State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

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TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Health Executives
All County Mental Health Directors
All CalWORKs Program Managers

Letter No.: 02-59

QUESTIONS AND ANSWERS – MEDI-CAL ELIGIBILITY DETERMINATION PROCESS AND MEDI-CAL REQUEST FOR INFORMATION FORM (MC 355)

Ref: All County Welfare Directors Letter (ACWDL) Nos. 01-36 and 01-39

This ACWDL gives clarification and answers to county questions regarding Senate Bill (SB) 87 implementation. SB 87 requires the county to follow a specific process when redetermining a beneficiary's continued Medi-Cal eligibility.

The SB 87 process consists of three steps. The county must follow each step until the beneficiary's continued Medi-Cal eligibility or ineligibility is accurately redetermined. The county is not permitted to substitute any step of this process with another county process or procedure.

STEP ONE
Ex Parte Review. The county evaluates all available information to establish continued Medi-Cal eligibility. If the county cannot establish continued Medi-Cal eligibility after the ex parte review, the county is required to complete Step Two.

STEP TWO
Direct Contact. The county contacts the beneficiary via telephone to request information not available during the ex parte review. The county should inform the beneficiary that their Medi-Cal eligibility is being redetermined and more information is needed to confirm continued eligibility. The county should further inform the beneficiary that their continued eligibility can be established under various avenues of eligibility including an allegation of disability.

If the telephone contact with the beneficiary cannot establish continued Medi-Cal eligibility and all avenues of eligibility have been exhausted (including the

allegation of disability), then Step Three is not required. *If telephone contact with the beneficiary is not possible, then Step Three must be completed.*

STEP THREE
Forwarding Of The Request For Information Form (MC 355). The county shall complete and send the MC 355 form to the beneficiary seeking information to establish continued Medi-Cal eligibility after the ex parte review and telephone contact have been unsuccessful.

Questions and answers are grouped into the following topics listed below:

A. EX PARTE REVIEW AND REDETERMINATION PROCESS

The first step in the SB 87 process is the ex parte review. Ex parte means without beneficiary contact. This review involves county evaluation of all resources available to the county to make a Medi-Cal eligibility redetermination.

Resources available to the county include the beneficiary's and/or their immediate family members' case files (e.g. Food Stamps, General Relief/Assistance, Foster Care, IHSS, CalWORKs, Medi-Cal, etc.). Acceptable information/verification is also available through other resources, wherever feasible that are readily available to the county, such as IEVS and EDD/SDI. All case files used for information/verification should be open and current or not closed for more than 45 days.

Counties will not require beneficiaries to provide information/verification not relevant to ongoing eligibility or already on file with the county and not subject to change, such as but not limited to date of birth, social security number or United States citizenship. Because ex parte is defined as "without beneficiary contact", the SB 87 table enclosed with ACWDL 01-36 (Discontinued CalWORKs Reasons – Ex Parte/Aid Code 3N/Aid Code 38) was formatted incorrectly and has been revised and renamed (see Enclosure).

Question A-1:

When is it necessary to obtain the MC 13 and MC 219 for discontinued CalWORKs cases going through the ex parte process?

Answer A-1:

A completed and signed SAWS 2 application form used by the CalWORKs program contains necessary information for beneficiary's citizenship status, as well as a rights and responsibilities statement. Once these cases have been transitioned into a Medi-Cal-Only case, the requirement continues to apply that the beneficiary complete a MC 13 only when there is a change in citizenship status. The MC 219 would be mailed at the next annual Medi-Cal redetermination (RV).

Question A-2:

For ex parte, can counties use information contained in General Assistance and Food Stamp case files, or is it limited to information contained in the discontinued CalWORKs case file only?

Answer A-2:

Ex parte is not limited to only information/verification contained in the discontinued CalWORKs case file. Ex parte is the use of any and all information/verification available to the county. This includes all public assistance/public benefit case files (e.g., Food Stamp, General Relief/Assistance, Foster Care, IHSS), as well as other resources, wherever feasible, that are readily available to the county, such as IEVS and EDD/SDI.

B. CALWORKS DISCONTINUANCES

SB 87 mandates continued Section 1931(b) Medi-Cal-Only eligibility for discontinued CalWORKs beneficiaries except in circumstances which indicate ineligibility (e.g., death, out-of-state residency).

Question B-1:

Can discontinued CalWORKs beneficiaries whose Section 1931(b) Medi-Cal-Only eligibility **is not** affected transition into Aid Code 38 before placement into Aid Code 3N?

Answer B-1:

Yes. However, these beneficiaries must transition into Aid Code 3N as soon as possible, with the transition being transparent to the beneficiary and without any interruption in benefits and with no additional forms to be completed.

Discontinued CalWORKs cases where Section 1931(b) Medi-Cal-Only eligibility ***is*** *affected (e.g. income increase, failure to complete the CalWORKs RV, loss of contact/whereabouts unknown) require an immediate review for continued Medi-Cal-Only benefits and timely transition into appropriate Medi-Cal-Only programs (e.g. TMC, AFDC-MN, ABD, etc.), if otherwise eligible. SB 87 replaces the Edwards vs. Myers court case (Procedure Manual 4O), however Aid Code 38 continues to be used as a transitional aid code.*

Question B-2:

How is the CalWORKs sanction for non-cooperation with District Attorney Family Support (DAFS) to be treated? Do these cases go into an Aid Code 38 or 3N and are the individuals given an opportunity to cooperate with DAFS when Section 1931(b) Medi-Cal-Only is being determined?

Answer B-2:

A CalWORKs sanction for failure to cooperate results in a 25 percent grant reduction. However, the Custodial Parent must still cooperate in medical support enforcement. If he or she does not, the Custodial Parent, AND NOT THE CHILDREN OR PREGNANT WOMEN UP TO 60 DAYS POST PARTUM, is to be denied or discontinued from Medi-Cal. Since Medi-Cal is delinked from CalWORKs, if the Custodial Parent does not cooperate with CalWORKs, he or she shall be given one more opportunity to cooperate with medical support requirements for receipt of Medi-Cal benefits. If the Custodial Parent does not cooperate with medical support requirements and does not demonstrate good cause for failure to cooperate, the Custodial Parent is denied or discontinued from Medi-Cal. The SB 87 table has been revised to reflect this situation, please see ACWDL 02-37 for further clarification.

Question B-3:

ACWDL 01-36 states that Welfare-to-Work (WTW) sanctioned beneficiaries are Section 1931(b) Medi-Cal-Only eligible. Does this also apply for beneficiaries

sanctioned due to immunization requirements, school attendance, fleeing felons, drug felons, IPV (Intentional Program Violator) and non-cooperation with SFIS (Statewide Fingerprint Imaging System)?

Answer B-3:

Yes. Sanctions for these reasons stem from CalWORKs requirements and not Medi-Cal-Only requirements. Therefore, these beneficiaries are also eligible for Section 1931(b) Medi-Cal-Only benefits.

Question B-4:

What termination reason codes will trigger Aid Code 38 on MEDS and are there going to be any new MEDS termination reason codes that trigger Aid Code 38?

Answer B-4:

Please see the MEDS Quick Reference Guide for details on MEDS termination reason codes. With the implementation of ACWDL 01-36 current MEDS termination reason code 098 (whereabouts unknown) has been revised to generate Aid Code 38 for beneficiaries who lose cash aid due to loss of contact/whereabouts unknown. MEDS termination reason code 098 is for use by the CalWORKs program only. Medi-Cal-Only programs must use new MEDS termination reason code 089 for discontinuance of benefits under whereabouts unknown/loss of contact (see answer C-1).

Question B-5:

Do we begin the SB 87 process (ex parte review, direct contact and forwarding of the MC 355) with CalWORKs cases discontinued as of June 30, 2001, or with cases discontinued after July 1, 2001?

Answer B-5:

The SB 87 process is to be completed on cases discontinued on or after July 1, 2001.

Question B-6:

Will beneficiaries get a Notice of Action (NOA) informing them of their transfer from CalWORKs linked Medi-Cal into Aid Code 38 and then another notice when they transfer from Aid Code 38 to 3N or whichever Medi-Cal-Only program they are transferred into?

Answer B-6:

Yes. Effective July 1, 2001, beneficiaries discontinued from CalWORKs who remain eligible for Medi-Cal under Section 1931(b) provisions must receive new Notice of Action MC 349: Continuation of Section 1931(b) Benefits. For discontinued CalWORKs beneficiaries not eligible for Medi-Cal under Section 1931(b) provisions but who remain eligible under another Medi-Cal program, a NOA with the name of the program they have been transferred to and a description of that program must be issued. Please see ACWDLs 01-17, 01-33, 01-53, 02-02 and 02-19 for the notice of action changes required by SB 87.

Question B-7:

If a CalWORKs case is discontinued for an incomplete status report, does the case transfer directly into Aid Code 38 or 3N?

Answer B-7:

Failure to complete a CalWORKs income report or failure to provide an income report does not necessarily signify a change in circumstances affecting Section 1931(b) Medi-Cal-Only eligibility. If CalWORKs is discontinued for failure to provide an income report, Medi-Cal eligibility is not affected, no redetermination is necessary, and the case shall be converted into Aid Code 3N. If, however, the beneficiary submits an incomplete income report which has enough information to reflect a change in circumstances affecting Section 1931(b) Medi-Cal-Only eligibility, then it is more appropriate to transition the case into Aid Code 38 for a complete and accurate Medi-Cal-Only eligibility redetermination.

Question B-8:

For a two-parent CalWORKs case, if one parent leaves the home, do we transition the absent parent into Aid Code 38 or discontinue Medi-Cal for the absent-parent?

Answer B-8:

The parent leaving the home must transition into Aid Code 38 for a continued Medi-Cal-Only eligibility redetermination, unless the county has facts that clearly demonstrate the absent parent cannot be eligible for continued Medi-Cal benefits (e.g. death, change in state residency); then Medi-Cal is discontinued.

Question B-9:

DHS has released ACWDLs 01-17, 01-33 and 01-53 describing new NOAs because of SB 87. Has CDSS issued any ACWDLs to staff describing SB 87 language mandated to be on CalWORKs discontinuance NOAs?

Answer B-9:

CDSS issued All County Information Notice (ACIN) I-08-02 on January 28, 2002, describing changes mandated by SB 87 for CalWORKs notices and forms.

C. MEDI-CAL-ONLY CASES

The Medi-Cal beneficiary must remain in his/her existing aid code and continue to receive Medi-Cal benefits during a redetermination of eligibility.

Question C-1:

Is the new MEDS termination reason code 089 ("whereabouts unknown") used for all Medi-Cal-Only cases or only for discontinued CalWORKs cases that transition into Aid Code 38?

Answer C-1:

The new MEDS termination reason code 089 applies to all discontinued Medi-Cal-Only cases and is not specific to Aid Code 38.

Question C-2:

What aid code does the 18 year old child who is not enrolled in school and expected to graduate by age 19 and who is discontinued from CalWORKs transition into?

Answer C-2:

Aid Code 38. An "adult" child who is no longer eligible for CalWORKs due to age is not eligible for Section 1931(b). The "no longer in school" requirement only applies to Section 1931(b). The child's eligibility for other programs is determined while the child is in Aid Code 38. If there is no eligibility for any other zero Share-of-Cost (SOC) Medi-Cal program, evaluate him or her for the Continuous Eligibility for Children (CEC) program (see ACWDLs 01-01, 01-40 and 02-1).

Question C-3:

How should SB 87 be coordinated with the Healthy Families Bridging program?

Answer C-3:

Per ACWDL 99-06, the purpose of the Bridging program is to provide an extra month of zero SOC Medi-Cal for children between age 1 and 19, who would otherwise have a SOC (without consideration of property eligibility), in the month immediately following a period of zero SOC Medi-Cal, and who would be eligible for the Healthy Families Program. For SB 87, counties must continue to allow children to receive zero SOC in this "bridging month" while the family is provided with Healthy Families enrollment information. (Please see ACWDL 01-57).

D. DISABILITY DETERMINATIONS – NEW AID CODES

Allegation of a disability when there is no other basis for eligibility.
New aid codes are assigned to beneficiaries who lose non-disability–related Medi-Cal and who at the time of discontinuance allege a disability and no other basis for eligibility exists. Please see ACWDL 02-40 (Processing Disability Evaluations Under SB 87) for further information about these aid codes:

New aid codes

6J (full-scope Medi-Cal benefits with no SOC)
6R (full-scope Medi-Cal benefits with a SOC)
5J (restricted Medi-Cal benefits only with no SOC)
5R (restricted Medi-Cal benefits only with a SOC)

These new aid codes are transitional aid codes only and are to be used when the potential basis for eligibility is (the allegation of) disability. When State Programs-Disability Adult Program Division (SP-DAPD) certifies the beneficiary is disabled, counties shall transfer the beneficiary into a qualified disability aid code and continue eligibility. However, if SP-DAPD denies the disability claim, counties shall discontinue the beneficiary with timely notice. All avenues of eligibility must be explored before discontinuance.

Allegation of disability but eligibility continues under a current Medi-Cal program. The beneficiary may allege a disability while currently receiving Medi-Cal benefits through a non-disability-related aid code (e.g., 34, 3N). The beneficiary remains in his or her existing aid code and the county forwards a disability packet to SP-DAPD for a decision. During the interim, the county must act upon any change to the beneficiary's current Medi-Cal case file (e.g. increase or decrease to a SOC, ICT, etc.). When SP-DAPD approves the disability claim, counties shall narrate in the current case file there is a certified disability or transfer the beneficiary into the appropriate disability aid code. However, when SP-DAPD denies the disability claim, the beneficiary (if otherwise eligible) remains in his or her current aid code for continued Medi-Cal benefits.

Question D-1:

Are counties to use the aged, blind and disabled (ABD) income deductions for new Aid Codes 6J, 6R, 5J and 5R?

Answer D-1:

No. The disability is merely alleged and not yet confirmed. Only after SP-DAPD determines the beneficiary is disabled will the ABD income deductions be allowed (counties must retroactively apply these ABD deductions back to the date of the disability determination if the beneficiary or any other active member on the case record has been disadvantaged by lack of these deductions).

Question D-2:

We have many concerns about beneficiaries who state in writing that they are disabled when they may have a broken arm or leg. Are we to roll these beneficiaries into new Aid Code 6J, 6R, 5J or 5R and await a disability decision?

Answer D-2:

Yes. However, Aid Codes 6J, 6R, 5J and 5R are only appropriate when the beneficiary is being discontinued and no other basis of eligibility exists.

NOTE: Counties must continue to follow Procedure Manual 22 C-1 when making any disability referral to SSA or SP-DAPD. Counties are encouraged to explain the definition of a disability to the beneficiary (i.e., a medical condition that has lasted or is expected to last 12 months or more and prevents the individual from working), however counties are not to influence the beneficiary's decision to pursue or not pursue Medi-Cal linkage as a disabled individual.

Question D-3:

When a beneficiary alleges a disability and is being discontinued because no other basis for eligibility exists, does the county automatically transfer the beneficiary into the new Aid Codes 6J, 6R, 5J or 5R and forward the disability packet to SSA or SP-DAPD?

Answer D-3:

Yes, the beneficiary must be transferred into Aid Code 6J, 6R, 5J or 5R. However, once the county receives the completed disability packet from the beneficiary, the county must follow the disability packet referral procedures outlined in Procedure Manual 22 C-1 before forwarding any disability packet to SSA or SP-DAPD.

Question D-4:

When a beneficiary who is being discontinued alleges a disability and has a SOC, do we make a new SOC determination if there is a maintenance need level change?

Answer D-4:

Yes. Current regulations requiring evaluation of MFBU and SOC determination due to a change in the maintenance need level have not changed; therefore, the county must determine whether there is creation of a SOC or an increase/decrease to a current SOC in this situation. Additionally, the

requirement to apply any change as soon as administratively possible with timely notice has not changed with implementation of SB 87.

Question D-5:

How long can a beneficiary remain in Aid Codes 6J, 6R, 5J or 5R?

Answer D-5:

Whenever the beneficiary is transferred into these new aid codes, he or she shall immediately be given a disability packet and be required to return the completed packet to the county within appropriate timeframes.

- *When the disability packet is not returned by the beneficiary within appropriate timeframes, the county shall discontinue the beneficiary with adequate and timely notice, if all eligibility is exhausted.*

- *When the disability packet is returned timely by the beneficiary, the county must forward the packet to SP-DAPD and the beneficiary remains in Aid Code 6J, 6R, 5J or 5R until a decision is rendered by SP-DAPD.*

E. CHILDREN IN FOSTER CARE

Children in Foster Care are eligible to continue their Medi-Cal coverage until their 21st birthday under the Former Foster Care Child Program for 18 to 21 year olds. Former foster children incarcerated, undocumented, in a residential treatment center or moved out of state are not eligible for this program. Please refer to ACWDLs 00-41 and 00-61.

Question E-1:

Can the MC 210 RV be used in place of the MC 210 E (obsolete July 1, 2001)?

Answer E-1:

Yes. The MC 210 RV must be used in place of the MC 210 E; however, it is not completed until the annual Medi-Cal RV is due. Foster Care cases transitioning into Section 1931(b) Medi-Cal-Only are treated the same as CalWORKs

discontinuance cases transitioning into Section 1931(b) Medi-Cal-Only. (See ACWDL 01-36 page 2 ' CalWORKs Discontinuances' and page 5 'Aid Code 38').

Question E-2:

When a child in Foster Care has left the foster home (runaway) and his or her whereabouts are unknown or there is a loss of contact, are they placed into Aid Code 38 or are they discontinued from Medi-Cal?

Answer E-2:

If a child's whereabouts are unknown the county should keep or place the child into Aid Code 38 and follow the SB 87 process to determine continued Medi-Cal eligibility.

NOTE: Whenever a child under age 19 loses Foster Care eligibility and does not qualify under the Former Foster Care Children Program (see ACWDLs 00-41 and 00-61) CEC is applicable. Therefore, the county must transition the Foster Care child to the CEC program after being terminated from the Foster Care program without requiring a new application (follow the ex parte process outlined in ACWDL 01-36). The child is entitled to CEC until the next annual Medi-Cal RV, which shall be 12 months from the last Foster Care program redetermination (see ACWDLs 01-01, 01-40 and 02-14).

F. MC 355 - REQUEST FOR INFORMATION FORM

Question F-1:

If the Statement of Facts at initial application is incomplete or more information is needed, can the new Request for Information form (MC 355) be used to obtain the missing information? If it is used in the initial application process, what timeframes are to be allowed?

Answer F-1:

Yes. Although the MC 355 was developed in response to SB 87 implementation, counties are not prohibited from using this form during the initial application process for the gathering of information not provided at the initial application. However, the county is not to use the MC 355 as an initial application.

Timeframes for the approval or denial of the initial application continue to be 45 days or 90 days (for SP-DAPD decisions) regardless if the county uses the MC 355 or another request for information form. Current initial application policy outlined in ACWDL 90-07 requiring the eligibility worker to make two contacts with the applicant and allowing 10 calendar days to respond prior to any action to deny the application is still valid and does not change whether or not the county uses the MC 355.

Question F-2:

ACWDL 01-36 stipulates that the eligibility worker is to send the Request for Information form (MC 355) when ex parte review and telephone contact are unsuccessful in making the redetermination. However, there is no instruction that the eligibility worker is to send the MC 355 if a determination can be made after the ex parte review and telephone contact. In this situation does the eligibility worker still send the MC 355 to the beneficiary? If yes, then is the form sent without any information/verification being requested? Or should the eligibility worker mark the *OTHER* box and enter a general statement like, "any new information that you feel would make you qualify for continued Medi-Cal benefits?"

Answer F-2:

There is no need to forward the MC 355 if the beneficiary's eligibility or ineligibility can be determined from the ex parte review and telephone contact.

The eligibility worker will at least have to contact the beneficiary by telephone to make a determination of ineligibility because up-to-date information such as pregnancy, alleged disability or any other relevant information will not necessarily be on file. If the eligibility worker conducts a thorough interview by telephone, including asking for "any other information" and determines that the beneficiary is not eligible for Medi-Cal-Only benefits, there is no need to send the MC 355. If the eligibility worker does not get all the necessary information from the telephone contact or is unable to make telephone contact, then the MC 355 must be sent to the beneficiary. Whenever the MC 355 is sent to the beneficiary it must be very clear and specific about providing any information that has not already been provided to the county and could be used to establish continued Medi-Cal eligibility. This could include a general request for "any other information" if that question has not been previously asked.

Question F-3:

Per ACWDLs 90-07 and 97-48 counties are required to make two contacts with the applicant/beneficiary prior to taking an action to deny or discontinue a case. The two contacts must be documented in the case file with the date, method of contact and the result of each contact. Does the SB 87 process replace the two contact requirements outlined in ACWDLs 90-07 and 97-48?

Answer F-3:

*SB 87 applies to Medi-Cal **beneficiaries** only, therefore, the SB 87 process replaces the requirements of ACWDLs 90-07 and 97-48 for beneficiaries and not applicants.*

Question F-4:

When a Medically Needy case is being discontinued because the only child in the case is turning 21 years old, is the MC 355 form supposed to be sent to the parent, the child or both?

Answer F-4:

If county staff are unable to determine eligibility or ineligibility through the ex parte and telephone contact, then the MC 355 must be sent to the head of household and the adult child.

Question F-5:

When a beneficiary is under 21 years old, on his or her own case as an adult and is turning 21 years old and losing linkage, is the MC 355 form supposed to be sent to him or her.

Answer F-5:

Only when the county is unable to determine eligibility or ineligibility through the ex parte and telephone contact then the MC 355 must be forwarded.

Question F-6:

Are counties required to send a notice when the discontinued beneficiary provides requested information/verification within 30 days after his or her discontinuance from Medi-Cal, even though the county determines that the information/verification provided is not adequate or incomplete?

Answer F-6:

Although a notice of action is not required, counties must inform the former Medi-Cal beneficiary (via the telephone or written correspondence) that the information/verification was not sufficient to rescind their discontinued Medi-Cal case. Counties must narrate this action in the case file.

Question F-7:

Are the counties allowed to modify the MC 355 so that the only information being requested prints on the back (request side) instead of the full page of listed items that don't need to be requested? Clients find it very confusing when things they are not being asked to provide are also listed on request forms even when they are not checked.

Answer F-7:

SB 87 mandates specific information about the Medi-Cal program be made available to the beneficiary via a cover letter (front side of MC 355) whenever the county requests information from the beneficiary to complete a Medi-Cal eligibility redetermination. Only the information needed to complete the redetermination may be requested. In addition, the beneficiary must be allowed 20 days to provide the requested information. The MC 355 was created by DHS with county and consumer advocate input as required by SB 87.

Counties may choose to modify the MC 355 to meet their particular county processes; however, the specific mandated language required by SB 87 must be on any county revision to the MC 355. Counties must also continue to abide by the mandated timeframes. Counties are reminded that SB 87 mandates only information/verification needed to complete the Medi-Cal eligibility redetermination be requested. Information/verification currently on file with the county that is not subject to change cannot be requested from the beneficiary.

Question F-8:

Is the Spanish translation of the MC 355 available in the DHS warehouse?

Answer F-8:

Yes.

Effective implementation of SB 87 requirements are crucial to continued benefits for Medi-Cal beneficiaries. The Department remains committed to providing counties with complete and accurate instructions to meet this goal. The Department hopes that this ACWDL provides clarification to many of the concerns counties have encountered while implementing SB 87 through ACWDLs 01-36 and 01-39.

If you have any questions or concerns regarding this ACWDL you may contact Mack Guynn at (916) 657-1064 or via e-mail at *mguynn@dhs.ca.gov*.

Sincerely,

ORIGINAL SIGNED BY

Beth Fife, Chief
Medi-Cal Eligibility Branch

Enclosure (SB 87 Table)

Aid Code Placement for CalWORKs Discontinuance
SB 87 TABLE
REVISED NOVEMBER 2002

REASON FOR CALWORKS DISCONTINUANCE*	ELIGIBLE AID CODE 3N PLACEMENT	REQUIRED AID CODE 38 PLACEMENT
Loss of California residency	No	No
Written request to discontinue CalWORKs and Medi-Cal	No	No
Incarceration	No	No
Death of beneficiary	No	No
Transition into another PA program that provides Medi- Cal benefits	No	No
Failure to cooperate with child/medical support requirements (applies to custodial parent or caretaker relative only and not children or pregnant women up to 60 days post partum)	No	No
Failure to provide monthly income report	Yes	No
Non-cooperation with Welfare-to-Work requirements	Yes	No
Expiration of CalWORKs time limits	Yes	No
Failure to complete the CalWORKs annual Redetermination	No	Yes
Loss of contact/whereabouts unknown	No	Yes
Only eligible child leaves home	No	Yes
Change in household composition that has resulted in non-cooperation with the evidence gathering requirements for the AU	No	Yes
Change in household circumstances that affect Medi-Cal eligibility	No	Yes
Resources exceeds limits	No	Yes
Income exceeds standards	No	Yes

*Counties are encouraged to contact DHS for further guidance on other discontinued CalWORKs reasons when uncertain as to what action is necessary.