

E-Note #132 – Wages from the Waiver Personal Care Services Program (WPCS) May Not Count for MAGI Medi-Cal Eligibility

References: MEDIL 15-03 (January 27, 2015); Internal Revenue Code §§ 36B(d)(2)(d), 131; Internal Revenue Notice 2014-7 (January 21, 2014)

April 28, 2015

This E-Note relates to income eligibility of applicants for Medi-Cal or Covered California programs. About 350,000 Californians have jobs providing personal care services to Medi-Cal beneficiaries under programs such as Waiver Personal Care Services (WPCS) and In Home Supportive Services (IHSS). When these providers apply for Medi-Cal or Covered California programs, they can sometimes exclude their personal care wages from their income for eligibility purposes.

SUMMARY

An applicant's wages from providing personal care services are excluded from the applicant's MAGI under MEDIL 15-03 and Internal Revenue Code section 131 when all three conditions are met:

- The applicant receives wages through the Waiver Personal Care Services (WPCS) program for providing personal care services to a Medi-Cal beneficiary who is a waiver participant.
 - A provider under WPCS receives Time Reports showing the hours approved under WPCS. Providers who also receive wages through an In Home Supportive Services (IHSS) program receive two Time Reports: one from IHSS and one from WPCS. (DHCS, "[WPCS Frequently Asked Questions](#)," p. 3) *IHSS wages are not excluded from MAGI.*
- The applicant and the WPCS recipient live in the same home.
- The applicant's exempt wages are for providing personal care services to no more than 5 WPCS recipients over age 19 or no more than 10 WPCS recipients under age 19.

([Internal Revenue Code § 36B\(d\)\(2\)\(b\)](#); [Internal Revenue Notice 2014-7](#), January 27, 2015; [MEDIL 15-03](#) January 27, 2015)

INTRODUCTION

Eligibility for Medi-Cal or advanced payment tax credits and cost sharing reductions under the Affordable Care Act depends in part on the applicant's modified adjusted gross income (MAGI).

Medi-Cal Eligibility Division Information Letter (MEDIL) 15-03, January 27, 2015, is a multi-page list of income included in or excluded from MAGI. Scholarships, *King/Ball* penalty payments, and certain American Indian and Alaska Native are among the exclusions.

MEDI 15-03 also excludes “Home and Community Based Waiver Caregiver Wages” from MAGI. (MEDIL 15-03, p. 7) This is important for applicants who earn money by providing personal care services to Medi-Cal beneficiaries. If the care provider’s income is excluded from MAGI, then the provider is more likely to be eligible for MAGI-based Medi-Cal.

This memo explains that in MEDIL 15-03, excluded “Home and Community Based Waiver Caregiver Wages” means caregiver wages paid through the Waiver Personal Care Services program under the In-Home Options (HO) waiver program or the Nursing Facility/Acute Hospital (NF/AH) waiver program, when the care provider and the applicant share a home. MEDIL 15-03 does not exclude wages paid through the four programs known as In Home Supportive Services (IHSS).

Briefly, the Internal Revenue Service treats some payments for personal care services as nontaxable income to the provider when (i) the services are funded through a Medicaid waiver under Social Security Act Section 1915(c) and (ii) the provider and the beneficiary live in the same home. The IRS excludes these payments from the provider’s gross income, and therefore from the provider’s MAGI. (Internal Revenue Notice 2014-7, January 27, 2015)

In California, beneficiaries may receive personal care services through the Waiver Personal Services program (WPSC) or through an In Home Supportive Services program (IHSS). The beneficiary must apply for the personal care services. The beneficiary’s personal service provider receives a notice stating how many hours of personal service are approved.

WPSC is funded through a Medicaid waiver under section 1915(c). Therefore, WPSC provider wages are excluded from the provider’s (MAGI) when the provider and beneficiary live in the same home.

IHSS programs are not waiver-funded. Therefore, IHSS provider wages are not excluded from the provider’s MAGI.

BACKGROUND

MAGI

Medi-Cal eligibility under the Affordable Care Act of 2010 is based on modified adjusted gross income, or MAGI, as that term is defined by the U.S. tax code. MAGI means adjusted gross income increased by: (i) any amount excluded from gross income under section 911 (foreign earned income), and (ii) tax-exempt interest the taxpayer receives or accrues during the taxable year, and (iii) Social security benefits (as defined in §86(d)) which is not included in gross income under section 86 for the taxable year. (See 26 U.S.C. §36B(d)(2)(B))

Under Section 131 of the Internal Revenue Code, “qualified foster care payments” are excluded from MAGI. (26 U.S.C. § 131) Qualified foster care payments include “difficulty of care payments,” which are compensation to a foster care provider for the additional care required because the qualified foster individual has a physical, mental, or emotional handicap. The

provider must provide the care in the provider's foster family home, a state must determine the need for the compensation, and the payor must designate the compensation for this purpose.

Qualified foster care payments are excluded from MAGI because they are excluded from adjusted gross income and are not listed as add-ins under 26 U.S.C. §36B(d)(2)(B). Other forms of income are excluded from MAGI by the MAGI-based eligibility rules. For example, scholarships, awards, or fellowship grants used for education purposes and not for living expenses; certain American Indian and Alaska Native income derived from distributions; and student financial assistance are all excluded under the MAGI rules. (42 CFR Section 435.603(e))

Medicaid Waivers

Medicaid provides medical coverage based on financial need. The California Medicaid program is called Medi-Cal.

Section 1915(c) of the Social Security Act (42 U.S.C. § 1396n(c)) allows a state to obtain a Medicaid waiver so that the state may include in its Medicaid program the cost of home or community based services provided to persons who would otherwise require care in a hospital or nursing facility. (42 Code of Federal Regs. § 440.180)

California's current home and community based programs with 1915(c) waivers include the following:

- Multipurpose Senior Services Program (MSSP) Waiver
- HIV/AIDS Waiver
- HCBS Waiver for Persons with Developmental Disabilities (DD) Waiver
- Assisted Living Waiver (ALW)
- Nursing Facility/ Acute Hospital Transition and Diversion (NF/AH) Waiver
- In-Home Operations (IHO) Waiver
- San Francisco Community Living Support Benefit (SFCLSB) Waiver
- Pediatric Palliative Care (PPC) Waiver

WPCS

Participants in California's IHO waiver and NF/AH waiver may receive Waiver Personal Care Services (WPCS). WPCS is available to waiver participants who receive IHSS but need more hours than IHSS can authorize. The participant must apply to DHCS to participate in the IHO waiver or NF/AH waiver.

WPCS does not allow the provider to be the parent of a minor participant or the spouse of an adult participant. If the same person provides both IHSS and WPCS, the provider receives two separate time reports: one from IHSS and one from WPCS. For more information, see DHCS's [WPCS Frequently Asked Questions](#), which states, at Page 3:

Can the IHSS worker be the WPCS Provider?

Yes, but the hours are authorized separately. The provider will receive two Time Reports:

- one from IHO for WPCS hours; and
- one from the county for IHSS hours.

Note: Any one provider may not receive payment for more than 12 hours per day of combined WPCS and IHSS.

WPCS is paid with funds from the Medicaid IHO waiver and NF/HA waiver under Social Security Act Section 1915(c).

IHSS

The In Home Supportive Services programs (IHSS) provide personal care to elderly or disabled Medi-Cal recipients who would otherwise be at risk of out-of-home placement. The term "IHSS" is used to refer generally to four distinct programs that provide in-home services to disabled populations. The recipient must apply for services and be approved by the county or the state.

These programs are the following:

- PCSP (Personal Care Services Program) provides services to individuals who otherwise qualify for Medi-Cal and have a chronic disabling condition. Eligibility is fully based on Medi-Cal eligibility. PCSP is unavailable to individuals whose provider is their spouse or to minor individuals whose parent is the provider. It is also unavailable if the provider is receiving advance payment or the recipient is receiving a restaurant meal allowance. See, generally, Welfare and Institutions Code 14132.95
- IHSS Plus Option (IPO) provides services for federally eligible Medi-Cal recipients who do not qualify for the PCSP Program. Such recipients often include individuals where the spouse is the provider or minors when the parent is the provider. Eligibility is fully based on Medi-Cal eligibility. See, generally, Welfare and Institutions Code 14132.97.
- Community First Choice Option (CFCO) provides services for federally eligible Medi-Cal recipients who meet IPO requirements and in addition require 195 hours over service or meet certain other levels of severity of need. See, generally, All County Letter 14-60, August 29, 2014.
- IHSS Residual (IHSS-R) is limited to disabled individuals who do not qualify for federal Medi-Cal program participation, primarily legal aliens. Eligibility is based on linkage to the SSI/SSP program. See, generally, Welfare and Institutions Code 12300 et. seq.

None of the four IHSS programs operates under a section 1915(c) waiver. (The IHSS Plus Option program was formerly a waiver program, but became a State Plan Option under Social Security Act section 1915(k) in October 2009.)

IRS Bulletin 2014-7

On January 21, 2014, the Internal Revenue Service issues IRS Bulletin 2014-7, which states that some payments for personal care services under Medicaid waiver programs are treated as difficulty of care payments and excluded from taxable income. (See also IRS Publication 4491, p. 96).

Under IRS Bulletin 2014-7:

- The IRS will treat qualified Medicaid waiver payments as difficult of care payments that are excludable under § 131, and this treatment will apply whether the care provider is related or unrelated to the eligible individual.
- An eligible individual receiving care under a Medicaid waiver program lives in a “foster family home” for purposes of excluding caretaker payments under § 131.
- Qualified Medicaid waiver payments are payments:
 - Made by a state, a political subdivision or a state, or an entity that is a certified Medicaid provider,
 - Under a Medicaid waiver program pursuant to section 1915(c) of the Social Security Act, which allows federal payments for home and community based services
 - To an individual care provider
 - For nonmedical support services provided under a plan of care to a Medicaid-eligible related or nonrelated individual
 - Who lives in the provider’s home.
- If the provider or the recipient lives outside the home where services are provided, the income is not excluded from MAGI.
- A provider may not exclude payments for the care of more than 10 individuals under age 19 or more than 5 individuals who are 19 or over.

By its terms, IRS Bulletin 2014-7 excludes from MAGI only “Medicaid waiver payments,” that is, payments for services provided under a Medicaid waiver pursuant to section 1915(c) of the Social Security Act (42 U.S.C. § 1396n(c)), which allows the state to include in the Medicaid program the cost of home or community based services provided to individuals who otherwise would require care in a hospital or nursing facility.

WPCS payments are made by the state under a section 1915(c) waiver to individual care providers who provide nonmedical support for waiver participants under a plan of care. Therefore, according to IRS Bulletin 2014-7, WPCS payments could be excluded from MAGI under Internal Revenue Code Section 131 if the provider and the recipient live in the same home.

IHSS payments are not made under a 1915(c) waiver program. Therefore, Bulletin 2014-7 does not exclude IHSS payments from MAGI.

MEDIL 15-03

Medi-Cal Eligibility Division Information Notice (MEDIL) 15-03, dated February 27, 2015, provides a chart that “classifies numerous income deduction types for Modified Adjusted Gross Income purposes” as counted or not counted when determining eligibility for MAGI-based Medi-Cal or for Advance Premium Tax Credits and Cost Sharing Reductions. MEDIL 15-03 indicates on page 7:

Home and Community Based Waiver Caregiver W ages	Not Counted	Not Counted
In-Home Supportive Services • Restaurant Meals Allowance • Advance Payments for Caregiver	Not Counted	Not Counted

“Home and Community Based Waver Caregiver Wages” refers to the wages excluded by Internal Revenue Notice 2014-7: WPCS payments to a person who provides WPCS services to a beneficiary who lives in the same home as the provider.

On the next line, the phrase “In-Home Supportive Services” does *not* mean that IHSS wages are excluded from the provider’s income. It means that payments to beneficiaries are excluded when they are designated as Restaurant Meals Allowance (for IHSS recipients whose disability prevents them from cooking (MPP § 30-757.133) or Advance Payments for Caregivers (for IHSS recipients who pay their providers directly (§12304; MPP §30-701(d)(3)). The IHSS Restaurant Meals Allowance and IHSS Advance Payment Allowance are not counted as income for the IHSS recipient who receives them. However, the IHSS wages to count as income for the provider, whether or not the wages are passed through an Advance Payment Allowance.

MAGI Medi-Cal Hearings

The distinction between waiver-based and non-waiver-based personal care services –that is, between WPCS and IHSS—is likely to arise when a Medi-Cal applicant’s income is from wages for providing personal services.

An applicant’s wages from personal care services are excluded from MAGI under MEDIL 15-03 and Internal Revenue Code section 131 when all these are true:

- The wages are paid through the WPCS program.
 - A provider under WPCS receives Time Reports showing the hours approved under WPCS. Applicants who also receive wages through IHSS receive two Time Reports: one from IHSS and one from WPCS. ([“WPCS Frequently Asked Questions,”](#) p. 3) *The IHSS wages are not excluded.*
- The provider and the WPCS beneficiary live in the same home.
- The provider’s exempt income is for providing services to no more than 5 WPCS beneficiaries over age 19 or no more than 10 WPCS beneficiaries under age 19.

(Internal Revenue Code § 36B(d)(2)(b); Internal Revenue Notice 2014-7; MEDIL 15-03.)

Since providers receive Time Reports showing their WPCS hours, a provider who appears for hearing may wish to use the Time Report to support a claim that income is excluded from MAGI. If there is a dispute as to whether a provider's income is from WPCS or IHSS, the ALJ may wish to request a copy of the Time Report from the party with the burden of proof.

E-NOTE #131 – Summary of ACLs/ACINs/ACWDLs/MEDILs

(April 13, 2015)

[MEDIL 15-03 \(February 27, 2015\)](#)

Modified Adjusted Gross Income Types and Deductions Table

The purpose of this letter is to provide counties with a table that classifies numerous income deduction types for Modified Adjusted Gross Income purposes. This information will be incorporated into the California Healthcare Eligibility, Enrollment and Retention System. Counties shall keep in mind that the client is responsible for reporting his/her taxable income.

ACL 15-22 (February 23, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-22.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKS) Program: Changes To The School Attendance Requirements

The purpose of this ACL is to inform the County Welfare Departments (CWDs) of changes to the CalWORKs program pursuant to AB 2382, which the Governor enacted on September 30, 2014. Effective January 1, 2015, CalWORKs Assistance Units (AUs) will not have their grant reduced when the CWD learns that a child under 16 years of age is not regularly attending school. Instructions for children ages 16 and older will follow later in this ACL. AB 2382 provided the California Department of Social Services (CDSS) with authority to implement this new school attendance rule change through an ACL. The CDSS will be adopting regulations no later than July 1, 2016.

[ACWDL 15-12 \(February 27, 2015\)](#)

New Limits and Disregards for the Aged and Disabled Federal Poverty Level Program for 2015 – Beginning April 1, 2015

Beginning April 1, 2015, income limits for the Aged and Disabled Federal Poverty Level (A&D FPL) are as follows: The income limit for an A&D FPL individual will be \$1,211. This income limit is equal to \$981 (100 percent of FPL) and the \$230 standard disregard for an individual. The A&D FPL couple limit will be \$1,638. This income limit is equal to \$1,328 (100 percent of the FPL for a couple) plus the \$310 standard disregard for couples. Welfare and Institutions Code, Section 14005.40 (1) requires that the A&D FPL effective income standard be the greater of the Supplemental Security Income/State Supplementary Payment (SSI/SSP) rates, or 100 percent FPL plus the standard deduction for an individual (\$230) or a couple (\$310). The May 1, 2009 SSI/SSP payment rate used by Medi-Cal programs remains in effect until the current payment rate is increased to a level that exceeds the May 1, 2009 payment rate. Since 100 percent of the FPL for individuals and couples, plus the applicable income disregard, is greater than the May 1, 2009 SSI/SSP payment standards, we use the 100 percent FPL plus standard disregard as the 2015 standards for the A&D FPL program.

ACL 15-06 (February 26, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-06.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs): Federal Fiscal Year (FFY) 2015 Income Reporting Threshold (IRT)

The purpose of this letter is to transmit the FFY 2015 IRT chart for the CalWORKs Program. The California Department of Social Services (CDSS) developed the attached IRT charts to provide the County Welfare Departments (CWDs) with the IRTs that trigger the recipient income reporting requirements in MPP Sections 44-316.321(e) and 44-316.324. These IRT levels became effective October 1, 2014 for all Assistance Units (AUs). This letter also has the updated IRT chart for April 2015 through September 2015 which reflects the five percent Maximum Aid Payment (MAP) increase as noted in ACL No. 14-58. The CWDs must inform all CalWORKs recipients of their individualized IRT amounts whenever they change.

The above ACL should be read in its entirety.

DHCS issued guidance to the counties, noting that MAGI Medi-Cal beneficiaries could be eligible to participate in Programs for All-Inclusive Care for the Elderly (PACE) as long as they met all other requirements. The letter provides a list of program contacts for PACE, a program that allows participants to avoid institutionalization and stay at home. [DHCS ACWDL 15-11 \(2/27/2015\)](#).

The purpose of this letter is to inform counties that Programs for All-Inclusive Care for the Elderly (PACE) programs are available to individuals who have their eligibility for Medi-Cal approved on the basis of Modified Adjusted Gross Income (MAGI) as long as the individual meets the criteria of the PACE program for participation. The letter also provides an updated list of PACE programs. The PACE programs provide care for the elderly and permit the elderly PACE participant to continue residing in the home instead of being institutionalized in a medical facility. Please see the All County Welfare Directors Letters referenced above, for information regarding Medi-Cal and non-MAGI eligibility.

ACL 15-27 (February 28, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-27.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs): Self-Certification Form For Motor Vehicles - CW 80 Form Instruction

The purpose of this ACL is to transmit the revised CW 80 form and provide additional instruction for its use. ACL 13-111 was released on December 31, 2013, which provided County Welfare Departments (CWDs) with implementation instructions associated with the passage of Assembly Bill 74 and Senate Bill 98, which became effective January 1, 2014. ACL 13-111 included a new form, the Self-Certification Form for Motor Vehicles – CalWORKs (CW 80), for clients to identify and self-certify the value of vehicles. CWDs will then use the information provided from the CW 80 form to determine the Assistance Unit's (AU's) resource eligibility for CalWORKs. Any equity value that exceeds the \$9,500 limit shall be counted toward the AU's resource level.

ACL 15-28 (March 2, 2015) <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-28.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Revised Forms: AR 3, SAR 3, SAR 7, SAR 7A, SAWS 2A SAR, CW 8A, CW 8, CW 2211, And CW 2212

The purpose of this All County Letter (ACL) is to highlight recent changes to certain CalWORKs and CalFresh forms with reference to mandatory reporting of felony drug convictions, since it will no longer be required. This ACL also makes additional miscellaneous changes to the forms, which are explained below.

Federal law prohibits individuals who have been convicted of certain felony drug offenses from receiving Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP) benefits, unless a state opts out, partially or entirely, through the enactment of state legislation. The AB 1468 (Chapter 26, Statutes of 2014) fully opts California out from the lifetime prohibition in both CalWORKs and CalFresh, effective April 1, 2015. AB 1468 enacts statutory changes in the CalWORKs program by amending Welfare and Institutions (W&I) Code section 11251.3 to state that people with felony drug convictions shall be eligible to receive CalWORKs benefits.

For CalFresh, section 50 of AB 1468 enacts statutory changes in the CalFresh program by amending W&I Code section 18901.3 to state that individuals with felony drug convictions shall be eligible to receive CalFresh benefits. For both programs, if the person with a felony drug conviction is on probation or parole, he or she must be compliant with the terms of his or her probation or parole, including participation in a government recognized drug treatment program, if required.

[ACWDL 15-13 \(March 3, 2015\)](#)

2015 Medicare Premiums and Supplemental Security Income Standard and Parent Allocations and Property Limits for the Medicare Savings Programs and Other Programs

The purpose of this letter is to inform counties of the 2015 Supplemental Security Income Standard Allocation, Parent Allocation, property limits for the Medicare Savings Programs (MSP), which include Qualified Medicare Beneficiary, Specified Low Income Medicare Beneficiary, Qualifying Individual, and Medicare premium amounts to be used in determining eligibility and the cost of Medicare premiums.

- [MEDIL I 15-04 \(March 4, 2015\)](#)
Upcoming Changes to the California Healthcare Eligibility, Enrollment and Retention System online Single Streamlined Application

The purpose of this letter is to inform counties of changes to the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) online Single Streamlined Application (SSApp). These online changes went into effect on March 2, 2015, with the CalHEERS Release Schedule 15.3.

- [MEDIL I 15-05 \(March 5, 2015\)](#)
Overview of Statewide Batch Processes

The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) is to provide counties with an informative overview of previous and current statewide batch processes. Attachment A also provides additional detailed descriptions of the batch processes that discusses the following areas: 1) reference to existing policy guidance; 2) purpose and goals of each batch process; 3) criteria for batch processing; 4) frequency of batch execution; 5) actions taken by The Department of Health Care Services (DHCS), impacted partners and counties; 6) batch processing timeline; 7) aid code usage; 8) healthcare delivery system; 9) exclusion criteria; 10) file name for the Medi-Cal Eligibility Data System (MEDS); and 11) method of file distribution to counties.

- [MEDIL I 15-06 \(March 6, 2015\)](#)
County Medical Services Program's Third Party Administrator Transition to Advanced Medical Management and its impact on the Medi-Cal Verification Systems and the Medi-Cal Provider Operations Manual

The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) is to notify the counties of the County Medical Services Program (CMSP) Governing Board's third party administrator (TPA) transition from Anthem Blue Cross (Anthem) to Advanced Medical Management (AMM) and its impact on the Automated Eligibility Verification System (AEVS) and the Medi-Cal Provider Operations Manual.

[MEDIL I 15-07 \(March 9, 2015\)](#)

Entering Reported Income

The purpose of this letter is to provide instructions regarding how to process income information when none or both Current Monthly Income (CMI) and Projected Annual Income (PAI) are entered on the paper or electronic Single Streamlined Application and/or reported by the applicant/beneficiary. It also provides direction on what to enter into the Statewide Automated Welfare Systems (SAWS) to send to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) currently, and after CalHEERS and SAWS program the appropriate PAI changes. The following chart depicts what was included in All County Welfare Directors Letter No. 15-06 and what action eligibility workers should currently take:

[ACWDL 15-14 \(March 11, 2015\)](#)

Federal Poverty Limits

The Department of Health Care Services (DHCS) is providing 2015 monthly Federal Poverty Level (FPL) values (Enclosure 1) as well as 2015 annual FPL values (Enclosure 2) with this letter. The enclosed charts provide the 2015 poverty level ceilings for Medi-Cal eligibility. These ceilings are derived from the annual FPL figures published in the Federal Register on January 22, 2015. Counties will note the addition of the new FPL limit of 128 percent. This FPL will be used to identify the disabled individuals in the New Adult Group for federal funding purposes

only. This FPL will not be utilized until new aid codes L6 and L7 are implemented. DHCS will update counties when those aid codes are ready for use.

[ACWDL 15-15 \(March 12, 2015\)](#)

Reminder to Eligibility Workers Working With Medi-Cal Applicants and Beneficiaries Who Are Determining Their Modified Adjusted Gross Income

The purpose of this letter is to remind counties not to provide tax information when assisting applicants and beneficiaries with Medi-Cal eligibility determinations. With the implementation of the Affordable Care Act, County Eligibility Workers (EWs) are now required to collect taxable income information for Modified Adjusted Gross Income (MAGI) eligibility determinations. Pursuant to Welfare and Institutions Code, Sections 14005 and 14005.60, income shall be determined, defined, counted and valued in accordance with federal law. Title 42, Code of Federal Regulations, Section 435.603, income is based upon the Internal Revenue Service (IRS) rules for Adjusted Gross Income with the addition of untaxed Social Security, untaxed interest income and untaxed foreign earned income, the sum of which is referred to as MAGI for Medi-Cal eligibility determination purposes.

County EWs are not authorized to interpret tax rules or inform individuals about what constitutes taxable income, deductions or expenses. The Department of Health Care Services (DHCS) strongly urges counties to remind their staff to refrain from providing tax information. If EWs provide information about how MAGI is determined, the client must be informed that any information provided is for Medi-Cal eligibility purposes only and cannot be relied upon for tax filing purposes.

ACIN I-18-15 (March 16, 2015) <

http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acin/2015/I-18_15.pdf>

Access To Criminal Record Summary Information

The purpose of this ACIN is to inform counties of the implementation of SB 1136 (Chapter 222, Statutes of 2014) which amends section 1522.08 of the HSC, and adds section 16504.7 to the WIC. This legislation allows the California Department of Social Services (CDSS) to share with county child welfare agencies a list of individuals associated to state-licensed or certified foster homes that have been granted criminal record exemptions and summary information used when making the determination to grant the exemption.

ACL 15-17 (March 13, 2015) <<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-17.pdf>**>**

California Work Opportunity And Responsibility To Kids (CalWORKs): Revised Notice Of Action (NOA) Message For Inter-County Transfers (ICT).

This All County Letter (ACL) transmits a copy of the revised CalWORKs ICT NOA message M40-195A. ACL 14-30, dated May 2, 2014, informed County Welfare Departments (CWDs) of changes to the CalWORKs ICT process. Receiving counties may not require or request a new SAWS 2 Plus unless the change in circumstances is such that a determination of continuing eligibility cannot be made without it. The below revised NOA message is to be used in

conjunction with this new instruction. CWDs must begin using the revised NOA message as soon as administratively possible, but no later than July 1, 2015.

ACL 15-31 (March 19, 2015) <<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-31.pdf>>

California Work Opportunity And Responsibility To Kids (CalWORKs): Home Visits As Reasonable Accommodation To Complete The Face-To-Face Interview Requirement For CalWORKs

The purpose of this letter is to clarify the CalWORKs program home visit requirements and to remind County Welfare Departments (CWDs) that pursuant to the Americans with Disabilities Act (ADA) and reasonable accommodation laws, the CWD must provide accommodations when an applicant(s) is unable to attend a face-to-face interview in the CWD office due to a physical or mental impairment. This ACL is not intended to describe the ADA or to define reasonable accommodation. Please see Government Code Sections 11135 and 12926 and the ADA for definitions of physical and mental impairments and detailed information on reasonable accommodations.

The above ACL should be read in its entirety

- [MEDIL I 15-08 \(March 18, 2015\)](#)
Low Income Health Program Closeout Activities

This letter provides information regarding the Department of Health Care Services' (DHCS) closeout activities supporting the transition of former Low Income Health Program (LIHP) beneficiaries to Medi-Cal. LIHP ended on December 31, 2013 and the program ceased providing health care services as of that date. The LIHP population with income at or below 133 percent of the Federal Poverty Level, was transitioned into Medi-Cal effective January 1, 2014 under Medicaid Expansion. (Reference: All County Welfare Directors Letter 14-01).

ACL 15-21 (March 19, 2015) <<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-21.pdf>>

California Work Opportunity And Responsibility To Kids (CalWORKs) Program: Release Of Sixth Set Of Questions And Answers For Senate Bill (SB) 1041 (Chapter 47, Statutes Of 2012) CalWORKs Welfare-To-Work (WTW) Program Changes

The purpose of this letter is to provide answers to questions that the California Department of Social Services (CDSS) has received about the implementation instructions issued to County Welfare Departments (CWDs) for major changes that were made to CalWORKs WTW requirements pursuant to SB 1041, codified in WIC sections 11320.3, 11322.8, and 11322.85. This letter addresses general questions regarding:

1. When to change the hourly participation requirement when one parent in a two-parent assistance unit becomes eligible for a disability exemption;

2. When months are counted toward the CalWORKs federal standards 12-month lifetime limit for vocational education;
3. Reengagement of sanctioned clients who received a temporary young child exemption; and
4. Issuance of the WTW 38 form.

The above ACL should be read in its entirety

[ACWDL 15-16 \(March 20, 2015\)](#)

Refugee Medical Assistance Beneficiaries Transition to Medi-Cal and Retroactive Eligibility

Refugee Medical Assistance (RMA) is a time-limited federal medical assistance program designed to provide no-cost health coverage to refugees during their first eight months in the United States. Individuals who have refugee status and individuals in groups treated as refugees by law (asylees, eligible trafficking victims, and special immigrants), but who previously lacked categorical linkage to Medi-Cal (e.g., non-disabled adults), have historically received full-scope medical benefits through the RMA program if otherwise eligible. Counties were required to first screen newly arrived refugees for all available Medi-Cal programs and only after they were found ineligible for any Medi-Cal program, could counties find them eligible for RMA.

RMA benefits are funded entirely by the federal Office of Refugee Resettlement (ORR) and are not Title XIX Medicaid benefits. States have the option to provide RMA coverage to individuals with countable incomes up to 200 percent of the Federal Poverty Level (FPL). California's RMA policy and procedures include that option. Under federal guidance issued by the ORR, RMA beneficiaries could be newly eligible for the new adult coverage group under the Patient Protection and Affordable Care Act (ACA) in states that expanded Medicaid eligibility to non-disabled adults under 138 percent FPL. As a result, states must determine eligibility for the RMA population under the new ACA eligibility groups, and, when appropriate, transition the client from RMA to Medicaid. Under ACA expansion, refugees in California who were previously not eligible for Medi-Cal, due to lack of categorical linkage, can now qualify for the Modified Adjusted Gross Income (MAGI) Medi-Cal expansion group instead of RMA. However, refugees who remain ineligible for Medi-Cal under the expansion because the RMA program remains in effect for this population if otherwise eligible.

Therefore, as of January 1, 2014, when Medi-Cal expanded coverage to adults between 19-64 years of age with countable income up to 138 percent of the FPL under MAGI rules, RMA beneficiaries who were previously ineligible for Medi-Cal were potentially eligible under the new expansion group and, should have been moved from RMA to MAGI

Medi-Cal, effective January 1, 2014. If, however, RMA beneficiaries remain ineligible for Medi-Cal even under the new expansion group due to income, they remain eligible for RMA and have coverage for the full 8-month time limit, if their MAGI income was between 138 and 200 percent of the FPL at time of application.

The above ACL should be read in its entirety

ACL 15-11 (March 24, 2015) <

<http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2015/15-11.pdf> >

Recording Developmental And Mental Health Screening, Referral, And Plan Intervention Information In The Child Welfare Services/Case Management System

This letter is to provide counties with information and instructions related to recording developmental health and mental health screening, referral, and plan intervention information into the Child Welfare Services/Case Management System (CWS/CMS). Over the past several years, California has increased its efforts to ensure that children and youth served by the child welfare system receive screenings and appropriate developmental and mental health services. These efforts are supported by requirements under the federal Child Abuse Prevention and Treatment Act (CAPTA), and the settlement agreement approved by the federal court in the class action lawsuit known as *Katie A. v. Bonta*.

ACL 15-35 (April 1, 2015) <<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-35.pdf>>

Child Care Monthly Report – CalWORKs Families CW 115 (7/15) And Child Care Monthly Report – Two-Parent Families CW 115A (7/15)

This letter informs counties of the revised CalWORKs Child Care Monthly Reports, CalWORKs Families (CW 115) and Two-Parent Families (CW 115A) that are required to be submitted monthly.

ACIN I-23-15 (April 7, 2015) <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acin/2015/I-23_15.pdf>

Commercially Sexually Exploited Children (CSEC) Model Interagency Protocol Framework

The purpose of this All County Information Notice (ACIN) is to assist counties in serving Commercially Sexually Exploited Children (CSEC). Specifically, this ACIN contains the CSEC Model Interagency Protocol Framework (Model Framework), guidance that counties may utilize when developing their own interagency protocol.

ACIN I-25-15 (April 9, 2015) <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acin/2015/I-25_15.pdf>

Additional Reasonable Accommodations Available to Blind or Visually Impaired (BVI) In-Home Supportive Services (IHSS) Applicants and Recipients to Ensure Access to the IHSS Program as Required by the Americans with Disabilities Act (ADA)

This All-County Information Notice (ACIN) informs County Welfare Departments (CWDs) of the additional resources that will be available to the CWDs, as part of their existing and ongoing responsibilities, to offer and provide reasonable accommodations to Blind or Visually Impaired (BVI) IHSS applicants and recipients, when requested, to ensure access to the IHSS program and related information.

The California Department of Social Services (CDSS) has developed additional forms, policies and procedures, and is making changes to the IHSS Case Management Information and

Payrolling System (CMIPS) to assist the CWDs with their responsibilities to comply with the ADA, as noted above. These additional resources will be available to all CWDs beginning in August 2015, following the below-noted Pilot Schedule. Some of the additional reasonable accommodation resources that will be available to BVI applicants and recipients include additional formats to access Notices of Action (NOA) and program forms as well as an alternative auditory process for blind IHSS recipients (and in some circumstances visually-impaired recipients when a county has assessed the requested preference) to review and approve or disapprove his or her IHSS provider's timesheet(s), hereafter referred to as the Telephonic Timesheet Approval System.

E-NOTE # 130 - PROTECTIVE SUPERVISION CLARIFICATIONS

March 31, 2015

References: ACL 15-25 (March 19, 2015), ACL 14-86 (December 9, 2014), *Notes from the Training Bureau* Item 00-03-01A (February 20, 2000)

ACL 15-25 (March 19, 2015) "Protective Supervision Clarifications" provides information about a number of important issues pertaining to IHSS-R/PCSP/CFCO/IPO protective supervision cases.

This E-Note is intended to provide judges with additional direction pertaining to particular sections of this ACL.

Assessing Protective Supervision For Minors:

Judges are to follow the four-step analysis in ACL 15-25 when assessing a minor for protective supervision. If the minor does not meet the required criteria at a step in the analysis, it is unnecessary to complete the analysis. A determination of ineligibility can be made.

The state hearing decision must include a thorough discussion of the key evidence in the case record pertaining to the findings made at any step of the analysis.

Excluded Needs and Behaviors under MPP § 30-757.172

CDSS's regulatory interpretation of the §30-757.172 exceptions to protective supervision is that they only apply to those who are otherwise potentially eligible, i.e. mentally impaired and nonself-directing (MI/NSD).

However, if a claimant in a state hearing is found to be self-directing, and the only behavior s/he is requesting protective supervision for falls into one of the .172 exceptions, e.g., aggressive or deliberately self-destructive, the state hearing should still address the issue of excluded behavior by explaining that while the .172 exceptions to protective supervision apply to those who are otherwise potentially eligible, that protective supervision is not available to protect against this type of behavior *for anyone*.

Actual Injury vs. Propensity to Harm Self

ACL 15-25 states: "It is CDSS' policy that a person does not have to suffer *actual* injury to be eligible for Protective Supervision, but only have a history of a propensity for placing him/herself in danger."

Therefore, even if there is no evidence of actual injury, the judge should obtain evidence and make factual findings about whether interventions have been necessary in order to prevent injury and if so, when and how often interventions have been necessary, etc.

Burden of Proof Issue – Discontinuance of Protective Supervision

ACL 15-25 states:” When the county discontinues Protective Supervision, it must establish the factual basis for the discontinuance.”

§22-073.36 provides that the county has “the burden of going forward in the hearing to support its determination.”

“*Notes from the Training Bureau*” Item 00-03-01A (February 20, 2000) set forth various bases on which the county can meet its burden. These are still relevant and are the following:

- a. By establishing that there has been a change in law or misapplication of law requiring that a specific IHSS need(s) that was previously authorized no longer be authorized.
- b. By establishing that there has been a change or misapplication in state policy requiring that a specific IHSS need no longer be authorized.
- c. By establishing that there has been a change in the claimant's medical condition requiring the reduction of IHSS hours from the prior assessment of IHSS.
- d. By establishing that the claimant or provider told the county social worker at the assessment that fewer hours of IHSS are needed than previously assessed in a particular need area or areas. In such case, the judge will make a finding as to the current need based on testimony at the hearing including testimony about the assessment, county records such as the written record of the assessment, and medical records.

An additional basis is the following:

- e. If the current county action either discontinuing benefits or reducing benefits is supported by an assessment that is more comprehensive, valid and reliable than the prior assessment. The burden would be on the county to prove the superior validity, etc., of the new assessment by a preponderance of the evidence. If the ALJ makes such a finding regarding the superior validity of the current assessment, the finding must be set forth in the state hearing decision, together with the ALJ's reasoning in support of the finding.

If there has been a prior state hearing decision that has adjudicated the same reduction or discontinuance action being taken by the county in the current case, reference to the order in the prior state decision should be included in the current decision's factual findings. If the current decision differs from the previous decision, the current decision should explain the basis for this change. Relevant considerations are the amount of time that has passed since the last state hearing decision and whether the current evidence, particularly the current medical evidence, is superior to what was available in the previous state hearing.

Example:

The county discontinues protective supervision in its 2012 reassessment on the basis that the claimant's mental impairment has improved and he is no longer at risk of self-

injurious behavior. An Administrative Law Judge upholds the county's determination in a state hearing decision, authorizing hours in other categories of service.

In 2014, the claimant, through an authorized representative, asks the county to reassess the claimant for protective supervision, stating that there have been instances where the claimant has wandered away from the home when left alone, has gotten lost and disoriented, and the police have had to bring him home. In the county's assessment, it determines that the claimant's condition has not worsened since 2012 and is still ineligible for protective supervision. The claimant requests a hearing.

The decision in this case should reference the prior state decision and determine whether the county has or has not met its burden of supporting its denial action. Factual findings should be made if the decision is different from the previous decision.

Burden of Proof Issues - Inter-County Transfers

If the discontinuance of protective supervision is due to an inter-county transfer (ICT), and a result of the receiving county's assessment, the receiving county is under the same burden of proof described above.

ACL 14-86 informs the counties that the SOC 873 must be included in the materials provided by the transferring county to the receiving county in an ICT. Program's position is that the transferring county should also send any existing SOC 821 to the receiving county. In a state hearing, the receiving county would present this 821, along with a more current SOC 821 if there is one, when presenting its case and explaining why it has determined the claimant is no longer eligible for protective supervision if it has made such a determination.

E-Note # 129

EMERGENCY REGULATIONS GOVERNING PARTICIPATION REQUIREMENT CHANGES TO THE CALWORKS WELFARE-TO-WORK (WTW) PROGRAM

March 13, 2015

References: Amended MPP sections 42-302, 42-701, 42-711, 42-712, 42-714, 42-716, 42-720, 42-721, 42-722, 42-802, 42-1009, 42-1010, 44-111; Adopted MPP sections 42-708, 42-709

Purpose: This E-Note informs judges of emergency regulations containing substantial changes to WTW participation requirements.

Background

Prior to January 1, 2013, CalWORKs WTW participants were subject to the following participation requirements:

An adult recipient in a one parent AU was required to participate each month for an average 32 hours per week in WTW activities, unless exempt. A minimum average of 20 hours per week was required in one or more core welfare-to-work activities.

An adult recipient in a two-parent AU whose basis for aid was unemployment was required to participate each month in WTW activities for a minimum average of 35 hours per week. Both parents could contribute toward the 35-hour requirement if one parent's participation was a minimum average of 20 hours per week, and a minimum average of 20 hours per week was required in one or more core welfare-to-work activities.

(MPP §§42-711.411 & 42-711.421, as effective prior to January 1, 2013)

Senate Bill (SB) 1041 (Chapter 47, Statutes of 2012) resulted in significant changes to the CalWORKs program effective January 1, 2013. As explained in E-Note # 86, December 18, 2012, among these changes were changes to WTW participation requirements. Starting January 1, 2013, state WTW hourly participation requirements now are aligned with federal requirements. This includes the total amount of hours required to participate in WTW activities, as well as the federal core/non-core activity hour requirements.

Along with new standards that mirror federal work participation requirements, starting January 1, 2013, there is a new WTW 24-Month Time Clock. During this 24-month period on aid the core and non-core components of the federal standards will not apply, meaning participants only are required to meet the total hourly requirements, with no requirement that any of these hours be in core activities. The 24 months need not be consecutive and can be used at any time during the adult's 48 months of time on CalWORKs aid. No months prior to January 1, 2013 count toward a WTW participant's WTW 24-Month Time Clock.

The WTW 24-Month Time Clock is intended to provide increased flexibility in the types of activities that adult CalWORKs recipients can participate in for 24 months in order to support opportunities to reach self-sufficiency. During the WTW 24-Month Time Clock period, recipients can participate in any of the CalWORKs WTW activities they need, consistent with their assessments, to obtain employment. After this 24-month period is exhausted, recipients are limited to activities that meet CalWORKs federal standards in order for them to continue receiving cash aid.

As stated in All County Letter No. 12-69, December 17, 2012, the WTW hourly requirements effective January 2013 are as follows:

The WTW 24-Month Time Clock (No Core Activity Hours Required)

- 20 hours per week for single parents with a child under six years old.
- 30 hours per week for single parents with no child(ren) under six years old.
- 35 hours per week for two-parent families (combined between two parents).
- In a two-parent family in which one parent is exempt because of a disability, the remaining parent's required hours are 20 or 30 hours, depending on the age of the youngest child(ren).

Post-WTW 24-Month Time Clock Requirements (Core Activities Required)

After 24 cumulative months, unless otherwise exempt or having received an extension of the 24 Month Time Clock, aided adults must meet the following hourly requirements:

- 20 hours of core activities per week for single parents with a child under six years old (20 hours total).
- 20 hours of core activities and 10 hours of non-core activities per week for single parents with no child(ren) under six years old (30 hours total).
- 30 hours of core activities and 5 hours of non-core activities per week for two-parent families where neither parent is disabled (35 hours total).
- 20 hours of core activities and 10 hours of non-core activities per week for two-parent families where one parent is disabled (30 hours total).

The WTW 24-Month Time Clock does not affect the 48-month CalWORKs time limit. WTW participants who reach their 48-month CalWORKs time limit but have not exhausted their WTW 24-Month Time Clock are not entitled to continue receiving WTW services offered during the 24-month time period, unless they qualify for a 48-month time limit exception. WTW participants who reach their WTW 24-Month Time Clock limit but have time remaining on their 48-month CalWORKs time limit are required to meet post-WTW Time Clock work participation requirements unless exempt or granted an extension of the WTW 24-month Time Clock.

Emergency Regulations

On January 12, 2015, CDSS submitted to the Office of Administrative Law (OAL) emergency regulations governing the new WTW requirements. These emergency regulations amend several existing MPP sections (42-302, 42-701, 42-711, 42-712, 42-714, 42-716, 42-720, 42-721, 42-722, 42-802, 42-1009, 42-1010, 44-111) and adopt two new MPP sections (42-708 & 42-709). Included are the definitions of what constitute core and non-core WTW activities for the CalWORKs Federal Standards. (§42-709.3)

The emergency regulations became effective January 22, 2015, and have now been incorporated into the MPP regulations found on the CDSS website, which can be linked through the computer ribbon Reference section under “Regulations and Manuals”/“Index to MPP on Web.”

Should ALJs be interested in identifying the specific amendments and adoptions that have been made to the WTW regulations, the emergency regulation packet reflecting those specific changes can be found on the OAL and CDSS websites:

OAL website:

http://www.oal.ca.gov/res/docs/pdf/emergencies/recent%20action,%20moved%20emergencies/2015-0112-01EFP_App.pdf

CDSS website: <http://www.dss.cahwnet.gov/ord/PG3671.htm>

Under OAL procedures, the emergency regulations will expire on July 22, 2015, during which time CDSS will take action to adopt the regulations as permanent through OAL’s regular rulemaking process. This includes a public comment period, meaning there could be revisions in the finalized permanent regulations. Should there be subsequent revisions to the permanent WTW participation regulations as adopted, another E-Note will be issued reflecting those revisions. Additionally, the paraphrased regulations will be updated to reflect the new WTW regulations.

E-Note #128- Summary of ACLs/ACINs/ACWDLs/MEDILs

February 27, 2015

ACIN I-72-14 (December 31, 2014)

[<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2014/I-72_14.pdf>](http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2014/I-72_14.pdf)

2014 Earned Income Tax Credit Outreach Publications

The purpose of this All County Information Notice (ACIN) is to notify County Welfare Departments (CWDs) that the Earned Income Tax Credit (EITC) outreach publications, Pub 428 and Pub 429, have been revised for tax year 2014. These publications are provided to strengthen state and county efforts to promote the EITC to low income residents in the State of California.

ACL 15-03 (January 9, 2015)

<http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2015/15-03.pdf>

Participation Requirements For California Work Opportunities And Responsibility To Kids (CalWORKs) Clients Who Have Exhausted Their Welfare-To-Work (WTW) 24-Month Time Clock

The purpose of this All County Letter (ACL) is to inform County Welfare Departments (CWDs) of participation requirements for CalWORKs clients who have exhausted their WTW 24-Month Time Clock. This letter also provides instructions regarding the process by which CWDs will transition clients from WTW 24-Month Time Clock participation (CalWORKs minimum standards) to post WTW 24-Month Time Clock CalWORKs federal standards and transmits the forms to be used in this process.

[Recommended that this ACL with attachments be read in its entirety](#)

ACWDL 15-02 (January 12, 2015) Out-Of-Pocket Personal Care Services Costs Used to Meet The Medi-Cal Share-Of-Cost

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-02.pdf>

[Set Forth Below In Its Entirety](#)

Background

Since the implementation of ACWDL 05-21, "The In-Home Supportive Services Independence Plus 1115 Demonstration Project Implementation and Changes to Processing In-Home Supportive Services Cases", the process utilized for determining Medi-Cal eligibility and certifying the Medi-Cal SOC for those needing personal care or In-Home Supportive Services (IHSS) is the same as the process used for all other Medi-Cal eligible individuals. ACWDL 05-21 stated that the Medi-Cal determination of eligibility and SOC replaced the determination previously done by IHSS. IHSS is a Medi-Cal covered benefit except for state-only IHSS-Residual cases.

Previous to this ACWDL, Title 22, California Code of Regulations (CCR), Section 50551.6 and MEPM, Article 10-E, placed limitations on using out-of-pocket costs for personal care services to lower income in determining the Medi-Cal SOC. These limitations required that the need for the personal care services be assessed and approved by IHSS, and only the out-of-pocket costs for the approved hours could be used as an income deduction.

Policy Clarification

The limitations described in Title 22, CCR, Section 50551.6 and MEPM, Article 10-E, which allowed personal care services assessed by county IHSS programs to be used as an income deduction are no longer applicable. These services are now provided as a Medi-Cal benefit and out-of-pocket costs for personal care services can be used to meet the Medi-Cal SOC. Because the personal care services can be used to meet the Medi-Cal SOC, they may not be used as an income deduction. Moreover, the limitations that were placed on using personal care services as an income deduction do not apply to using those services to meet the Medi-Cal SOC.

Out-of-pocket personal care services must be prescribed by a physician, nurse case manager, assessed as part of the IHSS Assessment of Need (but not provided under the IHSS program), or be included in the beneficiary's plan of care as necessary to prevent him/her from being moved to a long term care facility for essential treatment. The documentation from the physician or nurse case manager must certify that the beneficiary may remain safely in his/her home with the provision of the personal care services and/or any IHSS hours already assessed. The prescription or plan of care may be for multiple months. IHSS assessed hours or services need not be used first before applying the out-of-pocket expenses for personal care services toward meeting the SOC.

The out-of-pocket expenses for personal care services used toward meeting the Medi-Cal SOC need not be assessed by IHSS, or be provided by an IHSS provider so long as the plan of care or prescription specifies the need for at least one personal care service in order for the ancillary services to be allowed to meet the SOC. Personal care services are services which are required to accomplish the activities of daily living and are defined in Title 22, CCR, Section 51183(a). Ancillary services are described in Title 22, CCR, Section 51183(b).

The provider may be a family member. The provider may also be an IHSS provider providing hours beyond those paid for by the IHSS program, or that were assessed by IHSS but were part of a program-wide reduction in hours. Personal care services used to meet the Medi-Cal SOC may exceed the maximum assessed hours for the IHSS program, as long as the need for the hours is documented. This may be a temporary increase needed by a beneficiary being discharged from a hospital who wishes to avoid a nursing home stay, or the extended hours may prove necessary on a more consistent basis to avoid nursing home stays when a beneficiary's care needs increase.

Certain personal care services may require licensing or certification while others do not. Assuring proper licensing and certification for providers who are not IHSS providers is the responsibility of the beneficiary; however, the county must ensure that condition number three in the MEPM, Article 10R, page 10-R-3, is met. Article 10R requires that the services provided must be intended and used solely for the health care and medical treatment of the individual. If the county is uncertain about whether the services provided meet this standard, then the county may request a statement from the authorizing provider stating that this condition is satisfied. Furthermore, the county may still disallow these services despite the authorizing provider's statement if the county determines that the statement is contrary to common sense.

Frequently Asked Questions

1) Question -Are daily hours of incurred costs for unmet need from the IHSS Assessment allowable as an expense to spend down the SOC?

Answer – Yes. The reduction may be applied either to meet the SOC in the month in which the expense was incurred or, if the beneficiary is still financially responsible for paying the expenses and the Hunt v. Kizer guidelines are met, in future months.

2) Question -Is the beneficiary required to verify the expense of the paid attendant care hours each month and if so, what is acceptable verification?

Answer – Yes. The beneficiary must verify these expenses each month in order to meet the SOC. The following are examples of acceptable verification:

- Receipts specifying the services provided and the provider.
- Canceled checks to the provider accompanied by timesheets or other documentation showing the care provided and the provider.
- Credit card statements showing payments to the provider accompanied by timesheets or other documentation showing the care provided.
- Invoices showing payments billed to the beneficiary for services from the provider.

PLEASE NOTE: These expenses need not be accompanied by proof of payment if they are used for current month and must be unpaid if applied to future month's SOC pursuant to Hunt v. Kizer.

3) Question -Should the County apply the reduction to the SOC in the month the expense is incurred or the month following after the receipts are provided?

Answer -If the beneficiary is meeting the SOC in the month the expenses were incurred, then the expenses or receipts should be credited to that month. If the beneficiary is choosing to use unpaid expenses to meet a future month's SOC under Hunt v. Kizer, then the expenses would be applied to a future month after the expenses were approved for Hunt v. Kizer.

- 4) Question -Can the out-of-pocket personal care expenses be used retroactively to meet the SOC in a month prior to the current month?

Answer -As with other medical expenses used to meet the SOC for ongoing cases, the expenses may be applied to the month in which they were incurred for up to a year from the date the service was provided. For cases newly established that have retroactive Medi-Cal eligibility, the out-of-pocket personal care expenses would be applied as per current policy for meeting a retroactive SOC. For cases with unpaid medical costs seeking to reduce a previous month's SOC, the procedures in the MEPM Article 10-R must be followed.

- 5) Question – Is there a specific hourly rate for services that the county should use in evaluating whether the charges for the personal care services are correct?

Answer – No. , The county should evaluate the claim to see if it is reasonable and should ask for more detail if the information is not enough to make that determination. Counties should use the prevailing rate charged for the delivery of such services within the area where the services are received. For instance, if the beneficiary presents an invoice for a free-lance provider who is not associated with a personal care agency, unlicensed/not certified, and providing services not usually requiring skilled licensed/certified providers, that indicates the hourly rate is over \$100, then the county may wish to obtain more documentation from the beneficiary to ensure the charge is reasonable. If there is no basis for the hourly rate and the hourly rate exceeds the rate normally charged for that service in the city or county, then the county may allow only the prevailing rate to be applied to the SOC.

- 6) Question -Can the beneficiary hire an accountant to handle his or her financial affairs and the cost be allowed either as an expense in the Medi-Cal budget or as an expense to reduce the SOC?

Answer -No. There is no Medi-Cal income deduction allowed in federal or State law for accountant services. Additionally, the costs will not be allowed as a personal care service to meet the SOC as accountant costs are not a medical expense. (Please see condition 3, MEPM, Article 10-R, page 10-R-3, and paragraph 8 above.)

- 7) Question -Can prorated room and board expenses for a medically necessary out-of-pocket personal care service provider be used to meet the SOC?

Answer -No. The prorated share of out-of-pocket personal care service provider room and board costs may not be used to meet the SOC. There are other ways to meet the 24-hour care need that would meet the medical necessity requirement without requiring room and board for the provider. For instance, around-the-clock care can be met by employing different shifts of providers.

- **ACWDL 15-03 (January 20, 2015)**

Redetermination Process Pause and Further Instructions for Processing Pre-Affordable Care Act 2014 Redeterminations Where Age, Blindness, or Disability is the Basis of Eligibility

Set Forth Below In Its Entirety

The purpose of this letter is to provide counties with instructions regarding Aged, Blind, and Disabled (ABD) Pre-Affordable Care Act (Pre-ACA) individuals who are, or likely are, Medi-Cal eligible on the basis of Non-Modified Adjusted Gross Income (Non-MAGI) linkage. These beneficiaries were either discontinued from Medi-Cal, or are scheduled for discontinuance, for failing to respond to the request for tax household information (RFTHI) or return the RFTHI packet as part of their 2014 Medi-Cal annual redetermination.

Until further notice, counties shall immediately **stop** any further discontinuances of beneficiaries for the specific ABD aid codes, provided in the Attachment, for failing to respond to the RFTHI as part of their 2014 Medi-Cal annual redetermination. A table of the affected aid codes is enclosed with this letter. Counties will soon receive a list of beneficiaries, who have been potentially identified as having been discontinued due to not responding to the request for MAGI tax household information from the Department of Health Care Services (DHCS), via the Statewide Automated Welfare System (SAWS) Consortia.

This letter does not pertain to beneficiaries in long term care or to beneficiaries in the Medicare Savings Programs, as those beneficiaries were not asked to provide tax household information during their 2014 annual redetermination. However, should the county become aware of beneficiaries in these categories who were discontinued at annual redetermination for not responding to the request for tax household information, counties must restore their previous coverage immediately (rescind their discontinuance) as instructed in this letter. This letter also does not pertain to *Craig v. Bontá (Craig)* cases as the county evaluates these cases before requesting information and there are some circumstances where beneficiaries in the *Craig* group may only be eligible for continuing Medi-Cal eligibility in a MAGI eligibility group. Further, the instructions in this letter are only for 2014 redeterminations. Redeterminations for 2015 are to be conducted in accordance with All County Welfare Directors Letter (ACWDL) 14-35 and the erratum which will be published shortly.

If any beneficiary identified in the list from SAWS, or who otherwise is identified as a beneficiary affected by these circumstances, contacts the county or files a Medi-Cal state hearing request, and their discontinuance has not yet been rescinded in accordance with this letter, the county is to **immediately** restore eligibility back to the discontinuance date. This ensures there is no gap in coverage if the reason for discontinuance was a failure to respond to a RFTHI as part of the 2014 Medi-Cal annual redetermination process. The beneficiary shall not be required to provide the tax household information prior to having their coverage reinstated. If beneficiaries are members of a Medi-Cal household where different individuals have different linkage criteria, only the family members whose basis of eligibility is ABD are to be restored.

For example, mom, dad who is disabled, and two minor children, were all discontinued due to failure to respond to the RFTHI. Mom and the children are aided on the 1931(b) program with aid code 3N and dad is disabled and on aid code 64. In this instance, only the dad's benefits would be restored because his basis of eligibility is ABD. [Note: if contact is made with the family during the process of reinstating the

ABD individual's case, the county should use this as an opportunity to try to collect the needed tax household information to be able to restore eligibility to the remainder of the family.]

Once counties have evaluated the impacted beneficiaries that were discontinued for failure to respond to the RFTHI at their 2014 redetermination, the county should attempt to complete the 2014 redetermination checking first to see if the beneficiary is eligible on an ABD basis. The counties must follow the process laid out in ACWDL 14-35 for completion of the redetermination. Specifically, counties must first complete an ex parte review of all the information available pertaining to the beneficiary's circumstances. If sufficient information is not available through the ex parte process, counties must send the Medi-Cal Annual Redetermination (MC 210 RV) form, allow a 60-day period for return of the MC 210 RV form, and perform at least one contact during that time. If the household still fails to respond to this request, the beneficiary must be discontinued with a 10-day notice. If, after evaluation of the beneficiary's circumstances, the county determines that the beneficiary no longer has eligibility on an ABD basis, the county shall evaluate eligibility on any other basis, including MAGI, before discontinuing.

This action may create a change in eligibility that must be treated as a change in circumstances. A change in circumstances may change the beneficiary's annual redetermination date as described in ACWDL 14-22. Counties are reminded that beneficiaries may provide the information in alternate forms such as by phone, in person or by fax. If a beneficiary is discontinued, he/she has a 90-day cure period to provide the information and be restored without a break in coverage if otherwise eligible.

As noted above, DCHS will soon send to SAWS lists of cases identified as discontinued during this period for failure to respond to the RFTHI at annual redetermination and SAWS will communicate this information to the counties as appropriate. The lists provided by DHCS may identify individuals who were discontinued for reasons other than not providing tax household information at annual redetermination (such as other critical information not related to the tax household). There may also be beneficiaries on the list who were correctly discontinued in 2014 for failing to complete their 2013 annual redetermination. Additionally, some aid codes may identify individuals whose basis of eligibility is something other than age, blindness or disability. Counties are instructed to evaluate each case to determine which household members on the lists meet the requirements of this letter and only restore beneficiaries who meet the criteria (i.e., were discontinued due to not responding to the RFTHI rather than for other reasons).

ACWDL 15-04 (January 20, 2015)

2015 Medicare Catastrophic Coverage Act Spousal Impoverishment Caps

The purpose of this letter is to inform counties of an increase to the maximum income and property caps under the Medicare Catastrophic Coverage Act. Effective January 1, 2015, the community spouse resource allowance increased to \$119,220 and the maximum spousal income allocation/minimum monthly maintenance needs allowance increased to \$2,981 per month.

ACL 14-106 (December 31, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-106.pdf>

Revised CalFresh Supplemental Form For Special Medical Deductions

The purpose of this letter is to transmit revisions made to the CalFresh Supplemental Form for Special Medical Deductions (CF 31) (previously referred to as the DFA 285-C) and instructions on when to use this form. The content of this form was revised and also included in the two newly developed applications for public assistance [Application for CalFresh Benefits (CF 285) and the Application for CalFresh, Cash Aid and/or Medi-Cal/Health Care Programs (SAWS 2 PLUS)] to reduce the number of pages used during intake and recertification.

ACL 15-08 (January 21, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-08.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Welfare-To-Work Program Guidance for Disability Exemptions

Set forth below in its Entirety

The purpose of this letter is to provide County Welfare Departments (CWDs) with clarifying guidance on granting Welfare-to-Work (WTW) participation, WTW 24-Month Time Clock, and California Work Opportunity and Responsibility to Kids (CalWORKs) 48-month time limit exemptions to CalWORKs clients who have a physical and/or mental health disability that has been verified by a doctor. The California Department of Social Services (CDSS) has received questions from both CWDs and welfare advocates regarding how a disabled exempt client's case should be handled when a doctor indicates that the onset of the client's condition for disability predated the client's exemption request. This includes (1) when is it appropriate to grant retroactive aid payments and (2) how time should be counted towards the client's WTW 24-Month Time Clock and CalWORKs 48-month time limit. This letter provides guidance on granting disability exemptions retroactively and prospectively for clients in these types of situations which will be effective the date of this letter.

CalWORKs Disability Exemptions – General Information

The Welfare and Institutions Code (WIC) §11320.3 states that a client who has a verified disability is exempt from WTW participation when the following conditions exist:

- The disability is expected to last at least 30 calendar days.
- The disability significantly impairs the client's ability to be regularly employed or participate in WTW activities.
- The client is actively seeking appropriate medical treatment.

The CWDs are reminded that clients must provide verification from a doctor, defined by the CDSS Manual of Policies and Procedures (MPP) as a health care professional who is licensed by a state to diagnose/treat physical and mental impairments that can affect an individual's ability to work or participate in WTW activities (MPP §42-701.2, subdivision(d)(2)). The CDSS definition of state refers only to states within the United States.

The verification must: (1) identify the existence of a disability, (2) include the expected duration of the disability, and (3) include the extent to which the disability impairs the client's ability to be employed and/or participate in WTW activities (MPP §42-712.442, subdivision (a)). Any month in which a client is

exempt from WTW participation due to a verified disability shall not count toward the client's WTW 24-Month Time Clock or CalWORKs 48-month time limit (WIC §11320.3, 11322.85, and 11454.5; MPP §42-302.21).

Requests for CalWORKs Disability Exemptions

Requesting a disability exemption from WTW participation, the WTW 24-Month Time Clock, and the CalWORKs 48-month time limit is a single process. A client may request an exemption verbally or in writing (MPP §42-302.3). This can be done at application, on a *Semi Annual Eligibility Status Report* (SAR 7, Question #13), or as an informal written or verbal report to the CWD at any time.

When a client informs his or her CWD of a disability that is impairing his or her ability to be regularly employed or participate in WTW activities, the CWD shall document the situation in the client's case file and explain to the client that medical verification is necessary to process his or her request. The CWD then must provide the client with the *CalWORKs Exemption Request Form* (CW 2186A) and the *Authorization to Release Medical Information* (CW 61) in order for the client to complete his or her request (MPP §42-302.3).

The client may use the CW 61 or provide other medical verification which (1) states that the client has a disability, (2) includes the beginning date and expected duration of the disability, and (3) includes the extent to which the disability impairs the client's ability to be employed and/or participate in WTW activities. The client must also submit verification that he or she is seeking appropriate medical treatment for the disability. If the recipient prefers that the county obtain this information on the client's behalf, the CWD shall have the recipient sign a release that is compliant with the Health Information Insurance Portability and Accountability Act (HIPAA). For more information about HIPAA, go to <http://www.hhs.gov/ocr/privacy/>.

Granting CalWORKs Disability Exemptions

When a CWD receives a completed CW 2186A and the required disability verification components, the CWD must grant the disability exemption for WTW participation requirements, the WTW 24-Month Time Clock and the CalWORKs 48-month time limit as indicated by the required verification, and prospectively for as long as the disability and treatment continues to exist and can be verified. If the client's condition impaired his or her ability to be employed or participate in WTW activities and the client provides verification that they were actively seeking treatment prior to the exemption request date, the exemption must be granted retroactively for the months that verification is provided. If there is a delay in granting the exemption due to reasons outside of the client's control (i.e. delay on the part of an examining doctor to provide the necessary information or CWD error), and during the delay the client's condition impaired his or her ability to participate in WTW activities, at the time all proper verification is submitted, retroactivity must also be applied based on the date the client began treatment for the disability. In these situations, the client's CalWORKs 48-month time limit and WTW 24-Month Time Clock should be adjusted accordingly.

Example 1:

On October 1, 2013, Ms. Smith informs her CWD that she has become ill and is unable to participate in WTW activities. The CWD sends Ms. Smith the CW 2186A and CW 61 (to be completed by her doctor). On October 12th, Ms. Smith returns a doctor's note to the CWD which states that Ms. Smith has a disability that impairs her ability to work or participate in WTW activities, and that she is now working with her doctor to create a plan to treat her condition. The worker then asks Ms. Smith to request from her doctor the expected time period the disability will last, or to sign a release for the CWD to request this information directly from the doctor. She chooses to sign a release. There is a delay by the doctor's office in returning the requested verification to the CWD. On December 15th, the CWD is able to verify that the condition is expected to last for the next six months.

The CWD grants the exemption and adds months back towards Ms. Smith's CalWORKs 48-month time limit and (if applicable) WTW 24-Month Time Clock retroactively up to October 2013 (October 2013, November 2013, and December 2013 would be 'un-ticked').

If granting of the disability exemption results in the client no longer being sanctioned and being added back into the Assistance Unit (AU), the client must receive underpayments for those sanctioned months which he or she was verified as qualifying for the disability exemption. The CWDs are also reminded that in accordance with MPP §44-340, any resulting underpayment needs to be first used to offset existing overpayments for the AU. Months that were not counted towards the client's WTW 24-Month Time Clock and CalWORKs 48-month time limit (WIC §11454 and 11322.85) due to sanction, remain uncounted due to the disability exemption.

Example 2:

Ms. Johnson has been sanctioned since June 1, 2013, due to failing to participate in Job Club and/or Job Search. On November 15, 2013 Ms. Johnson brings in a note from her psychologist that says she is suffering from a condition that impairs her ability to participate in WTW activities. The psychologist also states that he or she began treating Ms. Johnson as a patient on October 5, 2013, and expects that he or she will need to continue treating Ms. Johnson for at least six more months.

Ms. Johnson is granted a disability exemption retroactively back to the month of October 2013 and prospectively. The client is not entitled to retroactive payments prior to October 2013 because she did not provide verification that she actively sought treatment for her illness prior to October 2013. Any resulting underpayment is first used to offset any existing overpayments for the AU. No Time On Aid (TOA) adjustments are necessary because the client was sanctioned and while in sanction status, time does not count towards either the WTW 24-Month Time Clock or CalWORKs 48-month time limit.

Noticing Clients of Approval/Denial of CalWORKs Disability Exemptions

The CWD shall inform the client of the approval or denial of the requested exemption using the *CalWORKs Exemption Determination Form* (CW 2186B) no later than 15 calendar days after receipt of the exemption request. This written notification shall state whether the request was granted or denied, and, if denied, the specific reason for the basis of the denial must be included on the form (MPP §42-302.34). The specified response time may be exceeded in situations where completion of the determination is delayed because of circumstances beyond the control of the CWD, including delay on the part of the examining doctor to provide the necessary information. When these situations occur, CWDs are instructed to document in the case file the cause for the delay (MPP §42-302.32).

If granting the exemption, the CWD must provide the client with the *Your Welfare-to-Work 24-Month Time Clock* notice (CW 2208) to inform him or her of any necessary adjustments to the WTW 24-Month Time Clock. The CWD must also provide a Notice of Action (NOA) that informs the client of any necessary adjustments to the CalWORKs 48-month time limit. The CDSS is in the process of developing a NOA message with the specific purpose of notifying clients of TOA adjustments. Until this form is released, CWDs shall use the existing M40-107b NOA (*Time on Aid at Redetermination or Application*), as an interim means of advising clients of any retroactive adjustments to their time limits/clocks related to disability exemptions.

For situations in which granting of a disability exemption results in the client no longer being sanctioned and being added back into the AU, the CWD must send out a NOA that advises the client of the change in the AU's grant amount (M40-107k – *Increase in Grant Due to TOA Adjustment*). This NOA will be updated to include language that identifies a disability exemption as a reason for an increase to a client's grant. Both this revised NOA and the new TOA adjustment NOA mentioned above will be released under separate cover.

A client's exemption shall be reviewed at the time the condition is expected to end, or sooner if there is reason to believe that the client's condition has changed or improved to a point where he or she may no longer qualify for the disability exemption

(MPP §42-712.443). The CWDs are reminded to include on the client's CW 2186B the expected exemption end date. The expected exemption end date should be based on the exemption verification received from the client's doctor. For cases in which the client's doctor has stated in writing that the condition is permanent or chronic with no end date, the CWD shall establish an appropriate re-evaluation time period. It is recommended this re-evaluation occur at a minimum annually (i.e. at redetermination), and the CWD assist the client in exploring more permanent disability assistance options such as Supplemental Security Income (SSI).

Although the CW 2186B notice provides the start and end dates of the exemption to the client, as a best practice, CDSS recommends CWDs contact the client with a reminder, allowing the client a reasonable amount of time to submit any verification of continued exemption eligibility before the exemption is scheduled to end. When the client does not qualify for a continued exemption, the county shall attempt to engage the client in work or appropriate WTW activities prior to beginning the non-compliance process.

Anticipated Form Revisions

The CDSS, in conjunction with welfare advocates and representatives from the various CWDs, formed a workgroup to revise the CW 61 to better assist clients to obtain the critical information that CWDs need in order to make a disability exemption determination. The revised CW 61 (including provider instructions), *Physical Capacities Form* (CW 61A), *Mental Capacities Form* (CW 61B), and new *Work Capacity Verification Form* (CW 62) will be released under separate cover.

ACWDL 15-05 (January 21, 2015)

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-05.pdf>

Rejected Cases That Did Not Transition From Covered California to Medi-Cal

The Department of Health Care Services (DHCS) is providing additional guidance to the counties and the Statewide Automated Welfare Systems (SAWS) regarding Covered California (Covered CA) cases transitioning to the Medi-Cal program with a January 1, 2015, effective date as a result of Covered CA's annual redetermination process.

ACWDL 15-06 (January 21, 2015)

Modified Adjusted Gross Income (MAGI) Based Upon Fluctuating or Self-Employment Income, Partnership Income, S-Corporation Income, Income from Royalties, Estates, Trusts and Real Estate Rental Income

Set forth In Its Entirety

The purpose of this letter is to provide counties with guidance regarding fluctuating or self-employment income, and the use of projected annual income when transmitting income to the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) to calculate MAGI. Self-employment or fluctuating income may include income received from self-employment, partnerships, s-corporations, royalties, estates, trusts and real estate rentals.

If an individual reports self-employment income, the amount the client enters or provides on the application should be the net taxable income from self-employment activities, the amount after applying expenses and deductions permitted by the Internal Revenue Service (IRS). The IRS rules are different from the rules for determining net income from self-employment for Non-MAGI eligibility. IRS rules for determining taxable net profit income from self-employment may result in a negative number, a net income loss, that may offset other income the individual reports on their application and, in fact, could result in a negative modified adjusted gross income, or MAGI.

The applicant or beneficiary needs to determine the amount of their net income/loss from self-employment, partnerships, real estate rentals, royalties, trusts and s-corporations. Eligibility Workers may assist individuals with finding answers to questions they have on MAGI expenses and deductions by referring the client to the reference pages of the Single Streamlined Application (SSApp). Please note that the IRS deductions for MAGI are broader than those allowed for non-MAGI net income from self-employment and rental property calculations pursuant to Title 22, CCR, Section 50505 and 50508.

The client may have various versions of the IRS Form 1040 that will contain the income attributable to the individual from taxable self-employment, sole proprietorships, partnerships, and net income from rental of real estate, royalties, estates, trusts, partnerships and s-corporations. The forms also provide guidance on how the amounts are determined (from Form 1065, and/or Schedules C, E, K-1, etc.). Individuals may also contact the IRS for assistance in determining their taxable income or for answers on what expenses or deductions are allowed. Additionally, the individual may contact their accountant or tax advisor. Ultimately, the amount that is entered on the SSApp is the amount that should be transmitted to CalHEERS and the federal hub will determine whether that amount is reasonably compatible. If it is not, then the client should be asked to provide paper verification of income. Acceptable forms of paper verification are contained in the Medi-Cal Eligibility Procedures Manual, Section 4M.

If the client provides projected annual income to the county, counties can divide that amount by 12 and enter the result as the monthly amount. When it comes to income that fluctuates month to month, the SSApp specifically asks for the projected annual income. This amount should take into consideration future increases or decreases of income. However, if the individual's current monthly income is lower than the projected annual income divided by 12, counties should enter the current monthly income. If the individual provides the projected annual income to CalHEERS, CalHEERS will divide the amount by 12, for an average monthly amount.

The Department of Health Care Services (DHCS) expects that in March 2015, an enhancement will be added to CalHEERS that will address the situation when both a monthly amount of income and an amount reflecting the projected annual income are present. CalHEERS will use the projected annual income divided by 12. Shortly thereafter, additional enhancements to CalHEERS will compare the result of the projected annual income divided by 12 to the monthly income amount also reported and then, use the lower of the two monthly amounts. DHCS will keep counties updated as to the effective date of that additional enhancement.

ACWDL 15-07 (January 21, 2015)

Lynch VS. Rank Annual Stuffer 2015

As required by the settlement of the Lynch v. Rank lawsuit, the Department of Health Care Services (DHCS) will mail the enclosed stuffer to individuals in aid codes 14, 17, 24, 27, 64 and 67 in January of 2015. In 1996, the enclosed version was updated to clarify that the Pickle program is for the aged, blind, and disabled. In addition, the revised Spanish version received changes to simplify the language for the public to utilize more commonly used phrases.

Background

In the past, beneficiaries receiving the Lynch v. Rank stuffer indicated that they were unable to obtain answers to their questions about the Pickle program. DHCS provides this All County Welfare Directors Letter for clarity to county public contact personnel on the specifics concerning the Pickle program to share with beneficiaries once DHCS releases the stuffer in January 2015.

ACL 15-10 (January 23, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-10.pdf>

Halt To Implementation Of Provisions Of Senate Bills 855 And 873 (Chapters 29 And 685, Statutes Of 2014) Relating To The IHSS And Waiver Personal Care Services Programs

Set Forth In Its Entirety

This All County Letter (ACL) is to inform counties of recent court orders issued by Judge Richard Leon of the United States District Court, District of Columbia, which impact the implementation of regulations adopted by the U.S. Department of Labor (DOL) pertaining to the payment of overtime compensation and other compensable activities for In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) providers that were to be effective January 1, 2015. The information provided in this ACL supersedes the information contained in ACL 14-76 (October 8, 2014)

BACKGROUND

On October 1, 2013, the DOL published the Final Rule on the Application of the Fair Labor Standards Act (FLSA) to Domestic Service (RIN 1235-AA05). This Final Rule was intended to extend the protections of the FLSA to Domestic Service workers by effectively removing the ability of “third party” agencies to claim an exemption for personal care workers from minimum wage and overtime pay as providers of “companionship services” or as live-in providers.

The Final Rule additionally narrowed the definition of “companionship services” to strictly “fellowship and protection” that may include “provision of care” (i.e., assistance with Activities of Daily Living and Instrumental Activities of Daily Living only if the care is provided as part of fellowship and protection and does not exceed 20 percent of the total hours worked per person and per workweek). On December 22, 2014, Judge Leon of the U.S. District Court, District of Columbia, vacated the section of the DOL Final Rule which precluded third-party employers from claiming applicable wage and overtime exemptions for services provided by live-in providers and employees performing companionship services. On December 31, 2014, Judge Leon granted a Temporary Restraining Order which stayed implementation of the DOL regulation on the revised definition of companionship services from going into effect until January 15, 2015. On January 14, 2015, Judge Leon issued a ruling, vacating the DOL’s revised companionship services definition that was scheduled to go into effect on January 15, 2015.

As a result of this recent federal court order, on January 15, 2015, California Director of Social Services (CDSS) Director Will Lightbourne announced a halt to the implementation of the changes related to overtime, travel time, and wait time pay for all IHSS providers, which had been initially scheduled to go into effect on January 1, 2015, pursuant to the requirements of SB 855 and SB 873.

REVISED PROGRAM REQUIREMENTS

In light of the above referenced court orders, CDSS will not be implementing changes related to overtime compensation, travel time, or wait time, nor the 61-hour weekly limitation. All of the newly-created forms and notices released pursuant to ACL 14-76 (SOC 2255 through SOC 2259A, SOC 2263 through SOC 2270, and TEMP 3000) are

not in effect and shall not be used. The forms (SOC 426A, SOC 846, and SOC 858) and notices (SOC 851 and SOC 855) that were revised to include language related to overtime compensation or other compensable changes are likewise not in effect, and the previous versions of these forms will be made available again for counties to use. If the county has already received a Workweek Agreement (SOC 2255 or SOC 2256) or Recipient Declaration (TEMP 3000), or Provider Enrollment Agreement (SOC 846) form from an IHSS recipient or currently enrolled IHSS provider, do not enter this information into CMIPS II. Instead, the county should place the documents in the recipient's case file for future reference. If the county has not yet received the documents, do not send the Notice to Recipient for Failure to Complete the Workweek Agreement notice (SOC 2270) or attempt to contact any recipient to receive the information.

As previously stated in ACIN I-73-14 (January 5, 2015), in those instances in which counties have conducted assessments that included wait time adjustments for medical accompaniment and those adjustments were entered into CMIPS II, counties must ensure that these adjustments are removed from CMIPS II as soon as possible.

However, the information should be retained by the counties within the IHSS recipient's case file for future reference.

All IHSS recipients will continue to receive all of the monthly hours for which they have been authorized and will continue to receive those services from the provider of their choice. All IHSS providers will continue to be paid straight-time at the locally bargained hourly wage rate in the same manner in which hours were reported and providers were paid in 2014.

All county IHSS offices and county public authorities should continue to operate under the requirements and regulations for payment of wages that were in effect on December 31, 2014. CDSS is continuing to move forward with the implementation of the new timesheet format, but CMIPS II will not process payments for overtime or travel time. However, in February 2015, CDSS will implement the new modified transitional timesheets.

The attached information notice has been designed to inform all IHSS providers and IHSS recipients of the halt in the implementation of overtime, travel, and wait time pursuant to the January 14, 2015, court order. This notice will be sent to all IHSS providers and recipients beginning in February 2015.

As stated in ACL 14-102 (December 31, 2014), the new IHSS program rules and requirements for the provider enrollment orientation required under SB 878 must be implemented by April 1, 2015. CDSS is currently working to update the provider enrollment materials to conform to the new rules and requirements. However, the training and materials detailing the applicable federal and state requirements regarding minimum wage and overtime pay, including paid travel time and wait time, required to be included in the provider enrollment orientation pursuant to Welfare and Institutions Code section 12301.24(a), will no longer be included due to the January 14, 2015, court order. Counties are advised to remove the 2015 new IHSS Program Requirements video from their websites to avoid confusion.

ACL 14-52 (January 16, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-52.pdf>

ICPC Regulation No. 12 – Private/Independent Adoptions

The purpose of this letter is to inform County Welfare Departments (CWDs) of the changes to the up-front sequence of WTW activities, known as the WTW flow, as a result of AB 74. Effective January 1,

2014, AB 74 altered the participation sequence of appraisal, job search, and assessment, per Welfare and Institutions Code (WIC) section 11320.1. This change to the WTW flow is one of the early engagement strategies implemented as a result of AB 74. Other early engagement strategies include Family Stabilization (ACL 14-12) and Expanded Subsidized Employment (ACL 13-81).

ACL 15-09 (January 27, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-09.pdf>

California Work Opportunity And Responsibility To Kids (CaWORKs) Welfare-To-Work (WTW) Flow Changes As A Result Of Assembly Bill (AB) 74

Recommended That This ACL Be Read In Its Entirety

The purpose of this letter is to inform County Welfare Departments (CWDs) of the changes to the up-front sequence of WTW activities, known as the WTW flow, as a result of AB 74. Effective January 1, 2014, AB 74 altered the participation sequence of appraisal, job search, and assessment, per Welfare and Institutions Code (WIC) section 11320.1. This change to the WTW flow is one of the early engagement strategies implemented as a result of AB 74. Other early engagement strategies include Family Stabilization (ACL 14-12) and Expanded Subsidized Employment (ACL 13-81).

ACIN I-01-15 (January 28, 2015)

http://www.dss.cahwnet.gov/lettersnotices/EntRes/getinfo/acin/2015/I-01_15.pdf

California Work Opportunity and Responsibility to Kids (CaWORKs) Final Regulations to Implement Assembly Bill (AB) 12 (Chapter 599, Statutes of 2010) Non-Minor Dependents (NMDs)

The purpose of this letter is to transmit final regulations that implement the extension of CaWORKs benefits to eligible NMDs due to the enactment of AB 12 (Chapter 599, Statutes of 2010). The relevant provisions of AB 12 were initially implemented through ACL No. 11-78, dated November 30, 2011, ACL No. 12-27, dated June 12, 2012, ACL No. 13-82, dated October 16, 2013 and ACL No. 13-82E, dated March 25, 2014. The attached final regulations were approved by the Office of Administrative Law, filed with the Secretary of State on July 7, 2014, and effective October 1, 2014. These updated regulation pages and the accompanying Eligibility and Assistance Standards Manual Letter 14-03 are posted on the internet at:

<http://www.dss.cahwnet.gov/ord/PG3153.htm>.

ACIN I-07-15 (January 29, 2015)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2015/I-07_15.pdf

Trafficking And Crime Victims Assistance Program (TCVAP) Eligibility Guidelines

The purpose of this ACIN is to provide County Welfare Departments (CWDs) with program guidelines to determine eligibility for TCVAP benefits and services to assist non-citizen victims of human trafficking, domestic violence, and other serious crimes.

ACL 14-50 (December 24, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-50.pdf>

Changes To The Requirements For Monthly Caseworker Visits With Children Authorized Through Senate Bill (SB) 342 (Chapter 492, Statutes Of 2013)

The purpose of this ACL is to provide instructions for changes to the monthly caseworker visits with children, required by SB 342, effective January 1, 2014. The specific sections of the WIC sections 16516.5 and 16516.6 that have been amended as a result of SB 342 are attached to this ACL.

ACL 15-13 (February 5, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-13.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Program: Use Of Promissory Notes For Overpayment Collection; And Implementation Reminder For All County Letter 11-80

Set Forth Below In Its Entirety:

The purpose of this ACL is to provide direction to County Welfare Departments (CWDs) regarding appropriate noticing requirements when establishing and demanding repayment of CalWORKs overpayments (OPs).

The California Department of Social Services (CDSS) has learned that there are some CWDs that are including a Promissory Note (Agreement to Reimburse) form or similar document when sending Notices of Action (NOAs) informing current and former recipients that a CalWORKs OP has been established to facilitate the CWD's collection efforts. These documents require the individual who received aid to which they were not entitled to sign an agreement to repay the OP and identify the method and amount of repayment. The document also advises the individual that the "County may take action against" him or her and assess additional fees for various administrative processing costs.

Upon careful consideration, the CDSS has determined that inclusion of the Promissory Note (Agreement to Reimburse) being used by some CWDs is not in accordance with the applicable Manual of Policies and Procedures (MPP) regulations as it constitutes a "request" or demand in violation of MPP section 44-351.1. Furthermore, nothing on the Promissory Note (Agreement to Reimburse) indicates the payments are voluntary or can be suspended at any time. While CWDs are able to pursue all methods of overpayment recovery concurrently, as described in MPP section 44-352.4, et seq., this regulation must be taken in concert with other MPP regulations.

The MPP section 44-351.1 clearly states that "voluntary cash recovery should be explained by the county to a recipient (or former recipient) but no request for voluntary payments should be made." In addition, any such agreement to voluntarily recover an overpayment from a client must be initiated by the client after an explanation of the process and "shall be in writing and shall clearly indicate to the individual that the repayment is voluntary" (MPP section 44-351.111). The client is not required to fulfill any voluntary agreement and as such can suspend any payments he or she has agreed to make (MPP section 44-351.112).

Upon receipt of this ACL, any CWDs and consortia that are currently engaging in this practice must immediately discontinue sending Promissory Notes or similar documents.

New Form – CW 2217, "CalWORKs Request for Voluntary Repayment" form

Upon implementation of this letter, the CWDs shall instead begin using the CW 2217, "CalWORKs Request for Voluntary Repayment" form. This form will be given to clients only under the following conditions:

- The client asked if voluntary repayment of their overpayment can be made.
- The request followed an explanation by the CWD of the overpayment.
- The CWD did not in any way initiate or request that the client undertake voluntary repayment.
- The client understands that he or she is not required to voluntarily repay the OP and can suspend voluntary repayment at any time.

The CW 2217 is designated as Required Form-Substitutes Permitted. Forms in this category are required forms for which modifications or substitutions with prior CDSS approval are permitted. The CWDs may modify these forms to add or obtain information that does not (a) conflict with program policies or regulations, or (b) change the legal content of the form.

ACWDL 15-08 (February 2, 2015)

January 2015 Social Security Title II and Title XVI Cost of Living Adjustments and Related Issues

The purpose of this letter is to provide counties with guidance for processing the above-referenced 2015 Cost of Living Adjustment (COLA) in the Statewide Automated Welfare System (SAWS). The application of the COLA to the Title II, Retirement, Survivor's and Disability Insurance (RSDI) eligibility group has not changed and is provided in this letter. Please proceed with processing the 2015 COLA in accordance with the policy of this letter.

The processing of the 2015 COLA will not affect the new Modified Adjusted Gross Income (MAGI) eligibility groups. The California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS) will not run Social Security Administration (SSA) COLA for MAGI beneficiaries at this time. Once 2015 FPLs are updated in CalHEERS, CalHEERS and Saws will run batch eligibility back to January 1, 2015 to redetermine eligibility for individuals whose initial eligibility or renewal was based on 2014 FPLs.

ACWDL 15-09 (January 30, 2015)

MC 216 Pre-Populated Renewal Form

The purpose of this letter is to transmit the MC 216 Pre-Populated Renewal Form to Counties, which is used to confirm and request verification of beneficiary information known to the California Healthcare Eligibility, Enrollment, and Retention System and the Statewide Automated Welfare Systems at annual renewal. Enclosed with this letter is a copy of the MC 216 form in all threshold languages. The current version of this form is dated September 2014.

ACL 15-18 (February 9, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-18.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Long-Term Welfare-To-Work (WTW) Sanction Population Move To Solely State Funded Program

This ACL transmits instructions for counties to change aid codes as of March 1, 2015, for specified CalWORKs cases that include certain parents/caretakers who have been sanctioned for noncompliance in the WTW program, as defined in this letter. Use of these codes as instructed in this ACL is required, and will help the state meet its federal work participation rate (WPR) requirement. The CalWORKs cases specified in the "Implementation" section of this ACL that include parents/caretakers who have been sanctioned due to failing or refusing to comply with program requirements without good cause in the WTW program for 12 consecutive months or longer (long-term sanctioned cases), must be tracked with one of two different aid codes, as instructed in this letter.

ACWDL 14-41 (February 5, 2015)

Enrollment in the Former Foster Care Children's (FFCC) Program for Mandatory Coverage Group and Optional Coverage Group— County Process for Medi-Cal Applicants and Beneficiaries

The purpose of this All County Welfare Directors Letter (ACWDL) is to provide County Department of Social Services (Counties) with guidance on the handling of the former foster care youth in the Mandatory

Coverage Group (MCG) and Optional Coverage Group (OCG). The mandatory coverage group includes youth who were receiving Medicaid (Medi-Cal) in foster care under the responsibility of any state or tribe on their 18th birthday or a later age. These youth are now eligible for benefits in the former foster care program until age 26 since January 1, 2014.

ACWDL 15-10 (February 10, 2015)

Implementation of new American Indian/Alaskan Native (AI/AN) Premium Payment Waiver Process for the Optional Targeted Low Income Children Program (OTLICP) and the Medi-Cal Access Infant Program

The purpose of this All County Welfare Director's Letter (ACWDL) is to provide guidance to counties on processing a request for waiver of premium payments for eligible AI/AN children per exemptions allowed by federal statute. This ACWDL supersedes guidance provided in MEDIL I 14-12.

ACL 14-108 (January 5, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-108.pdf>

Temporary Assistance For Needy Families (TANF) And California Work Opportunity And Responsibility To Kids (CalWORKs) Time Limit Exemption For Recipients Living In Indian Country Where The Unemployment Level Of Adults Is 50 Percent Or Higher

The purpose of this All County Letter (ACL) is to report the results of a survey that the California Department of Social Services (CDSS) recently completed. The goal of the survey was to document the names of the federally recognized tribes that have experienced a 50 percent or higher level of unemployment among adults in the previous calendar year. The process of conducting the survey and publishing the results allows the CDSS to act as a conduit to inform the County Welfare Departments (CWD) of Indian Country residents who qualify for the federal and state time limit exemption.

ACL 15-20 (February 13, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-20.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs): The Approved Relative Caregiver (ARC) Funding Option Program

This letter transmits instructions to County Welfare Departments (CWDs) regarding the implementation of the Approved Relative Caregiver (ARC) Funding Option Program (hereinafter referred to as the ARC Program) pursuant to SB 855. The ARC Program gives CWDs the option to make the amount paid to an approved relative caregiver for the care and supervision of a child who is under the jurisdiction of the California juvenile court—and who is *ineligible* for federal Aid to Families with Dependent Children-Foster Care (AFDC-FC)—equal to the basic amount paid on behalf of such a child who is *eligible* for AFDC-FC. The changes created by SB 855 were effective January 1, 2015.

Recommended That This ACL With Attachments Be Read In Its Entirety

MEDIL 15-02 (February 12, 2015)

Rescind the Instruction for a Third Request for Verification Requirement as Specified in Medi-Cal Eligibility Division Information Letter (MEDIL) I 14-23 Processing Income Verifications on Pended and Current Applications in the Statewide Automated Welfare System

The purpose of this MEDIL is to notify counties that the direction provided in MEDIL I 14-23 requiring counties to send out a third 10-day request for verification for all pending applications will be no longer required. Effective immediately, counties shall return to the Second Contact rules as outlined in All County Welfare Directors Letter 08-07.

E-Note #127- Summary of ACLs/ACINs/ACWDLs/MEDILs/CFLs

January 13, 2015

ACL 14-90 (December 2, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-90.pdf>

Electronic Benefit Transfer (EBT) Excessive Card Replacement Warning Letter Process

The purpose of this All County Letter (ACL) is to provide instructions to County Welfare Departments (CWDs) and other county staff regarding changes to the current EBT excessive card replacement (ECR) warning letter process. Please note that this process only applies to CalFresh benefits issued via EBT cards. These changes are a result of a federal FNS Final Rule.

Beginning 2015, the consortium or the CWDs will issue warning letters to any EBT cardholder after the fourth activated card replacement request within a 12-month period. The 12-month period for counting replacement requests is a rolling time period and is not based on calendar or fiscal year. The 12-month look back period begins with the first request for a replacement card. The first 12-month period begins January 2014 and therefore CWDs will begin to send out warning letters to EBT cardholders who have met the threshold within the last 12 months (January - December 2014). Note: Initially some counties may experience a large amount of warning letters due to the need to provide notice to all cardholders who have requested four replacement cards between January through December 2014.

MEDIL - I 14-59 (December 4, 2014) New Medi-Cal managed Care Ombudsman Online, Fillable Form-County Staff Use Only

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDIL%20I%2014-59.pdf>

The purpose of this letter is to notify counties of a new online, fillable form tool for urgent Medi-Cal Managed Care Ombudsman requests.

In order to increase efficiency and response times, ensure a secure transmission of Personal Health Information, and provide minimally required information for processing, the Medi-Cal Managed Care Office of the Ombudsman has created an easy to use online fillable form for county staff.

This new form should be utilized for urgent expedited matters only. All standard changes need to be processed through Health Care Options at 1-800-430-4263. The online, fillable form should be used when requesting expedited:

- Plan Changes
- Plan Enrollments
- Plan Disenrollments

- Removal of 59 Holds

MEDIL - I 14-60 (December 10, 2014) Medi-Cal Renewal Process – The 90-Day Cure Period Job Aid

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-60.pdf>

SUBJECT: Medi-Cal Renewal Process – The 90-Day Cure Period Job Aid

The purpose of this letter is to provide the attached job aid for counties outlining the requirements of the new 90-day cure period of the Medi-Cal renewal process. Per California Welfare and Institutions Code, Section 14005.37(i), the 90-day cure period begins from the date of the Notice of Action for discontinuance.

ACWDL 14-42 (December 10, 2014) Treatment of Impairment-Related Work Expenses and Blind Work Expenses for Medi-Cal Beneficiaries with Disability Linkage Enrolled in the 250 Percent Working Disabled Program, Disabled Adult Child, Disabled Federal Poverty Level, Blind FPL, Blind or Disabled Medically Needy, Disabled Widows/Widowers and Pickle Programs

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-42.pdf>

The purpose of this letter is to provide direction to counties to exclude IRWEs and BWEs from countable earned income retroactively to December 1, 1990, for all blindness and disability linked Medi-Cal programs, effective upon the receipt of this All County Welfare Director's Letter.

The Department of Health Care Services will be developing income eligibility worksheets, including the treatment of IRWEs or BWEs, for those programs that do not currently have one. Until such time as those worksheets become available, use the following Supplemental Security Income/State Supplemental Payment definition and methodology in determining eligibility:

Definition: IRWE or BWEs are expenses for items or services which are directly related to enabling a person with a disability or blindness to work and which are necessarily incurred by that individual because of a physical, visual or mental impairment. An expense may meet the criteria for an IRWE or BWE even if it also is used for daily activities other than work. The expense must not be reimbursable by another source such as Medicare or private health insurance. In the event that the beneficiary has other health coverage, it is the beneficiary's obligation to provide documentation that the BWE or IRWE was not reimbursable.

ACL 14-86 (December 9, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-86.pdf>

Clarification On The Requirements Of The In-Home Supportive Services (IHSS) Program Health Care Certification Form (SOC 873) Being Provided During An Inter-County Transfer

Set forth in its entirety below:

The purpose of this ACL is to provide clarification to counties on the eligibility documentation that must be maintained in recipients' case files and transferred appropriately during the Inter-County Transfer (ICT) process. This ACL will address the responsibility of the transferring and receiving counties and the importance of annotating Case Management, Information and Payrolling System II (CMIPS II) when the required documentation including the IHSS Program Health Care Certification form (SOC 873), is not available in hardcopy in the recipients' case file to be transferred.

BACKGROUND

Since the implementation of CMIPS II and the availability of case documentation within the system, counties have requested clarification regarding the required IHSS documents that must be transferred in hardcopy during an ICT. Counties have specifically requested clarification regarding receipt of an ICT absent the hardcopy of the SOC 873.

Counties have also expressed concern that California Department of Social Services' (CDSS) IHSS State Quality Assurance Monitoring Unit (QAMU) staff reviews their case files to determine if ICT processes are followed appropriately and therefore want to ensure they are in compliance by maintaining all necessary hardcopy documentation in the recipients' case file and annotating CMIPS II Case Notes screen when the required documentation is not available in hardcopy.

DOCUMENTS THAT MUST BE TRANSFERRED IN HARDCOPY DURING AN ICT

CDSS Manual of Policy and Procedures (MPP) section 30-759.911 lists the required documents that must be provided by the transferring county during an ICT. These documents include all IHSS forms which help to establish eligibility, including but not limited to the IHSS Application for Social Services (SOC 295); the most recent IHSS face-to-face assessment; including assessment narrative and any recent notes, an IHSS provider eligibility update; an IHSS Program Provider Enrollment form (SOC 426), if applicable; a Request for Order and Consent Paramedical Services form (SOC 321), if applicable; the current Notice of Action; and any information pertaining to overpayments and fraud investigations, if applicable. Some examples of overpayments and fraud information that must be transferred include but are not limited to the IHSS Complaint of Suspect Fraud Abuse Form (SOC 2248), IHSS Unannounced Home Visit Report form (SOC 2247), Overpayment Demand Letter, Repayment Agreement, and all documentation pertaining to an established lien, withholding, garnishment or tax intercept.

The SOC 873 is not currently listed in MPP section 30-759.911 as one of the documents required to be sent in an ICT since these regulations were written prior to the development of the SOC 873 in 2011, pursuant to Welfare and Institutions Code, section 12309.1. Notwithstanding, since the SOC 873 is a mandatory form that establishes IHSS eligibility, transferring counties must include a hardcopy of the SOC 873 with all documentation being transferred in an ICT. CDSS will update the ICT regulations in the future to include the SOC 873 as a required document that must be provided by the transferring county during an ICT.

For counties who use electronic record storage systems and scan case documents, the scanned version of the forms/documents stated above is sufficient to be sent to the receiving county.

COUNTY RESPONSIBILITY IF THE SOC 873 IS NOT PROVIDED IN HARDCOPY

Although CMIPS II has an indicator that identifies when a SOC 873 is received; it is not a document that is directly maintained in CMIPS II. In an ICT, the transferring county is required to provide the receiving county with hardcopies of all completed forms/documents that are maintained outside of CMIPS II, as listed above in the previous section "Documents that must be transferred in hardcopy during an ICT".

In the event that the transferring county, for unusual or unforeseen circumstances, does not have the hardcopy of the SOC 873 to send with all other required documents, the transferring county should annotate recipients case file and the CMIPS II Case Notes screen that the SOC 873 is not available and that the Health Care Certification requirement has been met and proceed with ICT process.

As stated in ACIN No. I-74-11, neither the transferring county nor the receiving county is required to request a new SOC 873 from the recipient if the SOC 873 has already been provided by the recipient in the transferring county. However, if the SOC 873 or alternate documentation has not already been provided by the recipient in the transferring county, the receiving county shall request one at or before the face-to-face assessment with the recipient, which the receiving county is required to complete during the transfer period pursuant to MPP section 30-759.94.

In order to successfully complete the ICT process it is critical that counties communicate, provide all required hardcopy documentation, provide clear notes in the recipient's case file and in CMIPS II and work together to ensure there is no interruption or overlapping of services as a result of a recipient moving from one county to another. Thorough documentation of a good faith effort to obtain the hardcopy of the SOC 873 (or other documents that establish eligibility for the IHSS program) by the receiving county in the recipient's case file and in CMIPS II, will ensure that there will be no negative findings by QAMU staff with regard to the SOC 873 not being available in hardcopy in the recipient's case file.

ACIN I-69-14 (December 11, 2014)

http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acin/2014/I_69-14.pdf

Social Security Administration (SSA) Cost Of Living Adjustment (COLA) –
effective January 1, 2015

Social Security recipients will receive a 1.7 percent COLA increase in their Social Security benefits effective December 31, 2014, which is payable January 2015. This increase will affect California Work Opportunity and Responsibility to Kids (CalWORKs) cash aid and CalFresh allotment amounts for those applicants and recipients who also receive Social Security benefits. When cash aid or CalFresh allotment amounts are adjusted due to the Social Security COLA benefit increase, the requirements for a timely and adequate Notice of Action shall apply pursuant to CalFresh MPP Section 63-504.261 and CalWORKs MPP Sections 22-071 and 22-072.

MEDIL - I 14-56E (December 15, 2014) Erratum to MEDIL 14-56 – Initial County Guidance on Short-Term Negative Action Approach

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-56E.pdf>

The purpose of this erratum is to clarify the top three priority categories identified by the Department of Health Care Services (DHCS) for the short-term negative action approach. As the first step, counties are instructed to review cases that fall within these top three priority categories. In an effort to avoid multiple reviews of a given case, counties are advised to make note of the case that needs to be denied or discontinued in accordance to the other remaining denial or discontinuance categories listed in Attachment A, even though it does not have a priority yet assigned.

ACIN I-71-14 (December 15, 2014)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2014/I-71_14.pdf

Availability Of Spanish-Translated Version Of IHSS Informational Video: 2015 New Program Requirements/IHSS Provider Timesheet Training

This ACIN provides information regarding the release of the Spanish-translated version of the In-Home Supportive Services (IHSS) video entitled, “*2015 New Program Requirements/IHSS Provider Timesheet Training*.”

This video is now available on the California Department of Social Services’ (CDSS) website at the following link: www.cdss.ca.gov/agedblinddisabled/PG1814.htm. Additionally, CDSS, in collaboration with the California State University, Sacramento, will distribute an initial DVD to each county.

ACL 14-94 (December 15, 2014) <

<http://www.dss.cahwnet.gov/lettersnotices/EntRes/getinfo/acl/2014/14-94.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Child Care Programs - Regional Market Rate (RMR) Ceilings

BACKGROUND

The RMR ceilings are the maximum amount child care providers can be reimbursed from the state for subsidized child care. It applies to the CalWORKs Stage One child care program administered by the California Department of Social Services (CDSS) and the CalWORKs Stages Two and Three and other child care programs administered by the California Department of Education (CDE). The CDE is responsible for the contract awarded on a competitive basis to conduct the biennial RMR survey for child care providers. The survey is based on a methodology of zip codes groupings that have similar socio-economic characteristics (e.g., similar housing costs, population density, and employment rates). The survey results are utilized to create the RMR ceilings based on an aggregate of the survey data for each county.

CHANGE IN RMR PAYMENT CEILINGS

The Budget Act of 2014, SB 852, maintains the current RMR ceilings at the 85th percentile of the 2005 RMR survey and the license-exempt child care provider ceilings at 60 percent of the Family Child Care Home ceilings through December 31, 2014.

The AB 1476 and the SB 876 require California to implement ceilings at the 85th percentile of the 2009 RMR survey reduced by 10.11 percent. If the new calculated ceiling is less than the 2005 RMR ceiling, then the county will continue to utilize the 2005 RMR ceiling. The license-exempt child care provider ceilings will continue to be 60 percent of the Family Child Care Home ceilings. The new RMR ceilings are effective January 1, 2015.

All Plan Letter 13-017 (December 12, 2104)

SUBJECT: REQUIREMENTS FOR COVERAGE OF EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES FOR MEDICAL BENEFICIARIES UNDER THE AGE OF TWENTY ONE

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf>

PURPOSE:

This All Plan Letter (APL) clarifies the responsibilities of Medi-Cal managed care health plans (MCPs) to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to eligible children under the age of 21. This policy applies to all children enrolled in MCPs. This guidance is intended to reinforce existing state and federal laws and regulations regarding the provision of Medi-Cal services, including EPSDT, and does not represent any change in policy. This APL supersedes Policy Letter 00-006.

Recommendation that this ACL be read in its entirety

ACIN I-68-14 (December 18, 2014)

http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acin/2014/1-68_14.pdf

New Payment Standards For The Cash Assistance Program For Immigrants Effective January 2015

This All County Information Notice provides new payment standards for the Cash Assistance Program for Immigrants (CAPI), effective January 2015. It also provides clarification on the computation of benefits for a CAPI recipient whose spouse receives Supplemental Security Income/State Supplementary Payment (SSI/SSP).

As required by Welfare and Institutions Code (WIC) section 18941, the CAPI payment standards are based on the SSI/SSP payment standards, less \$10.00 for an individual and \$20.00 for a couple per month. Although there will be no increase in the state-funded SSP amount in January 2015, there will be an increase in the federally-funded SSI payment due to a cost of living adjustment (COLA) and an increase in the combined SSI/SSP payment standards. Consequently, there will be an increase in CAPI payment standards. The attached table shows the new CAPI payment standards which become effective on January 1, 2015.

ACL 14-89 (December 16, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-89.pdf>

Approved Relative Caregiver (ARC) Funding Option Program

(See E-Note #126 Regarding ARC)

ACL 14-100 (December 19, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-100.pdf>

Changes In Eligibility For All People With A Prior Felony Drug Conviction In The California Work Opportunity And Responsibility To Kids (CalWORKs) And CalFresh Programs

The purpose of this letter is to transmit instructions to County Welfare Departments (CWDs) regarding the changes in eligibility in the CalWORKs and CalFresh programs pertaining to individuals with a prior felony drug conviction. The changes in eligibility provided within this letter are due to the enactment of recent legislation (AB 1468) which repealed the lifetime ban on individuals with a prior felony drug conviction to be eligible for CalWORKs and CalFresh benefits.

Recommendation that this ACL to read in its entirety.

ACL 14-99 (December 17, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-99.pdf>

Implementation Of Required New Screens In The Case Management And Information Payrolling System To Accommodate In-Home Supportive Services (IHSS) And Waiver Personal Care Services (WPCS) Overtime And Travel Time Forms Tracking

This All County Letter (ACL) provides counties with information and instructions on new and modified screens for new forms tracking in Case Management, Information and Payrolling System (CMIPS II) to support the implementation of Senate Bills (SB) 855, SB 873 and ACL No. 14-76 which require In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) providers to receive compensation for overtime and travel time effective January 1, 2015.

BACKGROUND

ACL No. 14-76 describes the U.S. Department of Labor's Final Rule on the Application of the Fair Labor Standards Act to Domestic Service, which requires compensation of IHSS and WPCS providers for overtime when they work more than 40 authorized hours in any workweek. The Final Rule also requires that providers be compensated for travel time and wait time in certain circumstances. SB 855 added section 12300.4 to the California Welfare and Institutions Code (W&IC), limiting the number of hours that IHSS and WPCS providers are permitted to work in any workweek. "Workweek" is defined as the period beginning at 12:00 a.m. on Sunday and terminating at 11:59 p.m. the following Saturday.

To meet the January 1, 2015, implementation date, CMIPS II will be modified to process and calculate overtime compensation at one and one-half times the regular rate of hourly pay when time worked exceeds 40 authorized hours per workweek. In addition, CMIPS II will also be modified to calculate and pay travel time, as well as calculate weekly authorized hours based on each recipient's monthly authorization and track recipient and provider workweek agreements.

ACL 14-103 (December 19, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-103.pdf>

Implementation Of New Timesheets To Accommodate In Home Supportive Services (IHSS) And Waiver Personal Care Services (WPCS) Overtime And Travel Time Compensation

This All County Letter (ACL) provides counties with information regarding the new timesheets and Travel Claim Form for IHSS and WPCS providers. In order to support the implementation of Senate Bill 855, Senate Bill 873 and ACL 14-76, the IHSS timesheet has been redesigned and the Remittance Advice (RA) has been modified. In addition, this ACL provides instructions for implementation of the modified timesheet issuance process, and the new travel claim form process. All new forms referred in this ACL are available in Attachment A.

Background

Individuals who provide services for multiple recipients living in separate households on the same workday will be able to claim hours to be paid for travel time in accordance

with Welfare and Institutions Code (WIC) section 12300.4(f). "Travel time" is defined as the time spent travelling directly from a location where authorized services are provided to one recipient, to another location where authorized services are to be provided to another recipient. This travel time rule will apply to providers travelling between recipients of either program (IHSS and WPCS) as of January 1, 2015.

Providers who are eligible for travel time compensation will be issued the new travel timesheet and will be required to submit a Travel Claim Form (SOC 2275) with each travel timesheet in order to receive compensation for travel time.

ACL 14-92 (December 22, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-92.pdf>

Removal Of The Treatment Of Individuals With A Prior Felony Drug Conviction From The Application For CalFresh Benefits

Assembly Bill (AB) 1468, Chapter 26, Statutes of 2014 makes those individuals convicted of any offense classified as a felony that has as an element the possession, use or distribution of a controlled substance, eligible to receive CalFresh benefits, if otherwise eligible, effective April 1, 2015. The California Department of Social Services (CDSS) and the three SAWS consortia must make the necessary changes to eliminate the drug felon questions on paper applications, online applications, and in the SAWS case management functionality by the effective date.

The purpose of this letter is to transmit the revised Application for CalFresh Benefits form (CF 285) and implementing instructions to County Welfare Departments (CWDs).

In addition, the CalFresh Program Qualifying Drug Felon Addendum (CF 26) will become obsolete as of April 1, 2015 due to the elimination of the ban on drug felons.

ACL 14-101 (December 22, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-101.pdf>

CF 37: New Form For CalFresh Recertification (RC)

The purpose of this letter is to transmit instructions on implementing a new form for the RC of Nonassistance CalFresh (NACF) household (HH) in which no member receives a CalWORKs grant. It is anticipated that this administrative change will improve program access, decrease churn (cases discontinued that reapply within 30-90 days), simplify RC requirements and decrease the administrative burden on County Welfare Departments (CWDs).

ACL 14-98 (December 23, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-98.pdf>

California Work Opportunity And Responsibility to Kids (CalWORKs): Immunization Good Cause Request Form – CW 2209

The purpose of this All County Letter (ACL) is to introduce the new Immunization Good

Cause Request Form (CW 2209) to County Welfare Departments (CWDs). The Immunization Good Cause Request Form will provide applicants and recipients an avenue to request a good cause exemption to the CalWORKs immunization requirements. Caretaker relatives can use the CW 2209 form to explain why one or all of the eligible children in the assistance unit have not been immunized by checking one or more boxes or describing why their child(ren) under the age of six have not received up-to-date vaccinations/shots.

ACL 14-104 (December 23, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-104.pdf>

Transitional Housing Placement Plus Foster Care (THP+FC) California Necessities Index (CNI) Increase; Update On Sharing Ratios

The purpose of this ACL is to clarify and inform counties and other interested parties of the manner in which the CNI will be applied to the THP+FC rate. The CNI for fiscal year (FY) 2014-15 is 2.17 percent and shall be applied to the entire THP+FC rate retroactive to July 1, 2014. In addition, this ACL communicates the THP+FC sharing ratios are to remain the same for FY 2014-15 as identified in ACL NO. 14-18.

MEDIL - I 14-61 (December 31, 2014) Accelerated Enrollment (AE) for Cases Where Medi-Cal Eligibility is Not Determined Within the 45-Day Timeframe

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-61.pdf>

The purpose of this letter is to inform counties about a new State process to provide pending Medi-Cal applicants with AE when eligibility has not been determined within the required 45-day timeframe.

Background

As stated in Medi-Cal Eligibility Division Information Letter 14-55, Workload Efforts for Individuals Pending in the Backlog, we have made great strides working collaboratively on reducing the backlog. In order to prevent a future backlog of pending cases during the current Covered California open enrollment period between November 15, 2014 through February 15, 2015, the Department of Health Care Services (DHCS) will be implementing a new batch process to provide AE to applicants where their Medi-Cal eligibility has not been determined within the 45-day timeframe, as required by federal and state regulations. This effort is a component of DHCS' ongoing mitigation strategy to address the pending case load and is tied to the approval of enhanced federal funding related to eligibility and enrollment work conducted by county eligibility workers.

45-Day Batch AE Process

The goal of this batch effort is to provide AE to all Medi-Cal applicants where eligibility has not been determined within the required 45-day timeframe. This batch process will

target Medi-Cal applications made during open enrollment and will be inclusive of cases with applications made on or after November 15, 2014, and up through at least February 15, 2015, regardless of the applicant's access channel. The batch will occur weekly beginning the week of December 29, 2014. As a result, some cases may be provided AE prior to the 45th day, as all cases must be provided AE prior to day 46.

ACL 14-102 (December 31, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-102.pdf>

New Program Rules And Requirements For IHSS Provider Enrollment Orientation And Clarification Of Provider Enrollment Identification Process Related To Social Security Numbers

This All County Letter (ACL) provides direction to counties on the changes to the law regarding the IHSS provider enrollment orientation as a result of the enactment of SB 878 (Chapter 689, Statutes of 2014). Additionally, this ACL provides clarification of the provider enrollment application procedures which are being provided due to adoption of a new policy by the U.S. Social Security Administration (SSA).

ACIN I-73-14 (January 5, 2014)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2014/I-73_14.pdf

Information Regarding Federal Court Order Impacting The Implementation Of The Federal Department Of Labor Regulations Pertaining To The Payment Of Overtime Compensation And Other Compensable Activities And To Related Provisions Of Senate Bills 855 And 873 (Chapters 29 And 685, Statutes Of 2014) For The IHSS And Waiver Personal Care Services Programs

Set forth in its entirety:

This All-County Information Notice is to inform counties of the two recent court orders issued by Judge Richard Leon of the United States District Court, District of Columbia, which impact the implementation of regulations adopted by the U.S. Department of Labor (DOL) pertaining to the payment of overtime compensation and other compensable activities for In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) providers that were to be effective January 1, 2015.

The first court order, dated December 22, 2014, vacated the DOL rule which precluded third-party employers from claiming applicable wage and overtime exemptions for services provided by live-in providers and employees performing companionship services. The second court order, dated December 31, 2014, enjoined the implementation of the revised definition of companionship services until January 15, 2015. However, a court hearing regarding the temporary injunction is calendared for January 9, 2015 wherein further information may be ascertained regarding the federal regulations at issue.

Based on the above-referenced court orders, CDSS Director Will Lightbourne notified County Welfare Directors on December 31, 2014, that the implementation of the new

FLSA regulations and the key provisions of Senate Bills 855 and 873 will be delayed until further court clarification.

All county IHSS offices and county public authorities should continue to operate under the requirements and regulations for payment of wages that were in effect on December 31, 2014. CDSS is continuing to move forward with the new timesheet format, but CMIPS II programming will not process payments for overtime or travel time until further clarification is ascertained based on the court decisions.

In those instances in which counties have conducted assessments that included wait time adjustments for medical accompaniment and those adjustments were entered into CMIPS II, counties will need to ensure that these adjustments are removed from CMIPS II with utmost expediency. However, counties should retain this information within the IHSS recipient's case file for future reference.

An information notice is currently in development to inform all IHSS providers and recipients of this delay. Mailing of the notices will begin this week to all IHSS providers and recipients. Please see attachment.

Depending on future court rulings, CDSS will issue further guidance to the counties via a Program Manager Letter, All-County Information Notice, or All-County Letter.

ACWDL 14-43 (January 5, 2015) Premium Refund/Waiver Requests for the Optional Targeted Low Income Children Program (OTLICP)

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-43.pdf>

The purpose of this All County Welfare Directors Letter (ACWDL) is to provide direction to counties for situations in which a beneficiary in OTLICP premium-based aid codes is entitled to a refund of premium payments or a waiver of their past due premiums. Counties must process a Premium Refund/Waiver Request when a beneficiary submits a written request to be discontinued from the program and the request is not effective by the last day of the month in which the request is made. Counties must also process a Premium Refund/Waiver Request when a beneficiary in a premium-based aid code is found to be eligible for a non-premium aid code retroactively (for example, a non-premium aid code overlays the premium-based aid code due to a retroactive determination of eligibility or an appeal/hearings decision).

ACL 14-109 (January 7, 2014)

<<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-109.pdf>>

California Work Opportunity And Responsibility To Kids (CaWORKs)

Program: Changes To Social Security And Supplemental Security Income Appeals Process

Set forth in its entirety:

The purpose of this letter is to notify County Welfare Departments (CWDs) of a 2011 ruling by the Social Security Administration (SSA) related to appeals of denied applications for Supplemental Security Income (SSI) and/or Social Security benefits and the impact to CalWORKs clients. This letter instructs CWDs on how to handle cases in which an individual has already applied for SSA benefits and the disability claim is in the appeals process to ensure CWDs do not require SSA applicants to submit subsequent applications for SSA benefits.

Background

Prior to July 28, 2011, claimants for Social Security or SSI who had their applications denied could file an appeal and/or file a new application. Effective July 28, 2011, with the issuance of Social Security Ruling (SSR) 11-1p, claimants are generally limited in their ability to file a subsequent application for the same type of benefits while the application is pending at any level of the administrative review. Although claimants may choose to file a subsequent application, in doing so, the claimant will generally be asked to drop their pending appeal, which results in the potential for loss of retroactive eligibility for Social Security, SSI, and Medi-Cal or Medicare.

Potentially Available Income

In order to be eligible for CalWORKs, an applicant or recipient is required to seek or accept potentially available income pursuant to Manual of Policies and Procedures (MPP) section 82-610.1. The CWD shall assist the applicant or recipient as needed in establishing their eligibility, as stated in MPP section 40-107.

As a result of the SSR 11-1p, effective immediately, CWDs shall not require CalWORKs applicants or recipients to file a *new* claim for Social Security or SSI benefits when the CalWORKs applicant or recipient has an application for Social Security or SSI benefits pending due to an appeal at any level of the administrative appeal process through the Appeals Council.

The CWD may require other evidence in order to demonstrate that the CalWORKs applicant or recipient has taken all actions necessary to obtain potentially available income, pursuant to MPP section 82-610. For example, providing proof of a pending Social Security hearing would be sufficient to show that a CalWORKs applicant or recipient is attempting to obtain social security benefits to which he or she may be entitled. CWDs are reminded that the SSA administers several types of income, and not all income administered by the SSA is considered potentially available. Sources of potentially available income are provided in MPP section 82-610.4.

ACL 14-91 (January 6, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-91.pdf>

Discontinuance Of Annual Work Registrant And Food Stamp Employment And Training (FSET) Program Caseload Report STAT 48 (10/06)

Revised Non-Assistance CalFresh Work Registrants, Able-Bodied Adults Without Dependents (ABAWD), And Employment And Training (E&T) Program Quarterly Statistical Report STAT 47 (10/14)

This letter informs the counties that the Annual Work Registrant and Food Stamp Employment and Training (FSET) Program Caseload Report (STAT 48) is being discontinued. The STAT 48 for October 1, 2013 (which was due on November 15, 2013) was the last STAT 48 report period that was required. This letter also informs counties that the Non-Assistance CalFresh Work Registrants, Able-Bodied Adults Without Dependents (ABAWD), and Employment and Training (E&T) Program Quarterly Statistical Report (STAT 47) is revised.

ACL 14-107 (December 31, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-107.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Changes To Asset Limits For Families

Set forth in its entirety:

The purpose of this ACL is to notify County Welfare Departments (CWDs) of the change to the maximum asset limit for families in the CalWORKs program. CalWORKs families are allowed to retain countable resources in an amount equal to the amount allowed by the Federal CalFresh program regulations.

The United States Department of Agriculture, FNS has increased the asset limit for CalFresh households in accordance with the Federal Fiscal Year (FFY) 2015 adjustment. In order to maintain maximum compatibility between the programs, CalWORKs is also adopting the increased resource limit for CalWORKs households from \$2,000 to \$2,250 effective October 1, 2014.

In addition, if CWDs find that an assistance unit (AU) was denied cash aid or has had their cash aid discontinued as a result of exceeding the \$2,000 asset limit, the CWD must re-evaluate eligibility for the AU and restore any benefits that would have been authorized under the increased asset limit as of October 1, 2014. Additionally, when re-evaluating resource eligibility limits for previously discontinued or denied cases, if the CWD has collected or is currently collecting an overpayment (OP) based on excess resources for AUs fitting this description for any period after September 30, 2014, the CWD shall review the case to determine if the AU was actually under the \$2,250 resource limit, and if so, immediately cancel the OP and return any funds collected pursuant to MPP Section 44-350.

The CDSS also made a change in the resource limit for a disabled member or person age 60 or over in the CalWORKs household from \$3,000 to \$3,250. This change was made effective with the issuance of ACL 13-97 which was released on December 12,

2013. The CDSS is in the process of amending the CalWORKs regulations to reflect the new asset limits for CalWORKs families.

ACL 15-01 (January 9, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-01.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs)

Program: Additional Guidance And Forms Regarding Welfare To Work (WTW) 24-Month Time Clock Extensions, And Release Of Related Welfare Data Tracking Implementation Project (WDTIP) Tracking Recipients Across California (TRAC) Impact Code

Recommendation that this ACL be read in its entirety:

The purpose of this ACL is to issue further guidance to County Welfare Departments (CWDs) regarding extensions to the WTW 24-Month Time Clock, including clarification of extension criteria, the determination process, and extension reevaluations. Initial guidance on extensions was issued in ACL 14-09.

This ACL also provides instructions to CWDs regarding an additional circumstance determined by the Department for which a client may request an extension to the WTW 24-Month Time Clock, as allowed in WIC Section 11322.87(a)(6) adopted by SB 1041, and transmits an additional WDTIP TRAC code for this extension circumstance. Initial guidance and transmission of WDTIP TRAC codes associated with extensions to the WTW 24-Month Time Clock were released in ACL 14-48.

This ACL also transmits the attached “WTW 24-Month Time Clock Extension Request Form” (WTW 44), the “WTW 24-Month Time Clock Extension Determination” (WTW 45), and provides additional guidance on the use of these forms for evaluation and determination of extension requests. The WTW 44 and WTW 45 were developed as a result of changes to the CalWORKs program enacted in SB 1041 and codified in WIC Section 11322.8, 11322.85, 11322.86, and 11322.87. Beginning in January 2015, some CalWORKs clients may reach the end of the WTW 24-Month Time Clock. In order to provide clients with the opportunity to request an extension to the WTW 24-Month Time Clock, CWDs must provide the WTW 44 to the client. The CWDs must also provide the WTW 45 to the client to inform him or her of the approval or denial of a WTW 24-Month Time Clock extension request. More guidance regarding the process for this transition will be provided in ACL 15-02.

ACL 15-02 (January 9, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-02.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Program: Senate Bill (SB) 1041 Welfare-To-Work (WTW) 24-Month Time Clock 20 Percent Extension Methodology And Target Estimates By County

The purpose of this ACL is to provide County Welfare Departments (CWDs) with the methodology used and target number of extensions estimated for the WTW 24-Month Time Clock.

ACL 15-05 (January 9, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2015/15-05.pdf>

Self-Certification Training For Altered Access To Medi-Cal Eligibility Data System (MEDS) Data Elements

The purpose of this letter is to inform county Adult Protective Services (APS) program staff of the availability of MEDSLite data and to instruct counties on the implementation of the self-directed certification training document, Training for the Access and Use of Electronically Exchanged Data Provided by the Social Security Administration (SSA), (see attached) for the access and use of electronically exchanged data based on the strict security and privacy requirements provided by the SSA.

ACL 14-51E (January 8, 2015)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-51E.pdf>

Corrections To ACL 14-51 County Temporary Assistance For Needy Families (TANF) Program Work Participation Data Reporting For Federal Fiscal Year (FFY) 2015

This letter provides a corrected instruction set for reporting county-specific FFY 2015 TANF work participation rate (WPR) data to the California Department of Social Services (CDSS) using the web-based Enterprise II Lite (E2Lite) system. The information in these ERRATA is consistent with the existing TANF Program Final Rule released on February 5, 2008. In addition, the instructions and definitions are consistent with the updated California's Work Verification Plan, which was approved by the United States Department of Health and Human Services, Administration for Children and Families (ACF) on January 15, 2014, effective September 1, 2013.

ACWDL 15-01 (January 7, 2015) Transitioning Covered California Cases to Medi-Cal

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-01.pdf>

The Department of Health Care Services (DHCS) is providing guidance to the counties and the Statewide Automated Welfare Systems (SAWS) regarding Covered California (Covered CA) cases that transitioned to the Medi-Cal program on January 1, 2015, as a result of Covered CA's annual redetermination process. DHCS will issue additional guidance in the near future pertaining to Covered CA cases transitioning to the Medi-Cal program as a result of a reported change in circumstance.

Recommended that this ACWDL be read in its entirety

E-Note No. 126

Introduction to the Approved Relative Caregiver Funding Option Program (ARC)

December 23, 2014

References:

Welfare and Institutions Code, Section 11461.3 (Stats. 2014, c. 29 (S.B. 855), §74, eff. Jun. 20, 2014; amended Stats. 2014, c. 685 (S.B. 873), §8, eff. Sep. 27, 2014.)

ACL 14-89, issued Dec. 16, 2014

Introduction:

The Department notes that some 36% of all foster children in the state are placed with relative caregivers. In order to be eligible for foster care level benefits, this population must rely upon federally funded benefits, meaning the child must be federally eligible through “linkage” with the former AFDC-FG/U program. The Department acknowledges there is a large subset of these children who cannot be linked to this former program, and therefore must rely upon CalWORKs funding, which is significantly less than what Foster Care funding provides for the care of these children.

As a result, the Approved Relative Caregiver Funding Option Program (ARC) was created to assist relative caregivers caring for federally ineligible children in receiving benefits similar to basic-funded federal and non-federal Foster Care.

Initially, ARC was created through legislative action in the Assembly (A.B. 1882), but the Senate introduced the operative version of the program in a trailer bill that passed in June 2014 (S.B. 855). A small legislative fix was made in September to address some funding concerns and to specify that care and custody of children in delinquency rests with county probation (S.B. 873).

Essentially, the state has fashioned a funding stream that provides a hybrid of CalWORKs (where available) and additional committed state general funds in order for children under the program to receive current basic Foster Care rates as adjusted annually by the California Necessities Index (CNI). Initially, the state has committed to \$30 million (with a potential one-time adjustment provision) for the amount exceeding the CalWORKs MAP portion, if any. Any additional funds needed to complete the ARC payment will be paid by counties.

County Obligations and Involvement:

Each county must opt into the ARC program annually, beginning October 1, 2014. Most counties sent non-binding letters of interest by that date, waiting for details on funding streams and obligations to be finalized by the state, relying upon the statute’s good cause provision for a delayed date to officially opt in.

ARC funding was anticipated to begin January 1, 2015. However, the state determined that the counties had good cause to delay their initial option determinations into the program. The initial deadline was extended to December 1, 2014 through March 1, 2015, with the initial funding dates to be initiated on the first of the month following the date the county opts in.

Once a county has opted in, it must pay all eligible ARC caregivers the basic rates in Foster Care for each child. This is the same basic rate paid in both federal and non-federal Foster Care programs as amended under A.B. 106, which is adjusted under the California Necessities Index (CNI) each fiscal year.

The county continues to pay eligible ARC relatives even if the county subsequently notifies the state it is opting out of the program. Once the opt-out is completed, ARC benefits are discontinued.

Payments will be paid through EBT using a new aid code. The state has not yet addressed what rules will be used to establish, quantify, or collect alleged overpayments under the ARC program.

Eligibility Criteria:

<p>1. The Child:</p>	<p>Dependent or delinquent ward minors; or Nonminor dependents or ward delinquents (up to 21)</p> <p>The child <u>cannot</u> be eligible for federal Foster Care.</p> <p>Undocumented children may be eligible based upon meeting MPP §42-431.23 for victims of trafficking, domestic violence, or other serious crimes; PRUCOL children under MPP §42-431.22 may also be eligible. (See ACL No. 06-60.)</p>
<p>2. Placement Authority:</p>	<p>The county's child welfare or probation department must be responsible for (vested with) placement and care of child (see W&IC §11401(b), (c), (e)).</p> <p><u>Except</u> – the child may be under a voluntary placement agreement (see W&IC §11401.1(b)), which has been “appropriately” converted to a dependency action through Court action.</p> <p>At this juncture, it is not clear if ARC benefits continue to be available if a county files its WIC 300 petition AFTER the voluntary placement agreement expires (i.e. after 180 days that the VPA was executed).</p>

3. Caregiver:	The child must be placed with an “approved” relative caregiver. Only traditionally-defined relatives are eligible (see W&IC 319(f)(2)). “Fictive” relatives including nonrelated extended family members (NREFM) are NOT eligible for ARC.
4. Home Approval:	<p>The relative caregiver’s home and adults must be approved under ASFA (see W&IC §309(d), HS §1522).</p> <p>Eventually, the relative caregiver must be approved under the Resource Family Approval (RFA) program, once this program is fully implemented (between now and July 2017, see W&IC §16519.5, critically made operable by Stats.2012, c. 35 (S.B.1013), § 136, eff. June 27, 2012 [the child welfare realignment bill]; and Stats.2013, c. 21 (A.B.74), § 42, eff. June 27, 2013).</p> <p>Presently, there are five early implementing counties conducting RFA assessments (SLO, Kings, Santa Barbara, San Francisco, and Santa Clara), with more being added over time. The Department currently plans full RFA employment by July 2017.</p>
5. Residence:	The child must be placed with relative caregiver residing in California.
6. CalWORKs Concerns	<p>The child need not be eligible for CalWORKs (if due to income or property), but the county must conduct the requisite CalWORKs eligibility determination in order to maximize any potential available CalWORKs funds.</p> <p>The county must complete the “Statement of Facts Supporting Eligibility for the Approved Relative Caregiver (ARC) Funding Option Program” (state form ARC 1), which serves as the ARC program’s application.</p>

A state hearing right exists for SHD to hear any dispute related to an individual child’s or relative caregiver’s eligibility to receive ARC benefits from an ARC participating county, or the amount of ARC benefits paid to the relative caregiver for the care of the eligible dependent or delinquent child.

There is no state hearing right if a relative caregiver’s ARC benefits are discontinued due to either a county opting out of the program and the opt out is effective following notice to the state, or the state reduces or discontinues the ARC program.

E-NOTE # 125 – IMPLEMENTATION OF THE COMMUNITY FIRST CHOICE OPTION (CFCO) PROGRAM

December 17, 2014

References: ACL 14-60 (August 29, 2014); SOCIAL SECURITY ACT (SSA) Section 1915(k) (42 United States Code Section 1396n); WELFARE and INSTITUTIONS CODE (WIC) Section 14132.956; IHSS PROGRAM MANAGERS' LETTER (DECEMBER 2, 2011); COUNTY FISCAL LETTER (CFL) No. 12/13-28 (JANUARY 24, 2013)

ACL 14-60 (August 29, 2014):

<http://www.dss.cahwnet.gov/lettersnotices/EntRes/getinfo/acl/2014/14-60.pdf>

IHSS Program Managers' Letter (December 2, 2011)

[http://www.cdss.ca.gov/agedblinddisabled/res/pdf/CFCO-FINAL%20PM's%20Letter%20\(12-2-11\).pdf](http://www.cdss.ca.gov/agedblinddisabled/res/pdf/CFCO-FINAL%20PM's%20Letter%20(12-2-11).pdf)

This E-Note is intended to address issues that may arise when determining eligibility for the CFCO Program, as well as the effective date of eligibility for the benefits.

Below are the pertinent sections from ACL14-60:

Background

The federal Patient Protection and Affordable Care Act (ACA) of 2010 (Public Law 111-148) was enacted March 23, 2010 and established CFCO as a new State Plan Option, which allows States to provide Home and Community-Based Attendant Services and Supports.

In December 2011, the California Department of Social Services (CDSS) and the California Department of Health Care Services (DHCS) submitted a State Plan Amendment (SPA) for the CFCO Program to the Centers for Medicare & Medicaid Services (CMS). This SPA allowed California to receive an additional 6% in federal funding for services for CFCO-eligible Personal Care Services Program (PCSP) and IHSS Plus Option (IPO) program recipients, who were moved into CFCO, and for new CFCO-eligible applicants. This initial CFCO SPA was approved by CMS on August 31, 2012, retroactive to December 1, 2011.

CFCO Eligibility

All CFCO participants must be eligible for Full-Scope, Federal Financial Participation (FS FFP) Medi-Cal (as in the PCSP and the IPO programs), and meet CFCO NF LOC eligibility based on one of the following criteria:

1. Have a total assessed need (excluding heavy cleaning and yard hazard abatement) of 195 or more IHSS hours per month.
2. Have a total assessed need (excluding heavy cleaning and yard hazard abatement) under 195 IHSS hours per month and:

Have 3 or more of the following services with the designated Functional Index (FI) Ranks:

Eating, FI Rank of 3-6
Bowel and bladder/menstrual care, FI Rank of 3-6
Bathing/grooming, FI Rank of 4-5
Dressing, FI Rank of 4-5
Mobility inside, FI Rank of 4-5
Transfer, FI Rank of 4-5
Respiration, FI Rank of 5-6
Paramedical, (FI Rank not applicable)

OR

Have a combined FI Rank of 6 or higher in mental functioning (memory, orientation, and judgment). FI Ranks for mental functioning can be either 1, 2, or 5.

3. Have a combined "Individual Assessed Need" total of 20 hours or more per week in one or more of the following services:

Preparation of meals
Meal clean-up (if preparation of meals and feeding are assessed needs)
Respiration
Bowel and bladder care
Feeding
Routine bed baths
Dressing
Menstrual care
Ambulation
Transfer
Bathing, oral hygiene, grooming
Repositioning and rubbing skin
Care and assistance with prosthesis
Paramedical services

The above NF LOC criteria were developed by DHCS in consultation with CDSS.

The new CFCO eligibility requirements are more stringent than those in effect from December 1, 2011 through June 30, 2013; therefore, individuals with FS FFP Medi-Cal eligibility who were, but are no longer, eligible for CFCO, due to the NF LOC criteria, will be served in the PCSP or IPO programs, effective July 1, 2013.

Please note that, as in the IPO program, recipients in CFCO may also receive Restaurant Meal Allowance, Advance Pay, service(s) provided by a recipient's spouse, and service(s) provided by a minor recipient's parent.

Required Services in CFCO

Required services in CFCO are:

1. Assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks, which currently include:

Personal Care Services
Protective Supervision
Domestic and Related Services
Paramedical Services
Medical Accompaniment
Heavy Cleaning
Yard Hazard Abatement

2. Acquisition, maintenance, and enhancement of skills necessary for recipients to perform ADLs, IADLs, and health-related tasks:

This service is provided via the IHSS Teaching and Demonstration Service, as described in Manual of Policies and Procedures (MPP) Section 30-757.18. This regulation section contains all the information regarding the Teaching and Demonstration service currently available. (Previously, only IHSS-R recipients were eligible for the Teaching and Demonstration Service.)

6% in Federal Medical Assistance Percentage (FMAP)

As previously stated in this ACL, the federal ACA provides an additional 6% in FMAP for CFCO Home and Community-Based Attendant Services and Supports. The required CFCO services eligible for the enhanced FMAP are: (1) assistance with ADLs, IADLs, and health-related tasks and (2) acquisition, maintenance, and enhancement of skills necessary for recipients to perform ADLs, IADLs, and health-related tasks.

Effective September 1, 2014, as the movement of IPO recipients into CFCO is completed, those recipients who are considered Non-Severely Impaired (NSI) and receive protective supervision, will be eligible for 195 hours of protective supervision, plus hours for other services, up to a maximum of 283 hours per month.

Questions and Answers from Program

Question: As of what effective date may a recipient receive benefits under the CFCO program?

Answer:

- The CFCO program became effective December 1, 2011. The initial State Plan Amendment (SPA) submitted for CFCO was based on the *draft* Center for Medicare & Medicaid Services regulations. The SPA required only that a recipient/applicant be eligible for FS FFP Medi-Cal to be eligible for CFCO.
- The second CFCO SPA became effective July 1, 2013 and was based on the *final* CFCO regulations. This SPA required that recipients/applicants be eligible for FS FFP Medi-Cal and meet the NF LOC criteria (see above).
- **Recipient eligibility for an increase in the amount of assessed hours under CFCO is not tied to the effective date of the CFCO program. The effective date of the policy change (September 1, 2014) was established by Program.**

Question: In a hypothetical case, the county stipulated to do a reassessment of IHSS needs, including protective supervision, back to February 2013. The recipient was previously approved for 195 hours. As of September 23, 2014, the county had not completed the reassessment.

On August 21, 2014, the county issued the recipient a notice of action informing him that he was approved for 276 hours under the CFCO program effective September 1, 2014. The recipient wants to know why the 276 hours did not go retroactive to February 2013.

If the county has not completed the reassessment of IHSS needs back to February 2013, how is it that the recipient was approved for the 276 hours effective September 1, 2014?

Answer:

- To provide parity with PCSP, a policy decision was made to set the maximum hours for Non-Severely Impaired (NSI) recipients, who receive protective supervision, at 195 hours of protective supervision + hours for other services, up to a maximum of 283 hours. This was made effective September 1, 2014. **This effective date was established by Program; it is not related to the case reassessment date.**

Question: If the CFCO program has been around since 2011, why only approve this recipient effective September 1, 2014?

Answer:

- Recipient eligibility for an increase in the amount of assessed hours under CFCO is not tied to the effective date of the CFCO program. The effective date of the policy change (September 1, 2014) was established by Program.

Question: If the CFCO program has been around since 2011, can this recipient be potentially approved for benefits back to February 2013? If so, what process must be followed?

Answer:

- Retroactive benefits cannot be applied to increase a recipient's hours, as the Department's policy decision to allow an increase in recipient hours, as described above, was made effective September 1, 2014.

Potential Hearing Issues:

State hearings may be filed where the claimant is asking for an increase in hours as of 2011. As indicated above, increased hours can only be made effective as of September 1, 2014.

Training and Quality Development Bureau
CDSS State Hearings Division

E-Note #124 – Summary of ACLs/ACINs/ACWDLs/MEDILs/CFL

December 1, 2014

ACL 14-40 (September 1, 2014)

<http://www.dss.cahwnet.gov/lettersnotices/EntRes/getinfo/acl/2014/14-40.pdf>

SUBJECT: IN-HOME SUPPORTIVE SERVICES (IHSS) PROVIDER WAGE REIMBURSEMENT FOR UNPAID EXCESS MEDI-CAL SHARE OF COST DEDUCTIONS

This ACL is set forth in its entirety below:

Background

Currently, some recipients are required to pay a Medi-Cal SOC in order to receive Medi-Cal benefits, including IHSS. When a provider for those individuals submits a timesheet, the IHSS program Case Management, Information and Payrolling System (CMIPS II) interfaces with the Medi-Cal Eligibility Data System (MEDS) to determine if the IHSS recipient has an outstanding Medi-Cal SOC. If so, that amount is deducted from the provider's pay warrant(s) for that time period. CMIPS II then generates letters to the IHSS recipient and provider indicating the recipient is required to pay the amount deducted from the pay warrant for the Medi-Cal SOC to the provider.

If the Medi-Cal SOC listed in MEDS is incorrect when the timesheet is processed, this will cause an erroneous deduction from the provider's pay warrant. Currently, if the Medi-Cal SOC was incorrect and the amount deducted from the provider's pay warrant is greater than the correct SOC and if the recipient has paid the provider the greater amount, the recipient is eligible to file a claim for reimbursement using the Beneficiary Reimbursement Process (Conlan II). However, there is no process to directly reimburse the provider if the recipient has not paid the provider the higher, incorrect Medi-Cal SOC.

New Provider Reimbursement Process

To remedy this issue, the California Department of Social Services (CDSS) has developed a process to directly reimburse providers who have had an erroneous Medi-Cal SOC deduction withheld from their pay warrant if they were not paid by the recipient. The IHSS Provider Wage Reimbursement Claim Form (GEN 1384) was created to facilitate the reimbursement process.

This new process will be available for incorrect Medi-Cal SOC deductions occurring on or after July 1, 2014. When either a recipient or provider contacts the county regarding an incorrect SOC deduction from a provider pay warrant, the county shall:

1. Determine if the provider is due reimbursement for an incorrect Medi-Cal SOC deduction by reviewing both MEDS and CMIPS II to determine if the amount taken from the provider's pay warrant for the pay period in question is greater than the Medi-Cal SOC for the same period.

- a. If the county determines the **correct** SOC was deducted, the county will notify the requestor that the SOC amount deducted from the IHSS provider's pay warrant for the period in question

was correct. If the requestor disputes the county's determination, the recipient should be directed to contact their Medi-Cal eligibility worker.

b. If the amount taken from the pay warrant is **greater** than the Medi-Cal SOC for the pay period in which an incorrect SOC was deducted, the county will send page one (section A and B) of the GEN 1384 to the requestor. Upon receipt of the completed page one, the county will verify that it has been completed correctly and signed by both the recipient and provider. The county will then complete page two (section C) of the GEN 1384.

The county will notify the requestor that the claim has been forwarded to the California Department of Social Services (CDSS) for review. If the requestor has any questions regarding the status of their claim, they should be directed to contact CDSS at 1-877-508-1327.

Counties should send scanned copies of the completed GEN 1384 to CDSS within 10 business days of receipt to the following secure email address: ProviderReimbursement@dss.ca.gov

Please note the claim form GEN 1384 will not be available on-line. The GEN 1384 should be provided to the provider or recipient only after the county has determined that there has been an incorrect SOC deducted. Counties may obtain a copy of the GEN 1384 by emailing a request to the secure email address listed above. Counties may copy the form for their use.

CDSS has responsibility for making the final decision regarding the provider's eligibility for reimbursement and for initiating reimbursement of any monies owed to the provider. A copy of the final decision will be mailed to the recipient, provider, and the county. Each county shall provide bilingual/interpretive services and written translations to non-English or limited-English proficient populations as required by the Dymally Alatorre Bilingual Services Act (Government Code section 7290 et seq.) and by state regulation (MPP Division 21, Civil Rights Nondiscrimination, section 115).

ACWDL 14-33 (September 19, 2014) Reviewing Caseloads for Individuals Who are Linked to Medi-Cal Coverage Groups Based upon Modified Adjusted Gross Income (MAGI)

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-33.pdf>

The purpose of this letter is to instruct counties to conduct a focused search of caseloads to identify individuals who are potentially eligible under the MAGI methodologies through the California Healthcare, Eligibility, Enrollment and Retention System for the January 2014 month of eligibility and on-going. Once identified, counties must send the attached letter with the Request for Tax Household Information (RFTHI) form. If the beneficiary returns the RFTHI form, the counties must complete the MAGI eligibility determination and reset the annual redetermination date. If the beneficiary does not return the RFTHI form, the beneficiary must remain eligible in their current aid code until their next annual redetermination or until the beneficiary has a change in circumstances.

ACWDL 14-34 (September 25, 2014) Safe at Home Confidential Post Office (P.O.) Box Process

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-34.pdf>

The purpose of this letter is to inform Counties of the Safe at Home (SAH) confidential P.O. Box process.

Background

On July 1, 1999, the Secretary of State implemented the confidential SAH Program to help victims or survivors of domestic violence or stalking to remain safe from an abusive situation. Government Code, Chapter 3.1 §6207, 6215.5 states “A state and local governmental agency shall accept the Safe at Home P.O. Box address, designated by the Secretary of State, of any active program participant who presents his or her authorization (ID card or certificate) at the time of creating, modifying or maintaining a public record which requires a street or mailing address.”

ACWDL 14-35 (September 29, 2014) 2015 Redeterminations for Non-Modified Adjusted Gross Income (MAGI) Cases and Non-MAGI/MAGI Mixed (Medi-Cal Mixed) Cases

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf>

The purpose of this letter is to provide counties with the interim policies and procedures for implementing annual redeterminations in 2015 for Non-MAGI and Non-MAGI/MAGI Mixed (Medi-Cal Mixed) cases.

MEDIL - I 14-48 (October 1, 2014) Hospital Presumptive Eligibility (HPE) Program Medi-Cal Eligibility Data Systems (MEDS) Pending Application Transaction – Extension of Presumptive Eligibility (PE) Period

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-48.pdf>

The purpose of this letter is to remind the counties that when individuals enrolled in HPE submit an insurance affordability programs application, a pending application transaction must be submitted to the Medi-Cal Eligibility Data System (MEDS) to extend the PE benefits for these individuals.

ACWDL 14-38 (October 23, 2014) Annual Redetermination Process For Medi-Cal and Covered California Mixed Household

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf>

The Department of Health Care Services (DHCS) is providing guidance as a result of Assembly Bill (AB) x1 1, Chapter 3, Statutes of 2013, as well as guidance provided by the federal Centers for Medicare and Medicaid Services (CMS) on the Affordable Care Act of 2010 (ACA). This letter is to provide the Statewide Automated Welfare Systems (SAWS) and counties with policy guidance. This guidance is focused on implementing annual redeterminations for Modified Adjusted Gross Income (MAGI) Medi-Cal and Covered California (Covered CA) mixed coverage households. A mixed coverage household is defined as a household with at least one member receiving MAGI Medi-Cal benefits and at least one member receiving Covered CA benefits. All

County Welfare Directors Letter (ACWDL) 14-32 outlines the process for implementing annual redeterminations for 2015 and beyond for Medi-Cal beneficiaries who are eligible under MAGI categories.

This ACWDL provides instructions supplemental to ACWDL 14-32 and 14-18.

ACWDL 14-39 (October 24, 2014) Every Woman Counts (EWC) Program Offers Free Breast and Cervical Cancer Screening Services to Uninsured Women

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-39.pdf>

The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) is to inform counties of policy instruction and guidance for the Every Woman Counts (EWC) Program, which offers free breast and cervical cancer screening services for uninsured women.

MEDIL I 14-52 (October 24, 2014) Translation of the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individuals Application (MC14A)

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-52.pdf>

The purpose of this letter is to inform counties of the availability of the July 2014 revision to the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individuals Application, MC 14A.

The revised MC 14A has been translated into all 12 threshold languages. The MC 14A is available on the Department of Health Care Services website at:

<http://www.dhcs.ca.gov/formsandpubs/forms/Pages/Index-MC13-MC0805.aspx>

ACL 14-78 (October 23, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-78.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKSs) Program: Exemption Of Child-Only Safety Net And Drug/Fleeing Felon Cases From Child Support Requirements

The purpose of this ACL is to provide county welfare departments (CWDs) with new child support (CS) instructions for cases that were moved into the new K1 and 3F aid codes, pursuant to ACL 13-70, dated September 6, 2013. This ACL provides instruction to CWDs regarding how to treat K1/3F cases with respect to the following CS activities:

- Referral to Local Child Support Agencies (LCSAs);
- Assignment of child and spousal support rights;
- Cooperation with LCSAs;
- Completion of CS related forms;
- Non-cooperation sanction and penalties;
- Department of Child Support Services (DCSS) child support collection and

“unticking” the CalWORKs/Temporary Assistance for Needy Families (TANF) clock;

- Treatment of the CS income in the K1/3F grant calculations;
- Application of the CS disregard; and
- Application of potentially available income rules.

Some pertinent sections of this ACL are the following:

ASSIGNMENT OF SUPPORT RIGHTS AND COOPERATION WITH LCSAs

CWDs are instructed to immediately stop requiring cases in aid codes K1/3F from assigning their child and spousal support rights as a condition of eligibility. For current recipients transitioning into the K1/3F aid codes, no action is required, as these individuals have already assigned their rights upon initial application. However, the LCSA and CWD may no longer retain any CS collected on the behalf of the family, but instead must pass through any CS collected directly to the family.

SANCTIONS AND PENALTIES

With CDSS no longer requiring referrals to LCSAs, assignment of support rights, and cooperation with LCSAs for the K1/3F cases, CWDs must remove all CS related sanctions and penalties for these cases retroactively, **effective back to June 1, 2014, the month in which SB 855 was enacted**. Because these cases are child-only cases, lifting the sanction for refusal to assign support rights will not increase the grant for the adult’s portion.

CalWORKs Families with Existing Child Support Cases

CalWORKs cases in the K1/3F aid codes that already have an existing, open case with the LCSA will continue to receive CS collection services. The only change for these families will be that any CS collected will be passed through directly to the CalWORKs family and not be retained by the CWD to reimburse aid paid. Previously the family received only the first \$50 each month and the remaining CS collected, if any, was sent to the CWD to reimburse the aid paid to the family. Now, all CS collected will go to the family. Prior to shifting SN/DFF cases into K1/3F aid codes, CS retained by the CWD would be used to reimburse aid paid to the family, and for each full month of aid that was reimbursed, that month was “unticked” from the adult’s CalWORKs 48-month time clock. Under the new policy, since CS collected will no longer be used to reimburse aid paid to the family, the CWD will no longer “untick” an adult’s time-on-aid unless arrearages are collected and retained by the CWD that are used to reimburse full months of aid paid to that AU.

TREATMENT OF CHILD SUPPORT INCOME IN THE K1/3F GRANT CALCULATION

CalWORKs AUs will be required to report the CS payments they receive in accordance with their CalWORKs and CalFresh income reporting rules. CalFresh Semi-Annual Reporting (SAR) households will be required to report CS received on their SAR 7 report, and CalWORKs Annual Reporting/Child-Only (AR/CO) AUs will be required to report CS received at application and during the annual redetermination. In addition, all AUs will be required to report receipt of direct CS income any time the family’s total monthly income exceeds the Income Reporting Threshold (IRT) if the AU also has earned income.

When a CalWORKs family reports receiving their CS payment directly, the CWD shall

determine the amount of the CS income and whether the income is expected to continue at that level. The CWD, along with the AU, must also determine whether the frequency and amount of income can be “reasonably anticipated” under AR/CO reporting rules (see ACL 12-49, page eight for more information regarding reasonably anticipating income in AR/CO cases). If the CS income can be reasonably anticipated and will continue at a level that will render the family financially ineligible (pursuant to MPP section 44-315.311), the CWD must discontinue the AU at the end of the month in which timely and adequate notice can be provided.

If the amount of CS income, along with other income for the AU, will not render the family ineligible, the CWD must determine if the CS can be reasonably anticipated to continue and determine whether the CS income must be used to calculate the grant for the next payment period. To be considered “reasonably anticipated,” the following conditions must apply or the CS income cannot be used in the grant calculation for the upcoming payment period:

- The CWD and recipient must be reasonably certain when the income is expected (date of payment); and
- The amount of income that is expected.

APPLYING FOR POTENTIALLY AVAILABLE INCOME

Pursuant to MPP section 82-610, all CalWORKs applicants and recipients are required to apply for income that is potentially available to them. CWDs are also required to inform applicants/recipients of income that may be available to them, so that the AU may take advantage of additional income to which they may be eligible.

CS income is income that the applicant/recipient may or may not be entitled to receive, depending on whether paternity of the child(ren) has been established or whether there is a court order for support. However, it is not considered “unconditionally available” to the family, and therefore, if the applicant/recipient chooses not to seek CS from the noncustodial parent, the CWD may not discontinue the adult for failure to apply for unconditionally available income.

CFL 14/15-28 (October 28, 2014) <

http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/cfl/2014-15/14-15_28.pdf>

Updates To Claiming Instructions For The CalFresh Low Income Home Energy Assistance Program And State Utility Assistance Subsidy Benefit

This CFL provides counties with updated instructions regarding changes to the Low Income Home Energy Assistance Program (LIHEAP) and State Utility Assistance Subsidy (SUAS) claiming process. Due to the Agricultural Act of 2014 (P.L. 113-79), as outlined in ACL 14-54, the LIHEAP energy assistance benefit amount of ten cents (\$0.10) is ending and will be replaced by the SUAS benefit (\$20.01). This change ensures that certain CalFresh households continue to qualify for the Standard Utility Allowance (SUA) in the computation of their CalFresh benefits. The new SUAS program will be solely state funded and the California Department of Social Services (CDSS) will no longer be using the LIHEAP Block Grant to fund the former LIHEAP benefit. For additional information about the SUAS program, please see ACL 14-66.

ACIN I-65-14 (November 5, 2014)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2014/l-65_14.pdf

Release Of IHSS Instructional Video: 2015 New Program Requirements / IHSS Provider Timesheet Training

The purpose of this All-County Information Notice (ACIN) is to provide counties with information regarding the release of a new In-Home Supportive Services (IHSS) Instructional Video. This video explains new IHSS program changes regarding overtime and travel time pay, information on violations, and instructions on completing the new timesheets that will be implemented January 1, 2015, pursuant to Senate Bill (SB) 855 and SB 873.

ACL 14-67 (November 4, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-67.pdf>

IHSS Eligibility For Medi-Cal Modified Adjusted Gross Income (MAGI)-Eligible Individuals

This ACL is set out in its entirety below:

This ACL provides counties with information regarding IHSS eligibility for individuals whose Medi-Cal eligibility is based on the MAGI category under the ACA.

Background

Effective January 1, 2014, individuals 19 through 64 years of age no longer need to be disabled or blind in order to receive Medi-Cal. Eligibility for full or restricted-scope Medi-Cal can be established based on the MAGI category under the ACA. Many individuals in full-scope MAGI aid codes are eligible for full-scope Medi-Cal with Federal Financial Participation (FFP).

MAGI Aid Codes

There are a number of MAGI aid codes, and the Department of Health Care Services is responsible for the Medi-Cal Aid Codes Master chart. This link goes directly to a document that includes all Medi-Cal Aid Codes. Many MAGI-eligible individuals are considered categorically needy, and those eligible for full-scope Medi-Cal with FFP will be evaluated for IHSS under MPP § 30-780.2(b), as stated below.

County Responsibilities for Determining IHSS Eligibility for MAGI Individuals

For individuals with full-scope Medi-Cal with FFP, a disability determination by the Social Security Administration or by the California Department of Social Services is not required for the receipt of IHSS based on one of the three Medi-Cal programs (Personal Care Services Program, IHSS Plus Option, and Community First Choice Option programs); however, counties must determine disability for Medi-Cal IHSS, for categorically-needy Medi-Cal recipients (full-scope FFP Medi-Cal recipients), pursuant to MPP § 30-780.2(b):

Personal care services may be provided only to a categorically needy beneficiary as defined in Welfare and Institutions Code § 14050.1, who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected

to result in death within 12 months and who is unable to remain safely at home without the services.

Eligibility Process

The eligibility process for **all** Medi-Cal IHSS programs consists of three parts:

1. Does the individual have full-scope Medi-Cal with FFP?

- Many individuals who meet Medi-Cal through MAGI have full-scope Medi-Cal with FFP.
- Full-scope Medi-Cal with FFP can be verified for individuals on the CMIPS II Medi-Cal Eligibility screen.

2. Is the individual aged, blind, or disabled?

- For those individuals with a MAGI aid code (which indicate they have not been determined aged, blind, or disabled based on Medi-Cal definitions), the individual must meet the disability criteria found in MPP §30-780.2(b).

3. Does the individual have an assessed IHSS need?

- MAGI individuals must go through the assessment process in the same manner as all IHSS applicants.

MAGI Medi-Cal has no impact on the IHSS-Residual program, and therefore, anyone who does not have full-scope Medi-Cal with FFP can be evaluated for the IHSS-R program, if appropriate.

ACL 14-85 (November 13, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-85.pdf>

Revised Forms For Stage One Child Care In The California Work Opportunity And Responsibility To Kids (CalWORKs) Program

The purpose of this letter is to transmit the revised Stage One Child Care forms and Notices of Action (NOAs): Declaration of Exemption from TrustLine Registration and Health and Safety Self-Certification (CCP1), Health and Safety Self-Certification (For license-exempt providers) (CCP4), CalWORKs Child Care Request Form and Reimbursement Rules (CCP7), NOA Child Care Services (NA832), and NOA Child Care Change (NA833). At the request of the County Welfare Directors Association (CWDA), the California Department of Social Services (CDSS) revised the forms and NOAs used for Stage One Child Care at the county level. The CDSS revised the forms and NOAs based on feedback from the CWDA and advocates. The joint effort was undertaken to update and standardize the forms for ease of use and understanding for both the County Welfare Departments (CWDs) and the CalWORKs families.

ACL 14-80 (November 14, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-80.pdf>

Changes To California Work Opportunity And Responsibility To Kids (CalWORKs) Hourly Work Participation Requirement Determinations

The purpose of this ACL is to inform County Welfare Departments (CWDs) of a change to how the CalWORKs Welfare-to-Work (WTW) program hourly participation requirements are determined, pursuant to SB 855, which was enacted by the Legislature, and signed by the Governor on June 20, 2014. Effective July 1, 2014, CalWORKs hourly participation requirements are determined by an average per week during the month, rather than by a weekly minimum.

Recommended that this ACL be read in its entirety

ACL 14-83 (November 17, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-83.pdf>

Work Incentive Nutritional Supplement (WINS) Monthly Caseload Report WINS 2 (10/14)

This letter informs the counties that effective with the October 2014 report month, counties are required to submit data on the WINS program by submitting the Work Incentive Nutritional Supplement Caseload Report (WINS 2) monthly report form.

The WINS program provides a ten dollar (\$10) per month additional food supplement benefit for each WINS-eligible CalFresh and California Food Assistance Program (CFAP) household. The monthly WINS report provides data on the number of CalFresh Non-Public Assistance households and persons participating in the federal and state CalFresh programs who are eligible for WINS benefits.

WINS Eligibility

WINS benefit will be given to all CalFresh recipients meeting the WINS eligibility requirement. The requirements are listed as follows:

- Must be a household receiving CalFresh, but not receiving CalWORKs or Tribal TANF;
- Must have a child in the home under age 18, or under the age of 19 if the child meets the requirements of Welfare and Institutions Code (W&IC) Section 11253;
- Must have at least one parent/caretaker who is receiving CalFresh and meeting the federal TANF definition of a "work-eligible individual (WEI)" in accordance with 45 Code of Federal Regulations (CFR) Part 261.2(n) and Title 42 United States Code (USC) Section 607;
- Must have the WEI participating in a sufficient number of hours in work activities that meet federal TANF work participation hours requirements under Title 42 (USC) Section 607 for subsidized or unsubsidized employment, which are as follows:
 - o 20 hours per week for single custodial parents/caretakers with a child under the age of six;
 - o 30 hours per week for non-two parent/caretakers with children age six or older;
 - o 35 hours per week for two-parent/caretaker families; and

☐ Must provide acceptable documentation when requested that the household met the federal work requirements for subsidized or unsubsidized employment, in accordance with the federally approved work verification plan (ACL NO. 14-27).

ACL 14-81 (November 20, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-81.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Program: Clarifying Guidance For The Implementation Of The Expanded Subsidized Employment (ESE) Program Resulting From The Passage Of [Assembly Bill \(AB\) 74](#) (Chapter 21, Statutes Of 2013)

The purpose of this letter is to provide answers to questions that the California Department of Social Services (CDSS) has received from county welfare departments (CWDs) about the ESE Program. The ESE Program went into effect on July 1, 2013 in accordance with AB 74 and provides funding for subsidized employment outside of the Single Allocation. ACL 13-81, released on September 30, 2013, has guidance for CWDs to implement the ESE Program.

ACL 14-88 (November 20, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-88.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Program: Revised Notice And Notice Of Action (NOA) Messages That Deny, Discontinue, Or Decrease Benefits For Lack Of Verification

The purpose of this ACL is to transmit 17 revised NOA and NOA message documents to the County Welfare Departments (CWDs). In order to ensure adequate notification, all notices sent to CalWORKs clients that deny, discontinue, or decrease benefits due to clients not providing the required verification must also specify that the client did not ask the County for help getting the required proof or evidence of eligibility. These revised notice and NOA messages must be put into use as soon as administratively possible, but no later than July 1, 2015.

The MPP Section 40-126.333 mandates that clients be notified in writing of the requirement that the CWDs must assist clients in obtaining evidence if the clients have made a good faith effort and cannot get the required proof. The CWDs must also provide assistance with verification when such assistance is a reasonable accommodation for a person with a disability. The regulations further state that benefits can only be denied, discontinued, or decreased when the client refuses to comply.

The CalWORKs Request for Verification Form (CW 2200) notifies clients that they should contact the County if they are having problems getting the required verification and that the County can help them try to get it. The form further states that benefits may be denied, discontinued, or decreased if the client does not submit the verification or contact the County by the due date listed. The attached NOA messages have been revised to conform to the above State regulations, in order to ensure clients are properly notified of their rights and responsibilities in regards to providing verification.

Effective immediately, if the County becomes aware of any cases where benefits were denied, decreased, or discontinued due to missing verifications despite the client asking the County for help, these negative actions must be rescinded.

The Notice and NOA messages that have been revised include:

Number Title

NA 960Y SAR Stop Aid, Report Not Complete
M40-105 Failed to Provide SSN When Received or Failure to Cooperate
M40-105A Failed to Provide SSN or Proof of Completed SSN Application
M40-105C Immunizations
M40-105E School Attendance
M40-129D1 Procedural Requirement
M40-129D5 Failed to Provide Proof of SSN Application
M40-171A Failure to Cooperate
M40-181A SAWS 2 Plus Redetermination/Other Essential Information
M40-181E SAWS 2 Plus Redetermination Immunization/School Attendance
M42-101B Age and School Requirements (Change)
M42-101C Age and School Requirements (Discontinue)
M42-213A Restricted Account (previously NOA message M89-130)
M42-431A4 No Eligible Noncitizen Status/Proof of Eligible Noncitizen Status
M42-769A Apply \$100 Penalty
M43-119G Missing SAR 72 (Change)
M43-119H Missing SAR 72 (Discontinue)

If CWDs use any additional forms, notices, or NOA messages that decrease, discontinue, or deny benefits due to lack of verification, these documents must all include language that the negative action is taking place because the client did not submit the required verification and they did not ask the County for help.

ACWDL 13-13 (May 14, 2013) MEDI-CAL GENERAL NOTICE OF ACTION (NOA) POLICY

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf>

PURPOSE

The purpose of this All County Welfare Directors Letter (ACWDL) is to provide counties with policy reminders regarding required Medi-Cal Notices of Action (NOA) relating to the counties' eligibility determinations, including share-of-cost (SOC) calculations and scope of benefits. This letter does not address NOA requirements pertaining to approval or denial of specific Medi-Cal services or benefits.

The intent of this letter is to provide general NOA regulation and policy reminders. The regulations and policy in this letter may possibly be affected or altered in the future due to changes resulting from the Affordable Care Act.

NOA DEFINITION

A Medi-Cal program NOA is used to give applicants and beneficiaries written notice of their Medi-Cal-only status. It provides notification of eligibility or ineligibility and of any changes made in eligibility status, level of benefits or SOC.
(22 CCR 50179 (a))

One of the types of notices that is described in the ACWDL is the following. Please note the footnote:

The NOA shall include a statement, when appropriate, regarding the information or action necessary to reestablish eligibility or determine a correct SOC. 2
(22 CCR 50179 (c) (7))

2 Please Note: DHCS interprets "when appropriate" to mean that such a statement is always required unless there is no possibility that eligibility could be reestablished or a SOC determined correctly. The NOA must be specific so that the applicant/beneficiary knows exactly what must be provided to the county to determine Medi-Cal eligibility. Applicants/Beneficiaries may have numerous bank accounts, life insurance policies, etc., and a generic statement to provide a 'bank statement or life insurance policy' is not adequate without additional identifying information. A denial NOA issued an applicant/beneficiary who has not provided information requested and needed for the eligibility determination must specifically list the items that had been previously requested but not provided to be an adequate notice of action (example: XYZ Bank Statement for the month of ____).

MEDIL - I 14-56 (November 21, 2014) Initial County Guidance on Short-Term Negative Action Approach

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-56.pdf>

a short-term negative action approach for Modified Adjusted Gross Income (MAGI) Medi-Cal cases, where all individuals on the case need to be denied or discontinued. Due to the current absence of the negative action functionality in CalHEERS, the Department of Health Care Services (DHCS) recognizes the critical need to have an interim solution to effectuate denials and discontinuances for pending and active MAGI Medi-Cal cases. This interim approach is part of the DHCS's ongoing effort and priority to reduce the pending Medi-Cal eligibility determination caseload. DHCS is currently working with the County Welfare Directors Association (CWDA), Statewide Automated Welfare Systems (SAWS), California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), and the DHCS Medi-Cal Eligibility Data Systems (MEDS) team on developing both a short-term and a long-term solution for negative actions. A long-term solution is currently in development and will involve changes to CalHEERS to resolve the issues previously identified.

The short-term solution requires counties to identify the appropriate cases that need to be denied or discontinued and the reason for this action. This solution will only address situations where the entire case requires a negative action. Independent backend data fixes will be applied through SAWS, CalHEERS, and MEDS in order to appropriately action the cases. The goal is to appropriately close-out (deny or discontinue) the applications and cases across all three systems and provide the appropriate Notice of Action (NOA) from SAWS using existing NOA language available within each county consortia system. The technical teams are still working to identify the frequency of execution until a long term negative action solution is developed and implemented. Counties will be notified by DHCS and SAWS once those details are finalized.

ACL 14-82 (November 25, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-82.pdf>

Wait Times Associated With Accompaniment To Medical Appointments And Alternative Resource Sites

This ACL is set forth below in its entirety:

The purpose of this ACL is to provide guidance to counties with assessing and authorizing wait times at medical appointments associated with medical accompaniment and alternative resource sites. Compensation for wait times at medical appointments/alternative resources sites, under certain circumstances, is now allowable in the IHSS program.

IHSS Social Workers will obtain the required information on IHSS recipients' medical appointments, including the type of appointment, the frequency and duration, in order to authorize medical accompaniment and wait times. To aid the counties in collecting the needed wait time information from the Licensed Health Care Professional (LHCP) and gather the information necessary to appropriately authorize wait time, the California Department of Social Services (CDSS) has developed an optional form, the "In-Home Supportive Services (IHSS) Program Accompaniment to Medical Appointment" form (SOC 2274) which may be used as a tool for the Social Worker or can be sent out directly to the LHCP for completion. The LHCP may include, but are not limited to, physicians, physician assistants, and specialists including oncologists, occupational therapists, physical therapists, psychiatrists, dentists, phlebotomists and other medical professionals responsible to provide treatment/care.

BACKGROUND

Welfare and Institutions Code section 12300(b) specifies that, "Supportive services shall include...accompaniment by a provider when needed during necessary travel to health-related appointments or to alternative resource sites". The MPP section 30-757.15 further defines this service and states:

"Assistance by the provider is available for transportation when the recipient's presence is required at the destination and such assistance is necessary to accomplish the travel, limited to:

- .151 Transportation to and from appointments with physicians, dentists and other health practitioners.
- .152 Transportation necessary for fitting health related appliances/devices and

special clothing.

□ .153 Transportation under .151 and .152 above shall be authorized only after social service staff have determined that Medi-Cal will not provide transportation in the specific case.

□ .154 Transportation to the site where alternative resources provide in-home supportive services to the recipient in lieu of IHSS.”

On October 1, 2013, the United States Department of Labor (DOL) published the Final Rule on the Application of the Fair Labor Standards Act (FLSA) to Domestic Service which is scheduled to take effect on January 1, 2015. Under the revised FLSA rules, employers are required to pay employees for certain periods of time when they are not actively engaged in the performance of work.

The federal rules relating to pay for wait times are now applicable to IHSS providers, which means that providers will now be compensated for “wait time” that is associated with accompaniment to medical appointments and alternative resource sites, under certain circumstances.

Under current IHSS regulations wait time is included in the authorization of hours in three specific service categories: (1) out-of-home laundry services (when laundry facilities are not available on the premises), MPP 30-757.134(b); (2) food shopping, MPP 30-757.135(b); and (3) other shopping/errands, MPP 30-757.135(c).

Accompaniment to medical appointments and alternative resource sites is the only IHSS service category in which wait time is not included in the authorization of hours

COMPENSABLE WAIT TIMES

The FLSA requires employers to pay an employee for compensable wait time. The DOL provides two definitions of wait time: time spent engaged to wait and time spent waiting to be engaged.

□ “Engaged to wait” means that the employee is not performing work duties but he/she is unable to use the time effectively for his/her own purposes. These periods of time are generally unpredictable and usually of short duration. The wait time is an integral part of the job; it belongs to and is controlled by the employer.

□ “Waiting to be engaged” means that the employee is completely relieved from performing work duties and he/she has enough time to enable him/her to use the time effectively for his/her own purposes such as taking a meal break, running a personal errand or reading a book. The employee must be informed in advance that he/she may leave the job and that he/she will not have to resume work until a specified time.

The following are examples of the two types of wait time that counties may encounter:
Example 1: “Waiting to be engaged” would occur when a provider accompanies his/her recipient to a dialysis treatment that is scheduled to last two or more hours. The provider is not required to remain on the premises but must return at a designated time to retrieve the recipient. The provider can effectively use the time on his/her own to engage in personal activities, either on the premises or not, such as reading a book, etc.
Example 2: “Engaged to wait” would be when a provider accompanies his/her recipient to a routine medical appointment of known duration of 30 minutes or less and the

provider is required to remain at the doctor's office because at any moment he/she may be called upon to assist the recipient with the travel back home.

When a recipient is authorized for medical accompaniment, if all of the following conditions are met, his/her provider will be considered to be waiting to be engaged, which is not compensable:

- The duration of the recipient's appointment is known in advance:
- The appointment is scheduled to last longer than 30 minutes; and
- The provider is not required or able to perform any other authorized service, e.g. food shopping, other shopping/errands, during the duration of the appointment

AUTHORIZATION

Consistent with regulations, medical accompaniment should not be authorized simply to fill the recipient's need for transportation. Medical accompaniment should only be authorized when the recipient needs assistance with specific IHSS tasks during transportation and/or to and from the destination, as specified in statute and regulations. When medical accompaniment services are authorized to a site where alternative resources are provided, the Social Worker must ensure the site provides services that would be authorized in the IHSS program. However, wait time associated with accompaniment to alternative resource sites would not typically be compensable since IHSS recipients are usually dropped off and picked up at a later time thus allowing the IHSS provider to effectively use the time for his/her own purposes, which would be deemed as waiting to be engaged.

To further clarify the policy on medical accompaniment, in the case where the recipient is able to drive himself/herself to appointments but needs assistance at the destination, medical accompaniment may be authorized. Since medical accompaniment is not simply to fill the recipient's transportation needs, this service is authorized only when the provider's presence is required at the destination and assistance with other authorized IHSS services is necessary to accomplish the purpose of the travel.

An example of authorizing medical accompaniment would be if a recipient, who is in a wheelchair and is unable to maneuver the wheelchair without the assistance of the provider, has a medical appointment; without the provider's presence, the recipient would not be able to get in and out of the vehicle, get through the door at the doctor's office and would not be able to transfer or ambulate from the wheelchair onto the exam table. In this example the provider's presence is required at the destination. Medical accompaniment should be authorized for the travel time it takes to and from the medical appointment and for the wait time based on the type of appointment in which the provider would be deemed "engaged to wait". The time for assistance with transfer and ambulation will be authorized appropriately under the IHSS service categories of transfer and ambulation.

In order to comply with MPP 30-759.153, the county is required to verify if transportation for the IHSS recipient is provided by the Medi-Cal program. The IHSS recipient must have an approved Treatment Authorization Request (TAR) on file with the Department of Health Care Services (DHCS) for nonemergency medical transportation, which is only covered subject to the written prescription of a physician, dentist or podiatrist. Medi-Cal funded transportation includes a nonemergency ambulance, wheelchair van or

litter van. If any of these TAR approved nonemergency modes of transportation has been approved by DHCS for the IHSS recipient to get to/from needed medical appointments, the IHSS program will consider that the IHSS recipient's transportation needs have been met in accordance with MPP 30-759.153.

COUNTY RESPONSIBILITY AND USE OF THE SOC 2274 FORM

Counties will follow their standard operational procedures in reassessing cases for the authorization of wait time. As a reminder, counties are to ensure that they comply with MPP 30-759.153, and verify if transportation is provided for the IHSS recipient by the Medi-Cal program for the specific appointment prior to authorizing medical accompaniment.

To authorize the wait time the Social Worker will assess the recipient by phone or in person by asking how frequently they have medical or other health-related appointments, the purpose of the appointment and if accompaniment by a provider is needed during travel to the appointment(s).

In order to assist the Social Worker in collecting needed information for the authorization of medical accompaniment and wait times, counties may make telephone contact with the IHSS recipient directly or utilize the SOC 2274 to obtain the required information from the LHCP by phone, fax or mail. The SOC 2274 includes instructions for the LHCP on what information the Social Worker needs in order to authorize wait time. The LHCP is requested to provide appointment information which includes the purpose, typical length/duration and frequency per year of medical appointments. Completion of the SOC 2274 by the LHCP may assist the Social Worker in determining if the wait time is compensable.

As stated in ACL 14-76, counties shall complete their review of impacted IHSS cases as soon as administratively feasible, but no later than the next regularly scheduled reassessment. To assist counties in this effort, CDSS will provide each county with a report that includes the cases with authorized hours for accompaniment to medical appointments and alternative resource sites. As cases are reassessed and wait time is authorized under medical accompaniment, counties will be responsible for ensuring that time is authorized in compliance with the statutory maximum of 283 hours per month and that the weekly authorized limits are not exceeded.

MEDIL - I 14-57 (November 26, 2014) Authorized Representative Appointment Period

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-57.pdf>
(CORRECTED)

The purpose of this letter is to remind counties about a recent change to the one year limit for the appointment of an authorized representative. Senate Bill x1 1, Statute of 2013, Chapter 4, Section 14014.5 was enacted to implement changes to rules for persons authorized to represent individuals applying for or renewing health coverage in accordance with the Affordable Care Act and Section 435.908 of Title 42 of the Code of Federal Regulations.

As a result of this change, the appointment of the Medi-Cal applicant's or beneficiary's Authorized Representative is in effect until the applicant or beneficiary cancels or modifies the authorization, appoints a new authorized representative, the authorized representative informs the agency that he or she is no longer acting in that capacity, or there is a change in the legal authority on which the authority was based.

Therefore, counties must continue to accept an appointment of an Authorized Representative under these new rules if the authorization was set to expire on January 1, 2014, or later. Since the new rules state that an appointment of an Authorized Representative no longer expires, counties must continue to recognize these appointments.

If the current written appointment of the Authorized Representative on file expired prior to January 1, 2014, counties must require an updated appointment of an authorized representative. The county staff must inform the beneficiary that the new authorization is in effect until cancelled or modified.

MEDIL - I 14-58 (November 26, 2014) Elimination of Deprivation Language from Notices of Action (NOAs)

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-58.pdf>

The purpose of this letter is to advise counties to remove language related to the deprivation requirement from Notices of Action (NOAs) generated by the Statewide Automated Welfare Systems and mailed by counties.

Background

All County Welfare Directors Letter 14-28, Elimination of the Deprivation Requirement for Medi-Cal Linkage for the Modified Adjusted Gross Income Parent/Caretaker Group and the Aid to Families with Dependent Children-Medically Needy Program, informed counties that effective January 1, 2014, linkage as, or through, a child no longer requires that the child be deprived. This affects applicants and beneficiaries in the Modified Adjusted Gross Income (MAGI) Parent/Caretaker group as well as those in the Aid to Families with Dependent Children-Medically Needy program.

<http://www.dhcs.ca.gov/services/medi-cal/Pages/BehavioralHealthTreatment.aspx>

Behavioral Health Treatment:

The Department of Health Care Services (DHCS) intends to provide Behavioral Health Treatment (BHT) services as a covered Medi-Cal benefit for individuals 0 to 21 years of age with Autism Spectrum Disorder to the extent required by the federal government. DHCS will seek federal approval to provide BHT as it is defined by Section 1374.73 of the Health & Safety Code. DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal, seek statutory authority to implement this

benefit in Medi-Cal, seek an appropriation that would provide the necessary state funding, and consult with stakeholders.

Pursuant to Section 14132.56 of the Welfare & Institutions Code, DHCS is required to make any State Plan Amendment (SPA) public at least 30 days prior to submitting to the federal Centers for Medicare & Medicaid Services, and to work with stakeholders to address the public comments in the SPA. The following is a link to the DHCS website where we have posted the first draft of SPA 14-026 and a draft of an All Plan Letter (APL) providing interim guidance to Medi-Cal managed care plans:

E-Note #123 (October 29, 2014)

Expansion of Relative Status – “Fictive” Relatives for Federal KinGAP

California Fostering Connections to Success Act, Stats. 2010, c. 559, §58 [A.B. 12], enacted Sept. 30, 2010, eff. Jan. 1, 2012; as amended by Stats. 2011, c. 459, [A.B. 212]; and as amended to expand relative status, Stats. 2012, c. 846, [A.B. 1712], effective Jan. 1, 2013.

Welf. & Inst. Code, §11386 (as amended Stats. 2012, c. 846, [A.B. 1712], §38); and § 11391 (as amended Stats. 2012, c. 846, [A.B. 1712], §40.)

ACL No. 14-28 (Mar. 25, 2014) – Expanding relative status for federal KinGAP (or FedGAP)

Federal DHHS Children’s Bureau Letter: ACYF-CB-PI 10-11 (issued Jul. 9, 2010)

Expansion of Relative Status for FedGAP Benefits:

Effective January 1, 2013 by passage of A.B. 1712, the state adopted Department of Health and Human Services’ (DHHS) permission to expand the definition of a relative for the purpose of receiving federally-funded KinGAP (FedGAP) benefits.

Back in 2010, DHHS, through issuance of ACYF-Children’s Bureau’s Program Instructions Number 10-11, DHHS stated that it would accept a state’s “reasonable interpretation of a relative, including a plan . . . that more broadly includes Tribal kin, extended family and friends, or other ‘fictive’ kin.”

In collaboration with DHHS, the state has redefined a relative through passage of A.B. 1712, under Welfare and Institutions Code, Section 11391, subdivision (c), which expands those adults who may be eligible to receive FedGAP upon granting of legal guardianship:

“(1) An adult who is related to the child by blood, adoption, or affinity within the fifth degree of kinship, including stepparents, stepsiblings, and all relatives whose status is preceded by the words “great,” “great-great,” or “grand” or the spouse of any of those persons even if the marriage was terminated by death or dissolution.

(2) An adult who meets the definition of an approved, nonrelated extended family member, as described in Section 362.7.

(3) An adult who is either a member of the Indian child’s tribe, or an Indian custodian, as defined in Section 1903(6) of Title 25 of the United States Code.

(4) An adult who is the current foster parent of a child under the juvenile court’s jurisdiction, who has established a significant and family-like relationship with the child, and the child and the county child welfare agency, probation department, Indian tribe, consortium of tribes, or tribal organization that has entered into an agreement pursuant to Section 10553.1 identify this adult as the child’s permanent connection.” (Welf. & Inst. Code, §11391, subd. (c).)

Note that subdivision (c)(1) above is the “traditional” relative or kin; whereas subdivision (c)(2) relates to the revised definition of a nonrelated extended family member (NREFM), which in 2013 was redefined through passage of A.B. 545, as follows:

A “nonrelative extended family member” is defined as an adult caregiver who has an established familial relationship with a relative of the child (defined in 361.3 (c)(2)), or a familial or mentoring relationship with the child. The county welfare department shall verify the existence of a relationship through interviews with the parent and child or with one or more third parties. The parties may include relatives of the child, teachers, medical professionals, clergy, neighbors, and family friends. (Welf. & Inst. Code, §§362.7, 11400, subd. (n), as amended Stats. 2013, [A.B. 545], Sept. 9, 2013.)

This revision for defining a NREFM essentially undid the limitations set out in *In re Samantha T.* (2011) 197 Cal.App.4th 94, and *In re Michael E., Jr.* (2013) 213 Cal.App.4th 670.), which had limited familial relationships where reunification rights remained, or where ethnic similarities existed between the minor and caregiver.

Subdivision (c)(3) adds Tribal kin, and subdivision (c)(4) provides an expansion of those nonrelatives to include an individual seen as having a “permanent connection” to the minor as a current foster care provider. Essentially, subdivisions (c)(2) through (4) create a new “fictive” relative status.

No Change for State-funded KinGAP:

For state KinGAP benefits, the state still mandates that the caregiver guardian remain a relative as traditionally defined, meaning a relative within the fifth degree of kinship.

NREFMs are still eligible to receive non-federal Foster Care benefits (formerly state Foster Care) providing their home is approved and placement authority exists (i.e., a Voluntary Placement Agreement, or under dependency, delinquency, or transitional jurisdiction in Juvenile Court).

Nonrelated Legal Guardians are still eligible to receive non-federal Foster Care benefits regardless of continuing dependency, as the minor is presumed to be in an eligible facility (see Welf. & Inst. Code, §11405).

E-Note #122 (October 29, 2014)

**Modification Petitions Reinstating Dependency Jurisdiction on KinGAP Cases –
When KinGAP Benefits May Continue**

References: Welfare and Institutions Code, Sections 11363, subdivision (b); and 11386, subdivision (f)

Introduction:

On August 28, 2012, we issued E-Note number 76, regarding the inability to fund federal Foster Care when the court reinstates dependency jurisdiction on a minor in KinGAP under the care and custody of a relative guardian in response to All County Letter (ACL) No. 11-64 (issued Oct. 18, 2011).

Where a petition is filed causing Juvenile Court to reinstate dependency jurisdiction on a case where a relative legal guardian had the care and custody of a minor and was receiving KinGAP benefits, Region IX of Children's Bureau, Administration for Children and Families, Department of Health and Human Services (DHHS) had determined that the reinstatement of dependency jurisdiction resulted in a new foster care "episode."

A new foster care episode essentially meant that a new linkage determination was required to establish federal eligibility for Foster Care funds. The state adopted DHHS' interpretation in ACL No. 11-64. In such cases, linkage was nearly impossible to establish as the minor had been removed from his/her parent(s) for over 6 months, in violation of federal law. (See 42 USC, §672, also see our MPP, §45-202.411(b) and ParaReg 181-1).

However, although federal Foster Care may not be available, in some cases KinGAP benefits may be continued.

As you are aware, a relative caregiver who becomes a legal guardian through a permanent plan order may begin to receive either federally or state funded KinGAP benefits once the Court terminates dependency jurisdiction, providing the remaining KinGAP eligibility criteria had been met. (For KinGAP under AB 12, see ACL Nos. 11-15 and 11-86.)

In E-Note number 76, we stated that if someone files a petition to reinstate dependency jurisdiction, and the Court does so, KinGAP benefits must be discontinued, but this is not necessarily true in cases where the Court temporarily reinstates dependency jurisdiction in response to the filing of a "modification petition" under Welfare and Institutions Code, Section 388.

Generally, the two most common petitions causing the Court to reinstate dependency jurisdiction are "supplemental petitions," filed under Welfare and Institutions Code, section 387 (WIC 387 petition), and "modification petitions," filed under Welfare and Institutions Code, section 388 (WIC 388 petition)

WIC 387 petitions are used to request the minor's removal and provide a more restrictive placement; whereas, WIC 388 petitions may be filed for a variety of purposes, such as obtaining Court services to assist the guardian (obtaining a birth certificate, attempting to get preference

in obtaining mental health services, etc.); changing the permanent plan to adoption; challenging the guardianship; and/or removing the minor from the guardian.

Continued KinGAP Benefits Following WIC 388 Petitions:

State and Federal Funding: Providing eligibility for KinGAP had already been established, KinGAP benefits can continue if:

“[A]ny parent or person having an interest files with the juvenile court a petition pursuant to Section 388 to change, modify, or set aside an order of the court, Kin-GAP payments shall continue unless and until the juvenile court, after holding a hearing, orders the child removed from the home of the guardian, terminates the guardianship, or maintains dependency jurisdiction after the court concludes the hearing on the petition filed under Section 388.” (Welf. & Inst. Code, §11363, subd. (b); for state KinGAP)

The same language is mirrored for federally funded KinGAP (FedGAP) under Welfare and Institutions Code, Section 11386, subdivision (f), governing eligibility for FedGAP. Under mandate from DHHS, one additional requirement is added, stating the placement and care not be transferred from the guardian to the county child welfare agency. Program and Legal now mandate this additional element be applied to state KinGAP, and this additional element has been added to the proposed regulations governing KinGAP eligibility now under APA rulemaking process.

In summary, both state and federal KinGAP may continue upon the filing of a WIC 388 petition providing:

- Guardianship is not terminated
- The minor is not removed from the guardian
- Dependency jurisdiction is again terminated at the conclusion of the hearing, AND
- Placement and care responsibility is not transferred from the guardian to the county.

This last element occurs if the guardianship, for example, is still in place, but Juvenile Court orders that the care and custody is now vested with the county child welfare agency, where it had previously been vested with the guardian.

Petition Examples Where Funding May Continue:

1. WIC 388 is filed to order the county to seek and obtain the minor’s birth certificate;
2. WIC 388 is filed to obtain priority for mental health services for the minor;
3. WIC 388 is filed to challenge the claimant’s guardianship, but is denied without the minor’s removal and without a change in vested care and custody, and where the temporary reinstatement of dependency jurisdiction has again been terminated upon completion of the WIC 388 hearing.

Petition Example Where Funding May Not Continue:

A WIC 388 is filed (with or without an accompanying WIC 387 for removal) that results in the Court's reinstatement of dependency and either the removal of the minor or termination of the guardianship; or, again vests the placement and care of the child back with the county.

Special Consideration for Petitions to Alter Permanent Plan from Guardianship to Adoption:

Relevant to this discussion, in order for the claimant's guardianship to move to an adoptive placement of a dependent minor or nonminor, it is first necessary for the county to complete an adoption home study, and for the court to conduct a "2-6" hearing on whether the parents from whom the minor was removed should lose their parental rights. (Welf. & Inst. Code, §366.26.)

In order for an interested person (e.g., the guardian or adoption social worker) to push towards an adoptive placement, a WIC 388 petition must be filed, which reinstates dependency jurisdiction to provide the Court the ability to assess whether to entertain a hearing towards terminating parental rights under Welfare and Institutions Code, Section 366.26.

From the filing of the 388 petition until the petition is granted, and the hearing to assess whether to terminate parental rights is initiated, KinGAP benefits may continue.

However, once the WIC 388 petition is granted and the "2-6" hearing (WIC 366.26) is set, KinGAP benefits must stop, as the WIC 388 petition will conclude without the termination of dependency jurisdiction.

This is true even though at this point in the court's proceedings, the guardianship remains intact and care and custody over the minor or nonminor remains with the guardian.

Proposed Decisions:

Any decision extending KinGAP benefits following the reinstatement of dependency jurisdiction must be written as a proposed decision.

E-NOTE # 117 – IN-HOME SUPPORTIVE SERVICES (IHSS) IN THE WORKPLACE

July 21, 2014

References: ACL 04-43 (October 13, 2004); Assembly Bill (AB) 925 (Chapter 1008, Statutes of 2002); Para-regulations to be drafted in the next update

This is intended to remind judges about ACL 04-43. This letter was issued on October 13, 2004 to inform the counties about the passage of AB 925 regarding transferring IHSS benefits to the workplace.

<http://www.dss.cahwnet.gov/lettersnotices/entres/getinfo/acl04/pdf/04-43.pdf>.

AB 925, effective on January 1, 2003, was designed to remove barriers to employment and independence for Californians with disabilities. This legislation affected several State Departments. ACL 04-43 only addresses implementation of Sections 6 and 9 of AB 925, which pertain to the IHSS and PCSP programs.

Below are the pertinent sections from the ACL 04-43:

Eligibility for IHSS/PCSP/IPO in the Workplace

All IHSS/PCSP/IPO participants are eligible to transfer a portion of their current authorized service hours to the workplace if they choose to do so. This includes recipients in all three modes of service delivery for IHSS/PCSP/IPO.¹

It is important to note that IHSS/PCSP/IPO recipients cannot receive additional service hours in the workplace beyond those currently authorized in the home. In addition, income and resource limits for the IHSS Residual and PCSP/IPO have not changed, so income generated by a recipient could affect program eligibility.

AB 925 states that only authorized IHSS program services that are relevant and necessary in supporting and maintaining employment may be transferred. IHSS in the workplace is not an alternative resource that reduces or substitutes for supports and services that are an employer's responsibility under programs such as the Americans with Disabilities Act (ADA).

Workplace

The new law specifically allows an IHSS/PCSP/IPO recipient to transfer service hours to a workplace setting in order to "obtain, retain or return to work."

Authorized IHSS service hours cannot be transferred to other locations outside the home, except for the specific exceptions in the IHSS Regulations that already exist, e.g., for accompaniment to medical appointments and alternative resource sites.

Services Available for Transfer to the Workplace

¹ The ACL refers to the IHSS-Plus Waiver (IPW) Program which has since been replaced by the IHSS Plus Option (IPO) Program. Additionally, IHSS in the workplace also applies to the Community First Choice (CFCO) Program

AB 925 allows the transfer of services that are “relevant and necessary in supporting and maintaining employment.”

Services that could be considered relevant and could be transferred to the workplace if necessary are:

IHSS Residual

1) Related Services, consisting of Preparation of Meals, Meal clean-up, Planning of Menus and Restaurant Meal Allowance, as described in the Social Services Standards MPP Chapter 30-757.13.

2) Personal Care Services, as described in MPP 30-757.14, with the exception of MPP 30-757.14(d) - Routine bed baths.

33) Paramedical Services, as described in MPP 30-757.19.

IPW (currently IPO)

Participants of the IHSS/IPO program, formerly referred to as the IHSS/IPW program, are recipients who have a parent or spouse provider, or receive Advance Pay or Restaurant Meal Allowance. The services listed above under IHSS Residual may be transferred to the workplace for IHSS IPO recipients.

PCSP

1) Personal Care Services, as described in MPP 30-780.1(a).

2) Meal Preparation and Cleanup, as described in MPP 30-780.1(b)(4).

NOTE: State law (WIC 12300(d)(1) and 14132.955(a)) requires that services requested for transfer must be both relevant and necessary to support employment. IHSS program services not listed above are not considered relevant and necessary to supporting employment, and are not available for transfer to the workplace.

Assessed and Authorized Services Only

An IHSS recipient who wants to transfer service hours to the workplace can only transfer hours that they have already been assessed and authorized for the recipient in their home. A recipient cannot obtain additional new service hours as a result of employment. The social worker is not required to complete a new needs assessment solely because a recipient wants to transfer IHSS hours to the workplace.

County Approval of Recipient Use of IHSS in the Workplace

In order for a recipient to utilize program service hours in a workplace, the recipient must first notify his/her IHSS social worker and obtain county approval. Prior to receiving county approval to transfer IHSS service hours to the workplace, the IHSS/PCSP recipient must specify the number of hours to be transferred for each specific service. The social worker must verify that the recipient has authorized service hours from the approved list of transferable services contained in this ACL, and that the recipient has not requested to

transfer more hours to the workplace than currently exist for their utilization in the home. The social worker must then notify the recipient of their approval, and record the total number of hours in each service category that the recipient plans to transfer. The counties are not responsible for determining whether the provider is legally eligible to work under state and federal law, as that is the recipient's responsibility.

Please note that there have been no ACLs or ACINs issued on IHSS in the workplace since ACL 04-03.

Finally, ACL 04-43 states the following: "CDSS is promulgating regulations that will define the word "obtain" for purposes of the AB 925 IHSS in the workplace provisions to mean only those recipient activities directly related to securing employment, such as going on a job interview or complying with pre-employment activities that are required by the employer. Coverage of IHSS in the workplace will not include services required by a recipient to attend college classes or vocational training, but will include pre-employment training that is offered or required by an employer in the workplace."

Such regulations have not yet been promulgated, nor have there yet been any other regulations adopted by the CDSS pertaining to IHSS in the workplace.

Training and Quality Development Bureau
CDSS State Hearings Division

E-NOTE #116 – DOMESTIC VIOLENCE WAIVERS APPLICABLE TO THE CALWORKS PROGRAM

June 11, 2014

References: Welfare and Institutions Code (WIC) §11495.1(a); WIC §11495.15; WIC §11320.3(f)(2), Manual of Policies and Procedures (MPP) §42-713.22; and All-County Information Notice (ACIN) 1-02-06 (January 9, 2006).

State Hearings Division (SHD) has recently received clarification and the following statement from the CDSS Welfare-to-Work Divisions regarding the interpretation and implementation of domestic violence (DV) waivers applicable to the CalWORKs program based on the above-noted references.

Clarification on the Legal Criteria for Granting a DV Waiver

The first point of clarification is that a DV waiver may only be granted “temporarily.” In other words, a DV waiver of a CalWORKs rule or requirement may not be granted permanently by a county. However, a DV waiver may continue for an indeterminate period as long as the county affirms that the conditions or circumstances that supported the granting of the DV waiver remain applicable. Specifically, WIC §11320.3(f) requires that a DV waiver of a CalWORKs rule or requirement shall be reviewed by the county not less than every three (3) months.

The second point of clarification is that the applicable WIC statutes and CDSS regulations require that a temporary DV waiver of a CalWORKs rule or requirement only be granted upon a finding of “good cause.” Specifically, WIC §11495.15 states:

“A county may waive a program requirement for a recipient who has been identified as a past or present victim of abuse when it has been determined that good cause exists pursuant to paragraph (2) of subdivision (f) of Section 11320.3. Until implementation of the regulations required pursuant to subdivision (b) of Section 11495.1, a county may utilize standards, procedures, and protocols currently available, and shall identify them in its county plan...” (Emphasis added).

WIC §§11320.3(f) and (f)(2) specifically provide that:

*“...(f) A recipient shall be excused from participation for good cause when the county has determined there is a condition or other circumstance that temporarily prevents or significantly impairs the recipient's ability to be regularly employed or to participate in welfare-to-work activities. The county welfare department shall review the good cause determination for its continuing appropriateness in accordance with the projected length of the condition, or circumstance, but not less than every three months. The recipient shall cooperate with the county welfare department and provide information, including written documentation, as required to complete the review. Conditions that may be considered good cause include, but are not limited to, the following:
... (2) In accordance with Article 7.5 (commencing with Section*

11495), the applicant or recipient is a victim of domestic violence, but only if participation under this article is detrimental to or unfairly penalizes that individual or his or her family.”

Consistent with the above-noted statutes, CDSS regulation, MPP §42-713.22 provides:

“Good cause for a person who is a victim of domestic violence is to be determined on a case by case basis but only for as long as domestic abuse prevents the individual from obtaining employment or participating in welfare-to-work activities.” (Emphasis added).

It is important to note that the applicable laws do not require that the applicant/recipient be currently involved in a DV situation but authorize a past or present victim of DV to request and be granted a temporary DV waiver from a CalWORKs rule or requirement if “good cause” exists. The analysis in granting a DV waiver is not whether the CalWORKs rule or requirement requested to be waived is detrimental to or penalizes the applicant, recipient or their family but whether the past or present DV circumstances or condition of the applicant/recipient prevents him/her from participating in the welfare-to-work requirements.

Example: Mary is a past victim of DV and has left her abuser. Mary has two children, one of whom was previously determined by the county to be a child subject to the Maximum Family Grant (MFG) rule (WIC §11450.04) i.e., the child was determined not to be eligible to be counted as part of the assistance unit (AU) and additional cash assistance for the child was not provided because Mary was receiving cash assistance for ten or more months prior to the birth of the child. Currently, Mary is depressed and suffering from post-traumatic stress disorder as a result of her prior abusive relationship and her current condition prevents her from being regularly employed or participating in welfare-to-work activities. Mary asks her social worker for a temporary DV waiver of the requirement to provide proof of immunization for her children, CalWORKs participation requirements, and the MFG rule for her MFG child. The county determines that Mary’s current condition, caused by her past domestic violence situation, meets the “good cause” requirement of WIC §11320.3(f) i.e., currently, it would be detrimental for Mary and her recovery efforts to be required to participate in welfare-to-work activities and to obtain the immunization records, and a temporary waiver of the MFG rule, receiving additional cash assistance for her MFG child, will benefit Mary at this time. After granting the temporary DV waivers, the county is required by statute to review the status of Mary’s temporary DV waivers, no less than every three (3) months. There is no time limit as to how long Mary may receive the DV waivers as long as the county verifies that Mary continues to be unable to work or participate in welfare-to-work activities based on her DV condition or circumstances. Once Mary is determined by the county to be capable of participating in welfare-to-work activities, the county will terminate the temporary DV waivers and require Mary to participate, provide the immunization records, and discontinue the temporary additional cash assistance for her MFG child.

In the above example, it demonstrates that there must be a linkage between the applicant’s or recipient’s past or present DV circumstances that temporarily prevents him/her from working or participating in welfare-to-work activities. If an applicant or recipient is requesting a DV waiver of a CalWORKs program rule or requirement, the analysis is not whether the program rule or requirements is detrimental to or unfairly penalizes the applicant, recipient or his/her family.

As noted previously, there is no statutory authority to grant a “permanent” waiver of the MFG rule or any program rule or requirement via the DV statutes or regulations nor is there a permanent waiver provision pursuant to WIC §11450.0, even if the child was conceived as a result of the DV relationship; however, a ‘temporary’ DV waiver of the MFG rule may be granted as described in the Example.

Please note that the following CalWORKs requirements set forth in MPP §42-715.511, are not allowed to be waived temporarily pursuant to a request for a DV waiver:

MPP Section 41-400: Deprivation

MPP Section 42-200: Assets

MPP Section 44-100: Income

MPP Section 44-211.542: Homeless Assistance

The third point of clarification is that an adult, who is undocumented or ineligible for CalWORKs benefits is not authorized to be granted a temporary DV waiver. This is based on the law that a DV waiver may only be granted pursuant to a finding of “good cause” as specified in 11320.3(f) which requires the DV condition (present/past) to prevent or significantly impair an applicant/recipient from participating in welfare-to-work activities. Undocumented or ineligible adults are not subject to program requirements and are not required to comply with CalWORKs welfare-to-work activities; therefore, they are ineligible for a temporary DV waiver.

The fourth point of clarification pertains to ACIN I-02-06 (January 6, 2006). The substantive body of the ACIN accurately states the above-referenced statutory and regulatory requirements; however, DV waivers for the MFG rule have been incorrectly granted by counties based on the following Question and Answer set forth in ACIN 1-02-06:

*11. **Question:** Are counties allowed to waive the Maximum Family Grant (MFG) rule pursuant to MPP Section 44-314.3 - .4 for victims of domestic abuse?*

***Answer:** Counties may waive the MFG rule, on a case-by-case basis, when it is determined that compliance would put at further risk or unfairly penalize those who are or have been victimized by such abuse. The MFG rule could be waived permanently for a child even if the domestic abuse situation is resolved or no longer exists. However, the county must make a separate determination of eligibility for an exemption to the MFG rule or a domestic abuse waiver, for any subsequent child.*

The criteria for granting a DV waiver of the MFG rule as stated in the Answer is incorrect as well as the statement that the MFG rule can be ‘permanently’ waived.

Retroactive Domestic Violence Waiver Requests:

As noted above, based on the county requirement to review a temporary DV waiver every three (3) months to determine if applicable circumstances continue to substantiate the need for a DV waiver, it has been determined that a request for and granting of a temporary DV waiver may be retroactively applied up to three (3) months, if it is determined by the county that the applicant’s or recipient’s condition or circumstances “temporarily prevented or significantly impaired the recipient from being regularly employed or from participating in welfare-to-work activities” (WIC sections 11320.3(f) and (f)(2)) during the retrospective three (3) month period.

However, it is important to note that a temporary DV waiver may be granted retroactively for more than three (3) months if the failure to grant the temporary DV waiver, at the time it was requested, was due to an error by the county. In this circumstance, the recipient would need to demonstrate that the recipient placed the county on notice that he/she was a DV victim and had requested a temporary waiver of a CalWORKs rule or requirement but the county failed to act and the condition or circumstances during the time period at issue “temporarily prevented or significantly impaired the recipient from being regularly employed or participating in welfare-to-work activities.” The DV waiver of the CalWORKs requirement would be effective retroactively to the date when the county was placed on notice by the recipient.

E-NOTE #115 – SUMMARY OF ACLs/ACINs/ACWDLs/MEDILs

February 6, 2014

MEDIL - I 14-02 (January 9, 2014) Affordable Care Act Guidance

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MCED2792.pdf>

The Department of Health Care Services (DHCS) is providing this additional guidance as a result of recently enacted state law, Senate Bill x1 1, Statute of 2013, Chapter 4, and Assembly Bill x1 1, Statute of 2013, Chapter 3, as well as recent guidance provided by the federal Centers for Medicare & Medicaid Services (CMS) on the Affordable Care Act of 2010 (ACA). This letter provides various ACA related policy guidance to counties and Statewide Automated Welfare Systems (SAWS) based on the analysis of state law, proposed federal regulations, and discussions with CMS as ACA policy and guidance continue to develop.

MEDIL - I 14-03 (January 13, 2014) Processing Health Coverage-Only Applications Received at the County January 13-20, 2014

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/14-03.pdf>

This letter provides guidance to counties and Statewide Automated Welfare Systems (SAWS) related to processing single streamlined applications during January 13-20, 2014. This is similar to the guidance that was released in Medi-Cal Eligibility Division Information Letter 13-14 on January 2, 2014.

The interface between the Statewide Automated Welfare Systems (SAWS) and the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) will not be active until the anticipated launch date of January 21, 2014. On January 1, 2014, SAWS converted their systems to accept all the data elements necessary to complete a single streamlined application.

ACWDL 14-01 (January 9, 2014) Low Income Health Program (LIHP) Transition to Medi-Cal

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-01.pdf>

The purpose of this All County Welfare Directors Letter (ACWDL) is to provide instructions to counties on the transition of LIHP enrollees to the Medi-Cal program pursuant to Assembly Bill (AB) x1 1 (Chapter 3, Statutes of 2013-14, First Extraordinary Session). ABx1 1 provides for the transition of eligible LIHP enrollees who are at or below 133 percent of the federal poverty level (FPL) to the Medi-Cal program, without an application, as prescribed by the Special Terms and Conditions of California's Bridge to Reform, Medicaid 1115 Waiver. The Centers for Medicare and Medicaid Services granted approval to the Department of Health Care Services (DHCS) to administratively move this population from LIHP to Medi-Cal, effective January 1, 2014.

MEDIL - I 14-04 (January 15, 2014) Suspending Denials of Applications Submitted Through the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS)

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-04.pdf>

This letter provides interim guidance to counties that they should not deny Medi-Cal applications submitted via CalHEERS until further notice from the Department of Health Care Services (DHCS), except for individuals who are already in an active Medi-Cal case in the Statewide

Automated Welfare System (SAWS) (consistent with previous Medi-Cal Eligibility Division Information Letter I-14-02).

When the interface between SAWS and CalHEERS is launched and all appropriate notices for denials are ready to be sent, counties will be notified by DHCS. At that point, upon notification by DHCS, counties should resume denial processes in accordance with current policy.

MEDIL - I 14-05 (January 17, 2014) Treatment of Former Foster Care Children's (FFCC) Program

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-05.pdf>

The purpose of this Medi-Cal Eligibility Division Information Letter is to notify County Welfare Departments (CWDs) of policy changes that will affect the handling of youth aging out of the foster care system, as well as youth who were in foster care in any state on their 18th birthday.

The FFCC program extension under the Affordable Care Act is effective January 1, 2014, counties shall enroll any new applicants who are between the ages of 18 and up to age 26, that were in foster care on their 18th birthday in any state, regardless of when or if they were previously transferred into the FFCC group. Those applicants who were previously enrolled in aid codes 40, 42, 43, 45, 46, 49, 4C,4H, 4L, 4N, or 5K are all eligible under the ACA FFCC extension with aid code 4M up to the age of 26. If an applicant has previously aged out of the FFCC aid code 4M, but is under age 26, they still qualify until the month of their 26th birthday. There may be situations where a child may have one of these aid codes that were not in foster care. If this is the case, after confirmation by the county that the applicant was not in foster care, the county does not have to grant FFCC benefits to the applicant, but must determine whether the applicant is nevertheless eligible for Medi-Cal. If the applicant is not eligible for any Medi-Cal program, the county should refer the applicant for other health insurance affordability programs.

After verification of FFCC status by the county, the applicant may be placed into this coverage group. There may also be situations where a child may have been in foster care on his/her 18th birthday, but was not enrolled in any of the aid codes listed above or from out-of state, they would be eligible for this program. Applicants and beneficiaries, if found eligible, will remain eligible with aid code 4M up through the month in which they attain age 26 and are residents of California.

MEDIL - I 14-06 (January 17, 2014) Long-Term Care Services and Supports (LTCSS) For Individuals With Eligibility Based Upon Modified Adjusted Gross Income (MAGI) or Mixed With Non-MAGI

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-06.pdf>

This letter provides interim guidance to counties that they should not calculate shares-of-cost (SOC) or move individuals who are eligible in MAGI full scope aid codes to other aid codes for purposes of receiving LTCSS. Individuals who are eligible under MAGI continue to receive LTCSS under their MAGI full scope aid codes without an SOC. Therefore, since the spousal income allocation is a part of the share of cost calculation, it will not be part of the MAGI eligibility determination either.

If you have one spouse in LTC on a non-MAGI basis and the other spouse applies for MAGI Medi-Cal, then counties need to determine eligibility with and without the spousal income allocation, provide that information to the couple or their representative and ask the couple whether or not they wish to continue with the allocation. Should the couple still wish to continue the spousal income allocations and the couple was expecting to file taxes jointly, then the

county would not include the spousal income allocation as income to the community spouse because when entering the information into the California Health Eligibility, Enrollment and Retention System all of the income of both spouses would be entered. If the community spouse was filing separately, then the income allocation from the institutionalized spouse would be included, just as we would if the community spouse were attempting to establish eligibility for the Aged Blind Disabled Federal Poverty Level or Medically Needy programs previously.

As a reminder, property is not a part of the MAGI eligibility determinations, so the spousal impoverishment Community Spouse Resource Allowance will not be applicable.

MEDIL - I 14-07 (January 21, 2014) County Compliance with CalHEERS Information Transmittals (CITs)

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-07.pdf>

The Department of Health Care Services (DHCS) is a sponsor of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) and provides policy instruction and guidance to CalHEERS staff and developers. This instruction and guidance is reflected in the CITs provided to counties from the CalHEERS support team. These CITs may or may not be coupled with formal guidance from DHCS or the Statewide Automated Welfare Services (SAWS).

Counties are instructed to read and treat each CalHEERS CIT as official guidance from DHCS similarly to how guidance released by DHCS, in the form of Medi-Cal Eligibility Division Informational Letters and All County Welfare Director Letters, is to be treated. CalHEERS releases CITs to specified county and consortia staff who ensure appropriate distribution of the notices and related information.

MEDIL - I 14-08 (January 21, 2014) E-Hit Workarounds – January 21, 2014

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-08.pdf>

This letter is to provide counties with interim guidance on policies and procedures for implementing workarounds during the initial launch of the E-HIT interface between the California Health Eligibility, Enrollment, and Retention System (CalHEERS) and the Statewide Automated Welfare System (SAWS). The policies and procedures contained in this letter are temporary and should be implemented until such time that the Department of Health Care Services (DHCS) instructs counties otherwise. SAWS will also be issuing informational guidance pertaining to these workarounds.

ACIN I-04-14 (January 23, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2014/I-04_14.pdf>

County Children's Trust Fund (CCTF) Share Of Kids' Plate Revenue

This notice is to inform you that the California Department of Social Services (CDSS) will distribute the CCTF's Kids' Plate revenue allocated by the State Fiscal Year (SFY) 2013-2014 Budget Act. The total distribution for SFY 2013-14 is \$963,000. Each county's share is based on their proportion of each county's population of children ages zero to 18 as reported by Department of Finance July 2013 statistics. The allocations for the fiscal year are shown on the enclosed chart (Attachment A).

Pursuant to California Welfare and Institutions Code (WIC) Section 18967, the purpose of the CCTF is to fund child abuse and neglect prevention and intervention programs operated by private nonprofit organizations or public institutions of higher education with

recognized expertise in fields related to child welfare. Under WIC Section 18983, CCTF monies are also used to fund Child Abuse Prevention Coordinating Councils (CAPCs). The intent of the Kids' Plate revenue is to strengthen health and safety protections for children and to help fund programs to reduce child injury and child abuse.

MEDIL - I 14-09 (January 23, 2014) Medi-Cal for Families Annual Eligibility Review (AER) Packet Mailing Discontinuance

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-09.pdf>

The purpose of this letter is to notify counties of changes being made to the Medi-Cal for Families AER mailing process.

During the transition of children from the Healthy Families Program (HFP) to the Medi-Cal for Families program beginning January 2013, the Single Point of Entry (SPE) was responsible for sending AERs to families where the children were eligible for Medi-Cal under transitional aid codes 5C or 5D. Beginning in April 2013, AERs that were completed and returned to the SPE were forwarded to the appropriate county for completion of the annual eligibility redetermination as part of the transition to Medi-Cal.

For annual redeterminations due in January 2014 or future months, the SPE will not send AER packets to the Medi-Cal for Families population covered under aid codes 5C and 5D. However, families who received the Medi-Cal for Families AER packets from the SPE during 2013 may still request a duplicate AER packet from the SPE through February 2014. Counties will be responsible for sending and processing the annual redeterminations for the HFP transitioned children in aid codes 5C or 5D with a January 2014 or later AER/annual redetermination date in accordance with future guidance issued by the Department of Health Care Services. Additionally, there is a required January 2014 through March 2014 moratorium on Medi-Cal annual redeterminations for those individuals whose eligibility is determined by the new modified adjusted gross income (MAGI) methodology, including for children in aid codes 5C or 5D. The January annual redeterminations will be processed in April 2014, the February annual redeterminations will be processed in May 2014 and the March annual redeterminations will be processed in June 2014.

ACL 14-08 (January 29, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-08.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Program: New Category Of Disability-Based Unearned Income (DBI) – Veteran's Disability Compensation (VDC) Benefits

This letter is set forth below in its entirety:

The purpose of this ACL is to provide County Welfare Departments (CWDs) with implementation instructions and information on the expansion of the definition of DBI to include VDC benefits in the CalWORKs program. This ACL also discusses how to apply the DBI disregard when calculating the CalWORKs grant for recipients who receive VDC benefits.

EXPANSION OF DBI DEFINITION

Pursuant to the passage of AB 1094, VDC benefits are now included in the definition of DBI effective January 1, 2014. Previously, DBI had been limited to disability insurance benefits, private disability insurance benefits, temporary workers' compensation benefits, and social security disability benefits. Recipients in a CalWORKs Assistance Unit (AU) who receive DBI are entitled up to \$225 in the form of an "income disregard" when CWDs determine the AU's ongoing eligibility and grant amount.

As a result of the expanded definition of the DBI, some AUs' grant amounts will increase if receiving VDC benefits. If the DBI does not exceed \$225, all of the DBI must be disregarded, and any unused amount of the \$225 plus 50 percent of any remaining earned income is also disregarded. Once all disregards are applied, any remaining income is treated as part of the AU's Net Non-Exempt Income (NNI). If the DBI exceeds \$225, only the first \$225 of the DBI is disregarded along with 50 percent of any earned income. Any remaining DBI and earned income is treated as part of the AU's NNI.

As stated earlier in this letter, the allowance of the \$225 disregard for VDC became effective January 1, 2014. CWDs must ensure that all cases in which any AU member receives VDC benefits have their grant amounts recalculated to allow the \$225 disregard. CWDs must implement the new disregard immediately. Policy changes should be automated into the consortia systems by the effective date of the new law or a process must be put in place to meet the requirements of the policy change until necessary automation changes are completed. If CWDs are not able to apply the \$225 disregard to cases with VDC benefits immediately, CWDs must retroactively apply the disregard where applicable by recalculating the grant the next time the CWD takes action on the case (e.g. processing a SAR 7, annual redetermination, voluntary report from the AU, etc.) or when it becomes known to the CWD and issuing a supplement for the underpayment, in accordance with Manual of Policies and Procedures (MPP) Section 44-340. CWDs must also rescind any discontinuances if the sole cause of the discontinuance was ineligibility due to receipt of VDC benefits, and the case would have remained eligible had the disregard been applied beginning January 1, 2014. Any cash aid the AU would have been eligible for had the AU not been discontinued due to the disregard not being applied must be repaid to the AU.

TYPES OF VDC BENEFITS INCLUDED

The Veteran's Administration (VA) has many types of VDC benefits. The main benefit type is Disability Compensation. There are some additional, special categories of supplemental VDC payments that veterans and their spouses, children, or parents may be entitled to receive depending on several different factors. Some of these additional types of VDC benefits include but are not limited to Special Monthly Compensation and Individual Unemployability benefits. In addition to the VDC benefits paid to veterans injured as a result of their active duty status, there is another benefit type called the Title 38 U.S.C. 1151 Claim. This compensation is paid to veterans who were injured while receiving care from the VA or while in VA rehabilitation programs. Following is an example of the latter type of VDC benefit.

A veteran pursuing training under the VA's Chapter 31 Vocational Rehabilitation and Employment program was receiving on-the-job training as a car mechanic. During training, a jack slipped from a car, crushing the veteran's left foot. Disability compensation may be paid for the foot injury because the injury occurred while the veteran was pursuing training under a VA Vocational Rehabilitation and Employment program.

Regardless of the type of VDC benefit being paid or to whom it's being paid, CWDs must apply the \$225 disregard if the payment is based on the veteran's disability.

VDC EARNED INCOME DISREGARD (EID) EXAMPLES

The following scenarios provide examples regarding how to calculate the grant amount using the new EID for VDC income.

Scenario 1 – DBI greater than \$225:

A nonexempt AU of four (two adults and two children) has gross earned income of \$500 per month. An adult in the AU receives \$300 per month in VDC benefits. The family lives in Region 1.

\$300.00 DBI
-225.00 DBI Disregard
\$75.00 Nonexempt Disability Income
\$500.00 Earned Income
-250.00 50 percent EID
\$250.00 Nonexempt Earned Income
\$250.00 Nonexempt Earned Income
+75.00 Nonexempt Disability Income
\$325.00 NNI*
\$762.00 Maximum Aid Payment (MAP) for four - Nonexempt (Region 1)**
-325.00 NNI*
\$437.00 Grant Amount

Scenario 2 – DBI less than \$225:

A nonexempt AU of four (two adults and two children) has gross earned income of \$500 per month. An adult in the AU receives \$200 per month in VDC benefits. The family lives in Region 1.

\$200.00 DBI
-225.00 DBI Disregard
-\$25.00 Unused DBI Disregard
\$500.00 Earned Income
-25.00 Unused DBI Disregard
\$475.00 Subtotal
\$475.00 Subtotal
-237.00 50 percent EID
\$237.00 NNI*
\$762.00 MAP for four - Nonexempt (Region 1)**
-237.00 NNI*
\$525.00 Grant Amount

*If NNI is not a whole dollar, it is rounded to the next lower dollar (MPP Section 44-315.34).

**Based on the current MAP level effective until February 28, 2014. The MAP will increase by five percent on March 1, 2014. ACL 14-05 with instructions was issued on January 13, 2014

IMPACT ON CalFresh

The new disregard, when applied to cases that receive VDC, may increase the AU's cash aid, which may consequently result in a decrease to the AU's CalFresh allotment. CWDs must provide these AUs with a timely and adequate notice before decreasing the CalFresh allotment.

ACWDL 14-02 (January 29, 2014) Employment Data Confidentiality

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-02.pdf>

SUBJECT: EMPLOYMENT DATA CONFIDENTIALITY

The Department of Health Care Services (DHCS) is party to an agreement with the Employment Development Department (EDD) that authorizes the use of confidential employment information to assist in Medi-Cal Program administration. DHCS received permission to re-disclose the EDD data to County Welfare Departments (CWDs). Confidential information disclosed to the CWDs may only be used for the sole purpose of verifying employment and eligibility of applicants for, and recipients of, under the Medi-Cal Program. The EDD Agreement requires DHCS to have all CWD employees that view EDD data sign the enclosed confidentiality agreement. The purpose of this letter is to provide CWDs with instructions for coordinating with DHCS on signing the EDD Confidentiality Agreement (Attachment D1).

MEDIL - I 14-10 (January 24, 2014) Instructions to Counties on Reinstatement of Eligibility for Children in Transitional Aid Codes

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2014/MEDILI14-10.pdf>

The purpose of this letter is to update counties and other interested parties regarding an opportunity for former Healthy Families Program (HFP) recipients who were recently discontinued due to non-receipt of Annual Eligibility Review (AER) forms to turn those forms in during early 2014 and have their eligibility reinstated. Additionally, former HFP recipients who had AERs due through December 2013 and did not return the AER will be provided with another opportunity to return their AER form in early 2014.

ACL 14-02 (January 22, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-02.pdf>

Coordinated Care Initiative (CCI) – Certification Requirements For Agencies To Contract With A Managed Care Health Plan (MCHP) For The Provision Of In-Home Supportive Services (IHSS)
This ACL provides direction for Agencies on how to become certified by the California Department of Social Services (CDSS) as a Qualified Agency in order to contract with a MCHP for the provision of IHSS (contract mode), pursuant to WIC section 12302.6. Specific information regarding certification for Agencies that have an existing contract with a county and are automatically certified as a Qualified Agency is provided in ACL No. 14-03.

BACKGROUND

As part of the Budget Act of 2012, Governor Brown signed SB 1008 and SB 1036 which enacted the CCI. SB 1036 (amended by AB 1471) added section 12302.6 to the WIC, authorizing MCHP providing IHSS as a managed care benefit pursuant to WIC section 14186.35 to contract with certain Agencies for the provision of IHSS in the CCI counties. Pursuant to WIC section 12302.6(b)(1) "Agency" is defined as a city, county, city and county agency, local health district, proprietary agency, or an entity that has or seeks a contract to provide IHSS. In order for an Agency to enter such a contract, they must be certified as a Qualified Agency. The legislature tasked CDSS, in consultation with the Department of Health Care Services (DHCS) to create and manage the certification and re-certification of Agencies as Qualified Agencies.

WIC section 12302.6 sets forth criteria upon which the MCHP may enter such contracts, establishes rules as to how IHSS may be provided by Qualified Agencies and sets forth minimum requirements for such contracts. Among other requirements to be determined by CDSS, the contract must provide for a minimum amount of service utilization.

However, IHSS recipients referred for services in contract mode may not exceed five (5) percent of the IHSS caseload in the county where the services are provided. Additionally, the contract must ensure that providers' wages and benefits are not less than the individual provider rate negotiated by the Statewide Authority for the county where the services are provided.

When a recipient is referred by a MCHP to a Qualified Agency, the Qualified Agency may provide IHSS to recipient who: 1) have been determined to be unable to function as the employer of the provider due to dementia, cognitive impairment, or other similar issues; 2) have been identified to need services under contract mode by the care coordination team created pursuant to paragraph (3) of subdivision (b) of WIC section 14186; or 3) are unable to retain a provider due to geographical isolation and distance, authorized hours, or other reasons. When a recipient who is severely impaired, as described in subdivision (b) of WIC section 12303.4, is referred to a Qualified Agency by a MCHP, the county, or the care coordination team, the Qualified Agency may provide emergency backup services, as needed, when a provider is unavailable due to vacation, illness, or other extraordinary circumstances, or the recipient is in the process of hiring or replacing a provider.

ACL 14-03 (January 22, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-03.pdf>

Coordinated Care Initiative (CCI) – Contractor Mode Agencies – Automatically Certified As A Qualified Agency

This ACL provides direction for Agencies that have an existing contract with a county which are being automatically certified by the California Department of Social Services (CDSS) as a Qualified Agency under the Managed Care Health Plan (MCHP) for the provisions of In-Home Supportive Services (IHSS), pursuant to WIC section 12302.6. Specific information regarding certification, re-certification, other requirements and general information regarding the Contract Mode are provided in ACL No. 14-02.

ACIN I-01-14 (January 17, 2014)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2014/I-01_14.pdf

California Work Opportunity And Responsibility To Kids (CalWORKs) and CalFresh: New "Reminder Letter" For Clients Who Submit An Incomplete Semi-Annual Status Report (SAR 7)

This ACIN is set forth below in its entirety:

The purpose of this ACIN is to inform County Welfare Departments (CWDs) about a new "reminder letter" for use in the CalWORKs and CalFresh programs. Currently, when clients do not submit their SAR 7 by the 11th of the month, or the SAR 7 is received but is not complete, CWDs send either the NA 960 X or NA 960 Y Notice of Action (NOA), as appropriate. These NOAs inform clients that benefits will be discontinued effective the end of the month unless a completed SAR 7 is received by the first day of the following month. If, after receiving the NA 960 X or NA 960 Y NOA,

the client submits a SAR 7 that is incomplete, CWDs are not required to issue another NOA. However, absent another NOA, the client is likely to think they complied with the original NA 960 X or NA 960 Y and that the discontinuance action will be rescinded.

The California Department of Social Services (CDSS) developed the attached “reminder letter,” the SAR 90, to inform clients that the SAR 7 they submitted is still not complete and to provide clients another opportunity to submit a complete SAR 7 to avoid discontinuance of their cash aid and/or CalFresh benefits. This process will aid in further informing clients that they are not fully meeting the CalWORKs/CalFresh requirements and may prevent clients from being discontinued. This may also provide administrative relief by reducing the number of reapplications and restorations that CWDs will need to process.

The SAR 90 is not a NOA and will not reset 10-day notice requirements or the case discontinuance date. The SAR 90 does not confer new hearing rights, although clients retain the right to request a hearing with respect to the original SAR 7 discontinuance notice. The SAR 90 must specify what questions need to be answered or what verifications need to be provided for the SAR 7 to be complete.

The CDSS strongly encourages CWDs to send the attached SAR 90 when they receive an incomplete SAR 7 after sending an NA 960 X or NA 960 Y. CWDs are reminded that if a resubmitted report includes all the information that was previously missing, but does not include all the information that was previously submitted in the first submission, the CWD is required to combine the two reports to get the complete report, and need not send the SAR 90. Instead, the CWD must stop the proposed discontinuance and ensure the issuance of benefits as soon as possible.

CWDs are reminded that the “Balderas” reminder pursuant to MPP Section 40-181.221 (SAR) is still required before the discontinuance takes place. CDSS regulations (as transmitted in ACL 13-99) require CWDs to attempt a personal contact by a county worker with the client and to document the attempt in the case record before discontinuing an individual from cash assistance in order to avoid unnecessary state hearing requests and help resolve eligibility issues through attempts to contact the client. Because the SAR 90 offers another opportunity to inform clients, CDSS strongly encourages CWDs to send the SAR 90.

When sending the SAR 90 reminder letter, CWDs must identify which program applies, either CalWORKs or CalFresh, or check both boxes if both programs are affected. CWDs are reminded that if the form is complete for one program, but not the other, to check only the box for the program still needing additional information, and to ensure that the program for which the existing information is sufficient is not scheduled for discontinuance.

To the extent that CWDs are adopting the recommended reminder letter process described in this ACIN, the SAR 90 is considered a required form with substitutes permitted. CWDs may modify or make substitutions to the SAR 90 with prior CDSS approval. CWDs may modify these forms to add or obtain information that does not (a) conflict with program policy/regulation, or (b) change the legal content of the form.

CWDs that adopt a policy of using the SAR 90 are strongly encouraged to post the written policy on their own department webpage as soon as administratively possible, pursuant to ACIN I-03-12.

ACL 14-07 (January 16, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-07.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Program: Assembly Bill (AB) 419 (Chapter 293, Statutes Of 2013) Changes To The Temporary Absence Rules For Children In A Public Hospital

This ACIN is set forth below in its entirety:

The purpose of this letter is to provide implementing instructions to County Welfare Departments (CWDs) for a new CalWORKs law established by AB 419 which became effective on January 1, 2014. Specifically, this All County Letter (ACL) addresses changes to the temporary absence rules in the CalWORKs program for children receiving treatment in a public hospital. As a result of AB 419, there is no longer any limit on the length of time a child is considered temporarily absent from the home while receiving treatment in a public hospital, and aid will continue for that child for the entire period of the hospitalization.

Under current CalWORKs rules, cash aid is allowed to continue unchanged, under certain conditions, for any member of an Assistance Unit (AU) who is not in the home, provided they are only temporarily absent. MPP Section 82-812 states that any member of the AU shall be considered temporarily absent when absent from the home for one full calendar month or less, unless an exception applies. Currently, MPP Section 82-812.62 provides for an exception that allows a child, who is a patient in a public hospital, to be considered temporarily absent from the home for up to two full calendar months.

AB 419 now requires that a child who is a patient in either a public or private hospital for medical or surgical care be considered temporarily absent from the home, and their CalWORKs benefits unchanged, for the duration of the hospital stay, regardless of the length of time.

NOTE: While AB 419 mandates any child who is a patient in a **public or private** hospital be considered temporarily absent for the duration of the hospital stay, current CalWORKs rules already provide no limit on the amount of time a child may be considered temporarily absent if receiving treatment in a private hospital. Therefore, as a practical matter, even before January 1, 2014, children temporarily absent while receiving treatment in a private hospital should have been receiving continued CalWORKs assistance. AB 419 only changes the CalWORKs rules for children receiving treatment in a public hospital.

Examples of how AB 419 will affect children undergoing hospital treatment are given below:

Example 1: A child enters a private hospital for treatment and remains there for 14 months. Under temporary absence rule exceptions in place before January 1, 2014, and AB 419, the child would be considered temporarily absent for the duration of the hospital stay, 14 months.

Example 2: A child enters a public hospital for treatment and remains there for 14 months. Under the temporary absence rule exceptions in place before January 1, 2014, the child would only have been considered temporarily absent for two calendar months. Because of AB 419, CWDs will now consider the hospitalized child temporarily absent for all 14 months of and will continue to aid the child.

When a household reports that a child is hospitalized, the CWD shall document the basis of the temporary absence. The CWD may do so by collecting verification to support the claim that the

child is hospitalized. Examples of acceptable evidence to support a claim that a child is hospitalized may include, but are not limited to, the following:

Admittance documentation from the hospital;

A letter from the admitting medical doctor or other legally qualified medical professional;

Other documentation that the CWD determines to be acceptable evidence that the child has been admitted to the hospital.

The documentation shall include the date the child was admitted to the hospital and, if possible, the anticipated duration of the hospital stay. If the child remains hospitalized beyond the anticipated duration of the hospital stay, the CWD shall re-verify if the child remains hospitalized.

NOTE: For CalWORKs cases, because changes in household composition are voluntary mid-period reports for Semi-Annual Reporting (SAR) cases but mandatory mid-period reports for Annual Reporting/Child Only (AR/CO) cases, verification shall occur with the SAR 7 or SAWS 2 Plus for SAR cases or any time during the AR/CO payment period for AR/CO cases.

CWDs shall make this change effective January 1, 2014. If the policy is currently automated, the policy change should be automated into the consortia systems by the effective date provided, or a process must be put in place to meet the requirements of the policy until necessary automation changes are completed. Due to the timing of the release of this ACL and the implementation date of January 1, 2014, if the grant amount for the month of January is not adjusted prior to the issuance of the January grant, the county shall issue a supplement for the month of January 2014 and any subsequent months in which the child was not included in the AU while receiving treatment in a public or private hospital on or after January 1, 2014. All supplemental underpayments are to be paid to the AU in accordance with regulations at MPP Section 44-340. For cases where the child was removed from the AU prior to January 2014 due to staying in a public hospital for longer than two months, at the next natural point of contact with the family, such as the client making a mid-period report or submitting a SAR 7 or SAWS 2, the CWD shall review the case file to determine if the child remains in the hospital. If so, the CWD shall issue any appropriate supplements effective January 1, 2014. No supplements shall be issued for any months prior to January 2014.

For CalFresh cases CWDs should continue to evaluate household circumstances on a case-by-case basis. AB 419 does not make any changes to CalFresh policy. As such, there may be cases in which individuals who are staying in a hospital for extended periods will be treated differently for the two programs.

CDSS will promulgate new regulations with reference to the applicable MPP section and notify CWDs of the new regulations via an ACL.

ACL 14-05 (January 13, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-05.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs): Five Percent Increase To The Maximum Aid Payment (MAP) Levels

The purpose of this All County Letter (ACL) is to inform the County Welfare Departments (CWDs) of changes to the CalWORKs program pursuant to AB 85, which was signed by the Governor on June 27, 2013. This letter includes instructions to be

used in the implementation of the five percent Maximum Aid Payment (MAP) increase.

The CalWORKs MAP increase takes effect on March 1, 2014. This policy change should be automated into the consortia systems by the effective date provided, or a process must be put in place to meet the requirements of the policy until necessary automation changes are completed.

ACIN I-05-14 (January 15, 2014)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2014/I-05_14.pdf

Sharing information With Caregivers

The California Department of Social Services (CDSS) wishes to remind counties of the importance of sharing information with caregivers in child welfare cases. **Information sharing is not only permitted under state and federal law, it is required.** Giving caregivers such information better enables them to meet the needs of children and youth living in their homes.

This All County Information Notice (ACIN) addresses information about the parents and the minor dependent child that should be shared with the caregiver as well as limitations on information sharing. Additionally, this ACIN describes approaches to sharing information in situations where the law appears to create barriers. This ACIN does *not* address sharing of information regarding nonminor dependents (NMDs), as NMDs are legal adults and have more control over what personal medical, mental health, and educational information is shared with others.

ACL 14-04 (January 14, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-04.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs): Cash Aid And Pregnancy Special Needs (PSN) For Pregnant Women With No Other Eligible Child

This ACL is set forth below in its entirety:

The purpose of this letter is to provide instructions to County Welfare Departments (CWDs) on the implementation of AB 1640, which expanded eligibility, under some circumstances, for CalWORKs aid for pregnant women with no other eligible children, beginning January 1, 2013. AB 1640 provides that a pregnant teen age 18 or younger, with no other eligible children in the home, can be eligible for CalWORKs cash aid and \$47 in pregnancy special need (PSN) payments upon verification of pregnancy. This rule applies when the Cal-Learn Program is operative. The Cal-Learn program was temporarily suspended from July 1, 2011 through June 30, 2012, as a result of SB 1041, and was reinstated July 1, 2012.

Prior to the passage of AB 1640, a pregnant woman with no other eligible child in the home was eligible for CalWORKs cash aid and \$47 in pregnancy special needs (PSN) payments beginning in the third trimester of her pregnancy. In other words, a "pregnant woman only" (PWO) case meant that the woman was eligible for CalWORKs cash aid and PSN payments in the month of the child's birth and the three months immediately prior to the birth month, pursuant to MPP Section 44-211.6. The exception to this rule was when the PWO was also eligible for Cal-Learn. A PWO who was eligible for Cal-Learn was also eligible for cash aid and PSN at any time after providing medical verification of her pregnancy and not limited to the last trimester of her pregnancy.

Prior to the passage of AB 1640, a pregnant (PWO) teen who was age 18 or younger and who had graduated from high school or obtained a high school diploma or its equivalent, would not be eligible for CalWORKs or PSN payments until her third trimester. With the passage of AB 1640, a PWO who is 18 years of age or younger, now may be eligible for CalWORKs and PSN payments upon verification of her pregnancy, regardless of whether she is eligible for the Cal-Learn program.

This law change was effective January 1, 2013; however due to challenges in attempting to isolate this population for time-on-aid tracking requirements and the uncertainty of policy changes anticipated with the pending implementation of the Affordable Care Act (ACA) or Covered California, implementation instructions were delayed. Upon receipt of this ACL, CWDs must implement the new rule immediately, by providing instructions to staff and ensuring new applicant eligibility is reviewed and approved in accordance with this law change.

CWDs must review cases at intake, redetermination, and during processing of the SAR 7 to identify clients who may have been eligible for expanded eligibility (e.g. additional CalWORKs aid payments and PSN payments from the date of pregnancy verification). Upon determining that a client would have been eligible to receive cash aid and PSN, the CWD shall provide a supplemental payment in accordance with MPP Section 44-340.

Once a pregnant teen is added through AB 1640, they remain eligible based on the pregnancy until they become financially ineligible or the pregnancy ends. This is true even if the pregnant teen reaches her 18th birthday prior to her third trimester. When determining eligibility for this cash supplement, CWDs must also review Welfare-to-Work (WTW) participation requirements and time-on-aid for this population.

When issuing the supplemental payment for any retroactive AB 1640 coverage, the CWDs are prohibited from retroactively counting the 24-month clock, unless the teen was offered the full WTW opportunities and services. Clients who receive the retroactive supplement payment shall be granted good cause from WTW participation for the period between the client meeting AB 1640 eligibility requirements and when regular CalWORKs was actually granted in the third trimester, if applicable.

24/48/60-Month Time Clocks

Current WTW exemption rules will apply to this population, with regard to pregnancy and whether it prevents the woman from participating in WTW activities, as well as all other exemptions. This letter provides clarification regarding pregnant and parenting teens for CWDs to accurately count the months of aid for the AB 1640 population (see Attachment A).

CWDs are reminded that the 24-month time clock never starts until the CWD has performed the comprehensive discussion and the individual has signed a WTW plan that identifies all the necessary supportive services (ACL 12-67).

ACL 13-100 (December 13, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-100.pdf>

Implementation Of Assembly Bill 1712 (Chapter 846, Statutes Of 2012) Non-Minor Dependent Adoption

This ACL is to provide county child welfare departments, county probation departments, licensed private adoption agencies, and the California Department of Social Services (CDSS) Adoption District Offices with instructions regarding the policies and procedures for the adoption of young adults age 18-20 that remain in Extended Foster Care (EFC) and are under the jurisdiction of the juvenile court. Young adults who remain in EFC are referred to as a Non Minor Dependent (NMD) as defined in W&IC section 11400(v). This definition includes NMDs served under an agreement between the state and tribes pursuant to W&IC section 10553.1 or supervised by probation.

Background

The signing of AB 12 into California law enacted California's implementation of optional provisions of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008. The AB 12, initially referred to as EFC and henceforth, known as the After 18 Program in this ACL. The primary goals of this program are to support youth who are in care to achieve permanency, including adoption as well as to assist them in preparing for successful adulthood. The NMD adoption will allow for youth age 18-20 to be adopted in juvenile court while retaining the extension of benefits afforded to them under the After 18 program. Adoption Assistance Program (AAP) benefits will be available to families who complete a NMD adoption through the juvenile court provided all other eligibility criteria are met. The NMD must be eligible for After 18 benefits as outlined in ACL No. 11-69 in order to qualify for NMD adoption.

This ACL provides framework for the process and implementation of NMD adoption in the juvenile court. Case planning for the NMD should include, but not be limited to, assisting the NMD in identifying permanent connections, including facilitating contact with a relative or a prospective tribal customary adoptive parent, and documenting the NMD's desire to be adopted by an adult who has been established as the NMD's permanent connection.

ACL 14-06 (February 5, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-06.pdf>

ICPC Regulation 4, Residential Placement, Amended And Adopted by The Association Of Administrators Of The Interstate Compact On The Placement Of Children (AAICPC), Effective October 1, 2012

This ACL provides a copy and summary of the amended ICPC Regulation 4, which governs residential placement of children across state lines. Additional instructions are also provided to ensure counties meet the new regulatory requirements. The amended regulation must be read in conjunction with this ACL.

Intent

The regulation provides for the protection and safety of children placed in a residential facility in another state and applies to all sending agencies including parents, guardians, courts or agencies ultimately responsible for the child's planning, financing, and placement. It requires a receiving state to approve requests prior to placement, to monitor the facility, to keep a record of children while placed and if necessary, to notify a sending state of changes of status at the facility that may be contrary to the child's interests. Compliance by both states prevents financial or physical abandonment of children in receiving states. All sending and receiving agencies are required to adhere to the amended regulation for residential placements entering and leaving California via the ICPC.

The regulation details the process and time lines for residential placements, clarifies supervision responsibilities of both sending and receiving agencies and sets forth conditions for the child's return to a sending state. It obligates compliance with ICPC Article V, which requires the sending agency to retain jurisdiction and responsibility for a child until the child becomes independent, self-supporting, is adopted or both sending and receiving agencies concur to close the placement.

Placements that occur before the receiving state has approved the proposed placement pursuant to Article III(d) **are a violation of the ICPC. When the child is placed prior to ICPC approval, the sending agency and residential facility are liable and responsible for the child's safety.** The receiving state may, but is not required to, proceed with the request and may require immediate removal of the child until it has made a placement decision, in addition to other Article IV remedies.

ACL 14-12 (February 4, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-12.pdf>

California Work And Opportunity And Responsibility To Kids (CalWORKs) Family Stabilization Program

This ACL is set forth below in its entirety:

The purpose of this All County Letter (ACL) is to provide counties instructions and materials for implementing the CalWORKs Family Stabilization (FS) Program established by AB 74. Effective January 1, 2014, FS is a new component of the CalWORKs program that provides intensive case management and services to clients that meet the criteria set forth in AB 74. FS is designed to ensure a basic level of stability within a family prior to, or concurrently with, participation in welfare-to-work (WTW) activities. The goal of FS is to increase client success in light of the flexible WTW 24-Month Time Clock through more intensive case management and the assignment of clients to the additional activities or barrier removal services necessary to ultimately achieve self-sufficiency. CalWORKs recipients are eligible to participate in FS if a county determines that a family is experiencing an identified situation and/or crisis that is destabilizing the family and would interfere with adult clients' ability to participate in WTW activities and services.

The passage of Senate Bill 1041 (Chapter 47, Statutes of 2012), established a prospective 24-month time limit, known as the WTW 24-Month Time Clock, for CalWORKs clients to participate in WTW activities without the hourly participation requirement for core activities. This change allows clients to receive a wide array of services and supports in order to enter and remain in the workforce for a cumulative period of 24 months. If the WTW 24-Month Time Clock is exhausted, clients must meet core hourly requirements in activities aligned to federal standards. In order to maximize the benefit of this new flexibility, AB74 enacted additional changes, including improvements to the process for initial engagement of CalWORKs clients in the WTW program. These reforms include FS and a new comprehensive appraisal process, which will be addressed in a separate ACL.

Family Stabilization Services

The FS program provides intensive case management and services that may be in addition to those provided by the county's WTW program to clients who are experiencing an identified situation or crisis. The County Welfare Department's (CWD) FS program will assist its clients transition to WTW 24-Month Time Clock activities that are best aligned with their continued success in the CalWORKs program, including education/training, work study, subsidized employment, or less intensive barrier removal activities. The FS services may be provided at any point in the WTW continuum, so long as the AU contains an eligible adult with time remaining on his or her WTW 24-Month Time Clock. The new robust appraisal process will improve the early identification of clients in need of FS services. WTW clients, however, may be eligible for FS at the referral to/participation in Job Search and at any time during participation in WTW 24-Month Time Clock activities.

Although not an exclusive list, W&I Code Section 11325.24 (a) (2) defines the type of situation or crisis that may qualify a client for FS. These situations or crises include, but are not limited to:

- Homelessness or imminent risk of homelessness;
- A lack of safety due to domestic violence; and/or
- Untreated or undertreated behavioral needs, including mental health or substance abuse-related needs.

Examples of additional services that counties may provide under FS include:

- Treatment for family members, if the situation interferes with client's ability to participate in WTW activities;
- Intensive day treatment, non-medical outpatient drug free treatment, and residential treatment;
- Emergency shelter;
- Movement to transitional housing;
- Rehabilitative services; and/or
- Substance abuse counseling/treatment.

However, FS is funded through the Temporary Assistance for Needy Families block grant and therefore, can only be used for non-medical services. FS does not alter the extent of services that can be offered through the mental health and substance allocation.

Intensive Case Management

A significant difference between the FS program and services clients might otherwise receive under the WTW 24-Month Time Clock is the increased level and intensity of case management. Specifically, FS case managers must have a lower caseload and more frequent contact with clients, especially upon initial acceptance into the program. Some examples of what additional support intensive case management may provide to clients participating in FS include the following:

- Ensure that each family understands the program and services available.
- Provide prompt referrals to appropriate, available community services needed to assist the family in order to be involved concurrently, or transition into, WTW 24-Month Time Clock activities.
- Develop a FS Plan in order to assist the family to regain stability and ultimately enter into a WTW plan.
- Frequent and on-going contact with each family, ranging from daily to weekly,

- depending on level of need and progress in FS, via phone and/or in-person, along with service providers to determine the effectiveness of service provision.
- Assess weekly progress toward FS plan goals and make the necessary changes to improve the family's success in meeting these goals.
 - Provide WTW program exemption, program deferral, good cause, and/or any other recommendations.
 - Make every effort to engage families who are not making adequate progress which may include home visits.

Eligibility for Family Stabilization Services

If in the course of appraisal, pursuant to W&I Code Section 11325.2, or at any point during a client's participation in WTW activities, it is determined that a case meets the eligibility criteria for FS, then eligible members of that case may enroll in those services and receive additional support and services.

All assistance units (AU) that contain individuals who are required to participate in the WTW program are eligible for FS services. This includes AUs in which the only adult is:

- Non-compliant;
- Sanctioned; or
- A recent non-citizen entrant.

FS services are not limited to the aided or work eligible adult and should address FS issues of the children in the AU and ineligible unaided AU members.

The following are ineligible for FS services:

- AUs that only include WTW clients who have exhausted the WTW 24-Month Time Clock prior to the basis for qualifying for FS;
- AUs that do not include an work eligible adult who is required to participate in WTW;
- Cases where all adults have exceeded the 48-month CalWORKs time limit;
- Drug and fleeing felons;
- Ineligible non-citizens;
- Non-needy caretaker relatives; and
- Adults receiving Social Security Supplemental Security Income.

As stated above, FS is designed to provide support to families in crisis during the process of engagement in the WTW program. However, a WTW client may request a review to determine eligibility for FS services at any time during the WTW 24-Month Time Clock. Since it is important to rapidly provide FS services to stabilize the family, the full WTW assessment or other testing should be integrated into the FS plan and should not delay the provision of FS services. If the CWD determines that the individual is ineligible for FS services, the CWD must issue an adequate notice of action (NOA) that includes an explanation of his or her hearing rights. Under a separate cover, CDSS will issue a specific statewide NOA to CWDs for use. In the interim, CWDs may develop their own NOA that must include hearing rights for notifying clients of their eligibility and ineligibility for FS services. The CWDs should reference ACIN I-02-14 regarding specific requirements for adequate notices.

Individual Client Family Stabilization Plans

Upon a CWD's determination that a family qualifies for FS services, the CWD must develop an individual family stabilization plan for the family. The CWDs may wish to designate a special unit or staff to provide FS services and develop FS plans. In any

event, CWDs shall ensure that any staff developing FS plans or providing intensive case management should have training, skills and experience in providing case management to families and individuals in crisis. The CWD case managers should develop a comprehensive plan that assists the family in resolving the identified situation or crisis that:

- Assesses the stability of the family's living situation, physical and emotional health, and safety;
- Provides intensive case management and referrals to appropriate services needed to assist the family;
- Provides supportive services for FS plan activities as needed;
- Reduces the chance of reoccurring crises;
- Enhances the family's ability to resolve issues; and
- Monitors each family's progress toward making the necessary changes to improve the situation or crisis.

After an FS assessment, CWDs shall review the existing WTW plan, if any, to determine whether it should continue or require modification based on the client's assessment. Counties may also develop an alternative FS Plan form. In addition, CWD case managers should assess the use of current programs that could be used in conjunction with FS services (such as the existing Homeless Assistance Program) when developing a client's FS Plan.

FS Compliance and the WTW 24—Month Time Clock

Clients participating in FS are not subject to WTW minimum hourly participation requirements. However, FS clients must comply with the requirements of the FS plan developed by the CWD, with the assistance of FS intensive case management. Participation in FS services will stop a client's WTW 24-Month Time Clock for up to six cumulative months (W&I Code Section 11322.85 (6)) if the CWD makes a finding that if the client was required to participate in WTW, he or she would meet the criteria for good cause for failing to participate in WTW activities found at W&I Code Section 11320.3(f). However, FS services may be provided to clients, who at initial engagement or thereafter may need additional assistance to transition into a WTW plan, but who would not have ultimately qualified for good cause for failure to participate in WTW activities. Also, the length of time clients remain in FS is dependent upon the individual circumstance of each family.

If a client is not complying with their FS plan, the CWD case worker should explore if the client may need a WTW exemption. If a client is not complying with their FS plan or making progress towards FS plan goals, and is not found to be exempt from WTW, then after exhausting additional attempts to assist clients via intensive case management the CWD must initiate the non-compliance process. Part of this process should consider whether FS services remain appropriate for the client or if the client is able to participate in WTW.

CWD Family Stabilization Plans Submittals

The CWDs are required to use the Assembly Bill (AB 74) County Welfare Department Family Stabilization (FS) Plan (WTW 40) to submit a written plan to the CDSS by March 31, 2014, that describes their FS program. Please contact the CDSS Employment

Bureau at (916) 654-2137 for a Microsoft Word version of the template. The CWDs should include any policy documents or county forms to document progress of FS clients, including, but not limited to the FS plans for clients described above. Additionally, FS plans should include services specifically targeted for non-compliant and sanctioned households.

The CWDs shall submit completed plans electronically to FSProgram@dss.ca.gov. The CDSS Employment Bureau will review county submittals and contact the county with any questions. All county FS plans will be posted on the CDSS website after being reviewed by the CDSS. The CWDs must submit updated plans to the CDSS if the county makes significant changes to its FS Program.

Family Stabilization Reporting Requirements

Beginning April 20, 2014, and quarterly thereafter, counties must submit to the CDSS the following information regarding their FS programs The total monthly number of CalWORKs cases served under FS;

- The total monthly number of individuals who received FS services;
- The total monthly number of FS cases who discontinued receiving FS services;
- The total monthly number of FS cases who began participating in WTW;
- The total monthly number of FS cases who participated concurrently in WTW;
- The total monthly number of FS cases who were provided good cause;
- The total monthly number and type of services received by FS cases; and
- A narrative description of any lack of availability of FS services.

Under a separate cover, the CDSS Data Systems and Survey Design Bureau will provide a separate reporting form for CWDs to submit the information above.

ACL 14-09 (February 5, 2014)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2014/14-09.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Program: Senate Bill (SB) 1041 (Chapter 47, Statutes Of 2012) Extensions To The CalWORKs Welfare-To-Work (WTW) 24-Month Time Clock

This ACL is set forth below in its entirety:

The purpose of this letter is to provide initial instructions regarding extensions to the WTW 24-Month Time Clock, as described in WIC Sections 11322.86 and 11322.87. This letter is intended as a general overview of the extension process and provides the methodology for calculating the number of extensions available to each County Welfare Department (CWD) as required in WIC Section 11322.86(c).

The establishment of the WTW 24-Month Time Clock, along with other changes to the CalWORKs up-front client engagement process, represents one of the most significant policy transformations to the CalWORKs program in the last 15 years. The increased flexibility for clients during the 24-month period, elimination of the WTW core and non-core hourly requirements, and alignment of work participation requirements with federal hourly requirements is intended to support clients' opportunities to reach self-sufficiency. To augment those efforts, CWDs have been instructed to use early engagement strategies and offer barrier removal

services as needed, not only to help clients achieve self-sufficiency, but also to help them be able to meet CalWORKs federal standards by the time they reach the end of their WTW 24-Month Time Clock.

Initial implementation instructions for the WTW 24-Month Time Clock program changes are contained in ACL 12-67 and ACL 12-69. The California Department of Social Services (CDSS) followed up with clarifying instructions through four additional Question and Answer (Q&A) ACLs: ACL 13-15, ACL 13-37, ACL13-59 and ACL 13-68. Please refer to these ACLs for a general understanding of the WTW 24-Month Time Clock.

Calculation of a Client's WTW 24-Month Time Clock

Prior to determining whether a client meets the WTW 24-Month Time Clock extension criteria, CWDs must thoroughly review a client's case to ensure an accurate accounting of his or her WTW 24-Month Time Clock, in accordance with instructions provided in the ACLs referenced above. For any given month, in which the client had good cause not to meet the participation requirements, that month does not count against the 24 months. The CWDs are reminded that ACL 12-67 states the WTW 24-Month Time Clock applies to all adult CalWORKs clients who are required to participate in the WTW program. Persons who are unaided or otherwise excluded by law are not subject to the WTW 24-Month Time Clock. If an aided adult reaches his or her 48-month CalWORKs time limit before exhausting the WTW 24-Month Time Clock, the adult is removed from the Assistance Unit (AU), and is no longer required to participate in WTW. Therefore, the WTW 24-Month Time Clock no longer applies and these individuals are not eligible for an extension.

Noticing Clients when the end of the WTW 24-Month Time Clock is approaching

The notice provided to clients as they near the end of the WTW 24-Month Time Clock is an important component in the extension request process. As instructed in ACL 13-12, and pursuant to WIC Sections 11322.85(c) and (d), CWDs are required to provide a Notice of Action (NOA) in order to adequately inform clients of the following:

- The number of months that have counted toward their WTW 24-Month Time Clock;
- The ability to modify their WTW plan to meet federal requirements and continue to receive aid;
- The ability to seek an exemption from the WTW 24-Month Time Clock and Participation; and
- The ability to extend their WTW 24-Month Time Clock.

As released in ACL 13-12, the CW 2208, "Your WTW 24-Month Time Clock" is to be provided to clients at the following periods:

- At application for CalWORKs cash aid, and
- At clients' annual redetermination.

In addition, CDSS is developing a new NOA to be released in an upcoming ACL that conforms to ACL 13-12 and WIC Section 11322.85. This upcoming NOA will inform clients of their WTW 24-Month Time Clock information, as described above, at least once between WTW 24-Month Time Clock months 18 and 21.

At the client's request, CWDs are strongly encouraged to discuss the status of the CalWORKs clients' WTW 24-Month Time Clock and the options available to them at any time.

In addition to the NOA, CWDs must also send a CW 2186A to provide clients the opportunity to request a CalWORKs 48-month time limit and/or WTW 24-Month Time Clock and Participation exemption. Please refer to ACL 12-67 for a list of existing WTW 24-Month Time Clock exemptions and CalWORKs 48-month time limit exemptions.

WTW 24-Month Time Clock Extension Criteria

Pursuant to WIC Sections 11322.86 and 11322.87, a client subject to the WTW 24-Month Time Clock who still has time remaining on the CalWORKs 48-month time limit and is unlikely to meet CalWORKs federal standards, may request an extension to the WTW 24-Month Time Clock. The client may present evidence to the CWD that he or she meets any of the following circumstances:

- The client is likely to obtain employment within six months;
- The client has encountered unique labor market barriers temporarily preventing employment, and therefore needs additional time to obtain employment;
- The client has achieved satisfactory progress in an educational or treatment program, including adult basic education, vocational education, or a self-initiated program that has a known graduation, transfer, or completion date that would meaningfully increase the likelihood of his or her employment;
- The client needs an additional period of time to complete a WTW activity specified in his or her WTW case plan due to a diagnosed learning or other disability, so as to meaningfully increase the likelihood of his or her employment;
- The client has submitted an application to receive Supplemental Security Income disability benefits, and a hearing date has been established;
- Other circumstances as determined by the CDSS.

The CDSS will issue additional guidance on these criteria, including a standardized form, that clients can use to request an extension as well as a determination form for the CWD to use when approving or denying a request for extension. At this time, the CDSS has not identified any "other circumstances" that may be considered for an extension.

Documentation and Verification

A CWD shall grant an extension to a client who presents evidence that he or she meets any of the extension criteria, unless the CWD determines that the evidence presented does not support the existence of the specified circumstance (WIC Section 11322.87(b)). The CDSS will issue additional guidance on the documentation that clients will need to provide in order to request an extension, and the CWD process for verification of that information, in a subsequent ACL.

In addition, if a CWD identifies that a client meets any of the extension criteria as a result of information already available to a CWD, including the client's WTW plan and verification of participation, the CWD may provide an extension of the WTW 24-Month Time Clock (WIC Section 11322.87(c)). Under these circumstances, it is not necessary for a client to initiate a request for an extension.

At any state hearing in which a client disputes a CWD's denial of an extension, the CWD shall have the burden of proof to establish that an extension was not justified in accordance with WIC Section 11322.87(b)(3).

Duration of an Extension to the WTW 24-Month Time Clock

An extension shall be granted for an initial period of up to six months, and shall be reevaluated by the CWD at least every six months (WIC Section 11322.87[d]). Further clarification regarding reevaluations of extensions will be provided in a separate ACL.

20 Percent Extension Methodology

According to WIC Section 11322.86, the CDSS will advise each CWD of the number of extensions available using a methodology that was determined through stakeholder collaboration.

To determine the target number of extensions available to each CWD, the CDSS will use CWD data from a fixed point in time that represents the number of individuals expected to reach the end of their WTW 24-Month Time Clock in the following six-month period. Using that data, the CDSS will notify each CWD of the target number of extensions that represents 20 percent of the AUs in the county in which all adult members are expected to reach the end of their 24-month period (who will not yet have exhausted their 48 months of CalWORKs) during that six-month period. If a CWD disagrees or has better data to support different target figures, the CWD will have the opportunity to submit data and arguments for consideration to the CDSS in order to modify the target.

The earliest that any client could exhaust his or her 24 months is January 2015; therefore, the first time the CDSS will provide CWDs with this information will be in December 2014. Using November 2014 data, the CDSS will provide a target number of extensions to CWDs for the January through June 2015 time period based on information derived from CWD and consortia reports. Every six months, the CDSS will provide CWDs with an updated figure for a new six-month period. Therefore in June 2015, the CDSS will send CWDs a new figure in advance for the July through December 2015 time period based on May 2015 data.

To illustrate how the process will occur, assume that in November 2014, the number of adults that have between 18 and 23 months counted toward their WTW 24-Month Time Clock in a particular county is 1,000. Twenty percent of this figure would yield a target of 200 extensions.

In December 2014, the CDSS would inform the CWD that 200 extensions may be granted for the period of January 1 through June 30, 2015. In May of 2015, the CDSS would use updated CWD and consortia data to project a new 20 percent figure for each CWD for July 1 through December 31, 2015. If new data from May 2015 shows that there are 1,200 individuals in the same CWD who have exhausted their WTW 24-Month Time Clock or who are between 18 and 23 months on the WTW 24-Month Time Clock, the new target extension figure for the CWD would be 240 through the end of the year, or an additional 40 extensions for 2015.

Should the new figure be calculated at a lower number than the prior six-month period, CWDs shall not rescind the extensions already granted in order to accommodate the lower figure.

Although CWDs are expected to monitor the number of WTW 24-Month Time Clock extensions they are granting to clients, counties shall grant extensions to those who qualify; and, therefore

it is possible that a county may exceed the target number. If a county does exceed the target number of extensions, CDSS will engage in a dialogue with the county about its application of the extension criteria and any factors that may be influencing the number of individuals qualifying for an extension. Every six months, the CDSS shall review the actual number of extension that were granted to clients in each county and engage in discussions as appropriate, especially if any CWD's actual experience differs significantly from the estimated figure.

More detailed instructions will be forthcoming in future ACLs and will include additional information regarding the ongoing calculation of the number of extensions available in each county, reporting requirements, noncompliance process, Welfare Data Tracking Implementation Project (WDTIP) codes, NOAs and forms, documentation and verification, and reevaluation of extensions.

Training And Quality Development and Special Projects Bureau

E-NOTE #114 – SUMMARY OF ACLs

January 10, 2014

Both of these ACLs are important and should be read in their entirety.

ACL 13-111 (December 31, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-111.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs)

Program: Changes In The Treatment Of Motor Vehicles

The purpose of this letter is to provide direction to County Welfare Departments (CWDs) on the implementation of AB 74, as well as the changes included in SB 98, regarding the treatment of vehicles in the CalWORKs Program. This policy change should be automated into the consortia systems by the effective date provided, or a process must be put in place to meet the requirements of the policy until necessary automation changes are completed.

This bill makes significant changes to the valuation and treatment of vehicles when determining resource eligibility for CalWORKs applicants and recipients. These changes are intended to reduce the workload on CWD staff by eliminating some of the steps currently required to determine the value of vehicles and simplifying the verification process.

The following bullet points highlight these changes:

CalWORKs applicants and recipients will now be able to retain non-exempt vehicles that have an equity value of \$9,500 or less. Equity is the amount of the Fair Market Value (FMV) of the vehicle less encumbrances (amount owed on vehicle, if any). The new law allows clients to self-certify the amount of encumbrances, if any. The department further specifies that clients may also self-certify the vehicle's FMV. Any equity value in excess of the \$9,500 vehicle asset limit will be counted as a resource attributable toward the Assistance Unit's (AU's) \$2,000 (or \$3,250 for families with an aged or disabled household member) maximum resource limit. The \$9,500 equity threshold will be adjusted upward annually for an increase, if any, in the United States (US) Transportation Consumer Price Index (CPI) for All Urban Consumers.

The existing \$1,500 equity exemption will be eliminated effective January 1, 2014. A new exemption has been added. Any vehicle for which ownership has been transferred to the client as a gift, donation, or family transfer, as defined by the Department of Motor Vehicles (DMV), will not count against the family's maximum resource limit.

The changes included in AB 74 and SB 98 become effective on January 1, 2014. AB 74 provided the California Department of Social Services (CDSS) with authority to

implement the new vehicle changes via All County Letter (ACL), to be followed by emergency regulations, which must be promulgated by July 1, 2015. SB 98 further clarified that the changes in statute apply to all motor vehicles, both licensed and unlicensed.

ACL 13-109 (December 31, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-109.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs): Federal Fiscal Year (FFY) 2014 Income Reporting Threshold (IRT)

This letter transmits the FFY 2014 IRT chart for the CalWORKs Program. It also reviews SAR rules pertaining to recipient IRT reporting requirements and the county's responsibility to notify the recipient of his/her IRT.

Training and Quality Development Bureau
State Hearings Division

E-NOTE #113 – ACIN 1-02-14 REQUIREMENTS FOR ADEQUATE NOTICE

January 8, 2013

ACIN I-02-14 (January 3, 2014)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2014/I-02_14.pdf

California Work Opportunity And Responsibility To Kids (CalWORKs) Program: Requirements For Adequate Notices

CONFIDENTIALITY, FRAUD, CIVIL RIGHTS AND STATE HEARINGS MANUAL OF POLICIES AND PROCEDURES (MPP) SECTIONS 22-001 AND 22-071 *TURNER v. MCMAHON*, AND ALL COUNTY INFORMATION NOTICE (ACIN) NO. I-151-82

Because of the importance of this ACIN, it is being reproduced in its entirety in this E-Note.

It states the following:

The purpose of this ACIN is to emphasize to County Welfare Departments (CWDs) the importance of providing adequate Notices of Action (NOAs) to CalWORKs applicants and recipients, and to remind them of the elements needed for a NOA to be considered “adequate.” Adequate notices are required so the applicant or recipient has sufficient information to understand the action that is being taken on their application or CalWORKs case.

In 1983, the *Turner v. McMahon* consent decree set the rules (often referred to as “Turner rules”) that are used to develop adequate NOAs. The Confidentiality, Fraud, Civil Rights and State Hearings Division Manual of Policies and Procedures (MPP) §22-001(a)(1) describes adequate NOAs as “A written notice informing the claimant of the action the county intends to take, the reasons for the intended action, the specific regulations supporting such action, an explanation of the claimant’s right to request a state hearing, and if appropriate, the circumstances under which aid will be continued if a hearing is requested, and for the CalWORKs Program, if the county action is upheld, that the aid paid pending must be repaid.”

Key Concepts

In many cases, the California Department of Social Services (CDSS) provides the language to be used for NOAs. The printed NOA forms are designed for specific types of action that will help the county worker provide adequate notice. In addition to filling in the appropriate blanks and checking the appropriate boxes on the NOA, the worker must assure that the notice is adequate. Every NOA sent must meet certain baseline criteria in addition to the regulatory definition in order to be adequate. Here are some key concepts to consider when creating NOAs for applicants and recipients.

The nature of what is said in the NOA is the central issue. The NOA is intended to be a personal communication to the applicant or recipient (client), addressing the client’s unique circumstances and resulting CWD action to the client’s cash aid. The NOA must provide specific information regarding items such as the amount of the family’s cash aid and how it was calculated, reasons the aid amount changed, whose income was used to calculate the new grant amount, what income was used in the calculation, and/or other circumstances that may be causing the family’s aid to be discontinued or changed.

In addition, each NOA must include client-specific information that is sufficient enough for the client to determine what the issue is, be able to understand the action taken, and decide if a request for a hearing is warranted. The worker should take the following into consideration to

ensure the NOA is adequate under the guidelines provided in this letter and at MPP Sections 22-001 and 22-071:

- What does the client need to know to understand what is happening and why?
- Does the information provided enable the client to decide if he or she agrees or disagrees with the CWD's proposed action?
- Can the client understand if there is something he or she needs to do in response to the NOA to stop or change the CWD's proposed action?

Examples of client-specific information include, but are not limited to, the following:

- Effective date of action.
- Assistance Unit (AU) or household member affected.
- Source/nature of income or property used in the action.
- Amount of income/property and the time period involved.
- Time On Aid (TOA) calculations
- Reason for the Welfare to Work (WTW) supportive services action.

The recipient should be informed of what facts were used, including the detail of computations affecting the amount of aid. ACIN I-151-82 provides examples of how CWDs can list the reason for the action so that the rule, the facts, and the application of the facts to the rule are adequately explained.

When utilizing "drop down" menus in automation systems that provide non-case specific summaries, the use of "fillable" note or "free form" fields to enter the case specifics is recommended, and completion of these fields should be required of workers. CDSS suggests that the CWD/Consortia can take steps to ensure NOAs include sufficient, adequate information by preventing a NOA from being printed or mailed if the fields are not completed. Automation systems should not permit the batch mailing (i.e. without review) of incomplete notices. On review, the CWD must ensure that sufficient case-specific information is provided prior to sending the NOA. If the automation programming does not provide for all of the information for the NOA to provide adequate information, the needed information should be hand-completed by the worker who is taking the case action to meet the requirement that the NOA contain case specific information to the client.

Readability

Turner rules require that all NOAs be written at a 6th grade level in order to be understandable. Tips to ensuring a NOA is easily understood include the following guidelines:

- a. Use short, direct sentences;
- b. Use simple words that the client can reasonably be expected to understand;
- c. Avoid multi-syllable words and acronyms as often as possible;
- d. Avoid compound sentences or combined reasons by breaking them into two sentences;
- e. Explain complicated ideas.

Language and Disability Access

CWDs are reminded that the client must be given the opportunity to choose the language to be used for their notices, and the CWD must document the client's language choice. The language

preference document, if in English, must include a notation of the name/worker number of the person who provided the interpretation of the form.

If the CWD or CDSS does not have NOAs translated into the client's preferred language, the CWD must explain that the NOAs will be issued in English, and that an interpreter will be provided at no cost to the client. In addition, if there is no CDSS translation and the CWD has not elected to translate the NOA, the English NOA must be sent to the client with a *GEN 1365-Notice of Language Services* (described later in this letter.)

The CWD must also provide a current telephone number and instructions on how to get an oral interpretation of the NOA, without a delay. CWDs may also choose to have NOAs translated into languages not provided by the CDSS. If CDSS has not provided the translation, the CWD must ensure that effective bilingual services are provided. This requirement may be met through utilization of paid interpreters, qualified bilingual employees, and qualified employees of other agencies or community resources. These services shall be provided free of charge to the client. Clients may use their own interpreter, but must not be compelled or encouraged to do so. The CWD should confirm that the self-provided interpreter is competent and should be a person who is of adult age, 18 years of age or older. The CWD should only allow a minor to act as a temporary interpreter under extenuating circumstances or at the request of the client. See All County Letter 08-65 for more information about using self-provided interpreters.

If CDSS has translated the NOA, the translated version must be sent, regardless of the size of that language population within the county. Thereafter, all NOAs are to be sent in that language, if translated by CDSS. If there is no CDSS translation and the county has not elected to translate the NOA, the English NOA is to be sent with the *GEN 1365-Notice of Language Services*. MPP §21-115.16 requires the CWD to either provide the NOA in the client's preferred language or to provide an interpreter if CDSS does not supply a NOA in that language. The GEN 1365 includes a statement in 16 different languages that instructs clients to call the CWD if they need help understanding the NOA they received and includes a local telephone number for requesting interpretive services at no charge to the client.

The Confidentiality, Fraud, Civil Rights and State Hearings Division MPP §22-001(l)(1) sets out the requirements for a NOA to be language compliant. For translated NOAs, the "fill-in" portion of the NOA must also be in the language of the notice, including the informing notice on the reverse side (NA Back 9) (MPP §21-115.2).

In regards to clients who have literacy or learning disability issues that interfere with their ability to read or understand written instructions, the CWD must flag the case as requiring reasonable accommodation, and provide the accommodations when sending out a NOA. This can include but is not limited to a message on the NOA to call the CWD if the client has any questions, provide a follow up call to advise the client of the county action, to call the CWD for an oral explanation if he/she receives paperwork, or for the visually impaired clients, sending the notice in large print.

Specific Regulations

As explained in ACIN I-151-82, the body or text portion of a NOA must explain the "essence" of the rule (in addition to the reason why the action is being taken). For example, the income eligibility rule at MPP §44-207.2 is that the family's countable income must be below the Maximum Aid Payment for their family size. The "essence" of this rule, which must be explained in the body of the NOA in text, is "income, unless it is a type that we do not count against your

grant, must be below the grant level for your family size in order to be eligible.” The specific facts would go on to say what income the family has, why the CWD is using a different amount from what the client reported, whether any of the income may have been excluded and why, and how the grant was calculated.

The NOA must also list the specific regulations that support the CWD’s action. While CWDs can include a citation to the general regulatory section (such as income), it must also include the specific citations to the regulations that apply in this specific case action. For example, NOAs regarding case actions based on income, must also include a specific citation that covers the type of income used in the grant calculation and any other regulations used to support the action taken by the CWD (e.g. Manual of Policies and Procedures Section 44-111 if excluding any income.)

Checklist

CWDs can use the following checklist to test the adequacy of a NOA. Though individual elements of the NOA can be tested with the questions below, the ultimate test is whether the NOA, as a whole, clearly provides the recipient with the information he/she needs as described above.

- Effective date shown?
- Description of the action complete?
- Amount of the aid payment shown?
- Reason for the action given?
 - Basis in state regulation described?
 - Cited?
 - Family’s circumstances that caused action shown?
- All pertinent computations provided in adequate detail and specifically identified with the persons to whom they pertain?
- Statement of information needed to reestablish eligibility or determine the correct amount of aid? (Use when pertinent.)
- Denials and discontinuances: Standard child support and family planning statements provided?
- Entire notice complete with adequate detail?
- Language clear and understandable?

E-NOTE #112 – SUMMARY OF ACLs/ACINs/ACWDLs/MEDILs/DHCS NEWS RELEASE

January 3, 2014

Medi-Cal Eligibility Division Information Letter No.: I 13-15

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%20I13-15.pdf>

December 31, 2013

SUBJECT: Temporary Eligibility for Medi-Cal Pending Cases

This MEDIL is the following in its entirety:

In response to the significant number of Medi-Cal applications received through the Covered California portal, and consistent with the Department of Health Care Services' (DHCS) commitment to ensuring a high-quality consumer experience for the Medicaid expansion in California, the Department is taking administrative action to provide temporary Medi-Cal eligibility for individuals who have submitted online applications to Covered California via the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) but require counties to complete the necessary administrative verifications. Administrative verifications could include state residency, citizenship, immigration status and income.

This process will provide presumptive eligibility for adults and children that are currently pending for verifications in CalHEERS. The consumers who will receive presumptive eligibility through this process are based on a point in time report of consumers who are listed as Medi-Cal "pending" status in CalHEERS. The initial report for such individuals is as of December 14, 2013. Consumers with duplicate applications will have the last dated application used for determining eligibility. It is important to note that the pending status for these consumers will remain in CalHEERS, so that counties will be able to identify those individuals needing verifications. Also note that consumers with unknown, inconsistent, or otherwise problematic Client Identification Numbers (CINs) will not be provided presumptive eligibility. In addition, for consumers that have been determined eligible for Medi-Cal in an ongoing aid code (not presumptive), their current aid code will not be over-written by the presumptive eligibility aid code of 8E. The '8E' aid code will be used for both adults and children for this population. On an ongoing basis, the 8E aid code will continue to be used for children in Accelerated Enrollment through the single point of entry.

Consumers affected by this administrative process will be sent a letter by DHCS (sample attached) to inform them of their presumptive eligibility status, to request that they respond to any inquiries for verifications requested from the county, and to inform them that their BIC will be mailed shortly and their coverage will be

effective as of January 1, 2014. Counties must follow the two contact requirement for obtaining verification data needed from consumers to determine eligibility. See All County Welfare Directors Letter 08-07 for more information on the two contact requirement. Eligibility transactions for the first group of individuals will be sent to MEDS (Medi-Cal Eligibility Data System) starting the week of December 23, 2013 and consumers' eligibility will be effective January 1, 2014.

As additional cases are targeted for this effort, DHCS will provide counties with a list of consumers that have been granted presumptive eligibility through this process and guidance on the effective dates of coverage for such individuals. Counties must continue to process eligibility verifications for these consumers, with adults as a priority from the oldest application date. Children are to be second priority, also working from the oldest application date.

Counties are instructed to do an ex-parte review prior to requesting any verification from the consumer. For example, if there is an active case in another public program and/or a closed case within the last 45 days (consistent with SB 87 requirements), counties may use that information to satisfy the verification. Pursuant to Section 14005.37(e)(1) of California Welfare and Institutions Code, starting January 1, 2014, a case can be closed within the last 90 days and still be used for verifying consumer information. Counties may use any information available to satisfy the state residency verification up to and including information for other social services programs. Counties will use existing policy to request information following the two contact rule for applications in ACWDL 08-07. Consumers can be denied after counties follow the two-contact requirement if there is no response.

Until the interface between SAWS (Statewide Automated Welfare Systems) and CalHEERS is operational, counties must process the verifications and re-run eligibility in CalHEERS. There is a verifications process guide for CalHEERS available for county eligibility workers to use.

The intent of this policy is that counties should complete the eligibility determination process and have a final disposition for these consumers no later than March 31, 2014.

Note: As indicated in this MEDIL, DHCS is doing the presumptive eligibility administratively at the state level. No notice of action is sent to an applicant informing them that he/she has been authorized Medi-Cal benefits. If and when the county determines that an applicant fails to submit the requested verification documents needed for a full eligibility determination, the county will send the applicant a discontinuance notice of action, and the applicant can request a state hearing if he/she disputes that determination.

News Release From DHCS is set forth in its entirety:

NUMBER: 13-07

December 31, 2013

CALIFORNIA'S LOW INCOME HEALTH PROGRAM TRANSITIONS HUNDREDS OF THOUSANDS OF NEW MEMBERS TO MEDI-CAL

SACRAMENTO, Calif. – Department of Health Care Services (DHCS) Director Toby Douglas announced today that more than 630,000 Californians from the state's Low Income Health Program (LIHP) will become Medi-Cal members on January 1.

Medi-Cal will immediately begin serving the former LIHP members, which is a group comprised of uninsured, childless adults ages 19 to 64, and parent and caretaker relatives, all with incomes below 138 percent of the federal poverty level. They will receive quality health care services from California's statewide network of Medi-Cal managed care plans, as well as mental health, substance use and long-term care services.

The vast majority of former LIHP members will remain with the same medical provider in Medi-Cal that they saw under LIHP. About 24,000 LIHP members have incomes too high to qualify for Medi-Cal. They may apply for coverage through Covered California, the state's health benefit exchange.

"California made a wise decision in 2010 to work with our county and federal partners to bring health care reform to the state early by providing coverage to uninsured childless adults under the LIHP," said Douglas. "This program was critical to our preparation for the full ACA Medicaid expansion on January 1. It allowed us to strengthen our provider networks and expand our use of the more coordinated services provided by organized delivery systems."

In partnership with the Legislature, 53 participating counties, and the federal Centers for Medicare and Medicaid Services, California enacted and implemented the state's "Bridge to Reform" waiver in 2010, which allowed the launch of the LIHP. Through the LIHP, counties and other local entities enhanced their primary and specialty care provider networks to meet the health care needs of program enrollees through a coordinated and managed approach that included the use of medical homes.

"The success of the LIHP program and the launch of the Medi-Cal expansion could not have happened without the tremendous partnership of California's county health and human services agencies," said Douglas. "We are extremely grateful for their support and we look forward to continuing our work on behalf of Californians in need."

DHCS has worked closely with Covered California to build and jointly operate CoveredCA.com, a one-stop-shop for health care coverage enrollment in California. Since the website's October 1 launch through the month of November, over 180,000

applicants have been found likely eligible for Medi-Cal. Another 280,000 applicants applied for Medi-Cal in October and November through the existing Medi-Cal county application process. Enrollment for Medi-Cal is open throughout the year, with coverage retroactive to the date an application is received.

Please visit “Medi-Cal Eligibility and Covered California - Frequently Asked Questions” on the DHCS [website](#) for additional information.

ACL 13-108 (December 31, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-108.pdf>

Implementation Of Assembly Bill 191 (Chapter 669, Statutes Of 2013) – CalFresh Categorical Eligibility For Medi-Cal
ACL is set forth below in its entirety:

The purpose of this All County Letter (ACL) is to provide County Welfare Departments (CWDs) with information on the implementation of Assembly Bill (AB) 191 (Chapter 669, Statutes of 2013) effective January 1, 2014.

AB 191 requires the California Department of Social Services (CDSS), to the extent permitted by federal law, to design and implement a program of categorical eligibility (CE) for CalFresh, for any household that includes a member who receives, or is eligible to receive, assistance under the Medi-Cal program. AB 191 also requires the use of the maximum federal gross income limit (200 percent of the Federal Poverty Level [FPL]) allowable for conferring CE via a non-cash Temporary Assistance for Needy Families (TANF) funded service (see ACL No. 12-62). Therefore, those CalFresh applicant and recipient households with income at or below 200 percent of the FPL with a household member who receives (or is eligible to receive) Medi-Cal would also be categorically eligible for CalFresh providing the household meets all other CalFresh eligibility requirements other than the CalFresh resource limits. The CDSS is currently working with the Department of Health Care Services, the California Welfare Director’s Association and the Statewide Automated Welfare System to implement an automated process for identifying and processing these households. In the interim, a workaround at the county level will be necessary. As soon as additional information is available, an updated ACL with specific implementation instructions will be issued.

As stated, the effective date of this statute is January 1, 2014. Therefore, if CWDs are not able to implement the provisions of the statute as of that date, impacted households must be tracked and provided benefits retroactive to January 1, 2014. In addition, households recertifying during this time shall not have their CE removed if their gross income is between 130 percent and at or below 200 percent and are receiving, or eligible to receive, Medi-Cal.

CalFresh households with a Medi-Cal recipient that is determined to be ineligible for CalFresh benefits effective December 31, 2013 due to gross income over 130 percent, will be discontinued and must reapply for CalFresh benefits as AB 191 is not effective until January 1, 2014.

ACWDL - 13-26 (December 24, 2013) Increase in Substantial Gainful Activity (SGA) Wage from \$1,040 per month to \$1,070 per month,

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-26.pdf>

Effective January 1, 2014

The purpose of this letter is to notify counties that the federal SGA amount will increase to \$1,070 effective January 1, 2014. All SGA determinations made on or after January 1, 2014, shall utilize the new amount. If counties are unable to implement this change in SGA by January 1, 2014, once the change is implemented, counties must retroactively redetermine Medi-Cal eligibility based on disability if a case has been denied erroneously or budgeted incorrectly.

SGA is the maximum amount of wages a person can earn in a month and still be considered disabled. The SGA level is set by the Social Security Administration and may be changed annually based on the national average wage index. Applicants who have average monthly earnings at the SGA level cannot be considered disabled even if severe physical or mental medical impairments exist. However, SGA rules do not apply to legally blind individuals who meet the federal Supplemental Security Income criteria, Medi-Cal beneficiaries who return to work after disability has been approved, or to persons applying for Medi-Cal under the 250 Percent Working Disabled Program.

Further, for work activity to be considered substantial, it need not necessarily be performed on a full-time (eight hours per day) basis. SGA is the first consideration in determining whether an applicant will be disabled under federal disability guidelines.

ACL 13-107 (December 30, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-107.pdf>

Changes To The CalFresh Employment And Training Program With The Passage Of Senate Bill 134

The purpose of this letter is to inform County Welfare Departments (CWDs) of the passage of Senate Bill (SB) 134 and to explain the impact of this legislation on CalFresh Employment and Training (E&T) requirements. SB 134 amends Section 18926.5 and adds Section 18926.6 to the Welfare and Institutions Code. The changes identified in this All County Letter (ACL) are effective January 1, 2014.

The CalFresh E&T Program is California's employment and training program for non-assistance CalFresh applicants and recipients. Within the CalFresh work registrant population, certain persons may be temporarily excused or "deferred" from participation

in E&T for reasons that include those listed in the Manual of Policies and Procedures (MPP) Section 63-407.811. With the passage of SB 43 in 2012, individuals are also deferred from E&T if they are (1) under 18 years of age or 50 years or older, (2) living in a CalFresh household with a child under 18, or (3) living in a federally determined work surplus area. Individuals that are deferred from E&T may participate on a voluntary basis.

SB 134 adds to the existing E&T deferrals those work registrants who are veterans that have been honorably discharged from the United States Armed Forces.

Verification of Honorable Discharge Status

County case workers shall inquire into the military service history of clients within the CWD's E&T target population. The CWDs shall verify a claim of honorable discharge from the military by requiring the veteran to submit a completed DD 214 or other appropriate verification. The DD 214 is the current form used by the military to prove separation from active duty. It provides evidence of military service which may be necessary to obtain Veterans Assistance benefits, employment, retirement and membership in veterans organizations. A Statement of Service (SoS) may also be an acceptable form of verification.

If the veteran is unable to produce a DD 214 or SoS confirming honorable discharge, the CWD shall refer him/her to the local and /or state Veteran agencies such as the VSO, California Department of Veterans Affairs (CalVet), and/or the U.S. Department of Veterans Affairs (VA) for assistance in securing the document. The CWD shall inform the veteran that he/she will be temporarily deferred from CalFresh E&T participation when the CWD receives evidence that the DD 214 or SoS has been recipient to the local and/or state Veteran office for assistance acquiring the needed documentation.

Once the CWD receives the DD 214 or SoS confirming that the veteran was honorably discharged, the document should be placed in the case file and the veteran shall be permanently deferred from CalFresh E&T. The veteran shall then be referred to the County VSO and those local veterans assistance and job training agencies known to the CWD.

If the DD 214 or SoS states that the veteran was not honorably discharged or the veteran fails to provide the needed form within a 30 day period, the temporary deferral shall end. The veteran shall be subject to E&T participation requirements if not otherwise exempted or deferred. Such evidence must be provided within five business days from the date the county refers the CalFresh

ACL 13-15 (March 12, 2013) <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-15.pdf>

California Work Opportunity And Responsibility To Kids (CaWORKs)
Program: Questions And Answers For the CaWORKs Welfare-To-Work (WTW) 24-Month Time Clock

The purpose of this letter is to provide answers to questions that the California Department of Social Services (CDSS) has received about the implementation instructions issued to County Welfare Departments (CWDs) for the new WTW 24-Month Time Clock and hourly participation requirements, established by SB 1041, which became effective on January 1, 2013.

In general, during the WTW 24-Month Time Clock period, CalWORKs clients are able to participate in any of the CalWORKs WTW activities they need, consistent with an assessment, to become self-sufficient without the previously required CalWORKs WTW core hourly requirements. Any WTW plan developed after January 1, 2013, must be based on clients' needs that are consistent with their assessment. In addition, the weekly hours of participation have been aligned with federal hourly requirements (30 hours per week for single parents with no child under six years old, 20 hours for single parents with a child under six, and 35 hours for two-parent families). Initial implementation instructions for these program changes are contained in ACLs 12-67 and 12-69.

Note: ACL 13-15 was inadvertently overlooked for inclusion in an earlier E-Note. Qs and As 1 through 4 regarding transition to the 24 Month Time Clock are no longer relevant, because these transitions started on January 1, 2013, so should have taken place by now.

Training and Quality Development Bureau
California Department of Social Services
State Hearings Division

E-NOTE #111 – SUMMARY OF ACLs/ACINs/MEDLs/CFLs

December 31, 2013

ACL 13-89 (October 31, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-89.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) And CalFresh: Steps To Determine Referrals For Investigations

The purpose of this ACL is to remind counties of the current policies related to the steps and considerations to be taken in determining whether it is appropriate to make a referral for investigation in the California Work Opportunity and Responsibility to Kids (CalWORKs) and CalFresh programs. This letter is not intended to restrict referrals for investigation; rather, it is meant to ensure that policy is followed and to remind counties to consider other factors or situations that could prevent the applicant/recipient from providing necessary information when the Eligibility Worker (EW) has received inconsistent case file information. In this letter, the term EW refers to any county staff assisting in eligibility determinations and/or employment services.

The requirements and practices detailed in this letter are to assist the EW in identifying situations that may warrant a request for investigation, and include: early fraud prevention program efforts, review and resolution of reporting discrepancies, effective communications with applicants/recipients regarding the importance of reporting along with the consequences of failing to report that information, and where appropriate, the provision of interpretive services and reasonable accommodations to aid the applicant's/recipient's understanding of the rules. We have also included examples as an attachment.

(This ACL contains 5 hypos at the end.)

ACIN I-68-13 (November 5, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-68_13.pdf

Federal Fiscal Year 2015 County Disaster CalFresh Plans

The purpose of this letter is to inform counties that their Federal Fiscal Year (FFY) 2015 County Disaster CalFresh (D-CalFresh) Plans are due to the California Department of Social Services (CDSS) by March 5, 2014. County disaster plans are intended to be an internal guide for county staff for use in the event of a natural or man-made disaster.

ACIN I-70-13 (November 12, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-70_13.pdf

Application And Allocations For The CBCAP (COMMUNITY-BASED CHILD ABUSE PREVENTION) Program State Fiscal Year (SFY) 2013-14

The purpose of this letter is to release the CBCAP application and allocations for SFY 2013-14. The California Department of Social Services (CDSS) utilizes this annual CBCAP application and allocation process for county administered child welfare agencies in order to support local prevention and early intervention efforts statewide. This annual application and allocation process requires county submission of the CBCAP Application and Assurances Form and Certification of County Children's Trust Fund (CCTF) Revenue Form.

ACL 13-91 (November 1, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-91.pdf>

After 18 Program (AB 12 Extended Foster Care) And Indian Non-Minor Dependents (NMDs) Covered By The Indian Child Welfare Act (ICWA)

This ACL contains information on both case management and eligibility issues related to Indian youth as Non-Minor Dependents (NMDs). This ACL highlights and provides clarification regarding policies and procedures for the placement of NMDs that have been determined to be an "Indian child" per the Indian Child Welfare Act (ICWA), hereafter referred to as "Indian youth."¹ Also, this ACL provides guidance to Indian youth in out-of-home placements who are seeking to participate in the After 18 Program. Pursuant to AB 12, this Program allows foster youth to remain in foster care under court jurisdiction, up to age 21 as NMDs.

ACL 13-92 (November 20, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-92.pdf>

Sharing Ratios For Group Home Programs Fiscal Year 2013-14

This ACL provides current information regarding sharing ratios for group home programs for FY 2013-14.

MEDIL - I 13-13 (November 18, 2013) Discontinuance of Printing Forms MC 321, MC 219 and MC 210

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%2013-13.pdf>

This Medi-Cal Eligibility Division Information Letter is to advise counties that the Department of Health Care Services (DHCS) is discontinuing printing forms MC 321 (Healthy Families/Medi-Cal Application), MC 219 (Important Information for Persons Requesting Medi-Cal) and MC 210 (Medi-Cal Mail-In Application).

Some forms are available in limited quantity to order through MAXIMUS (MC 210 Spanish and MC 219 English are not available). Orders received will be fulfilled until current inventory is depleted. These forms continue to be available on the DHCS website for counties and other interested parties to download and print as needed. <http://www.dhcs.ca.gov/formsandpubs/Pages/default.aspx>

Printing of the MC 219 form will resume upon final approvals and completion of the development of the new single streamlined paper application form that will replace the current MC 210 and MC 321 application forms.

CFL 13-14-30 (November 20, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/cfl/2013-14/13-14_30.pdf

Changes To County Assistance (CA) 800 Claiming Instructions For Federal Aid To Families With Dependent Children-Foster Care (AFDC-FC), Federal Adoption Assistance Program (AAP), Federal Kinship Guardianship Assistance Payment (FED-GAP), And Federal Extended Foster Care (EFC) Overpayments

This CFL provides updated reporting and claiming instructions for all assistance claims effective July 1, 2012, as a result of SB 1013, which revised the overpayment timeframes and responsibilities for the federal AFDC-FC program, federal AAP, the Fed-Gap program and the federal EFC program. The California Department of Social Services (CDSS) has developed revised claims, as well as one-time claims, to capture these overpayments. Prior to July 1,

2012, the state and county shared the responsibility to repay the federal share of costs for overpayments.

Beginning July 1, 2012, the county is required to repay the entire federal share for overpayments upon completion of due process for the federal AFDC-FC, AAP, Fed-GAP and EFC programs due to the implementation of SB 1013. A one-time claim for federal AFDC-FC and federal AAP is required to correct costs from July 1, 2012 through October 31, 2013. Additionally, revised claims included with this letter should be used beginning with the November 2013 claiming month and forward.

ACL 13-79E (November 22, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-79E.pdf>

CalFresh Administrative Overissuances

The purpose of the errata is to make a correction to All County Letter (ACL) No. 13-79 regarding the threshold establishment of an administrative error (AE) overissuance for inactive CalFresh households. This errata shows the prior and corrected language for the impacted paragraph only, and should be implemented in conjunction with ACL No. 13-79.

Prior Language

Page three, under "AE OVERISSUANCE THRESHOLD", establishes the AE overissuance threshold for inactive CalFresh cases at \$125 and states that CWDs will not establish an AE overissuance claim if the AE overissuance is less than \$125. This statement regarding the threshold is incorrect.

Corrected Language

ACL No. 13-79 should have instructed counties to not establish an AE overissuance claim for inactive CalFresh households if the AE overissuance is **\$125 or less**. AE overissuances are to be established and subsequently collected for inactive CalFresh households if the AE overissuance is **above** \$125.

ACIN I-72-13 (November 26, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-72_13.pdf

New Payment Standards For The Cash Assistance Program For Immigrants Effective January 2014

This All County Information Notice provides new payment standards for the Cash Assistance Program for Immigrants (CAPI), effective January 2014. It also provides clarification on the computation of benefits for a CAPI recipient whose spouse receives Supplemental Security Income/State Supplementary Payment (SSI/SSP).

As required by Welfare and Institutions Code (WIC) section 18941, the CAPI payment standards are based on the SSI/SSP payment standards, less \$10.00 for an individual and \$20.00 for a couple per month.

Although there will be no increase in the state-funded SSP amount in January 2014, there will be an increase in the federally-funded SSI payment due to a cost of living adjustment (COLA) and an increase in the combined SSI/SSP payment standards. Consequently, there will be an increase in CAPI payment standards.

There is a table attached to this ACIN which shows the new CAPI payment standards which become effective on January 1, 2014.

ACL 13-62E (November 25, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-62E.pdf>

Aid To Families With Dependent Children-Foster Care (AFDC-FC) California Necessities Index (CNI) Increases And Other Rate Increases

The purpose of this erratum is to inform counties and other interested parties of the CNI increase that is applicable to the Transitional Housing Placement Plus Foster Care (THP+FC) and Wraparound rates for Fiscal Year (FY) 2013-14. In addition, we are clarifying the Infant Supplement rate for THP+FC providers.

The W&IC 11403.2(b) required the California Department of Social Services to convene a workgroup with various stakeholders to establish a new rate structure, including applicable rate adjustments, for the Title IV-E funded THP+FC placement option.

Attached to this ACL is Table A which provides the rate established by the workgroup and issued in ACL No. 12-44 on September 11, 2012 and the adjusted rate reflecting the CNI increase of 2.65 percent for FY 2013-14.

ACL 13-95 (December 2, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-95.pdf>

Statistical Report On The Number Of Children, Ages 5-17, In Families Receiving California Work Opportunity And Responsibility To Kids (CalWORKs) Cash Assistance Above The Poverty Level – Title I, Part A, Of The Elementary And Secondary Education Act (ESEA) Of 1965

This ACL is to inform counties regarding the process for the October 2013 statistical report on the number of children ages 5 through 17 in families receiving CalWORKs cash assistance payments exceeding the federal poverty income level. The collection and reporting of this data is required by Title I, Part A, of the ESEA of 1965, as amended.

CFL 13-14-32 (November 27, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/cfl/2013-14/13-14_32.pdf

Fiscal Year (FY) 2013-14 California Work Opportunity And Responsibility To Kids (CalWORKs) Family Stabilization (FS) Allocation

This letter notifies counties of the CalWORKs FS allocation for FY 2013-14 pursuant to AB 74. A total of \$10.8 million in federal Temporary Assistance for Needy Families funds and General Fund was made available upon approval of the FY 2013-14 Budget Act.

Family Stabilization is a new component of the CalWORKs program that provides intensive case management and services to address immediate crisis situations and needs. As indicated in Welfare and Institutions Code section 11325.24, effective January 1, 2014, CalWORKs recipients shall be eligible to participate in family stabilization if a county determines that a family is experiencing an identified situation or crisis that is destabilizing the family and would interfere with participation in Welfare-to-Work (WTW) activities and services. Funds allocated for FS shall be in addition to and independent of the county Single Allocation.

ACIN I-73-13 (December 2, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-73_13.pdf

2013 Earned Income Tax Credit Outreach Publications

The purpose of this letter is to notify County Welfare Departments (CWDs) that the Earned Income Tax Credit (EITC) outreach publications, Pub 428 and Pub 429, have been revised for tax year 2013. These publications are provided to strengthen state and county efforts to promote the EITC to low income residents in the State of California. Changes for 2013 include increases authorized by the American Tax Relief Act of 2012. This act extended the expanded credit for taxpayers with three or more qualifying children to December 31, 2017. This expansion was originally implemented under the American Recovery and Reinvestment Act of 2009 (ARRA) and was set to expire at the end of 2012. Additional changes include increases in earned income limits and the maximum credit amount that can be received.

ACL 13-93 (December 9, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-93.pdf>

Release Of The California Child And Family Services Review (C-CFSR) Instruction Manual

The purpose of this ACL is to release the revised Instruction Manual for the California Child and Family Services Review (C-CFSR). The revised C-CFSR Instruction Manual is now a single comprehensive document which includes updated instructions for completing the County Self-Assessment (CSA), the System Improvement Plan (SIP) and SIP Progress Reports.

Background

Assembly Bill 636, Chapter 678, Statutes of 2001, enacted the Child Welfare Services Outcomes and Accountability Act of 2001 requiring the California Department of Social Services (CDSS) to establish the C-CFSR process to ensure county accountability and improve outcomes for children through the implementation of the core outcomes of the federal CFSR.

Over the last 12 months, in response to recent legislative changes resulting from the passage of SB 1013 Chapter 35 Statutes of 2012, the CDSS has undertaken efforts to revise the C-CFSR process to improve the effectiveness of California's quality assurance system. A state/county workgroup, comprised of representatives from the CDSS' Children's Services Outcomes and Accountability Bureau (CSOAB), the Office of Child Abuse Prevention (OCAP), CWDA, Chief Probation Officers of California (CPOC), Center for Social Services Research, University of California, Berkeley and representatives from several California county child welfare and probation agencies, participated in the development of this manual.

ACL 13-96 (December 11, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-96.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) And CalFresh: Revised SAWS Application Forms

The purpose of this letter is to transmit revised public assistance application forms and provide county welfare departments (CWDs) with instructions regarding the use of the forms in preparation for the implementation of the Affordable Care Act (ACA) in California effective January 1, 2014.

BACKGROUND

Interoperability between programs is an essential goal that has been emphasized with the implementation of the ACA of 2010. The California Department of Social Services (CDSS) has committed to take part in the Horizontal Integration efforts to ensure that our common clients (often referred to by the Department of Health Care Services (DHCS) and Covered California as customers or consumers in other programs under ACA) experience a seamless process as they apply for various programs at any of our state-wide county offices. For further guidance on Horizontal Integration, please refer to ACINs I-37-13 and I-53-13. The CDSS will continue to disseminate communications regarding ACA and Horizontal Integration policies as soon as they are released.

Implementation of the ACA and California state law requires California to have a streamlined, multi-program, single application for individuals and families to apply for CalWORKs, CalFresh and health care coverage, including Medi-Cal and other programs associated with ACA.

This is an important ACL to read in its entirety.

ACL 13-97 (December 12, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-97.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Changes To Asset Limits For Families That Include Elderly Or Disabled Household Members

The entire ACL is set forth below:

The purpose of this ACL is to notify County Welfare Departments (CWDs) of changes to the maximum asset limit for CalWORKs families in which there is an elderly or disabled household member. CalWORKs families are allowed to retain countable resources in an amount equal to the amount allowed by the CalFresh program regulations. Currently, CalWORKs regulations at MPP Handbook Section 42-207.2 identify the asset limit to be \$3,000 for households in which at least one Assistance Unit (AU) member is age 60 or older, or disabled. In October 2011, the Food and Nutrition Service increased the asset limit for CalFresh households in which there are elderly and disabled members to \$3,250. In order to maintain maximum compatibility between the programs, CalWORKs is also adopting the increased property limit for families in which there is a disabled member or person age 60 or over.

CWDs must make this change immediately. In addition, if CWDs find that an AU was denied cash aid or has had their cash aid discontinued as a result of exceeding the \$3000 asset limit, the CWD must re-evaluate eligibility for the AU and restore any benefits that would have been authorized under the increased asset limit as of October 2011. Additionally when re-reviewing resource eligibility for previously discontinued or denied cases with an elderly or disabled member, if the CWD has collected or is currently collecting an overpayment (OP) based on excess resources for AUs fitting this description for any period after September 30, 2011, it shall review the case to determine if the AU was actually under the \$3,250 resource limit, and if so, immediately cancel the OP and return any funds collected pursuant to MPP Section 44-340. CDSS is in the process of amending the regulations to reflect the new asset limit.

ACL 13-103 (December 18, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-103.pdf>

Processing Consumer Requests For Referral To The CalFresh Or California Work Opportunity And Responsibility To Kids (CalWORKs) Programs Under The Patient Protection And Affordable Care Act (ACA)

The ACA provides individuals who are interested in and seeking health insurance several avenues for obtaining health insurance for themselves and their families. It has created an environment in which interoperability between social services programs becomes critical in order to ensure the application process is seamless for the individual or family who may be eligible for multiple programs (e.g. CalWORKs and CalFresh). This coordinated effort, or interoperability, between the California Department of Social Services (CDSS) and the Department of Health Care Services is also known as “horizontal integration.” Under the ACA, individuals seeking health insurance are referred to as “consumers,” because they are shopping for a health plan.

The purpose of this All County Letter (ACL) is to transmit policy to County Welfare Departments (CWDs) on how to process consumer requests for a referral to the CalFresh or CalWORKs programs when they have applied for a health insurance affordability program (IAP). The IAP application can be through any of the channels offered by the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) or the California Department of Health Care Services’ Single Streamlined Application (SSApp). The CWDs may receive requests for referrals in-person (walk-in or by appointment), by telephone, online, by mail, by fax, or through the CalHEERS interface with the Statewide Automated Welfare Systems (SAWS). Beginning January 1, 2014, CWDs may receive these referrals electronically from Covered California, California’s ACA marketplace for individuals and families to obtain health insurance, via CalHEERS. January 1, 2014 is when the CalHEERS and SAWS systems are slated to interface. The CWDs must implement this policy effective with ACA implementation on January 1, 2014.

ACL 13-99 (December 19, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-99.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Program: Regulations To Implement The Semi-Annual Reporting (SR) System

The purpose of this letter is to notify County Welfare Departments (CWDs) of new regulatory provisions for the SAR system in the CalWORKs program. These regulations contain SAR provisions already issued in ACL No. 12-25, as well as clarifying provisions added as a result of AB 74 (Chapter 21, Statutes of 2013). These regulations were issued on an emergency basis, were effective July 1, 2013, and are available at the web address listed below. CalFresh SAR regulations will be issued separately.

ACL 13-102 (December 24, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-102.pdf>

Verification Of Dependent Care Expenses In CalFresh

The purpose of this letter is to provide information and a new form to implement the recently enacted Welfare and Institutions Code Section 18901.1 (added by Senate Bill (SB) 672 (Chapter 568, Statutes of 2013)). Effective January 1, 2014, Welfare and Institutions code section 18901.1 mandates that County Welfare Departments (CWDs) consider dependent care expenses to be verified when the household submits a self-certified statement of monthly dependent care expenses.

ACL 13-104 (December 20, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-104.pdf>

Implementation Of Assembly Bill (AB) 309 Regarding Homeless Youth In The CalFresh Program

The purpose of this letter is to provide county welfare departments (CWDs) with information regarding the treatment of homeless youth in the CalFresh program as prescribed by Welfare & Institutions Code sections 18901 and 18904.25 (amended per AB 309, Chapter 97, Statutes of 2013).

CALFRESH ELIGIBILITY FOR HOMELESS YOUTH

Welfare & Institutions Code section 18901 clarifies that there are no minimum age requirements for CalFresh eligibility except for those imposed by federal law. Section 18904.25 requires CWDs, upon receipt of a CalFresh application from an unaccompanied child or youth, to determine the youth's eligibility, which shall include determining whether the youth is eligible to apply as the sole member of the household and screening the application for entitlement to expedited service. It also requires CWDs to provide written notice to a homeless youth if his or her CalFresh application is denied.

ACIN I-76-13 (December 27, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-76_13.pdf

Coordinated Care Initiative (CCI) – Voluntary Provider Training Curriculum

BACKGROUND

WIC Section 12330 requires the California Department of Social Services (CDSS) in consultation with the State Department of Health Care Services (DHCS) and in collaboration with stakeholders, to develop a voluntary IHSS provider training curriculum that addresses issues of consistency, accountability, and increased quality of care for IHSS recipients, no later than January 1, 2014.

A workgroup was composed of representatives from CDSS; DHCS; counties; Public Authorities; IHSS consumers and providers; advocates; labor unions; and California State University, Sacramento, College of Continuing Education. The workgroup held three meetings between May 2013 and December 2013, to develop the curriculum.

VOLUNTARY PROVIDER TRAINING CURRICULUM RELEASE

The resulting voluntary provider training curriculum is a compilation of training resources that include 15 topics and a variety of subtopics, which are available on the CDSS website at: <http://www.cdss.ca.gov/agedblinddisabled/PG1788.htm>. The curriculum allows IHSS providers to voluntarily review documents and links to websites that will assist them in providing consistency, accountability, and increased quality of care to IHSS consumers.

ACWDL - 13-18 (December 20, 2013) MEDI-CAL AND RELATED PROGRAMS FOR STATE AND COUNTY INMATES

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-18.pdf>

This letter provides a description of the various Medi-Cal programs the Department of Health Care Services (DHCS) has implemented or is preparing to implement for eligible state and county inmates. Where appropriate, this letter will include information that will assist counties as they implement Medi-Cal for county inmates.

Training and Quality Development Bureau
California Department of Social Services
State Hearings Division

E-NOTE # 110 - ADEQUATE NOTICE REQUIREMENTS INVOLVING INCOMPETENT MEDICAL LONG TERM CARE PATIENTS

November 26, 2013

Reference: Para-regulations 414-5:414-5A: 414-6: W&IC §§14110.05(a) and (b)); CCR 50032; 50163; 50166; ACWDL 94-62; ACWDL 94-70

This E-Note is intended to remind judges of the special adequate notice requirements that apply to incompetent long-term care (LTC) individuals applying for the Medi-Cal Program or being evaluated for ongoing eligibility at the time of an annual redetermination.

CCR §50032 defines "Competent" is defined as being able to act on one's behalf in business and personal matters.

The Department of Health Care Services generally considers "unable to act on one's own behalf in business and personal matters" as a matter of mental incompetence.^[1]

State law and Department of Health Care Services policy as set forth in ACWDL 94-62 (August 2, 1994) provides that if a Medi-Cal applicant or recipient is incompetent and a patient in a long term care facility, and there is no spouse, conservator, guardian or executor, such individuals may be entitled to special assistance from the county when processing a Medi-Cal application or doing an annual redetermination.

In pertinent part, ACWDL 94-62 states the following, under "**Diligent Search:**"

*"The eligibility worker may assume total control of a Medi-Cal case if:
"If a person is not able to complete the Medi-Cal eligibility determination due to incompetency, or being in a comatose condition or suffering from amnesia (Title 22 §50163(D), or does not have a spouse, conservator, guardian or executor (Title 22 §50163(3).*

It is also DHS policy that if an applicant has a representative assuming case management responsibilities due to the applicant's mental condition, the CWD may take over the case management should the representative become non-cooperative or if contact is lost.

In this situation, the EW must refer the case to protective services to determine if the public guardian or adult protective service staff become the responsible agency. If not, the EW must undertake a diligent search of known information to determine eligibility.

LTC applicants should not be denied Medi-Cal due to the non-cooperation of the individual acting on their behalf. In these cases, unless a suitable individual is located, the non-cooperative individual should be notified that the application is denied. The county should then proceed with filing a second SAWS I, and shall proceed with diligent search procedures in order to make the appropriate eligibility determination.

^[1] For individuals who are mentally competent but physically incapable of signing a statement of facts form, a mark may be used when witnessed by an individual who must also sign the statement of facts form as the witness pursuant to Civil Code Section 14.

Please Note: While ACWDL 94-62 is still a valid ACWDL, DHCS no longer requests that the county deny the original application and fill out a new SAWS 1 when the individual (who is not a spouse, conservator, guardian or executor) acting for the LTC applicant becomes non-cooperative. This is for simplicity of administration and to ensure that LTC patients obtain coverage and is consistent with 22 CCR 50143, which allows any individual with knowledge of a person's need for Medi-Cal to apply for Medi-Cal on their behalf. In the case where the individual acting for a LTC applicant becomes non-cooperative, the original application should remain on file to preserve the application date. However, the county performing the diligent search should complete and sign a new statement of facts using the knowledge the county has regarding the applicant. 22 CCR 50163 and 50166 require that county's complete and sign the statement of facts when the county is performing a diligent search.

An incompetent LTC patient is not to be denied or discontinued due to the action or inaction of an individual acting on the patient's behalf if the individual is not the spouse, guardian, conservator, or executor.

Therefore, if you have a case in which an otherwise legally adequate notice of action is sent by the county denying or discontinuing an incompetent LTC patient, and that action is due to the non-cooperation of the person acting on the incompetent LTC patient's behalf, the notice of action should not be considered adequate if that person is not the patient's spouse, guardian, conservator, or executor. If a hearing request filed on the patient's behalf is not timely, the claimant's claim should not be dismissed for untimely filing.

ACWDL 94-70 (August 23, 1994) provides some guidance regarding power of attorney for competent individuals. The power of attorney can assist as an authorized representative for a competent individual, as can anyone. However, for an incompetent person the power of attorney is equivalent to the "person who has knowledge of the applicant's circumstances" who is able to sign on behalf of the incompetent applicant when there is no spouse, conservator, guardian or executor. The power of attorney would not be treated differently than the "non-cooperative individual" described in ACWDL 94-62 and the county would not deny the incompetent LTC applicant's application if the power of attorney became non-cooperative. This is because there is no guidance other than 22 CCR 50163 regarding who may sign the statement of facts and act for an incompetent person, and no specific allowance for powers of attorney beyond the "person with knowledge."

It should be pointed out that it is the DHCS's position that the mandates described in this E-Note apply to all Medi-Cal applicants/recipients, not just those in LTC. The legal authority for this is 22 CFR 50163 and 50166.

Legal References:

Para-Reg 414-5:

The legislature finds and declares that nursing facility residents face particular barriers to eligibility because they may have great difficulty or be unable to assist in completing Medi-Cal eligibility paperwork requirements when their own resources are too diminished to pay for their care.

Nursing facilities have no role in assuring completion of the Medi-Cal application process. They may be left with neither a source of private payment nor government reimbursement.

It is the legislative intent to ensure nursing facility residents receive assistance in the application process, that applications be processed timely, and that nursing facility participation in the Medi-Cal program be encouraged. (Senate Bill 635, Statutes of 1992, §§1 and 2)

Para-Reg 414-6:

The DHCS shall ensure that nursing facility applicants have access to assistance in identifying and securing information necessary to complete the Medi-Cal application and to make the eligibility determination.

The DHCS shall ensure that Medi-Cal applications for nursing facility residents are processed in a timely manner. (W&IC §§14110.05(a) and (b))

Para-reg 414-5A:

LTC applicants should not be denied Medi-Cal due to the non-cooperation of the individual acting on their behalf. In these cases, unless a suitable individual is located, the non-cooperative individual should be notified that the application is denied. The county should then proceed by filing a second SAWS 1 as well as an application for retroactive coverage if the second SAWS 1 is filed after the month in which the initial SAWS 1 was submitted (Welfare and Institutions Code (W&IC) §14016.2). The county should proceed with the diligent search procedures per Title 22 CCR §50163 in order to make the appropriate eligibility determination. (ACWDL 94-62, August 2, 1994)

Para-Reg 410-2B:

"Competent" is defined as being able to act on one's behalf in business and personal matters. (§50032)

Para-Reg 410-2:

The applicant or spouse of the applicant shall complete and sign the Statement of Facts, unless:

- (1) The applicant is a child, unless there is no parent, caretaker relative, or other person or agency with legal responsibility for the child; or unless the child is applying for minor consent services.
- (2) The applicant has a conservator, guardian or executor.

- (3) The applicant is incompetent, in a comatose condition or suffering from amnesia and there is no spouse, conservator, guardian or executor. In this case:
- (A) The county department shall evaluate the applicant's circumstances and determine whether or not there is a need for protective services.
 - (B) The Statement of Facts may be completed and signed on the applicant's behalf by a relative, a person who has knowledge of the applicant's circumstances, or a representative of a public agency or the county department.
 - (C) The person completing the Statement of Facts on behalf of the applicant shall provide all available information required on the Statement of Facts regarding the applicant's circumstances.
- (D) If a county department representative completes and signs the Statement of Facts, another representative of the county department shall confirm, by personal contact, the applicant's inability to act on his own behalf and countersign and approve any recommendations for eligibility.

(§50163(a))

Obtaining Information for the Completion of the Statement of Facts.

(a) The county department or the representative of a public agency completing the Statement of Facts in accordance with Section 50163(a)(3) shall:

(1) Perform a diligent search to obtain available information regarding the applicant's circumstances applicable to Medi-Cal eligibility determination.

(2) Complete the Statement of Facts based upon the findings of the diligent search.

(3) Establish disability in accordance with Section 50167(a)(1).

§ 50166

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E-NOTE #109 – MANDATORY INCLUSION ISSUES INVOLVING STEPPARENTS AND SIBLINGS AND HALF-SIBLINGS

November 19, 2013

References: W&I Codes 11450.16((a)b)(c)and (d); Para-regulations 050-1; 050-3; 071-1A: 071-2A; 071-2C: 074-2A: 133-5E; §40-118.1§41-400; 41-401; §44-209.3; §40-118.1; §44-133.511; §44-209.3; 82-804.1; §82-808.1; §80-301(s)(9); §82-820.3; §82-828.2

This E-Note is intended to address issues that may arise when determining who must be included in a CalWORKs assistance unit.

§82-808.1 defines “caretaker relative” for the purpose of the CalWORKs Program. A stepparent is included in that definition and considered to be a nonparent caretaker relative.

Depending on the circumstances that exist in a particular case, a stepparent, along with his/her income, is either a mandatory or optional member of the assistance unit.

W&IC §11450.16(d) provides that state law provides that the family comprising the CalWORKs AU has the option to include in the AU: the nonparent caretaker relative of the eligible child; the spouse of the parent of the eligible child; otherwise eligible nonsibling children in the care of the caretaker relative of the eligible child; and the alternately sentenced offender parent of the eligible child.^[1]

The pertinent regulations mandating this option are the following:

§82-828.21 provides that any nonparent relative who has been determined to be the caretaker relative by the county is considered to be an optional person who is not otherwise required to be in the assistance unit.

§82-828.121.provides that the nonparent caretaker relative shall be included in the assistance unit upon request of the applicant/recipient. If the nonparent caretaker relative is included in the assistance unit upon the applicant/recipient’s request, her income and resources will also be included in the grant computation.

§82-828.12 provides that it is the county’s responsibility to explain the effect of including/excluding the stepparent (optional person) in the assistance unit.

Example:

If claimant-stepmom is caring for her stepdaughter because the stepdaughter’s biological father moved out of the home or is incarcerated, stepmom can apply for aid for her stepdaughter and has the option (emphasis added) to be in the assistance unit. If she chooses to be included, her needs and income will be considered in the CalWORKs budget. If she chooses not to be

^[1] §41-400 provides that deprivation of parental support or care is a separate and specific eligibility factor for CalWORKs. So, in the context of 11450.16(d) “eligible” means a sibling or half-sibling who has met the deprivation requirement by meeting on of the deprivation linking factors for CalWORKs eligibility under §41-401.

included, she is considered a nonneedy caretaker relative, in which case her needs and income are not considered in the CalWORKs budget.

However, W&I Code §11450.16(c) provides that every AU shall (emphasis added) include the eligible parents of the eligible child and the eligible siblings, including half-siblings, of the eligible child when those persons reside in the same home as the eligible child.

§82-820.3 mirrors this statute:

The AU shall include the following persons when living in the same home and eligible at the time of initial family application:

- .31 The applicant child.
- .32 Any eligible sibling or half-sibling of the applicant child who meets the age requirement.
- .33 Any parent, except for alternatively sentenced parents, of:
 - .331 The applicant child, or
 - .332 The applicant child's eligible siblings or half-sibling who meet the age requirement.

Therefore, if a family contains a stepchild who is related, by blood or law, to his/her stepparent's biological child(ren) who are also living in the home, the stepparent's biological child(ren) and the stepparent **must** be included in the assistance unit if the stepparent applies for aid for the stepchild.

Example:

Claimant-stepmom is caring for her stepdaughter because the stepdaughter's biological father moved out of the home or is incarcerated. Also in the home is the stepmom's biological daughter. The claimant's stepdaughter and biological daughter share the same father.

If the claimant applies for aid for just her stepdaughter, the law requires that both her biological daughter and the claimant-stepmom be included in the assistance unit. This is because the stepdaughters are half-siblings, because they share a biological parent, and the claimant-stepmom is the parent of a half-sibling.

In addition to sharing a biological parent, a sibling relationship can also be created **by law**.

Example:

Bob and Sue each had one son from a previous marriage. Bob adopts Sue's son during the marriage. They then separate, Bob moves out of the home, and Sue applies for cash aid for only her stepson as a nonneedy nonparent relative/stepparent. Because the two boys are legally siblings as a result of the adoption, both Sue and her son must be included in the assistance unit.

Note that a marriage, by itself, does not create a sibling or half-sibling relationship between children who are not otherwise biologically related or adopted. If children are living together only because their parents married, they are considered step-siblings and do not fall under the above statute or regulations as mandatorily included in the assistance unit under the CalWORKs Program.

Therefore, when you have a case involving the issue of who is and is not required to be in the assistance unit, be sure to obtain evidence on the biological and legal relationships that the minor children in the family have with one another. This will determine which members of the family must be included in the assistance unit when the county does its CalWORKs budget to determine financial eligibility for CalWORKs benefits.

§44-133.511 provides that parents whose needs and income are considered include, but are not limited to: A stepparent who is the spouse of the applicant and/or recipient child's parent when the child's parent is residing in the home and the stepparent is not the parent of any natural or adoptive children who are required to be included in the AU.

Note that this regulation pertains to when a stepparent is living in the home with the caretaker relative/parent, which is different from the scenarios above where the stepparent is the caretaker relative who is applying on behalf of a child.

Also note that §44-133.511 establishes that the income and needs of the stepparent are included even though the stepparent may be excluded from the AU.

Legal References:

W&I Code 11450.16(a)(b)(c)(d):

For purposes of determining eligibility under this chapter, and for computing the amount of aid payment under Section 11450, families shall be grouped into assistance units.

(b) Every assistance unit shall include at least one of the following persons:

(1) One of each of the following:

(A) An eligible child.

(B) The caretaker relative of an otherwise eligible child who is not receiving aid under Section 11250 because that child is receiving benefits under Title XVI of the Social Security Act (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code), or Kin-GAP payments under Section 11364 or 11387, or foster care payments under Section 11461.

(2) A pregnant woman who is eligible for payments under subdivision (c) of Section 11450.

(c) Every assistance unit shall, in addition to the requirements of subdivision (b), include the eligible parents of the eligible child and the eligible siblings, including half-siblings, of the eligible child when those persons reside in the same home as the eligible child. This subdivision shall not apply to any convicted offender who is permitted to reside at the home of the eligible child as part of a court-imposed sentence and who is considered an absent parent under Section 11250.

(d) An assistance unit may, at the option of the family comprising the assistance unit, also include the nonparent caretaker relative of the eligible child, the spouse of the parent of the eligible child, otherwise eligible nonsibling children in the care of the caretaker relative of the eligible child, and the alternatively sentenced offender parent exempted under subdivision (c).

Para-reg 050-1:

§41-400 provides that deprivation of parental support or care is a separate and specific eligibility factor for CalWORKs (formerly AFDC).

Para-reg 050-3:

In CalWORKs (formerly AFDC) a child is considered deprived of parental support or care if:

- (1) Either parent is deceased;
- (2) Either parent is physically or mentally incapacitated;
- (3) The principal earner is unemployed;
- (4) Either parent is continually absent from the home in which the child is living.

(§41-401)

Para-Reg 071-1A:

“Applicants” shall include the following persons if living in the home, and shall be listed on the applicable Statement of Facts:

1. The applicant child.
2. Children who are siblings or half-siblings of the applicant child.
3. The parents of any child listed above.
4. A pregnant woman, in a one-person AU.
5. The caretaker relative, stepparent, California domestic partner of the SSI/SSP child’s parent and second parent of an SSI/SSP child when aid is requested.
6. The caretaker relative, stepparent, California domestic partner of the child’s parent and second parent of a child who is sanctioned by the GAIN program.
7. A senior parent.
8. The sponsor of an alien.
9. The spouse or California domestic partner of persons mandatorily included in the filing unit.

(§40-118.1)

“Applicants” shall include optional persons if aid is requested for them. The county shall determine whether the appropriate individuals are included on the applicable Statement of Facts. The application, redetermination, request to add a person or request for restoration shall be denied if the applicant refuses to include on the application any individual listed above. (§§40-118.2 and .4)

Para-reg 071-1C:

"Stepparent" means a person who is not the biological parent, but is either married to, or the California domestic partner of, the parent of the child. (§80-301(s)(9))

Para-reg 071-2A:

The AU shall be established when all eligibility factors have been met and aid has been authorized.

Every AU shall include at least one eligible child, or a pregnant woman, or the caretaker/relative of an SSI/SSP child or of a child receiving federal, state, or local foster care maintenance payments, or the relative of a child who has been sanctioned by GAIN.

The AU shall also include the following persons, if living in the home and eligible: the applicant child, any eligible sibling or half-sibling of the applicant child who meets the age requirement, and any parent of the child or the child's eligible siblings, except an alternatively sentenced parent. §82-820

Para-reg 072-2:

State law provides that the family comprising the CalWORKs AU has the option to include in the AU: the nonparent caretaker relative of the eligible child; the spouse of the parent of the eligible child; otherwise eligible nonsibling children in the care of the caretaker relative of the eligible child; and the alternately sentenced offender parent of the eligible child. (W&IC §11450.16(d), effective January 1, 1999)

Para-reg 074-2A:

In order to be eligible for CalWORKs (formerly AFDC)-FG/U payments a child must be living in the home of a caretaker relative. (§82-804.1)

§82-828 Optional Persons

.1 County Responsibility

.11 Identify Optional The county shall identify, for the applicant or Persons recipient, any person living in the home who may be included in the AU.

.111 This shall be done at the time of application, redetermination, or at any other time the county is informed of a change in the number of persons living in the home.

.12 Effect on AU The county shall explain to the applicant or recipient the effect of including or excluding the optional person. The applicant or recipient shall decide who is to be included.

.121 The explanation shall include a description of the AU composition which will result in the maximum aid to which the family is eligible, considering the income and resources of each person who may be included.

.2 Optional Persons The following persons who are not otherwise required to be in the AU shall be included upon request of the applicant/recipient.

.21 Nonparent Caretaker Any nonparent relative who has been determined Relatives to be the caretaker relative.

.22 Other Eligible Any other eligible children, including, but not Children limited to, a niece or nephew.

.23 Essential Persons Any essential person who meets the requirements of Section 44-209.3.

§44-209.3 Essential Persons

.31 An essential person is a stepparent, California domestic partner of the child's parent, or ASP who is not an otherwise federally eligible person under .2 and who:

.311 Is related to a child determined to be federally eligible under .21, or

.312 Is related to a child who is either receiving SSI/SSP or sanctioned by GAIN who would otherwise be federally eligible under .21.

Para-reg 074-3A:

The caretaker/relative of an eligible CalWORKs (formerly AFDC) child shall be related to the child as follows: The caretaker/relative may be any relative by blood, marriage or adoption who is within the fifth degree of kinship to the eligible child. This includes a parent, grandparent, sibling, great-grandparent, uncle or aunt, nephew or niece, great-great grandparent, great-uncle or aunt, first cousin, great-great-great grandparent, great-great uncle or aunt, or a first cousin once removed; or the stepfather, stepmother, California domestic partner of a parent, or stepbrother, or stepsister; or the spouse or California domestic partner of any person named above, even after the marriage has been terminated by death or dissolution; or a person who legally adopts the child, or that person's relatives, as specified. (§82-808.1)

In addition to those relatives who must be included in the AU, other eligible relatives living in the home may be included in the AU upon request of the applicant or recipient. At the time of application, redetermination, or at any other time the recipient informs the county of any additional relatives in the home, the county shall identify for the applicant or recipient which additional relatives in the home may be included in the AU, and the county shall advise the applicant or recipient of the effect of including or excluding such relative(s). This advice shall include a description of the AU composition which will result in the maximum aid to which the family is eligible. (§§82-820.3 and 82-828.1)

Para-reg 133-5E:

§44-133.511 provides that parents whose needs and income are considered include, but are not limited to: A stepparent who is the spouse of the applicant and/or recipient child's parent when the child's parent is residing in the home and the stepparent is not the parent of any natural or adoptive children who are required to be included in the AU.

^[1] §41-400 provides that deprivation of parental support or care is a separate and specific eligibility factor for CalWORKs. So, in the context of 11450.16(d) "eligible" means a sibling or half-sibling who has met the deprivation requirement by meeting one of the deprivation linking factors for CalWORKs eligibility under §41-401.

**E-Note #108 – Extended CalWORKs for Nonminor Dependents
California Fostering Connections to Success Act (AB 12, as amended)**

November 5, 2013

References: California Fostering Connections to Success Act, Stats. 2010, c. 559, §58 [A.B. 12], enacted Sept. 30, 2010; as amended by Stats. 2011, c. 459, [A.B. 212]; as amended by Stats. 2012, c. 35, [S.B. 1013]

Welf. & Inst. Code, §11253 – Extending age for CalWORKs for Nonminor Dependents
§11253.3 – Providing Special Rules for Extended CalWORKs
§ 11400(v) – Defining a Nonminor Dependent (NMD)
§11403(b) – The Five Participating Criteria
§11454.5 – Exemption from CalWORKs Rules for NMDs

ACIN No. I-40-11 – General Information on AB 12 and Nonminor Dependents
ACL No. 11-61 (Nov. 4, 2011) – General Information on AB 12
ACL No. 11-69 (Oct. 13, 2011) – Part 1 EFC – Age Requirements and Five Participating Criteria
ACL No. 11-78 (Nov. 30, 2011) – Introduction to Extended CalWORKs (Out-of-County Rules)
ACL No. 12-12 (Mar. 23, 2012) – New Jurisdictions for NMDs, Dependency Reentry
ACL No. 12-27 (Jun. 12, 2012) – Questions on Extended CalWORKs
ACL No. 12-43 (Aug. 16, 2012) – SB 1013 (age clarification, extension of benefits to 21)
ACL No. 13-82 (Oct. 16, 2013) – Questions on Extended CalWORKs

ParaRegs: 038-1 through 038-8

Introduction:

In 2010, the California Legislature passed the California Fostering Connections to Success Act (AB 12, the Act). With the AB 212 and SB 1013 amendments, the Act extended California Work Opportunity and Responsibility to Kids (CalWORKs) benefits for nonminor dependents and delinquents, effective January 1, 2012.

California passed AB 12 to participate in Congress's Fostering Connections to Success and Increasing Adoptions Act of 2008 (enacted Oct. 7, 2008, Pub.L. 110-351), which promoted extending the eligibility to benefits in Title IV-E programs and CalWORKs for NMDs to 21 years of age (SB 1013 has now approved funding under these programs to age 21).

E-Note #77 addressed the impact of AB 12 on both KinGAP and AAP; and, E-Note # 78 addressed "Extended Foster Care" under AB 12.

This E-Note discusses the extension of CalWORKs benefits under these acts. Effective January 1, 2012, AB 12 and subsequent trailer bills provide for "Extended CalWORKs" for NMDs who are residing in the home of an approved relative.

Eligibility for Extended CalWORKs:

Summary: In order for a youth to receive Extended CalWORKs, the youth must be an age-appropriate NMD you is living with an approved relative caregiver, and who is not eligible for federal or state Foster Care benefits.

A. Defining “NMD” and Age Requirements for Extended CalWORKs (see W&IC §11400(v)):

An NMD is defined as:

1. A youth in foster care (dependency W&IC §300, or delinquency W&IC §602), or a nonminor under the “transition jurisdiction” of the Juvenile Court (W&IC §450, see para reg 180-32);
2. Is under placement and care responsibility of the county child welfare agency;
3. Is participating in a transitional independent living case plan (see W&IC §11403(c), updated every 6 months, using the “Six-Month Certification of Extended Foster Care Participation” (state form SOC 161);
4. Age Requirements:
The youth attained 18 years of age while under an order of foster care placement by Juvenile Court; is not more than 19 years of age on or after January 1, 2012, not more than 20 years on or after January 1, 2013, or not more than 21 years on or after January 1, 2014.

Also, upon the passage of the Child Welfare Realignment Budget Trailer Bill (SB 1013; see ACL No. 12-43, p. 7), youth receiving Title IV-E or CalWORKs aid between January 1st and December 31, 2012 and who attained 19 years of age prior to January 1, 2013, or who has been receiving aid January 1st and December 31, 2013 and attains 20 years of age prior to January 1, 2014, may continue to receive aid in the applicable program to 21 years of age.

In addition, the nonminor, who was either a dependent or delinquent ward at 18 years of age, may reenter dependency in Juvenile Court (W&IC §388(e)). The nonminor reenters through a Voluntary Reentry Agreement (state form SOC 163). (See ACL No. 12-12, and E-Note #78.)

It should be noted that the fulltime student and “completion rule” to 19 years or graduation (under MPP §42-101, et seq), continues operable for standard CalWORKs (as modified where appropriate by Fry v. Saenz).

(B) Meet At Least One of the Five Participating Criteria (see W&IC §11403, ACL No. 11-69):

- (1) The NMD must be enrolled in secondary education, such as a high school, adult education classes, or any course of study leading towards completion of a high school diploma, GED, high school proficiency certificate, or high school completion certificate.
- (2) The NMD must be enrolled at least half-time in an institution providing post-secondary or vocational education.
- (3) The NMD must be participating in a program or activity designed to promote or remove barriers to employment, which is an individualized program based on a youth-centered assessment of skills and needs, such as unpaid employment, volunteer activities, internships, apprenticeships, drug or alcohol addiction programs, etc. Also, the NMD will be deemed to meet this condition if participating in regular meetings with his or her case manager to develop and implement the Transitional Independent Living Program (TILP).
- (4) The NMD must be employed for at least 80 hours each month. OR,
- (5) The NMD must have a medical condition rendering the NMD incapable of participating in the prior 4 conditions as verified in writing by a health care provider. The NMD will not be required to undertake remedial measures to cure the medical condition. An NMD who is eligible for a disability program such as SSI, Social Security Disabled Adult Child benefits, State Disability Insurance, or Regional Center services, is deemed sufficient to meet this condition, and would not be required to provide a written verification from a health care provider establishing the medical condition.

(C) Agree and Adhere to the Mutual Agreement (state form SOC 162):

And, as noted in the definition of an NMD, cooperate with the six-month review for the Transitional Independent Living Plan (TILP) certification and Court hearings.

(D) Reside in the Approved Home of a Relative Caregiver (ACL Nos. 11-78):

ACL No. 11-78 states that this approval is “determined by the children’s services case manager.”

Extended CalWORKs cannot be paid until the relative becomes “approved for foster care placement.” However even if the relative is not yet approved, the NMD may be eligible for Extended Foster Care benefits under a Supervised Independent Living Placement (SILP) while living with the relative (see ACL No. 13-82, question 4, p. 2). The NMD cannot receive both SILP-based Extended Foster Care and Extended CalWORKs at the same time.

The approved relative caregiver can receive needy CalWORKs providing there is another eligible minor in the home upon which the benefits are based. The NMD receiving Extended CalWORKs does not provide the basis for the relative to receive needy CalWORKs (see ACL No. 12-27, question 2, p. 1).

Other Provisions for Extended CalWORKs:

(A) The Beginning Date of Aid and Payments:

Upon execution of the “Six-Month Certification of Extended Foster Care Participation” (state form SOC 161), Extended CalWORKs may begin the first of the following month, and the NMD is placed into his/her own AU (see ACL No. 12-27, question 4, p. 2). Payment will be issued separately from the other family’s CalWORKs benefits.

The NMD will not be required to fill out a SAWS 1 or SAWS 2. Eligibility is established through execution of the Six Month Certification, SOC 161, and the Mutual Agreement, SOC 162 (see ACL No. 12-27, question 8, p. 2).

For a relative receiving needy CalWORKs, the county has the responsibility of issuing a timely and adequate NOA to notify the caregiver that CalWORKs will be reduced or discontinued, as the NMD is no longer deemed an eligible minor for the relative’s needy benefits upon receipt of Extended CalWORKs.

For an NMD reentering Court jurisdiction under a W&IC section 388(e) petition, the beginning date of aid follows the NMDs and county’s execution of the Voluntary Reentry Agreement (state form SOC 163). The first month’s benefits would be prorated as of the beginning date of aid (see ACL No. 13-82, question 2, p. 1).

In order to avoid disruption of Extended CalWORKs benefits, the CalWORKs eligibility worker must be provided the updated six-month certification (state form SOC 161) at the end of the first month of the next six-month certification period (see ACL No. 13-82, question 17, p. 6).

(B) Waiver of CalWORKs Rules for Extended CalWORKs:

AB 12 waived most CalWORKs rules for NMDs, such as Welfare-to-Work requirements, etc., but the NMD is still mandated to meet the Statewide Fingerprint Imaging System (SFIS) requirements when reaching 18 years of age or older (see ACL No. 12-27, question 10, p. 3; referencing ACL No. 00-32, question 3).

The NMD is not subject to either property or income rules, and is not subject to CalWORKs time limits (see ACL No. 12-27, questions 13 and 14, p. 4).

Under Extended CalWORKs rules, the relative caregiver has no reporting requirements, as the relative’s income and property are not relevant to the NMD’s eligibility for Extended CalWORKs (see ACL No. 13-82, question 3, pp. 1-2).

(C) NMD Moving to Another County:

Payments of Extended CalWORKs do not cause an Inter-County Transfer (ICT) shift in payments to the NMD's new county of residence. The county of Court jurisdiction continues to pay these benefits regardless of the NMD's county of residence. The NMD must maintain residence with the approved relative caretaker to remain eligible for these benefits. However, ICT rules would apply to shift the payment of regular CalWORKs provided to the caretaker or other eligible children in the family (see ACL No. 12-27, question 19, p. 5, referencing ACL No. 11-78).

(D) The NMD Becoming a Parent:

The child of an NMD receiving Extended CalWORKs cannot increase the benefits the NMD receives. Extended CalWORKs is paid to the NMD in an AU of one person. The NMD may choose to apply for regular CalWORKs for the NMD and infant.

Maximum Family Grant (MFG) rules do not apply in the provision of Extended CalWORKs and therefore appropriate informing notices will not have been issued. If the NMD converts the case to regular CalWORKs, the MFG rules would not apply as the NMD had not received the requisite informing notices. The MFG rule could potentially apply however with later born infants (see ACL No. 12-27, questions 21 and 22, p. 6).

(E) Social Security Benefits and Extended CalWORKs:

Title II benefits may continue after a youth turns 18 years of age if disabled as an adult, or until the youth graduates or for two months after the youth turns 19, whichever comes first. Title II benefits will be counted as income against the NMD's receipt of Extended CalWORKs (see ACL No. 13-82, question 11, pp. 3-4).

According to ACL Number 13-82, question 11, an NMD receiving SSI benefits can also receive Extended CalWORKs, but the SSI benefits are anticipated to be reduced by the amount of Extended CalWORKs paid to the NMD (see ACL No. 13-82, question 11, pp. 4).

(F) CalFresh Benefits for the NMD Receiving Extended CalWORKs:

An NMD is eligible for CalFresh as a "boarder" and the caregiver may wish to include the NMD into the household composition. In this case, the NMD's Extended CalWORKs benefits are deemed income for the purpose of calculating the household's CalFresh benefits (see ACL No. 13-82, question 15, p. 5; referencing ACL No. 11-78 discussing how an NMD is a boarder for purposes of household composition).

E-NOTE #107 - ACL/ACIN/MEDIL SUMMARIES

November 1, 2013

ACIN I-61-13 (September 25, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-61_13.pdf

Sunset Of The American Recovery And Reinvestment Act Of 2009 (ARRA) – Effective **November 1, 2013**, Resulting In Changes To The Supplemental Nutrition Assistance Program (SNAP) Maximum Monthly Benefit Levels Previously Issued In All County Information Notice I-52-13

This letter transmits information on the sunset of the American Recovery and Reinvestment Act of 2009 (ARRA). Under ARRA, the maximum allotments were raised by 13.6 percent of the June 2008 value of the Thrifty Food Plan (TFP) and provided that benefits could not decline below this level for Supplemental Nutrition Assistance Program (SNAP) households, during the period of October 1, 2009 through October 31, 2013. However, as a result, of the sunset of ARRA effective November 1, 2013, maximum allotments will decrease for SNAP households.

ACIN I-62-13 (September 25, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-62_13.pdf

Disaster Guidance Attachment – Disaster Supplemental Nutrition Assistance Program Income Eligibility Standards And Allotments Effective **October 1, 2013**

This letter is to inform counties that the United States Department of Agriculture, Food and Nutrition Service (FNS) has issued the Federal Fiscal Year (FFY) 2014 Disaster Supplemental Nutrition Assistance Program (D-SNAP) Income Eligibility Standards and Allotments for the following period October 1, 2013 through October 31, 2013. The allotment amounts remain unchanged for FFY 2014.

However, effective October 1, 2013, the D-SNAP net monthly income eligibility levels are increasing for all household sizes. The maximum shelter deduction will increase from \$469 to \$478, and will apply to *all* households, including those with elderly or disabled members. The standard deduction amount for household sizes one, two, and three will increase from \$149 to \$152 a month.

ACIN I-60-13 (September 26, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-60_13.pdf

Electronic Records And Telephonic Signatures In The CalFresh And CalWORKs Programs

The purpose of this letter is to provide county welfare departments (CWDs) with information regarding the use of telephonic signatures in the CalFresh and CalWORKs programs. California Government Code requires that the Office of the Secretary of State, in consultation with the

Department of General Services, approve and adopt appropriate standards for electronic storage and recording of documents. The information contained in this letter is applicable and limited to the CalFresh and CalWORKs programs.

ACL 13-72 (September 26, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-72.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Form Revisions In Regards To Changes Due To Senate Bill (SB) 1041

The purpose of this letter is to inform County Welfare Departments (CWDs) of revisions to several California Department of Social Services (CDSS) CalWORKs Welfare-to-Work (WTW) program forms. These forms have been updated to reflect changes made pursuant to SB 1041.

ACL 13-76 (September 27, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-76.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Senate Bill (SB) 1041 Implementation Surveys

The purpose of this letter is to request County Welfare Departments (CWDs) to complete the attached SB 1041 Implementation Survey. This survey will be reissued approximately three times over the next 18 to 24 months.

Background

The passage of SB 1041 resulted in significant changes to the California Work Opportunity and Responsibility to Kids (CalWORKs) program, including the establishment of the Welfare-to-Work (WTW) 24-Month Clock, alignment of hours to federal participation requirements, and the new birth to 23 month young child WTW exemption.

Due to the significance of the changes implemented as a result of SB 1041, it was determined that the California Department of Social Services (CDSS) would be conducting Field Monitoring Visits (FMV) to ensure that counties receive the necessary oversight and support to implement these changes. FMVs will review county implementation of program changes enacted by SB 1041 including the WTW 24-Month Time Clock, the utilization of the new WTW Plan Activity Assignment (WTW2), the completion of the comprehensive discussions, the curing of sanctions as impacted by the alignment to federal participation hours, and the reengagement of formerly exempt participants.

ACIN I-63-13 (September 25, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-63_13.pdf

Changes To The Disaster Guidance Attachment – Disaster Supplemental Nutrition Assistance Program Income Eligibility Standards And Allotments – Effective **November 1, 2013**

This letter transmits information on the sunset of the American Recovery and Reinvestment Act of 2009 (ARRA). Under ARRA, the maximum allotments were raised by 13.6 percent of the June 2008 value of the Thrifty Food Plan (TFP) and provided that benefits could not decline below this level for Supplemental Nutrition Assistance Program (SNAP) and Disaster Supplemental Nutrition Assistance Program (D-SNAP) households, during the period of October 1, 2009 through October 31, 2013. However, as a result, of the sunset of ARRA, effective November 1, 2013, maximum allotments will decrease for D-SNAP households.

However, the D-SNAP net monthly income eligibility levels previously listed in All County Information Notice I-62-13 remain unchanged.

ACL 13-83 (September 27, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-83.pdf>

Implementation Of The Uniform Statewide Protocols For Program Integrity Activities In The In-Home Supportive Services (IHSS) Program

This letter provides implementation guidelines for the *Uniform Statewide Protocols for Program Integrity Activities in the IHSS Program* (hereinafter referred to as “the protocols.”)

Background

On July 24, 2009, Assembly Bill 19, fourth extraordinary session (ABX4 19) amended components of the California Welfare and Institutions Code (WIC) Sections 12305.7, 12305.71, and 12305.82, requiring the California Department of Social Services (CDSS) to establish a State and county stakeholders’ workgroup to address key requirements pertaining to IHSS program integrity. The goal of this workgroup was to develop protocols clarifying state and county roles and responsibilities for the implementation and execution of standardized program integrity measures in the IHSS Program.

In March 2010, CDSS established the workgroup which included representatives from CDSS, the Department of Health Care Services (DHCS), the California Department of Justice Bureau of Medi-Cal Fraud and Elder Abuse, county program staff and district attorneys’ offices. In 2011, IHSS recipients and advocacy groups representing both IHSS recipients and providers were added to ensure sufficient diversity in addressing the protocols. Over a two-year period, the full workgroup met seven times, there were numerous subcommittee and focus group meetings, and CDSS conducted two public meetings to ensure public input. The workgroup engaged in a robust dialogue addressing issues as they pertain to workload concerns, implementation specifics and challenges faced by small counties versus large counties.

The focus of the workgroup was to encourage a coordinated effort between all of the involved stakeholders to ensure a consistent approach towards program integrity activities. In March 2013, the workgroup completed the protocols which are available at: <http://www.cdss.ca.gov/agedblinddisabled/PG2170.htm>.

It is essential that each county develop its own policies and procedures clearly addressing how they will implement the components of the protocols.

Purpose

The purpose of the protocols is to establish the basis for State and county policies, procedures, and timelines, and to provide instructions regarding acceptable activities to be performed, and acceptable measures to be taken for the purposes of program integrity and fraud prevention, detection, and coordinated investigation and prosecution in the IHSS Program. The protocols are intended to assist counties in developing and implementing policies and procedures to ensure consistency.

ACL 13-66 (September 30, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-66.pdf>

Documented Unmet Need

BACKGROUND

Documented unmet need is a recipient's total hours for non-Protective Supervision In-Home Supportive Services that are in excess of the statutory maximum. A recipient is not considered to have a documented unmet need if his/her total authorized non-Protective Supervision hours are less than the statutory maximum.

When a recipient's individually-assessed service needs exceed the statutory maximum, the IHSS Case Management, Information, and Payrolling System (CMIPS) automatically considers the case as having a documented unmet need and prorates the total number of unmet need hours across all authorized non-Protective Supervision service categories.

NOTICES OF ACTION

The total number of documented unmet need hours is reflected on the Notice of Action (NOA) which will have a system-generated NOA message indicating the documented unmet need hours. If the NOA does not have a message reflecting documented unmet need hours, this means the recipient does not have a documented unmet need. The following CMIPS II NOA messages address unmet need.

ACL 13-81 (September 30, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-81.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Expanded Subsidized Employment Program Implementation Guidelines

The purpose of this All County Letter (ACL) is to inform County Welfare Departments (CWDs) of the guidelines to implement the CalWORKs Welfare-to-Work (WTW) Expanded Subsidized Employment (ESE) Program resulting from the passage of AB 74. CDSS is encouraged by the expansion of subsidized employment program opportunities in California and the benefits of the ESE Program for CalWORKs clients.

The ESE Program is one part of Early Engagement strategies being implemented as a result of the passage of AB 74. Other Early Engagement strategies include robust appraisal and family stabilization, which will be discussed in separate, upcoming ACLs.

AB 74 amends WIC Section 11322.63 and adds WIC Section 11322.64 to implement the ESE Program starting on July 1, 2013.

ACWDL 13-19 (October 7, 2013) 2013/2014 Family Member base Allocation Amount

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-19%20wAttach.pdf>

The purpose of this letter is to provide counties with the updated family member base allocation amount per Section 1924(d) of the Social Security Act. The family member base allocation amount is used to determine how much the long-term care (LTC) beneficiary may allocate to family members.

Effective July 1, 2013 through June 30, 2014, the family member base allocation amount [for use in Section IX, A.2 and B.2 of the Allocation/Special Deduction Worksheet B, Form MC 176W (05/08)] for a family member living with the community spouse of a beneficiary with LTC status is \$1,939. The family member base allocation amount for the July 1, 2013 through June 30, 2013 period was \$1,891.

ACL 13-84 (October 3, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-84.pdf>

National Youth In Transition Database (NYTD) Survey: Second Cohort

The purpose of this ACL is to provide updated information and direction regarding the surveying of the second cohort of 17 year olds participating in the NYTD survey beginning October 1, 2013 through September 30, 2014. The second cohort consists of all youth in foster care turning 17 years of age during this timeframe. For the purpose of this letter, tribes having Title IV-E Agreements must follow the same requirements as counties.

The first cohort of 17 year olds was surveyed in FFY 2011. Those youth who participated in the survey at age 17 in FFY 2011 were surveyed as the follow-up population at age 19 in FFY 2013 (October 1, 2012 through September 30, 2013) and will be surveyed again at age 21 in FFY 2015.

ACL 13-82 (October 16, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-82.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs): Extending Benefits To Non-Minor Dependents – Questions And Answers (Part Two)

Assembly Bill (AB) 12 (Chapter 559, Statutes of 2010) established a new category of youth, Non-Minor Dependents (NMDs), eligible to receive CalWORKs benefits. Under AB 12, NMDs who meet at least one of the five AB 12 eligibility conditions, agree and adhere to the Mutual Agreement (SOC 162), and cooperate with the six-month review hearings/certification (see ACL 11-69) are eligible for extended CalWORKs benefits.

In order to be eligible for extended CalWORKs, a youth must meet one of the five AB 12 eligibility conditions, which include:

- (1) Completing secondary education or a program leading to an equivalent credential,
- (2) Being enrolled at least half-time in an institution which provides post-secondary or vocational education,
- (3) Participating in a program or activity designed to promote or remove barriers to employment,
- (4) Being employed for at least 80 hours per month, or
- (5) Being incapable of doing any of the activities described in (1) to (4) due to a documented medical condition.

ACL 13-88 (October 23, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-88.pdf>

Households Leaving CalWORKs Due To Failure To Provide A Complete SAR 7

The purpose of this All County Letter (ACL) is to notify County Welfare Departments (CWD) of a change in Transitional CalFresh (TCF) policy. The Food and Nutrition Service (FNS) has recently advised the California Department of Social Services (CDSS) that TCF benefits may not be issued to households leaving CalWORKs due to a failure to submit a complete SAR 7 (periodic report) for CalWORKs or CalFresh. This policy change is effective immediately with the transmission of this letter. According to Title 7, CFR part 273.26 (c)(6), all household members are ineligible to receive TCF benefits when the case is closed for not providing information necessary to determine eligibility or for a subsequent review of eligibility. As interpreted by FNS, the failure to submit a complete SAR 7 or submit an application for, or complete the redetermination/recertification (RD/RC) constitutes a failure to provide necessary information to determine eligibility or for a subsequent review of eligibility.

If a household submits a SAR 7 and fails to meet all of the CalWORKs reporting requirements, but meets the CalFresh requirements, then CWDs shall evaluate the household's ongoing eligibility for CalFresh. The household should be converted to a nonassistance CalFresh (NACF) household, retain the current certification period, and benefits are to be calculated based upon the information provided on the SAR 7 and the removal of the CalWORKs grant from the CalFresh benefit calculation.

If the household does not respond to the request for RD/RC or submits an application for RD/RC and fails to complete the RD/RC process, the household will not be eligible for TCF benefits at the time the CalWORKs and CalFresh benefits are stopped. If the household completes the RC, but fails to complete the CalWORKs RD, and is otherwise eligible to CalFresh, then the CWD should set-up a new certification period converting the household to a NACF household because the household is ineligible to TCF.

All policy regarding how to establish TCF benefit amounts remain unchanged. All other current reasons a CalFresh household is not eligible to TCF still apply.

Example 1

The public assistance CalFresh (PACF) household submits a SAR 7 and fails to answer a CalWORKs-only question. The household does not respond to the NA 960Y and is discontinued from CalWORKs following normal CalWORKs procedures.

The household had provided all information required to be reported for CalFresh and based on the information provided the household continues to be eligible to CalFresh. The CWD converts the case to a NACF household and maintains the household's current certification period and TCF would not be issued.

If the household submits the SAR 7 in the month following the discontinuance from CalWORKs, effectively restoring the CalWORKs case, then the household would be converted back to PACF and CalFresh benefits adjusted for the inclusion of the CalWORKs grant with timely and adequate notice.

Example 2

The PACF household fails to submit a SAR 7 and does not respond to the NA 960X. The household is discontinued at the end of the submit month from both CalWORKs and CalFresh following existing procedures. TCF is not issued to the household. Some examples of TCF eligible households include, but are not limited to the following:

- Discontinued from CalWORKs due to excess income. The new IRT for CalFresh does not impact TCF rules. If the household is eligible to TCF then changes in income are not considered when determining the amount of benefits the household is eligible to during the TCF benefit period
- Households that voluntarily withdraw from CalWORKs.
- The reason the CalWORKs case discontinued is due to a parent timing out or child aging out when that individual was the last eligible person in the AU. In this circumstance for households in which an individual would otherwise be eligible to CalWORKs if not for a CalWORKs sanction are not eligible to TCF since the CalWORKs case would not be closed.

Further guidance on additional criteria for households leaving CalWORKs (the remainder of 7 CFR 273.26), which are ineligible for TCF, will be addressed in a subsequent letter when clarification is received from FNS. State regulations governing TCF benefits will be amended to reflect the above changes.

ACL 13-87 (October 28, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-87.pdf>

Changes To The Requirements For Placement In Group Homes For Children Ages Twelve And Under With The Passage Of Assembly Bill 74

This All County Letter (ACL) is to inform counties and tribes of changes to the requirements for placement in group homes for children ages twelve and under, authorized through Assembly Bill (AB) 74 and effective immediately. These requirements apply to child welfare and probation agencies as well as tribes with Title IV-E Agreements. The specific sections of the Welfare and Institutions Code (W&IC) with changes made by AB 74 are attached to this ACL.

ACL 13-86 (October 25, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-86.pdf>

Assessing Youth Residing In Group Care Longer Than One Year

In September 2012 the California Department of Social Services (CDSS) began working with stakeholders to reform the state's congregate care system, emphasizing that children and families are best served when children live with a committed, permanent, and nurturing family. Congregate care, when necessary, is best used as a short-term, high-quality intervention that is part of a continuum of care for children and youth. Congregate care in California is no longer a destination, rather, an intervention tailored to meet the needs of the individual child being served.

To date, this work has resulted in two significant statutory changes regarding foster youth placed in group care. Specifically, the 2011 Realignment Trailer Bill added W&IC section 11467(c)(2) requiring CDSS to work with stakeholders to develop a procedure for identifying youth who have been in group care for one year or longer to determine the reason for the continued stay and to develop a plan for each child to transition to a family-like setting as appropriate. In addition, AB 74 (Chapter 21, Statutes of 2013), added W&IC section 16010.8 requiring CDSS to report to the legislature on the outcomes of the assessment of each youth in group care for longer than one year and the outcomes of transitions or plans to transition each youth to family settings.

E-Note #106 - Jurisdictional Issues in Caretaker Relative/Joint Custody of Children Cases

October 25, 2013

References: Para-Reg 005-2 re §22-054.34; Para-Reg 1202-1 Regarding Collateral Estoppel; Para-Reg 075-2A, 075-2B, and 076-1A re Joint Custody of Minor Children; Para-Reg 240-3 re CalFresh household composition

Listed below are paraphrased regulations pertaining to who the caretaker relative is when there is a joint custody arrangement between the parents, as well as para-regulations pertaining to the procedural considerations in these types of cases.

It is not unusual for there to be hearing requests by both the parents when the county has made a determination about which one is the proper caretaker relative for the purpose of receiving cash aid and CalFresh benefits on the child(ren)'s behalf.

If parent A requests a state hearing, and the judge makes a determination in his/her favor, parent B may request his/her own state hearing disputing that decision. Since our state hearing process does not currently allow for both parent A and parent B to be claimants in a single hearing, each parent does have the right to file his/her own appeal and have a state hearing under certain circumstances.

Specifically, since parent B is not a party to the state hearing involving parent A, a hearing request may not be dismissed pursuant to §22-054.34 because while the issue is identical, the claimant in the prior state hearing (parent A) is not identical to the claimant in the current state hearing (parent B). Similarly collateral estoppel is not applicable because the party in the prior hearing is not the same as the party in the current hearing. Therefore, if Parent B gets a discontinuance and/or overpayment/overissuance notice of action based on a state hearing decision that determined Parent A to be the proper caretaker relative, Parent B has the right to request a state hearing, and the issue for review would be whether the county's discontinuance/overpayment/overissuance action was correct.

Each case is based on its own merits, so it is possible to have inconsistent decisions, with each judge being correct based on the preponderance of evidence in the case before him/her.

It is not until both parents have each had his/her own state hearing and decision pertaining to a specific time period, and then requests another hearing involving the same issue and time period will §22-054.34 apply, i.e., where the case shall be dismissed because the identical issue which the claimant is protesting has already been the subject of a previous state hearing involving the claimant.

One way to avoid multiple inconsistent decisions is to have the second parent appear as a witness, either voluntarily or by subpoena.

Para-Reg: 075-2A:

If a child stays alternately for periods of one month or less with each of his/her parents who are separated or divorced, in most circumstances the caretaker/relative is the parent with whom the child stays for the majority of the time. The temporary absence of the parent or the child from the home does not affect this determination. The parent with whom the child stays for less than the majority of the time may be the caretaker/relative, if the parent can establish that he or she

has majority responsibility for the care and control of the child. When the child spends an equal amount of time with each parent and each parent exercises an equal share of care and control responsibilities, the parent who applies for aid shall be the caretaker/relative provided that the child's other parent is not currently applying for or receiving aid for the child. (§82-808.4)

Para-reg:075-2B:

When each parent exercises an equal share of care and control responsibilities, and each has applied for aid, the caretaker/relative shall be determined in the following order:

- (a) The parent designated as the primary caretaker for purposes of public assistance, by a court order, pursuant to Civil Code §4600.5(h), revised to Family Code §3086, effective 1/1/94.
- (b) The parent who would be eligible for aid, when there is no court designation.
- (c) The parent designated by mutual agreement when both parents would be eligible.
- (d) The parent who first applied for aid, when the parents cannot mutually agree.

(§82-808.413)

Para-Reg 240-3:

In general, state regulations define a household for CalFresh purposes as a group of individuals who live together and customarily purchase food and/or [emphasis added] prepare meals together for home consumption. (§63-402.13) State regulations define "customarily purchasing and preparing meals together" as a CalFresh household which is doing so usually, or as a matter of course. (§63-402.131)

Para-Reg 005-2:

A hearing request shall be dismissed when the identical issue which the claimant is protesting has already been the subject of a previous state hearing involving the claimant. (§22-054.34)

Para-Reg 1202-1:

Collateral estoppel precludes a party to an action from relitigating in a second proceeding matters litigated and determined in a prior proceeding by a court of competent jurisdiction. (*Teitelbaum Furs, Inc. v. Dominion Ins. Co. Ltd.* (1962) 58 Cal.2d 601, 25 Cal.Rptr. 559, 375 P.2d 439, *Clark v. Leshner* (1958) 46 Cal.2d 874, 239 P.2d 865)

In *Teitelbaum*, the Supreme Court held that a guilty plea is admissible in a subsequent civil trial as an admission, but such plea is not conclusive for the purpose of applying the doctrine of collateral estoppel.

The principles of collateral estoppel apply to the decisions of administrative agencies when the agencies are acting in a judicial or quasi-judicial capacity. (*Hollywood Circle, Inc. v. Department*

of Alcoholic Beverage Control (1961) 55 Cal.2d 728, 13 Cal.Rptr. 104, 361 P.2d 712; *People v. Sims* (1982) 32 Cal.3d 468, 186 Cal.Rptr. 77)

In order for the principles of collateral estoppel to apply, three elements must be present: (1) the issue decided at the previous proceeding is identical to the one which is sought to be relitigated; (2) the previous proceeding resulted in a final judgment on the merits; and (3) the party against whom collateral estoppel is asserted was a party or in privity with a party at the prior proceeding. (*People v. Taylor* (1974) 12 Cal.3d 686, 117 Cal.Rptr. 70)

Only judgments which are free from direct attack are final and may not be modified. See *Morris v. McCauley's Quality Transmission Service* (1976) 60 Cal.App.3d 964, 132 Cal.Rptr. 37. With respect to administrative hearings, an agency's hearing decision is to be regarded as final unless the agency has the statutory authority to subsequently modify the decision. See *Olive Proration Program v. Agriculture Commission* (1941) 17 Cal.2d 204, 109 P.2d 918.

E-NOTE #105 - ACL/ACIN/MEDIL SUMMARIES

September 25, 2013

1. ACL 13-67 (August 30, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-67.pdf>

Final County Instructions For Implementation Of Assembly Bill 2013, Electronic Benefit Transfer (EBT) Electronic Theft

This All County Letter (ACL) is to provide final instructions for the implementation of Assembly Bill (AB) 2035 (Chapter 319, Statutes of 2012) which requires the prompt restoration of EBT cash benefits lost due to electronic theft. Electronic theft occurs when a recipient (or authorized representative) has not lost physical possession of their EBT card and money is stolen from their EBT account electronically (often called skimming).

Pursuant to AB 2035, the CDSS has established a protocol for recipients who believe their EBT cash benefits have been stolen via electronic theft, to be able to report this, and if determined to meet the requirements established in this ACL, to have the stolen benefits promptly restored into their EBT account. The protocol includes a reporting form, timelines for county review, instructions regarding when a referral for investigation is made, and notice of action language.

It is recommended that this ACL be read in its entirety.

2. ACIN I-54-13 (August 30, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-54_13.pdf

Able-Bodied Adults Without Dependents Statewide Waiver For FFY 2014

The purpose of this letter is to inform counties that the California Department of Social Services (CDSS) has received federal approval for a statewide waiver of the Able-Bodied Adults without Dependents (ABAWD) work requirement for Federal Fiscal Year (FFY) 2014. The waiver is effective from October 1, 2013 through September 30, 2014. The waiver was approved by the United States Department of Agriculture, Food and Nutrition Service (FNS) on July 29, 2013. It is based on a recent 12 month average unemployment rate exceeding 10 percent for California from January through December of 2012. Consistent with federal regulations at 7 CFR 273.24 (f)(2)(i), having a recent unemployment rate above 10 percent is one of the criteria that qualifies a geographic area for an ABAWD waiver.

This letter satisfies the provisions of Welfare and Institutions Code Sections 18926 which requires CDSS CalFresh Branch to announce the beginning of another waiver for

all eligible counties within California except for those counties that decline to participate. This letter contains ABAWD policy information for counties that choose to participate in the ABAWD waiver. Instructions are also provided for any counties that choose not to do so. California received statewide ABAWD waivers for FFY 2012 and 2013. As no counties opted out of the waiver in 2013, no CalFresh recipients are currently subject to the ABAWD work requirement in California.

3. ACL 13-71 (September 10, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-71.pdf>

Implementation Of The Work Incentive Nutritional Supplement (WINS) Program Automation

The purpose of this letter is to provide County Welfare Departments (CWDs) with instructions for the automation implementation of the Work Incentive Nutritional Supplement (WINS) program via the issuance of the WINS benefit for eligible CalFresh recipients. Welfare and Institutions Code (WIC) Section 15525 specifies payment of WINS benefits shall not commence prior to January 1, 2014, with full implementation by all counties no later than July 1, 2014. WINS is a mandatory program. Therefore, WINS benefits will automatically be given to all CalFresh recipients meeting the WINS eligibility requirement by the full implementation deadline. Thereafter, the eligibility determination for WINS benefits shall occur at an initial application, a Semi-Annual Reporting period, and at annual recertification consistent with CalFresh requirements.

The WINS program will allow each county to provide a ten dollar (\$10) per month additional food supplement benefit for each WINS eligible CalFresh household.

4. ACL 13-73 (September 9, 2013)

http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-73_13-19.pdf

Providing Services To The *Katie A.* Subclass; Semi-Annual Progress Reports For *Katie A.* Implementation For The Time Period Of May 15, 2013-August 31, 2013: Due On October 18, 2013

The purpose of this MHSD Information Notice/All County Letter is to outline expectations for county Child Welfare Departments (CWDs) and Mental Health Plans (MHPs) for providing Specialty Mental Health Services, and preparing and submitting semi-annual progress reports related to Specialty Mental Health Services for children who have an open child welfare case. In November 2012, the United States District Court approved an Implementation Plan setting forth how the California Department of Social Services (CDSS) and the Department of Health Care Services (DHCS) will fulfill the obligations specified in the Settlement Agreement in the *Katie A. v. Bonta* lawsuit.

The *Katie A.* Settlement Agreement, Implementation Plan, and related court orders obligate the state to ensure the provision of Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and after January 1, 2014, and upon federal approval, Therapeutic Foster Care (TFC), to a subclass of children. Under federal and state Early Periodic Screening Diagnosis and Treatment (EPSDT) and Specialty Mental Health Services law and their current contract with DHCS, MHPs are required to provide Specialty Mental Health Services as determined medically necessary. Pursuant to the *Katie A.* Settlement Agreement, Implementation Plan and related court orders, ICC and IHBS, delivered consistent with the interagency Core Practice Model (CPM), are Specialty Mental Health services that must be provided when determined medically necessary. The Implementation Plan also provides that MHPs and county CWDs are to jointly prepare and submit semi-annual progress reports related to the implementation of these services. This MHSD Information Notice/All County Letter addresses both of these matters.

5. ACIN I-52-13 (September 12, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-52_13.pdf

Information On Cost-Of-Living Adjustments (COLAs): Maximum Supplemental Nutrition Assistance Program (SNAP) Allotments, Standard Deduction, Shelter Deduction, Homeless Household Shelter Allowance, Standard Utility Allowance (SUA), Limited Utility Allowance (LUA), Telephone Utility Allowance (TUA), Income Eligibility Standards And CalFresh Tables Of Coupon Issuance – Effective October 1, 2013

This letter transmits information on the COLAs for Federal Fiscal Year (FFY) 2014, for the following period October 1, 2013 through September 30, 2014. The CalFresh COLAs provided in this letter are effective October 1, 2013 for all households.

6. MEDIL - I 13-12 (September 16, 2013) AFFORDABLE CARE ACT FOLLOW-UP GUIDANCE

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%20I13-12%20wAttach.pdf>

The Department of Health Care Services (DHCS) is providing this follow-up guidance as a result of recently enacted state law, Senate Bill (SB) x1 1 and Assembly Bill (AB) x1 1 Statutes of 2013, as well as recent guidance provided by the federal Centers for Medicare & Medicaid Services (CMS) on the Affordable Care Act of 2010 (ACA). This letter provides various ACA related policy guidance to counties and Statewide Automated Welfare Systems (SAWS) based on the analysis of state law, proposed federal regulations, and discussions with CMS as ACA policy and guidance continue to develop. This letter provides the counties and SAWS with high-level policy guidance where possible, and also identifies

policy areas where insufficient federal regulations or guidance limit DHCS' ability to provide such policy guidance to counties and SAWS. Furthermore, this letter supersedes and obsoletes Medi-Cal Eligibility Division Information Letter (MEDIL) 13-03.

ACA requirements described in this letter pertain to Medi-Cal eligibility policies and procedures that need to be implemented no later than either October 1, 2013, or January 1, 2014, depending on the requirement. To further define these requirements, State statute has been enacted via the aforementioned AB x1 1 and SB x1 1, and will be followed by policy guidance in the form of All-County Welfare Directors' Letters (ACWDLs) and state regulations. Given the timing of implementation, this follow-up guidance is being provided to inform preparatory steps towards implementation.

7. ACL 13-75 (September 19, 2013)

<http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-75.pdf>

Revised CalFresh Application Form

The purpose of this letter is to transmit the revised CalFresh application form and the implementing instructions to county welfare departments (CWDs). Also included in this transmittal is a list of the forms that have been made obsolete due to the revision of the CalFresh application form.

8. ACL 13-78 (September 19, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-78.pdf>

CalFresh Intercounty Transfer (ICT)

The purpose of this ACL is to provide counties with additional clarification on the ICT process for CalFresh. In addition, this letter transmits the CF 215, CalFresh ICT Form, which is to be included in all CalFresh ICTs. Finally, this letter will provide examples related to budgeting, recertification, and responsibility for benefit payment. As described in ACL 11-22, CWDs were to begin using the existing CalWORKs ICT process for those CalFresh cases with a CalWORKs component and the existing Medi-Cal ICT process for those CalFresh cases with a Medi-Cal component effective April 1, 2011. In addition, County Welfare Departments (CWDs) were to begin using the process described in ACL 11-22 for CalFresh only cases no later than July 1, 2011.

ACL 11-22 excluded households receiving Transitional CalFresh from the ICT process. Due to clarification received from the United States Department of Agriculture (USDA), Food and Nutrition Service (FNS), Transitional CalFresh households are subject to recertification at the end of the 5-month transitional period (refer to ACL 11-70 dated October 26, 2011). This change results in certain Transitional CalFresh cases being subject to ICT procedures.

Per Welfare & Institutions Code Section 11053.2, the ICT process shall facilitate a recipient's move from one county to another without a break in benefits and without requiring a new CalFresh application or interview in the new county of residence. Households that move during either of the final two months of their certification period shall be recertified at the end of the certification period in the former county of residence to prevent a break in benefits. Following the recertification, an ICT should be initiated.

In order to ensure that household's are not subjected to a break in benefits, it is critical that counties communicate and share information to determine in which county it is more beneficial for the recertification to be completed. It is the responsibility of the sending county to confirm that the receiving county is provided with all information necessary to complete the transfer. A household cannot be terminated for being a resident of the receiving county until the receiving county has assumed responsibility for the case.

9. ACL 13-69 (September 20, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-69.pdf>

Temporary Assistance For Needy Families (TANF) And California Work Opportunity And Responsibility To Kids (CalWORKs) Time Limit Exemption For Recipients Living In Indian Country Where The Unemployment Of Adults Is 50 Percent Or Higher

The purpose of this All County Letter (ACL) is to report the results of a survey that the California Department of Social Services (CDSS) recently completed. The purpose of the survey was to document whether federally recognized tribes in the state have experienced 50 percent or higher unemployment among adults in their tribal service areas in the previous calendar year. The process of conducting the survey and publishing the results allows the CDSS to act as a conduit to inform the counties if the Indian Country residents who participate in a Temporary Assistance for Needy Families (TANF) program qualify for the federal and state time limit exemption.

10. ACL 13-79 (September 24, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-79.pdf>

CalFresh Administrative Overissuances

The purpose of this letter is to provide County Welfare Departments (CWDs) with instructions regarding changes to CalFresh administrative error (AE) overissuances mandated by Senate Bill (SB) 1391, Chapter 491, Statutes of 2012. SB 1391 does the following: (1) establishes a single percentage allotment recoupment rate for AE overissuances for all active CalFresh households; (2) raises the AE overissuance claim establishment threshold for inactive CalFresh households from \$35 to \$125, and; (3)

requires CalFresh overissuance Notices of Action (NOAs) to include a statement of the overissuance threshold. SB 1391 requires that implementation be completed by January 1, 2014.

11. ACIN I-52-13E (September 23, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-52_13E.pdf

Correction To The Attachments Included In All County Information Notice (ACIN) I-52-13, Information On Cost-Of-Living Adjustments (COLAs), Effective October 1, 2013

County Information Notice (ACIN) I-52-13. This correction is due to the changes in the Income Reporting Threshold (IRT) for households under the implementation of Semi-Annual Reporting (SAR) effective October 1, 2013. The attachments are corrected to read as follows:

Attachment I

Under the heading entitled Gross Monthly Income Eligibility Standards (130% of Poverty Level) is changed to include the IRT's for households and the heading reads: Gross Monthly Income Eligibility Standards/Income Reporting Threshold (IRT) for Semi-Annual Reporting (SAR) (130% of Poverty Level).

E-NOTE #104 – ACL/ACIN/ACWDL/MEDL SUMMARIES

August 27, 2013

ACL 13-57 (July 5, 2013)

CALFRESH: NEW (AND REVISED) FORMS FOR THE SEMI-ANNUAL REPORTING (SAR) SYSTEM

This ACL includes revised SAR forms.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-57.pdf>

ALL COUNTY INFORMATION NOTICE I-39-13 (July 8, 2013)

The purpose of this letter is to provide counties with clarification of policies regarding the treatment of homeless youth in CalFresh. Attached to the ACIN is Administrative Notice (AN) 13-19 from the United States Department of Agriculture (USDA), Food and Nutrition Service (FNS), clarifying the treatment of homeless youth. Specifically, the memorandum provides details regarding the proof of verification of photographic identification, verification of a permanent address, and the misconception there is an age requirement.

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-39_13.pdf

A link to the FNS memo is: http://www.fns.usda.gov/snap/outreach/pdfs/Homeless_QA.pdf

ALL COUNTY INFORMATION NOTICE NO. I-33-13 (July 9, 2013)

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs): POSTING DISPLACEMENT GRIEVANCE GUIDELINES FOR NON- UNION EMPLOYEES AT WORKSITES WITH WELFARE-TO-WORK (WTW) PARTICIPANTS

This All County Information Notice (ACIN) is to update guidelines regarding the requirement for County Welfare Departments (CWD) to provide non-union employees with information about their rights to file displacement grievances, as provided for in the California Department of Social Services (CDSS) Manual of Policies and Procedures (MPP) Section 42-720.3.

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-33_13.pdf

ALL COUNTY LETTER (ACL) NO. 13-06 (July 3, 2013)

ICPC AND INDEPENDENT ADOPTION AGENCY RESPONSIBILITIES

This ACL provides new ICPC information regarding recently enacted legislation,

AB 687, as it relates to licensed private adoption agencies and independent adoptions. AB 687 added Family Code section 7913 effective January 1, 2012.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-06.pdf>

ALL COUNTY LETTER NO. 13-43 (July 11, 2013)

NEW ROLES AND RESPONSIBILITIES IN THE SPECIALIZED CARE RATE PROGRAM

This ACL advises counties of the changes in the Specialized Care Rate Program (or Specialized Care Increment (SCI)), and clarifies roles and responsibilities pursuant to the changes to W&IC section 11461(e)(1) Regulations implementing these changes are forthcoming.

The W&IC section 11461(e)(1) as amended by SB 1013 now states (new requirements are in *italics*):

“Specialized care increment” means an approved AFDC-FC amount paid on behalf of an AFDC-FC child requiring specialized care to a home listed in subdivision (a) in addition to the basic rate. *Notwithstanding subdivision (a), the specialized care increment shall not be paid to a nonminor dependent placed in a supervised independent living setting as defined in subdivision (w) of Section 11403. A county may have a rate-setting system for specialized care to pay for the additional care and supervision needed to address the behavioral, emotional, and physical requirements of foster children. A county may modify its specialized care rate system as needed, to accommodate changing specialized placement needs of children.*

(2)(A) The department shall have the authority to review the county's specialized care information, including the criteria and methodology used for compliance with state and federal law, and to require counties to make changes if necessary to conform to state and federal law.

(B) The department shall make available to the public each county's specialized care information, including the criteria and methodology used to determine the specialized care increments.

(3) Upon a request by a county for technical assistance, specialized care information shall be provided by the department within 90 days of the request to the department.”

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-43.pdf>

ALL COUNTY LETTER (ACL) NO. 13-59 (July 11, 2013)

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO

KIDS (CaIWORKs) PROGRAM: RELEASE OF THIRD SET OF

QUESTIONS AND ANSWERS FOR SENATE BILL (SB) 1041

(CHAPTER 47, STATUTES OF 2012) CaIWORKs WELFARE-TOWORK

(WTW) PROGRAM CHANGES

The purpose of this letter is to provide answers to questions that the California Department of Social Services (CDSS) has received about the implementation instructions issued to County Welfare Departments (CWDs) for major changes that were made to CalWORKs WTW requirements pursuant to SB 1041. This letter addresses questions on various subjects including but not limited to the new WTW 24-Month Time Clock, the new state standards that are based on federal participation requirements, and reengagement of clients whose short term exemption ended on December 31, 2012, for caring for a young child 12 to 23 months of age, or two or more children under the age of six.

Initial implementation instructions for these program changes are contained in ACLs 12-67, 12-69, and 13-01. The first and second set of answers to questions relating to these program changes are contained in ACL 13-15 and ACL 13-37.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-59.pdf>

ACL 13-52 (July 16, 2013)

California Work Opportunity And Responsibility To Kids (CalWORKs) New Young Child 48-Month Time Limit And Welfare-To-Work (WTW) Participation Exemption Clarifying Guidance

The purpose of this letter is to provide answers to questions about the implementation instructions issued to County Welfare Departments for CalWORKs exemptions for providing care for a young child; specifically, the new one-time exemption for the parent or other relative has primary responsibility for personally providing care to one child from birth to 23 months, inclusive. An individual may be exempt only once for this criteria. This letter contains Questions and Answers (Attachment I) gathered from stakeholders in response to the passage of SB 1041 and the release of ACL 12-72 to clarify implementation issues regarding the new one-time young child exemption.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-52.pdf>

ACL 13-51 (July 16, 2013)

California Work Opportunity And Responsibility To Kids (CalWORKs) Immunization And School Attendance Notices Of Action (NOAs) And Immunization Information

The purpose of this All County Letter (ACL) is to provide County Welfare Departments (CWDs) information regarding a new combination vaccine and to inform CWDs of two revised NOAs for immunization and school attendance.

<<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-51.pdf>>

ACIN I-40-13 (July 15, 2013)

Release Of The CalWORKs Minimum Basic Standards Of Adequate Care (MBSAC) Region Two Table To Assign A Value to In-Kind Assistance Only To Determine Indigence In The CalFresh Program

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-40_13.pdf>

ACIN I-37-13 (July 22, 2013)

Guidance On The Implementation Of The Affordable Care Act Of 2010

The purpose of this All County Information Notice (ACIN) is to inform counties of the Department of Health Care Services' (DHCS) approach to providing policy guidance to counties over the coming months regarding the implementation of the Affordable Care Act of 2010 (ACA) which begins October 2013.

DHCS will be issuing a Medi-Cal Eligibility Division Information Letter (MEDIL) rather than a traditional All County Welfare Director's Letter (ACWDL) to expedite providing counties and the

Statewide Automated Welfare System (SAWS) with policy guidance continuously over the coming months.

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/l-37_13.pdf

ACL 13-33 (July 23, 2013)

Foster Care - Sibling Placement - Assembly Bill (AB) 743

The purpose of this All County Letter is to provide information regarding AB 743 which was signed into law on September 30, 2010. The AB 743 makes technical changes to statute in regard to placing siblings together in foster care, relative, guardianship, or adoption placements consistent with implementation of federal mandates of PL 110-351 section 206 and establishes noticing requirements when siblings, who are placed together, are separated. The intent of AB 743 is to help maintain and strengthen the ties between siblings.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-33.pdf>

ACL 13-61 (July 24, 2013)

CalFresh Waiver To Send E-Notifications And View Notices Electronically

The purpose of this All County Letter (ACL) is to notify County Welfare Departments (CWDs) of the United States Department of Agriculture, Food and Nutrition Service (FNS) approval of waivers that allow households to receive an electronic notification, or e-notification, of official correspondence. The waiver includes instructions for implementation and will become effective once programmed by statewide automated welfare systems (SAWS). E-notifications will alert households to view CWD correspondence via their secure personal online account in the CWD's automated system. CalFresh and CalWORKs clients may opt in or opt out of receiving e-notifications and receive traditional paper correspondence at **any** time.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-61.pdf>

ACL 13-60 (July 24, 2013)

2012 Title IV-E Foster Care Eligibility Review Results And Findings

In November 2012 the United States Department of Health and Human Services (DHHS) conducted California's fourth Title IV-E Foster Care Eligibility Review. This ACL contains examples of errors made by the county in IV-E cases.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-60.pdf>>

ACIN I-35-13 (July 24, 2013)

Best Practices For Increasing Eligible Youth Participation In The CalFresh Program

The purpose of this ACIN is to communicate with counties about best practices to engage former foster youth and Non-Minor Dependents (NMDs) in applying for and receiving CalFresh benefits. The California Department of Social Services (CDSS) would like to emphasize the importance of providing youth who are exiting foster care and non-minor dependents with one-on-one assistance filling out the benefits application on-line, by fax, mail, or in person, and submitting it to the proper CalFresh office. It is the goal of CDSS to ensure all eligible youth are referred to and connected with CalFresh benefits.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-35_13.pdf>

ACL 13-18 (July 30, 2013)

Timely Submission Of Recertification Applications

The purpose of this letter is to transmit policy guidance regarding the timely submission of CalFresh recertification applications. The California Department of Social Services has become aware that the Manual of Policies and Procedures (MPP), Sections 63-504.61(c)(1) through (3) pertaining to timely applications for recertification requires modification and will be corrected as soon as administratively possible. In the interim, County Welfare Departments shall comply with this letter until the regulations are codified.

To the degree that MPP Section 63-504.61(c)(1) through (3) is not consistent with federal regulations found at 7 CFR § 273.14(c)(1) and (2), counties shall implement the following policies:

For households certified longer than two months, an application for recertification is considered timely when submitted by the 15th day of the last month of the certification period.

In the rare circumstance that a household is given a one or two month certification period, an application for recertification is considered timely when it is submitted within 15 days of receipt of the Notice of Expiration of Certification (NEC). In this instance, the NEC would be provided with the approval for CalFresh benefits.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-18.pdf>

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 13 -17 (July 19, 2013)

FILE RETENTION REQUIREMENTS – REMINDER

PURPOSE AND BACKGROUND

The purpose of this All County Welfare Directors Letter (ACWDL) is to provide counties with requirements associated with the retention of documents in paper files and/or imaged files of Medi-Cal cases.

ACWDL No.: 00-31 advises counties that each case record must contain adequate information with supportive documentation to verify an individual's eligibility. Necessary documentation includes the original application, income and resource verifications. In addition, Welfare and Institutions Code 10850 requires the confidential maintenance of applications and Welfare and Institutions Code 10851(a) states, "The case record must be maintained for a period of three years. The three-year retention period begins on the date on which public social services were last provided.

ACIN I-27-13 (August 1, 2013)

Senate Bill (SB) 1521, Chapter 847, Statutes Of 2012 Regarding Reunification Services For A Parent Registered On A Sex Offender Registry; And County Assessments And Reports On The Multipurpose Child Welfare Training Program

FAMILY REUNIFICATION SERVICES TO A PARENT OR GUARDIAN REGISTERED ON A SEX OFFENDER REGISTRY

In order to align California law with the federal requirement at Section 106(b)(2)(B)(xvi)(VI) of the CAPTA Reauthorization Act of 2010, SB 1521 added paragraph (16) to WIC Section 361.5(b). This new provision states that reunification services need not be provided to a parent or guardian when the court finds, by clear and convincing evidence, that the parent or guardian has been required by the court to be registered on a sex offender registry as specified in the federal Adam Walsh Child Protection and Safety Act of 2006. Under WIC Section 361.5(c), the court shall hold a dispositional hearing to decide whether to order reunification. The court shall not order reunification services to a parent described in (b)(16) unless the court finds by clear and convincing evidence that reunification is in the best interest of the child.

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-27_13.pdf>

ACIN I-41-13 (July 31, 2013)

Federal Fiscal Year (FFY) 2014, Standard Utility Allowance (SUA), Limited Utility Allowance (LUA), And Telephone Utility Allowance (TUA) – Effective October 1, 2013

Effective October 1, 2013, the SUA amount will increase from \$331 to \$363. The LUA amount will increase slightly from \$104 to \$109. However, the TUA remains unchanged at \$20. We have not yet received the Cost of Living Adjustment (COLA) information provided by FNS, which includes additional deductions, income eligibility standards, and benefit amounts. This information will be provided in a subsequent letter as soon as it is received.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-41_13.pdf>

MEDIL - I 13-08 (August 7, 2013)

MC 003 Form, Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Informational Notice Available in all Threshold Languages

The EPSDT informational notice (MC 003 revision 11/12) has been translated into the following threshold languages and is posted on the Department of Health Care Services website for counties to print as needed: Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Russian, Tagalog and Vietnamese.

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%20I13-08.pdf>

MEDIL - I 13-09 (August 7, 2013)

Preorder for the Single Streamlined Paper Application, Revised Pub 68 and Revised MC 219 Forms

The purpose of this letter is to request counties to preorder the new single streamlined paper application form and other Department of Health Care Services (DHCS) forms that are contained in the Medi-Cal mail-in application packet that are being updated. Preordering by August 19, 2013, will assist DHCS and the publication and distribution vendors to have sufficient quantities available for the initial open enrollment period of the California Health Benefit Exchange, Covered California, beginning October 1, 2013.

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%20I13-09%20wAttach.pdf>

ACWDL 13-16 (August 8, 2013)

Annual Redetermination

The purpose of this All County Welfare Directors Letter (ACWDL) is to provide counties with Federal and State requirements associated with performing timely redeterminations of Medi-Cal cases.

ACWDL 06-16 provides the Federal and State codes and regulations, policy clarification and instructions that counties may reference. Title 42, Code of Federal Regulations, Section 435.916 (a), states that the agency must redetermine the eligibility of Medicaid recipients with respect to circumstances that may change at least once every 12 months. Welfare and Institutions Code (W&I), Section 14012 states that reaffirmation shall be filed annually and may be required at other times in accordance with general standards established by the California Department of Health Care Services (CDHCS). Title 22, California Code of Regulations (CCR), Section 50189 (c) (1), states the county shall complete the redetermination within 12 months of the most recent approval of eligibility on any application, reapplication or restoration which requires a Statement of Facts form. Further guidance is provided in ACWDL Nos.: 06-17, Medi-Cal Annual Redetermination Form, and 11-23, Questions and Answers – Medi-Cal Annual Redeterminations.

Please note this ACWDL does not supersede Federal or State requirements that become effective January 1, 2014 pursuant to the Affordable Care Act of 2010.

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-16.pdf>

ACIN I-50-13 (August 23, 2013)

Traditional And Modified Categorical Eligibility

The purpose of this letter is to provide clarification regarding traditional Categorical Eligibility (CE) and Modified Categorical Eligibility/Broad-Based Categorical Eligibility (MCE/BBCE).

Eligibility

Non-assistance CalFresh households that have been approved for CalFresh as MCE/BBCE are subject to the same conditions that result in ineligibility as all other CE households. Federal guidance and regulations (7 CFR 273.2(j)(2)(vii) and State regulations (MPP Section 63-301.74) state that households are not categorically eligible and are subject to all CalFresh eligibility requirements in the following scenarios:

- Any household member is disqualified for an intentional program violation (IPV).
- Failure to comply with reporting requirements.
- The head of household does not comply with work requirements.
- Any member of a household has been convicted of a drug-related felony (refer to MPP Section 63-402.229).

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-50_13.pdf>

MEDIL - I 13-10 (August 21, 2013)

Delay of Low Income Health Program Redeterminations from October to December 2013

The purpose of this letter is to inform counties that the Department of Health Care Services (DHCS) has received approval from the Center for Medicare and Medicaid Services (CMS) for the Low Income Health Program (LIHP) to delay annual redeterminations for LIHP enrollees during the last quarter of 2013. The purpose of the delay is to minimize confusion during the transition period for enrollees moving to the Medi-Cal program or coverage options under Covered California.

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%20I13-10%20wAttach.pdf>

E-NOTE #103 – FLEEING FELON ISSUE

July 12, 2013

References: 7 U.S.C. §2015(k)(1); 7 U.S.C. §2015(k)(2); §63-402.224;63-102(p)(2); 63-102(f)(4) Para-regulations 243-7; 243-7A; 243-7C; ACIN I-58-08 (August 13, 2008)

The following SHD para-regulations pertain to “fleeing felon” regulations in the CalFresh Program:

243-7:

Individuals who are fleeing felons as specified in §63-102f.(4) [actually §63-102(f)(4)] and/or persons in violation of their probation or parole, as set forth in §63-102p.(2) [actually §63-102(p)(2)], are excluded from the CalFresh household. (§63-402.224, as revised effective July 1, 2000)

243-7A:

A "fleeing felon" is an individual who is fleeing to avoid prosecution, or custody or confinement after conviction, under the law of the place from which the individual is fleeing, for a crime or attempt to commit a crime, that is a felony (or, in New Jersey, a high misdemeanor) under the law of the place from which the individual is fleeing. Effective July 1, 2000, the existence of a warrant for arrest shall be presumed to be evidence of fleeing, which can be rebutted if it is established that the individual had no knowledge of being sought by law enforcement. (§63-102(f)(4))

243-7C:

A "Person in Violation of Probation or Parole" is a person who has violated such a condition under federal or state law. The initial offense for which probation or parole was ordered need not have been a felony. (§63-102(p)(2), effective July 1, 2000)

In addition, ACIN I-58-08, August 13, 2008, has the following Q&A:

SCENARIO:

A client has an active felony warrant from the state of Minnesota. The client acknowledges the warrant. He states he is not a "Fleeing Felon" as he has been pulled over by local police and they will not take him into custody to extradite him to Minnesota for the outstanding warrant. The county Special Investigation Unit confirmed the felony warrant is active and is not extraditable per Minnesota.

QUESTION:

Since the warrant is not extraditable, does it change the fact that he has an active felony warrant?

ANSWER:

No. Per MPP section 63-102(f)(4), the client is a "Fleeing Felon" and the regulations apply, thereby making him ineligible for food stamp benefits.

FEDERAL LAW:

7 U.S.C. § 2015(k)(1) sets forth the fleeing felon rule as it was established in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). It prohibits an individual who is fleeing to avoid prosecution, or custody or confinement

after conviction, of a felony offense from Supplemental Nutrition Assistance Program (SNAP) eligibility during that period.

7 U.S.C. § 2015(k)(2), added by the Food and Nutrition Act of 2008, states the following:

(k) DISQUALIFICATION OF FLEEING FELONS.—

(1) IN GENERAL.—No member of a household who is otherwise eligible to participate in the supplemental nutrition assistance program shall be eligible to participate in the program as a member of that or any other household during any period during which the individual is—

(A) fleeing to avoid prosecution, or custody or confinement after conviction, under the law of the place from which the individual is fleeing, for a crime, or attempt to commit a crime that is a felony under the law of the place from which the individual is fleeing or that, in the case of New Jersey, is a high misdemeanor under the law of New Jersey; or

(B) violating a condition of probation or parole imposed under a Federal or State law.

(2) PROCEDURES.—The Secretary shall—

(A) define the terms “fleeing” and “actively seeking” for purposes of this subsection; and

(B) ensure that State agencies use consistent procedures established by the Secretary that disqualify

individuals whom law enforcement authorities are actively seeking for the purpose of holding criminal proceedings against the individual.

As set forth above, this law requires the Secretary of the Department of Agriculture to define the terms “fleeing” and “actively seeking” and to establish a policy for states to follow, so that that the states can use uniform procedures to “disqualify individuals whom law enforcement authorities are actively seeking for the purpose of holding criminal proceedings against the individual.”

On August 19, 2011, at 76 Federal Register 51907, the Food and Nutrition Service (FNS) published proposed regulations to comply with the mandate of paragraph (k)(2), including a definition of the term “actively seeking.” To date, these regulations have not been formally enacted.

Therefore, CDSS’s position is that until proposed regulations have been enacted based on §7 U.S.C. § 2015(k)(2), CDSS judges are required to follow the pertinent MPP regulations cited above pertaining to fleeing felons, as well as ACIN I-58-08, also cited above.

Where there has been a change in federal law but, as of yet, no adopted final federal FNS regulations implementing the federal statutory change, any CalFresh case involving a fleeing felon issue is to be written as a proposed decision.

E-NOTE #102 – SUMMARY OF ACWDs/ACINs/ACLS

1. MEDIL - I 13-04 (June 7, 2013)

Affordable Care Act of 2010 – Provision of Policy Guidance to Counties

The purpose of this letter is to provide counties with information regarding the Department of Health Care Services' (DHCS) approach to providing policy guidance to counties over the coming months until implementation of the Affordable Care Act of 2010 (ACA) begins in October 2013.

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL%2013-04.pdf>

2. ACL 13-45 (June 7, 2013)

California CalFresh Alert Case Process

The purpose of this letter is to provide instructions regarding the review, processing and reporting actions to be taken as a result of information received from the United States Department of Agriculture (USDA), Food and Nutrition Service (FNS) about permanently disqualified EBT retailers, otherwise known as ALERT cases. These instructions are part of the California CalFresh Integrity Plan (IP) developed in response to a request by the FNS Western Region Office. The IP details the expectations of FNS and state agencies to address fraud issues, including the handling of the ALERT cases, data mining, excessive card replacements, social media, and trafficking prevention.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-45.pdf>

3. ACL 13-47 (June 7, 2013)

Implementation Of SB 67 As It Relates To Service Reductions In The In-Home Supportive Services Program

The purpose of this All-County Letter (ACL) is to instruct counties on the implementation of a new state law which increases the current reduction of 3.6 percent to a total of eight percent. The eight percent service reduction shall be applied to every recipient in the In-Home Supportive Services (IHSS) program, in accordance with the mandates of Senate Bill (SB) 67.

http://inet.dss.ca.gov/wm7_landn/EntRes/getinfo/acl/2013/13-47.pdf >

4. ACL 13-41 (June 7, 2013)

Adoption Assistance Program (AAP) Eligibility

The purpose of this letter is to ensure California's compliance with federal law and clarify the effect of the Kinship Guardianship Assistance Payment (Kin-GAP) program on a child's AAP eligibility. A provision of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351) allows for a child placed with a

relative in a Kin-GAP arrangement to be assessed for AAP eligibility, if the child is later placed for adoption.

AAP ELIGIBILITY

When determining AAP eligibility for a child placed with a relative guardian, any Kin-GAP payments made on the child's behalf are not to be considered for the purpose of establishing eligibility and negotiating benefits. If a child's Kin-GAP agreement has terminated or the child is later adopted by the relative guardian or another individual, the responsible public agency is not to consider the Kin-GAP agreement. Rather, the responsible public agency will need to determine AAP eligibility based on the child's status prior to the Kin-GAP agreement and the termination of dependency.

<http://www.dss.cahwnet.gov/lettersnotices/EntRes/getinfo/acl/2013/13-41.pdf>

5. ACL 13-46 (June 10, 2013)

California Work Opportunity And Responsibility To Kids (CalWORKs) Program And CalFresh: Changes In The Treatment Of Federal Tax Credits And Refunds In The CalWORKs And CalFresh Programs

The purpose of this ACL is to provide instruction to County Welfare Departments (CWDs) regarding changes in the way federal tax credits and refunds will be treated in the CalWORKs and CalFresh Programs, as a result of passage of the American Taxpayer Relief Act of 2012 (PL 112-240). There are two major changes for CWDs: federal tax credits and refunds received on or after January 1, 2013, shall be permanently excluded as income when determining eligibility and benefit amount in the CalWORKs and CalFresh programs; and these tax credits and refunds shall also be disregarded as a resource for 12 months from the date of receipt.

<<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-46.pdf>>

6. ACL 13-48 (June 11, 2013)

California Work Opportunity And Responsibility To Kids (CalWORKs): Cost Of Living Adjustment (COLA) Increase To The Minimum Basic Standard Of Adequate Care (MBSAC) Levels

The purpose of this letter is to inform counties of an increase to the CalWORKs MBSAC levels effective July 1, 2013. The W&I Code Section 11453 provides CalWORKs MBSAC levels shall be adjusted annually to reflect any increases or decreases in the cost of living. This year's COLA increases the MBSAC and Income-In-

Kind (IHK) levels by 2.65 percent. The new MBSAC levels are to be used in determining applicant financial eligibility for those families that apply for CalWORKs on or after July 1, 2013.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-48.pdf>

7. ACIN I-29-13 (June 6, 2013)

Extended Foster Care (EFC) Update

The purpose of this All County Information Notice (ACIN) is to inform counties about the statutory changes to the Welfare and Institutions Code (W&IC) via passage of AB 1712, signed on September 30, 2012, and SB 1013, signed on June 27, 2012, concerning the EFC Program. Information regarding changes to the Kinship Guardianship Assistance Payment (Kin-GAP) and Adoption Assistance Payment (AAP) programs will be released in a separate ACL or ACIN.

Both pieces of legislation make changes to several sections of the W&IC that cover EFC, also known as After 18 Program; however, most of these changes clarify that existing child welfare laws also apply to Nonminor Dependents (NMDs). References to foster youth in this ACIN include both dependents and those youth on probation who are also under an order for foster care placement.

The SB 1013 made two significant changes to the EFC program. The first change removed the phased-in maximum age limits for foster care in 2012 and 2013 through the addition of W&IC section 10103.5. This allows a NMD who continuously remains in foster care to stay until the age of 21. However, the phased-in maximum age limits still apply for re-entry (W&IC 388[e]) in 2013. The changes in age limitations are further described in [ACL No. 12-43](#). Second, it requires that a provider for the Transitional Housing Program-Plus-Foster Care be licensed by Community Care Licensing Division as described in [ACL No. 12-44](#). These changes were effective July 1, 2012.

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-29_13.pdf

8. ACL 13-49 (June 17, 2013)

Questions And Answers Regarding The Restoration Of The California Work Opportunity And Responsibility To Kids (CalWORKs) Cal-Learn Program

The purpose of this letter is to provide answers to questions received by the California Department of Social Services (CDSS) Employment Bureau from counties regarding the restoration of the Cal-Learn program.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-49.pdf>

9. ACWDL 13-14 (June 20, 2013)

Medi-Cal Privacy and Security Agreements

The purpose of this letter is to notify counties of the 2013 Medi-Cal Privacy and Security Agreement (Agreement) and to provide counties with instructions for returning signed Agreements to the California Department of Health Care Services (DHCS). This letter supersedes All County Welfare Directors Letter No. 12-27. The purpose of the Agreement between DHCS and each County Welfare Department (CWD) is to ensure the security and privacy of the Medi-Cal Personally Identifiable Information. The federal Social Security Administration (SSA) is requiring that DHCS enter into these Agreements with CWDs because they are viewing SSA information during the Medi-Cal eligibility determination process. All 58 counties are required to sign the 2013 Agreement.

<http://dhcsinternetauthoring/services/medi-cal/eligibility/Documents/13-14%20wAttach.pdf>

10. ACIN I-31-13 (June 25, 2013)

California Work Opportunity And Responsibility To Kids (CalWORKs): Senate Bill (SB) 1041 Reengagement Requirements And The Optional New Young Child Exemption

The purpose of this All County Information Notice (ACIN) is to highlight some key implementation components of the reengagement of clients exempt from participation under the short-term young child exemptions, originally implemented by Assembly Bill (AB) X4 4, and the availability of a new young child exemption for a parent or caretaker relative who has primary responsibility for personally providing care to one child from birth through 23 months of age. The intent is to ensure consistent implementation throughout the state. The elements discussed in this ACIN were also included in the following ACLs:

CalWORKs Program: New CalWORKs Welfare-to-Work (WTW) 24-Month Time Clock (ACL 12-67), CalWORKs SB 1041 Extension of Short Term Changes and the New Young Child Exemption (ACL 12-72), and Reengagement of CalWORKs Short-Term Exempt Individuals in WTW Activities (ACL 13-01)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-31_13.pdf

11. ACWDL 13-15 (June 24, 2013)

Follow-Up Questions and Answers To All County Welfare Directors Letter (ACWDL) No: 13-03, Screening of Child Applicants In The Age Group 6-18 For Potential No-Cost Medi-Cal Eligibility Under Section 1931(b) Before Enrolling Them Into Healthy Families.

The purpose of this ACWDL is to respond to questions submitted by the counties to the Department of Health Care Services (DHCS) after the release of ACWDL13-03. ACWDL 13-03 informed counties regarding the implementation of Medi-Cal Section 1931(b) program screening processes at the Healthy Families Program (HFP) per the July 10, 2012, San Francisco Superior Court Order Enforcing Writ in the case of MCHA vs. DHCS and MRMIB.

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-15.pdf>

12. ACL 12-74E (June 24, 2013)

Correction to All County Letter 12-74 Implementation Of Policy Changes Regarding CalFresh Expedited Service

ACL is set forth below in its entirety:

After receiving additional guidance from the United States Department of Agriculture (USDA) Food and Nutrition Service (FNS), the California Department of Social Services (CDSS) is releasing this letter to correct policy that was transmitted in All County Letter (ACL) 12-74, released on December 24, 2012.

The second paragraph on the first page of ACL 12-74 regarding the waiver that was denied by FNS, and has not yet been approved after being resubmitted, reads: "Recently, the California Department of Social Services (CDSS) submitted a federal waiver to the USDA, FNS requesting the ability to issue CalFresh benefits under ES without conducting an interview if the following conditions are met:"

The sentence indicates that an interview would not need to be conducted to issue benefits under ES. The sentence now reads:

"Recently, the California Department of Social Services (CDSS) submitted a federal waiver to USDA FNS, *which was denied*, requesting the ability to *postpone the interview and* issue CalFresh benefits under ES if the following conditions are met:"

This information was only provided as background to illustrate what CDSS had requested in the waiver that was denied by FNS. After implementing the change in statute requiring that all applications be screened for ES entitlement, the waiver request has been resubmitted to FNS and CDSS continues to wait for an approval or denial. Until CDSS receives response from FNS, counties are instructed to continue to conduct interviews for all households prior to issuing benefits under ES. Should the waiver be

approved, CDSS will release an ACL to provide counties with specific instructions for implementing the waiver.

The last sentence in both bulleted paragraphs on page three, under the heading; Receipt of ES CalFresh Benefits with Postponed Verification reads:

“If the household fails to satisfy postponed verification requirements and does not appear for the interview, the CWD does not need to contact the household again.”

This last sentence comes from the federal regulations and only applies to households given a one or two month certification period under ES. ACL 12-74 transmitted policy guidance for counties to no longer give one or two month certification periods under ES for any households. Therefore, this sentence has been removed from the two paragraphs. The paragraphs now read:

If the application was submitted on or before the 15th day of the month:

The household shall be issued prorated CalFresh benefits for the month of application only. Satisfaction of the verification requirements may be postponed until the second month of participation. The county will pend the subsequent month’s CalFresh benefits until postponed verifications are completed. If verifications are not completed within 30 days of application the case will be discontinued and the household will need to reapply or restore eligibility. Households, who reapply, are not entitled to ES (see ACL 10-32). *If the household fails to satisfy postponed verification requirements and does not appear for the interview, the CWD does not need to contact the household again.*

If the application was submitted after the 15th day of the month:

The household shall be issued both the prorated CalFresh benefits for the application month and subsequent month at the same time. Satisfaction of the verification requirements may be postponed until the third month of participation, if necessary, to meet the expedited timeframe. When the household has provided the required postponed verification, the CWD shall issue the third month’s benefits within five working days from receipt of the verification or by the first working day of the third month, whichever is later. If verifications are not completed within 30 days of application, the case will be discontinued before the third month’s benefits are issued and, the household will need to reapply. Households, who reapply or have their eligibility restored, are not entitled to ES (see ACL 10-32). For subsequent months, the household must reapply and satisfy the verification requirements which were postponed or be certified under normal processing standards. *If the household fails to satisfy postponed verification requirements and does not appear for the interview, the CWD does not need to contact the household again.*

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2012/12-74E.pdf>

13. ACIN I-36-13 (June 28, 2013)

Federal Fiscal Year 2014 Plan Template, Preliminary Allocations, And Policy Guidelines For Counties Participating In The CalFresh Employment And Training Program

This letter transmits the Federal Fiscal Year (FFY) 2014 CalFresh Employment and Training (E&T) preliminary allocations, plan template and policy guidelines to be used by counties participating in the E&T program. Federal and state regulations specify that counties who want to participate in CalFresh E&T must submit a completed plan for inclusion in California's statewide E&T plan.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-36_13.pdf>

14. ACL 13-54 (July 1, 2013)

California CalFresh Integrity Plan; Excessive Card Replacement Process

The purpose of this letter is to provide instructions regarding the process when clients have requested an excessive number of Electronic Benefit Transfer System (EBT) card replacements. These instructions are part of a plan developed by the California Department of Social Services (CDSS), in response to a request by the Food and Nutrition Service (FNS) Western Region Office to develop a CalFresh Integrity Plan (IP). The plan details the expectation of FNS and state agencies to address fraud issues, including the handling of the "Anti-Fraud Locator using EBT Retailer Transactions" (ALERT) cases, data mining, excessive card replacements, and social media and trafficking prevention.

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-54.pdf>

E-NOTE #101 DEPARTMENT OF HEALTH CARE SERVICES PRECEDENTIAL DECISION

June 20, 2013

Below is a Department of Health Care Services' Precedential Decision that Medi-Cal beneficiaries do not have a right to a notice of action, fair hearing, or aid paid pending when benefits end by operation of Federal or State law.

The Department designated this specific portion of a state hearing decision as a Precedential Decision in accordance with Government Code Section §11425.60(b).



TOBY DOUGLAS
Director

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
Governor

ACTION: Notice of Availability of Precedential Decisions and Decision Index
Government Code Section 11425.60(b)

SUBJECT: No Right to a Notice of Action, Fair Hearing, and Aid Paid Pending When
Benefits End by Operation of Federal or State Law, DHCS-13-001

PUBLIC NOTICE: NOTICE IS HEREBY GIVEN that the Department of Health Care Services (DHCS), pursuant to the requirements of section 11425.60 of the Government Code, has designated as precedential specific portions of a fair hearing decision relating to Medi-Cal beneficiaries. This precedential decision affirms that Medi-Cal beneficiaries do not have a right to a Notice of Action, Fair Hearing, and Aid Paid Pending when benefits end by operation of Federal or State law.

NOTICE IS ALSO GIVEN that the Department maintains an index of precedential decisions. The public may access the index and text of the precedential decisions through the DHCS website <http://www.dhcs.ca.gov>. Additionally, the public may request copies of the index and precedential decisions by submitting a Public Records Act request to:

Ms. Jeannie Smalley, Chief
Monitoring and Oversight Section
Long-Term Care Division
Department of Health Care Services
MS 0018
P.O. Box 997413
Sacramento, CA 95899-7413

DEPARTMENT OF HEALTH CARE SERVICES

DHCS-13-001

Dated: June 5, 2013

Toby Douglas
Director

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BEFORE THE
DEPARTMENT OF HEALTH CARE SERVICES
STATE OF CALIFORNIA

In the Matter of Medi-Cal beneficiaries not having a
right to a Notice of Action, Fair Hearing, nor Aid
Paid Pending when Benefits End by Operation of
Federal or State law.

P. C.

Claimant.

Hearing No. 2012275358

PRECEDENTIAL DECISION
No. 13-001

PRECEDENTIAL DECISION
(Government Code Section 11425.60(b))

The Department of Health Care Services hereby designates as precedential Section 2 of the Decision in the Matter of Medi-Cal beneficiaries not having a right to a Notice of Action, Fair Hearing, nor Aid Paid Pending when benefits end by operation of Federal or State law.

This precedential decision shall become effective on June 5, 2013.

IT IS SO ORDERED June 5, 2013.



Toby Douglas, Director
DEPARTMENT OF HEALTH CARE SERVICES

1 The right to receive a NOA is predicated upon DHCS taking an action that gives rise to
2 such an entitlement. The question before this tribunal is whether DHCS took any action that
3 entitled the claimant to a NOA. In the present situation DHCS took no action to terminate or
4 reduce claimant's services. As such, the claimant was not entitled to receive a NOA.

5
6 The claimant was authorized to receive private duty nursing services through the Medi-Cal
7 EPSDT benefit. EPSDT services are a Medi-Cal benefit for beneficiaries under the age of 21.
8 (42 USC §§ 1396a(a)(10)(A), (a)(43), 1396d(a)(4)(B), (r); Welf. & Inst. Code § 14132(v); Cal.
9 Code Regs., tit. 22, § 51184(c)(2).) Authorization for services provided through the EPSDT
10 benefit end by operation of law when the recipient reaches 21 years of age. (Id.) The parameters
11 of the EPSDT benefit were set forth by Congress and subsequently adopted by the California
12 legislature. DHCS is complying with a federal and state mandate to cease authorization for
13 EPSDT services when Medi-Cal beneficiaries age-out of the benefit. As such DHCS is not taking
14 any action to terminate or reduce EPSDT services for ineligible beneficiaries through the
15 implementation of the EPSDT benefit. The claimant was therefore not entitled to receive a NOA.

16
17 Additionally, federal and state law clearly state that an individual does not have a right to a
18 hearing when the sole issue is that of "a Federal or State law requiring an automatic change
19 adversely affecting some or all recipients," 42 CFR § 431.220(b). (See also Cal. Code Regs., tit.
20 22, § 50951.) When there is no right to a hearing, there is no right to receive a NOA.
21 Specifically, the California Code of Regulations states that an individual is entitled to a NOA
22 informing the individual of his or her hearing rights when DHCS takes specific actions. (Cal.
23 Code Regs., tit. 22, 51014.1(a).) If an individual does not have a right to a hearing because the
24 sole issue is the application of a state or federal law to that individual, then the only plausible
25 reading of this regulation is that no NOA is required when there is no right to a hearing. To read
26 the regulation otherwise would be nonsensical in that it would require DHCS to notify an
27 individual of a hearing right to which he or she is not entitled.

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Here, the claimant has alleged that he was entitled to receive a NOA notifying him of the pending termination of his EPSDT services. However, since his EPSDT services were to end by operation of law, the claimant has no right to a hearing related to this termination and, as such, had no right to a NOA notifying him of the termination.

Additionally, the claimant’s home health agency (HHA) provider submitted a TAR to DHCS on August 20, 2012, to provide private duty nursing services to the claimant. The requested dates of service for which authorization was requested were from July 12, 2012, to [XXX], 2012. This TAR was approved by DHCS as submitted by the provider; DHCS took no action to deny or reduce the authorization for EPSDT private duty nursing services for this time period. The claimant turned 21 years of age on [YYY], 2012. After expiration of the time period authorized by this TAR, claimant’s HHA provider did not submit a TAR to DHCS requesting reauthorization of EPSDT private duty nursing services. The TAR expired of its own terms, not pursuant to any action taken by DHCS. The provider could have requested a TAR with an end date up to 180 days after the requested service start date (Cal. Code Regs., tit. 22, § 51003(e)); however, the provider chose not to do so. This tribunal surmises from the end date on the submitted TAR that the provider knew that the claimant would no longer be eligible for EPSDT private duty nursing services once he turned 21 and chose to act accordingly. DHCS took no action to terminate claimant’s EPSDT private duty nursing services; they were to end both by operation of law and by operation of the submitted TAR.

The claimant has cited *Hodges v. Smith* (1995) 910 F. Supp. 646, 650, as precedent requiring DHCS to provide the claimant with notice prior to terminating his private duty nursing services provided through the EPSDT benefit, regardless of the fact that he is no longer eligible to receive such services by operation of law. However, this tribunal chooses not to apply the court’s finding in this decision as it is a non-binding, non-precedential decision issued by a District Court in the Northern District of Georgia based on an incorrect interpretation of federal regulations.

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B. Right to Aid Paid Pending:

Federal and state law mandate that when a Medicaid beneficiary has a right to a NOA, he or she has a right to a hearing to challenge the action taken that led to the issuance of the NOA. Additionally, the beneficiary has the right to receive APP so long as he or she meets the requisite hearing request filing deadlines. (42 CFR 431.230; Cal. Code Regs., tit. 22, § 51014.2.) Conversely, when a Medicaid beneficiary does not have a right to a NOA, he or she does not have a right to a hearing to challenge an action that did not give rise to a right to receive a NOA. As such, he or she does not have a right to receive APP. As set forth above, the claimant does not have a right to a NOA. Therefore, the claimant does not have a right to receive APP to continue services for which he is ineligible by operation of both state and federal law.

DHCS assessed the claimant in July 2012 to determine his LOC for future services through the Nursing Facility/Acute Hospital (NF/AH) Waiver. Although he has been enrolled in the NF/AH Waiver since 2005, he was ineligible to receive NF/AH Waiver private duty nursing services prior to reaching the age of 21 as they were available to the claimant through the State Plan (42 CFR 440.180(a); California Medicaid State Plan Attachment 3.1-A, Page 2). As such, his LOC determination based upon his July 2012 home assessment comprised an initial assessment for NF/AH Waiver private duty nursing services. Generally, and as the claimant asserts in this case, a Medi-Cal beneficiary is eligible for APP when there has been a termination or reduction of a particular service. (Cal. Code Regs., tit. 22, § 51014.2(b).) Here, there was no termination or reduction of claimant’s EPSDT private duty nursing services by DHCS. DHCS found, and this tribunal agrees, that the claimant does not have a right to receive APP for NF/AH Waiver private duty nursing services, a benefit he was not receiving, nor the right to appeal from the denial of APP for these services.

1 The claimant has stated that DHCS denied his request for APP. However, the claimant
2 introduced no evidence into the record that he had requested APP or that, in doing so, he followed
3 the appropriate procedure through which to make the request. As of November 1, 2012, no TAR
4 had been received by DHCS requesting reauthorization of EPSDT private duty nursing services.
5 Regardless, since the claimant is not entitled to APP to continue receiving private duty nursing
6 services through the EPSDT benefit nor through the NF/AH Waiver, this tribunal need not
7 address defects on the part of the claimant in submitting appropriate evidence to this tribunal for
8 consideration.

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11 ORDER

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13 The claimant was not entitled to a NOA informing him of his ineligibility for the EPSDT
14 benefit. Additionally, the claimant is not eligible for APP, as there was no action taken on the
15 part of the Department that granted him such an entitlement.
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1 Claimant's Right to a Notice of Action and to Aid Paid Pending for Early Periodic Screening

2 Diagnosis and Treatment (EPSDT) Private Duty Nursing Services

3 The claimant and DHCS disagree about whether the claimant was entitled to receive a
4 Notice of Action (NOA) notifying him that he would no longer be eligible for private duty
5 nursing services at the pediatric sub-acute LOC through the Medi-Cal EPSDT benefit upon his
6 21st birthday. Additionally, the parties disagree about whether the claimant was entitled to
7 continue to receive private duty nursing services at the level he had been authorized to receive
8 prior to turning 21. Aid Paid Pending (APP) is the term for the continuation of a benefit upon the
9 timely filing of a state fair hearing request by a beneficiary. APP runs from the time a beneficiary
10 timely files a state fair hearing request up to when the administrative forum adjudicating the
11 hearing issues a final decision in the matter. (Cal. Code Regs., tit. 22, § 51014.2.) DHCS'
12 position is that the claimant was not entitled to receive either a NOA or APP; the claimant
13 disagrees on both counts.

14
15 A. Right to a Notice of Action:

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17 Generally, a Medi-Cal beneficiary is entitled to receive a NOA when DHCS takes any
18 action "to terminate or reduce any medical service" that the beneficiary is receiving. (Cal. Code
19 Regs., tit. 22, § 51014.1(a)(2); see also 42 CFR 431.206(c).) The purpose of the NOA is to notify
20 the beneficiary of his or her right to appeal the action of DHCS as well as the procedure to do so,
21 and must provide the beneficiary with an explanation of the action taken and DHCS' reason for
22 taking the action. (Cal. Code Regs., tit. 22, § 51014.1(b) and (c); see also 42 CFR 431.210.)
23 Although IHO staff did notify the claimant that he would be ineligible to receive private duty
24 nursing services through the EPSDT Medi-Cal benefit on multiple occasions, DHCS never sent
25 the claimant a formal NOA informing him of his ineligibility for services through the EPSDT
26 benefit.

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E-Note #100 – Medical Marijuana As A Medical Expense Deduction in CalFresh Program

June 5, 2013

References: Para-regulation 275-1; §63-502.33

Para-Regulation 275-1 states the following:

Excess medical costs excluding the costs of a special diet are allowable as a deduction if they exceed the amount specified in §63-1101. The amount specified in §63-1101.25 is \$35. The deduction is only available if the expense is incurred by a household member who is elderly or disabled as defined in §63-102e (now (e)). Allowable medical expense items include medical or dental care, hospitalization, prescription drugs and medical supplies, insurance premiums, Medicare premiums or Medi-Cal shares of cost, seeing eye or hearing dog costs, eye glass or contact lens costs, transportation expenses and the cost of maintaining an attendant. (§63-502.33)

The question has been raised about whether medical marijuana is an allowable medical expense in the CalFresh Program under the above regulation. The answer is no.

Administrative Notice 12-25, dated July 11, 2012, from the USDA Food and Nutrition Services (FNS) states, in pertinent part, that “(u)nder Controlled Substances Act, 21 U.S.C. §801 et seq. marijuana is a Schedule 1 controlled substance that has no currently accepted medical use and cannot be prescribed for medical purposes. 21 U.S.C. §812(b)(1)(c). SNAP is a Federal Program and must conform to Federal law regarding illegal substances. Therefore, marijuana and other Schedule 1 controlled substances are not ‘allowable medical expenses’ under Federal law.”

There is a prescription drug called Marinol that is an FDA approved substitute for marijuana. While Program has not specifically asked FNS whether Marinol is a potentially allowable medical expense, Program has indicated that it believes it would be, because it is FDA-approved. However, if this issue arises in a case, the judge is advised to submit a program inquiry request.

E-NOTE #99 ACL/ACIN/ACDWL/MEDIL SUMMARIES

May 29, 2013

Below are summaries of Department of Social Services and Department of Health Care Services letters, along with hyperlinks. The most important letters are bolded in red.

ACL 13-35 (April 24, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-35.pdf>

Heat And Eat Program

The purpose of this letter is to provide County Welfare Departments (CWDs) with additional instructions for the Heat and Eat Program as it pertains to certain homeless households (refer to ACL 12-61). As stated in Assembly Bill (AB) 6 (Chapter 501, Statutes of 2011), all CalFresh households will annually receive a nominal Low Income Home Energy Assistance (LIHEAP) payment. Receipt or the expectation of receipt of a LIHEAP benefit entitles households to the full Standard Utility Allowance (SUA) for the purpose of calculating CalFresh benefits.

In addition, because federal regulations prohibit households receiving the homeless shelter deduction from having the SUA used in the calculation of benefits, ACL12-61 states that "...the homeless shelter deduction, Telephone Utility Allowance and Limited Utility Allowance will no longer be used in the determination of CalFresh allotments." Subsequent to the implementation of Heat and Eat, it has become evident that some homeless households which were previously eligible for the homeless shelter deduction have experienced a decrease in benefits due to the SUA being used in their CalFresh benefit calculation instead of the homeless shelter deduction.

ACIN I-22-13 (May 1, 2013)

http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-22_13.pdf

California Work Opportunity And Responsibility To Kids (CalWORKs): Final Regulations On Assembly Bill (AB) 98 Subsidized Employment

The purpose of this notice is to transmit final regulations for changes made to the AB 98 (Chapter 589, Statutes of 2007) Subsidized Employment (SE)

Program through the enactment of SB 72. Effective March 24, 2011, SB 72 expanded the eligibility and time limits of the AB 98 SE Program. The relevant provisions of SB 72 regarding the AB 98 SE Program were initially implemented through ACL 11-32, dated April 6, 2011, and emergency regulations became effective July 1, 2012. The attached final regulations were approved by the Office of Administrative Law and certified by the Secretary of State on November 29, 2012.

SB 72 amended Section 11322.63 of the WIC to expand the eligible population for AB 98 funded wage subsidies and increase the duration of qualifying job placements. Additionally, AB 98 SE participants who reapply for cash assistance may be considered current recipients for the purposes of CalWORKs eligibility income and work requirements if he or she applies within three calendar months of the SE placement ending. Furthermore, SB 72 added AB 98 SE as an activity for CalWORKs clients who have reached the 48-month time limit and continue to receive Welfare-to-Work services.

ACL 13-29 (May 7, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-29.pdf>

Cal-Learn Teen Parent Monthly Status Report STAT 45 (4/13)

This letter provides the revised form for the Monthly Status Report for the Cal-Learn Teen Parent Program (STAT 45). As of July 1, 2012, the Cal-Learn Program suspension ended and qualifying pregnant and parenting teens may once again be served under the newly restored Cal-Learn Program. The ACL 12-60, dated October 31, 2012, informed counties of the restoration of the Cal-Learn Program and that County Welfare Departments had until April 1, 2013, to fully implement their Cal-Learn Program.

The title of the STAT 45 report has been revised from "Welfare-to-Work (WTW) Teen Parent Monthly Status Report" to "Cal-Learn Teen Parent Monthly Status Report" due to the restoration of the Cal-Learn Program. This change reflects the transfer of teen parents from the WTW Teen Parent Program into the Cal-Learn Program

ACL 13-14 (May 7, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-14.pdf>

County Temporary Assistance For Needy Families (TANF) Program Work Participation Data Reporting For Federal Fiscal Year (FFY) 2013

This letter provides updated instructions for reporting county-specific FFY 2013 TANF work participation rate (WPR) data to the California Department of Social Services (CDSS) using the web-based Enterprise II Lite (E2Lite) system.

It is more than 50 pages long, and even though its purpose is to provide reporting instructions to the county, it includes a lot of information that will be helpful to judges.

Brief descriptions of the major changes are as follows:

The Definitions of ‘Parent’ and ‘Two-parent Family’ are Clarified to Include ‘A Parent with a Minor Child in the Family’

To ensure consistency with federal data reporting requirements, a work-eligible Step-parent may be considered a parent with a minor child in the family when determining a two-parent family for purposes of WPR calculation.

Clarified the Definition of ‘Providing Care for a Disabled Family Member’

The language of this definition is updated to clarify the verification requirements. The definition will remain consistent with federally approved language upon the expected approval of California’s updated Work Verification Plan by the Administration for Children and Families (ACF).

A Description is Added for Deeming of Work Experience Hours, Community Service Hours and School Attendance Hours

This section clarifies that deemed hours of participation are automatically calculated and applied when processed by the Federal Data Reporting and Analysis Bureau (FDRAB) in a batch process.

Clarified the Instructions for Excused Absence and Holiday Hours Rounding in Unpaid Work Activities

To ensure consistency with federal data reporting requirements, counties are required to round excused absence and holiday hours independently from the corresponding activity hours before combining the data into E2Lite.

The “Participation: Calculating Average Weekly Hours” Section Replaces the “Participation for Partial Months of Aid” Section

This section is updated to provide clearer and more concise instructions for calculating average weekly hours of participation.

Instructions are Updated for Implementation of the Semi-Annual Reporting (SAR) System and Annual Reporting

The SAR system will be implemented as a new reporting method beginning April 1, 2013. The Quarterly Report (QR) process will transition to the SAR process during FFY 2013 and impact the projection of hours process. Upon the expected approval of California’s updated Work Verification Plan by the ACF, projection of hours for up to six months will be allowed for E2Lite data reporting.

ACL 13-37 (May 9, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-37.pdf>

California Work Opportunity And Responsibility To Kids (CalWORKs) Release Of The Second Set Of Welfare To Work (WTW) 24-Month Time Clock Questions And Answers, And Associated Welfare Data Tracking Implementation Project (WDTIP) Tracking Recipients Across California (TRAC) Impact Codes

The purpose of this letter is to provide answers to questions that the California Department of Social Services (CDSS) has received regarding the implementation instructions issued to County Welfare Departments (CWDs) for major changes that were made to CalWORKs WTW

requirements and the creation of the WTW 24-Month Time Clock pursuant to SB 1041. This letter also transmits two new WDTIP TRAC codes associated with new WTW 24-Month Time Clock exceptions.

This letter addresses questions related to the implementation of the new WTW 24-Month Time Clock, including but not limited to clarifying information regarding job search, WTW good cause, and WTW plans. Initial implementation instructions for these program changes are contained in ACLs 12-67 and 12-69. The first set of questions and answers relating to these program changes is contained in ACL 13-15. The second set of questions and answers relating to these program changes can be found in Attachment A of this letter.

ACIN I-24-13 (May 10, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-24_13.pdf>

CalFresh Administrative Error Overissuances

This All County Information Notice is to provide clarification to state regulations regarding the collection of CalFresh administrative error (AE) overissuances subject to the Lomeli v. Saenz court case settlement agreement. MPP Sections 63-801.222 and 63-801.736(a) could be interpreted to be in conflict with one another regarding the amount that may be recouped through benefit reduction for CalFresh AE claims.

Both MPP Sections 63-801.222 and 63-801.736(a) provide regulations that establish the maximum amount that may be recouped from CalFresh benefits for AE claims. For those CalFresh AE claims in which benefit allotment reduction began on or after March 1, 2000, MPP Section 63-801.222 requires that CalFresh AE overissuances be collected through allotment reduction by five percent or \$10.00, whichever is greater, for up to a total of 36 consecutive calendar months. This regulation is in compliance with the Lomeli v. Saenz court case settlement agreement. In contrast to the settlement agreement, MPP Section 63-801.736(a) states that AE as well as inadvertent household claims are to be recouped by ten percent or \$10.00, whichever is greater.

Effective immediately, CWDs are only to recoup **AE claims as prescribed at MPP Section 63-801.222**. CWDs are to follow the allotment recoupment level stated at MPP 63-801.736(a) for the recoupment of inadvertent household claims only. If there is a change to be made to an existing AE allotment recoupment for Quarterly Reporting households pursuant to this letter, CWDs are to follow the recoupment by allotment adjustment for QR households as outlined in MPP 63-801.737.

ACWDL 13-13 (May 14, 2013) **MEDI-CAL GENERAL NOTICE OF ACTION (NOA) POLICY**

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf>

The purpose of this All County Welfare Directors Letter (ACWDL) is to provide counties with policy reminders regarding required Medi-Cal Notices of Action (NOA) relating to the counties' eligibility determinations, including share-of-cost (SOC) calculations and scope of benefits. This letter does not address NOA requirements pertaining to approval or denial of specific Medi-Cal services or benefits.

The intent of this letter is to provide general NOA regulation and policy reminders. The regulations and policy in this letter may possibly be affected or altered in the future due to changes resulting from the Affordable Care Act.

ACL 13-13 (May 15, 2013)

<<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-13.pdf>>

Monthly Caseworker Visits With Children

The purpose of this ACL is to convey changes made to the Caseworker Visit mandate with the passing of the federal Child and Family Services Improvement and Innovation Act (PL 112-34) of 2011 (provided in Attachment A). This ACL will also: 1) provide counties with updated information on the progress of the state's performance in meeting the federal caseworker visit mandate contained in the federal Child and Family Services Act (the Act) of 2006 (PL 109-288) and associated penalties; and 2) inform counties that due to the implementation of revised Division 31 regulations, Measure 2C in the California Child and Family Services Review is being replaced by Measure 2F, which is the federally mandated Monthly Caseworker Visit measure.

ACL 13-38 (May 16, 2013) <

<http://www.dss.cahwnet.gov/lettersnotices/EntRes/getinfo/acl/2013/13-38.pdf> >

Tracking Of State Hearings In The Case Management, Information And Payrolling System II (CMIPS II), And The State Hearings Report

This All-County Letter (ACL) provides information regarding the new requirement for counties to enter information for all In-Home Supportive Services (IHSS) cases for which a State Hearing has been requested into the new CMIPS II. Also, how the data entered into the system, including State Hearing outcomes will be displayed on the new State Hearings Report in the CMIPS II.

MEDIL - I 13-03 (May 16, 2013) **Affordable Care Act of 2010 – Initial Guidance**

<http://www.dhcs.ca.gov/services/med-cal/eligibility/Documents/MEDIL%2013-03.pdf>

SUBJECT: Affordable Care Act of 2010 – Initial Guidance

The Department of Health Care Services (DHCS) has been working closely with the federal Centers for Medicare & Medicaid Services (CMS) on the Affordable Care Act of 2010 (ACA) regarding the required Medicaid eligibility changes. There are various ACA related policy changes DHCS would like to provide high-level policy guidance to counties and Statewide Automated Welfare Systems (SAWS) based on analysis of federal regulations and discussions with CMS as they plan for implementation. There are various ACA related policy changes where DHCS cannot provide policy guidance at this time pending final federal guidance and interpretation of ACA requirements and enabling state statute. This letter provides the counties and SAWS with high-level policy guidance where possible, and also identifies policy areas where insufficient federal regulations or guidance limit DHCS' ability to provide such policy guidance to counties and SAWS.

ACA requirements described in this letter pertain to Medi-Cal eligibility policies and procedures that need to be implemented no later than either October 1, 2013, or January 1, 2014, depending on the requirement. To further define these requirements, counties and SAWS can expect state statute to be enacted, followed by policy guidance in the form of All-County Welfare Directors' Letters (ACWDLs) and state regulations. Given the timing of implementation, this initial guidance is being provided to inform preparatory steps towards implementation.

ACL 13-40 (May 20, 2013)

<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2013/13-40.pdf>

State Hearings Division Procedures In Processing Expedited State Hearing Requests

This entire ACL is as follows:

This All County Letter (ACL) is to provide information regarding the procedures for processing expedited state hearings requests. To improve access and communication about the availability of expedited state hearings, this letter is located on the California Department of Social Services (CDSS), State Hearings Division (SHD) website, under the "Expedited Hearings" tab.

ELIGIBILITY FOR EXPEDITED STATE HEARINGS:

Only issues that require an expedited decision will be set for an expedited hearing. The issues that will be subject to this process are cases involving:

1. Expedited CalFresh (formerly Food Stamps);
2. California Work Opportunity and Responsibility to Kids (CalWORKs) Immediate Need, including a failure to process applications within 15 days after payment and denial/failure to issue Expedited Grant funds;
3. CalWORKs Homeless Assistance;
4. Denial of supportive services for welfare-to-work which would result in the loss of employment or inability to participate or make satisfactory

progress in a Self- Initiated Program (SIP) or approved educational/training activity; and

5. Any other issue of urgency that the CDSS/SHD deems necessary.

PROCESSING THE EXPEDITED HEARING REQUEST:

Requests for these hearings shall be made to the regional office Presiding Judge or to the SHD at 1-800-743-8525 or fax (916) 651-2789, or for hearings for speech impaired (TDD) 1-800-952-8349.

1. The SHD will field requests for expedited state hearings from claimants/authorized representatives (ARs) and counties. The Presiding Judge (PJ) of the county's regional office will determine if an expedited state hearing is necessary. The PJ may contact the county appeals representative and the claimant to get, as necessary, further information about the necessity for an expedited state hearing, and may be done through a three-way call. Unless made through a three way call, if such a contact is made, the contact and the information provided must be revealed to the other party no later than the beginning of the hearing. The contact and the information provided may be revealed in writing or via telephone or other electronic means.

2. If the request for an expedited state hearing is granted, the PJ shall ensure the case is calendared on an expedited basis, giving both claimants/ARs and the county at least ten (10) calendar days advance notice of the time, date and the type of hearing that will be convened and conducted by the Administrative Law Judge (ALJ). Notices to county and claimant/AR will be transmitted in writing or by other electronic means specifying the expedited state hearing has been set.

3. If the request for an expedited state hearing is denied, the PJ or his or her designee shall notify the claimant/AR and the county of the determination, and the case will be set for a regular state hearing. Notices to county and claimant/AR will be transmitted in writing or by other electronic means specifying the expedited state hearing has been denied.

CONDUCTING THE EXPEDITED HEARING:

1. Generally, the most expeditious way the SHD can conduct an expedited state hearing within its resource limits is by telephone. However, if the expedited state hearing can be incorporated into an existing in-person calendar, the SHD will set the case accordingly. If the expedited hearing cannot be set within the existing in-person calendar, the claimant shall be informed via telephone that the matter will be set by telephone. If the claimant wants the hearing conducted in-person, the matter will set for the next regular in-person calendar offered by the county.

2. The county is required to have its Statement of Position (SOP) available for the claimant to pick up at its county offices two working days before the scheduled hearing, including for expedited hearings. If the county does not have it ready, the claimant can request and receive a postponement or can opt to proceed without the SOP. The SHD will reset the hearing immediately if the claimant opts for a postponement, in order to attempt to resolve the urgent issue as soon as possible. Counties are reminded that offering to “reconsider” a matter, when no new information is needed is not appropriate, as the claimant has the right to receive a decision on the matter.

3. The ALJ will issue a decision in the case within five (5) business days of record closure.

4. The SHD has found that a high percentage of cases involving emergency circumstances are subject to settlement. Therefore, parties are encouraged to engage in settlement negotiations as soon as possible, so that the county can take immediate action if settlement is reached, thereby obviating the need for the administrative hearing. If the matter has been resolved, the county must contact the SHD and issue a Notice of Action to the claimant/AR specifying the action taken. If the claimant disagrees with the action, the claimant can file a new request for hearing based on the new Notice of Action.

It is SHD’s intention that the expedited state hearings process will continue to provide more effective due process in those cases where emergency relief is at issue.

ACIN I-09-13 (March 21, 2013) <

http://www.dss.cahwnet.gov/lettersnotices/EntRes/getinfo/acin/2013/I-09_13.pdf >

Assembly Bill (AB) 2488; Adoption: Sibling Mutual Consent Program – Confidential Intermediary

The provisions of AB 2488 permit adoptees and siblings greater opportunities to initiate and make contact with each other. Implementation of this program was suspended until July 1, 2012. At the time, the Legislature said that implementation of some or all of the changes made to Section 9205 of the Family Code “shall continue, to the extent possible”, and many counties have provided this service over the last several years. This All County Information Notice is to inform you that commencing July 1, 2012, it is still the intent of the Legislature that this program “shall continue, to the extent possible”.

ACL 11-06E (May 23, 2013)

<<http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2011/11-06E.pdf>>

Continuing Of All County Letter (ACL) 11-06 Sponsor Deeming, Indigent Noncitizen Determination And Sponsor Income Verification

The purpose of this errata is to transmit a continuation of All County Letter (ACL) 11-06 regarding: (1) the procedure for reviewing sponsor deeming when a child receiving benefits turns eighteen years old; (2) the updated address and procedure for notifying the United States Citizenship and Immigration Services (USCIS) of the names of the indigent sponsored noncitizen and the sponsor in accordance with federal guidance; and (3) the valuation of in-kind assistance solely for the purpose of making the indigent determination.

Sponsor Deeming Review at Age Eighteen

When a child receiving CalFresh benefits who is “exempt from sponsor deeming while under eighteen years of age” turns eighteen years old, counties may delay reviewing program eligibility and sponsor deeming until the next certification period for administrative ease. “The household does not have a requirement to report when a member turns eighteen years of

age”; however, “a review of continued eligibility to federal benefits needs to be made and may include sponsor deeming if appropriate.”

As an example, a child is receiving CalFresh benefits in a household with a certification period from January to December. The individual has resided in the U.S. in a qualified noncitizen status for more than five years. In July the child turns eighteen. The household’s recertification will occur the following December, at which time, sponsor deeming rules will apply.

ACL 13-42 (May 23, 2013) <

<http://www.dss.cahwnet.gov/lettersnotices/EntRes/getinfo/acl/2013/13-42%20.pdf> >

California Work Opportunity And Responsibility To Kids (CalWORKs) Program: Change To The Earned Income Disregard (EID)

The purpose of this ACL is to inform County Welfare Departments (CWDs) of the restoration of the \$225 EID in the CalWORKs program effective October 1, 2013, and to provide implementation instructions to CWDs. In addition, this ACL provides a recommended informing notice, new and revised forms, notices of action (NOAs), and messages, which reflect the reinstated EID. The CWDs should begin using the attached forms and NOA message as of October 1, 2013.

The Department has developed an informing notice (TEMP 2252 [4/13]) that CWDs may use to inform applicants and recipients of the changes to the EID and how it can affect their cash aid. The CWDs may choose to develop their own informing notice; however, any CWD that chooses to use an informing notice other than the one included in this letter is required to seek advance approval of the notice from CDSS. The Department recommends that CWDs mail the informing notice to recipients no later than August 2013, and in addition, as a reminder, provide the notice to recipients whose annual redeterminations are due before November 2013.

INCREASE IN INCOME DISREGARD

The SB 1041 amends the W&I Code Section 11451.5 to restore the EID to the unused amount of the \$225 Disability-Based Unearned Income (DBI) disregard, plus 50 percent of the remaining earned income effective

October 1, 2013. Beginning October 1, 2013, Net Non-Exempt Income (NNI) must be calculated using the increased EID as follows:

If the Assistance Unit (AU) has earned income only, the first \$225 and 50 percent of the earned income is disregarded when determining the NNI to calculate the family's grant amount.

If the DBI does not exceed \$225, all of the DBI is disregarded and the unused amount of the \$225 plus 50 percent of the remaining earned income is disregarded. Any remaining earned income is treated as part of the family's NNI. If the DBI exceeds \$225, only the first \$225 of the DBI and 50 percent of any earned income is disregarded. Any remaining DBI and remaining earned income is treated as part of the family's NNI.

The new EID must be used to calculate eligibility and grant amounts beginning in October 2013. Automation systems should be reprogrammed to calculate October grants using the new EID for all cases in which there is earned income. If the recalculated grant should result in increased cash aid for the AU, and the grant is not increased automatically by October 1, 2013, the CWD shall issue a supplemental payment as soon as administratively possible. When re-calculating the October grant with the new EID, in accordance with Semi-Annual Reporting (SAR) rules, the CWDs may not consider any voluntary reports that would result in a decrease to the grant. For example, if a client previously made a voluntary report of increased income mid-period that was below the Income Reporting Threshold (IRT), the CWDs may not consider this additional income when re-calculating the grant due to the higher EID.

The ACL provides examples of scenarios in this ACL on how to calculate the grant amount using the new EID.

E-NOTE # 98 SUMMARY OF LETTERS, ACLS, And ACINS

April 29, 2013

**INTERIM INSTRUCTIONS TO IMPLEMENT ASSEMBLY BILL
2035, ELECTRONIC BENEFIT TRANSFER (EBT) ELECTRONIC
THEFT - December 31, 2012**

The purpose of this letter is to provide interim instructions for the January 1, 2013 implementation of Assembly Bill (AB) 2035 (Chapter 319, Statutes of 2012) which requires the prompt restoration of EBT CalWORKs benefits lost due to electronic theft. Electronic theft occurs when a client has not lost physical possession of their EBT card and money is stolen from their EBT account electronically (often called "skimming").

These interim instructions are being issued pending detailed instructions which will include Notice of Action language, claiming and tracking instructions, and implementation regulations.

The Department had anticipated releasing final instructions in March 2013. However, the anticipated release date is now sometime in late May 2013.

ACL 13-26 - April 8, 2013

CalWORKs AND CALFRESH PROGRAMS: NEW AND REVISED FORMS AND NOTICES OF ACTION (NOAs) FOR THE SEMI-ANNUAL REPORTING (SAR) SYSTEM

ACL No. 12-25, dated May 17, 2012, issued new policy instructions to the County Welfare Departments (CWDs) for the implementation of SAR in CalWORKs and CalFresh. ACL No. 12-59, dated, October 29, 2012, issued the first set of new and revised forms and NOAs to be used in conjunction with the new SAR policies. The purpose of this ACL is to transmit the second set of SAR forms. The remaining SAR forms and NOAs will follow in a subsequent ACL.

ACL 13-28 - April 10, 2013

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs) AND CALFRESH PROGRAMS: IMPLEMENTATION OF THE ANNUAL REPORTING/CHILD ONLY (AR/CO) SYSTEM QUESTIONS AND ANSWERS (Q&A)

The purpose of this letter is to provide responses to questions received by the California Department of Social Services (CDSS) regarding the CalWORKs and CalFresh annual reporting rules implemented October 1, 2012 in certain child-only cases.

In addition, this letter directs county welfare departments and automation consortia to change the reporting requirements of CalFresh households associated with CalWORKs Annual Reporting/Child-Only cases no later than October 1, 2013.

All County Letter (ACL) No. 12-49 previously instructed CWDs that CalFresh households associated with CalWORKs AR/CO cases would be assigned Change

Reporting (CR) status. This ACL requires that these CalFresh households be transitioned from CR status to Semi-Annual Reporting (SAR) status by October 1, 2013.

This ACL is 17 pages long, and is recommended reading.

ACIN I-15-13 - April 11, 2013

**RESOURCES AVAILABLE TO COUNTY AND TRIBAL CHILD WELFARE AGENCIES AT NO COST
REFERENCE: ALL COUNTY INFORMATION NO. 1-05-11**

The purpose of this ACIN is to notify counties and tribes about no cost resources available to county and tribal child welfare agencies that are funded by the California Department of Social Services, and primarily overseen by the Office of Child Abuse Prevention (OCAP).

ACIN I-21-13 - April 18, 2013

CALIFORNIA'S FOSTERING CONNECTIONS TO SUCCESS ACT, (AB 12)

The purpose of this All County Information Notice is to provide counties with up-to-date information regarding training activities for the Extended Foster Care (*After 18*) Program contained in California's Fostering Connections to Success Act, Assembly Bill (AB) 12. *After 18* allows youth to remain in foster care and continue to receive foster care benefits and services beyond age 18, provided the youth meets participation and eligibility requirements and lives in an approved or licensed setting. In accordance with existing law, *After 18* allows a non-minor who left foster care, at or after the age of majority, to petition the court to resume foster care benefits.

ACIN 13-25 – April 18, 2013

NEW AID CODE FOR CalWORKs TRAFFICKING AND CRIME VICTIMS ASSISTANCE PROGRAM (TCVAP) TRAFFICKING VICTIMS

This letter provides information and instructions regarding the new aid code, R1, in the Medi-Cal Eligibility Data System (MEDS). This aid code applies to noncitizen CalWORKs TCVAP trafficking victims who are undocumented, or otherwise ineligible for federally-funded benefits and services due to immigration status. These noncitizen

individuals also must be identified as trafficking victims as defined in the California Department of Social Services (CDSS) MPP Sections 70-102 and 70-103.

ACL 12-48E –ERRATA – April 23, 2013

The purpose of this erratum is to delete the table on page two of ACL 12-48 under the Age section. The chart on page two did not correctly identify the non-minors who may return to the care of the guardian and continue payment until their 21st birthday. Non-minors with former NRLG who lost benefits when they turned 19 in 2012 *due solely to attaining age 19*, may return to the care of the guardian and resume AFDC-FC benefits up to the age of 21. The non-minor does **not** have to be under 19 in order to re-enter care. NOTE: Non-minors in NRLGs wishing to return to the care of their former guardian and resume payment benefits will need to complete a Voluntary Re-Entry Agreement for Extended Foster Care, SOC 163. This provision does not apply to non-minors who attained age 19 in 2011.

ACL13-32 – April 24, 2013

MODIFIED CATEGORICAL ELIGIBILITY/BROAD-BASED CATEGORICAL ELIGIBILITY AND ELDERLY/DISABLED CALFRESH HOUSEHOLDS

The purpose of this ACL is to provide County Welfare Departments (CWDs) with clarification regarding Modified Categorical Eligibility (MCE), known federally as Broad-based Categorical Eligibility (BBCE) for Elderly or Disabled (E/D) households.

This ACL is being reproduced in its entirety because of its importance.

It states the following:

Assembly Bill (AB) 433 (Chapter 625, Statutes of 2008) required the California Department of Social Services (CDSS) to establish a program of categorical eligibility "...to improve nutrition and promote the retention and development of assets and resources for needy households who meet all other [CalFresh] eligibility requirements." As stated in 7 CFR 273.2(j)(2)(ii)(B), the United States Department of Food and Agriculture, Food and Nutrition Services (FNS) allows states the option for households to have gross income up to 200 percent of the Federal poverty level (FPL) in order to have categorical eligibility conferred. E/D households are not subject to a gross income

test for actual program eligibility and therefore, to comply with AB 433, E/D households, with gross income at or below 200% of the FPL, must be conferred MCE/BBCE status if they are issued or have online access to the “Family Planning - PUB 275” brochure. CWDs should refer to ACL 12-62 for MCE/BBCE examples of households that are non-E/D.

The FNS identifies three types of categorical eligibility:

1. *Broad-based categorical eligibility (BBCE)*: Refers to the policy that makes most households eligible for CalFresh benefits because the household receives a Temporary Assistance to Needy Families (TANF)/Maintenance of Effort (MOE)-funded service, such as a brochure or pamphlet.

2. *Narrow categorical eligibility*: Narrow categorical eligibility refers to the policy that makes a smaller number of households eligible through the receipt of a specific TANF/MOE-funded service such as child care or counseling. Both BBCE and Narrow categorical eligibility are for households not receiving a cash benefit, such as CalWORKs.

3. *Traditional categorical eligibility*: Traditional categorical eligibility refers to the mandatory policy that makes households eligible for CalFresh benefits because the household receives cash benefits through TANF (CalWORKs), or General Assistance.

On July 1, 2009, California implemented MCE for households with children under the age of 18 who would otherwise be eligible for CalFresh benefits, except for their exceeding the resource limit. MCE was conferred by providing the household with a TANF/MOE-funded service. The TANF/MOE-funded service for MCE is the “Family Planning – PUB 275” brochure. MCE was expanded to all Non-Assistance CalFresh (NACF) households on February 1, 2011.

Receipt of the PUB 275 exempts all resources in the determination of eligibility for households **who meet all other CalFresh eligibility requirements**. In California, 200% of the FPL has been established as the maximum gross income that an E/D household (for the TANF-funded service, the PUB 275) can have in order to have MCE/BBCE conferred through receipt of the PUB 275. Receipt of the PUB 275 does not, in itself, confer MCE/BBCE to a household. Counties must document the case record, or otherwise identify the case, as MCE/BBCE for quality control purposes. In addition, the case must be re-evaluated and documented for MCE/BBCE at recertification.

Elderly or Disabled Household Examples

Example 1

An E/D household comes into the CWD and receives an application packet (or completes an online application). Included in the application packet (or on a linked website) is the PUB 275 (Family Planning brochure).

During the intake interview, it is determined the household has gross income that does not exceed 200% of the FPL for its household size. Therefore, the household can be considered MCE/BBCE-eligible because the gross income did not exceed the maximum allowable for the TANF-funded service and they have received the PUB 275.

The individual case record must first document (1) the household's gross income did not exceed the limit for the TANF-funded service (PUB 275), (2) the PUB 275 was provided to the household and (3) that MCE/BBCE was conferred.

Example 2

An E/D household comes into the CWD and receives an application packet (or completes an online application). Included in the application packet (or on a linked website) is the PUB 275 (Family Planning brochure).

During the intake interview, it is determined the household has gross income that exceeds 200% of the FPL for its household size. Therefore, even though the household has received the PUB 275, it cannot be considered to be MCE/BBCE-eligible because the gross income exceeds the maximum allowable for the TANF-funded service.

The household must now be evaluated for CalFresh based on **all** eligibility factors. If the household has countable resources that exceed the maximum amount allowable (\$3,250) for an E/D household, the application must be denied. E/D households are not subject to a gross income test in the determination of CalFresh eligibility. However, if the household's resources do not exceed the maximum, the household must be net income eligible to receive CalFresh benefits. If the household's **net** income exceeds the maximum amount allowable, the application must be denied. The individual case record must first document that the household's gross income exceeded the limit for the TANF-funded service (PUB 275) and that MCE/BBCE was not conferred, even if the PUB 275 was provided to the household.

NOTE:

Households of one or two persons that have been conferred MCE/BBCE status will be entitled to the minimum CalFresh benefit even though the household's net income exceeds the maximum allowable for their household size. In addition, households of three or more persons that have been conferred MCE/BBCE status will be entitled to the allotment amount indicated in the tables of benefit issuance by household size even if the household's net income exceeds the maximum amount allowable.

REVISED IN-HOME SUPPORTIVE SERVICES PROGRAM HEALTH CARE CERTIFICATION FORM AND RELATED NOTICES; CLARIFICATION ON INTER-COUNTY TRANSFERS IN RELATION TO HEALTH CARE CERTIFICATION REQUIREMENTS

This ACIN is currently not in our para-regulations but will be included in the next update.

It transmits the revised In-Home Supportive Services (IHSS) Program Health Care Certification Form (SOC 873), Notice to Applicant of Health Care Certification Requirement (SOC 874), and Notice to Recipient of Health Care Certification Requirement (SOC 875). It also provides a clarification on policy regarding inter-county transfers of IHSS cases in relation to the health care certification requirements.

In addition, it includes a discussion of what types of “licensed health care professionals” can fill out the certification form or provide “alternative documentation.”

E-NOTE #97 – PRORATING IHSS/PCSP PROTECTIVE SUPERVISION HOURS WHEN THERE IS MORE THAN ONE PROTECTIVE SUPERVISION RECIPIENT IN THE SAME HOME

April 26, 2013

MPP §30-763.33 provides the following:

The need for protective supervision shall be assessed based on the recipient's individual need provided that:

.331 When two (or more) IHSS recipients are living together and both require protective supervision, the need shall be treated as a common need and prorated accordingly. In the event that proration results in one recipient's assessed need exceeding the payment and hourly maximums provided in Section 30-765, the apportionment of need shall be adjusted between the recipients so that all, or as much as possible of the total common need for protective supervision may be met within the payment and hourly maximums.

.332 For service authorization purposes, no need for protective supervision exists during periods when a provider is in the home to provide other services.

The Department is currently reviewing whether there are problems with the protective supervision calculation spreadsheet that was created for the purpose of prorating protective supervision hours in these types of cases. This spreadsheet is posted on the CDSS website, and was included in IHSS Training Academy materials developed in 2006. This review will ultimately determine whether it will be necessary for the

Department to revise departmental policy and/or regulations to support the proration calculation or, if in the alternative, it will be necessary to develop a new proration calculation.

Until it is clear what the Department's policy is with respect to this issue, any decision that involves the proration of protective supervision hours for two or more protective supervision recipients in the same household must be written as a proposed decision.

E-Note #96 – SUMMARIES OF ACLs/ACINS

April 1, 2013

ACL 13-17 (March 22, 2013)

UPDATED INFORMATION FOR SEMI-ANNUAL REPORTING IMPLEMENTATION FOR CALFRESH

The purpose of this ACL is to provide counties with updates on Semi-Annual Reporting (SAR) implementation instructions in ACL 12-25 and expand on policy and procedures for CalFresh. Assembly Bill 6 requires CDSS to replace the current Quarterly Reporting/Prospective Budgeting (QR/PB) with a SAR system no later than October 1, 2013.

ACL 12-25 was released on May 17, 2012 with instructions that were contingent on federal waiver approvals and clarification from the United States Department of Agriculture (USDA), Food and Nutrition Service (FNS). FNS has denied several reporting waiver requests as addressed in ACL 13-08.

This letter provides updated implementation instructions with specific procedures and examples as stated in ACL 13-08. This letter explains how waiver denials impacted ACL 12-25 CalFresh instructions, expands upon procedures, and clarifies procedures for reports of changes in income and household composition.

Link: <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-17.pdf>

ACL 13-16 (March 22, 2013)

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CaWORKs) PROGRAM: RESTRICTED ACCOUNTS

The purpose of this letter is to transmit final amended regulations MPP sections 42-213 and 44-211) relative to restricted accounts. These manual sections were amended due to the enactment of SB 1341. The relevant provisions of SB 1341 were initially implemented through ACIN I-59-11, dated October 12, 2011.

SB 1341 made changes to allow recipients to spend funds held in a restricted account to help pay for costs associated with securing permanent rental housing or to pay for rent arrearages to avoid becoming homeless. In addition, any savings that are held in a restricted account are now exempt from being counted toward the \$100 limit when determining eligibility for special needs payments.

Link: <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-16.pdf>

ACL 13-15 (March 12, 2013)

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CaWORKs) PROGRAM: QUESTIONS AND ANSWERS FOR THE CaWORKs WELFARE-TO-WORK (WTW) 24-MONTH TIME CLOCK

The purpose of this letter is to provide answers to questions that the California Department of Social Services (CDSS) has received about the implementation instructions issued to County Welfare Departments (CWDs) for the new WTW 24-Month Time Clock and hourly participation requirements, established by SB 1041, which became effective on January 1, 2013.

It provides six pages of questions and answers, and is recommended reading.

Link: <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-15.pdf>

ACIN I-11-13 (March 6, 2013)

RELEASE OF THE NEW LOW INCOME HOME ENERGY ASSISTANCE INFORMING NOTICE (CF 1) AND REVISION OF THE NOTICE OF APPROVAL FOR CALFRESH BENEFITS

The purpose of this letter is to inform counties of the release of the new Low Income Home Energy Assistance Program (LIHEAP) informing notice (CF 1) and the revisions to the Notice of Approval for CalFresh Benefits.

Link: http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-11_13.pdf

ACL 13-12 (February 27, 2013)

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO
KIDS (CalWORKs) PROGRAM: NEW CalWORKs WELFARE-TOWORK
(WTW) 24-MONTH TIME CLOCK INFORMING NOTICE (CW 2208)

The purpose of this ACL is to transmit the attached CW 2208 informing notice. County Welfare Departments (CWDs) must use the CW 2208 to provide recipients information regarding the number of months remaining on his or her WTW 24-Month Time Clock. The CW 2208 was developed as the result of changes to the CalWORKs program promulgated in SB 1041, effective January 1, 2013. The California Department of Social Services (CDSS) has developed this informing notice in consultation with a full stakeholder workgroup that includes representatives from the County Welfare Directors' Association (CWDA), welfare rights organizations, legislative staff, CWDs and community colleges.

Link: <http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-12.pdf>

ACIN I-08-13 (February 28, 2013)

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs)
WELFARE-TO-WORK (WTW) 24-MONTH TIME CLOCK IMPLEMENTATION TRAINING AID

The purpose of this notice is to provide County Welfare Departments (CWDs) with a suggested training aid for the SB 1041 changes, effective January 1, 2013.

The passage of SB 1041 on June 27, 2012, resulted in significant changes to the CalWORKs program. Among these changes was the creation of the WTW 24-Month Time Clock, alignment of state participation requirements to federal requirements (referred to as *federal standards*), and the formalized reengagement over a 24 month period of all clients who previously received the Assembly Bill (AB) X4 4 young child exemption.

This training module is 59 pages long, but is recommended reading. It is a good and easy to understand overview of SB 1041 changes as described to the counties.

Link: http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-08_13.pdf

E-Note #95 – Increases to Both Dual Agency Rates in Foster Care, KinGAP, and AAP

March 28, 2013

W&IC §11461(g)(2), amended by Stats. 2012, c. 35 [S.B. 1013], §89, eff. Jun. 27, 2012;

W&IC §11464(e)(3), amended by Stats. 2012, c. 47 [S.B. 1041], §30, eff. Jun. 27, 2012;

ACL No. 12-43 (Aug. 16, 2012) – Increases in Dual Agency Rates using the California Necessities Index (CNI) for federal and state funded Foster Care, and federal and state funded KinGAP.

ACL No. 12-45 (Sep. 13, 2012) – Increases in Dual Agency Rates using the California Necessities Index (CNI).for the Adoption Assistance Program

Introduction:

Since July 1, 2007, dual agency children, that is children who are both consumers of a Regional Center and are either dependent children or adopted, have been potentially eligible for dual agency rates defined under Senate Bill 84 (W&IC §11464 for Foster Care, and §16121 for AAP).

For children up to age 3 years being provided Early Start resources under the California Early Start Intervention Services Act (CESISA), the monthly rate was set at \$898.00 effective July 1, 2007; and, for children of any age who were deemed eligible consumers under the Lanterman Developmental Disabilities Services Act, the monthly rate was set at \$2,006.00 effective July 1, 2007.

KinGAP children were added as potentially eligible for both dual agency rates upon the passage of the California Fostering Connections to Success Act (or AB 12), effective July 1, 2011 (W&IC §11364(g) for state-funded KinGAP, and §11387(g) for Federal KinGAP).

California Necessities Index (CNI) Increases to Dual Agency Rates:

Beginning July 1, 2012, counties have been ordered to adjust the dual agency rates for recipients of federal and state funded Foster Care, state and federal funded KinGAP, and AAP. (See ACL No. 12-43, issued August 16, 2012, for Foster Care and KinGAP programs; and ACL No. 12-45, issued September 13, 2012, for AAP.)

As of July 1, 2012, counties are to retroactively adjust dual agency rates effective July 1, 2011 using the 1.92 percent CNI adjustment; and effective July 1, 2012, using the 2.98 percent CNI adjustment, as follows:

<i>Effective Date</i>	<i>CNI Adjustment</i>	<i>Early Start Rate</i>	<i>Lanterman Act Rate</i>
Prior to 7/1/11	None	\$898	\$2,006
As of 7/1/2011	1.92%	\$915	\$2,045
As of 7/1/2012	2.98%	\$942	\$2,106

As noted in ACL No. 12-45, agencies shall adjust monthly AAP basic rates and the Dual Agency rate to include an annual CNI increase should one occur, effective July 1st of each year. The adjustment must be documented by sending AAP recipients a Notice of Action (NOA) reflecting the AAP rate change. A copy of the NOA must be placed in the AAP case file for documentation purposes.

Of critical note, unlike other changes to AAP benefits that require an amended agreement, CNI increases do not require an amended AAP agreement.

It is anticipated that notwithstanding the need to adjust KinGAP benefits through an amended Addendum KinGAP Agreement (state form SOC 369A), there is no need to do so for an increase to basic rates or dual agency rates based upon the CNI adjustment occurring each July 1st of each year.

There is no CNI adjustment to minor or nonminor's supplement to the dual agency rate (set at \$250, \$500, \$750, or \$1,000).

Note #94 – Superseding E-Note #14 Nonparty's Right To Hearing On Overpayment Or Overissuance Issue

March 22, 2013

In February 2009, E-Note #14, below, was issued that discussed the rights of a nonexempt assistance unit or household member to whom the county did not address a notice of action and who was never a party to a state hearing, but against whom the county is taking action to collect an overissuance or overpayment.

The SHD has recently received clarification from Program that E-Note #14 does not reflect the Department's position.

The Department's position is that if one member of the CalFresh household or the CalWORKs assistance unit receives a legally adequate and language-compliant notice of action, this meets the legal requirement for notice for *all* members of the household and assistance unit during the overissuance and overpayment period. This is because there is no federal or state law that requires that the county give individual notice to household and assistance unit members of their state hearing rights or the right to an administrative review prior to the interception of one's tax refund, and because household and assistance unit members are jointly and severally liable for an overissuance or overpayment. In the CalFresh Program, 7 CFR 273.13 only requires notice to the household, not individual members of the household.

If a judge believes that collection action against an assistance unit/household member who has not received notice is a violation of constitutional procedural due process, and writes a decision that requires the county to prove the overpayment/overissuance before it can recoup any money, such a decision must be written as a proposed decision.

E-note #14 Nonparty's Right to Hearing on Overpayment or Overissuance Issue

2/10/09

On occasion, the county will seek to recoup a CalWORKs overpayment or food stamp overissuance against other assistance unit or household members after the county first sent a Notice of Action (NOA) to the caretaker relative. The question is whether the other assistance unit or household member has a right to a hearing separate from the caretaker relative's hearing rights. Three scenarios are discussed below.

If No Hearing Conducted

If the original NOA was only addressed to the caretaker relative and the caretaker relative did not request a hearing, the other AU or household member may have all overpayment or overissuance issues reviewed if he/she filed a timely hearing request after receiving a NOA addressed to him/her. This is true regardless of whether the caretaker relative received the NOA or whether the NOA was adequate or language compliant.

Assume the county sent an adequate and language-compliant NOA in 2007 to a parent of an aided child demanding repayment of an alleged \$2000 CalWORKs overpayment from September 2005 through August 2006. It is established that the parent received the NOA. In 2009, the county sends a NOA to the aided child who is now 18 years old demanding repayment of the same \$2000 overpayment. He requests a hearing. If the 18 year old filed a timely hearing request after receiving the 2009 NOA, the 18-year old is entitled to a state hearing to dispute the amount and cause of the alleged

overpayment and the county fs right to recoup the overpayment. This could include an equitable estoppel issue.

If Hearing Conducted

The issue is somewhat different if the caretaker relative had a hearing on the \$2000 overpayment. In the example above, the 18-year old would still be entitled to a hearing regarding the recoupment of the overpayment even if the first judge had upheld the county fs right to collect the overpayment against the caretaker relative. This could include an equitable estoppel issue.

The 18 year old may however be precluded from having the amount and cause of the overpayment or overissuance reviewed.

Courts now generally hold that a nonparty's claim is precluded by a prior suit based on a particular form of privity known as virtual representation. The virtual representation concept applies when the interests of a nonparty to the original case were adequately represented by a party to the original action.

Courts have held that identity of interests and adequate representation are necessary before the concept of virtual representation may be applied to preclude a nonparty to the first hearing from having a hearing right separate from the original party. In addition, there must be a showing that at least one of the following three factors is present:

There must be a close relationship between the nonparty and the original party

(This is likely to apply in the state hearing context)

*There was substantial participation by the nonparty in the original hearing
(possible but unlikely in the state hearing context)*

*Tactical maneuvering on the part of the nonparty to avoid preclusion by the prior
judgment (very unlikely in the state hearing context)*

*Thus in the rare instance where the county has received a decision on the merits
upholding the right to collect an overpayment against a party such as a caretaker
relative, the nonparty may be precluded from having a hearing on the amount and
cause of the overpayment under the virtual representation form of privity, but the
nonparty must be given an opportunity to demonstrate that virtual representation does
not apply.*

If Hearing Scheduled but Not Conducted

*If the claimant in the original action fails to attend the scheduled hearing and a dismissal
decision is issued, there has been no decision on the merits. The concept of virtual
representation is a privity concept and it will not preclude a nonparty from exercising
hearing rights on all issues when the original party failed to attend the hearing.*

*Furthermore, there clearly was not adequate representation at the non-appearance
hearing. Thus, the 18-year old can ask for review of all issues related to the
overpayment.*

E-NOTE #93 - NEW CalWORKs WELFARE-TOWORK (WTW) 24-MONTH TIME CLOCK; EXPIRATION OF THE CalWORKs 48-MONTH TIME LIMIT EXEMPTION FOR LACK OF SUPPORTIVE SERVICES

January 25, 2013

ACL 12-67 (December 21, 2012); ACL 13-02 (January 24, 2013)

References: ACL 12-53; ACL 12-60; ACL 69; ACL 12-72

ACL 12-67 provides the most comprehensive overview, to date, of the new Welfare to Work 24 Month Time Clock. This letter addresses the CalWORKs population that will be affected by the WTW 24-Month Time Clock, when the new clock starts, how to count months toward the new clock, who is exempt from the clock, and how to transition existing adult recipients into the new WTW 24-Month Time Clock period.

Because this ACL is 11 pages long and has attachments, including a chart of the Welfare to Work time exemptions and good cause for not participating, the entire ACL is being circulated as an attachment to this e-mail.

ACL 13-02 provides the counties with informing instructions for the expiration of the CalWORKs 48-month time limit exemption for good cause for lack of supportive services. As of January 1, 2013, CWDs can continue to grant good cause to clients for a lack of supportive services when clients are unable to participate in their assigned WTW activities because a necessary supportive service is unavailable. However, this no longer stops a client's CalWORKs 48-month time clock.

The CWDs must inform, in writing and at least 10 days in advance, clients who were exempt for good cause for lack of supportive services on December 31, 2012, that their 48-month time clock will begin to tick the first of the following month. Counties must ensure that these clients are offered an appointment for a comprehensive discussion on the new CalWORKs rules as soon as possible.

E-NOTE #92 - Maximum Hours in Protective Supervision Decisions Depends On The IHSS/PCSP Program At Issue

January 10, 2013

References: Para-Reg 560-2A: Para-Reg 567-1: Para-Reg 563-3B: Para-Reg 567-13: Para-Reg 612-5: Para-Reg 612-1: Para-Reg 612-2: Para-Reg 612-4:

Because of mistakes being made in the number of hours being ordered in IHSS protective supervision decisions, this E-Note is intended to remind judges of some basic concepts that apply when determining the maximum hours that should be ordered.

The basic concept to remember is that under the Personal Care Services Program (PCSP), there can be a maximum of 283 hours per month regardless of whether the recipient/claimant is severely or nonseverely impaired. The only exception to this is when a PCSP recipient is NSI and receives protective supervision. In those cases, the recipient can only receive up to 195 hours/month of protective supervision plus their other service hours for a total maximum of up to 283 hours.

However, under the IHSS Plus Option (IPO) (formerly IHSS-Plus Waiver), it does matter whether the claimant/recipient is severely or nonseverely impaired. If nonseverely impaired, the maximum hours that he/she can receive are 195 hours per month for both protective supervision and hours in all other service categories.

A hypo that will illustrate this is the following:

The parent is a provider for a child who is 17 years and 364 days old. He received 15 hours per week in non-medical personal services, and, therefore, does not meet the definition of severely impaired. He also needs protective supervision. His total monthly non-protective supervision hours are 64.95 hours (15 hours/wk x 4.33) plus 130 hours/month in protective supervision for a total of 195 hours per month. 195 hours per month is the maximum he can receive because he is a minor with a parent provider and, therefore, the case is an IPO case.

Nothing else changes except the next day that child turns 18. The case is now a PCSP case and the child is entitled to 64.95 hours per month in non-protective supervision categories plus 195 in protective supervision, or 259.95 hours rounded to 260 hours per month total.

If you use the IHSS Computation program in our Decsystem, it will compute maximum hours automatically depending on the information inputted. I.e., after inputting the hours in the categories of services, you are prompted to answer the question "Is protective supervision allowed?" You are then asked if the case is a PCSP case. Depending on your answers, combined with whether the number of hours entered into the nonmedical personal care services categories totaled 20 hours per week or more, the program will automatically compute either up to 195 hours or up to 283 hours per month.

The Social Service and Medi-Cal para-regulations that are relevant to this issue are set forth in the reference section.

It is important that these regulations are implemented correctly, because when they are not, they prevent the counties from being able to input the order into CMIPS, the county IHSS payroll system, so that the order can be implemented, and the recipient/claimant can receive services.

[1] Please note that the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), enacted March 23, 2010, established a new State Plan Option entitled the Community First Choice Option (CFCO). CFCO is one option a State may choose to provide home and community-based attendant services and supports. The maximum hour rules that will apply to this program are currently being determined. A future E-Note will be issued that discusses this program.

E-Note #91 - Low Income Health Program (LIHP)

December 26, 2012

Medi-Cal Eligibility Division Information Letter No: I 12-08

References: SHD LIHP Memo distributed on October 18, 2012

SHD distributed a memo to judges on October 18, 2012 which goes into detail about the LIHP internal county grievance/appeal process and state hearing process. It is attached again here for reference.

Medi-Cal Eligibility Division Information Letter (MEDIL) No. I 12-08 provides the counties with basic information on the LIHP.

The MEDIL states, in pertinent part, the following:

Counties should provide LIHP information to applicants and beneficiaries who are determined ineligible to receive benefits under the Medi-Cal program. The Department of Health Care Services (DHCS) encourages each county to develop a Medi-Cal and LIHP referral and coordination process to facilitate individuals' enrollment into LIHP pursuant to Welfare and Institutions Code (W&I), Section 10500. W & I, Section 10500 states:

Every person administering aid under any public assistance program shall conduct himself with courtesy, consideration, and respect toward applicants for the recipients of aid under that program, and shall endeavor at all times to perform his duties in such manner as to secure for every person the amount of aid to which he is entitled, without attempting to elicit any information not necessary to carry out the provisions of law applicable to the program, and without comment or criticism of any fact concerning applicants or recipients not directly related to the administration of the program.

Background

DHCS received approval from the Center for Medicare and Medicaid Services (CMS) to administer the California's Bridge to Reform, Section 1115(a) Medicaid Demonstration (Demonstration) effective November 1, 2010 to October 31, 2015. The LIHP is a component of the Demonstration which provides health care coverage to eligible low income individuals statewide in preparation for health care reform implementation by 2014. At that time, those individuals covered through LIHP will transition into the Medi-Cal program or the new statewide Health Benefits Exchange under the Patient Protection and Affordability Care Act of 2010. The LIHP is authorized by W & I Code, Sections 14053.7 and 15909-15915.

Basic LIHP Information

LIHP is a voluntary county-funded program administered by the county health department or social services agency. LIHP includes two components distinguished by family income level: Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). MCE enrollees have family income at or below 133 percent of the Federal Poverty Level (FPL). HCCI enrollees have family income above 133 and up to 200 percent of the FPL. Local LIHPs may elect to operate only a MCE program, but must have a MCE in order to implement a new HCCI. The local LIHP can set the FPL income levels below the maximum allowable amount according to the Special Terms and Conditions (STCs) approved by CMS.

LIHP is an asset waiver program that covers individuals age 19-64. LIHP eligibility and enrollment process for both the MCE and HCCI components require that individuals are ineligible for Medicaid or Children Health Insurance Program (CHIP), not pregnant, meet the income eligibility standards as set by the county, and have proof of U.S. citizenship or satisfactory immigration status. For MCE, an individual may have other health insurance as long as he/she meets the other program requirements for enrollment. For HCCI, an individual must not have other health coverage and meet all other program requirements for enrollment. County participation in LIHP under the Demonstration is optional and based on available local funds. Using a CMS approved claiming process, participating counties will receive federal reimbursement for the local LIHPs' cost of providing health services for eligible programs. The local LIHP must follow all federal Medicaid rules in determining an individual's eligibility, pursuant to the STCs under the Bridge to Reform Demonstration.

The LIHP Division has released a LIHP Policy and Procedures Letter (PPL) #12-004, on Low Income Health Program Eligibility for Individuals Eligible for other Medi-Cal and State Funded Health Care Programs, to provide guidance in determining LIHP eligibility for individuals who are eligible for other health care programs with similar benefits. Medi-Cal program staff shall reference PPL #12-004 to refer potential eligibles to their local LIHP when an individual is determined not eligible for Medi-Cal benefits.

All LIHP PPLs are posted on the LIHP webpage, under the Publications section:
<http://www.dhcs.ca.gov/provgovpart/Pages/lihp.aspx> Medi-Cal Eligibility Division Information Letter No.: I 12-08
Page 3 December 21, 2012

Because LIHP is a county-administered and funded program, when an enrollee moves from one participating county to another, the individual will be disenrolled by the county in which he/she no longer resides, and will be required to reapply in the county in which he/she becomes a resident. In addition, some local LIHPs have "branded" their programs and may not refer to them as LIHP. Examples of some of the counties' branded names are: Los Angeles County - Healthy Way LA (HWLA), Alameda County - Health Program of Alameda County (HealthPAC), Orange County - Medical Services Initiative (MSI) and County Medical Services Program (CMSP) - Path2Health.

A complete list of the county LIHP contacts and telephone numbers is available on the DHCS website at:
<http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/LIHPConsCntcts62812.pdf>

Currently, 16 counties and 35 County Medical Services Program (CMSP) counties have been approved by CMS to administer a LIHP. The 16 counties are: Alameda, Contra Costa, Kern, Los Angeles, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz and Ventura. The 35 CMSP counties are: Amador, Alpine, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Tuolumne, Trinity, Yolo and Yuba. Three counties have withdrawn their application to implement a LIHP and they are: Fresno, Merced and San Luis Obispo. The remaining counties that plan to implement a LIHP will have a program effective date after approval from CMS.

The latest LIHP information is available at:
http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Resources/Name-Impl_Date-FPL_10-31-12.pdf

Note #90 - IMPLEMENTATION OF POLICY CHANGES REGARDING CALFRESH EXPEDITED SERVICE

ALL COUNTY LETTER NO. 12 -74 (December 24, 2012)

References: W&IC18914; ASSEMBLY BILL 1359; §63-300.32, 63-301.51 63-301.522, 63-301.533, 63-301.544, AND 63-301.545; Title 7 of the CFR §§273.2(i), 273.2 (i)(2), 273.2(i)(4)(iii)(A) AND (B); ACL 10-32

In summary, this ACL reports on a change in state law, effective January 1, 2013, which requires that counties no longer limit CalFresh Expedited Service (ES) screening to those who have answered specific questions on the application. Counties will, instead, be required to screen all CalFresh applications to determine if applicants meet the criteria for ES. It also reports on the Department's simplification of the certification process for all households with postponed verifications under ES. § 63-301.522 will be revised to reflect these changes.

The ACL specifically states the following:

This letter is to inform counties of the two policy changes regarding CalFresh Expedited Service (ES): 1) identifying households that are entitled to ES as a result of recently enacted state legislation, Assembly Bill (AB) 1359, (Chapter 468, Statutes of 2012) which amended Welfare and Institutions (W&I) Code Section 18914, and 2) simplifying the existing policy regarding receipt of CalFresh benefits under ES when verifications are postponed.

Recently, the California Department of Social Services (CDSS) submitted a federal waiver to the United States Department of Agriculture (USDA) Food and Nutrition Service (FNS) requesting the ability to issue CalFresh benefits under ES without conducting an interview if the following conditions are met:

- 1) An interview is attempted;
- 2) The applicant's identity can be verified; and
- 3) The applicant provides sufficient information to determine entitlement to ES.

FNS' response stated that California's policies regarding screening applications for ES are not in compliance with federal policy. FNS also stated that ensuring CalFresh benefits issued under ES for applications submitted on or before the 15th, do not extend past the month of application (when postponed verifications are not completed), is not clearly stated in State regulations.

Assembly Bill 1359

Effective January 1, 2013, W&I Code Section 18914 will require the screening of all CalFresh applications to determine if applicants meet the criteria for ES as defined in Title 7 of the Code of Federal Regulations (CFR) Section 273.2(i) and Manual of Policies and Procedures (MPP) Section 63-301.51.

As a reminder, applicants determined to be entitled to ES will continue to receive CalFresh benefits no later than the third calendar day following the date the application was filed. For purposes of this section, a weekend (Saturday and Sunday) shall be considered one calendar day. However, if the third calendar day is a nonworking day or holiday, the County Welfare Department (CWD) shall make benefits available on or before the working day immediately preceding the nonworking day.

AB 1359 amended previous state rules (MPP Section 63-301.522) which required CWDs to screen only CalFresh ES applications where the applicant made a request for ES by attempting to answer the identifiable questions for ES entitlement either on the DFA 285-A1, SAWS 1, or online application forms. Per AB 1359, CWDs will no longer limit ES screening to those who have answered specific questions on the application.

Corresponding state rules at (MPP Section 63-301.522) will no longer be applicable and are scheduled to be revised as soon as administratively possible.

Receipt of ES CalFresh Benefits with Postponed Verifications

CDSS is simplifying the certification process for all households issued CalFresh benefits under ES in conjunction with the implementation of AB 1359. This simplification is in compliance with 7 CFR § 273.2(i)(4)(A) and (B). In current state regulations, quarterly reporting (QR) and change reporting (CR) households are treated differently regarding certification length. Effective January 1, 2013, in an effort to promote program simplification, all households issued CalFresh benefits under ES will be certified for the maximum certification allowable, in accordance with the household's circumstances.

The following procedures will be used to determine the issuance of benefits to households with postponed verifications under ES:

" If the application was submitted on or before the 15th day of the month:

The household shall be issued prorated CalFresh benefits for the month of application only. Satisfaction of the verification requirements may be postponed until the second month of participation. The county will pend the subsequent month's CalFresh benefits until postponed verifications are completed. If verifications are not completed within 30 days of application the case will be discontinued and the household will need to reapply or

restore eligibility. Households, who reapply or have their eligibility restored, are not entitled to ES (see ACL 10-32). If the household fails to satisfy postponed verification requirements and does not appear for the interview, the CWD does not need to contact the household again.

" If the application was submitted after the 15th day of the month:

The household shall be issued both the prorated CalFresh benefits for the application month and subsequent month at the same time. Satisfaction of the verification requirements may be postponed until the third month of participation, if necessary, to meet the expedited timeframe. When the household has provided the required postponed verification, the CWD shall issue the third month's benefits within five working days from receipt of the verification or by the first working day of the third month, whichever is later. If verifications are not completed within 30 days of application, the case will be discontinued before the third month's benefits are issued and, the household will need to reapply or restore eligibility. Households, who reapply or have their eligibility restored, are not entitled to ES (see ACL 10-32). For subsequent months, the household must reapply and satisfy the verification requirements which were postponed or be certified under normal processing standards. If the household fails to satisfy postponed verification requirements and does not appear for the interview, the CWD does not need to contact the household again.

Migrant Farmworker Households:

The following are reminders of ES verification provisions particular to migrant farmworker households:

" Where the only missing verification is from an out-of-state source, migrant households shall receive the second month's benefits regardless of when the application was submitted during the month of application.

" Migrant farmworker households shall be entitled to postpone out-of-state verification only once each migrant farm season. If a migrant farmworker household is entitled to ES and has already received this exception during the current migrant farm season, the CWD shall grant a postponement of the out-of-state verification for only the initial month.

" If the household provides the required out-of-state postponed verification, the CWD shall issue the third month's benefits within five working days from receipt of the verification or by the first working day of the third month, whichever is later.

" If the out-of-state verification is not completed within 60 days, following the date the application was filed, the household's participation shall be terminated, and the household will need to reapply or restore eligibility. Households, who reapply or have their eligibility restored, are not entitled to ES (see ACL 10-32).

For all three instances households must be notified on the DFA 377.1 of the date when CalFresh benefits will be stopped unless postponed verifications are submitted. Revisions to MPP Sections 63-301.544 and 63-301.545, the Notice of Approval of CalFresh benefits (DFA 377.1), and the CalFresh Expedited Service Quarterly Statistical Report (DFA 296X) will follow as soon as administratively possible.

Late Determinations

Per existing policy, if the applicant was not eligible for ES at application or if the CWDs' screening process required at 7 CFR Section 273.2(i) and MPP Section 63-301.522, fails to identify the household as being entitled to ES and the CWD subsequently discovers the household is entitled to ES, the CWD must determine eligibility for ES by conducting an interview within the standard three-day processing time frame. In this instance, ES processing standards must be calculated from the date the CWD discovers the household is entitled to ES in accordance with MPP Section 63-301.533

Partial Completed Applications

A partially completed application which contains the applicant's name, address, and signature is considered filed, even if the household has not been interviewed prior to submitting the application (MPP Section 63-300.32). Counties cannot reject applications which contain this limited information, however, if the household does not provide sufficient information in order for the CWD to make a determination for ES entitlement, the household must be scheduled for normal processing.

E-Note #89 - CalWORKs SB 1041 EXTENSION OF SHORT TERM CHANGES AND THE NEW YOUNG CHILD EXEMPTION

December 21, 2012

ACL 12-72 (December 20, 2012)

References: ACL 12-49; ACL 12-53; ACL 12-69; ACL 12-67; ACL 12-60

ACL 12-72, released on December 20, 2012, provides specific information about the short-term young child exemptions.

The ACL provides the information:

Extension of the Short-Term Young Child Exemptions

SB 1041 extended the current short-term young child exemptions originally enacted by AB X4 4, which created additional exemptions from WTW activities for a parent or caretaker relative who has primary responsibility for personally providing care to one child who is from 12 months through 23 months of age, or at least two children who are under six years of age. For two-parent assistance units (AUs) meeting this exemption criteria, the exemption is limited to one parent in the two-parent AU. Counties must continue to exempt all clients who qualify for these exemptions through December 31, 2012. Clients granted these exemptions are not required to participate in WTW and will not have months count against their CalWORKs 48-month time limit until the client is reengaged sometime after January 1, 2013. (More information on reengagement will be provided in a future ACL.) Likewise, clients granted these exemptions do not have months count against the new WTW 24-Month Time Clock until they are reengaged.

Extension of the Current Time Limit Exemption due to Good Cause for Lack of Supportive Services

Clients who receive good cause from WTW participation for lack of funding for supportive services will not have months counted against their CalWORKs 48-month time limit through December 31, 2012. On January 1, 2013, counties can continue to grant good cause to clients for lack of supportive services; however, this will no longer exempt months from a client's 48-month time limit. Counties must inform clients in writing prior to December 31, 2012, that their 48-month time limit will begin to tick as of January 1, 2013. A separate ACL will be issued in December 2012 that will provide informing instructions for those clients that have had months exempt from the CalWORKs 48-month time limit due to good cause for lack of supportive services.

Extension of Counties' Option to Redirect Mental Health and Substance Abuse Funding

SB 1041 extended the flexibility to redirect, if needed, CalWORKs mental health and substance abuse treatment services funding to and from other employment services through June 30, 2014. This means that counties may continue to use resources from their county's mental health and substance abuse services

allocations to pay for other critical CalWORKs services, and vice versa. However, if counties shift mental health and substance abuse funds to cover other CalWORKs employment services expenses and mental health and substance abuse treatment services become unavailable, the clients who exhibit a need for these activities in their WTW plan must be granted good cause. Counties are reminded that if employment services funds are redirected from the CalWORKs Single Allocation, those funds can only be used for non-medical substance abuse and mental health treatment services.

New Young Child Time Limit and WTW Exemption

SB 1041 created a new one-time young child exemption for a parent or caretaker relative who has primary responsibility for personally providing care to one child from birth through 23 months of age. For two-parent AUs meeting this new young child exemption criterion, each parent in the AU must be provided the option to receive this exemption. Only one parent at a time may be granted the exemption; however, the parents have the option to alternate which parent is exempt. For example, one parent may receive the exemption for 12 months, and then alternate so that the other parent receives the exemption for the remaining 12 months. In this example, the exemption is fully exhausted after 23 months for both parents and neither parent is eligible to receive it again. This new exemption begins on January 1, 2013. Clients granted this exemption are not required to participate in WTW and will not have months count against their CalWORKs 48-month time limit until they no longer meet the criteria for this exemption. Additionally, months while receiving this exemption do not count against the new WTW 24-Month Time Clock.

This exemption is a once-in-a-lifetime option and is at the discretion of the client. This means that a client who has a child between zero and 23 months of age on January 1, 2013 has the option to reserve his or her right to use it for the caregiving of a future child (or to exercise it at a later date with respect to that existing child.) Anyone who is exempt under the AB X4 4 young child exemption on December 31, 2012, should not be offered this exemption until he/she is in the reengagement process.

Example

Jane is exempt on December 31, 2012, for providing care for her two children, both under the age of six. Her youngest child will be six months old at the end of 2012. Based on her county's reengagement process, she will not be reengaged until sometime in mid-2013. Since her child will still be under two at the time of reengagement, she would be eligible for the new once-in-a-lifetime exemption. The county would not offer her the exemption until her reengagement contact/meeting. At the time of the reengagement contact/meeting, the full list of potential exemptions will be reviewed with Jane. Assuming that Jane is not eligible for any other exemptions, when offered the exemption Jane can:

choose to take the new young child exemption for the time remaining until her youngest child turns two; or choose not to take the exemption and save it to use it in the future. (For example, Jane may want to finish a semester of training and then take the exemption, or "save" the exemption in case she has another young child.)

If Jane takes the exemption, she can volunteer to participate, and her time would not be counted toward either the WTW 24-Month Time Clock or the CalWORKs 48-month time limit clock. In the future; however, if Jane is caring for a child under two, she will no longer have this exemption available to her, since she used her one-time exemption.

The existing WTW exemption for parents caring for one child six-months or under is still available. On a case-by-case basis, a county can reduce this time to 12-weeks, or extend this time to 12-months. For subsequent children, a 12-week WTW exemption remains available as well. On a case-by-case basis, this can be extended to six-months. Counties must continue to offer these WTW exemptions to parents with children who meet

these criteria. All WTW exemptions will stop a client's WTW 24-Month Time Clock. However, the exemptions described in this paragraph do count against the CalWORKs 48-month time limit, and the parent/caretaker must be informed of this prior to taking the exemption.

Counties are reminded that clients meeting WTW exemption criteria must be provided the opportunity to volunteer.

E-Note #88 HEALTHY FAMILIES PROGRAM TRANSITION TO MEDI-CAL;
Targeted Low-Income Children's Program

December 20, 2012

References: ACWDL No.:12-30 (October 31, 2012); ACWDL 12-33 (November 16, 2012)

The purpose of ACWDLs 12-30 and 12-33 is to inform counties of the changes to the Medi-Cal program pursuant to Assembly Bills 1494 and 1468 which provides for the transition of children from the current State Children's Health Insurance Program (S-CHIP) known as the Healthy Families Program (HFP), to the California Medi-Cal program. Additionally, Medi-Cal will cover these children under a new optional coverage group, the targeted low-income children. This new coverage group is named the Targeted Low-Income Children's Program (TLICP).

This E-Note is intended to provide only the most basic information about the transition from HFP to TLICP, and basic information about TLICP. It is necessary to read these ACWDLs for details.

Transition Phases:

ACWDL 12-30 states that upon implementation of the transition, which will occur in four phases and begin no sooner than January 1, 2013, the HFP will stop enrolling new children, with the exception of Access for Infants and Mothers (AIM)-linked children, and these children will be subsequently covered under the Medi-Cal program.

The Department of Health Care Services (DHCS) intends to begin the transition of the HFP children into the Medi-Cal program no sooner than January 1, 2013. The last phase of the transition will begin no sooner than September 1, 2013.

As the children transition to the Medi-Cal program, their Medi-Cal eligibility will be temporarily granted based on their last known annual eligibility date under the HFP. Granting temporary eligibility allows for a smooth transfer to the Medi-Cal program without the need for the family to reapply for Medi-Cal at the time of transition.

ACWDL 12-30 outlines the following Transition Phases:

Transition Phase	Start Date	Cases Transitioning
Phase 1A		

Phase 1B	No sooner than January 2013	
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No sooner than March 2013 Individuals currently enrolled in a HFP health plan that is a Medi-Cal managed care plan will be enrolled in the same plan, unless they choose a different Medi-Cal Managed Care plan.

Phase 2 No sooner than April 2013 Individuals currently enrolled in a HFP health plan that is a subcontractor of a Medi-Cal Managed Care plan will be enrolled in a Medi-Cal managed care plan that includes the individual's current plan.

Phase 3 No sooner than August 2013 Individuals currently enrolled in a HFP plan that is not a Medi-Cal managed care plan and does not contract or subcontract with a Medi-Cal Managed Care plan will be enrolled in a new Medi-Cal managed care plan in the county.

Phase 4 No sooner than September 2013 Individuals currently in a county that has not implemented Medi-Cal Managed Care

Targeted Low Income Children's Program:

ACWDL 12-33 states the following:

"TLICP will create a new bright line of income eligibility for children zero to 19 years of age, at 250 percent of the Federal Poverty Level (FPL). The enabling legislation also gives DHCS the ability to implement a premium payment program pursuant to §1916A of the federal Social Security Act for children with incomes greater than 150 percent of the FPL. In accordance with Section 14005.26 of the Welfare & Institutions (W&I) Code, monthly premium amounts shall equal thirteen dollars (\$13) per child with a maximum family contribution of thirty-nine dollars (\$39) per month (i.e. \$13 per month/one child, \$26 per month/two children, and \$39 per month/for three or more children) in families with incomes above 150 percent and up to and including 250 percent of the FPL. Pursuant to ACWDL 91-82, health insurance premiums are not allowed as a deduction against income for members of the Medi-Cal family budget unit; the calculated premiums for TLICP is the result of the eligibility determination and is the Medicaid cost sharing obligation of the family."

The chart below represents the current Medi-Cal FPL, the Medi-Cal FPL for TLICP, and those FPL incomes subject to premium payments.

Age of Child	Current Medi-Cal FPL Limits	Medi-Cal Targeted Low-Income Children's Program FPL Limits	Medi-Cal FPL
0 - 1	Up to 200 percent	Above 200 percent and up to and including 250 percent of the FPL	Not Subject to Premiums
1 - 6	Up to 133 percent	Above 133 percent and up to and including 250 percent of the FPL	Applicable
6 - 19	Up to 100 percent	Above 100 percent and up to and including 250 percent of the FPL	Applicable for incomes above 150% to and including 250% of the FPL

Access for Infants and Mothers (AIM)

The AIM Program, established in 1992, provides medically necessary services to pregnant women with incomes between 200 and 300 percent of poverty through participating health plans.

HFP will continue to cover all AIM-linked infants at income levels above 250 percent FPL up to 300 percent FPL throughout Fiscal Year 2012-2013. AIM-linked infants with family incomes up to 250 percent FPL will enroll in TLICP.

There will be further discussions with the Legislature during the upcoming 2013-2014 Budget Year to address the AIM program. As warranted, DHCS will provide additional updates as they become available on the AIM program.

Role of MAXIMUS:

Currently, the Single Point of Entry (SPE) for mailed in and on-line application for both Medi-Cal and the HFP is administered by MAXIMUS, the administrative vendor under contract with the Managed Risk Medical Insurance Board (MRMIB). Under the new process, DHCS will contract with MAXIMUS to continue SPE operations.

Premiums

Effective January 1, 2013, if the county worker determines the family income is above 150 percent the FPL, a notification will be made to MAXIMUS for collection of the premium and non-eligibility case maintenance, and beneficiaries will make payment arrangements with the Medi-Cal Premium Payment Section at MAXIMUS.

The county eligible worker will maintain and perform all eligibility-related case maintenance for children with incomes up to 150 percent of the FPL. These cases will not be subject to premiums and the county should not forward information to MAXIMUS for these children.

Eligibility for New Applicants

Medi-Cal Hierarchy

Once the county completes the Medi-Cal eligibility process, children will be placed in the appropriate Medi-Cal program according to the Medi-Cal Program hierarchy.

Because TLICP is an optional program it falls after the FPL programs. The TLICP will coincide with the 250 percent Working Disabled, the Aged and Disabled FPL and the FPL Blind programs, which are similarly, situated optional coverage groups.

Continuous Eligibility for Children

The process for determining CEC is no different. If a change happens to a family currently eligible for Medi-Cal and that change causes the family to exceed 150 percent FPL the child has CEC coverage until the Medi-Cal Redetermination (RV).

Impact on State Hearings:

As set forth in ACWDL 12-33, counties will continue to follow the current hearing process when the beneficiary has an eligibility dispute.

Since the TLICP is more generous than the HFP because it increases the income limits before premium payments are required, it is not anticipated that there will be a significant number of state hearing requests as a result of this transition. However, some possible state hearings issues could pertain to an income determination, and whether a premium was or was not paid.

#87 E-Note - Treatment of Same-Sex Spouses and Registered Domestic Partners Subject to Transfer of Property Penalties or a Share-of-Cost (SOC) for Nursing Facility Level of Care

December 19, 2012

References: ACWDL 12-36 (December 10, 2012); AB 641; W&I Code 14015.2

ACWDL 12-36 provides information to the counties about how to retroactively implement the provisions of Assembly Bill (AB) 641 which added W&I, Section 14015.12, effective January 1, 2012.

According to Program, the purpose for the change in law is to create parity for same sex married couples and registered domestic partners with opposite sex married couples when one spouse/partner goes into long term care (LTC). Identification of marriage or registered domestic partnership for same sex married couples will be handled in essentially the same way as identification of a marriage for an opposite sex couple. This is also true for verification of a transfer of property when a spouse goes into LTC, as well as in the application of the Community Spouse Resource Allowance (CSRA) and Minimum Monthly Maintenance Needs Allowance (MMMNA). This ACWDL provides detailed instructions to the counties about this.

Because of the importance of all of the information in this ACWDL, it is being included in its entirety in this E-Note.

It states the following:

AB 641 extends the full array of spousal protections now available to married, opposite-sex couples, to same-sex spouses and registered domestic partners through the transfer of property undue hardship provisions.

As a result of AB 641, an undue hardship exists when certain transfers of property and income, described in the letter below, have been made between same-sex spouses or registered domestic partners that would otherwise have resulted in a period of ineligibility for nursing facility level of care or an SOC. This change permits same-sex spouses and registered domestic partners to retain largely the same amount of income and property that opposite-sex spouses are permitted to retain when one of the spouses is an institutionalized spouse and the other spouse is a community spouse pursuant to All County Welfare Directors Letters (ACWDLs) 90-01 and 90-03.

BACKGROUND

In accordance with ACWDL 90-01, if an institutionalized individual makes a disqualifying transfer of property for less than fair market value in order to establish eligibility for

Medi-Cal anytime during or after the 30 months immediately preceding the most recent of the date of application or date of admission to nursing facility level of care (the "look back period"), the institutionalized individual may be subject to a period of ineligibility for

Medi-Cal payment for the nursing facility level of care per diem rate only. He or she remains eligible for all other Medi-Cal covered services for which he or she would otherwise be eligible. The period of ineligibility for nursing facility level of care is equivalent to the number of months that the institutionalized individual could

have paid for his/her own nursing facility level of care at the average private pay rate, had he/she retained the property.

Transfers of any property between opposite-sex spouses are an exception and are not considered disqualifying transfers subject to period(s) of ineligibility for nursing facility level of care. This means the institutionalized individual's principal residence and/or other property (separate or community) may be transferred to the opposite-sex spouse at any time without penalty. However, in accordance with ACWDL 90-01, all of the property held in the name of either or both the institutionalized individual and community spouse is considered when determining the eligibility of the institutionalized spouse.

The opposite-sex community spouse is allowed to retain the Community Spouse Resource Allowance (CSRA) which, in California, is \$115,920 for 2013 and the institutionalized spouse is allowed to retain no more than \$2,000 in available nonexempt property. Once initial eligibility for Medi-Cal is established, the institutionalized spouse can allocate monthly income in amounts sufficient to bring the community spouse's income up to the Minimum Monthly Maintenance Needs Allowance (MMMNA) each month, known as the Spousal Income Allocation (SIA). SIA is deducted from the institutionalized individual's income used to determine his/her SOC, if any. The CSRA and SIA are intended to protect the community spouse against impoverishment.

Under current rules, a same-sex spouse or registered domestic partner is not afforded the same protections as an opposite-sex spouse. The same-sex spouse or registered domestic partner may have to sell the home he/she shares with the institutionalized individual who no longer intends to return home. The same-sex spouse or registered domestic partner may also become impoverished when the institutionalized individual must spend down his/her share of nonexempt available property, such as other real property, bank accounts or investments, to the allowable \$2,000 limit. The same-sex spouse or registered domestic partner also loses the institutionalized individual's income because it must be applied to the institutionalized individual's SOC each month.

In June 2011 the Center for Medicare and Medicaid Services issued specific guidance permitting states to expand the determination of undue hardship to allow the shared principal residence to be transferred in whole or in part from one to the other same-sex spouse or registered domestic partner without penalty. The guidance also permits states to extend the transfer of property undue hardship provision transfers of other property, income or rights to receive income. In response to this guidance, the California Legislature enacted AB 641 and provided for the expansion of the transfer of property undue hardship criteria for same-sex spouses and registered domestic partners in California so that these spouses and partners may benefit from protections that more closely align with the protections provided to opposite-sex spouses.

As a result, when counties:

a) Consider transfers of property, and any of the transfers listed below have been made between same-sex spouses or registered domestic partners, a finding of undue hardship shall be found to exist if the institutionalized applicant/beneficiary:

1) Verifies that he/she has a same-sex spouse or registered domestic partner, or makes such attestation;

Please note: The status as a same-sex spouse or registered domestic partner is verified by an indication on the Statement of Facts or by a signed statement of the institutionalized applicant/beneficiary included with the other verification submitted to the county as described below. At the option of the applicant/beneficiary, same-sex spouse or registered domestic partner, either spouse may provide a copy of the marriage license or registered domestic partner certificate.

And,

2) Provides verification that any or all of the following transfers have been made to his/her same-sex spouse or registered domestic partner and provides verification of the net market value of those items other than the principal residence;

a. All or any portion of his/her ownership interest in the shared principal residence.

b. His/her interest in property (other than the shared principal residence), or property right (including a right to receive income) to the extent that the net market value of that property does not exceed the CSRA that would be available to that person if he/she were an opposite-sex spouse. Amounts of nonexempt available property transferred in excess of the CSRA continue to be subject to the transfer of property rules.

b) Calculate the SOC. When the requirements of 1) above have been satisfied, the county shall reduce the SOC as necessary to allow for the transfer of the SIA, if the amount of the transferred income does not cause the income of the same-sex spouse or registered domestic partner's income to exceed the MMMNA. Any amount of excess nonexempt

All County Welfare Directors Office Letter No.: 12-36 Page 4 December 10, 2012

income transferred that causes the same-sex community spouse to exceed the MMMNA shall be deemed available to the institutionalized applicant/beneficiary and shall continue to be included in the SOC calculation. If the requirements of 1) above are not met, the county must ask the individual completing the Statement of Facts whether there is a same-sex spouse or registered domestic partner.

When considering the criteria above, the Medi-Cal eligibility determination rules contained in ACWDLs 90-01 and 90-03, applicable to opposite-sex spouses' income and property evaluations, will be used to determine the nonexempt income and property available to the institutionalized applicant/beneficiary and his/her same-sex spouse or registered domestic partner. Additionally, the CSRA and the SIA amounts may be increased using the same procedures as provided for opposite-sex spouses via fair hearing or court order.

When counties provide notice that the transfer of property undue hardship provisions are being considered and request the verification/documentation to make the undue hardship determination, counties must also present the new criteria and request the necessary verification, or attestation if needed.

Counties shall apply these new provisions retroactively to all same-sex spouses and registered domestic partners currently receiving nursing facility level of care and to those who received nursing facility level of care on or after January 1, 2012. Counties shall:

1) Implement these changes at application, redetermination, and whenever a case is brought to their attention.

2) Conduct a review of their county systems to locate and correct any periods of ineligibility for nursing facility level of care as appropriate.

3) Retroactively reinstate any denied or discontinued cases, retroactively correct SOC's, and void or adjust any periods of ineligibility for nursing facility level of care as appropriate.

4) Rescind and reissue notices of action as appropriate.

5) Issue MC 180s as appropriate and assist institutionalized applicants/beneficiaries and their same-sex spouses/registered domestic partners in obtaining reimbursement for Medi-Cal covered services.

E-Note #85 - EXAMPLES OF MODIFIED CATEGORICAL ELIGIBILITY/BROAD-BASED CATEGORICAL ELIGIBILITY HOUSEHOLDS FOR CALFRESH

November 30, 2012

References: ACL 12-62 (November 2, 2012); W&I Code §18901.5, ACL 11-11 (January 27, 2012), ACL 09-24 (May 27, 2009); Para-regulations 245 10A-10D

Background:

ACL 09-24 (which contains questions and answers) and ACL 11-11 reported on the change in law, effective July 1, 2009, and the implementation of Modified Categorical Eligibility (MCE). Under this change in law, for new CalFresh applicants, CWDs were to start conferring MCE to those households with children under 18 who would otherwise be eligible for food stamps--except for their exceeding the resource limit--by providing the household with a TANF/MOE-funded service. This service will be in the form of the "Family Planning - PUB 275" brochure (sample attached). The brochure contains information on locating family planning services providers and the benefits of family planning services available to assist households in need. At the time of implementation, counties must apply this process on a county-wide basis.

Under MCE, CWDs have the option of providing the PUB 275 in all Non-Assistance Food Stamps (NAFS, now referred to NACF), including elderly/disabled households, application packets for households with a child under 18 at intake and recertification or at such time it is discovered that such a household is ineligible due to excess resources.

This can be accomplished by presenting the head of household or authorized representative with the PUB 275 during the face-to-face interview or by mail in the case of a telephone or other out-of-office interview. Receipt of this brochure by a household with a child under 18 will confer MCE for the FSP. CWDs should order a quantity of "Family Planning - PUB 275" brochures from the CDSS Warehouse in sufficient number for all households with children under 18 to which the county plans to distribute the brochure. (These brochures are also available on line.)

ACL 12-62 states that through Quality Control reviews, it became apparent to CDSS that the CWDs' application of Modified Categorical Eligibility (MCE) has not been consistent with federal Broad-based Categorical Eligibility (BBCE) rules. Therefore, the purpose of this latest ACL is to provide CWDs with clarification and examples regarding MCE based on direction received from the United States Department of Agriculture, Food and Nutrition Service (FNS).

This ACL provides general information about MCE, but the majority of it consists of examples of how to evaluate for MCE. Because these examples provide helpful guidance on MCE, these examples have been included in this E-Note.

ACL 12-62 states the following:

The FNS identifies three types of categorical eligibility:

1. Broad-based categorical eligibility (BBCE): The BBCE refers to the policy that makes most households eligible for CalFresh benefits because the household receives a Temporary Assistance to Needy Families (TANF)/Maintenance of Effort (MOE)-funded service, such as a brochure or pamphlet.
2. Narrow categorical eligibility: Narrow categorical eligibility refers to the policy that makes a smaller number of households eligible through the receipt of a TANF/MOE-funded service such as child care or counseling. Both BBCE and Narrow categorical eligibility are for households not receiving a cash benefit, such as California Work Opportunity and Responsibility to Kids (CalWORKs).

3. Traditional categorical eligibility (CE): The CE refers to the mandatory policy that makes households eligible for CalFresh benefits because the household receives TANF (CalWORKs), or General Assistance.

Receipt of the PUB 275 exempts all resources in the determination of eligibility for households who meet all other CalFresh eligibility requirements. In California, 130% of the Federal Poverty Level (FPL) has been established as the maximum gross income that a household can have in order to have MCE/BBCE conferred through receipt of the PUB 275. It must be documented by the CWDs that the income requirement (130% FPL) for the TANF-funded service is satisfied before MCE/BBCE can be conferred. Receipt of the PUB 275 does not, in itself, confer MCE/BBCE to a household.

The following examples illustrate various case situations and how they should be treated under MCE/BBCE.

Intake Non-Assistance CalFresh Applications

Example 1

A CalFresh applicant (non-Elderly/Disabled) comes into the CWD and receives an application packet (or completes an online application). Included in the application packet (or on a linked web-site) is the PUB 275 (Family Planning brochure).

During the intake interview, it is determined that the household has gross income that does not exceed 130% of the FPL for its household size. Therefore, because the household has received the PUB 275, it can be considered to be MCE/BBCE-eligible because the gross income did not exceed the maximum allowable for the TANF-funded service.

The individual case record must first document (1) that the household's gross income did not exceed the limit for the TANF-funded service (PUB 275), (2) the PUB 275 was provided to the household and (3) that MCE/BBCE was conferred All County Letter No. 12-62 Page 3

Example 2

A CalFresh applicant (non-Elderly/Disabled) comes into the CWD and receives an application packet (or completes an online application). Included in the application packet (or on a linked web-site) is the PUB 275.

During the intake interview, it is determined that the household has gross income that exceeds 130% of the FPL for its household size. Therefore, even though the household has received the PUB 275, it cannot be considered to be MCE/BBCE-eligible because the gross income exceeds the maximum allowable for the TANF-funded service. It must be established in the CWD's procedures that the income requirement (130 % of FPL) for the TANF-funded service must be satisfied before MCE/BBCE can be conferred.

The individual case record must first document that the household's gross income exceeded the limit for the TANF-funded service (PUB 275) and that MCE/BBCE was not conferred, even if the PUB 275 was provided to the household. As a result of the household not being entitled to MCE/BBCE, the CalFresh application would be denied because the household's gross income exceeded the CalFresh gross income limit.

Example 3

It is discovered that a continuing CalFresh case (that previously received or had on-line access to the PUB 275) has gross income exceeding 130% of the FPL. Because the gross income limit for MCE/BBCE (130% of the FPL for its household size) has been exceeded, the household is no longer considered eligible for the

TANF-funded service, and is no longer MCE/BBCE eligible. The individual case record must first document that the household's gross income exceeded the limit for the TANF-funded service (PUB 275) and that MCE/BBCE status no longer exists, even if the PUB 275 was provided to the household.

For change-reporting households, the CWD shall issue a timely notice of action within 10 days of the date the change was reported and terminate the case no later than the end of the month for which the timely notice was issued. The household cannot be terminated for exceeding the gross income limit for CalFresh until the MCE/BBCE status has been removed.

" For example, a household reported an increase in earned income on October 12. The CWD sent a notice of action to the household on October 20 stating the household would be terminated on October 31 because their gross income for the household was over the threshold and their MCE/BBCE status was removed. The individual case record must first document that the household's gross income exceeded the limit for the TANF-funded service (PUB 275) and that MCE/BBCE status no longer exists, even if the PUB 275 was provided to the household.

For Quarterly Reporting (QR) households, the case should be terminated at the end of the current payment quarter. It is critical that the case record reflects that MCE/BBCE eligibility no longer exists, and that the household's CalFresh eligibility has ended, in that chronological order. The household cannot be terminated for exceeding the gross income limit for CalFresh until the MCE/BBCE status has been removed.

" For example, a QR household's payment quarter is January through March. The household reports an increase in income on February 7 which makes the household ineligible for MCE/BBCE because the gross income for the household has been exceeded for its size. The CWD will send a notice of action stating the case will be terminated as of March 31 because their gross income for the household was over the threshold and their MCE/BBCE status was removed. The income exceeded the limit for the TANF-funded service (PUB 275) and that MCE/BBCE status no longer exists, even if the PUB 275 was provided to the household.

Example 4

A household of one or two persons comes into the County Welfare Department and receives an application packet (or completes an online application). Included in the application packet (or on a linked web-site) is the PUB 275.

During the intake interview, it is determined that the household has gross income that does not exceed 130% of the FPL for its household size. In California, 130% of the FPL has been established as the maximum gross income (for the TANF-funded service, the PUB 275) that a household can have in order to have MCE/BBCE conferred through the receipt of the PUB 275. Therefore, because the household has received the PUB 275, it can be considered to be MCE/BBCE-eligible as the gross income does not exceed the maximum allowable for the TANF-funded service.

During the determination of the household's benefit allotment, it is determined that the household's net income exceeds the maximum amount allowable for its household size. Households of one or two persons that have been conferred MCE/BBCE status will be entitled to the minimum CalFresh benefit (\$16) even though the household's net income exceeds the maximum amount allowable for their household size. The same is true for Traditional CE households. The individual case record must first document the household's gross income did not exceed the limit for the TANF-funded service (PUB 275) and that MCE/BBCE was conferred and the PUB 275 was provided to the household. All County

Example 5

A household of three or more persons comes into the County Welfare Department and receives an application packet (or completes an online application). Included in the application packet (or on a linked web-site) is the PUB 275.

During the intake interview, it is determined that the household has gross income that does not exceed 130% of the FPL for its household size. Therefore, because the household has received the PUB 275, it can be considered to be MCE/BBCE-eligible as the gross income does not exceed the maximum allowable for the TANF-funded service.

During the determination of the household's benefit allotment, it is determined that the household's net income exceeds the maximum amount allowable for its household size. Households of three or more persons that have been conferred MCE/BBCE status will be entitled to the allotment amount indicated in the tables of benefit issuance by household size even if the household's net income exceeds the maximum amount allowable. The individual case record must first document the household's gross income did not exceed the limit for the TANF-funded service (PUB 275) and that MCE/BBCE was conferred and that the PUB 275 was provided to the household.

E-NOTE #84 - CASH ASSISTANCE PROGRAM FOR IMMIGRANTS (CAPI)

CLARIFICATION OF THE INDIGENCE EXCEPTION RULES

November 30, 2012

References: ACIN I-47-12 (November 27, 2012); §49-037.4, All-County Letter No. 02-63; para-regulations 825-4; 825-4A

I.

The purpose of this ACIN is to provide the counties with clarification regarding the Indigence Exception and its appropriate application in the Cash Assistance Program for Immigrants (CAPI).

The clarifications involve verifying a sponsor's income and resources when the Indigence Exception (IE) is being claimed, and what procedures to follow when the applicant claims the sponsor's whereabouts are unknown.

BACKGROUND AND GENERAL POLICY OF THE INDIGENCE EXCEPTION

Generally, if an immigrant's sponsor has signed the new affidavit of support (New Affidavit or I-864 form); the income and resources of the sponsor(s) (and the sponsor's spouse if living in the same household) are deemed to the immigrant for purposes of determining CAPI eligibility. This general rule is suspended under the indigence exception when all of the criteria under MPP § 49-037.41 are met. (References throughout this ACIN to "sponsor" also include the sponsor's spouse who lives in the same household as the sponsor).

MPP Section 49-037.41 states:

.41 The indigence exception applies when all of the following are met:

.411 Sponsor-deeming results in denial, suspension, or reduction of CAPI benefits;

.412 The non-citizen is unable to obtain both food and shelter [see MPP 49-037.43 below];

.413 The non-citizen completes and signs the CAPI Indigence Exception Statement (SOC 809) and

.414 The county determines that the indigence exception applies.

MPP Section 49-037.43 states:

.43 If the non-citizen is living apart from his or her sponsor and not receiving free food and shelter in another person's household, the non-citizen shall be considered unable to obtain food and shelter if:

.431 The total gross income that the non-citizen receives from all sources is less than the federal SSI Individual rate if the non-citizen is not living with his or her spouse, or the federal SSI Couple rate if the non-citizen is living with his or her spouse, and

.432 The resources available to the non-citizen are less than the applicable CAPI resource limit.

CLARIFICATION OF POLICY FOR VERIFYING SPONSORS' INCOME AND RESOURCES FOR INDIGENCE EXCEPTION (IE) PURPOSES

CAPI regulations indicate that to qualify for the IE deeming must cause a person to be ineligible or have reduced CAPI, which implies a need to obtain a statement of the sponsor's income and resources. It is difficult to actually determine the amount of the sponsor's income and resources because the applicant/recipient may not have that information.

It is also unnecessary because all CAPI sponsors must have an income of at least 125% of the federal poverty level, which would be enough to affect CAPI eligibility and/or payment amount for most CAPI recipients and applicants.

Counties may, therefore, presume that sponsor deeming would affect CAPI eligibility and/or grant amounts in all IE cases, thereby meeting the requirement in MPP Section 49-037.411. Although counties can presume that the deeming criteria in MPP Section 49-037.411 is met, a determination will still need to be made as to whether or not the applicant/recipient can obtain food and shelter by confirming how much support the applicant/recipient is actually receiving from the sponsor.

PROCEDURES FOR INDIGENCE EXCEPTION CASES WHERE THE APPLICANT ALLEGES THAT SPONSOR'S WHEREABOUTS ARE UNKNOWN

Counties have indicated that numerous CAPI indigence exception applicants are alleging that their sponsor's whereabouts are unknown and have asked for guidance in following the procedures outlined in MPP Section 49-037.46 and .462, which states:

.46 The county must do all of the following whenever the non-citizen has requested the indigence exception:

.461 Obtain a completed form (SOC 809) signed by the non-citizen specifically applying for the exception that provides information regarding his or her living arrangements and income.

.462 Contact the sponsor to confirm the non-citizen's allegations regarding the amount of income and resources that the sponsor provides or makes available to the

non-citizen.

(a) Contact INS for the sponsor's address if the sponsor's whereabouts are unknown.

(b) If the sponsor cannot be located, accept the non-citizen's allegation if it is credible and does not conflict with other information in the file.

If an indigence exception applicant alleges the sponsor's whereabouts are unknown the following steps should be followed and documented by the counties:

" If the applicant/recipient or the county has a last known address for the sponsor, send a letter to the last known address asking for confirmation of the amount of support he/she is providing.

" Mail the Department of Homeland Security form G845 (or G845 Supplement) requesting the sponsor's address. If they provide an address different from the last known address the county has; send a letter to the new address.

" If either letter to the sponsor is not returned as undeliverable, then counties should assume that the mail is being ignored and should deny the indigence exception because they cannot confirm the support being provided to the applicant/recipient. MPP Section 49-037.51 indicates the applicant/recipient is responsible for obtaining the sponsor's cooperation in obtaining information needed to make an IE determination. This responsibility includes obtaining confirmation that support is not being provided.

" If the letter is returned (both letters if two different addresses are used) for "addressee unknown" or similar reasons then counties should accept the applicant's allegation that the sponsor cannot be located and their allegation regarding support (if credible, and it does not conflict with other information.)

As a reminder, the total gross income and all available resources, including otherwise excludable income and resources, are to be counted for the purpose of determining IE eligibility. Common examples of otherwise excludable income that can be counted for this purpose include general assistance, food stamps and housing subsidies. Also, for the indigence test, in-kind items such as housing subsidies should be evaluated at their actual value, not the presumed maximum value.

II.

Not cited in this ACIN but also relevant to the indigence exception is the following section in the Social Security POMS:

If the alien is living apart from his or her sponsor, the alien will be found to be unable to obtain food and shelter if 1) the total income (of all kinds and from all sources) the alien actually receives is less than the Federal benefit rate (FBR); 2) and the resources available to the alien are under the applicable resource limit.

Developing And Documenting A Deeming Exception:

Cases involving the indigence exception are sensitive cases and, as such, require tactful questioning. There are several prompts that indicate the indigence exception should be developed: while you are discussing deeming provisions, the applicant alleges the indigence exception applies to his or her case; or while developing the income/resources, the alien indicates he/she gets little or no support from his or her sponsor. Even if the claimant does not explicitly request the indigence exception, or the county does not present evidence that it considered it and determined that the claimant was eligible for it, we should raise it on our own if there is sufficient evidence presented that it may potentially apply.

E-Note #82 END OF CAL-LEARN SUSPENSION

November 14, 2012

References: ACL 12-60 (October 31, 2012); ACLs 11-36 and 11-60

ACL 12-60, released on October 31, 2012, informs the counties of the restoration of the Cal-Learn program following its suspension from July 1, 2011 through June 30, 2011, pursuant to SB 72. Pursuant to SB 1041, CWDs have until April 1, 2013 to restore their Cal-Learn program.

Below are the major points set out in this ACL:

Implementation Period

During the period from July 1, 2012 through March 31, 2013, CWDs may restore the Cal-Learn program. Restoration of Cal-Learn must be completed by April 1, 2013. Restoration consists of restoring case management and other services according to Manual of Policies and Procedures (MPP) Sections 42-762 through 42-769.

Until restoration of the Cal-Learn program is achieved, CWDs must continue to use the Welfare-to-Work (WTW) Teen Parent rules outlined in ACLs 11-36 and 11-60, which explained the suspension of the Cal-Learn program, with one exception: Beginning July 1, 2012 a pregnant teen with no high school diploma or equivalent and no other children may qualify for aid and services in the first or second trimester of her pregnancy, even if the county has not restored Cal-Learn.

Transitioning Pregnant and Parenting Teens

Upon each county's restoration of the Cal-Learn program, MPP Sections 42-762 through 42-769 shall apply to qualifying pregnant and parenting teens in that county. How a teen is transitioned from WTW to Cal-Learn will depend on whether the teen was a Cal-Learn participant prior to the 2011-12 suspension.

Teen parents who entered the WTW Teen Parent program during the suspension, and never participated in Cal-Learn, shall be treated as new Cal-Learn participants. For teens who participated in Cal-Learn prior to the suspension, a Cal-Learn Program Requirements (CL 2) must be sent to each teen when the county restores Cal-Learn.

The WTW Teen Parent program included all pregnant and parenting teens 19 years old or younger without high school diplomas or equivalents. Some 19-year old pregnant and parenting teens without high school diplomas may qualify for Cal-Learn, and may continue in the program as a volunteer under MPP Section 42-763.12. In order to volunteer, the teen must meet one of the following conditions:

" The teen was enrolled in the Cal-Learn program prior to July 1, 2011, and has not yet earned a high school diploma or equivalent when the county Cal-Learn program is restored.

" The teen would have qualified for Cal-Learn prior to turning 19, but was unable to enroll in Cal-Learn due to the suspension and was instead a WTW teen parent.

During the Cal-Learn suspension, teen parents in the WTW Teen Parent program were subject to WTW sanctions. WTW sanctions will continue until the county Cal-Learn program is restored. Cal-Learn participants are not subject to WTW participation requirements or sanctions, nor are their households subject to school attendance penalties.

Therefore, a pregnant or parenting teen in WTW sanction status, or receiving a school attendance penalty, who qualifies for the Cal-Learn program will have his or her WTW sanction cured or penalty removed and aid restored effective when his or her county restores the Cal-Learn program. Cal-Learn participants are subject to Cal-Learn sanctions for lack of satisfactory progress as described in MPP Sections 42-766 and 42-769. A Cal-Learn sanction cannot be imposed as a result of a grade report submitted prior to the restoration of Cal-Learn.

Cal-Learn Funding

Funding for Cal-Learn administration, transportation and ancillary expenses, and case management services has been restored for Fiscal Year. 2012-13.

E-Note #81 EX PARTE COMMUNICATION ISSUES

November 9, 2012

Reference: CDSS Administrative Law Judge Bench Book; MPP § 22-049.82; Govt Code §11430.10 et seq.

This E-Note is intended to remind judges of what is permissible and non-permissible ex parte communication with a party when a proceeding is pending. It is specifically intended to address this issue in the context of Medi-Cal cases where the Department of Health Care Services is a party to the action, i.e., managed care and Medi-Cal scope cases, and where the Department typically appears through its position statement, not at hearing.

For a fuller discussion of ex parte communication issues, go to the Bench Book under the chapter "Ex Parte Discussions." (Our Bench Book appears on our Decsystem under "Reference Materials.")

The Bench Book provides the following explanation about SHD's policy and practice of how to handle ex parte communication issues when the Department of Health Care Services is a party:

MPP §22-049.82 states "merits of a pending state hearing shall not be discussed between the Administrative Law Judge (judge) and a party outside the presence of the other party."

This regulation prohibits a judge from contacting a party, outside the presence of other parties, to discuss the merits of a case. This regulation, however, does not prohibit a judge from contacting a party, outside the presence of other parties, to discuss nonsubstantive matters about the case, or from contacting a non-party to discuss substantive issues. Program contacts are not ex parte communications because program staff are not parties.

For example, a judge may not contact a claimant to ask if the claimant was orally advised of Medi-Cal property spend-down. However, a judge may contact a claimant to reopen the record, ask for an oral time waiver, or schedule a continued hearing.

California Department of Health Care Services (CDHCS) Medi-Cal Field Office and Denti-Cal Office are parties in scope of benefit cases, CDHCS eligibility program staff is not a party in Medi-Cal eligibility cases. A judge may not contact the Field or Denti-Cal office regarding the merits of the case. However, a judge may contact these offices to request a position statement.

Judges may properly contact program staff to determine CDHCS policy on a particular issue. Judges may also properly contact program staff to ask about CDSS or CDHCS policy, federal waivers, litigation, federal Action Transmittals, proposed regulations, etc.

Government Code §11430 applies to CDSS judges. That section is set out verbatim, in pertinent part below:

§11430.10 Pending proceedings

(a) While the proceeding is pending there shall be no communication, direct or indirect, regarding any issue in the proceeding, to the presiding officer from an employee or representative of an agency that is a party or from an interested person outside the agency, without notice and opportunity for all parties to participate in the communication.

(b) Nothing in this section precludes a communication, including a communication from an employee or representative of an agency that is a party, made on the record at the hearing.

(c) For the purpose of this section, a proceeding is pending from the issuance of the agency's pleading, or from an application for an agency decision, whichever is earlier.

§11430.20 Permissible communications

A communication otherwise prohibited by §11430.10 is permissible in any of the following circumstances:

(a) The communication is required for disposition of an ex parte matter specifically authorized by statute.

(b) The communication concerns a matter of procedure or practice, including a request for a continuance that is not in controversy.

§11430.30 Permissible communications from employees or representatives of agencies

A communication otherwise prohibited by §11430.10 from an employee or representative of an agency that is a party to the presiding officer is permissible in any of the following circumstances:

(a) The communication is for the purpose of assistance and advice to the presiding officer from a person who has not served as investigator, prosecutor, or advocate in the proceeding or its preadjudicative stage. An assistant or advisor may evaluate the evidence in the record but shall not furnish, augment, diminish, or modify the evidence in the record.

(b) The communication is for the purpose of the advising the presiding officer concerning a settlement proposal advocated by the advisor.

(c) The communication is for the purpose of advising the presiding officer concerning any of the following matters in an adjudicative proceeding that is nonprosecutorial in character.

(1) The advice involves a technical issue in the proceeding and the advice is not otherwise reasonably available to the presiding officer, provided the content of the advice is disclosed on the record and all parties are given an opportunity to address it in the manner provided in §11430.50.

Therefore, if you have a managed care case, for example, where the claimant and/or authorized representative appears and presents additional evidence that you believe the Department of Health Care Services should be apprised of, because it is significant enough to potentially change its position in the case, you can handle this in one of several ways that is consistent with regulation and statute:

(1) You may avoid ex parte communication altogether by mailing the additional evidence to the Department, with a cover letter identifying what is being sent to the Department and the amount of time the Department has to respond, with a copy of the letter sent to the claimant. SHD considers this to be the preferred method of contact; or

(2) You may ask the claimant or authorized representative for permission to make ex parte verbal communication to the Department for the exclusive purpose of providing the additional evidence.

As set forth in the Bench Book, you may not contact the Department of Health Care Services outside the presence of the claimant for the purpose of discussing the merits of the case. However, if there is a question about the Department's policy on a particular matter, ex parte communication is permissible for that sole and limited purpose.

For example, if your case involves a request for an exemption from assignment to managed care based on an AIDS diagnosis, it would be permissible to make ex parte communication for the purpose of asking the Department what its policy is as to how it evaluates AIDS exemption requests.

This is different from discussing with the Department, ex parte, the particular facts in your case (other than providing the additional evidence as discussed in (2), above), and why the Department denied the exemption request based on an AIDS diagnosis. This type of ex parte communication is not permissible.

Note that even when the contact pertains to departmental policy, the program contact should not be with the person who prepared the position statement. It should be with someone in the Department who had no input in preparing the position statement.

Finally, while not required, it is within the discretion of the judge to inform the claimant about what the judge learned about departmental policy from the ex parte contact made, and give the claimant the opportunity to respond.

E-NOTE #79 CLARIFYING THE EXCLUSION OF AMERICORPS PAYMENTS AS INCOME

September 25, 2012

References: ACL 12-41 (August 28, 2012); ACIN I-70-02 (September 23, 2002); ACIN I-34-05 (June 24, 2005); MPP Section 44-111.6.61(f); 42 U.S.C. § 12637(d); MPP Section 63-502.134), 7 CFR § 273.9(c)(10); 63-507(a)(17)

ACL 12-41 instructs counties to exclude any payments or income-in-kind from AmeriCorps programs as income for the purposes of determining CalWORKs eligibility and grant amounts, as well as to exempt certain AmeriCorps payments from CalFresh benefit calculations.

Background

AmeriCorps VISTA is a government corporation that was initially established as Volunteers in Service to America in 1965, in an effort to fight national poverty. Since its inception, AmeriCorps expanded into three main branches in an effort further reduce poverty, improve community welfare, provide disaster relief and improve youth development. AmeriCorps VISTA, AmeriCorps State and National, and AmeriCorps National Civilian Community Corps (NCCC) are administered by the Corporation for National and Community Service (CNCS), which is a federally assisted program.

As an organization funded under 42 U.S.C. §12651, payments from it cannot be considered income when determining eligibility or grant amount in federally funded needs-based programs. Members of all three AmeriCorps programs may receive a living allowance for housing, meals, member uniforms (sometimes referred to as a stipend), limited medical benefits, an education award, and childcare benefits in certain circumstances.

ACIN I-70-02, released on September 23, 2002, issued directions to counties to exclude AmeriCorps Volunteers In Service To America (VISTA) payments from consideration as income. However, that letter did not instruct CWDs to exempt other types of AmeriCorps payments.

ACL 12-41 supersedes ACIN I-70-02 and instructs counties that §44-111.6 exempts payments from all three AmeriCorps branches, that is AmeriCorps VISTA, AmeriCorps National Civilian Community Corps [NCCC], and AmeriCorps State and National, from consideration as income.

CalWORKs

Because payments received from the three AmeriCorps programs are excluded as income by federal law, existing regulations related to payments made to Vista Volunteers currently encompasses all AmeriCorps payments. Such payments, when received by recipients from any of the three AmeriCorps branches are exempt as income §44-111.6.61(f) and 42 U.S.C. § 12637(d)].

CalFresh

AmeriCorps VISTA payments are not treated like other AmeriCorps payments that are excluded from income for CalFresh. As stated in ACIN I-34-05, the authorizing legislation for VISTA (the Domestic Volunteer Service Act of 1973) requires volunteer payments received by new CalFresh applicants, who were not receiving public assistance or food stamps at the time they joined VISTA, to be counted as earned income (MPP Section 63-502.134), in accordance with 7 CFR § 273.9(c)(10).

However, MPP Section 63-507(a)(17) exempts AmeriCorps State and National and AmeriCorps NCCC payments from consideration as income for food stamp eligibility and benefit determination.

E-Note #78 - California Fostering Connections to Success Act (AB 12, AB 212) - Extended Foster Care
September 11, 2012

California Fostering Connections to Success Act, Stats. 2010, c. 559, §58 [A.B. 12], enacted Sept. 30, 2010, eff. Jan. 1, 2012; as amended by Stats. 2011, c. 459, [A.B. 212].)

Welf. & Inst. Code, §11400, et seq.

ACL No. 11-61 (Nov. 4, 2011) - General Information

ACL No. 11-69 (Oct. 13, 2011) - Part 1 EFC - Age Requirements and Five Participating Criteria

ACL No. 11-77 (Nov. 18, 2011) - Part 2 EFC - Eligible Facilities (SILPs)

ACL No. 11-85 (Dec. 15, 2011) - Part 3 EFC - Reentry of NMDs

ACL No. 12-12 (Mar. 23, 2012) - New Jurisdictions for NMDs

ParaRegs: 180-30 through 30D - Introduction to Extended Foster Care (EFC)
 180-31 and 31A - Reentry of Nonminor Dependents (NMD) for EFC - AB 212
 180-32 through 32D - Types of Court Jurisdictions for EFC
 180-33 and 33A - Reentry Methods of NMD into EFC
 181-53 through 53C - Eligible Facilities for EFC (including new SILP)
 182-3I - EFC not available for Probate nonrelated legal guardians
 184-1A - Limited EFC Funds for NMDs in SILPs

Introduction:

In 2010, the California Legislature passed the California Fostering Connections to Success Act (AB 12, the Act). With the AB 212 amendments, the Act now potentially extends the age of benefits in all Title IV-E programs (Extended Foster Care for dependent and delinquent minors, KinGAP, and AAP).

E-Note #76, issued recently, addressed the impact of AB 12 on both KinGAP and AAP. This E-Note, the last in this introductory series regarding the California Fostering Connections to Success Act, is intended to inform on the creation of "Extended" Foster Care due to the passage of AB 12 and AB 212.

California passed AB 12 to participate in Congress's Fostering Connections to Success and Increasing Adoptions Act of 2008 (enacted Oct. 7, 2008, Pub.L. 110-351), which promoted extending the eligibility to benefits in Title IV-E programs to 21 years of age.

Effective January 1, 2012, AB 12 and 212 provided for both state and federally funded Extended Foster Care (EFC) for most classes of caregivers (but EFC is not available for nonrelated legal guardianships established through Probate Court).

Under AB 12 and 212, nonminors who are otherwise eligible for Extended Foster Care (EFC) may either remain in foster care (under dependency or delinquency), or reenter foster care.

General Provisions for EFC:

The former fulltime student and "completion rule" to 19 years or graduation (under MPP §45-201.11), was anticipated to become inoperable January 1, 2012, and to be replaced by AB 12 rules, which are:

(A) Age Requirement:

The nonminor dependent (NMD) must be in foster care under the county's vested placement and care on his or her 18th birthday. AND, effective January 1, 2012, a youth may remain eligible for state or federally-funded EFC until age 19 years; effective January 1, 2013, the age limit is extended to 20 years. It is anticipated that

the age will be extended to age 21 years effective January 1, 2014, once the Legislature acts to provide this final extension. Initially, a potentially eligible NMD must turn 18 years of age in 2011, and have been under dependency or delinquency on January 1, 2012.

(B) Meet At Least One of the Five Participating Criteria (see Welf. & Inst. Code, §11403, ACL No. 11-69):

(1) The NMD must be enrolled in secondary education, such as a high school, adult education classes, or any course of study leading towards completion of a high school diploma, GED, high school proficiency certificate, or high school completion certificate.

(2) The NMD must be enrolled at least half-time in an institution providing post-secondary or vocational education.

(3) The NMD must be participating in a program or activity designed to promote or remove barriers to employment, which is an individualized program based on a youth-centered assessment of skills and needs, such as unpaid employment, volunteer activities, internships, apprenticeships, drug or alcohol addiction programs, etc. Also, the NMD will be deemed to meet this condition if participating in regular meetings with his or her case manager to develop and implement the Transitional Independent Living Program (TILP).

(4) The NMD must be employed for at least 80 hours each month. OR,

(5) The NMD must have a medical condition rendering the NMD incapable of participating in the prior 4 conditions as verified in writing by a health care provider. The NMD will not be required to undertake remedial measures to cure the medical condition. An NMD who is eligible for a disability program such as SSI, Social Security Disabled Adult Child benefits, State Disability Insurance, or Regional Center services, is deemed sufficient to meet this condition, and would not be required to provide a written verification from a health care provider establishing the medical condition.

(C) Be verified and documented by the youth's case manager on the Six-Month Certification of Participation Form (state form SOC 161), certifying the youth is currently in compliance with one or more of the participating conditions and is anticipated to remain so for the next six months.

(D) Have requisite placement authority, meaning:

(1) The NMD must remain under the jurisdiction of the juvenile court as a dependent or delinquent with placement and care vested to the county (county child welfare or probation). Six month court reviews and annual permanent planning hearings continue to be required for NMDs. A WIC §391 order terminating court jurisdiction also terminates EFC benefits. (Rules of Court have altered the Court's processing of WIC §391 dependency terminations to protect against premature terminations).

NOTE: However there are now provisions under AB 212 for nonminors to reenter into dependency, under delinquency status, or under "transitional jurisdiction," which is a new court process (WIC §450) for former delinquency minors who completed probation but wish to reenter or remain in foster care as a dependent. (For description on the three types of EFC jurisdictions see ParaRegs 180-32 through 32C)

(2) The NMD must also enter into a Mutual Agreement (state form SOC 162) specifying that he or she intends to remain in EFC and comply with program requirements and eligibility conditions; as well as being informed as to what resources the NMD shall receive from the county. The Mutual Agreement must be entered into within 6 months of turning 18 years of age.

AND,

(E) Be in an eligible facility:

Group Homes: Continued placements of NMDs in group homes have strict limits (para reg 181-53).

SILPs: AB 12 created a new eligible facility called a "Supervised Independent Living Placement" or SILP. Once an NMD has demonstrated readiness for this (not necessary in post-secondary education housing), the NMD may be "placed" away from the caregiver, alone or with siblings or roommates (shared living arrangement agreements are recommended in these circumstances). Unless post-secondary educational housing, the county must approve the facility, using standards less strict than used under ASFA for minor placements. EFC Funds may be paid directly to the NMD, but SILP funds can never include specialized care rates.

Nonminors Reentering Foster Care:

Effective January 1, 2012, AB 212 provided that a former foster youth (either previously a dependent or delinquent minor) may re-enter into dependency jurisdiction and again become eligible for EFC benefits.

Reentry of the youth into dependency is accomplished by filing a petition under Welfare and Institutions Code section 388, subdivision (e) (WIC 388e petition).

To be eligible for EFC, the reentering youth must:

1. Must meet the age requirement (see above)
2. Must have had court-ordered foster care placement on the youth's 18th birthday;
3. Must agree to comply with at least one of the five participating criteria;
4. Have authority for placement - i.e., by completing the "Voluntary Reentry Agreement" (state form SOC 163), and have Juvenile Court resume jurisdiction; and,
5. Be placed in an eligible facility.

The case manager has 60 days from the date jurisdiction is resumed or assumed to develop the Transitional Independent Living Case Plan (TILCP), including the Transitional Independent Living Plan (TILP) for the NMD.

Youth voluntarily reentering foster care through a WIC 388e petition after turning 18 years of age following a dismissal of dependency, are deemed to be entering a foster care episode, mandating a new federal eligibility determination. AFDC-FG/U linkage is based upon the nonminor's income only (not parents). Also, a deprivation determination is deemed met as long as the minor is not living with a biological or adoptive parent.

E-Note #77 - California Fostering Connections to Success Act (AB 12, AB 212)
For KinGAP and Adoption Assistance Program

September 4, 2012

California Fostering Connections to Success Act, Stats. 2010, c. 559, §58 [A.B. 12], enacted Sept. 30, 2010, eff. Jan. 1, 2012; as amended by Stats. 2011, c. 459, [A.B. 212].)

KinGAP:

ACL No. 11-15 (Jan. 31, 2011)
ACL No. 11-86 (Mar. 1, 2012)
Welf. & Inst. Code, §§ 11363, 11385.

ParaRegs: 190-10 and 11; 191-1C through 1G; and 192-5 and 6.

AAP:
ACL No. 11-86 (Mar. 1, 2012)
Welf. & Inst. Code, §16120, subd. (d)(3) - New Age Extensions

ParaReg: 923-2B

Background:

In 2010, the California Legislature passed the California Fostering Connections to Success Act (AB 12, the Act). With the AB 212 amendments, the Act now potentially extends the age of benefits in all Title IV-E programs (Foster Care for dependency and delinquency, KinGAP, and AAP).

California passed AB 12 to participate in Congress's Fostering Connections to Success and Increasing Adoptions Act of 2008 (enacted Oct. 7, 2008, Pub.L. 110-351), which promoted extending the eligibility to benefits in Title IV-E programs to 21 years of age.

This E-Note is intended to inform about the changes to KinGAP and AAP due to the passage of AB 12. Another E-Note will follow discussing Extended Foster Care under AB 12 and 212.

KinGAP:

The Kinship Guardianship Assistance Payment Program (KinGAP), the first program to be impacted by the Act, became a potentially federally-funded, in addition to a new state-funded program, operable on January 1, 2011.

The essential changes pertinent to state hearings that are now incorporated for both the new state and federally funded KinGAP program under AB 12, are:

1. The residency requirement of 12 months is shortened to 6 months, but now clearly mandates the 6 months be during formal dependency, not informal custody.
2. Welfare and Institutions Code, section 360, voluntary guardianships are now eligible for KinGAP.
3. Caregiver and agency must now enter a new binding agreement for KinGAP benefits (SOC 369A), in addition to the Agency-Relative Guardianship Disclosure (SOC 369) and KinGAP Statement of Facts (KG 2). [The SOC 369A must be executed PRIOR to granting guardianship in order to receive federally-funded KinGAP, or FedGAP].
4. Minors could potentially be funded a specialized care incremental (SCI) rate, if eligible, even if an SCI rate wasn't paid while in Foster Care.
5. Minors receiving SSI/SSP benefits were no longer denied KinGAP eligibility. [Treatment of the minor's SSI/SSP benefits differ depending on whether state or federally funded KinGAP benefits are paid - under state funded KinGAP, the SSI may be treated as income.]

6. Welfare and Institutions Code, section 11363, as amended by AB 12 now clearly states that the prospective guardian's home must be approved. [Our regulations have always mandated this - see MPP, §§90-105.111, .112. Counties generally will require the home to be approved under the Adoption and Safe Families Act (ASFA) as adopted under our state laws; and the adults to be cleared under our Community Care Licensing (CCL) laws, as well as comply with the Adam Walsh Child Protection and Safety Act - but remember if the home was already approved while a Foster Care case, the regulations state a new approval for KinGAP is not necessary - MPP, §90-105.112].

7. Upon the conversion of a KinGAP case to AB 12 rules [this had to be accomplished by Dec. 31, 2011 pursuant to ACL No. 11-15], an overpayment that formerly followed CalWORKs rules, where the caregiver was NOT a member of the minor's AU, ended, and KinGAP overpayments became subject to Foster Care overpayment rules [see Welf. & Inst. Code, §11466.24; MPP, §§45-302, et seq.]

8. The new KinGAP age extensions became effective for those youths who entered KinGAP at 16 years or over. [Just for the first year extension to 19, under FedGAP, the youth must have attained 16 years of age before the KinGAP negotiated agreement payments began, for state-funded KinGAP, the youth must have attained 16 years of age before the KinGAP payment commenced]. These extensions are as follows:

January 1, 2012 - up to 19 years of age

January 1, 2013 - up to 20 years of age

January 1, 2014 - up to 21 years of age (if legislatively appropriated.)

To get these age extensions, the youth must enter a Mutual Agreement (KG 1), and meet one or more of the five participating criteria [see Welf. & Inst. Code, §§11403, subs. (b)(1)-(5)], which are:

(1) The individual is completing secondary education or a program leading to an equivalent credential.

(2) The individual is enrolled in an institution which provides postsecondary or vocational education.

(3) The individual is participating in a program or activity designed to promote, or remove barriers to employment.

(4) The individual is employed for at least 80 hours per month.

(5) The individual is incapable of doing any of the activities described in (1) through (4), inclusive, due to a medical condition, and that incapability is supported by regularly updated information in the individual's case plan.

9. However, effective January 1, 2011, a minor who warrants extension due to a disability, is now extended to 21 years [this appears similar to the disability extension under the AAP program].

Adoption Assistance Program:

Effective January 1, 2012, the Adoption Assistance Program (AAP) became impacted by AB 12. Essentially, AB 12 added an additional age extension mechanism to the program.

Prior to AB 12, the program provided for an extension to age 21 years, when the adopted youth had a mental or physical disability ("handicap") that warranted the continuance of AAP assistance. (See Welf. & Inst. Code, §16120, subd. (b)(2).)

AB 12 now provides a new age extension option: Adopted minors that are aged younger than 19 years as of January 1, 2013, receiving AAP benefits are subject to age extensions to 19, 20, and 21 years of age in consecutive years under AB 12. However, the minor must have attained the age of 16 years before the AAP agreement "became effective."

In addition, the youth must meet one or more of the five participating criteria (as specified in Welf. & Inst. Code, §11403, subs. (b)(1) through (b)(5)):

- (1) The individual is completing secondary education or a program leading to an equivalent credential.
- (2) The individual is enrolled in an institution which provides postsecondary or vocational education.
- (3) The individual is participating in a program or activity designed to promote, or remove barriers to employment.
- (4) The individual is employed for at least 80 hours per month.
- (5) The individual is incapable of doing any of the activities described in (1) through (4), inclusive, due to a medical condition, and that incapability is supported by regularly updated information in the individual's case plan.

(Welf. & Inst. Code, §16120, subd. (d)(3), amended by the California Fostering Connections to Success Act, Stats. 2010, c. 559, §58 [A.B. 12], enacted Sept. 30, 2010, eff. Jan. 1, 2012.)

Anticipated State Hearing Issues:

Age Extension Cases under AB 12: It is anticipated that we will begin to start seeing requested extended benefits on both AAP and KinGAP following a minor's 18th birthday based upon AB 12 rules towards the end of 2012.

These requests will differ dramatically from the age extension based upon a disability warranting continued AAP or KinGAP benefits. In particular, be aware that of the five participating criteria above, the participation in a program actively designed to promote, or remove barriers to employment, will potentially be the most cited eligibility criterion for age extensions under AB 12. The consensus is that a nonminor who is cooperating and discussing life options with a county social worker meets this criterion.

Conversion of Prior KinGAP Cases to AB 12: It will be critical for the county to identify the date a particular existing KinGAP case was converted to AB 12 rules (sometime between Jan. 1, 2011 and Dec. 31, 2011), as this will identify which overpayment rules to use (CalWORKs or Foster Care), will make an SSI/SSP minor eligible for KinGAP, and could signal the need for the county to determine if the minor may be eligible for an SCL rate, even if one was never paid while the minor was still a dependent in foster care.

E-Note #76 - Impact of Reinstating Dependency Jurisdiction on Kinship (KinGAP) and Nonrelated Legal Guardianships

August 28, 2012

All County Letter (ACL) No. 11-64 (issued Oct. 18, 2011)

Following a federal review of federal Foster Care cases from October 1, 2008 through March 31, 2009, Region IX of Children's Bureau, Administration for Children and Families, Department of Health and Human Services (DHHS), raised concerns related to how the state treats petitions that result in reinstating dependency jurisdiction on minors placed with both kinship and nonrelated legal guardians.

The concern is whether such reinstatements result in a new foster care "episode," that is, whether a new linkage determination must be made in order to secure federal Foster Care funding.

1. KinGAP Guardians: As you are aware, a relative caregiver who becomes a legal guardian through a permanent plan order may begin to receive KinGAP benefits once the Court terminates dependency jurisdiction, providing the remaining KinGAP eligibility criteria had been met.

If someone files a petition to reinstate dependency jurisdiction, and the Court does so, KinGAP benefits must be discontinued.

Generally, the two most used petitions for this purpose are "supplemental petitions," filed under Welfare and Institutions Code, section 387 (WIC 387 petition). WIC 387 petitions are used to request the minor's removal and provide a more restrictive placement.

"Modification petitions," filed under Welfare and Institutions Code, section 388 (WIC 388 petition), may be filed for a variety of purpose, such as obtaining Court services to assist the guardian (obtaining a birth certificate, attempting to get preference in obtaining mental health services, etc.); changing the permanent plan to adoption; challenging the guardianship; and/or removing the minor from the guardian.

ACL No. 11-64 clearly states that any petition (WIC 300, WIC 387, WIC 388, etc.) used to remove a child from a guardian results in a "disruption" of the guardianship and a new foster care episode, which mandates a new linkage determination for federal Foster Care funding (see sample case number 74 listed in ACL No. 11-64).

If in ordering the minor removed, the Court reinstates dependency jurisdiction that essentially renews the order detaining the minor from the initial parents or relative, as opposed to creating a new WIC 300 against the guardian, any linkage determination will inevitably fail. This is because the minor has been out of the initial home of removal for over 6 months, violating federal law (42 USC, §672, also see our MPP, §45-202.411(b) and ParaReg 181-1). In this case, Federal Foster Care funding cannot be paid. This change will now be incorporated into our ParaRegs (181-12C, about to be added).

The more difficult question is whether a WIC 388 petition causes the Court to reinstate dependency jurisdiction to provide Court services, or to move the permanent plan towards adoption. In such cases, the minor is clearly not being removed from the guardian. Since KinGAP benefits must be terminated, can the county begin funding federal Foster Care to prevent the loss of benefits to the guardian and minor?

DHHS' present position is that ANY petition reinstating dependency jurisdiction will "disrupt" the guardianship, regardless of whether or not the minor is removed. This poses a challenge to State Hearings Division, as well as to counties and the Courts, as federal Foster Care cannot be initiated immediately to take the place of the discontinued KinGAP benefits in such cases. Obviously, we will begin to see cases on "disrupted" guardianships where the minor remains in the guardian's home but federal Foster Care funding was denied, because dependency jurisdiction was reinstated.

The Division is presently working with Program and Legal to provide some guidance on how to proceed in such cases to stakeholders, including the Courts, dependency counsel, county child welfare agencies, and caregivers. For example, there has been some discussion to have the Courts provide services without reinstating dependency jurisdiction, but relying upon its residual "ward" jurisdiction provided under Welfare and Institutions Code, sections 366.3 and 366.4.

This unfortunately will not help where adoption becomes the permanent plan, as the Court must reinstate dependency jurisdiction in order to determine whether or not to terminate parental rights before approving the minor's adoption to the caregiver.

If there is a change in this federal policy on guardianship disruptions, we will alert you immediately. However, for the present, the state has adopted this federal policy.

2. Nonrelated Legal Guardians: Under current law, a nonrelated legal guardian (NRLG), deemed by regulation to be an "eligible facility," may receive state Foster Care benefits even after the Court terminates dependency (see MPP, §§45-203.41-.417, and ParaReg 182-1).

The concern is that if the Court reinstates jurisdiction on a WIC 388 or WIC 387 petition to remove the minor from an NRLG, federal Foster Care cannot be paid as the case will be deemed a new foster care episode, mandating a new linkage and federal eligibility determination.

This becomes problematic because if the minor is now placed with a relative after removal from a NRLG under one of these two petitions, federal Foster Care funding will not be available, since federal funding is only available when a minor is removed from a "specified relative" (42 USC, §672(a)(1)).

E-Note # 74 - Changes In The Processing of Discontinued CalWORKs and CalFresh Cases

August 2, 2012

References: All County Letter 12-35 (July 30, 2012); Assembly Bill 959; W&I Code 11265.4(a); §40-125.92; §63-508; §40-181.23; FNS #2090046; ACL 10-32

ACL 12-35 was recently issued to inform County Welfare Departments (CWDs) of changes pursuant to AB 959. The new law will change the way CWDs process recently discontinued CalWORKs and CalFresh cases who submit a completed QR 7 in the month following discontinuance for failure to submit the quarterly eligibility report form (QR 7) in the Submit Month.

Currently, if a recipient does not submit a complete QR 7 by the end of the first working day of the month following a discontinuance of benefits for an incomplete QR 7 or for nonsubmission of a QR 7, the discontinuance remains in effect, and the client must reapply for aid as a new applicant.

In addition, currently, if a recipient is determined to have good cause for not submitting a complete and timely QR 7, CWDs are required to rescind the discontinuance and restore aid back to the first of the month following discontinuance.

Effective July 1, 2012, the new law under Welfare and Institutions Code (WIC) Section 11265.4(a) requires that when a recipient submits a complete QR 7 within the month following the discontinuance for an incomplete QR 7 or for nonsubmission of a QR 7, the CWD must restore benefits to the AU/household without requiring a new application or intake interview, provided all other eligibility criteria are met.

Eligibility and benefits shall be determined based on the complete submitted QR 7 and prorated from the date that the AU/household provides the complete QR 7 and the recipient shall be issued a NOA informing them of this change. **These restored AU/households shall be considered recipient cases and shall not be subject to applicant eligibility criteria.**

If the information reported on the complete QR 7 results in a decrease in benefits from the amount issued in the month prior to their QR 7 discontinuance, CWDs would be required to restore benefits at the decreased level.

If the recipient does not submit a complete QR 7 within the month following discontinuance or if he/she submits an incomplete QR 7, the original discontinuance shall remain in effect. Current good cause rules for failure to submit a complete and timely QR 7 continue to apply. If the CWD has discontinued a client, and the client is determined to have good cause for not submitting the QR 7, the CWD will still be required to rescind the discontinuance and restore full aid back to the beginning of the month. Implementation of AB 959 primarily changes the rules for restoring aid in the month following QR 7 discontinuance for those AUs who do not have good cause for failing to submit their QR 7.

Implementation Date:

AB 959 became effective July 1, 2012; therefore, any client who applies for aid in the month of July after being discontinued June 30, 2012, for failure to submit a complete and timely QR 7, or who submits a May 2012, QR 7 in the month of July 2012, shall be considered under the new AB 959 rules. The June 30 discontinuance must either be rescinded (if the client had good cause) back to the discontinuance date or restored as the date the May QR 7 is submitted if the

client did not have good cause.

As of August 1, cases discontinued for non-receipt of a complete QR 7 must also be considered under the new AB 959 rules shared in this ACL.

CalWORKs/ Transitional CalFresh (TCF):

Public Assistance CalFresh (PACF) households who do not submit their complete QR 7 by the first working day of the next QR payment quarter will have their CalWORKs benefits terminated, but they will receive TCF benefits. AB 959 allows PACF recipients to submit a completed QR 7 within the month following the discontinuance. Regular CalFresh benefits will be restored effective the first of the following month, providing the county issues a timely NOA prior to the termination of TCF benefits.

Under the provisions FNS Waiver #2090046, Non-Assistance CalFresh (NACF) recipients already are permitted to submit a completed QR 7 within the month following discontinuance without having to re-apply (See ACL 10-32). The new law extends this same opportunity to PACF recipients.

Attached to ACL 12-35 are examples of how these changes are to be implemented based on different fact patterns.

E-Note # 73 - Medicare Set-Aside (MSA) Accounts

July 31, 2012

References: ACWDL 90-01 (January 5, 1990), Section 50402 of that letter; 97-41 (October 24, 1997); CFR 416.1201(a); SSA §1902(r)(2)(B); SSA §1902(a)(10)(C)

Background:

Medicare Set Aside (MSA) accounts are defined on the Workers Compensation Medicare Set-aside Arrangements (MCMSAs) page of the Centers for Medicare and Medicaid Services (CMS) website in the following manner:

“All parties in a Workers’ Compensation (WC) have significant responsibilities under the Medicare Secondary Payer (MSP) laws to protect Medicare’s interests when resolving WC cases that include future medical expenses.

The recommended method to protect Medicare’s interests is a Workers’ Compensation Medicare Set-aside Arrangement (WCMSA), which allocates a portion of the WC settlement for future medical expenses. The amount of the set aside is determined on a case-by-case basis and should be reviewed by CMS, when appropriate. Once the CMS determined set aside amount is exhausted and accurately accounted for to CMS, Medicare will agree to pay primary for future Medicare covered expenses related to the WC injury.”

Department of Health Care Services was asked how this particular type of account should be treated when determining a person’s eligibility for the Medi-Cal Program.

The Department of Health Care Services’ response is the following:

MSA accounts are not countable income and property on the basis of their unavailability. This is because the Social Security Administration does not treat them as available income and property for SSI/SSP eligibility purposes, and pursuant to SSA §1902(r)(2)(B); SSA §1902(a)(10)(C), the Medi-Cal Program can be no more restrictive than the SSI/SSP.

If an account is identified to the county as a Medicare Set-Aside account and is not identified on its face as such, the county should ask for verification as to its type. This can be in the form of a copy of the agreement or verification from the financial institution. If the county doesn't obtain this evidence prior to a state hearing, the claimant should be given an opportunity to present it. It is unnecessary for the claimant to provide evidence as to the specific medical expenses the account has been established to pay.

Whether the account is self-administered or administered by a third party has no bearing on whether the proceeds in it are considered available for the purposes of determining whether they are exempt property under the Medi-Cal Program. They are considered unavailable in both cases. The rationale for this is the assumption is that they will be used for their intended purpose. They are also audited by CMS. If the County Welfare Department is informed that the funds are being used for expenses other than those medical expenses agreed to in the terms of the Worker's Compensation settlement agreement, the eligibility worker will evaluate the effect of the converted property on the individual's eligibility for Medi-Cal benefits.

E-Note # 72 Reminder About The Unenforceability Of The Two-Parent IHSS Provider Regulation

July 7, 2012

References: §30-763.453; Welfare and Institutions Code 12300(d)

This is a reminder that the Department of Social Services has determined that there is no statutory authority for §30-763.453 – the regulation limiting payment for IHSS services when the nonprovider parent is in the home -- on the basis that W&I Code 12300(d) does not contain authority for this regulation. This regulation should, therefore, not be enforced in our decisions.

Until there is a regulatory change or an All-County Letter that clarifies the Department's position on this, there is nothing that we can cite in our decisions as authority except to say that the Department of Social Services has determined that there is no statutory authority for this regulation and, for this reason, it is not being followed.

Judges are reminded of this by what is stated at the bottom of the following para-regulation:

Para-Regulation 614-2:

When both parents are in the home, a parent may receive a payment as an IHSS provider only under the following conditions:

- 1. The conditions specified in §§30-763.451(a) through (c) are met.*
- 2. The nonprovider parent is unable to provide the services because he/she is absent because of employment or in order to secure education or is physically or mentally unable to provide the services, as specified in §30-763.442.*

3. *If the nonprovider parent is unable to provide services because of employment or educational purposes, payment shall be made to the provider only for services normally provided during the periods of the nonprovider's absence.*

(§30-763.453)

There is no statutory authority for MPP §30-763.453

If you decide to write a decision that is contrary to the Department's position, and determine that the regulation should be followed, you must write your decision as a proposed.

E-Note # 71 - PCSP/IPO/CFCO Protective Supervision For Young Children and Age-Appropriate Guidelines

July 5, 2012

References: All County Letter 98-87 dated October 30, 1998; "Notes From the Training Bureau" Item 00-03-01A

This is to serve as a review of issues that arise in PCSP, CFCO,¹ or IPO cases when protective supervision is being requested for very young children, as well as those cases when the "age-appropriate" guidelines are submitted into evidence by either the county or the claimant.

Protective Supervision For Very Young Children:

Para-Reg 626-5 sets out the criteria in the 1998 *Garrett* court order, and the correct procedure to follow when evaluating a child's eligibility for protective supervision:

The following procedures should be followed when assessing a minor's need for protective supervision in the IHSS program.

A county social worker should always assess an IHSS eligible minor for mental functioning. (§§30-756.1, 756.2, 761.261; Welfare & Institutions Code (W&I) §§12300(d)(4), 12301.1, 12309, (b)(1)(2)(c)) The following shall be used to assess a minor's mental functioning:

¹ According to ACL 12-24, released on May 12, 2012, the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), enacted March 23, 2010, established a new State Plan Option entitled the Community First Choice Option (CFCO). CFCO is one option a State may choose to provide home and community-based attendant services and supports. In order to implement CFCO, the California Department of Social Services (CDSS) and the California Department of Health Care Services submitted a State Plan Amendment to the federal Centers for Medicare and Medicaid Services (CMS) on December 1, 2011, pursuant to Section 1915(k) of the SSA (42 United States Code Section 1396n). Once approved by CMS, CFCO will be retroactively implemented in California effective December 1, 2011. There will be an E-Note issued about this in the future.

The county social worker must review a minor's mental functioning on an individualized basis and must not presume a minor of any age has a mental functioning score of "1". (§30-756.372; W&IC §§12301(a), 12301.1)

A county social worker must assess all eligible minors for a mental impairment. In doing so, the worker must request the parent or guardian to obtain available information and documentation about the existence of a minor's mental impairment. A county social worker is not required to independently obtain such information and documentation, but must review any information provided. (§§30-756.31, 756.32, 761.26). For example, is the minor SSI eligible based on mental impairments, or is the minor eligible for regional center services based on mental retardation, autism, or a condition like mental retardation or does the minor need services like someone with mental retardation?

A county social worker must evaluate a mentally impaired minor in the functions of memory, orientation, and judgment. (§30-756.372)

A county social worker must advise parents or guardians of a minor with a mental impairment of the conditions for receiving protective supervision, and the availability of that service. (§§30-760.21, 760.23, 760.24; W&IC §§10061, 12301.1, 12309(c)(1))

A county social worker is not to presume that services, which are otherwise compensable, will be provided voluntarily by a parent or guardian or anyone else in accordance with §30-763.622.

A county social worker must assess the minor's need for protective supervision under §30-757.17 based on the minor's individual need, if the minor has a mental impairment. (§§30-756.1, 756.2, 761.261; W&IC §§12300(d)(4), 12301.1, 12309(b)(1)(b)(2)(C))

A county social worker must determine whether a minor needs more supervision because of his/her mental impairments than a minor of the same age without such impairment. (W&IC §12300(d)(4))

A minor must not be denied protective supervision based solely on age, or solely because the minor has had no injuries at home due to the mental impairment, as long as the minor has the potential for injury by having the physical ability to move about the house (not bedridden). (§§30-761.26, 30-763.1; W&IC §§12300, 12301.1)

A minor must not be denied protective supervision solely because a parent leaves the child alone for some fixed period of time, like five minutes. (§§30-761.26, 30-760.24, 30-763.1; W&IC §12301.1)

A county social worker must consider factors such as age, lack of injuries and parental absence, together with the other facts, in determining whether or not a minor needs protective supervision. (W&IC §12301.1)

(These instructions are based on the above-cited state laws and regulations, and the court order in Lam v. Anderson and in Garrett v. Anderson, San Diego County Superior Court No. 712208, Stipulation for Entry of Final Judgment and Judgment, June 12, 1998 and implemented through All-County Letter (ACL) No. 98-87, October 30, 1998.)

Therefore, whenever you have a PCSP/CFCO case that involves a very young child, e.g., 4 years old or younger, you must consider the criteria set out in the *Garrett* court order. In particular, any decision must include a finding of fact about whether the child at issue needs *more supervision* because of his/her mental impairment than a child of the same age without such an impairment.

Also, a denial determination cannot be based solely on the age of the child. For example, the following reasoning and denial decision would be in violation of the *Garrett* court order: Because all three year old children require supervision, no three year old child requires more supervision as a result of his/her impairment. Therefore, the three year old child at issue is ineligible for protective supervision under the program.

Age-Appropriate Guidelines:

The Vineland Social Maturity Scale, the Functional Index Ranking for Minor Children in IHSS Age Appropriate Guideline Tool, and the Developmental Guide are often entered into evidence by the county when a minor is the applicant or recipient at issue and to support the county's assessment, particularly in Related Service categories.² These tools have been developed and modified by the Department over the years.

The February 29, 2000 Issue of "Notes From the Training Bureau" (Item 00-03-01A)³ provides hypothetical examples involving children of different ages and disabilities, and questions and answers about how to handle various aspects of these types of cases.

Even though this particular Training Note was written nearly 12 years ago, it is still relevant. In particular, it states the following:

The purpose of IHSS is to provide services to aged, blind and disabled persons that they are unable to provide for themselves and who would be unable to remain safely in their homes without such services (Welfare and Institutions Code (W&IC) §12300(a)). CDSS has come up with age appropriate guidelines to consider when evaluating a child's needs. The age appropriate guidelines are CDSS policy. They are not regulations. There is no statutory authority for these guidelines.

Because these guidelines are not regulations, a judge would not be able to cite them as authority in writing a decision. However, since the purpose of IHSS is to provide services to a blind or disabled child and not to a child who is not blind or disabled, the county must evaluate Mark's needs based on his disability.

The county could cite the age appropriate guidelines (including the Vineland study upon which the guidelines are based) as a factor for the judge to consider when determining if a healthy child could complete a task.

The regulations require that the county do individual assessments in each case to determine what the needs of the individual child-applicant or child-recipient are, and while the judge can consider these guidelines, they are only *one factor* and should be afforded appropriate evidentiary weight in the context of all of the evidence presented pertaining to the individual child's needs based on his/her disability. A judge's decision must not rely on these guidelines as determinative.

² Domestic Services can also be an issue when the provider is not the recipient's parent.

³ This Training Note is on our Decsystem. Go to "Notes from the Training Bureau" under "Reference," click on the + sign next to 2000, and scroll down " ITEM 00-3-1: IHSS Questions and Answer."

Please also remember that since these guidelines have not been incorporated into departmental regulations, they should not be cited in the LAW section of our decisions. In addition, they should also not be described in a decision as departmental policy.

Finally, if you believe that a case involving these types of issues qualifies as “novel, sensitive, or controversial in nature,” you are to write the decision as a proposed decision.

E-NOTE #70 - Student Eligibility For CalFresh Benefits

July 2, 2012

ALL COUNTY INFORMATION NOTICE (ACIN) NO. I-36-12 (June 27, 2012)

§§63-406.1, 63-406.22, and 63-503.1, ACIN I-45-11

All County Information Notice (ACIN) I-36-12 clarifies the eligibility status of an applicant (aged 18-49) who informs the County Welfare Department (CWD) that s/he does not intend to continue his/her enrollment at least half-time at an institution of higher education (per M.P.P. 63-406.11).

M.P.P. §63-406.22 indicates that once a student enrolls in an institution of higher education, such enrollment shall be deemed to continue through normal periods of class attendance, including vacation and recess, unless the student graduates, is suspended or expelled, or drops out.

This regulation should not be interpreted to authorize CWDs to continue the practice of classifying individuals as ineligible for CalFresh who otherwise inform the CWD that they do not intend to enroll in school for a future term.

Pursuant to M.P.P. 63-503.11, a household’s eligibility for the month of application is to be determined by considering the household’s circumstances as of the date of the interview. Therefore, regardless of having been continually attending school prior to the application and interview, if an applicant specifically states that they do not intend to register for an upcoming term at least half-time in an institution of higher education, CWDs may not assume that the student will in fact be attending school and determine them to be ineligible (refer to verification requirements as stated in ACIN I-45-11).

If, at a later date, the recipient reports that they have in fact enrolled in an institution of higher education at least halftime, the provisions and conditions of M.P.P. 63-406.1 would be applied at that time.

E-NOTE #69 - Mid-Quarter Reporting Presumption In Administrative Error Overpayments and Overissuance Cases

July 2, 2012

All-County Letter No. 03-18, April 29, 2003

This E-Note is intended to remind judges of a State Hearings Division policy in administrative error overpayment and overissuance cases that *presumes* the recipient would file a mid-quarter status report when there has been a reduction in the income during the quarter that would have increased benefits had the claimant made such a report.

Specifically, in cases where the county determined that due to administrative error, the claimant was overpaid cash aid benefits or overissued CalFresh benefits, it is important to find out whether there was a decrease in the claimant's income during the quarter(s) at issue. If there was such a decrease, it is presumed that the claimant would have made a mid-quarter report of this decrease.

This policy is based on the idea that the county should not benefit from its own mistake. A person is likely to make a mid-quarter report if faced with a sudden decrease of income. But when the county has issued an administrative error overpayment or overissuance, the recipient is far less likely to make a mid-quarter report because the recipient is already receiving a grant/allotment without regard to the income the claimant properly reported on the QR 7.

Example:

A claimant reports \$1000 in income on the QR 7 and the county fails to budget this income. The county issues the MAP for CalWORKs. In the meantime, during the second month of the quarter, the claimant's income is reduced to \$500.00 per month, but does not report this change. Under these facts, it should be presumed that the claimant would have reported the reduced income if he/she was not already getting MAP. This should be factored in when computing the amount of the overpayment

Para-Regulations 026-12 through 026 describe mid-quarter reporting policy set forth in ACL 03-18:

In both CalWORKs and CalFresh benefits, recipients may voluntarily report changes in income and circumstances that may increase benefits any time during the quarter. The county will only take action mid-quarter on voluntary reports if the change results in increase to benefits. Examples of such changes include:

- household income decreases;*
- someone moves into the home;*
- a CalWORKs assistance unit member becomes pregnant;*
- a teen become pregnant or gives birth and meets Cal-Learn requirements; or*
- in the CalFresh program, when allowable deductions increase.*

In some cases, voluntarily reported changes may result in an increase in benefits in one program and a decrease in benefits in the other program. The county must take action to increase benefits but must suppress the decrease in the other program's benefits. Increases in benefits due to decreased income are effective the first of the month in which the change is reported. Increases due to the addition of a new household member are effective the first of the month following the report of the change.

The county shall recalculate the current quarter's CalWORKs and CalFresh benefits when a recipient reports a decrease or discontinuance of income. In calculating such benefits, the county shall determine the month in which the decrease or loss of income was reported. The county shall add additional income the assistance unit/household reasonably anticipates for the current and remaining months of the quarter. The county shall then determine a new average monthly income for the current quarter by dividing the total income by the amount of months equal to the current and remaining months of the quarter.

The county shall do the above calculation for earned income, disability based unearned income and unearned income. In these calculations the county shall apply all applicable income disregards and/or CalFresh allowances for each income type to the new average gross income amounts to generate average net non-exempt income (NNI) for each month.

The county shall then recalculate benefits for the quarter by subtracting the newly averaged NNI from the applicable Maximum Aid Payment for CalWORKs. To determine the CalFresh allotment, the county shall refer to the coupon allotment issuance chart using the net income for appropriate household size.

E-NOTE #68 - EXTENDING BENEFITS TO NON-MINOR DEPENDENTS - QUESTIONS AND ANSWERS (PART ONE)

June 15, 2012

ACL 12-27 (June 12, 2012)

ACL states, in pertinent part, the following:

Assembly Bill (AB) 12 (Chapter 559, Statutes of 2010) established a new category of youth, Non-Minor Dependents (NMDs), eligible to receive CalWORKs benefits.

Under AB 12, NMDs who meet at least one of the five AB 12 eligibility conditions, agree and adhere to the Mutual Agreement (SOC 162), and cooperate with the six-month review hearings/certification (see ACL 11-69) are eligible for extended CalWORKs benefits up to age 19, effective January 1, 2012, up to age 20 effective January 1, 2013, and up to age 21 effective January 1, 2014 contingent upon legislative approval.

The five AB 12 eligibility conditions include (1) completing high school or an equivalency program, (2) enrolling in post-secondary or vocational school, (3) participating in a program or activity that promotes or removes barriers to employment, (4) employed at least 80 hours per month, or (5) is incapable of enrollment in school or employment due to a documented medical condition.

This letter transmits a series of questions and answers (Q&As) initiated by counties regarding NMDs under the CalWORKs program. A second Q&A will be forthcoming.

ACL 12-27 attaches 24 questions and answers pertaining to various issues related to extended benefits for NMDs.

They include the following:

- A relative caretaker may only receive CalWORKs if another eligible minor lives in the home, or the caretaker is a qualifying pregnant woman. However, if the NMD is the youth in the home, the caretaker is not eligible to receive CalWORKs. (ACL No. 12-27, issued Jun. 12, 2012; question 2.)
- If the minor approaching 18 years of age remains eligible for tradition CalWORKs as a fulltime student anticipated to graduate by 19 years of age, a caregiver who has opted into the AU may continue to receive CalWORKs. However, if the minor wishes to participate with extended CalWORKs under AB 12, the NMD shall be discontinued from the caregiver's case on the first of the month following the

youth's request for extended benefits with a 10-day Notice of Action, once the signed SOC 161 [Six-Month Certification of Extended Foster Care Participation] form is received. There is no need for the NMD entering extended CalWORKs to execute a SAWS 1 or 2.

- An NMD transferring into his or her own AU is a mid-quarter county initiated action. (ACL No. 12-27, issued Jun. 12, 2012; questions 3, 4, 8.)
- The NMD is not subject to either property or income rules, or Welfare-to-Work rules, for eligibility and/or grant computation purposes in receiving extended CalWORKs under AB 12. (ACL No. 12-27, issued Jun. 12, 2012; questions 13, 14, and 16.)
- If the NMD moves to another county of residence, the county of responsibility continues to pay extended CalWORKs under AB 12; there is no inter-county transfer of the case to the new county of residence, unless the minor's Court dependency is transferred to a new county of responsibility. (ACL No. 12-27, issued Jun. 12, 2012; questions 19 and 20.)
- An infant born to the NMD receiving extended CalWORKs under AB 12 does not cause an increase in extended CalWORKs benefits, as the NMD is the only eligible member of that AU.
- An infant born to the NMD will not be subject to Maximum Family Grant (MFG) rules. If the NMD later wishes to initiate a regular CalWORKs case, the infant already born to the NMD would also not be subject to the MFG rules, as the NMD was never given informing notices of the MFG rule, but may apply for any new infants born to the NMD after entering regular CalWORKs. (ACL No. 12-27, issued Jun. 12, 2012; questions 21 and 22.)

E-Note #67 AAP Regulatory Changes (Effective 12/10/2011)

May 31, 2012

ACL 12-14 (April 23, 2012)

Title 22 Calif. Code Regs., §§35326 through 35344

On April 23, 2012, ACL 12-14 was issued informing of the recent changes to AAP regulations under Title 22 of the California Code of Regulations; these changes became effective on December 10, 2011 in response to a Program Improvement Plan completed with the federal Administration of Children Youth and Families Program, Department of Health and Human Services. These changes also reflect state statutes from 2009 and 2010 impacting AAP, including that of the California Fostering Connections to Success Act (AB 12).

The ACL notes that significant changes were made to a number of sections, which will be fully stated in an upcoming update to the paraphrased regulations for Foster Care, KinGAP, and AAP benefits, which will include the impact of the age extensions from AB 12 on all three programs.

However, there are a number of AAP regulatory changes that require immediate disclosure and discussion – these are:

1. Section 35326, which establishes AAP eligibility, now incorporates the updated version of Welfare and Institutions Code section 16120; this version incorporates the federal “de-linkage” process as well as the age extensions caused by AB 12.

2. Section 35327, which formerly stated the rules relating to an unsuccessful search for an unaided adoption (as mandated under WIC 16120(b)), is now been stricken. These rules are now incorporated into section 35326(a)(3). One change from the original language in 35327, is that the exception to a search effort now states:

“A child who develops significant emotional ties with the prospective adoptive parents while in their care as a foster child or if a relative is adopting a child, then it would be in the child’s best interest to remain with them and additional efforts to place the child are not required.”

Otherwise, the language is substantially similar as before, and still includes the section stating (§35326(a)(3)1.): “This search shall not be required when the current foster parents, or other person with whom the child has been living and has established significant emotional ties have both expressed interest in adopting the child, and been determined by the agency to be suitable adoptive parents.”

3. Section 35333, which addresses identifying and negotiating the AAP rate, has undergone significant changes.

The former language in 35333(c), stating that the agency shall determine the maximum AAP benefit for which the child is eligible, is now stricken. Emphasis is now placed on both the agency and the adoptive parents to negotiate and agree on the amount of AAP benefit and to make a final determination.

35333(a) mandates the agency make a “good faith effort” to negotiate the AAP benefit with the adoptive parent. The agency “shall encourage” the parents to request the benefit they require to meet the child’s needs, and the agency shall base the negotiated benefit on the needs of the child and circumstances of the family.

Without the language mandating the agency must determine the maximum eligible rate, new emphasis must now be placed on determining whether the adoptive parents intelligently and voluntarily enter negotiations with the agency.

4. Section 35334, which addresses an adopted child’s temporary placement away from the adoptive parents, continues to state an adopted child can be placed voluntarily or by court dependency, in an out-of-home care facility to treat a condition that the agency determined to have existed prior to the adoptive placement.

However, in all future agreements, the agency must state such temporary placements cannot exceed 18 months (§35334(e)). Also, section 35334(e)(1)(A) states: “The adoptive parent(s) may request the financially-responsible public agency to pay the facility directly using the child’s eligible AAP funds, or the adoptive parents may request the AAP check continue to be sent to them to pay the facility.”

This provision may clarify that where the facility is paid for by “another agency” noted in section 35334(a)(2)(B), providing for continued basic or share of cost AAP benefits to the adoptive parents, this other agency may not include the “responsible public agency” providing AAP benefits.

5. Section 35343, which addresses reassessments for AAP benefits, now clarifies (§35343(b)(1)(A)) that the agency can no longer discontinue AAP benefits when an adoptive parent fails to return a completed Reassessment Information AAP form (form AAP 3). When this happens, the agency is to continue paying the same benefits as reflected on the prior payment instructions (form AAP 2), and the last AAP agreement (form AD 4320).

6. Section 35344, which addresses AAP overpayments, now includes (§35344(e)) a provision mandating that the county shall not demand overpayment collection “when the overpayment was due to county error.”

Formerly, §35344 noted that an AAP overpayment may exist when:

- (1) The adoptive parent receives aid after the child becomes ineligible for assistance because:
 - (A) The child has attained 18 years of age, or, if the agency has determined that the child has a mental or physical condition which warrants the continuation of assistance, 21 years of age.
 - (B) The adoptive parent is no longer supporting the child.
 - (C) The adoptive parent is no longer legally responsible for the support of the child.
- (2) The adoptive parent has committed fraud in his or her application for, or reassessment of, the adoption assistance benefit.
- (3) The AAP payment exceeds the foster care payment which would have been paid on behalf of the child if the child had not been placed for adoption.

Noting that the adoptive parents have a duty to immediately notify the agency when significant changes occur impacting the adopted child’s eligibility for AAP benefits, the county will have a more of a burden to prove the adoptive parents have contributed to the overpayment of AAP benefits.

E-Note #66 Mid-Quarter Change When Child Moves To a New Assistance Unit or Household

April 26, 2012

ACIN No. I-21-12 (April 23, 2012)

§40-161; §40-181.3; §44-316.312(c); §44-316.331(i); §82-808; 63-509.671(g), §63-509(h), §63-509(h)(2), and §63-509(m)

Because this ACIN provides particularly important and helpful information pertaining to when a child moves to a new CalWORKs assistance unit or CalFresh household, and what the county is required to do under those circumstances, it is being incorporated into this E-Note in its entirety.

It states the following:

The purpose of this letter is to remind counties of the steps to take when a family applies for cash aid or CalFresh benefits for a child who is currently aided in another assistance unit (AU) or household (HH). In these situations, a prompt determination of eligibility is critical, in order to reduce the time before the new AU/HH can receive cash aid and food benefits, if eligible. In general, if the county determines that pursuant to the relevant program rules, the child should be aided in the applicant household; the county discontinues aid for the child in the former AU/HH mid-quarter and grants cash aid and CalFresh benefits to the new AU/HH. If the child was the only eligible child in the former AU, and the remaining adult is not an eligible pregnant woman, both cash aid and CalFresh benefits are discontinued for the entire AU/HH, and Transitional CalFresh benefits are provided to the remaining member(s) in order to prevent duplicate aid for the child that moved to the new AU/HH. Next are more detailed guidelines regarding the treatment of these situations.

Process for Handling Applications for Aided Members

When cash aid is requested for a child who is already part of another aided AU/HH, counties must verify who has care and control of the child in question before they grant cash aid to the applicant family. For CalFresh, the county must verify with whom the child shares the majority of his/her meals, in accordance with MPP Section 63-402.15. Since delay of a timely determination of the care and control/food arrangements can result in a needy family going an additional month without eligible benefits, it is crucial that counties complete these investigations as soon as possible.

Counties must immediately contact the currently aided parent or caretaker relative and others who can provide evidence responding to the criteria in MPP Section 82-808.3. These criteria include but are not limited to: who decides where the child attends school or child care; who deals with the school on educational decisions and problems; who controls participation in extracurricular and recreational activities; who arranges medical and dental care services; who claims the child as a tax dependent; and, who purchases and maintains the child's clothing. Such evidence may be established by sworn statements by witnesses, information from child welfare agencies, etc. To make a determination of care and control, counties may also check with the child's school or daycare provider to see who drops off and picks up the child (with written permission from the currently aided parent or caretaker relative). Per MPP Section 40-161, a home visit is required when living arrangements or other factors cannot be satisfactorily determined without such a visit.

Due to confidentiality requirements, eligibility workers should be reminded that they cannot acknowledge to the applicant HH or others that anyone is on aid. Also, if either AU parent is a victim of domestic abuse, the county should be alert to the possibility that one parent may be making a false claim to harass, intimidate, and control the other parent.

Cash aid cannot be discontinued in the open case or granted in the new case until the investigation and determination of who has care and control is complete. For this reason, counties must complete this determination as soon as possible in order to be able to grant aid to the applicant family at the earliest opportunity, if the applicant family is found to have custody of the child. If the window of opportunity permitting discontinuance at the end of the month pursuant to a timely and adequate 10-day notice is fast approaching (e.g. it is the 18th or 19th of the month) counties should do everything possible to complete the determination of care and control before the 10-day notice deadline so that the new caretaker relative does not have to wait an additional month before s/he can begin receiving aid for the child in their care.

Because the new applicant will not have apparent eligibility for cash aid until care and control is determined and the child is removed from the former AU (with timely and adequate notice), s/he will not be eligible for emergency benefits such as homeless assistance or immediate need in the month of application (unless s/he has other apparently eligible children who are not currently aided in another AU). For CalFresh, the new applicant may be entitled to get Expedited Service, if otherwise eligible, for the applicant HH except for the child whose presence is in question. In order to decrease this hardship on the applicant family, counties should direct them to any local resources that may be available to help them during this time of transition, including county welfare department social workers, if available.

When discontinuing the child from the first AU/HH, the county must provide that AU/HH with timely and adequate notice, and may not grant aid to the applicant AU/HH until the first of the month after the child's current benefits have been discontinued. The first AU/HH may be discontinued at the end of the current month without timely (10-day) notice only if the caretaker relative in that AU/HH requests a mid-quarter discontinuance in writing.

Since reporting AU/HH composition changes is a voluntary mid-quarter report, no overpayment may be assessed on the current AU/HH based on their not reporting the child leaving the home outside of the quarterly reporting timeframe, not requesting a mid-quarter discontinuance, or the inability of the county to discontinue aid due to timely notice requirements. If it is determined that the new applicant has care and control of the child(ren) being aided in another household, and that fact had not been reported timely under change and QR reporting rules, an Overpayment/Overissuance action should be initiated against the former (now non-custodial) head of household.

Example 1: A single-parent AU has one eligible child and is receiving cash aid and CalFresh benefits. On May 15, a man applies for CalWORKs and CalFresh for himself and that same child, his son. The county immediately realizes that the child is already on aid with his mother. There are no other eligible children in the applicant's family. The county contacts the currently aided parent who states that her son continues to reside with her. The applicant parent states that there is an open child welfare case against the mother, and he has been asked to take custody of their son. The county contacts Child Welfare Services who confirms the arrangement, and that it is expected to continue for more than 30 days. Given that the mother already was not caring for the child, CWS did not yet get a court order or voluntary placement. The county discontinues aid for the first AU by May 20 with a timely and adequate notice and the father's application is approved for cash aid as of June 1. If otherwise eligible, the father would be entitled to Expedited Service for the May 15 application with the child being added to the CalFresh benefits effective June 1. The mother would be eligible for Transitional CalFresh benefits for herself only upon termination from CalWORKs and CalFresh.

Example 2: Same scenario as above, but dad does not apply for benefits until May 22. Even though the county gets confirmation of the living arrangements from Child Welfare Services before the end of the month, they cannot discontinue aid to the current AU because there is not time to issue timely 10-day notice. Unless, the mother gives the county written permission to discontinue her case at the end of May, or if CWS gets a court order or voluntary agreement from the mother (MPP Section 22-072.2(f) requires adequate but not timely notice in these cases) cash aid for the applicant family cannot be approved until July 1. For CalFresh, dad, if otherwise eligible, would be entitled to Expedited Service for himself only for the May 22 application with the child being added to the CalFresh benefits as of July 1. In this situation, the county should make every effort to provide the applicant family with referrals to any other community

resources that may be available to help them during this time of transition until their CalWORKs application can be approved.

E-Note #65 Multiple CalWORKs Overpayment and CalFresh Overissuance Notices of Action As They Pertain To Timeliness Of State Hearing Request Determinations

(April 19, 2012)

It is not uncommon for a county to send multiple notices of action pertaining to an overpayment or overissuance. This raises a question as to which of these notices should be used when determining whether the claimant asked for a state hearing in a timely manner. This E-Note is intended to provide some broad guidelines on this question.

If the county sends a legally adequate and language-compliant notice of action and it is found that that notice was received by the claimant, the 90/180 day time period runs from the date of that notice was mailed or given to the claimant. Any new notice or notices that are identical to the first notice do not provide a new start-date for the 90/180 day time clock. (If the initial notice is a demand for repayment it must include the *Anderson* language in order to be adequate)

However, if a new notice increases the overpayment/overissuance amount, e.g., from \$1000.00 to \$1500.00, even for the same time period, the 90/180 day period would run from the new notice alleging an increased amount.

There are cases in which the claimant will bring to hearing a collection notice from a particular county's revenue and recovery office, which will state that if the claimant disagrees with the balance owing on the statement, he/she may request a hearing within 90 days. This can be confusing to the claimant, but this collection notice is not treated as a notice of action under our regulations when determining the 90/180 day time period. (Please note, however, that if the reason that the claimant is requesting the hearing is to dispute the balance owing, and not the underlying merits of the case, there is always jurisdiction in a state hearing to review that.)

Finally, as a related matter, a determination of legal adequacy must be based on whether an individual notice meets all of the criteria of legal adequacy, not whether it, in *combination with* other notices, meet all of the criteria for legal adequacy.

It is important to remember that the different programs have different requirements for an NOA to be adequate. So the general definition of "adequate notice of action" in para-regulation 004-2 may not be sufficient to decide whether the particular notice of action in your case is adequate. For example, unlike in a CalWORKs overpayment notice, an initial CalFresh overissuance notice must include how the claimant was calculated in order to be legally adequate, as explained para-regulations 201-12A and 201-12C, and E-Note #58.

Also, depending on the type of action being taken in the CalWORKs Program, the notice might have to provide very specific information in order to be considered legally adequate, such as specify certain information that is being required from the claimant, or, in a Maximum Family Grant (MFG) determination, list the regulatory exceptions to the application of the MFG rule.

E-Note #64 Less Restrictive Provisions For 250% Working Disabled Program (January 14, 2012)

All County Welfare Director's Letter (ACWDL) 11-38 (November 9, 2011); ACWDL 09-33 (June 25, 2009); ACWDL 02-40 (July 3, 2002); ACWDL 00-16 (March 16, 2000); para-regulations 437-2 through 437-10

Program Background:

E-Note #1 (August 28, 2008), reported on the Working Disabled Program.

The primary advantage of this Program is that they can pay a low monthly premium instead of a high Medi-Cal share of cost. This Program also allows individuals to earn above the Substantial Gainful Activity (SGA) limit and still qualify for linkage through disability. Because of this, counties must not base a decision to process a disability determination for working persons on SGA. The county must refer the case to the Disability and Adult Programs Division (DAPD) and alert the DAPD analyst to evaluate the individual's disability based on criteria for the 250% Working Disabled program so that SGA is not considered the basis for disability.

Back in 2008, it was reported in E-Note #1 that it was necessary to be financially eligible for SSI/SSP if earnings were disregarded in order to be eligible for this program. While disability income was exempt, retirement income was not. Since then, there have been significant changes in that program that make it much more likely that someone can financially qualify for it.

Assembly Bill 1268, effective August 1, 2011:

ACWDL 11-38 reports on the following changes in this program pursuant to AB1269, effective August 1, 2011:

- Permit 250 Percent WDP participants to remain on the program during periods of temporary unemployment up to 26 weeks during each annual eligibility time period as long as the participants continue paying their monthly premiums.
- Exempt retained earned income when held in a separately identifiable account as long as it is not comingled with other resources.
- Exempt a 250 Percent WDP participant's Social Security disability income that has converted to Social Security retirement income when the individual retires, including any increase (cost-of-living increases) in that income.
- Extend the current exemption of retirement arrangements for the 250 Percent WDP participants to those who leave the 250 Percent WDP for other Medi-Cal programs that serve aged, blind and disabled individuals

Role of Counties Pertaining To This Program:

ACWDL 09-33 was issued to remind counties of what they are supposed to do pertaining to the Working Disabled Program.

The Letter stated the following:

While we have seen a slight increase in enrollment for the WDP, we want to ensure that individuals that are determined with high share-of-cost (SOC) are made aware of the WDP.

Counties must place working disabled individuals in the WDP whenever their Medi-Cal SOC exceeds their WDP premium amount, if otherwise eligible. Counties must then contact the individual to explain the advantages and disadvantages of the WDP versus the Medically Needy program with a SOC. Upon providing an explanation about both programs, the counties must allow the individual to choose which program they prefer.

Role of Judges In State Hearings Pertaining To This Program

It is within a judge's discretion to discuss this program in a state hearing if it seems like something that the claimant might potentially qualify for, even if he/she is not currently employed.

Important Things to Remember About the "Work" Aspect of this Program:

- It allows individuals the choice to work full time, part time, or to be self-employed.
- "Work" is undefined for the purposes of qualifying for this program.
- Someone must be earning some amount of income every month and be able to prove earned income (letter from employer, photocopy of payment, paystub, contract or documentation of income from self-employment, such as W-2 forms, etc.).

Since "work" as used in this Program is undefined, someone can conceivably be earning money as a baby-sitter, dog-walker, or a newspaper delivery person, provided that they can prove this income and it is earned every month.

The Department of Health Care Services allows for periods of unemployment for up to 26 weeks due to illness or actual unemployment as long as a person continues to pay his/her monthly premium.

If a claimant is interested in this Program, he/she should be referred him/her to the county to apply. It is within the discretion of the individual judge as to whether he/she wants to indicate in either dicta or a footnote in the decision that s/he discussed this Program with the claimant.

E-Note #63 Changes to the CalFresh Employment and Training Program

All County Letter 12-03; January 9, 2012

PASSAGE OF SENATE BILL 43 AND CHANGES TO THE CALFRESH EMPLOYMENT AND TRAINING PROGRAM: SENATE BILL 43

SB 43 adds Section 18926.5, which contains modifications to CalFresh Employment and Training (E&T) requirements to the Welfare and Institutions Code. CalFresh E&T was formerly known as the Food Stamp Employment & Training (FSET) program.

The changes made in this ACL are effective January 1, 2012. CalFresh E&T only serves Non-Assistance CalFresh recipients.

The pertinent parts of ACL 12-03 state the following:

Additional E&T Deferrals Applicable To All Counties Offering an E&T Program

Within the work registrant population, certain persons may be excused or “deferred” from participation in E&T for reasons that include those listed at Manual of Policies and Procedures (MPP) Section 63-407.811;¹ however, individuals that are deferred from E&T may participate on a voluntary basis.

SB 43 adds additional deferral criteria to which all E&T counties must adhere, irrespective of their existing deferral policies. Work registrants must be deferred from participation if they are:

- o Under 18 years of age or 50 years of age or over;
- o Living in a CalFresh household with a child under the age of 18, regardless of whether or not the child is receiving, or is eligible to receive, CalFresh benefits; or
- o Living in a federally determined work surplus area

For Federal Fiscal Year (FFY) 2012, the majority of California counties must defer their entire work registrant population from mandatory participation in E&T due to being a federally determined work surplus area. Only Contra Costa, Inyo, Marin, Mono, Napa, Orange, San Diego, San Francisco, San Mateo, Santa Barbara, and Santa Cruz counties, as a whole, are not considered federally determined work surplus areas for FFY 2012.

Within the aforementioned counties, there may be cities that are considered federally determined work surplus areas. Those counties with cities that are considered work surplus areas are Contra Costa, Orange, San Diego, San Mateo, Santa Barbara, and Santa Cruz. In those areas that are work surplus areas, work registrants are not required to be assigned to mandatory E&T participation.

¹All bases for deferral listed in §63-407.811 are discussed in para-regulations 303-2, 303-2A, and 303-3. Some of them include: 1. A person who resides in a federally approved geographically excluded area; 2. A person who is unable to participate due to personal circumstances, e.g., lack of child care, lack of transportation, severe family crisis, etc. and 3. Temporary illness or disability

For FFY 2012, the following cities have been determined work surplus areas within a county that is NOT a federally determined work surplus area:

Contra Costa: Antioch, Concord, Pittsburg, Richmond, and San Pablo

Orange: Anaheim, Buena Park, Fullerton, Garden Grove, La Habra, Santa Ana, Stanton, and Westminster

San Diego: Chula Vista, El Cajon, Escondido, Imperial Beach, Lemon Grove, National City, San Diego, San Marcos and Vista

San Mateo: Daly City, East Palo Alto, and South San Francisco

Santa Barbara: Lompoc and Santa Maria

Santa Cruz: Santa Cruz and Watsonville

Impact On E&T Sanction Policies

In counties aligning General Assistance/General Relief (GA/The claim is granted.) with CalFresh, failure to comply with a GA/GR activity, which also serves as an E&T activity, will not result in the loss of CalFresh benefits if the E&T component is voluntary.

**E-Note #62 CHANGE IN CalWORKs OVERPAYMENT COLLECTION
(January 8, 2012)**

All County Letter 12-02 (January 6, 2012); MPP §44-352; W&I Code 11004

ACL 12-02 states the following:

After a careful review of state and federal law, the California Department of Social Services (CDSS) has the authority to forego collection of CalWORKs overpayments from adults or emancipated minors who were minors receiving cash aid in an assistance unit when an overpayment occurred. The CDSS authority results from its ability to redefine by regulation the meaning of the term "family" set forth in Welfare and Institutions Code Section 11004 to exclude from that definition adults or emancipated minors who were minors receiving cash aid in an assistance unit when an overpayment occurred.

The CDSS is directing counties to immediately terminate all current collection actions via grant reduction, tax intercept or other collection methods, and to prospectively forego pursuit of repayment from adults or emancipated minors who were minors receiving cash aid in an assistance unit when an overpayment occurred. This change is effective prospectively and as of the date of this All County Letter.

The CDSS will amend the applicable regulations to be consistent with this change in policy in accordance with the requirements of the Administrative Procedures Act and has begun to work with counties to make relevant programming changes to stop current tax intercepts for the specified population for 2011.

Further instructions will be forthcoming under separate cover regarding specific procedures and processes moving forward.

Our para-regulations will be revised in the next up-date to reflect this change.

E-Note #61 CalFresh Program County Residency Requirement (January 3, 2012)

Para-Regulations 234-1: 234-2; MP §63-401:

Para-regulation 234-1 provides the following:

A household must be living in the county in which it files an application. The county shall not interpret residency to mean domicile which is sometimes defined as a legal place of residence or principal home. The county shall not impose any durational residency requirements nor shall residency require an intent to remain permanently in the county. The county shall not require an otherwise eligible household to reside in a permanent dwelling or have a fixed mailing address as a condition of eligibility. (§63-401)

ACL 10-01 (Jan. 29, 2010) discusses the roles and responsibilities of assistance unit and household in the CalFresh Program and the CalWORKs Program of regarding residency and reporting of address changes, the rules governing the use of EBT and EBT administrative data, and the actions to be taken when information regarding residency is in question. This letter also reminds CWDs of the rules associated with referrals to the Special Investigative Unit (SIU).

The ACL has been in the CalWORKs para-regulations but has recently been added to the CalFresh para-regulations at 234-2. It is important to note that the ACL sets forth different requirements, depending on which program is involved.

Para-reg 234-2 states the following:

If it is discovered that a CalFresh household is purchasing food, other than in the county of residence and benefit issuance, or purchasing food out of state, the CWD cannot assume a loss of residence and immediately terminate the household or refer the household to the SIU.

The CWD must first determine if there is reliable information, such as a pattern of returned mail, attempts by the CWD to reach the household which have failed, appointments for recertification which are sent and returned, a call from another county indicating an application has been made in the other county, etc. [MPP Sections 63-401 and 63-504.266(b)], which indicates a loss of residency in the county of benefit issuance. According to MPP Section 63-401.1, a household must be living in the county in which it files an application for participation. If it is determined the household has lost residency in the county in which they last resided, the household must be discontinued for loss of residency.

ACL 10-01 specifically states the following:

Mail returned as “Undeliverable” or “Addressee Unknown:

A discontinuance based on “whereabouts unknown” is not appropriate in the FSP; the

discontinuance must be based on loss of residency gained from reliable information which indicates a move out of county. Therefore, when mail is returned as “undeliverable” or “addressee unknown,” the CWD cannot immediately assume a loss of residence in the county of benefit issuance. There must be, as determined by the CWD, enough reliable information to make a determination of loss of residency. For example, a pattern of returned mail continues, attempts to reach the household is futile, appointments for recertification are sent and returned, a call from another county indicates an application in the other county, etc. MPP Section 63- 401 states a household must be living in the county in which it files an application for participation; therefore, the discontinuance Notice of Action must be based on loss of residency; the reason of “whereabouts unknown” is not an appropriate reason for discontinuance in the CalFresh Program.

Loss of Residence:

If it is discovered that a household is purchasing food, other than in the county of residence and benefit issuance, or purchasing food out of state, the CWD cannot assume a loss of residence and immediately terminate the household or refer the household to the SIU. The CWD must first determine if there is reliable information, such as a pattern of returned mail, attempts by the CWD to reach the household which have failed, appointments for recertification which are sent and returned, a call from another county indicating an application has been made in the other county, etc. [MPP Sections 63-401 and 63-504.266(b)], which indicates a loss of residency in the county of benefit issuance. According to MPP Section 63-401.1, a household must be living in the county in which it files an application for participation. If it is determined the household has lost residency in the county in which they last resided, the household must be discontinued for loss of residency.

CWD Referrals to the SIU In Both CalWORKs and CalFresh Programs:

If the AU/household refuses to provide additional necessary information or provides conflicting information to the CWD after an attempt is made to clarify their residency, the CWD has reasonable grounds to refer these cases to the SIU for a fraud investigation.

E-Note #60 CalFresh Program Student Rule Involving the Work-Study Exception

(November 21, 2011)

Para-Reg: 244-3 provides:

In order to be eligible to participate in CalFresh, a student must satisfy one of the exemption criteria listed in Manual of Policies and Procedures (MPP) 63-406.21.

Any person age 18 through 49, physically and mentally fit for employment, and enrolled at least half time (as defined by the institution) in an institution of higher education (as defined in §63-406.111(a)) is ineligible to participate in the CalFresh program unless that person meets the requirements of §63-406.2. (§63-406.1)

These student eligibility requirements do not apply to persons: Aged 17 or under, or aged 50 or over; physically or mentally unfit for employment; attending high school; participating strictly in the job-training portion of OJT programs as opposed to the class attendance portion; enrolled less than half time in an institution of higher education, as defined in §63-406.111(a)(1); enrolled less than half time in a regular curriculum in an institution of higher education as defined in §§63-406.111 and .111(a)(2); or enrolled full time in school and training programs which are not institutions of higher education. (§63-406.12)

Para-Reg 244-5 provides:

A “student” as defined in §63-406.1 must meet one of the following criteria on the date of the interview in order to participate in the CalFresh program:

1. Be a paid employee for at least 20 hours per week, or be self-employed for at least 20 hours per week and earning at least the federal minimum wage multiplied by 20 hours.
2. Be approved for state or federally financed work study for the current school term and anticipate working during the term. This exemption begins the later of the month work study is approved, or the term starts, and continues through the end of the month the school term ends or the student refuses a work assignment. The exemption does not continue through term breaks of a full month or longer unless the student participates in work study during the break.
3. Be exerting parental control over a dependent household member under the age of six.
4. Be exerting parental control over a dependent household member aged 6 to 12 when adequate child care services are not available for the individual to attend class and work 20 hours per week or participate in a state or federally financed work study program.
5. Be a recipient of AFDC (now CalWORKs).

6. Be assigned to or placed in an institution of higher education through or in compliance with the requirements of subsections (a) through (e). These include self-initiated placements, and voluntary participation, in certain situations, through JTPA, the FSE&T program, the JOBS Program, any program under §236 of the Trade Act of 1974, or a state or local program for low-income individuals, determined by the county to be providing at least one of the components specified in §63-407.841.
7. Be enrolled full time in an institution of higher education, and is a “single” parent with responsibility for the care of a dependent child under age 12. A “single” parent can be married, or have been married, as long as no other natural, adoptive, or stepparent lives in the household; or the single parent may be a full-time student who exercises parental control over the child when there is no natural, adoptive, or stepparent in the household.

(§63-406.21)

Pertaining to the work-study exception under the above list, if it is undisputed that a student has been approved for work study during a specific school term, but he/she testified that he/she is not actually working in a work-study position but, instead, is on a waiting list for employment, because there are no jobs available, he/she is still potentially eligible for CalFresh benefits. The fact that no jobs are available does not disqualify the student for the exemption.

If you have a case involving these types of facts, you want to make findings of fact on the following: that the student was approved for state or federally financed work study during a specific school term, that he/she anticipates working during that term, and that he/she has not refused a work assignment.

If these facts are established, that student is potentially eligible for CalFresh benefits.

E-Note #59 State Hearing Order In A Case Where Spend-Down Instructions Were Not Given By County

(November 14, 2011)

Notes From The Training Bureau Item 07-6-2 (June 7, 2007) discusses the “evolution” of Medi-Cal property spend down rules. Even though this particular Note is more than 4 years old, it is still relevant to our Medi-Cal cases involving spend down rules, and provides important and helpful information about what the county must do to meet informing requirements.

In any case in which it is determined that the county has not meet these informing requirements, and, therefore, where the claimant did not have the requisite opportunity to spend down his/her property before the end of the month at issue, a state hearing decision must provide a remedy.

One acceptable and reasonable remedy is to allow the claimant to have 30 days from the date of a state hearing decision to spend down property at issue if he/she has not already done so, i.e., to grant back to the date of application, but condition the grant of benefits upon the claimant spending down within 30 days from the date of the hearing decision.

In the event where someone reasonably needs extra time, e.g., where there is a need to obtain cash surrender value (CSV) of a life insurance policy, the claimant could be given 30 days from the state hearing decision to request the CSV, that the money be considered unavailable until such time as she receives the funds, and if and when she receives the funds, that the claimant be given another 30 days to spend the funds below the property limit, with the authorization of Medi-Cal benefits made effective the application date conditional on the claimant completing these steps.

E-Note #58 What Is Necessary For A Notice of Action To Be Legally Adequate

(September 6, 2011)

The purpose of this E-Note is to report on one recent change affecting CalFresh overissuance notices of action. It is also intended to remind judges of the essential legal adequacy requirements for overissuance and overpayment notices of action in particular, and all county notices of action in general.

1. Pertaining to CalFresh overissuance notices of action, All County Letter 11-26 (March 14, 2011) reported on the court order in the Rosie Heathcock et al v. Allenby lawsuit. In Para-regulation 201-12, it states the following:

The court order set out the requirements for initial collection Notice of Action in the CalFresh Program.

The overissuance notice must include:

- *The amount of benefits the household received; and*
- *The amount of benefits the household should have received;*
- *The time period benefits were over issued;*
- *The specific reason that caused the overissuance;*
- *The amount of the benefits that are to be repaid;*
- *How the household or sponsor may pay the claim;*
- *The type of error, i.e., Administrative Error (AE), Inadvertent Household Error (IHE), or Intentional Program Violation (IPV).*

The county is now required to use an overissuance budget worksheet (NA 1263), which is a newly developed required form and must be sent as an attachment with all the CalFresh O/I NOAs. The information on the budget worksheet must include the calculation used to determine the claim amount for each month the household incurred an overissuance.

2. Both CalFresh overissuance and CalWORKs overpayment notices of action must include language about certain types of federal benefits not required to be used for repayment.

Specifically, Para-regulation 155-6 states the following:

CDSS has agreed to include in its collection letters which demanded repayment the following specific language: "You do not have to use any Social Security or SSI benefits you get to repay this overpayment." (Louis v. McMahon, Case No. 869355, Stipulated Judgment of April 7, 1989, San Francisco County Superior Court; Handbook §44-352.451(c))

Para-regulation 296-9 states:

The repayment demand notice should contain the following language, in accord with All-County Information Notice (ACIN) No. I-27-90, April 19, 1990, implementing Louis v. McMahon: "You do not have to use any Social Security or SSI benefits you get to repay this overpayment."

Although the Order in Louis v. McMahon has not been modified, according to the CDSS, the Food and Nutrition Service (FNS) has directed California to change its CalFresh collection notices, to remove the language which states that Social Security does not have to be used to repay the CalFresh overissuance. The FNS position is based on the Debt Collection Improvement Act, which according to the CDSS, authorizes the collection of SSA benefits to repay debts owed to the Federal Government, but exempts the collections from SSI but not SSA. (All-County Information Notice (ACIN) No. I-109-00, November 17, 2000)

(Please note that while Social Security benefits can be required to be used to repay a CalFresh overissuance, not all county overissuance notices of action have been modified to say this.)

3. Both overissuance and overpayment initial notices of action issued after January 1990 must also include tax refund intercept language.

Para-regulation 004-13 states:

Effective January 1, 1990, all CalWORKs (formerly AFDC) notices of action concerning overpayments, or CalFresh notices of action concerning overissuances, must include substantially the following language:

WARNING: If you think this overpayment is wrong, this is your last chance to ask for a hearing. The back of this page tells how. If you stay on aid, the county can collect an AFDC overpayment by lowering your monthly grant. It can lower your CalFresh benefits to collect an overissuance unless it was the county's fault. If you go off aid before the overpayment or overissuance is paid back, the county may take what you owe out of your state income tax refund.

(Anderson v. McMahon, Alameda County Superior Court, Case No. 620039-4; All-County Letter No. 90-14, February 9, 1990)

4. For all CalFresh and CalWORKs notices of action, basic legal adequacy requirements are set out in Para-regulation 004-2.

The county is required to provide adequate notice when aid is granted, increased, denied, decreased, not changed following a recipient mid-quarter report, cancelled or discontinued. Adequate notice must also be provided when the county demands repayment of an overpayment or CalFresh overissuance. Adequate notice is defined as written notice informing the claimant of the action that the county intends to take, the reasons for the intended action, the specific regulations supporting such action, an

explanation of the claimant's right to request a state hearing, and if appropriate, the circumstances under which aid will be continued if a hearing is requested. When appropriate, the notice shall also inform the claimant regarding what information or action, if any, is needed to reestablish eligibility or determine a correct amount of aid. In CalWORKs (formerly AFDC), the notice shall state that if the county action is upheld, aid pending must be repaid. In all cases, the notice is to be prepared on a standard form approved by the California Department of Social Services. The notice shall be prepared in clear, nontechnical language and if a claimant submits a request for a state hearing on the back of the notice, a duplicate copy shall be provided to the claimant on request. (§§22-071.1 and 22-001(a))

Para-regulation 004-2A states:

Although the printed Notice of Action forms designed for specific types of action will help the county provide adequate notice, filling in the appropriate blanks and checking the appropriate boxes on a notice of action form will not assure that the notice is adequate.

In broadest terms, the recipient needs to know and understand what is happening to the family's aid. The recipient needs enough information to be able to judge whether or not the action is correct—including the detail of computation affecting the amount of aid. The recipient should be informed of what facts were used and how they were used so that he or she can make an informed decision whether or not to request corrective action or to appeal the action. (All County Information Notice I-151-82, November 23, 1982)

5. All county notices of action must meet language-compliance requirements if CDSS provides the notice in the claimant's primary language. Interpretive services are required if the notice is not provided by CDSS in the claimant's primary language.

Para-regulation 004-1D states:

A "Language-Compliant Notice" is a notice of action that meets the applicable requirement in (a) or (b) below:

- (a) *For notices of action provided by the California Department of Social Services (CDSS) in the claimant's primary language:*

A written notice of action that complies with the requirements of Section 21-115.2 for a claimant who chose to receive written communications offered in his/her primary language pursuant to Section 21-116.21. There shall be a rebuttable presumption that a claimant chose to receive written communications offered in the claimant's primary language if the claimant identified a primary language other than English to the county pursuant to Section 21-201.211.

(b) For CDSS notices of action that CDSS does not provide in the claimant's primary language:

The county must offer and provide interpretive services for the notice of action if either of the following applies:

- (1) The claimant contacts the county about that notice of action prior to the deadline for a timely request for hearing on an adequate notice of action and indicates a need for interpretive services; or*
- (2) The claimant previously identified a primary language other than English to the county and contacts the county about that notice of action prior to the deadline for a timely request for hearing on an adequate notice of action.*

(§22-001(l)(1) effective January 24, 2007)

6. Some Additional Requirements Specific to Particular Types of Notices Of Action

Para-regulation 201-4 Pertaining to CalFresh Notices of Action:

A CalFresh notice shall be considered adequate if it explains in easily understandable language the proposed action, the reason for the proposed action, the household's right to request a state hearing, the availability of continued benefits, and the potential liability of the household for any overissuance received while awaiting a state hearing, if the hearing decision is adverse to the household. The notice must also contain the telephone number that an individual may contact for additional information. For households living outside the local calling area, the notice shall contain a toll-free number or a number where collect calls will be accepted. An adequate notice must also advise the household of the availability of free legal representation, if any. (§63-504.211)

Para-regulation 601-4 Pertaining to the IHSS Program:

A notice which denies, reduces, discontinues or suspends a service, or which increases a fee, shall include the information concerning the IHSS recipient's circumstances which has been used to make the determination and shall cite the regulations which support the action. (§10-116.42)

Notices which alter an existing service authorization shall indicate the circumstances under which the service will continue during the hearing process if a hearing is requested (§10-116.43)

7. Finally, MPP §22-009.2, discussed in Para-regulation 004-1A, provides the following:

A recipient shall have the right to request a hearing to review the current amount of aid. At the claimant's request, such review shall extend back as many as 90 days from the date the hearing request is filed and shall include review of any benefits issued during the entire first month in the 90-day period. This review shall only apply to facts that occurred during the review period. (§22-009.2 effective January 24, 2007)

Therefore, except for IHSS cases, as set forth in ACL 10-61 (December 17, 2010), the above regulation can be applied to reach the merits of a case involving the *current amount of aid* even if someone receives a legally adequate notice and files an untimely hearing request without good cause.

However, please note that the period of review cannot extend back more than 90 days from the date that the hearing request is filed.

E-Note #57 CalFresh Cases Involving Self-Employment Income From More Than One Business In the Same Household

(August 31, 2011)

At least several judges have had a CalFresh case involving self-employment income from two separate businesses operated by one person. It has been unclear how to interpret and apply the self-employment regulations in this kind of case.

Program submitted the question to the USDA Food and Nutritional Service (FNS) and just received a response, both indicated below.

Question: The issue pertains to determining income for a self-employed household that has two businesses (one business produced a profit and the other produced a loss). E.g., in such a case, the county chooses to count the gross income and expenses of only the profitable business. CFR 273.11 allow self-employment gross income to be reduced by the cost of producing the income, however, in the situation of a self-employed household with two businesses, should the income and expenses be counted separately or should they be pooled to determine the net household income?

Response: the gross earned income from each self-employment enterprise should be computed separately (see calculation examples, below). FNS regulations at 273.9(b)(1)(ii) defines earned income as including the “gross income from a self-employment enterprise... excluding the costs of doing business.” The regulations cite refers to “a” self-employment enterprise, not all self-employment enterprises in the household, which supports that the income from each self-employment enterprise must be calculated separately. 273.11(a)(2) describes the method for determining monthly income from self-employment income and states that the monthly net self-employment income must be added to other earned income coming into the household.

Note that the answer would be different if the enterprise is farming. Generally, for farming, you can offset losses from one enterprise against another enterprise.

Example Provided by FNS:

A. Income & expenses counted separately:

Mom is a self-employed hair dresser.

\$800 gross income

\$300 in expenses

\$500 ($\$800 - \$300 = \500) Net income counted/used in SNAP

Dad is a self-employed landscaper.

\$100 gross income

\$400 in expenses

\$0 ($\$100 - \$400 = \0) Net income counted/used in SNAP

\$500 Total Net Income (\$500 mom net + \$0 dad net)

B. Income & expenses pooled:

Pool

\$800 mom gross income

\$100 dad gross income

\$900 pooled gross income \$900 (\$800 + \$100)

Expenses pooled

\$300 mom expenses

\$400 dad expenses

\$700 pooled self-employment expenses \$700 (\$300 + \$400)

\$200 Total Net Income (\$900 pooled gross income less \$700 pooled expenses)

Example A is the appropriate calculation.

E-Note #56 Qs and As and UIB Income

1. ALL COUNTY LETTER: 11-57 - August 11, 2011: CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS (CalWORKs) AND CALFRESH PROGRAMS FREQUENTLY ASKED QUESTIONS AND ANSWERS

This ACL contains frequently asked questions and answers pertaining to CalWORKs immunizations, CalWORKs time limit extenders, CalWORKs compulsory school attendance/truancy penalty, and CalWORKs redeterminations/CalFresh recertifications.

If you have a case that involve any of these issues, it is recommended that you read this ACL for clarification on them.

2. ALL-COUNTY LETTER NO. 11-49 - August 11, 2011: CALFRESH ELIGIBILITY AND BUDGETING OF ANTICIPATED UNEMPLOYMENT INSURANCE INCOME

The purpose of this letter is to reiterate the appropriate method by which County Welfare Departments (CWDs) shall evaluate Unemployment Insurance Benefits (UIB) as income when determining eligibility and benefit amount for applicants and recipients of CalFresh.

Whether the household is QR or change reporting, CWDs are not to anticipate UIB if the payment amount and date of receipt are unknown. If there is no reasonable certainty of the amount and the date of receipt, anticipated UIB income cannot be used to establish eligibility and/or benefit levels.

Further, when the CWD has used UIB income to determine eligibility and/or benefit levels from a source other than the household, they shall be made aware of the source of information and shall be provided with a copy of that verification. For example, a copy of an Income Eligibility Verification System (IEVS) report shall be made available to the client if IEVS was used to verify the anticipated income.

Additionally, if UIB was not used due to the fact that it could not be reasonably anticipated and at a later time the CWD learns that the client did indeed receive UIB, no over-issuance exists. Only that income that was anticipated with reasonable certainty may be used in the determination of eligibility and benefit amount and information acquired subsequently is not relevant to the initial budget quarter.

E-Note #55 – CalWORKs Changes Effective July 1, 2011

ACL 11-33 (April 29, 2011); also see ACL11-29; ACL 11-32; ACL 11-34; ACL 11-36

Pursuant to SB 72, signed on March 24, 2011, there will be major changes to the CalWORKs Program effective July 1, 2011. For a more detailed explanation, the link to ACL 11-33 is <http://www.dss.cahwnet.gov/lettersnotices/entres/getinfo/acl/2011/11-33.pdf>

A summary of the changes is as follows:

- An eight percent Maximum Aid Payment (MAP) reduction
- Changes to the earned income disregard
- A reduction from 60-month time limit to 48-month time limit for aided adults.
- Incremental 5% grant reductions for Child-Only cases at 60, 72, and 84 months
- Extension of the CalWORKs Short-Term exemptions for cases with young children and cases with good cause for lack of supportive services
- One year suspension of the Cal-Learn program from July 1, 2011 to June 30, 2012 except for school bonuses for satisfactory progress and high school graduation

In addition, there will be changes to CalWORKs mental health and substance abuse funding and changes to the AB 98 subsidized employment program, however these changes are unlikely to result in any hearings.

Changes to the Earned Income Disregard (EID):

Under old rules, the Net Nonexempt Income (NNI) is calculated by disregarding the first \$225 of Disability-Based Unearned Income (DBI) and/or any earned income and 50 percent of any remaining earned income. If the assistance unit (AU) has earned income only, \$225 and 50 percent of the earned income is disregarded when calculating the aid payment.

SB 72 changes the income disregards for earned income. The new income disregard structure retains the \$225 disregard for DBI, but limits the earned income disregard to any remainder of the \$225 disregard or \$112, whichever is less.

If the DBI does not exceed \$225, all of the DBI plus any amount of non-exempt earned income is disregarded not to exceed the lesser of \$112 or the difference between the DBI and \$225, plus 50 percent of any remaining earned income.

If the DBI exceeds \$225, only the first \$225 of the DBI and 50 percent of any earned income is disregarded. Any remaining DBI and remaining earned income is treated as part of the family's NNI.

The new EID will be used to calculate eligibility and grant amounts beginning with any income reported in July 2011 or any income to be used for a recipient's July/August/September Quarterly Reporting (QR) payment quarter.

Scenario 1 – Disability Based Income (DBI) less than \$225:

A nonexempt Assistance Unit (AU) of three (an adult and two children) has gross earned income of \$800 per month. The children each receive \$100 per month in unearned income from the absent parent's disability claim. The family lives in Region 1.

\$200 DBI
-225 DBI disregard
(\$25) Remainder - Earned Income Disregard (EID)
\$800 Earned Income
-25 Remaining EID
\$775
-387 50 percent EID
\$387 Net Non-Exempt Income (NNI)
\$638 MAP for three (Region 1)
-387 NNI
\$251 Grant Amount

Scenario 2 – DBI greater than \$225:

A nonexempt AU of three (an adult and two children) has gross earned income of \$600 per month. The children each receive \$200 per month in DBI from the absent parent's disability claim. The family lives in Region 1.

\$400 DBI
-225 DBI Disregard
\$175 Nonexempt Disability Income
\$600 Earned Income
-300 50 percent EID
\$300 Subtotal
+175 Nonexempt Disability Income
\$475 NNI
\$638 MAP for three (Region 1)
- 475 NNI
\$163 Grant Amount

Scenario 3 – Earned Income Only:

A nonexempt AU of three (an adult and two children) has gross earned income of \$800 per month. The family lives in Region 1.

\$800 Earned Income
-112 EID
\$688 Subtotal
-344 50 percent EID
\$344 NNI
\$638 MAP for three (Region 1)
-344 NNI
\$294 Grant Amount

Scenario 4 – Minor Parent

Minor parent is receiving aid for herself and her dependent child. Minor parent lives with both her parents and a sibling. One senior parent earns \$900 per month from full-time employment. The other senior parent earns \$400 per month from part-time employment and receives \$125 in State Disability Insurance benefits. The minor parent has no income. The minor parent is nonexempt and resides in Region 1.

\$125 DBI
-225 DBI disregard
(-100) Remainder-EID
\$1300 Gross Earned Income
-100 EID (lesser of \$112 or \$100 Differential)
\$1200
-600 50 percent EID
\$ 600 NNI
\$866 MAP for five (Region 1)
-600 NNI
\$266 Grant Amount

Incremental Grant Reductions (IGRs) for Certain Child-Only Cases:

Grants for certain Child-Only cases will be reduced by 5%, 10%, and 15% of months 61, 73, and 85 respectively. All months in which the aided member of the assistance unit who has received CalWORKs the longest since January 1, 1998 will count towards these time limits. The cases subject to IGRs are Safety Net families and assistance unit with a non-needy caretaker relative or a caretaker relative who is an undocumented non-citizen, drug, or fleeing felon, or is in a sanction status. Child-Only cases in which the parent(s) or caretaker relatives are unaided due to their SSI/SSP status are not subject to these IGRs.

Note the Following:

- CalFresh benefits will be recalculated and may be increased as a result of the reduction in the CalWORKs grant resulting from the implementation of the new 48-month time limit
- There is no child care policy change as a result of the time limit changes. Timed out adults will continue to receive subsidized child care for up to 24 months in Stages One and Two, as well as in Stage 3 as otherwise eligible. However, effective July 1, 2011 and pursuant to SB 70, all license-exempt provider payment rates will be reduced and eligibility for subsidized child care services will be limited to children who are 10 years of age or younger, with specific exceptions.² There will also be certain family income and family fee schedule changes.
- Counties will continue on-going Medi-Cal eligibility determinations for timed out adults
- All current time clock exemptions, domestic abuse waivers, and extenders continue to apply under the new 48-month time limits.
- Children of time-expired adults will continue to receive aid in the Safety Net program, subject to the Incremental Grant Reductions (IGR) and other eligibility requirements.
- The current time clock exemptions, domestic abuse waivers, and time extenders will not apply to the IGR reductions

Recipient Noticing Requirements:

Because of the significant impact of these changes, counties are required to provide 30 day notices of action to cases that are affected, either by a grant reduction or a discontinuance of

² An ACL will be issued shortly about the child care changes pursuant to SB 70 and the specific exceptions to these changes. A future e-note will be circulated about this.

aid, during the initial six months of transition. This 30-day notice of action will temporarily replace the existing 10-day notice requirement through December 2011.

Overpayment Instructions:

Although adults who exhaust their CalWORKs 48-month time limit as of July 1, 2011 will be discontinued from the case, some of these adults will have exhausted their 48-month time limit well before this date. Counties are instructed not to assess overpayments for any months in which these adults exceed the 48-month time limit prior to July 1, 2011.

Counties are being instructed that if they cannot issue NOAs about the change in time limits by June 1st, providing the required 30 day notice, they may forgo collection action for overpayments in July for not being cost-effective to establish and recover. If counties are unable to provide a timely 30 day NOAs for actions effective on or after August 1st, an administrative error shall be assessed for all months in which the assistance unit received aid to which they were not entitled.

Impact on State Hearings:

Where the claimant is disputing the change in law re the 8% MAP reduction or the change in the EID, those cases will be dismissed prior to being assigned for a state hearing. We should not hear these types of cases.

E-Note #54

Decreases in Cash Assistance Program for Immigrants (CAPI) Payment Standards Effective July 1, 2011 and Increases in Family Foster Family Home (FFH) Rates Effective May 31, 2011

ACIN I-28-11 – May 17, 2011 http://www.dss.cahwnet.gov/lettersnotices/entres/getinfo/acin/2011/I-28_11.pdf

Pursuant to SB 72, signed on March 25, 2011, SSI/SSP payment standards were reduced to the minimum allowable under federal regulations. CAPI payment standards effective July 1, 2011 are the result of the new Budget reduction on the SSI/SSP rates and will be reduced by an amount comparable to the SSI/SSP reductions.

Specifically, as required by W&I Code §18941, the CAPI payment standards are based on the SSI/SSP payment standards, minus \$10.00 for an individual and \$20.00 for a couple.

So, for example, effective July 1, 2011, the total SSI/SSP payment will be \$830.40 per month for an individual and 1,407.20 per month for a couple (both SSI/SSP recipients) residing in his/her/their own household. The CAPI payment, effective July 1, 2011 will be \$820.40 per month and \$1,387.20 per month respectively.

ACL 11-42 (May 31, 2011) <http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl/2011/11-42.pdf>

As the result of the court order issued on May 27, 2011, in the case of the California State Foster Parent Association v. William Lightbourne, et al., the United States District Court ordered the California Department of Social Services (CDSS) to “immediately” increase foster family home rates to reflect the methodology chosen by CDSS and filed with the Court April 8, 2011.

The Court ordered that the new rates be paid with the “next round of checks.” Under CDSS’s interpretation of the Order, the increased rates will be effective from May 31, 2011. Therefore, the checks issued by counties to foster family home providers for services provided after May 31, 2011; that is, for services provided in June 2011, the checks for which will issue in July 2011 shall be as follows:

Age Range: Current Rate: New Rate:

0-4	\$446	\$609.
5-8	\$485	\$660
9-11	\$519	\$695
12-14	\$573	\$727
15-19	\$627	\$761

The Court further ordered that cost of living adjustments to these rates be made “annually or no later than the first day of the State’s fiscal year, to reflect the change in the California Necessities Index (CNI) for the current fiscal year.” Therefore the rate above shall be increased on July 1, 2011 by 1.92 percent to reflect the change in fiscal year 2011-12 CNI.

E-Note #45 (Addendum) Exemption From Deeming for Battered Non-citizens June 13, 2011

Re: MPP §63-502.492

E-Note #45 (issued on September 14, 2010) explained that both CalWORKS and CalFresh rules provide for an exemption from sponsor deeming for victims of abuse and/or battery. An initial 12 month exemption can be extended under certain circumstances.

The CalWORKs regulation (§43-119.222) specifically provides that an ALJ has the authority to determine whether the 12 month exemption should be extended. The CalFresh regulations do not contain this provision. Section 431 of PRWORA, which FNS cites for authority, provides that the exemption can be continued if the alien “demonstrates that the battery is recognized by a court, administrative order, or by the INS.”

At the time of that e-note, we had not yet received a formal legal opinion from the Department as to the meaning of “administrative order.” We have finally received that.

The Department takes the following position:

“Federal law upon which the CDSS regulation is based specifically recognizes a finding by an administrative law judge. Consequently, CDSS administrative law judges may extend the sponsor deeming exemption if they recognize the abuse or battery and find that the abuse or battery has a substantial connection to the need for benefits and the noncitizen does not live with the batterer.”

E-Note #53 – 3.6 % Reduction in IHSS/PCSP Hours

ACL 10-61 (December 17, 2010)

Welfare and Institutions Code 12301.06 implemented a 3.6% reduction of IHSS/PCSP hours, effective February 1, 2010 and to remain in effect until July 1, 2012.

W&IC 1301.06 specifically states the following:

For those individuals who have a documented unmet need excluding protective supervision because of the limitations on authorized hours under Section 12303.4, the reduction shall be taken first from the documented unmet need.

The Department has provided the following explanation and direction (in italics) for how to apply this change in law to our cases:

True unmet need is the amount of total authorized hours for Non-PS services in excess of the statutory max of 195 or 283. There is essentially no unmet need for PS because it's always supposed to be met by IHSS and/or alt resources. Any increase in Non-PS hours authorized by an ALJ would result in a like decrease in the hours authorized for PS because by rule PS is assumed to be provided at the same time as other services.

If a person requests a hearing claiming the 3.6% reduction should not apply due to unmet need, the ALJ should look to see if the Non-PS hours exceed the stat max of 283 or 195, (or would exceed them after ALJ's change in non-PS auth hours). If not, any changes the ALJ makes to the Non-PS hours will not affect total authorized or the 3.6% reduction. If the Non-PS hours do exceed the stat max thus creating an unmet need, then the maximum 3.6% reduction (10.1 for SI stat max of 283, 7.0 for NSI stat max of 195) would first be applied to the unmet need before any reductions are made to the authorized stat max hours. This is true for PCSP, IPO or Residual cases.

If you see NOAs or SOC 293 indicating unmet need when the Non-PS hours are not at the stat max amounts, it is probably a county error related to the PS line that can be corrected using the worksheet below. Completing the PS line correctly on the SOC 293 has always been problematic because of the complex calculations required, but in many cases the person will still end up receiving the stat max hours, so it often remains undetected since the bottom line stays the same. (Counties and ALJs should use the PS worksheet from our website <http://www.cdss.ca.gov/agedblinddisabled/PG1292.htm>) to calculate the correct data to enter for PS.

There are not many unmet need cases statewide, therefore, the unmet need issue should be a relatively rare occurrence.

WIC §12301.06 also states:

Notwithstanding any other provision of law, except as provided in subdivision (d), the department shall implement a 3.6-percent reduction in hours of service to each recipient of services under this article which shall be applied to the recipient's hours as authorized pursuant to the most recent assessment. This reduction shall be effective 90 days after the enactment of the act that adds this section. The reduction required by this section shall not preclude any reassessment to which a recipient would otherwise be entitled. However, hours authorized

pursuant to a reassessment shall be subject to the 3.6-percent reduction required by this section. A recipient of services under this article may direct the manner in which the reduction of hours is applied to the recipient's previously authorized services.

As stated in ACL 10-61, if a person asks for a hearing in response to the 3.6% reduction notice of action, because he/she is asserting that there has been a change in his/her circumstances, that person has a right to a hearing on the merits and the Administrative Law Judge should review the county's assessment as usual, and determine if the assessment is correct as usual.

ACL 10-61 also states the following: "Administrative Law Judges only have jurisdiction to review cases within 90 days of a county action such as, an assessment, failure to assess or reassess or denial of services."

Therefore, if you get a case in which the claimant has asked for a hearing more than 90 days/180 days from the date of the county action, and there is no good cause for an untimely filing, you are required to dismiss the case. In any IHSS/PCSP case in which the judge applies §22-009.2 for the purpose of reviewing the 90 days extending back from the hearing request, the decision must be written as a proposed.

E-Note #52 Change in CalFresh Program Resource Limits

All County Letter 11-11, February 1, 2011

Effective February 1, 2011, CalFresh Property/Resource Limitations have been effectively eliminated by the Expansion of Categorical Eligibility. Modified Categorical Eligibility has now expanded to all non-assistance CalFresh households. This change effectively eliminates the determination of resource eligibility in the CalFresh program.

Liquid resources will still be counted when determining entitlement to expedited service.

The background of this change is the following:

On July 1, 2009, California implemented this Modified Categorical Eligibility (MCE) policy for families with members under the age of 18. Otherwise eligible families are made MCE eligible by receiving or having access to the "Family Planning – PUB 275" brochure which is funded through Temporary Assistance for Needy Families.

Effective February 1, 2011, this policy was expanded to apply to all non-assistance CalFresh households, not just those with minor children. This expansion includes able-bodied adults, seniors, and disabled to California's CalFresh Program.

E-Note #51 Unavailable Property In The Medi-Cal Program

Authority: ACWDL 90-01 (January 5, 1990), Section 50402 of that letter; 97-41 (October 24, 1997); CFR 416.1201(a); SSA §1902(r)(2)(B); SSA §1902(a)(10)(C)

The Department of Health Care Services has indicated that a state Medicaid Plan's methodology when determining Medi-Cal eligibility shall be *no more restrictive* than the methodology used by the Social Security Administration when determining SSI/SSP eligibility. There is nothing in federal law, cited above, that specifies the minimum amount of time a person must be deprived of the power to liquidate their property in order for it to be excluded as a resource, nor the particular circumstances under which someone is considered to have lost this power.

The general rule is that property is treated as unavailable when a person does not have the legal right, power, or authority to liquidate, or the conditions in ACWDL 90-01, Section 50402 of that letter are met. ACWDL 97-41 also indicates that the criteria may be met if the individual is unconscious, comatose, or incompetent at any time during the month under review.

Since spend down rules do not apply to property that is considered to be "unavailable," the above applies to retroactive months as well. I.e., if the applicant is found to be unconscious, comatose, or incompetent at any time during a retroactive month, his/her property shall be treated as "unavailable" in that month.

E-Note #50 Overpayment Caused When the Recipient Doesn't File a Complete or Timely QR7 and the County Does Not Discontinue Benefits

Legal has provided clarification on whether it is necessary for the county to prove that a claimant is *substantively ineligible* for benefits before it can demand repayment of an overpayment caused by the county not discontinuing benefits after receiving a late or incomplete QR7.

The Department's position on this is as follows:

Not meeting a condition of eligibility makes a person ineligible for aid; they do not need to be "substantively ineligible" based on income or property, etc. An overpayment is any amount of any aid payment an AU received to which it was not eligible. Under CalWORKs, there are conditions of eligibility as well as the "eligibility factors" set forth in MPP 40-107(c). Filing a QR7 is a condition of eligibility to continue receiving aid. A recipient who does not file a QR7 has failed

to satisfy a condition of eligibility, and is therefore, no longer eligible to receive aid.

If the county does not discontinue a recipient's aid for failure to file a QR7, any aid payment the recipient receives is an overpayment, provided that the county made the required Balderas contact to remind the recipient that the QR7 is due.

This does not in any way change the application of the doctrine of equitable estoppel that is otherwise available when the overpayment is administratively caused.

If any decision is written in a manner that doesn't conform to Legal's opinion set forth above, it should be written as a proposed decision.

E-Note #49 Pro Ration of IHSS/PSCP Related Service Categories

All County Letter 08-18 (August 23, 2008) provides the following:

11. Q: If an IHSS recipient chooses to eat meals separately from other family members residing in the home, must the IHSS recipient's needs be prorated unless the recipient has a health and safety need requiring his/her meals to be prepared separately?

A: No, these services do not have to be prorated. MPP Section 30-763.32 discusses when it is appropriate to prorate related services, which includes meal preparation. The regulation states that meal preparation should not be prorated, "when the service is not being provided by a housemate and is being provided separately to the recipient." This regulation does not speak to the issue of a housemate preparing separate meals. However, the intent of the regulation is to prorate hours when the needs of multiple persons are being met. When a housemate prepares food it does not automatically follow that the food prepared is meeting the needs of multiple individuals. Therefore, when a housemate prepares food separately for a recipient, the hours are not prorated because they are not meeting multiple needs. The regulation does not require that there be a health and safety reason for the recipient to eat meals separately. Consequently, the recipient may have meals provided separately in this situation solely because he/she chooses to eat separately.

This is true for all of the Related Services. I.e., if the related service is not being met in common with other housemates, whatever the reason is -- e.g., the recipient *chooses* to have his/her laundry done separately from the other housemates or family members -- that service is not prorated.

Note, however, that MPP §30-757.135 defines "reasonable food shopping and other shopping errands" as "*limited to the nearest available stores or other facilities consistent with the recipient's economy and needs.*" This does not include traveling to a distant store for food the recipient is fond of. Therefore, a provider cannot be paid for separate food shopping for this purpose.

E note #48 Presumption that mail is received
November 1, 2010

Re: Evidence Code Section 641

In hearings involving a potentially untimely hearing request, the ALJ is frequently required to make a finding as to whether or not the notice was received by the claimant. In arguing for a dismissal, counties frequently cite the presumption found in Evidence Code §641, which states that “(a) letter correctly addressed and properly mailed is presumed received in the normal course of the mail.”

It is recommended that an ALJ not use this presumption in making his/her finding unless there is specific evidence regarding the mailing of the notice. The existence of a notice addressed to the claimant does not establish that the notice was in fact mailed. Unless the county has presented specific evidence to establish that the Notice of Action was mailed, beyond testimony regarding custom and practice, the ALJ will need to make a finding of fact whether or not the claimant received the notice. Even if the county has presented evidence that the Notice of Action was mailed, the judge should make a finding of fact rather than rely on the Evidence Code if the claimant testifies with certainty that he/she did not receive the notice. If the claimant testifies that he/she does not recall or is not sure whether he/she received the notice and the county has presented specific evidence that the Notice of Action was mailed, then the judge may rely on the presumption in Evidence Code 641.

E note #47 Transitional Food Stamps and state residency
October 1, 2010

RE: ACIN I-41-10

In ACIN I-21-04, program stated that TFS benefits should be discontinued if the county had reliable information that the recipient had left the state.

This is no longer state policy. TFS benefits are only to be discontinued if there is evidence that the recipient has been approved for FS benefits in another state.

E note #47 Transitional Food Stamps and state residency

October 1, 2010
RE: ACIN I-41-10

In ACIN I-21-04, program stated that TFS benefits should be discontinued if the county had reliable information that the recipient had left the state.

This is no longer state policy. TFS benefits are only to be discontinued if there is evidence that the recipient has been approved for FS benefits in another state.

E note #46 CalWORKs Policy Interpretations

September 15, 2010
Re: ACIN I-35-10

CalWORKS has developed a new system for obtaining policy interpretations. ALJs, among others, are instructed to submit a form CW 2202 to obtain answers from program. The specific instructions are contained in ACIN I-35-10 which is attached.

This procedure does not apply to Welfare-to-Work questions.

If you obtain a policy interpretation that you think should be shared with other judges, please save a copy to the server; it would be helpful if the document was named in some manner that identifies the subject. A folder has been set up on the server for this purpose:

\\Cdssfps06\sh\common\CalWORKS_policy_interpretations

E note #45 Exemption from deeming for battered non-citizens

September 14, 2010
Re: MPP §63-502.492

Both CalWORKS and Food Stamp rules provide for an exemption from sponsor deeming for victims of abuse and/or battery. An initial 12 month exemption can be extended under certain circumstances.

The CalWORKS regulation (§43-119.222) specifically provides that an ALJ has the authority to determine whether the 12 month exemption should be extended. The FS regulations do not contain this provision.

Section 431 of PRWORA, which FNS cites for authority, provides that the exemption can be continued if the alien “demonstrates that the battery is recognized by a court, administrative order, or by the INS”. We have not received a formal legal opinion from the Department as to the meaning of “administrative order”.

Any hearing decision that relies on the PRWORA should be submitted as a proposed decision.

E note #44 Restoration of optometry services

Re: Medi-Cal Eligibility Division Information Letter I-10-10
September 3, 2010

Effective July 26, 2010, adult optometry services have been restored to the Medi-Cal program. These include eye examinations and testing only. It does not include payment for eye glasses or contact lenses except for children, residents of ICFs and SNFs, and pregnant women if necessary to prevent harm to the pregnancy.

E note #43 Anticipated UIB in CalWORKs

RE: E note #33 Anticipated UIB in FS
August 17, 2010

The CalWORKS program has advised that their policy interpretation is the same as that reflected in E note #33 for FS benefits. If Congress has not authorized an extension of UIB at the time that the claimant completes the QR7 report and the benefits would otherwise be exhausted, the county cannot reasonably anticipate this income for the quarter.

E note #42 MBSAC increase effective July 1, 2010

Re: ACL 10-34
August 2, 2010

Please note that the MBSAC increased effective July 1, 2010. The new levels are set forth in ACL 10-34. Updates to the decision program are forthcoming.

E note #41 FS restoration of benefits

Re: ACL 10-32
July 26, 2010

The state has been granted a waiver that allows for restoration of FS benefits in the month following the month of discontinuance without requiring a reapplication as long as the recipient has resolved whatever issue caused the initial discontinuance. The ACL provides detailed instructions for both QR7 and change-reporting households.

E note #40A Implementation of Short Term WTW Changes

Re: ACL 09-46

ACIN I-60-10

July 15, 2010

Attached is a link to ACIN I-60-10, which contains additional information regarding the WtW participation changes that were the subject of the last e note issued.

This ACIN contains questions and answers, as well as a WtW flow chart, all of which might be helpful if you have the issue of exemption of a parent with a young child or the issue of lack of supportive services due to lack of funding.

http://www.dss.cahwnet.gov/lettersnotices/entres/getinfo/acin/2010/I-60_10.pdf

E note #40 WTW changes effective August 1 2009

Re: ACL 09-46 (November 10, 2009)

July 12, 2010

As part of last year's budget negotiations, there were several short term changes in the Welfare-to-Work program. The changes broadened the WTW exemption and thus, have not directly resulted in an increase in hearings. We want to make sure you are aware of the most critical changes:

1. There is now a WTW exemption for the care of one child under 24 months of age or two children under the age of six. One parent can receive this exemption if it is a two-parent household. This change automatically cures any sanction of someone with a child of those ages. The parent is automatically exempt but can request to participate as a volunteer if there is funding available. It is a 60-month CalWORKS time limit exemption.
2. Counties are instructed to find good cause for not participating in WTW activities if supportive services are not available due to lack of funding. This is considered a "clock stopper" for determining time on aid.

These changes are in effect until July 1, 2011.

E-Note 39-Recouping CalWORKs Overpayments and Food Stamp Overissuances from Expunged Benefits

June 24, 2010

Authority: MPP §16-750.1; ACL 03-58

There is a difference between how a county is to treat recoupment of benefits when the county demands repayment of a CalWORKs overpayment from how it recoups a food stamp overissuance.

In food stamps, the county shall allow a household to pay its food stamp overissuance claim using benefits from its EBT account. For making an adjustment with expunged EBT benefits," the county must adjust the amount of any claim by subtracting any expunged amount from the EBT benefit account for which the county becomes aware." (§ 16-750)

In food stamps, the county shall allow a household to pay its food stamp overissuance claim using benefits from its EBT account, even if the benefits have been expunged. The county must adjust the amount of any claim by subtracting any expunged amount from the EBT benefit account for which the county becomes aware. (§ 16-750)

In CalWORKs, expunged benefits cannot be used against overpayment claims (i.e., the county may not adjust the amount of the claim by subtracting the expunged amount from the EBT benefit) because such benefits must be reactivated and reissued to recipients upon contact or reapplication. (ACL 03-58) (In food stamps, expunged benefits may not be reactivated.)

However, a CalWORKs recipient or former CalWORKs recipient may repay a CalWORKs overpayment once benefits from an expunged account are reactivated by simply returning the reactivated benefits to the county. If the county reactivates the benefits by sending a check to a former recipient, the former recipient may then return the check and the returned check will count toward repayment of the overpayment.

E note #37 Changes to Homeless Assistance rules

June 23, 2010

RE: MPP Section 44-211

Regulations have been amended effective June 16, 2010 to change HA eligibility rules as well as the rate of payment. The changes are summarized below.

Assembly Bill (AB) 1808, Sections 31.1 and 31.2 (Chapter 75, Statutes of 2006) amended the CalWORKs Homeless Assistance (HA) Program. Under the new provisions, the total maximum daily rate for the temporary HA is increased from \$40 per day to \$65 per day for families of four or fewer and \$15 per day for each additional family member, up to a maximum of \$125 daily. Homelessness criteria are expanded to include families who receive a notice to pay rent or quit. The rent threshold for permanent HA is changed from 80 percent of the maximum aid payment level to 80 percent of the total monthly household income (TMHI). Permanent HA is available to pay up to two months of rent arrearages to prevent eviction. Each month of the rent arrearage payment shall not exceed 80 percent of the TMHI.

AB 1808 also results in two types of permanent HA payments; one that helps homeless families secure a permanent residence, and a new type of permanent HA payment that would prevent eviction. Receipt of either of these two permanent HA payments would constitute an AU's once-in-a-lifetime payment.

Paraphrased regulations will be revised in the near future to reflect these changes.

E note #36 Medi-Cal Income rules/UIB Stimulus

June 10, 2010]

RE: ACWDL 10-10 (May 25, 2010)

Title 22, CCR Section 50517

ACWDL 10-10 advises counties that the weekly \$25 UIB stimulus payment continues to be excluded when determining income in Medi-Cal programs. Counties had originally been notified by ACWDL 09-22 that such benefits were excluded; the new ACWDL continues this provision.

Please also remember that income averaging provisions only apply if a person is seeking Medi-Cal for more than two months. There may be situations when the beneficiary would prefer a break-in-aid in order to reduce the share of cost. Section 50517, as quoted in the paraphrased regulations, provides as follows:

Income shall be converted to monthly income by multiplying weekly income by 4.33 or biweekly income by 2.167 if the beneficiary wishes to receive Medi-Cal for more than two months, and if the beneficiary is to receive the income for a full month. (parareg 464-2)

E note #35 IHSS-R Sponsor Deeming

RE: ACIN I-18-08

May 5, 2010

Non-citizens receiving services through the IHSS-R program are subject to sponsor-deeming rules if they have a sponsor. Most persons lawfully admitted for permanent residency (LAPRs) have sponsors. The LAPRS are likely receiving IHSS-R rather than PCSP or IPW because during their first five years of U.S. residency they are not eligible for federal Medi-Cal benefits; their Medi-Cal benefits are state-funded. An issue may arise about share of cost, or deemed income in excess of IHSS need. Deeming is based upon SSI/SSP rules.

LAPRs become eligible for federal participation after five years and would then be switched to PCSP or IPW and be subject to Medi-Cal rules for their eligibility and share of cost. Although they may still be subject to sponsor-deeming under SSI/SSP rules, Medi-Cal rules do not provide for sponsor-deeming.

E note #34 Replacement of Lost/Stolen Benefits

RE: ACIN I-25-03

May 5, 2010

It is Department policy in accordance with ACIN I-25-03 that CalWORKS and FS benefits that are accessed from an EBT card which is subsequently reported as being lost or stolen cannot be replaced if the benefits were used prior to the report. This is specifically set forth in the ACIN: "Any benefits accessed prior to the report of the loss or theft of the original card cannot be replaced."

Welfare and Institutions Code Section 10072(g) provides that a "recipient shall not incur any loss of electronic benefits after reporting his or her electronic benefits transfer card or personal identification number has been lost or stolen." The section is silent as to the issue of benefits lost prior to the report of a lost or stolen EBT card or PIN.

Any decision which orders the replacement of these benefits must be submitted as a proposed decision.

E note #33 Anticipated UIB in the FS Program

April 28, 2010

According to the FS program policy contacts, ongoing UIB cannot be reasonably anticipated if the receipt of ongoing benefits is dependent upon Congress extending such benefits. Thus, if the recipient is reporting that UIB is ending, or the UIB stub reflects an upcoming exhaustion of benefits, the county cannot continue to budget such income to the next quarter unless the legislation extending benefits has in fact been enacted.

E-note #32 Good Cause for Late/Incomplete QR7 in the FS program

Re: ACL 10-10

Food Stamp Regulation MPP 63-508.644

This ACL clarifies that a FS recipient cannot request the county to grant good cause for the late submission of a QR7 report if more than one month has elapsed. For example, if QR7 was due in March, the recipient cannot ask for good cause in May, although he/she can make this request in April.

This provision applies to counties only. Nothing in the regulations limits a judge's ability to find good cause for the late submission of a QR7, or the submission of an incomplete form.

Further, the one-month limitation does not apply to the CalWORKS program.

Pararegulations citing this ACL are forthcoming.

E note #31 Medi-Cal Prucol Status

Reference :ACWDL 09-40

April 8, 2010

ACWDL 09-40, issued by DHCS on October 14, 2009, advises counties that the SAVE process is not available to authenticate a Medi-Cal applicant/beneficiary's claim of PRUCOL status under the last category set forth on the MC 13.

If the person claims that that he/she can show (1) INS knows he/she is in the United States and (2) INS does not intend to deport him/her, either because of the person's status category or individual circumstances, the county should not be requiring additional verification of this status.

Counties are required to grant full-scope Medi-Cal if an immigrant claims the last PRUCOL category on the MC 13 without performing SAVE verification or collecting any documentation relating to immigrant status.

E note #30 Foster Care/AAP Specialized Care Rate

Reference: ACIN I-05-10

April 7, 2010

The attached ACIN, issued by the Department on April 6, 2010, provides a basic introduction to the specialized care rate systems in use in the state. The notice also

provides links to websites with additional information, as well as current contact people. Bert recommends looking at Question and Answer #10 which addresses the issue of out-of-county placement. The answer unequivocally states that the host county's methodology, criteria and rates apply.

E note #29a Refugee Medical Assistance and SB 87

Re: ACWDL 08-43 (September 24, 2008)

It has been brought to our attention that our paraphrased regulations do not accurately reflect current DHCS policy regarding Refugee Medical Assistance (RMA) and SB 87 procedures. Per the ACWDL, RMA is a special program and not considered a Medi-Cal program and thus, no SB 87 evaluation is required.

Our paraphrased regulations at 417-1A, 446-3 and 446-3A are incorrect and should not be used. We will correct the paraphrased regulations in our next update.

E note #29 Extension of QI-1 sunset date

Reference: ACWDL 09-11

The Qualified Individual Program (QI-1), which provides for the payment of Medicare Part B premiums for persons with income below 135% of the federal poverty level (or \$1219 for an individual/\$1640 for a couple, was due to expire on December 31, 2009. The program was extended again, with a new ending date of December 31, 2010. The current paraphrased regulation (433-4) is no longer up-to-date and will be corrected.

E note #28 Conlan II and IHSS/PCSP SOC

Re: ACIN I-03-10

January 21, 2010

The Conlan claims process was originally set up in order to reimburse Medi-Cal recipients for medically necessary services incurred and paid for out-of-pocket. However, the Conlan claims process is also available to IHSS recipients who are disputing an excess share of cost.

Specifically, if it is determined that the county computed an excess IHSS share of cost, and the recipient requests that the hearing decision orders the county to reimburse him/her for the excess share of cost already paid to a provider, we must dismiss that portion of the case and direct him/her to file a Conlan II claim for reimbursement. For those recipients who have not incurred an out of pocket excess share of cost -- i.e., the provider's paycheck has been reduced by the incorrect share of cost but the recipient has not yet paid it -- the recipient must first pay the share of cost and then file a Conlan claim to be reimbursed. This requirement might or might not change in the future.

When we dismiss a request for reimbursement of an excess IHSS share of cost, we direct the claimant to the DHCS Beneficiary Services Center at 916-403-2007 to request a Conlan II claim packet for IHSS. (See Paraphrased regulation 527-2)

E note #27 Federal Poverty Level for 2010

The FPL usually increases effective April 1 of each year. As of now, there is no proposed increase for 2010. Thus, we should continue to use the 2009 FPL for Medi-Cal programs.

We have not heard anything about an increase in the nursing home private patient rate. If there is, we will let you know.

E note #26 Expansion of the 250% Working Disabled Program

Welfare and Institutions Code Section 14007.9 (the 250% Program) was expanded by AB 1269 to include disabled persons who become unemployed, as well as Social Security recipients whose benefits are switched from Disability to Retirement. However, these provisions do not become effective until such time as federal stimulus money is no longer available. According to program, the provisions will not become effective until no earlier than 2011.

E note #25 Treatment of UIB Stimulus Money in the FS Program

Re: ACL 09-82
December 19, 2009

Effective November 2009, the \$25 per week UIB Stimulus payment is excluded from consideration as income in the FS program. This change is based upon a change in federal law. The ACL has just been issued, instructing counties to make this change retroactive to November.

This change does not affect the CalWORKS program; the \$25 is still income in this program.

E note #24 Expansion of CalWORKS restricted property exclusions

RE: ACL 09-75

November 23, 2009

CalWORKS property rules have been revised effective October 22, 2009 to allow for the exclusion and/or exemption of additional property. The \$5000 limit for excluded accounts has been removed. Additionally, deferred compensation accounts are exempted for both applicants and recipients; IRAs, 529 college savings plan, and Coverdell ESAs are exempt for recipients only.

Pursuant to 63-501.3(r), CalWORKS rules for restricted accounts are followed for FS, so the \$5000 limit is also removed for FS households. The retirement and student accounts are exempt

E note #23 Elimination of IHSS Buy Out Effective October 1, 2009

Re: ACL 09-47

The elimination of the IHSS Buy Out was implemented effective October 1, 2009 by ACL 0947 (September 16, 2009). Effective October 1, 2009, those services recipients with a Medi-Cal SOC in excess of the previously calculated IHSS SOC will now be responsible for payment of the full Medi-Cal SOC; the state will no longer be paying the difference between the two.

This ACL also provides instructions for implementation of the July 1 buy out change for those recipient who were potentially eligible for the buy out for the period July 1 through

September 30th but did not receive it because they were certified to the program after July 1 (but had an earlier effective date)

E note #22 Calculation of a Food Stamp overissuance occurring after 3/09

Reference: ACL 09 112
ACIN I 1158 1109

In ACL 09 112, counties were advised to calculate overissuances that occurred in April 2009 or later by using the October 2008 allotment tables. The intent was to disregard the portion of the benefits actually issued that represents the stimulus supplement.

This instruction has been rescinded by ACIN I 1158 1109. This ACIN advises that overissuances should be computed in accordance with usual overissuance computation rules. Overissuances are to be computed by using the allotment tables in effect at the time the overissuance occurred. The answer to Question #13 of the ACIN explains how this disregards the stimulus amount.

E Note #21 FS Gross Income Limits for Elderly and Disabled Households

August 4, 2009
RE: 63-1101.33

A few ALJs have expressed confusion about the applicability of the gross income tables for Elderly and Disabled Households found in 63-1101.33.

This income limit is only applicable to a very narrow group of households, as defined in 63-402.17. These are households consisting solely of members who are elderly and disabled who cannot prepare food separately from the others with whom they live because of their disabilities. They are entitled to be given separate household status, but the income of the people with whom they live must first be used to determine gross income eligibility based upon these tables. These tables reflect 165% of the federal poverty level.

There is no gross income limit for households with elderly and/or disabled members or for households consisting of elderly and/or disabled people who do purchase and prepare food separately from those with whom they live, or who live alone.

We will be adding a paraphrased regulation in the next package.

E note #20 July 1 Scope of Benefits changes

June 25, 2009

Included in this e-note are a link to the list of Medi-Cal service cuts effective July 1, implementation policies, and DHCS contact information for both claimants and providers.

(1) The following links you to the notification that was sent to beneficiaries regarding the cuts. It appears to be the most complete list as it explains such things as the deletion of psychology services, which does not include cuts to services through Mental Health.
http://www.dhcs.ca.gov/services/medical/Documents/Benefits/NoticeReduction_ENG_0509.pdf

(2) The cuts are being implemented along the same lines as Denti-Cal in that the TAR

has to be submitted by 6/30, even if approved through the state hearing process at a later date. The following is from DHCS:

If a TAR is approved before 7/1/09, example 5 visits, then the approved service will be covered/reimburse after June 30, 2009 to complete the remaining visits.

If a TAR is submitted prior 7/1/09, example 5 visits, but UMD-FO denied the TAR and the Medi-Cal recipient went to fair hearing and the judge reverses the UMD-FO decision and approved the requested service, then the service will be reimburse even if it is after June 30, 2009

If a TAR is approved before 7/1/09 example 5 visits and the Provider determined that additional 5 visits are needed to complete the treatment, then the additional five visits will still be approved as part of continuing care. Provider should follow how to bill for continuing care as outlined in the provider manual

If the treatment is completed let say R foot ulcer then the client develop another problem on the L foot which occurred after June 30, 2009, then it will no longer meet the continuing exemptions and the service is no longer covered.

(3) Beneficiaries can call the Beneficiary call center with questions: 1-888-284-0263.

This will be operational through September 30th.

Provider-related calls can be directed to 1-800-541-5555.

E note #19 Food Stamp Reg Group Error

There is an error in the current FS Reg Groups for Gross and Net Income maximums. These groups indicate that the limits changed effective April 2009 when they did not.

If you are using these groups for a current case, you should not check the box for g4/09 h. The gross and net income limits effective October 2008 remain in effect.

It will get fixed at some point.

E Note #18 Institutional Deeming in IHSS/IPW/PCSP

Reference: ACIN I-28-06 (Question and Answer 10)

ACL 00-83; MEPM 19D-12

Institutional deeming is a Medi-Cal waiver concept that applies to both children and spouses who live at home. As applied to children, institutional deeming means that the income and resources of a parent of a child under the age of 18 who is approved for a Departmental Development Services (DDS) waiver are waived for Medi-Cal purposes. The rationale for the waiver is that children living in their home should not be ineligible for Medi-Cal based on the parent's income or resources if the child would otherwise be institutionalized.

Institutional Deeming applies to the IHSS Plus Waiver (IPW) program. Thus under IPW, a parent may be the in-home services provider for his/her child and the income and resources of the parent are waived for eligibility and share of cost purposes. However, institutional deeming simply means that income and resource requirements are waived.

All other IHSS regulations still apply. This includes restrictions on when a parent can be

a provider such as when the parent is employed full-time.

Institutional Deeming also applies to PCSP; however, parents and spouses cannot provide services in this program.

Institutional Deeming does not apply to IHSS-Residual since this is not a Medi-Cal program.

E-note #17 Changes to the Denti-Cal Program

1. Title 22, CCR, Section 51307 was repealed effective December 1, 2007. So it should not be cited as authority in our decisions.

2. Most adult dental benefits will no longer be available effective July 1, 2009. Services will be available if a TAR is required and was submitted by June 30, 2009. If the hearing involves a TAR submitted by June 30th, it should be reviewed under the rules in effect as of that date; the fact that the TAR was acted upon or would be granted after June 30th is irrelevant.

More information about these changes, including information regarding what will still be covered, can be found at the following link:

http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_25_Number_22.pdf

It is anticipated that an ACWDL will be issued; in the interim, the bulletin can be cited as authority.

E-note #15: Medi-Cal Transfers of Property

4/28/09

The following paraphrased regulation was added to the Medi-Cal Pararegs in the last update. Although this procedure has been in effect since 1997, we were previously unaware of it. If an issue at hearing is a Medi-Cal transfer of property, the ALJ should not determine whether there is a period of ineligibility unless and until the county has sent the case to DHCS for its review. If there is a disqualifying transfer, the judge should remand the case to the county with the proper instructions

Please note that the current paraphrased regulation has the incorrect address; we will correct it soon to reflect the address included below.

Effective January 1, 1997, counties are instructed to gather all the necessary information as usual, determine whether or not the transfer was made on or after January 1, 1997 and whether or not it is potentially disqualifying in accordance with ACWDL No. 90-01, Section 50408 . 50411.5. If the transfer still appears to be a disqualifying transfer, counties shall complete the Medi-Cal 176 PI. If in completing the Medi-Cal 176 PI, any months remain for which a period of ineligibility would be imposed resulting in restricted services eligibility for the institutionalized individual, then the counties shall copy and send or fax all pertinent case record documentation to:

DHCS/MCED
1501 Capitol Avenue, Suite 71-4063, MS 4607
P. O. Box 997417
Sacramento, CA 95899-7417
Attn: Property Analyst

The county shall pend the case and shall NOT send a Notice of Action for restricted services eligibility to the institutionalized individual until the property analyst has completed the review of the case record documentation and determination. When the property analyst completes the review, counties will be notified whether or not the Notice of Action should be sent and if any modification in the imposed period is required. Only at that point shall counties issue Notices of Action granting restricted services or reducing services to restricted services for institutionalized individuals. (All County Welfare Director fs Letter 97-05, February 26, 1997)

E-note #14 Nonparty's Right to Hearing on Overpayment or Overissuance Issue

2/10/09

On occasion, the county will seek to recoup a CalWORKs overpayment or food stamp overissuance against other assistance unit or household members after the county first sent a Notice of Action (NOA) to the caretaker relative. The question is whether the other assistance unit or household member has a right to a hearing separate from the caretaker relative fs hearing rights. Three scenarios are discussed below.

If No Hearing Conducted

If the original NOA was only addressed to the caretaker relative and the caretaker relative did not request a hearing, the other AU or household member may have all

overpayment or overissuance issues reviewed if he/she filed a timely hearing request after receiving a NOA addressed to him/her. This is true regardless of whether the caretaker relative received the NOA or whether the NOA was adequate or languagecompliant.

Assume the county sent an adequate and language-compliant NOA in 2007 to a parent of an aided child demanding repayment of an alleged \$2000 CalWORKs overpayment from September 2005 through August 2006. It is established that the parent received the NOA. In 2009, the county sends a NOA to the aided child who is now 18 years old demanding repayment of the same \$2000 overpayment. He requests a hearing. If the 18 year old filed a timely hearing request after receiving the 2009 NOA, the 18-year old is entitled to a state hearing to dispute the amount and cause of the alleged overpayment and the county's right to recoup the overpayment. This could include an equitable estoppel issue.

If Hearing Conducted

The issue is somewhat different if the caretaker relative had a hearing on the \$2000 overpayment. In the example above, the 18-year old would still be entitled to a hearing regarding the recoupment of the overpayment even if the first judge had upheld the county's right to collect the overpayment against the caretaker relative. This could include an equitable estoppel issue.

The 18 year old may however be precluded from having the amount and cause of the overpayment or overissuance reviewed.

Courts now generally hold that a nonparty's claim is precluded by a prior suit based on a particular form of privity known as virtual representation. The virtual representation concept applies when the interests of a nonparty to the original case were adequately represented by a party to the original action.

Courts have held that identity of interests and adequate representation are necessary before the concept of virtual representation may be applied to preclude a nonparty to the first hearing from having a hearing right separate from the original party. In addition, there must be a showing that at least one of the following three factors is present:

There must be a close relationship between the nonparty and the original party
(This is likely to apply in the state hearing context)

There was substantial participation by the nonparty in the original hearing
(possible but unlikely in the state hearing context)

Tactical maneuvering on the part of the nonparty to avoid preclusion by the prior judgment (very unlikely in the state hearing context)

Thus in the rare instance where the county has received a decision on the merits upholding the right to collect an overpayment against a party such as a caretaker relative, the nonparty may be precluded from having a hearing on the amount and cause of the overpayment under the virtual representation form of privity, but the nonparty must be given an opportunity to demonstrate that virtual representation does not apply.

If Hearing Scheduled but Not Conducted

If the claimant in the original action fails to attend the scheduled hearing and a dismissal decision is issued, there has been no decision on the merits. The concept of virtual representation is a privity concept and it will not preclude a nonparty from exercising hearing rights on all issues when the original party failed to attend the hearing. Furthermore, there clearly was not adequate representation at the non-appearance hearing. Thus, the 18-year old can ask for review of all issues related to the overpayment.

E note #13

2/10/09

Decisions Involving Demand for Repayment of CalWORKs Overpayment from Non-Aided Caretaker Relative

MPP 44-352.31 and .33 establish that the county may not demand repayment of an overpayment from a non-aided caretaker relative. Nonetheless, counties often make the mistake of demanding repayment of a CalWORKs overpayment from a non-aided caretaker relative. (Note that the county may demand repayment from an excluded member of the food stamp household.)

When writing a decision in a case involving a demand for repayment from the non-aided caretaker relative-claimant, the judge should ask the claimant whether (s)he is disputing the determination of the overpayment or just the county's demand for repayment. If the claimant is disputing both issues, the judge must decide both issues on the merits. If the claimant is disputing only the county's right to demand repayment and not the overpayment itself, the judge needs only to decide that issue and rule that the county may not demand repayment. (If at the hearing the judge can see that an overpayment was incorrectly determined and is adverse to the claimant, he/she should advise the parties that the overpayment was incorrectly determined and add the overpayment determination as an issue if the claimant then wishes to add this issue.) Sometimes a claimant (or authorized representative on behalf of a claimant) will seek to have the judge decide whether the county may recoup the overpayment from the remainder of the assistance unit even though it is stipulated that the county may not recoup against the non-aided caretaker relative. The claimant or authorized representative may claim that the county is equitably estopped from recouping the overpayment from other family members.

Unless the county has taken a separate action to attempt to recoup the overpayment from the other assistance unit member(s), the judge should dismiss such a claim because there is no pending action against the other family members. The other family member(s) would have the right to request a hearing if and when the county seeks to recoup the overpayment from any of them. An equitable estoppel argument would be appropriate at that time.

E note #12 State Hearing Jurisdiction and Good Cause

2/10/09

RE: ACIN I-66-08

Effective January 1, 2008, a judge can find a hearing request timely even though it was filed more than 90 days from the receipt of an adequate, language-compliant notice of action if the judge finds good cause for the late filing. The filing must be made within

180 days of the notice.

The implementing ACIN was adopted November 19, 2008 and can be cited in any decision where good cause for late filing is an issue. The regulations themselves have not been amended. There are some technical errors in the ACIN; it is not known when a corrected version will be issued.

Good cause is also an issue if a claimant files a new hearing request after previously abandoning a hearing on the same issue. A discussion of how to address this issue at hearing is contained in Notes from the Training Bureau 07-11-2, Questions 5 and 6. The change in treatment of these requests was effective January 24, 2007.

E note #11 ACL and ACIN Website

1/13/09

The Department has established a website for researching old ACLs and ACINs. This may be an invaluable tool for us and initial impressions are that it is user friendly. I am forwarding a copy of the email that was sent out last week; I recommend adding the web link as a shortcut to your desktop

From: Help Desk@DSS

Sent: Wednesday, January 07, 2009 3:24 PM

To: Outlook CDSS

Cc: Help Desk@DSS; Customer Support Bureau Staff

Subject: Enterprise Management Systems (DMS)

JANUARY 7, 2009, 2009

TO: All Staff

FROM: INFORMATION SYSTEMS DIVISION - DSSnet HELP DESK

SUBJECT: Enterprise Management Systems (DMS)

For several months, Information Systems Division and Administration Division have been working together to launch phase one of the Department's Document Management System (DMS) which is accessible from our Intranet under "Enterprise Document Search" or from the search page located on the following link:
<http://internalweb.dss.ca.gov/SearchCenter/Pages/default.aspx>

Phase one of the DMS is a simple storage and search enterprise document repository for researching historical documents for policy development and other purposes that currently includes:

- . All County Letters (1974 thru September 2008)
- . County Fiscal Letters (1989 thru September 2008)
- . All County Information Notices (1999 thru September 2008)
- . Subvention Binders (1986 thru September 2008)

Plans are underway to include historical or policy documents for other divisions. For assistance, or to suggest process improvements, email Internet.support@dss.ca.gov or contact the DSSNet Help Desk at (916) 323-4464.

E note #10 Mandatory proposed decisions

12/8/08

We are seeing an increase in the number of final decisions that should actually be submitted as proposed decisions, especially DHCS cases. Attached to this e-mail is a chart of all the decisions that must be sent as proposed. This list can also be found on the delegation document as well as in Reginfo in the decision-writing program; the Reginfo list needs to be updated as it is missing one mandatory issue (FC cases where the request is more than one year from the NOA)

E-note #9: Abandonment Hearing Procedures

12/7/08

Reference: MPP Section 22-054.22

Notes from the Training Bureau 07-11-2, Question 6
Effective January 2007, the regulations for resolving hearing requests that have previously been dismissed as abandoned were amended.

Prior to that time, ALJS were instructed to dismiss these hearing requests and remand them to the rehearing unit as the new request was considered a request for rehearing.

This is no longer the procedure to be followed as the request is considered a request for a new hearing and not a request for rehearing.

Claimants are instructed on the dismissal cover that they have 15 days from the date the decision was received in which to request a new hearing and that they must establish good cause for not having appeared. If the hearing is then scheduled, the judge hears the substantive issue without needing to review good cause. However, situations occur where the claimant instead files a new hearing request, which is scheduled to be heard without this process having been followed.

If the hearing request is scheduled, the ALJ is to hear the case. If the new filing is within 15 days of the date of the original hearing decision, the judge must decide whether or not there was good cause for the initial non-appearance. If there is good cause, the judge should then hear the substantive issue.

If the hearing request is not within 15 days of the date of the decision, the judge must decide first if there is good cause for the late filing and then if there is good cause for the initial non-appearance. If there is dual good cause, the substantive issue must then be reviewed.

The regulation specifically provides that the failure to receive the hearing notice because of a move is not good cause if the claimant failed to notify the county or state department of the move.

Additional instructions can be found in Training Notes 07-11-2

E note #8 Suspension of SSI/SSP cost-of-living raise

11/20/08

RE: ACWDL 08 j40

Due to the state financial woes, the 2008 SSP cost of living increase was suspended. Thus, the couple rate remains at \$1524 for the remainder of the year, contrary to information previously issued by DHCS. This has specific implications for A&DFPL couple determinations which use the SSI/SSP rate if it is higher than the FPL rate.

The link to the ACWDL, which includes corrected charts, is:
http://www.dhcs.ca.gov/services/medi_cal/eligibility/Documents/c08_140.pdf

E-note #7 A&DFPL eligibility for one spouse

11/5/08

Reference: ACWDL 02-38 (Parareg 438-8); attachment to ACWDL 00-57
ACWDL 02-38 specifically states that if a couple is not financially eligible for A&DFPL, one member of the couple can be found eligible; however, the letter does not set forth instructions as to how to determine financial eligibility for this spouse. The only instructions are contained in the attachment to ACWDL 00-57.

The following methodology should be used if the couple is not eligible as a couple, or only one member of the couple meets A&DFPL linkage requirements. The combined net nonexempt income of the couple is computed, allowing any disregards and deductions. The spouse to be excluded is then allowed the \$600 Medi-Cal maintenance need to meet his/her needs. The remaining income is then compared to the program limit for an individual (\$230 plus FPL for one). If the net non-exempt income is less than this figure, that person can receive Medi-Cal under the A&DFPL program.

This computation will currently benefit those couples with net non-exempt no greater than \$1697 (\$600 plus current program limit of \$1097 for one). Please note that if both spouses could be eligible for the program as both are either aged and/or disabled, it is the beneficiary's option as to who gets to take advantage of this provision. Also, if there are additional members of the MFBU, the amount of the exclusion increases to reflect a larger maintenance need.

E note #6 Exemptions from Managed Care

11/3/08

County Operated Health Systems (COHS) are Medi-Cal managed care plans that operate via contract with the California Department of Health Care Services (CDHCS) to be the sole provider of Medi-Cal in the county. The nine COHS Counties are Monterey, Napa, Orange, San Mateo, San Luis Obispo, Santa Barbara, Santa Cruz, Solano and Yolo.

In the counties that have COHS systems, all Medi-Cal recipients must receive Medi-Cal through the COHS and all Medi-Cal providers in the county are COHS providers. Unlike in Two-plan model counties or Geographic Managed Care (GMC) counties, there is no provision for a person in a COHS county to be exempted from receiving Medi-Cal in the COHS plan in order to receive Medi-Cal on a fee-for-service basis.

If a Medi-Cal recipient in a COHS county is unable to receive a particular needed Medi-Cal covered service from any COHS provider in the county, then the COHS plan would be required to make a referral for treatment out of the county.

Please remember that all decisions involving managed health plans, irrespective of substantive issue, must be proposed decisions.

E note #5 Changes to Medi-Cal Buy in

10/31/08

Effective December 1, 2008, the state is no longer paying the Medicare Part B premiums for Medi-Cal recipients with an SOC in excess of \$500. Recipients are receiving letters from Social Security advising of the change in income. Attached are copies of ACWDL 08-48 and 08-48E, as well as a sample Social Security Administration letter.

Once the state is no longer paying the premium, the cost becomes a Medi-Cal deduction if the beneficiary chooses to continue paying the premium. This will result in some beneficiaries becoming eligible to A&DFPL, and a SOC below \$500. Payment of the premium is an allowable deduction in computing the Medi-Cal SOC.

We do not yet know how this will impact our hearings but we will keep you posted.

E note #4 Hourly Maximums for IHSS/IPW/PCSP

9/5/08

Reference: Pararegs 567-13, 563-3B, 612-5

This e-note is a reminder to judges that the 195/283 hourly maximums have different application in the three in home services programs.

The non-severely impaired/severely impaired differentiation applies to the IHSS-R and IHSS plus waiver (IPW) programs. Thus, a services recipient under either of these programs can only receive more than 195 hours per month if he/she is found to be severely impaired. The issue usually arises in a protective supervision case, although it can arise in other fact patterns. A parent provider for a child is an IPW case.

This distinction does not exist in PCSP. A recipient under this program can receive any number of hours up to 283 per month. Thus, a recipient of protective supervision can receive 195 hours of protective supervision plus the hours needed in other services areas.

E note #2 Language Compliant Notices in Medi-Cal

9/5/08

The following is the DCHS response to our question about their current policy on language-compliance and Medi-Cal notices. Please see ACWDL 08-32 for Department's position effective 10/1/08:

Recently, CDSS has had a large workload translating forms and NOAs into the threshold languages. To date, DHCS has not had the resources available to translate all NOAs, however the DHCS is committed to translating new NOAs prior to release and translate existing NOAs have yet to be translated once the final NOA policy is formulated.

In the past month, DHCS issued ACWDL 08-32 with instructions to send the multilingual flyer with all NOAs to advise applicants / beneficiaries of free interpretation services. DHCS plans to distribute another ACWDL that will further document DHCS requirements for providing language assistance and translated materials.

As our policy is currently being drafted and has not yet been approved, we do not know whether it will fully mirror CDSS's regulations. Therefore, we cannot advise the ALJs to follow CDSS regulations for Medi-Cal in regards to 22-001 (I) (1) Language-Compliant Notice.

E note #1 Working Disabled Program

8/28/08

In many Medi-Cal SOC hearings, ALJs and/or the county representatives mention the possibility of obtaining Medi-Cal at a reduced SOC through the 250% Working Disabled program. We just want to remind staff that in order to qualify for this program, the beneficiary must be otherwise eligible for SSI/SSP, without regard to SGA. This can be a significant stumbling block for beneficiaries who are receiving Social Security retirement benefits. Although they can be evaluated for disability through the DDSD process, their retirement benefits are not exempt from the income determination and thus, they are unlikely to be financially eligible to receive SSI/SSP. If they will be financially ineligible anyway, the disability evaluation serves no purpose. An explanation of the 250% Working Disabled Program eligibility determination can be found in ACWDL 00-16.