STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
7[illegible]44 P STREET
[illegible]MENTO, CA 95814
([illegible]6) 445-1912

September 29, 1988

TO: All County Welfare Directors
All County Administrative Officers

Letter No.: 88-76

SUBJECT: REESE V. KIZER RETROACTIVE CLAIMING

REFERENCE: ACWDL 85-53, 85-78, 86-47, and 88-50

The purpose of this letter is to provide counties with retroactive claiming instructions pursuant to the Reese v. Kizer settlement. Instructions for case identification, case monitoring and other administrative functions are contained in the body of this letter. Procedures and forms for the actual claiming process are attached.

I. BACKGROUND

In 1983 legislation (AB 1667) was enacted which required recognition of the community property division of income when one spouse is in long term care (LTC) and the other spouse resides at home, if federally permissible. That law was not implemented at the time because the Department of Health and Human Services (DHHS) had indicated that such a division conflicted with federal law.

Reese v. Kizer (Alameda Superior Court) was initiated because AB 1667 had not been implemented. On April 29, 1985 a preliminary injunction was issued ordering the Department to implement a portion of the law. The Department filed an appeal which automatically stayed the injunction. Pending the appeal decision, the Department entered into a stipulated agreement with the plaintiffs in which partial implementation was agreed to (see All County Welfare Directors Letter No. 85-53). With the passage of AB 987 (1985) state law changed to require that all current and future LTC share of cost cases be computed using the community property division of income rule (ACWD Letter 85-78). AB 987 differed from AB 1667 in that it required the Department to implement its provisions pending a final determination of consistency with federal law in the courts. In March 1986 the plaintiffs in Reese moved for summary judgment in Alameda Superior Court, seeking payment of retroactive relief for those who had been adversely affected by the Department's decision to not implement AB 1667 from its effective date (January 1, 1984) until the enactment of AB 987 in 1985. In May 1986 the trial court granted the motion and in August 1986 the court ordered the Department to implement a plan for the provision of retroactive relief agreed to by the plaintiffs and the Department. The Department appealed both of these orders.

(Department of Health Services (DHS) v. DHSS (9th Circuit, 1987)). The Department prevailed in that action and the Ninth Circuit Court found that the State law did not conflict with federal law. On December 24, 1987 the Ninth

Circuit denied the federal agency's petition for rehearing. The ninety day period in which the federal agency could petition the U.S. Supreme Court for review expired on March 24, 1988 with no petition filed. As a result, a final judicial decision binding on the federal government with respect to this issue now exists.

II. CURRENT STATUS

As a result of the ninth circuit ruling the Department entered into an agreement with the plaintiffs in Reese to provide the retroactive relief ordered by the trial court. Therefore, a claim procedure for retroactive Reese cases has been prepared and is now ready for implementation by the county.

Please note that activity on the Reese case continues in the State Supreme Court. While the issue does not affect counties, it is of significant value to all State agencies. The Department desires a State Supreme Court ruling setting forth a State department's responsibilities where a state statute provides that the provisions of the statute may only be implemented where there is no conflict with federal law. Such a ruling may help to avoid future retroactive litigation such as Reese.

III. COUNTY OF RESPONSIBILITY

In order to preclude the possibility of having to process more than one claim for any given beneficiary, only one county will be responsible for any beneficiary's claim regardless of the number of counties that handled the case during the retroactive period. For the purpose of claim processing, the claim will be the responsibility of the current county of responsibility for current beneficiaries or the last county to have the case for persons no longer receiving Medi-Cal. Where a beneficiary has resided in more than one county during the claim period, the last county of residence or current county will be required to process the entire claim using copies of the records from prior counties. In the majority of cases the county processing the claim will already have copies of all necessary materials due to the requirements of the inter-county transfer regulations. However, where there has been a break in aid or where a new application was taken for other reasons, the county processing the claim will be required to obtain the necessary documents from any prior counties the beneficiary may have resided in.

In order to facilitate claims processing as well as ensure that all pertinent case records were preserved, a revised listing of potential claims was sent to the counties in ACWDL 88-50.

This revised Listing #2 sorted cases by Social Security Number (SSN) and identified all case numbers for the same person together in the last county

to have responsibility for the case. The purpose of this list was to provide each county with a complete list of all potential claims to be reviewed by that county as well as a list of case records in other counties. This would permit each county to identify exactly which cases to review and which counties to contact to obtain copies of earlier case information necessary to process the claim.

Example: Jon Doe entered LTC in Alameda county in April, 1984. He remained there until January 15, 1985 when he moved to another facility in Los Angeles county. The case was transferred to Los Angeles county at that time.

The revised listing for this case would appear as follows:

Listing #2 -

Los Angeles Listing -

Jon Doe	19-13-0000000010	000-00-0008
	01-13-0000000001	

As a result, while Alameda is not responsible for processing the claim, it must preserve the case record should information be needed to process the claim by Los Angeles. Los Angeles who is responsible for the claim will be aware of the Alameda case and case number via the revised listing. If the Los Angeles file does not contain the inter-county transfer material and/or sufficient information to process the claim, Alameda must be contacted to obtain the missing material.

IV. DETERMINATION OF CLAIM AND CLAIM PROCESSING

Upon identification of all potential Reese claims, the county shall determine the community property division of income in accordance with the attached procedures within the timeframes noted. Where community property division of income is not appropriate (for instance, the spouse at home had more community income than the spouse in LTC) the county shall note the result of this review for each case name and SSN. The county may note this information on the revised Listing #2 released in ACWDL 88-50 dated July 7, 1988 or may maintain a separate listing of such determinations. The county shall report the total cases reviewed to DHS by the 10th of the month following the review month using Monitoring Form #2. Where the case meets the community property division of income requirements, the county shall determine the share of cost and claim amount as described in the attached procedures.

V. TREATMENT OF RETROACTIVE PAYMENTS

For the purposes of Medi-Cal eligibility, retroactive payments made in accordance with this procedure are not to be considered income or resources for six months following the date the beneficiary receives the payment. Transfers of these payments are not to be considered subject to the transfer of assets rule if the transfer occurs within that six month period. The beneficiary will be notified of the six month exemption by DHS in a NOA at the time of reimbursement.

After six months, any retroactive claim funds remaining shall be considered countable personal property.

VI. MONITORING AND REPORTING REQUIREMENTS

A. For each case determined to be a potential retro-Reese claim, the county must keep a log noting the following information. A sample log format has been attached. The county may use this form or develop its own form providing all the following information is included:

1. The date of each personal contact, whether initiated by the county or the beneficiary, along with a brief description of that contact as well as any action resulting from that communication.

2. A record of each request for information which must include the date of the request and a description of the information requested. Copies of all written information requests must be retained in the case file and must clearly indicate the date the request was sent.

3. The date on which the requested information was received. Where the information is received piecemeal, each piece of information and the date it was received must be recorded. Copies of all information received must be retained in the case file.

4. The date records were requested from other counties (where applicable) as well as the date such records were received.

5. Copies of all notices sent including the date of the original notification on closed cases, and a record of the dates.

6. Any returned notices and a record of the date returned.

7. The date the claim form was completed.

8. The date the beneficiary indicated to the county a choice of cash reimbursement or future share of cost adjustment.

9. The date the county computed the future share of cost adjustment (if applicable).

10. The date the county forwarded the claim to DHS (where applicable).

These logs shall be maintained in the case files and must be available for review by State Corrective Action staff. Further, should problems arise, these logs may be requested by and must be sent to DHS for review.

B. The county shall report the following information for each month where cases are reviewed by the 10th of the following month using monitoring form #2:

1. The number of closed cases where the Notice was returned and no other address or individual could be located as discussed in ACWD Letter 88-50.

2. The number of closed cases where no response was received as discussed in ACWD Letter 88-50.

3. The number of cases determined to be eligible for reimbursement.

   a. The number of cases who elect a future share of cost adjustment.

   b. The number of claimants requesting cash reimbursement.

4. The number of cases not processed within 210 days of the date of this letter.

   a. The number of cases where good cause existed (verification not received despite claimant's attempts to cooperate, etc.).

   b. The number of cases where a $100 payment was required as described in VII below.

C. For each claim where cash is requested or a future share of cost is adjustment made, the county worker shall complete the claimant monitoring sheet (Monitoring Form #3) which shall contain the following information:

1. The <u>case</u> name. The name of the Medi-Cal beneficiary shall be entered regardless of the name of the individual or entity acting on the beneficiary's behalf or receiving the check.

2. The case SSN and County identification number.

3. The date the determination of the amount of payment was completed.

4. The date the beneficiary was sent the notice informing him/her or his/her representative of the payment options.

5. The date the notice was received back from the beneficiary/representative noting the option.

6. Whether the county's activities were completed within the 210 days and whether good cause was found.

VII. TIME REQUIREMENTS AND DEADLINES

All claims must be processed within 210 days of the date of this letter unless good cause exists. Good cause shall be determined using the criteria set forth in Title 22, California Code of Regulations, Section 50175 (c) 2 through 6. Good cause shall not include lack of county staff or problems attributable to county administration of these procedures.

Where the county fails to process a claim within the specified time limits and no good cause exists, the county shall, in accordance with the Reese order, issue payment to the claimant in the amount of $100. This penalty payment shall be issued to the beneficiary, the spouse, or the estate of the beneficiary.

In order to avoid payment of the $100 penalty, the county must document that good cause existed for failure to process the claim timely. The case file must carefully document all contact attempts made by the county as well as any delay resulting from the claimant's actions or inability to act or any other information which establishes good cause.

If you have any questions, please contact Toni Bailey at (916) 324-4967.

Sincerely,

Original signed by

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

REESE V. KIZER

CASE MONITORING FORM NUMBER 2

County: Month

I. Number of Cases Not Meeting *Reese* Income Criteria A + B (from Monitoring Form Number 1): _____ (A + B + C + D)

A. Total Cases With No Community Property Income: _____

B. Total Cases Where At-Home Spouse Has More Income Which is Community Property: _____

C. Total Non-LTC Cases: _____

D. Other: *(Attach explanation for each case.)* _____

II. Number of Closed Cases with No Response: _____ (A + B)

A. Total Cases Where Notices Returned by Post Office as Undeliverable: _____

B. Total Cases with No Response to Contact Attempts: _____

III. Number of Cases Where Claim Found Payable: _____ (A + B + C + D)

A. Total Claims with Future Share of Cost Adjustment Requested: _____

B. Total Cases with Automatic Future Share of Cost Adjustment Due to No Response (open case): _____

C. Total Claims with Cash Payment Requested: _____

D. Total Closed Cases Where Reimbursement Notice (Number 2) Not Returned): _____

IV. Number of Claims Not Processed Within 210 Days: _____ (A + B)

A. Total Late Claims with Good Cause: _____

B. Total Claims Paid $100 Penalty: _____

V. Cumulative Claims Completed: _____

Instructions:

- Totals from parts I, II, and III must equal Part V Total.
- A written explanation for each case shown under Part I.D. Other must be attached or the monitoring form will be rejected.
- Cases must only be listed under one category other than Total lines.

REESE V. KIZER

CASE LOG FORM

Case Name: _____ Case Number: _____

Social Security Number: _____ Open Case: _____ Closed Case: _____

Worker Name and Number: _____

I. Personal Contacts:

a. Date: _____ Initiated By: _____

Description of Contact: _____

_____

_____

Action Taken: _____

_____

_____

b. Date: _____ Initiated By: _____

Description of Contact: _____

_____

_____

Action Taken: _____

_____

_____

c. Date: _____ Initiated By: _____

Description of Contact: _____

_____

_____

Action Taken: _____

_____

_____

II. Information Requests:

Date(s) Information Received*

a. Date Request Sent: _____
Information Requested: _____ _____
_____ _____
_____ _____
_____ _____

b. Date Request Sent: _____
Information Requested: _____ _____
_____ _____
_____ _____
_____ _____

c. Date Request Sent: _____
Information Requested: _____ _____
_____ _____
_____ _____
_____ _____
_____ _____

*Date and description for each piece of information received if not received together

III. Documents Requested From Other County:

Date Requested: _____ Date of Follow-Ups: _____ Date Information Received: _____

Request Addressed To: _____

_____

IV. Notices Sent:

a. Type: _____ Date: _____

b. Type: _____ Date: _____

c. Type: _____ Date: _____

d. Type: _____ Date: _____

VI. Date Claim Form Completed: _____

VII. Date Beneficiary Indicated Claim Payment Choice: _____

VIII. Claim Completion:

a. Date Future Share of Cost (SOC) Adjustment Computed: _____

b. Date Claim Forwarded to DHS: _____

ATTACH ADDITIONAL PAGES WHEN NECESSARY—ALL CONTACTS MUST BE DOCUMENTED.

REESE V. KIZER RETROACTIVE CLAIMING PROCEDURES

I. DETERMINATION OF REESE ENTITLEMENT

The county must review all identified cases in accordance with ACWDL 88-50 to determine whether the community property income is to be divided pursuant to Welfare and Institutions Code Section 14005.16 (a). The county shall make such determination using the criteria set forth in Title 22, CCR (California Code of Regulations), Section 50512 and Medi-Cal Procedures Manual Section 10K.

Where the case meets the criteria for division of income, process the case in accordance with Part II below if the case is currently open. Closed cases which meet the criteria for division must be processed in accordance with Part III below.

Report to the county Reese coordinator any case which does not meet the criteria for division. The information to be reported must include the case name, case number, and SSN as well as the reason the case does not meet the Reese criteria (i.e., no income which is considered community property, the spouse at home has more community property income than the spouse in LTC, etc. See Monitoring Form #2).

II. OPEN CASES - DETERMINATION OF AMOUNT OF CLAIM

The county in which the beneficiary currently receives Medi-Cal shall be responsible for processing the claim and determining the amount of reimbursement for the period January 1, 1984 through December 31, 1985, regardless of whether the beneficiary resided in other counties during the retroactive Reese period. All claim determinations shall be made in the following manner:

A. Calculate the beneficiary's share of cost in accordance with All County Welfare Directors Letter 85-53 (July 15, 1985) for each relevant month from January 1, 1984 until the month the community property income division criterion were first applied to the beneficiary's case. In cases where the criteria was not applied until after January, 1986, the claim period shall be extended to include all months in which the beneficiary was entitled to the community property division until that division was actually made.

   The share of cost shall be recalculated using the MFBU composition rules in effect for December 1985, and the income, and share of cost regulations in effect for the month being recalculated. Use of the MC176M applicable during the Retro period should reflect most of these changes.

B. Where the beneficiary has received aid in another county during the retroactive period, the case shall be reviewed to determine whether the

case file includes (generally through the inter-county transfer process) copies of all forms MC 176M/176M-LTC, MC 176W and all other necessary documents and income verifications from the case file in each previous county. Where documents are missing the previous county of residence must be contacted to obtain the missing documentation. The previous county shall supply the missing documentation to the requesting county within 30 days of receipt of the request.

C. If additional information is necessary which is not available in the case file or in the case file of another county, a written notice shall be sent to the beneficiary or to his/her responsible party or authorized representative (i.e. spouse, relative, friend, conservator, etc.) clearly indicating the following:

1. The following paragraph must be included in NOA requesting additional information:
"You or your spouse may be entitled to reimbursement under the Reese v. Kizer court order. That order enforced a statute which required that, when one spouse is in a nursing home, the spouse living at home in the community must be allowed to keep at least one-half of the couple's total community property income to live on. This court order affects the period January 1, 1984 through December 31, 1985."

2. In order to determine if the State owes the beneficiary money and/or the amount owed, specific information must be provided.

3. A list of the information required. The dates for which the information is required must be indicated.

4. A statement explaining the possible adverse consequences of failure to provide the information, i.e. possible incorrect calculation of the claim which could result in no reimbursement or a smaller claim amount.

5. A deadline for compliance of 30 days from the (date of the notice).

6. The name and telephone number of the eligibility worker or Reese coordinator.

The county shall allow the beneficiary and/or the person acting on his/her behalf thirty days from the date of the notice to respond to the notice. If no response is received, the county shall make one attempt within the next two weeks to personally contact the beneficiary or the person acting on his/her behalf.

The contact shall be by telephone where a telephone number can be found. If no telephone number is included in the case file or that number is not in service, the eligibility worker shall attempt to ascertain the new number by matching the name and address of the beneficiary and/or his/her representative with a

name and address in the telephone book. The eligibility worker shall attempt, on at least two separate occasions to telephone the beneficiary and/or his/her representative.

Where no telephone number can be identified, the eligibility worker shall send a follow-up notice reminding the beneficiary and/or his/her representative of the need to respond. This notice shall include the name and telephone number of the eligibility worker and a deadline of 30 days.

If the beneficiary fails to provide the requested information following one such attempt, the claim shall be calculated using the information in file.

D. After having received or attempted to obtain all necessary information, determine the amount of reimbursement using claim form B as follows:

1. The amount of the revised share of cost determined in accordance with II A of these procedures.

2. The amount of the share of cost actually assigned during the retroactive period.

3. Subtract the amount determined in step 1 from the amount determined in step 2. The difference is the claim amount.

4. Retain a copy of this form in the case file.

This determination must be completed within 90 days of the later of the following:

a. Identification of the case.

b. Receipt of necessary information from the beneficiary.

c. The date of the personal contact with the beneficiary or the attempt at such contact. If the personal contact attempt is by written notice, the 90 days shall commence at the end of the 30 day waiting period.

d. The date of receipt of necessary documents from another county.

E. Once the amount of the claim has been determined, apply the appropriate payment method from IV B, below.

III. CLOSED CASES - DETERMINATION OF AMOUNT OF CLAIM

A. Immediately upon receipt of an oral or written statement from the beneficiary or his/her representative or executor, stating the desire to pursue the claim, the case shall be pulled. Calculate the claim amount as described in II A thru II D, above.

B. Once the claim amount has been determined, apply the appropriate method of payment from IV A or B below.

IV. METHODS OF REIMBURSEMENT

A. Deceased Beneficiaries

Where the beneficiary is deceased send the spouse, other next of kin or executor Notice #2 explaining the claim determination and payment method and requirements. Include a self addressed, stamped return envelope. Allow thirty days from the date of mailing for the spouse or next of kin to return the notice. If the notice is not returned make one additional attempt to follow up in accordance with these procedures. If a completed form #2 is returned, forward the original returned notice, together with Claim Form B indicating the amount of reimbursement due to DHS for payment. A copy of the completed notice #2 must be retained in the case file.

B. Living Beneficiaries

1. If the beneficiary is currently receiving Medi-Cal with a share of cost, send Notice #1 to the beneficiary together with a pre-addressed, stamped return envelope. Allow the beneficiary thirty days from the postmark date to indicate, either orally or in writing, his/her choice (where that choice is a future share of cost adjustment). That choice shall be documented in the case file by a copy of the written statement or form, or case notations where the choice was indicated orally. The case notes must include the name and telephone number of the person making the statement as well as the date.

   If the beneficiary wishes cash reimbursement, he/she must so state in writing on Notice #1. Notice #1 must be signed and forwarded to the county. A copy of the notice is to be kept in the case file and the original must be sent to DHS with the claim.

2. If the beneficiary or his/her representative fails to reply or return notice #1 within thirty days, reimburse the beneficiary by adjusting future months share of cost. This adjustment shall be made in accordance with Title 22, CCR, Section 50653.3 (c). The beneficiary shall be sent a Notice of Action explaining the change in the share of cost. This notice shall explain that the lower share of cost amount is the result of retroactive reimbursement pursuant to the Reese case and the beneficiary's failure to indicate a payment choice. Complete Monitoring Form #3 and forward to:

   Toni Bailey
   Department of Health Services
   Medi-Cal Eligibility Branch
   714 "P" Street, Room 1692
   Sacramento, CA 95814

3. If the beneficiary chooses to have his/her future share of cost adjusted, make the adjustment in accordance with Section 50653.3 (c). The Notice of Action explaining the share of cost change must state that the adjustment is being made pursuant to the option chosen by the beneficiary for reimbursement of the Reese claim. Complete

Monitoring Form #3 and submit it to DHS. (See name and address in 2 above).

4. If the beneficiary indicates that he/she wishes cash reimbursement or if the beneficiary is not currently receiving Medi-Cal, forward the claim form showing the amount due and owing to DHS for payment. This claim form must be accompanied by the signed Notice #1 showing the beneficiary wishes cash payment. In the absence of a signed notice, a check can not be issued. FORWARD THE ORIGINAL SIGNED NOTICE TO DHS AS SOON AS POSSIBLE. Complete Monitoring Form #3 and submit it with the claim to DHS (See name and address in 2 above).

V. TIME LIMITATIONS

All necessary actions must be taken to provide reimbursement through future share of cost adjustments or to notify DHS of reimbursement amounts due within 210 days of the date of All County Welfare Directors Letter 88-__. This deadline may be extended for good cause, however, the circumstances and dates of contact must be documented in the case record.

VI. REQUESTS FOR HEARING

If the beneficiary or his/her representative or executor requests a hearing to dispute the amount of reimbursement, the claim must still be processed and paid in accordance with the county determination. Following the hearing decision, the county shall adjust the amount of reimbursement if so directed by the decision.

REESE V. KIZER

CASE MONITORING FORM NUMBER 3

I. Case Name: _____

Case Number: _____

II. Social Security Number: _____

a. Open Case: _____

b. Closed Case: _____

III. Date Determination of Adjustment Amount Completed: _____

IV. Date Claimant Advised of Adjustment Amount and Options: _____

a. Date Claimant Chose Option: _____

b. Date Contact Attempts Ceased: _____
(If closed case, do not complete V, VI or VII)

V. Adjustment Method to Be Used: *(Check only one.)*

a. Claimant Chose Forward Share of Cost (SOC) Adjustment: _____

b. Forward SOC Adjustment Due to Lack of Response (open cases): _____

c. Cash Adjustment Requested: _____

VI. Date Case Completed: _____

a. Date Forward SOC Adjustment Made: _____

b. Date Claim Forwarded to DHS: _____

VII. Was Case Completed Within 210 Days? ☐ Yes ☐ No

a. If No, Was Good Cause Established? ☐ Yes ☐ No

b. If No Good Cause, Date $100 Check Sent: _____

State of California—Health and Welfare Agency

Department of Health Services
Medi-Cal Program

(County Stamp)

MEDI-CAL NOTICE OF ACTION
REESE V. KIZER REIMBURSEMENT
(NOTICE 1)

State Number: _____

District: _____

Denial/Discontinuance For: _____

_____

_____ County has determined that you (your spouse) (your next of kin) is entitled to reimbursement under the court order in *Reese v. Kizer*. That case enforced a statute which requires that, when one spouse is in a nursing home, the spouse living at home in the community must have at least one-half of the couple's total income to live on.

The *Reese v. Kizer* court order covered the period from January 1, 1984 through December 31, 1985.

You are entitled to $ _____. This was calculated as follows:

Date LTC spouse in nursing home from _____ to _____.

Share of cost charged from _____ to _____.

S tached for explanation of the share of cost charged and the share of cost which should have been charged.

YOU HAVE A CHOICE OF HOW TO RECEIVE THIS MONEY:

1. You may have the money paid in cash. If you choose this option, the money will not affect Medi-Cal eligibility for six months after you receive it. It may be spent for any purpose; *OR*

2. The money may be applied toward the share of cost of the spouse in the nursing home. His/her share of cost will be $0 until the reimbursement amount is used up.

   NOTE: If the person in the nursing home dies before the reimbursement is used up, his/her spouse or next of kin will NOT receive the remainder in cash.

TO RECEIVE CASH, YOU MUST COMPLETE THIS FORM AND RETURN IT TO THE WORKER LISTED AT THE TOP OF THIS FORM. An envelope is enclosed for you to use.

RETURN THIS FORM WITHIN THIRTY (30) DAYS.

Your Name: _____ Your Spouse's Name: _____

Check one:

☐ I WANT TO RECEIVE CASH.
☐ I WANT THE MONEY TO BE USED TO PAY THE SHARE OF COST FOR THE NURSING HOME.

Signed: _____

Hearing Rights: The amount stated has been found to be the entire amount owed to you. If you think that the amount of reimbursement i orrect, you can request a hearing. Follow the instructions on the back of this form. You will be paid the amount stated on this form. If the hearing decision finds that the amount was incorrect, an adjustment for the additional amount will be made.

RETURN THIS FORM EVEN IF YOU REQUEST A HEARING.

MC 239M (8/88)

OUR HEARING RIGHTS

For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free:	1-800-952-5253
If you are deaf and use TDD call:	1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child Support: The District Attorney's office will help you collect child support even if you are not on cash aid. There is no cost for this help. If they now collect child support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ...

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W. & I. Code Section 10950)

BACK

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to:

You may also call 1-800-952-5253.

HEARING REQUEST

I want a hearing because of an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal
☐ Other (list) _____

Here's why: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I will bring this person to the hearing to help me (name and address, if known):

_____

_____

_____

I need an interpreter at no cost to me. My language or dialect is: _____

My name: _____

Address: _____

_____

Phone: _____

My signature _____

Date: _____

State of California—Health and Welfare Agency
Medi-Cal Program

Department of Health Services

(County Stamp)

MEDI-CAL
NOTICE OF ACTION
REESE V. KIZER
REIMBURSEMENT
(NOTICE 2)

State No. _____
District: _____
Denial/discontinuance for: _____
_____
(Names)

1. _____ County has determined that you (your spouse) (your next of kin) is entitled to reimbursement under the court order in *Reese* v. *Kizer*. That case enforced a statute which requires that, when one spouse is in a nursing home, the spouse living at home in the community must have at least one-half of the couple's total income to live on.

   This court order covered the period January 1, 1984 through December 31, 1985.

2. You are entitled to $_____. This was calculated as follows:

   Spouse in nursing home: _____

   Share of cost charged from _____ to _____:

See attached for an explanation of the share of cost charged and the share of cost that should have been charged.

3. TO RECEIVE CASH, YOU MUST COMPLETE THIS FORM, AND RETURN IT TO THE WORKER LISTED AT THE TOP OF THIS FORM. An envelope is enclosed for you to use.

   RETURN THIS FORM WITHIN THIRTY (30) DAYS.

Beneficiary's Name: _____

Name of Beneficiary's Spouse: _____

I WANT TO RECEIVE CASH _____

Signed: _____

HEARING RIGHTS:

The amount stated has been found to be the entire amount owed to you. If you think that the amount of reimbursement is incorrect, you can request a hearing. Follow the instructions on the back of this form. You will be paid the amount stated on this form. If the hearing decision finds that the amount was incorrect, an adjustment for the additional amount will be made.

RETURN THIS FORM EVEN IF YOU REQUEST A HEARING

)UR HEARING RIGHTS

A)r a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free:	1-800-952-5253
If you are deaf and use TDD call:	1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office or welfare rights group.

her Information

ild Support: The District Attorney's office will help you collect child port even if you are not on cash aid. There is no cost for this help. If they collect child support for you, they will keep doing so unless you tell them writing to stop. They will send you any current support money collected. y will keep past due money collected that is owed to the county.

nily Planning: *Your welfare office will give you information when*

aring File: If you ask for a hearing, the State Hearing Office will set up a . You have the right to see this file. The State may give your file the Welfare Department, the U.S. Department of Health and Human vices and the U.S. Department of Agriculture. (W & I. Code Section 950)

BACK 6

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and *send or take it to:*

You may also call 1-800-952-5253.

HEARING REQUEST

I want a hearing because of an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

Here's why: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I will bring this person to the hearing to help me *(name and address, if known)*:

_____

_____

_____

I need an interpreter at no cost to me. My language or dialect is: _____

My name: _____

Address: _____

_____

Phone: _____

My signature _____

Date: _____

REESE V. KIZER

CASE CLAIM FORM B

Claimant's Name _____

Social Security Number _____ County Name _____

Month/Year	Original Share of Cost	Revised Share of Cost	Claim Amount
1/84			
2/84			
3/84			
4/84			
5/84			
6/84			
7/84			
8/84			
9/84			
10/84			
11/84			
12/84			
1/85			
2/85			
3/85			
4/85			
5/85			
6/85			
7/85			
8/85			
9/85			
10/85			
11/85			
12/85	TOTAL	TOTAL	TOTAL