rather than an LVN and, therefore, Claimant had not demonstrated that the requested service was necessary and cost-effective. (Exhibit 19, p. 5 of 8.)

24. In the May 11, 2022 letter, Service Agency further acknowledged "[C]learly the parent needs help with her child, and current nursing market conditions present unique challenges in acquiring support." (Exhibit 19, p. 5 of 8.) Nevertheless, Service Agency asserted that the actual needs of Claimant and the family did not match their requested increase in LVN respite services as supported by the findings of Claimant's private insurance in denying the requested service.

25. In the May 11, 2022 letter, Service Agency concluded that "a lay person can be trained to care for the child instead of having a nurse do it." (Exhibit 19, p. 5 of 8.) To resolve Claimant's appeal, Service Agency offered to refer Mother to a Coordinated Life Services (CLS) vendor to assist her in following up with Medi-Cal and CCS, in addition to working within the medical systems to find a qualified personal assistant or respite care provider. In addition, Service Agency asserted that the CLS "may help the IPP procure training for a personal assistant, respite care provider or IHSS worker." (*Id.*)

26. Service Agency's informal meeting decision did not address the additional care Claimant would require after her scheduled hip surgery in August 2022.

27. After the informal meeting decision, Claimant's family continued to pursue its request for Service Agency to fund the requested increase in LVN respite

services. The family also accepted Service Agency's offer to work with a CLS vendor and independently pursued CCS funding. (Exhibit T.)

28. On May 11, 2022, Claimant's father submitted a request to CCS for private duty nursing services for Claimant. (Exhibit Q.) On June 27, 2022, CCS denied Claimant's request for private duty nursing for eight hours per day, based on Claimant's private insurance deeming the request not "medically necessary." (Exhibit AA.)

29. On June 15, 2022, Claimant's counsel contacted the CLS vendor, MDH Network, to inquire of the status of its efforts to obtain full-time private duty nursing services for Claimant through Medi-Cal. (Exhibit Z.) In response, MDH Network stated it would begin providing the family with services on July 1, 2022. However, the Medi-Cal request had not been submitted as of the date of hearing on July 11, 2022.

Service Agency's Evidence and Contentions

30. In March 2022, Service Agency transferred Claimant's case to a new Service Coordinator, Mayra Santana, who testified at hearing regarding her unsuccessful efforts to locate a Service Agency vendor to provide either an LVN respite worker for 48 hours per month or a personal assistant for Claimant.

31. At hearing, Jacob Romero testified as to former ELARC Nurse Coordinator Registered Nurse (RN), Joel Teppang, documentary analysis advising Service Agency that Claimant's request for an increase in LVN respite pending her submission of an application to Medi-Cal should be denied. Mr. Teppang did not testify at hearing and no longer works for Service Agency as of June 2022.

32. Mr. Teppang's documentary analysis of Claimant's request contains no acknowledgment or discussion of Claimant's upcoming August 2022 surgery and what, if any, additional medical care needs will result to the family; no mention of Service Agency's ongoing failure to locate an LVN respite provider or potential personal assistant staff; and no mention of the fact the family is still waiting for assistance from the CLS vendor to submit Claimant's request for LVN private duty nursing staff at a rate of eight hours per day to Medi-Cal. (Exhibit 23.) His analysis is primarily limited to a summary review and dismissal of Claimant's doctor's recommendations for skilled nursing to assist with G-tube care, noting that ELARC's policy states that G-tube care is no longer a requirement for nursing services at the bedside and asserting a family member or regular staff trained in G-tube care is sufficient. (*Id.*)(Exhibit 6, p. 2 of 14.)

33. Mr. Romero testified at hearing Service Agency did not believe that LVN respite service was warranted at any level for Claimant and asserted that Service Agency only approved the service as an accommodation to Mother, whom Service Agency acknowledged was having difficulty caring for Claimant. He further asserted that LVN respite care at a rate of 40 hours per week was the equivalent of placing Claimant in a facility to receive care. Mr. Romero's testimony is not convincing and ignores the fact that Claimant requires 24-hour care.

Claimant's Evidence and Contentions

34. In further support of her request, Mother submitted February 17 and March 17, 2022 letters from Claimant's pediatrician, Dr. Ashaunta Anderson, detailing her opinion Claimant requires home skilled nursing care based on her medical condition and the demands of her care. (Exhibits D and H.) Mother also submitted a March 18, 2022 letter from Dr. Nusrat Ashan, Child Neurologist, Children's Hospital Los Angeles Neurology Department, in which he wrote, "[Claimant] requires extensive

monitoring, support and constant care in the presence of significant neurologic deficits. Would require help and support with home nursing care." (Exhibit I.)

35. Mother testified credibly in detail at hearing regarding the demands of Claimant's care. (Factual Finding 18.) Mother addressed the care Claimant would require, based on her past post-surgery experiences, after Claimant's next scheduled hip surgery in August 2022. Mother's concern that she will be unable to fulfill Claimant's medical care needs if left unassisted as Claimant's primary caregiver was convincing and sincere. Mother is not an LVN. However, she is capable of meeting Claimant's daily care demands including protecting Claimant's airway and managing feeding via Claimant's G-Tube.

36. Kenny Ha, Aveanna Healthcare's Director of Business Development, testified at hearing. Aveanna Healthcare has been working with Claimant's family and ELARC for more than six months to locate staff for the 48 hours per month of LVN respite services authorized by Service Agency. Mr. Ha testified his agency is more successful staffing for LVN positions for 32 to 40 hours per week than the 48 hours per month authorized by Service Agency.

37. At the conclusion of hearing, Claimant, through counsel, modified her fair hearing request, requesting solely that ELARC fund for two months of LVN respite services, 40 hours per week, to allow the necessary TAR notes to be generated so that Claimant can pursue an application with Medi-Cal to fund the service.

Ultimate Findings

38. The issue in this matter is not limited to solely, as Service Agency asserts, whether LVN respite is medically necessary. The reality of this situation is that Claimant has not received the 48 hours per month of LVN respite services for almost two years

since the service was authorized. In addition, while Service Agency maintains that a trained personal assistant could provide the care Claimant requires, Service Agency has not been successful in its inquiries to locate personal assistant staff to help the family, and it is likely that there is insufficient time between late July 2022 and Claimant's currently scheduled August 6, 2022 surgery to locate and train a personal assistant.

39. Accordingly, to ensure Claimant's current demonstrated needs are met, it must be considered whether Claimant requires the full-time LVN respite service at a rate of 40 hours per week after her August 2022 surgery. Based on the totality of the circumstances and the evidence presented, Claimant should receive LVN respite services for a limited period of two months from the date of her release from the hospital after her August 2022 surgery. The service is necessary and warranted based on the extraordinary event and exceptional circumstances of Claimant's scheduled surgery to ensure Claimant receives the proper medical care, to provide Mother with necessary respite as the 24-hour caregiver based on Mother's past demonstrated inability to emotionally and physically withstand the demands of Claimant's care to the detriment of Claimant's health and safety, and to facilitate Claimant's application to Medi-Cal by facilitating the staffing of an LVN so that TAR notes can be generated.

40. The 40 hours per week of LVN respite services funded for a period of two months after Claimant's release from the hospital post August 2022 surgery shall terminate at the conclusion of the two-month period. Claimant has provided insufficient evidence that her care needs under ordinary circumstances cannot be met by a trained caregiver, such as a personal assistant, as proposed by Service Agency. To facilitate the transition from LVN respite care at the rate of 40 hours per week to a trained respite caregiver after the two-month period, Claimant and Service Agency

shall take part in an IPP meeting 30 days after the effective date of this decision to arrange for the transition from an LVN respite provider to a trained respite caregiver.

LEGAL CONCLUSIONS

1. The Lanterman Developmental Disabilities Services Act (Lanterman Act) governs this case. (Welf. & Inst. Code, §§ 4500 et seq.) All further section references are to the Lanterman Act unless otherwise noted.

2. Because Claimant seeks a change in the status quo on the issue of the amount of authorized LVN respite services in the home, she has the burden of proving that a change is necessary. (Evid. Code, §§ 115 and 500.) The standard of proof in this case requires proof by a preponderance of the evidence, pursuant to Evidence Code section 115, because no other law or statute requires otherwise. "Preponderance of the evidence" means evidence which is of greater weight or more convincing than evidence which is offered in opposition to it. (*Glage v. Hawes Firearms Co.* (1990) 226 Cal.App.3d 314, 324.)

3. An administrative hearing to determine the rights and obligations of the parties is available under the Lanterman Act to appeal a contrary regional center decision. (§§ 4700-4716.) Claimant timely requested a hearing following the Service Agency's denial of an increase in LVN respite service hours, and therefore, jurisdiction for this appeal was established.

4. A regional center is required to secure services and supports that meet the individual needs and preferences of consumers. (§§ 4501 and 4646, subd. (a).)

Section 4648, subdivision (a)(1), provides:

> In order to achieve the stated objectives of a consumer's individual program plan, the regional center shall conduct activities including, but not limited to, all of the following:
>
> (a) Securing needed services and supports.
>
> (1) It is the intent of the Legislature that services and supports assist individuals with developmental disabilities in achieving the greatest self-sufficiency possible and in exercising personal choices. The regional center shall secure services and supports that meet the needs of the consumer, as determined in the consumer's individual program plan, and within the context of the individual program plan, the planning team shall give highest preference to those services and supports which would allow minors with developmental disabilities to live with their families, adult persons with developmental disabilities to live as independently as possible in the community, and that allow all consumers to interact with persons without disabilities in positive, meaningful ways.

Section 4646, subdivision (a), provides, in pertinent part:

> [I]t is the further intent of the Legislature to ensure that the provision of services to consumers and their families be effective in meeting the goals stated in the individual program plan, reflect the preferences and choices of the

consumer, and reflect the cost-effective use of public resources.

5. The Lanterman Act requires regional centers to control costs in its provision of services. (§§ 4640.7, subd. (b), 4651, subd. (a), and 4659.) Consequently, while a regional center is obligated to secure services and supports to meet the goals of each consumer's IPP, a regional center is not required to meet a consumer's every possible need or desire but must provide a cost-effective use of public resources.

Section 4512, subdivision (b), provides, in part:

> [T]he determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. . . .

Section 4646.4 provides:

> (a) Effective September 1, 2008, regional centers shall ensure, at the time of development, scheduled review, or modification of a consumer's individual program plan developed pursuant to Sections 4646 and 4646.5 . . . , the establishment of an internal process. This internal process

shall ensure adherence with federal and state law and regulation, and when purchasing services and supports, shall ensure all of the following:

(1) Conformance with the regional center's purchase of service policies, as approved by the department pursuant to subdivision (d) of Section 4434.

(2) Utilization of generic services and supports when appropriate.

(3) Utilization of other services and sources of funding as contained in Section 4659.

(4) Consideration of the family's responsibility for providing similar services and supports for a minor child without disabilities in identifying the consumer's service and support needs as provided in the least restrictive and most appropriate setting. In this determination, regional centers shall take into account the consumer's need for extraordinary care, services, supports and supervision, and the need for timely access to this care. . . .

6. Considering the totality of the evidence, Claimant did not establish that her caregiving needs are normally medically necessary and could only be met by an LVN rather than the ELARC proposed trained caregiver. The fact is that Mother is not an LVN and has, for the most part except for exigent post-surgery circumstances, cared for Claimant's daily needs on an ongoing basis.

7. However, ELARC Purchase of Service (POS) Guidelines and In Home Respite Services Policy do provide that exceptional circumstances may occur, to be reviewed on a case-by-case basis, which would warrant the purchase of health services that are specialized, such as LVN respite care. (Exhibits 5 and 6.) In fact, ELARC may pay for medical services while coverage is being pursued, but before a denial is made. (Exhibit 5.) Regarding In Home Respite Services, ELARC may grant an exception to its assessed family need if there is an extraordinary event that impacts the family member's ability to meet the care and supervision needs of the consumer. (§ 4686.5, subd. (a)(3)(A); Exhibit 6.)

8. Based on Factual Findings 1 through 40, and Legal Conclusions 1 through 11, Claimant established by a preponderance of the evidence that exigent and extraordinary circumstances exist in this matter such as to warrant Service Agency to fund for a limited period of two months of 40 hours per week of LVN respite services for Claimant. The two-month time period shall begin on the day Claimant is released from the hospital after her upcoming hip surgery, currently scheduled for August 6, 2022. Service Agency's obligation to fund the LVN respite care at the rate of 40 hours per week shall cease when the two-month post-operative period is completed. At that time, a trained caregiver can provide the necessary respite care at a rate to be determined by Service Agency and Claimant through the IPP process.

ORDER

1. Claimant's appeal is denied in part and granted in part.

2. Service Agency shall fund a total of 40 hours per week of LVN Respite Services for Claimant for a limited period of two months. The two-month period shall commence on the date Claimant is discharged from the hospital to her home after her

surgery, currently scheduled for August 6, 2022. Service Agency's obligation to fund for the LVN Respite Services shall cease once the two-month period is completed.

3. Claimant and Service Agency shall participate in an IPP meeting 30 days after the effective date of this decision to facilitate the establishment of the services of a trained caregiver to provide respite for Claimant, such as a trained personal assistant. The hourly frequency that the trained caregiver shall provide respite to Claimant is to be determined by the parties through the IPP process.

DATE:

IRINA TENTSER
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.