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TO: ALL COUNTY WELFARE DIRECTORS Letter No: 19-13
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY MEDS LIAISONS
ALL CONSORTIA PROJECT MANAGERS

SUBJECT: NON-COMPLIANCE WITH MEDI-CAL ELIGIBILITY REQUIREMENTS
(Reference: Welfare & Institutions Code § 14005.37 and 14011.2; Title 22 California Code of Regulations § 50168, 50185, 50186, 50187, 50763, 50771, and 50777; All County Welfare Directors Letters 05-08, 08-07, 13-12, 14-18, 14-22, 15-26, 15-27, 16-04, 16-24, 17-32, Medi-Cal Eligibility Division Information Letter 16-04)

PURPOSE

The purpose of the All County Welfare Directors Letter (ACWDL) is to inform counties of California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) change request (CR) 119408 Non-Compliance Reasons and provide counties with guidance on the following eligibility requirements that certain Medi-Cal applicants and beneficiaries must comply with:

- The requirement to apply for or accept unconditionally available income;
- The requirement to apply for Medicare;
- The requirement to provide information about other health insurance;
- The requirement to provide Veteran's information;
- The requirement to provide information about third party liabilities;
- The requirement to apply for or provide a Social Security number (SSN).

Additionally, this ACWDL will provide guidance on required county actions when Medi-Cal applicants and beneficiaries fail to comply with these requirements (Non-Compliance). This ACWDL is not inclusive of all eligibility requirements for the Medi-Cal program and is only intended to provide updated guidance on the requirements listed above. More information on the requirement to comply with medical support enforcement will be released in an upcoming ACWDL.

CR 119408 NON-COMPLIANCE REASONS

CR 119408 Non-Compliance Reasons is intended to provide counties the ability to send more detailed denial and discontinuance reasons to the CalHEERS, and to allow the Statewide Automated Welfare System (SAWS) to automate notices on behalf of county eligibility workers (CEWs). Currently, counties must send a generic reason of failure to cooperate with the application or redetermination process to CalHEERS, using the long-term negative action process, to deny or discontinue individuals for failing to comply with the requirements outlined in this ACWDL. Additionally, CEWs are required to manually create notices of action (NOAs) to deny or discontinue individuals for failing to comply with the requirements outlined in this ACWDL.

Once CR 119408 is released, CEWs will be able to utilize SAWS to send specific denial or discontinuance reasons to CalHEERS for non-compliance with the requirements outlined below:

- The requirement to apply for or accept unconditionally available income;
- The requirement to apply for Medicare;
- The requirement to provide information about other health insurance;
- The requirement to provide Veteran’s information;
- The requirement to provide information about third party liabilities;
- The requirement to apply for or provide a Social Security number;
- The requirement to comply with medical support enforcement.

Additionally, the NOAs with the appropriate denial or discontinuance reason will be automatically generated by SAWS. CR 119408 is expected to be released in June 2019 (R 19.6). Counties should reach out to their SAWS representative for specific questions regarding how the functionality will work within their SAWS.

MEDI-CAL APPLICANT/BENEFICIARY REQUIREMENTS

For each of the requirements outlined below, approval of eligibility may not be delayed if the individual is otherwise eligible for Medi-Cal. This means that for a new applicant or a beneficiary renewing Medi-Cal eligibility, if the only item(s) pending is one or more of the requirements outlined in this ACWDL, eligibility must be approved pending the outcome of compliance with the requirement.

Requirement to Apply for or Accept Unconditionally Available Income

In accordance with Title 22, California Code of Regulations (CCR), Section 50186, Medi-Cal applicants and beneficiaries shall, as a condition of eligibility, take all actions necessary to obtain unconditionally available income (UAI). This includes applying for the income and providing the information requested by the agency making the UAI determination. Income is considered unconditionally available if the applicant or beneficiary only has to claim or accept the income. Examples of UAI include:

- Unemployment Insurance benefits (UIB) through the Employment Development Department (EDD),
- Disability Insurance Benefits, including Retirement, Survivors, Disability Insurance benefits and state disability insurance through EDD or the Social Security Administration (SSA),
- Social Security Old Age, Survivors and Disability Insurance benefits through the SSA once an individual has reached full retirement age, and
- Benefits available to U.S. military veterans through the U.S. Department of Veterans' Affairs (VA).

Public assistance benefits, including cash assistance programs, are not considered UAI. All applicants/beneficiaries that provide information indicating they may be potentially eligible for UAI (e.g. claiming they recently lost their job or are a U.S. Veteran) must be referred to apply for it. However, the following individuals must not be referred to EDD to apply for UIB:

- Individuals who have not worked in employment covered by UIB;
- Individuals who have a UIB claim pending;
- Individuals who are receiving or have exhausted their UIB;
- Individuals who are receiving disability insurance benefits;
- Individuals who are full-time employed;
- Individuals denied or discontinued from the UIB program;
- Children under 16 years of age with no employment history;
- Applicants who are not applying for full-scope Medi-Cal benefits.

With the implementation of the Affordable Care Act (ACA), the Centers for Medicare and Medicaid Services provided states with guidance on March 23, 2012, through the Final Rule on Eligibility Changes under the ACA. The Final Rule states that Medi-Cal eligibility shall not be delayed while waiting for an applicant to provide proof of the application for or acceptance of UAI. This means that an applicant who is otherwise eligible for Medi-Cal must be made eligible pending the outcome of the UAI application. Information regarding the county process for obtaining this information from the

applicant or beneficiary is provided below in the **REQUIRED COUNTY ACTIONS** section of this letter.

Requirement to Apply for Medicare

In accordance with Title 22, CCR, Sections 50763(a)(1) and 50777, Medi-Cal applicants and beneficiaries must, as a condition of eligibility, apply for any other available health coverage, including Medicare, if they qualify for it and when no cost is involved. Counties shall inform applicants and beneficiaries of their requirement to apply for Medicare if they are either citizens of the United States or are aliens legally present in the United States for at least five years, in accordance with Title 22, CCR, Section 50775, and meet at least one of the following conditions:

- Applicants and beneficiaries who are 64 and 9 months of age;
- Applicants and beneficiaries in the month they turn 65;
- Applicants and beneficiaries who are over 65 and it is past their initial enrollment period. An individual's initial enrollment period for Medicare is a total of seven months: three months prior to their 65th birthday, the month of their 65th birthday, and the three months after their 65th birthday. The county shall inform the individual that they are required to apply during the next Medicare open enrollment period which occurs annually from January 1 through March 31, with benefits effective July 1.
- Applicants and beneficiaries who are eligible for Medicare prior to turning age 65. This includes:

  - Individuals applying on the basis of disability, including blindness, unless the county can obtain verification of receipt of Social Security title II disability payments. For those receiving Social Security title II disability payments, Medicare enrollment is automatic beginning with the 25th month of receipt of this benefit and application for Medicare is not required.
  - Individuals applying for the dialysis special treatment program, or individuals that the county is aware are receiving dialysis-related health care services, unless the county can obtain verification of receipt of Medicare Part A benefits. For individuals in need of dialysis who are enrolled in Medicare Part A, Medicare Part B enrollment is deemed to be automatic and application is not required.

Under Title 22, CCR, Section 50168 and 50777, Medi-Cal applicants and beneficiaries have 60 days from the date they are notified of the need to apply for Medicare to provide proof of their Medicare approval or denial. If an applicant or beneficiary does not receive their Medicare approval or denial within 60 days, they are required to provide to

the county the proof of approval or denial of Medicare within 10 days of receiving it from SSA. This means that if an individual informs the county that they have not yet received their approval or denial during the 60-day period, counties must allow the individual additional time to obtain it. Counties may determine their own best practices for following up with the individual after a reasonable amount of time to determine if the individual has received the approval or denial or is not responding to the county.

An applicant who is required to apply for Medicare and who is otherwise eligible for Medi-Cal must be made eligible pending the outcome of the requirement to apply for Medicare. Information regarding the county process for obtaining this information from the applicant or beneficiary is provided below in the **REQUIRED COUNTY ACTIONS** section of this letter.

Requirement to Provide Information about Other Health Coverage (OHC)

In accordance with Title 22, CCR, Sections 50185 and 50763, Medi-Cal applicants and beneficiaries must, as a condition of eligibility:

- report to the county on the availability of OHC at the time of application, reapplication, or redetermination; and
- report to the county any change in the availability of OHC no later than 10 calendar days from the date the beneficiary was notified of the change by the employer or insurer.

The Department of Health Care Services (DHCS) currently receives OHC data from health insurance carriers, the Department of Child Support Services, the SSA, California Children's Services, and other automated systems through a data matching process. The entities that share OHC data with DHCS are referred to as Current Trading Partners and the OHC information they share is stored in the individual's Medi-Cal Eligibility Data System (MEDS) record.

According to ACWDL 13-12, counties must only add OHC records to MEDS when:

- The applicant or beneficiary provides information that the OHC they have is not on the list of Current Trading Partners found at http://dhcs.ca.gov/OHC.
- The applicant or beneficiary has OHC that is not showing in MEDS and wants their OHC added to their record.

As a result of the data matching process, counties shall not request additional OHC information from applicants and beneficiaries unless the applicant or beneficiary:

- Informs the county they have OHC that is not on the list of Current Trading Partners and/or not on MEDS; and
- Does not initially provide enough information for counties to add the OHC to the MEDS record.

Additionally, the county is not required to obtain OHC information when reporting the OHC could endanger an applicant or beneficiary or create a barrier to care, such as when:

- A child is in foster care or removed from the home, pending evaluation of foster care status;
- A child is in an Adoption Assistance Program or Kin-GAP aid code;
- An applicant or beneficiary is a victim of domestic violence or human trafficking;
- Medical support is being enforced by the local child support agency;
- The OHC is limited to a specific geographic service area and the applicant or beneficiary lives outside that area; or
- The OHC requires use of specified provider(s) and the beneficiary lives more than 60 miles or 60 minutes travel time from the specified provider(s).

Additional information about the circumstances under which the county is not required to obtain, and the applicant or beneficiary is not required to provide, the OHC information, the circumstances under which the county should request removal of OHC, and the process for updating OHC information in MEDS can be found in ACWDL 13-12. An applicant who is required to provide information about OHC and who is otherwise eligible for Medi-Cal must be made eligible pending the outcome of the requirement to provide information about OHC. Information regarding the county process for obtaining this information from the applicant or beneficiary is provided below in the **REQUIRED COUNTY ACTIONS** section of this letter.

Requirement to Provide Veteran's Information

In accordance with Title 22, CCR, Sections 50185 and 50763, Medi-Cal applicants and beneficiaries must, as a condition of eligibility, apply for and/or retain OHC when there is no premium cost to the applicant or beneficiary, such as insurance available to veterans of U.S. military service or their dependents. Additionally, as mentioned in the *"Requirement to Apply for or Accept Unconditionally Available Income"* section above, applicants and beneficiaries must, as a condition of eligibility, take all actions necessary to obtain UAI such as benefits available to veterans of U.S. military service or their spouses/dependents. Applicants and beneficiaries who indicate they are U.S. military veterans, or the spouses/dependents of U.S. military veterans, are required to apply for veteran benefits available through the VA.

An applicant who is required to apply for veteran benefits and who is otherwise eligible for Medi-Cal must be made eligible pending the outcome of the requirement to apply for veteran benefits. For more information about the referral process to the County Veterans Service Offices (CVSO) for U.S. military veterans, please see ACWDL 16-04 and ACWDL 05-08. Information regarding the county process for obtaining this information from the applicant or beneficiary is provided below in the **REQUIRED COUNTY ACTIONS** section of this letter.

Requirement to Provide Information about Third Party Liabilities

In accordance with Title 22, CCR, Section 50771, Medi-Cal applicants and beneficiaries must, as a condition of eligibility:

- report to the county on services received as the result of an accident or injury;
- furnish DHCS with an assignment of rights to receive payment for those services, if those services will be billed to Medi-Cal.

Applicants and beneficiaries who indicate they have a lawsuit due to injury or accident are required to cooperate with the county in obtaining the information regarding third party liabilities. Online forms used to report information to DHCS may be found here. An applicant who is required to cooperate with the county in obtaining the information regarding third party liabilities, and who is otherwise eligible for Medi-Cal, must be made eligible pending the outcome of the requirement to cooperate. Information regarding the county process for obtaining this information from the applicant or beneficiary is provided below in the **REQUIRED COUNTY ACTIONS** section of this letter.

Requirement to Apply for or Provide a Social Security Number

In accordance with Title 22, CCR, Sections 50168 and 50187, and Welfare and Institutions (W&I) Code, Section 14011.2, Medi-Cal applicants and beneficiaries must, as a condition of eligibility, apply for and provide a SSN, if:

- they are requesting or already have Medi-Cal benefits; and
- they declare they are a citizen or national of the United States, or that they have satisfactory immigration status.

An applicant or beneficiary does not have to provide an SSN if they have not declared that they are a citizen or national of the United States, or if they have not declared that they have satisfactory immigration status. Additionally, a deemed infant who was born to an individual covered by Medi-Cal in the month of delivery is eligible for Medi-Cal even if the SSN of the infant has not been provided. According to the Medi-Cal Eligibility

Procedures Manual, Section 5H, the mother should be informed of the need to provide an SSN for the infant by the age of one year.

Applicants and beneficiaries that are required to provide an SSN, other than deemed infants, have 60 days from the date of Medi-Cal application to provide proof of their SSN or application for SSN. Additionally, once an SSN provided by an applicant or beneficiary has been verified, the applicant/beneficiary shall not be required to provide the SSN again, even if they are transferring to or applying in a new county. An applicant who is required to provide an SSN or proof of application for an SSN and who is otherwise eligible for Medi-Cal must be made eligible for full-scope Medi-Cal benefits pending the outcome of the requirement to provide the SSN or proof of application for the SSN. Information regarding the county process for obtaining this information from the applicant or beneficiary is provided below in the **REQUIRED COUNTY ACTIONS** section of this letter.

REQUIRED COUNTY ACTIONS

Application Process

When it is determined that a Modified Adjusted Gross Income (MAGI) or Non-MAGI applicant must comply with any of the eligibility requirements described in this ACWDL, the county must request compliance during the course of the Second Contact application process (see ACWDL 08-07) **only when** other items of verification or information are also needed to confirm Medi-Cal eligibility. Additionally, the county must only deny an application for failure to provide after the Second Contact process has ended if other items of verification or information are also needed to confirm Medi-Cal eligibility. Once an applicant has complied with all other eligibility requirements, eligibility may not be delayed pending the outcome of the request to comply with the requirements outlined in this ACWDL. This means that if all other eligibility requirements are met after either the first or second contact, the application would be dispositioned and eligibility granted pending the outcome of the request to comply with the requirements outlined in this ACWDL. The requirement to not delay eligibility also applies to:

- a new application that is received for an individual who was previously denied or discontinued from Medi-Cal for non-compliance with any of the requirements in this ACWDL, regardless of whether it is during the 90-Day Cure Period; and
- a new application that is received for an individual who was previously denied or discontinued from Medi-Cal for non-compliance with any of the requirements in this ACWDL, who is requesting retroactive coverage; and

- an individual referred from Covered California to the county in Carry Forward Status (CFS) who was previously denied or discontinued from Medi-Cal for non-compliance with any of the requirements in this ACWDL. Per ACWDL 17-07, CFS referrals are to be treated as new applications.

Additionally, only the individual who fails to comply with the requirements outlined in this ACWDL would be denied. Other household members would have their eligibility determined. As a reminder, Title 22 of the CCR, Section 50185(d) requires that counties assist the applicant or beneficiary as necessary in complying with requests to gather information required in the application process or in the determination of continuing eligibility.

Example 1: An individual applies for Medi-Cal. The applicant reports on the application that they recently lost their job. The county notes that the individual is not included on the list of those who should not be referred to apply for unemployment benefits. The county runs eligibility, all information electronically verifies, and as there are no pending items other than the need to apply for UAI in the form of unemployment benefits, the individual is determined eligible for MAGI Medi-Cal. The county sends the approval NOA. As the individual is now a beneficiary, the county informs the individual of the need to apply for unemployment benefits following the process outlined in the Beneficiary Process section below.

Example 2: A MAGI applicant has pending eligibility due to income that is not reasonably compatible. The applicant has indicated they are a U.S. military veteran. The county follows the Second Contact process to request income verification and inform the applicant of their need to comply with the CVSO in applying for veteran benefits. The county sends the completed Military Verification and Referral Form MC 05 to the CVSO. After the required two contacts, each providing a minimum of 10 days to return the requested information, the applicant does not provide income verification and the county has confirmed with the CVSO that the applicant has not cooperated with applying for veteran benefits. The county sends a denial NOA informing the applicant of the specific verification and information that was not received, in accordance with ACWDL 15-26. The NOA informs the applicant that both income verification and proof of application for veteran benefits were not provided.

Example 3: A Non-MAGI applicant has pending eligibility due to income and property verification that is needed. The applicant has indicated they are involved in a lawsuit due to injury or accident. The county follows the Second Contact

process and requests income verification, property verification and third party liability information, providing a minimum of 10 days to return the requested information for each request. After the first contact, the applicant provides the income and property verification and is found eligible for Non-MAGI Medi-Cal. Eligibility is approved and the county sends the approval NOA. Once the individual becomes a beneficiary, the county informs the individual of the need to provide information about third party liability following the process outlined in the Beneficiary Process section below.

Example 4: An individual applies for Medi-Cal and the county determines the individual was previously discontinued from Medi-Cal for failing to apply for UAI. The county runs eligibility, all information electronically verifies and the individual is determined eligible for MAGI Medi-Cal. The county sends the approval NOA. Once the individual becomes a beneficiary, the county informs the individual of the need to apply for UAI following the process outlined in the Beneficiary Process section below. This example is correct regardless of whether the individual is within the 90-day cure period or whether the individual requests retroactive coverage.

Example 5: The county receives a referral from Covered California for an individual in CFS as a result of reported decrease in income that has been electronically verified. The county determines the individual was previously discontinued from Medi-Cal as a result of a failure to apply for veteran benefits. As the individual's eligibility has been determined and they are not required to comply with any requirement other than the need to apply for veteran benefits, the county accepts the Medi-Cal eligibility, lifts the CFS flag and sends the approval NOA. Once the individual becomes a beneficiary, the county informs the individual of the need to cooperate with the CVSO in providing information for veteran benefits following the process outlined in the Beneficiary Process section below.

Beneficiary Process

When it is determined that a MAGI or Non-MAGI beneficiary must comply with any of the requirements described in this ACWDL, the county must request compliance following the change in circumstance redetermination process requirements outlined in W&I Code, Section 14005.37 and ACWDL 14-18 by completing the following steps:

- Complete an ex parte review using all available sources as required by W&I Code, Section 14005.37. This includes information from case files, including

California Work Opportunity and Responsibility to Kids and CalFresh case files, of the beneficiary or of any of his or her immediate family members that are open, or closed in the last 90 days, to determine if the individual has already complied with the requirement.

- Only after the county eligibility worker conducts an ex parte review and is unable to verify compliance, send out a Medi-Cal Request for Information form (MC 355) informing the individual of the need to comply with the requirement.
- Allow 30 days* for the beneficiary to respond. *Note that as described above, proof of application for SSN and Medicare have different timeframes to respond (see examples #5 and #7 below).
- Follow up with the client through their preferred method of communication within the 30-day period if the information is not received.

If a beneficiary fails to provide the proof needed to show that the requirement was met within the required timeframe, the county must take action to discontinue the individual and send a 10-day discontinuance NOA that includes the 90-day cure period language. The NOA must include the specific information or verification that was not provided in accordance with ACWDLs 17-32 and 15-27. Note that if a beneficiary informs the county that an application has been made to comply with the requirement, and the delay is a result of the entity making the decision, the beneficiary shall not be discontinued pending the outcome of the decision. Counties may determine their own best practices for following up with the individual after a reasonable amount of time to determine if the individual has received the approval or denial or is not responding to the county.

Additionally, only the individual who fails to comply with the requirements outlined in this ACWDL would be discontinued. Other household members would remain covered, if otherwise eligible. As a reminder, Title 22 of the CCR, Section 50185(d) requires that counties assist the applicant or beneficiary as necessary in complying with requests to gather information required in the application process or in the determination of continuing eligibility.

Example 6: A Non-MAGI beneficiary with no Share-of-Cost will turn 65 on November 1, 2019. On August 1, 2019, the beneficiary is aged 64 and 9 months and is required to apply for Medicare as the Medicare will be at no cost. The county does an ex parte review and confirms there is no proof of approval or denial of Medicare in existing case files. The county sends the MC 355 on August 1, 2019 informing the beneficiary they must apply for Medicare and provides a due date of September 30, 2019. The county follows up with one additional contact during the 60 day time period. As of September 30, 2019, the beneficiary has not provided proof of approval or denial from Medicare and has not informed the county they are still waiting

for the outcome of their application for Medicare. The county sends a discontinuance NOA informing the beneficiary that they did not provide proof of application for Medicare and providing a 90-day cure period.

Example 7: A MAGI beneficiary reports that they have recently lost their job. The county determines the beneficiary is not included in the list of those who should not be referred to apply for unemployment benefits. The county does an ex parte review, including a review of the Income Eligibility Verification System and EDD real-time information to see if there is a new or current UIB claim, and confirms there is no proof of existing benefits or a new application for UIB in existing case files. The county sends the MC 355 informing the beneficiary they must apply for UIB and provides 30 days to provide the proof. The county follows up with one additional contact during the 30 day time period. Prior to the end of the 30 day time period, the beneficiary provides proof that they have applied for UIB and the amount of UIB received. The county reruns eligibility, determines the beneficiary is still eligible for MAGI Medi-Cal, and resets the annual renewal date in accordance with ACWDL 14-22. The county sends a NOA informing the individual of their ongoing Medi-Cal eligibility.

90-Day Cure Period

In accordance with W&I Code, Section 14005.37, an individual that is discontinued from Medi-Cal as a result of a failure to provide information or verification needed to confirm ongoing eligibility during a change in circumstance or annual renewal process must be provided with a 90-day cure period. If the individual provides the needed information during the 90-day cure period and the beneficiary is found eligible, the discontinuance shall be rescinded and eligibility shall be restored as though the information or verification was provided timely. As a result, any time a beneficiary is discontinued for failing to comply with the requirements in this ACWDL, the NOA must provide the individual with the 90-day cure period language provided in Medi-Cal Eligibility Division Information Letter 16-04 and ACWDL 16-24. Additionally, if the discontinued individual provides proof to the county that they have complied with the requirement within the 90-day cure period, the county must reevaluate eligibility and restore coverage to the date of discontinuance if otherwise eligible. As a reminder, counties should ensure that the good cause regulations are followed if a beneficiary presents proof outside of the 90-day cure period with good cause for not providing timely information.

Example 8: An individual applies for Medi-Cal for herself and her son on August 15, 2019, and the SSN is not electronically verified for either the mom or the son. Using the Second Contact process, the county requests that the

applicant provide proof of the SSN for mom and son, citizenship/identification for both mom and son, and income verification for mom, providing a minimum of 10 days to return the requested information for each request. After the first request, the mom provides proof of the mom's SSN, both mom and son's citizenship/identification, and mom's income. As everything has been provided except for proof of the son's SSN, the county runs eligibility for both the mom and the son. On August 27, 2019, the mom is found eligible and the son is provided with conditional eligibility during the time needed to obtain proof of his SSN. The county sends the approval NOA for both mom and son.

As the son is now a beneficiary, the county promptly follows up on the need to provide the SSN by doing an ex parte review and confirming that proof of SSN has not been provided for the son. The county sends the MC 355 informing the mom that they must provide proof of the son's SSN. However, as described above, the SSN or proof of application for SSN must be provided within 60 days of the date of application. Therefore, the MC 355 would provide a due date of October 14, 2019. The county follows up with one additional contact. As of October 14, 2019, the mom has not provided proof of the son's SSN. The county sends a discontinuance NOA effective October 31, 2019, for the son, which explains that they did not provide proof of the son's SSN and provides a 90-day cure period. In December 2019, the mom provides the county with proof of the son's SSN. The county runs eligibility, determines the son is eligible for Medi-Cal and restores the son's eligibility back to the date of discontinuance. The county sends a NOA explaining that the son's eligibility is approved back to the date of discontinuance.

Example 9: A beneficiary is discontinued from Medi-Cal because of their failure to apply for UAI. The NOA informs the individual of their right to a 90-day cure period. Four months later the individual submits a new application that includes proof of their application for UAI. The individual does not request retroactive coverage. The county runs eligibility and the individual is determined to be eligible for Medi-Cal. The county sends a NOA explaining that eligibility is approved as of the month of application. Note that if the individual did request retroactive coverage and was otherwise eligible, the retroactive months would be approved regardless of whether the individual was previously discontinued for failing to apply for UAI.

If you have any questions or if we can provide further information, please contact Alison Brown by phone at (916) 345-8078 or by email at Alison.Brown@dhcs.ca.gov.

Original Signed By

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