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REASON FOR THIS TRANSMITTAL

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

March 22, 2018

ALL-COUNTY LETTER NO: 18-31

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY IN-HOME SUPPORTIVE SERVICES PROGRAM
MANAGERS

SUBJECT: IMPLEMENTATION OF SENATE BILL (SB) 89 HUMAN
SERVICES / OVERTIME EXEMPTIONS

REFERENCE: [SB 89 \(JUNE 27, 2017\)](#); [WELFARE AND INSTITUTIONS CODE \(WIC\) SECTION 12300.4](#); [ACL 16-07 \(January 21, 2016\)](#), [ACL 16-22 \(April 1, 2016\)](#) and [ACL 17-13 \(April 7, 2017\)](#)

This All-County Letter (ACL) provides counties with information and instructions for implementing the provisions of [Senate Bill \(SB\) 89](#) which formally established exemptions to limits on the number of authorized hours providers in the In-Home Supportive Services (IHSS) program are permitted to work in a workweek. This ACL provides information and instructions for implementing policies that require the counties to begin reviewing Extraordinary Circumstances Exemption (Exemption 2) referrals and establishes the Exemption 2 State Administrative Review (ESAR) process for providers and recipients who the county deems ineligible for an Exemption 2. Finally, this ACL transmits new and revised forms and notices to be used by counties in the implementation of the exemption referral review process.

Currently, the Case Management Information and Payrolling System II (CMIPS II) is being reprogrammed to implement the requirements of SB 89. The exemption review process will be transferred from the state to the county upon completion of CMIPS II system testing and validation, with the transfer of responsibilities scheduled to occur in May 2018.

BACKGROUND

On June 27, 2017, the legislature passed Senate Bill (SB) 89 (Chapter 24, Statutes of 2017) formally establishing the California Department of Social Services' (CDSS) existing Live-In Family Care Provider Exemption (Exemption 1), and Extraordinary Circumstances Exemption (Exemption 2). These exemptions were initially created in February 2016 to maintain continuity of care and to ensure that IHSS recipients who are potentially at risk of out-of-home placement are able to remain safely in their homes. If granted, the exemptions allow care providers to work hours in excess of the 66-hour workweek limitation implemented by the passage of [SB 855](#) and [SB 873](#).

The Extraordinary Circumstances Exemption, or Exemption 2, applies to providers who provide services for two or more recipients whose extraordinary circumstances place them at serious risk of placement in out-of-home care, and each of the recipients meet at least one of the following criteria:

- **Criteria A** – He or she has complex medical or behavioral needs that must be met by a provider who lives in the same home as the recipient.
- **Criteria B** – He or she lives in a rural or remote area where available providers are limited, and, as a result, the recipient is unable to hire another provider.
- **Criteria C** – He or she is unable to hire another provider who speaks the same language as the recipient, resulting in the recipient being unable to direct his or her own care.

In addition to meeting one of the exemption criteria, the recipients, with the assistance of the county, as needed, must have explored available options for hiring an additional provider(s). Prior documented attempts to find/utilize other providers may be considered in meeting this requirement.

SB 89 requires CDSS to mail a one-time informational notice about Exemption 2 to potentially eligible providers and their associated recipients. It further requires counties, at the time of assessment or reassessment, to evaluate each recipient to determine if the recipient's circumstances appear to indicate that the provider for that recipient may be eligible for an exemption. The county shall then inform those recipients about the potentially applicable exemptions and the process by which their provider may apply for the exemption. The bill also transfers exemption review responsibilities from the state to the counties.

SB 89 requires the state to establish and implement an administrative review process for Exemption 2 ineligibility determinations (ESAR) and standardized notification letter(s). The ESAR process will provide recipients and providers an opportunity to present additional information regarding their case.

SB 89 also requires the state to count the number of Exemption 2 requests received and the number of requests approved or determined ineligible. The state shall also

record the number of requests for an ESAR that are received and the number that are upheld or overturned. These numbers must be posted no later than every three months on the department's internet website.

Finally, SB 89 requires the department to develop the exemption review and administrative review processes with input from stakeholders.

Transfer of Exemption 2 Eligibility Evaluation Responsibilities

The CDSS will continue to review exemption referral justifications until this responsibility is transferred to the counties in May 2018. An informational mailer (TEMP 2314 and TEMP 2315) and a Request for Exemption from Workweek Limits for Extraordinary Circumstances (Exemption 2) form (SOC 2305) will be sent to providers who are potentially eligible for Exemption 2 in March 2018. Until the transfer of exemption eligibility review responsibilities in May 2018, counties that receive an exemption request form (SOC 2305) should complete an Exemption from Workweek Limits for Extraordinary Circumstances Referral Justification form (APD 005) and mail it to CDSS.

COUNTY RESPONSIBILITIES

Pursuant to [Welfare and Institutions Code \(WIC\), Section 12300.4 \(d\)\(3\)\(E\)](#), upon completion of CMIPS II modifications, the county will be responsible for reviewing exemption request forms (SOC 2305). During the review, the county shall determine whether the case meets the established Exemption 2 criteria.

Upon receipt of an exemption request form (SOC 2305), the county will have 30 calendar days to make an eligibility determination and submit a standardized notification letter to the provider and associated recipients. If the county determines that the provider is ineligible for an exemption, the notification letter shall explain the reason for their ineligibility and provide information about the ESAR process.

Exemption 2 Criteria and Policy Guidance

The Extraordinary Circumstance Exemption applies to IHSS providers who provide services for two or more recipients whose circumstances leave them vulnerable and place them at serious risk of placement in out-of-home care if the IHSS authorized hours cannot be provided by that provider.

The following criteria was developed to assist counties in evaluating an exemption request to ensure that exemption policy is consistently applied statewide. All the applying provider's active recipients must meet at least one of the following criteria to qualify for an Exemption 2:

Criteria A: Recipient has complex medical or behavioral needs that must be met by a provider who lives in the same home as the recipient.

A complex medical and/or behavioral condition for the purpose of Exemption 2 means that an IHSS recipient has personal care services authorized in the IHSS program, pursuant to the [Manual of Policies and Procedures \(MPP\) section 30-757 et seq.](#) which require specific attention and care, and these services cannot be provided by anyone other than his or her Live-In IHSS provider without having an impact on the recipient's physical tolerance and/or an impact on their behavioral temperament as it relates to a mental health condition (e.g. autism spectrum disorder, dementia, Alzheimer's, etc.). If the services were provided by someone other than the existing provider, it would cause the IHSS recipient harm due to physical and/or emotional stress leading to out-of-home care.

Any information provided during the evaluation should be supported by the recipient's diagnosis, functional assessment and case narrative and the provider's CMIPS II person notes. Proper justification is needed to establish that the provider applying for the exemption is the only provider who can deliver the recipient's services without the recipient experiencing undo harm. IHSS county staff conducting an exemption referral justification for Criteria A should consider the following criteria guidance when assessing the case.

- **Whether the recipient is authorized ongoing paramedical services that require a high level of skill to perform (i.e., catheter care, ostomy irrigation, enemas, insertion of suppositories, treatments requiring sterile procedures, etc.)** This is an indication that the recipient may have complex medical needs that must be met by a live-in provider.
- **Whether the recipient receives personal care service tasks requiring specialized care (i.e., recipient requires a provider able to complete repositioning, bowel and bladder, etc.).** This is an indication that the recipient may have complex medical needs that must be met by a live-in provider.
- **Whether the recipient has a documented mental health diagnosis, mental impairment or developmental disability diagnosis and exhibits adverse behaviors resulting in undue harm upon introduction of new providers.** This is an indication that the recipient may have complex behavioral needs that must be met by a live-in provider.
- **Whether the recipient attends a day program or receives respite care from another provider, and whether the program or caregiver provides specialized therapeutic or medical care.** Attending a day program or receiving respite care does not preclude the need for IHSS to be provided by a live-in provider depending on the circumstances. If the day program or respite care is provided by individuals trained in specialized care this may indicate that the recipient may have complex medical or behavioral needs that must be met by a live-in provider.

- **Whether the recipient currently or recently has had other IHSS providers, and the impact the providers had on the recipient's well-being.** Termination of additional providers from a recipient's case for a primary provider to qualify for an exemption is considered a personal preference and does not qualify as an extraordinary circumstance. Counties must evaluate each case to determine whether additional providers have been terminated and/or have left the employment of the recipient due to health and safety risks posed by the introduction of the provider. Counties should also inquire and consider if additional provider(s) have left employment voluntarily due to difficulty in working with recipients' behavioral needs.

Criteria B: Recipient lives in a rural or remote area where available providers are limited, and, as a result, the recipient is unable to hire another provider.

For the purposes of this exemption, a rural or remote area is defined as all territory, population, and housing units located outside of urbanized areas and urban clusters. The county should evaluate the recipient's accessibility to available providers within the recipient's geographic area. The county should also consider the number of available providers (including the provider registry, family members, neighbors, etc.) that are willing to travel a lengthy distance to provide services. Recipients attempts to access and/or hire these providers should be considered in the exemption evaluation process. Living in a rural or remote area does not exclude recipients from the criteria of searching for additional providers. The county should document identified barriers that limit the recipient's ability to hire additional providers. Prior to approving a request for Exemption 2, the county must determine whether the location where the recipient resides meets the standard for being considered rural or remote.

Criteria C: Recipient is unable to hire another provider who speaks the same language as the recipient, resulting in the recipient being unable to direct his or her own care.

When determining whether an extraordinary circumstance exists related to the recipient's inability to hire a provider who speaks his/her same language, the county must determine the extent to which the circumstance presents a barrier in the provision of the recipient's authorized services. The county must assess if certain tasks, e.g. domestic and related services tasks, can be accomplished effectively by a provider who does not speak the recipient's same language after some initial interpretative assistance. An extraordinary circumstance only exists when the recipient's inability to hire a provider who speaks his/her same language results in a barrier to the recipient directing his/her own care which cannot be overcome.

Assisting Recipients with Hiring Additional Providers When Requested

As part of the mandated provider enrollment process, IHSS applicant providers must attend the required provider orientation which provides them with information regarding

statutory workweek limitations. The applicant providers must then agree to adhere to established statutory workweek limitations when they sign the IHSS Program Provider Enrollment Agreement (SOC 846) acknowledging that they understand the IHSS program rules and requirements as they relate to their responsibilities as an IHSS provider. Furthermore, recipients are made aware of the statutory workweek limitations during the application and/or assessment process and are responsible for hiring additional providers with assistance from the county, if requested. It is important to emphasize that the IHSS Program, as a Medi-Cal service, is intended to meet the recipient's needs. Thus, the financial impact on a provider due to the workweek limits is not among the exemption criteria and shall not be a consideration when determining whether an extraordinary circumstance exists.

The review of available providers should be completed prior to considering an exemption for the case. The review can include both current and prior attempts to identify to find/utilize additional providers. The recipient's search for an additional provider should include but not be limited to the following: contacting friends, family and neighbors; working with the Public Authority to utilize the provider registries to obtain additional providers; and following up with back-up providers identified on the IHSS Program Individualized Back-Up Plan and Risk Assessment form (SOC 864). Counties with provider registries should assist recipients by providing a list of available providers from the provider registry. Those counties without provider registries should assist recipients and their families as needed pursuant to the [Manual of Policies and Procedures section 30-760.23](#).

The recipients' or their authorized representatives' efforts and outcomes to explore available options should be documented in the recipient's CMIPS II assessment or person notes and included in the referral justification. When reasonable attempts to find additional providers have occurred prior to a case being identified for an exemption referral, the documentation should include the history of a detrimental impact to the recipient's health and safety due to being served by other providers. This documentation may be considered when determining whether the requirement of searching for additional providers has been satisfied.

IHSS Minor Recipient(s) Living with Parent(s) Regulations/Exemption Impact

If one parent in a household is providing IHSS to a minor recipient(s), the second parent in the household is typically not permitted to provide IHSS services to the minor recipient(s). However, due to the statutory workweek limitations, CDSS now permits a second parent in the same household to provide IHSS services when the first parent who is providing IHSS has reached the workweek limitation because the first parent would no longer be considered able and available to provide services beyond the statutory workweek maximum. The second parent may provide services to fulfill the remaining authorized hours of the recipient(s) in the home, once the first parent has reached the statutory workweek maximum, as long as they meet the requirements set forth in [MPP Section 763.45 et seq.](#) Pursuant to [MPP Section 763.45 et seq.](#), in order

for a parent to be an IHSS paid parent provider, that parent must have left or be prevented from full-time employment because no other suitable provider is available, and the inability of that parent to perform supportive services may result in inappropriate placement or inadequate care.

If a parent provider in a two-parent household who serves two or more minor recipients has qualified for an exemption, and has reached the 360 hours a month maximum permitted by the exemption, the parent providing IHSS services would no longer be considered able and available to provide the remaining authorized hours to the minor recipients in the home. As a result, the second parent may provide the remaining authorized hours of the minor recipients as long as they meet the requirements of [MPP Section 30-763.45 et seq.](#) However, because a second parent may qualify as an IHSS provider once the first parent provider reaches the statutory workweek maximum, it is possible that the authorized hours of the recipients can be captured without an exemption. County social workers should evaluate the case and determine whether the recipients' authorized hours can be worked within the standard workweek limitations if the second parent meets the requirements to be an IHSS paid provider once the first parent reaches the standard workweek maximum.

Exemption Evaluation

Upon receipt of the exemption request form (SOC 2305) the county should review the provider's and recipients' CMIPS II profiles to gather case information needed to validate basic exemption criteria. If basic exemption criteria is not met (i.e., provider does not serve two or more recipients, total hours of all recipients does not exceed 264 hours, etc.) the case is considered ineligible and the county should send out a notice of ineligibility determination and a request for administrative review of extraordinary circumstances form to the provider and all recipients included in the exemption request. *Note: The administrative review request form will be released in a forthcoming ACL regarding the ESAR process.* County staff shall document the reason for the ineligibility determination in the provider's CMIPS II person notes.

For cases that meet basic exemption criteria, county staff should complete a referral using the referral justification form (SOC 2306) as a template for data entry into the provider's CMIPS II person notes. *Note: IHSS county staff may complete the referral justification on the template and then cut and paste the information into the provider's CMIPS II person notes.* IHSS county staff will complete this process by using CMIPS II data (assessment narratives, person notes, time sheet history, etc.) as well as information collected from the recipients, the recipients' authorized representative (if applicable), assigned social worker, and all active provider(s) to determine whether recipients are at risk of out-of-home placement. The referral justification must include documentation that the recipient with assistance from the county if requested, has made reasonable attempts to obtain additional providers. Any information provided during this process that was not previously reported during an assessment should be substantiated and added to the CMIPS II case record. The county will ensure that all recipients for

which the provider status is currently active have been listed on the exemption referral and evaluated using the exemption criteria. Request forms submitted without all recipients listed are considered incomplete and must be resubmitted.

During the exemption eligibility review period overtime violations will be suppressed. Violation suppression will be initiated once an exemption request is entered into CMIPS II by the county reviewer. *Note: There will be a forthcoming ACL instructing county users on how to enter exemption requests into the system.*

Secondary Review

Exemption determinations should be validated by a secondary reviewer to ensure that the referral justification is consistent with policy guidance and whether an exemption is appropriate for the IHSS provider. Given the varying operational structures among the counties, the county shall decide which level of staff will conduct the secondary review. The assigned secondary reviewer will analyze the referral justification entered into the provider's CMIPS II person notes and use the Secondary Evaluation Review Worksheet (SOC 2307) as a template to document the secondary review and eligibility determination in the provider's CMIPS II person notes. *Note: IHSS county staff may complete the secondary review on the template and then cut and paste the information into the provider's CMIPS II person notes.*

Determination Notification

After the IHSS secondary reviewer evaluates the exemption referral justification, the county staff shall submit determination letters to the provider and recipients. As a condition of an approval, a blank Exemption from Workweek Limits for Extraordinary Circumstances Approved Exemption Provider Agreement form (SOC 2308) must be sent to the provider for signature and returned to the county. If the provider refuses to sign or otherwise fails to return the signed document, the social worker should request a copy by submitting a Notice of Non-Receipt of Exemption from Workweek Limits Provider Agreement (SOC 2311) and advise the provider that the exemption cannot be renewed until the SOC 2308 is received. The county must not process a renewal if the county has not obtained the signed SOC 2308 and should instead initiate a "[Change in Exemption Eligibility](#)".

For ineligibility determinations, the county shall submit an ineligibility notice to the provider and recipients including the reason for their ineligibility with a copy of a request for administrative review form. *Note: The administrative review request form will be released in a forthcoming ACL regarding the ESAR process.*

Duration of an Exemption 2 Approval

Previously, all Exemption 2 approvals for Criteria A were approved for one year, and all Criteria B and C exemptions were approved for six months. Given the length of time

required for the evaluation of exemption cases and to maintain consistency, all cases deemed eligible for an Exemption 2 will be approved for one year. This policy change will occur once the county assumes exemption eligibility review responsibilities.

Exemption Renewals

All approved exemptions must be renewed on an annual basis. The exemption renewal process should be initiated 30 calendar days in advance of the exemption expiration date. To assist counties in ensuring this deadline is met, CMIPS II has been programmed to automatically alert the county (assign a task) 60 calendar days in advance of the expiration. *Note: Due to CMIPS II system restrictions, the renewal exemption segment may not be entered into the system until 30 days prior to the expiration of the initial exemption.*

The IHSS county staff will review the case's previous exemption documentation and complete a renewal exemption referral justification (SOC 2306) and enter it in the provider's CMIPS II person notes. The secondary reviewer will complete a secondary review worksheet (SOC 2307) documenting their review and eligibility determination into the provider's CMIPS II person notes. Once the determination has been completed, the county staff will submit a notice of eligibility determination to the provider and recipients.

If during the renewal process it is discovered that there has been a change affecting the eligibility of the exemption, the assigned IHSS county staff will process a "Change in Exemption Eligibility" as the circumstances of the exemption approval no longer exist. The county will determine whether the circumstances of the case warrant the initiation of a new exemption request for the new circumstances of the case.

Change in Exemption Eligibility

The county should initiate a "Change in Exemption Eligibility" action if, at any point in time, the social worker determines that there has been a change in a recipient's case resulting in the exemption no longer being needed (e.g. the recipients' combined hours have been reduced to less than 264 hours a month) and/or the conditions upon which the exemption was granted no longer exist, (e.g., a recipient has been terminated from IHSS, the provider granted an exemption on the basis of Criteria A no longer lives in the same home with the recipients, the provider is activated under a new recipient's case, the provider has been terminated from an active recipient's case, etc.)

Within 15 calendar days of the date the county learns of changes in exemption eligibility, the county must end date the exemption in CMIPS II and submit notices to the provider and the recipients notifying them that the exemption is no longer valid. The Notice of Change in Extraordinary Circumstances Exemption Eligibility (SOC 2312 and 2312A) should be used to notify the provider and recipients of the county's action.

Inter County Transfer (ICT)

Pursuant to the [Manual of Policy and Procedures \(MPP\) section 30-759.92](#), “there shall be no interruption or overlapping of services as the result of a recipient moving from one county to another;” therefore, if an exemption existed in the previous county, the receiving county must honor the exemption as a part of services carrying over from the transferring county. Due to CMIPS II system restrictions, the exemption is automatically ended when the provider is terminated by the previous county. When the receiving county begins setting up the new provider profile, they must re-enter the exemption into CMIPS II.

As part of the ICT process, the county is responsible for conducting a face to face assessment with the recipients within the 30-day transfer period pursuant to [MPP sections 30-759.93 and 30-759.94](#). During the assessment, the social worker will conduct an evaluation of the recipient’s care needs and determine whether the circumstances under which the exemption was issued still exist. If the circumstances of the exemption still exist, the exemption will be approved and continue for the span of one year. If the circumstances of the exemption no longer exist, the county shall process a “change in exemption eligibility” and end the exemption in CMIPS II.

Evaluating the Authorized Hours of the Provider’s Active Recipients

An exemption approval authorizes the provider to provide up to 360 hours of authorized services to the recipients covered under the exemption approval. Recipients authorized hours in excess 360 hours per month are permitted to hire an additional IHSS provider(s). The county should notify any recipient attached to the provider who did not meet the eligibility criteria that they are responsible for hiring a new IHSS provider with the assistance of the county social worker, if requested.

If the provider is determined ineligible for the exemption, IHSS county staff should work with the provider and recipients to establish a workweek schedule that adheres to the statutory workweek maximum. Any of the recipients’ authorized hours that were previously assigned to the provider that exceed 264 hours per month should be re-assigned to a new IHSS provider. Additionally, in order to assist a recipient, schedule his/her provider(s)’s weekly hours, the county will provide a copy of the IHSS Program Recipient and Provider Workweek Agreement (SOC 2256) to serve as a tool to assist those recipients with multiple providers to establish a work schedule that complies with the recipient’s needs.

STATE RESPONSIBILITIES

County Training

Training regarding the policy guidance and CMIPS II system modifications for Exemption 2 will be developed and provided by the Provider Benefits and Exemptions

Unit (PB&E) in conjunction with Systems Operations and Data Analysis Bureau. The webinar training(s) are expected to be conducted in April 2018.

Quality Assurance Monitoring

The Exemption 2 Eligibility Evaluation contained in the provider's CMIPS II person notes may be reviewed by county Quality Assurance staff as well as the State Quality Assurance Monitoring staff to verify that each exemption evaluation has been conducted in accordance with statutory requirements and CDSS policy guidance.

Exemption 2 State Administrative Review Process

If a provider or recipient disagrees with the county's decision which finds him/her ineligible for an Exemption 2, the provider or recipient may request a review of the county's determination by the CDSS' ESAR Unit. Any request for administrative review must be submitted with a postmarked date within 30 calendar days of the date of the exemption ineligibility notice. The ESAR Unit in turn will have 20 calendar days from the date of the administrative review conference to submit a final determination to the provider, recipients and the county. The Appeals, Administrative Review and Reimbursements Bureau will issue a forthcoming ACL detailing ESAR forms and the overall ESAR process.

Reporting Requirements

SB 89 requires the state to collect exemption request data from the county and post updated data to the department website once every three months. Data include the total number of exemption requests, exemption approvals and ineligibility determinations. It also includes the number of administrative review requests, exemption approvals and ineligibility determinations. As this data will be entered directly into CMIPS II when the state and counties are evaluating exemption cases, CDSS can then extract data reports from CMIPS II and post it to the department website as required.

NEW AND REVISED FORMS AND NOTICES

CDSS has revised and developed new forms and notices for use by counties in implementing the Extraordinary Circumstances Exemption Evaluation process. The attached table provides the numbers, titles and intended uses of new and revised forms and notices.

Counties will no longer utilize the exemption forms and notices issued in previous ACLs and begin using the new forms and notices upon transfer of exemption eligibility evaluation duties. The new forms, which are designated as "Required – No Substitutes Permitted," will be made available in camera-ready format upon completion of the

accessibility requirements. Counties will be able to access the forms on the [CDSS Forms/Brochures web page](#) at:

<http://www.cdss.ca.gov/inforesources/Forms-Brochures>

Upon completion of translations, CDSS will post Armenian, Chinese and Spanish versions of the forms on the [Translated Forms and Publications webpage](#) at:

<http://www.cdss.ca.gov/inforesources/Translated-Forms-and-Publications>

The designated Forms Coordinator for your county must distribute translated forms to each program and location. Each county shall provide bilingual/interpretive services and written translations to non-English or limited-English proficient populations, as required by the Dymally-Alatorre Bilingual Services Act (California Government Code section 7290 et seq.) and by state regulation (CDSS Manual of Policies and Procedures Division 21, Civil Rights Nondiscrimination, section 115).

Questions about accessing the forms may be directed to the Forms Management Unit at fmudss@dss.ca.gov. Questions about translations may be directed to the Language Services Unit at LTS@dss.ca.gov.

FORTHCOMING ACLs/ACINs

This ACL is the first in a series of ACLs and ACINs that will be issued to provide additional information and instructions for implementing the provisions of SB 89. In the coming months, CDSS will release ACLs/ACINs to address the following issues:

- Changes to CMIPS II system functionality
- Future Quality Assurance Monitoring visits regarding overtime requirements and Exemption 2 Eligibility Evaluation process.
- State Procedures for the ESAR Process

Questions regarding the content of this ACL may be directed to the Policy and Operations Bureau within the Adult Programs Policy and Quality Assurance Branch at (916) 651-5350.

Sincerely,

Original Document Signed By:

DEBBI THOMSON
Deputy Director
Adult Programs Division
Attachments