State of Kansas Department of Social and Rehabilitation Services
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Economic and Employment Support - Bobbi Mariani, Director (785) 296-3349
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MEMORANDUM

TO:	EES Program Administrators All Asst. Regional Directors	DATE:	09/26/07
FROM:	Bobbi Mariani, Director Economic and Employment Support	RE:	Implementation Instructions - KEESM Revision 33 Effective October 1, 2007

This memo provides implementation instructions and information for the following October 1, 2007 policy changes in the Kansas Economic and Employment Support Manual (KEESM):

I. **FOOD ASSISTANCE**

A. **Work Related Exemptions -** See Summary of Changes item IV, A, 1. The change to food stamp work related exemptions in 3210(1), shall be applied at the time of the next case review or case change involving the affected policy. For example, an 18 year old (with one child under age 6) working on her GED is mandatory for the Food Stamp Employment and Training Program (FS E & T). With the change to this manual section, effective October 1, 2007, she is no longer mandatory for FS E & T and her status shall be changed to exempt at the time of the next review, or case change involving the affected policy (such as a FS E & T work penalty).

B. **Averaging of Child Support and Alimony Income -** See Summary of Change, item IV, B, 3. This revision contains several clarifications regarding the averaging and prospecting of child support income. 7124 (1)(a) is being clarified by stating that current support income is converted up to the amount of the court order (for current support) and that arrears are projected separately if not included in the court ordered amount. The following example is being provided to illustrate this clarification.

Example: Mrs. Smith has court ordered current support of $400 a month. Mr. Smith just got a job and will have $150 a week withheld, $50 of which is for arrearage. He does not have a separate court order for the arrearage amount owed. He is paid weekly and the converted current amount is $100 x 4.3 = $430. However, since we can only count to the amount of the court order, we will prospectively budget $400 a month in current support. Since his past history of payment indicates he will also pay an extra $50 a week for arrearage, we will also prospect $50 X 4.3 = $215. The total prospected child support amount is $400 + $215 for a total of $615.

C. **Expenses Not Allowed -** See Summary of Change, item IV, B, 5. The following example helps to illustrate this policy clarification.

Example: Mrs. Wright lives in HUD housing and has a rent obligation of $77. She also pays for heating and cooling. She receives a utility allowance of $39 which reduces her rent obligation to $38. Per KEESM 6410(27), the utility allowance is exempt income. Per 7227.1, the portion of the rent expense that is covered by the exempt HUD housing payment is not allowable. Therefore the allowable rent in this example is $38. She is also entitled to the SUA.

II. FOOD STAMP EMPLOYMENT AND TRAINING (FS E&T)

A. **Work Components -** See Summary of Changes item V, B, 1, KEESM 3300, and Appendix E-10, **Comparison of TAF and FS E & T Employment Services Chart**.

Effective October 1, 2007, Food Stamp E & T customers need to be assigned to an approved work component according to the FS E & T State Plan in order to receive services. The approved FS E & T components are: Work Experience; Vocational Education; Job Search/Job Readiness; Job Skills Training; Education Related to Employment; and Secondary School Attendance. Please note that none of the **Components Not Countable for Federal Work Participation Components** in KEESM 3330 are now appropriate for FS E & T.

The work program assessment may be the first step in the approved component assignment.

FS E & T customers in work components which are not included in the FS E & T State Plan need to be transitioned into an approved component by January 1, 2008.

Example: Current FS E & T customer is in the Assessment (ASE) component in October 2007. This customer should be moved into the Job Search/Job Readiness (JSR) component. Assessment screenings (SASSI, CASAS, etc.) may continue as the first step in the JSR component assignment.

III. KANSAS EARLY HEAD START

A. **Expanded Services -** As of July 1, 2007, Kansas Early Head Start (KEHS) expanded services in fourteen new counties. This brings the total number of KEHS grants to 15 covering 48/105 counties.

1. **Coordination -** Head Start/Early Head Start Programs and SRS serve similar and sometimes mutual customers. Central Office SRS staff who work with Head Start/Early Head Start Programs have asked those programs to initiate and establish MOA's, Memorandums of Agreement, with SRS Regional Offices. The time frame for this process is mutually agreed upon between HS/EHS and SRS. This coordination expectation and establishment of an MOA continues as KEHS expands services.

IV. MEDICAL ASSISTANCE

A. **Newborns Born to SOBRA Medicaid Moms -** Based on an interim final rule published by CMS on 7/02/07, a child born to a woman receiving Medicaid under the SOBRA provision is automatically eligible through the month of the child's first birthday under the newborn continuous eligibility provisions of KFMAM 2320. Prior to this change, a complete eligibility determination was required for the newborn, as well as the SOBRA mother. Under the new policy, these newborns are eligible without a separate determination provided all requirements applicable to newborn continuous eligibility are met. This change is applicable to all applications made on or after 10/1/2007.

No changes to service delivery responsibilities are being implemented with this change. SRS staff continue to be responsible for all SOBRA determinations and the HealthWave Clearinghouse is responsible for the ongoing maintenance of any family medical case for eligible plan members. In addition, KAECSES processing procedures outlined in the SOBRA memorandum issued 7/16/1999 continue to be applicable.

Note: Verification of citizenship and identity is not required when adding a newborn born to a Medicaid or Title XXI mother. Therefore, the verification of citizenship and identity is not required when providing coverage to these newborns born to SOBRA Medicaid moms. The information will, however, be required at the time of the next review.

Procedures outlined in this memo shall be used by both SRS and HealthWave Clearinghouse staff for processing SOBRA pregnant woman cases.

1. **Adding the Newborn when there is Open Medical at the Clearinghouse -** When an application is received for a SOBRA mother and the family has an open medical case at the Clearinghouse, SRS is responsible for the SOBRA determination and ensuring initial medical coverage is provided to the newborn. If the woman is eligible in the month of birth, the following procedures should be followed to provide coverage to the newborn.

    a. The SRS staff member approving the SOBRA coverage shall add the newborn to the SOBRA case for the month of birth through the current system month. Action to add the baby must be taken the day after the SOBRA case is approved to ensure accurate information is sent to the MMIS. Providing initial coverage at the time of approval ensures no delay in accessing benefits for this baby.

    b. The SRS staff member must update PRAP with the appropriate citizenship and identity information for the newborn. If documents are available, they must be copied and sent to the Clearinghouse.

    c. The SRS staff member must send appropriate notices informing the mother of her eligibility as well as her newborn's eligibility.

    d. The SRS staff member must then complete a HW - Information form and submit it to the Clearinghouse to add the baby to their open medical case for the remainder of the newborn's continuous eligibility period. The newborn's name, date of birth, client ID and the months for which coverage

has already been provided must be listed on the HW - Information form.

e. The Clearinghouse ensure the baby is added beginning with the month following the current system month.

Example: Gabriella delivers a baby on August 3rd, 2007, and submits an application for SOBRA coverage to her local SRS office on August 10th. The SRS staff member processes the application on August 13th and approves SOBRA eligibility for Gabriella for the month of August 2007. On August 14th, the SRS staff member approves coverage for the newborn for the months of August 2007 through the current system month of September 2007. The SRS staff member then completes a HW - Information form and submits it to the Clearinghouse. The form includes the child's name, DOB, Bene ID, and informs them that coverage has been provided for the months of August – September 2007. The Clearinghouse staff receive the HW - Information form and add the newborn to the open medical case at the Clearinghouse for the months of October 2007 – August 2008.

2. **Adding the Newborn when there is Not an Open Medical Case -** For SOBRA applications where no open family medical case exists, the SRS staff member is responsible for an initial determination for the SOBRA applicant as well as the newborn.

   a. Complete the SOBRA determination for the mother. If the mother is eligible in the month of birth, the newborn is continuously eligible.

   b. Provide coverage for the newborn under the MP program on a separate case number using the date of the SOBRA application. Authorize benefits through the current system month. The review date for the new case is the end of the newborn continuous eligibility period.

   c. The SRS staff member must update PRAP with the appropriate citizenship and identity information for the newborn. If documents are available, they must be copied and sent to the Clearinghouse.

   d. SRS sends appropriate notices.

   e. Transfer the newborn's case to the Clearinghouse following standard case file transfer protocol.

3. **Preventing duplicate ID numbers -** Adding a newborn is one of the most common ways that a duplicate ID is created. Please review the attached handout, "Name Standards on Systems," as a reminder on how to prevent the creation of a duplicate ID.

B. **Citizenship and Identity -** Based on an interim final rule published by CMS on 7/02/07, additional flexibility has been added to the citizenship and identity verification process. These changes are effective with all cases processed on or after October 1,

2007.

The following outlines the changes that have been made to the verification requirements of citizenship and identity.

When processing a review, if it is found that an unacceptable form of documentation was allowed when the case was last processed, new verification must be obtained for the consumer. However, if this occurs, the consumer will be in a reasonable opportunity period and may continue coverage until the next review or program change. PRAP needs to be updated in these situations.

1. **Foster Care and Adoption Support Exemption -** CMS has provided instruction that allows a specific exemption from the citizenship and identity verification requirements for persons who are foster care or adoption support recipients

   For persons exempt under these criteria, a person alert of IC is entered on the KAECSES PRAP screen. The ES-3850, Record of Identity and Citizenship Documentation, is also to be noted with the applicable information.

   When a child transitions from Foster Care to regular medical coverage, the citizenship and identity documentation will then be required. Contact can be made with CFS staff to determine if they have acceptable documentation on file. Instructions will be issued under separate cover regarding communication between CFS staff and EES or CH staff regarding citizenship and identity documentation.

   In situations where there is less than a calendar-month's break in coverage, the child leaving foster care is treated as a recipient and may be conditionally eligible under other Medicaid programs. If more than a one-month break in coverage has occurred, citizenship and identity will be required prior to providing Medicaid coverage.

2. **Establish Third and Fourth Level of Citizenship and Identity Verification -** The appendix was originally outlined to include three levels of citizenship verification:

   • Chart A = Primary
   • Chart B = Secondary
   • Chart C = Other

   In order to correctly align with the levels of verification provided by CMS, this document has been expanded to include four levels of documentation. The new levels of citizenship verification are as follows:

   • Chart A = Primary
   • Chart B = Secondary
   • Chart C = Third level
   • Chard D = Fourth level

   You will find that the documents previously listed in 'Other' are now divided

among the new Chart C and Chart D.

3. **Additional Allowable Documents -** Appendix A-12 has been updated to include additional documents which are acceptable as verification of citizenship and identity. The new forms of acceptable documents are outlined below. Please review the actual appendix for the specific information which must be included on these documents for them to be acceptable.

   Proof of citizenship:

   • Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000.
   • Religious records
   • Early school records
   • Roll of Alaskan Native
   • Declaration of citizenship for naturalized citizens

   Proof of identity:

   • School records now only require the child's name, but must be verified with the issuing school.

4. **Multiple Documents -** If an applicant has none of the acceptable forms of documentation to prove identity, multiple documents will be accepted. This option is only available to applicants who were able to provide a second or third level of citizenship documentation. Three or more of the following documents can be provided to prove identity:

   • Employer identification cards
   • High school or college diplomas, including GED
   • Marriage certificates
   • Divorce decrees
   • Property deeds/titles

5. **Declaration of Identity -** The P-7 form which is used as a declaration of identity for children has been modified. The declaration can now be completed by a caretaker relative.

   A new form has been created, P-9, Declaration of Identity for Disabled Adults. New CMS instructions allow the administrator or director of a residential facility to complete a Declaration of Identity on behalf of one of their disabled residents when no other form of identification is available.

C. **Case File Transfers -** The Medical Program Transfer Checklist has been revised based on input from the Family Medical workgroup and the Implementation Planning Team. This form is attached to all medical cases transferred from a local SRS Service Center to the HealthWave Clearinghouse. The purpose of this form is to ensure that all files transferred out of the SRS Service Center have correctly approved benefits, correct notices sent, and coverage has been rolled to the current system month.

The list of required documents has been modified, primarily to include the requirement to submit the entire application rather than just a select number of pages. The citizenship and identity documentation along with form ES-3850 have also been added to the list of required documents. In addition, several questions have been removed and new questions added. It also includes general reminders about PRAP codes, CARCing the case, and the Case locator field on ADDR.

In addition to the form revisions, the transfer notices have also been revised. With recommendation from the Family Medical workgroup and input from the Implementation Planning team, the four transfer notices have been reduced to one.

The V043 notice has been revised and is now the only notice available when transferring a case from a local SRS office to the HealthWave Clearinghouse.

Notices V046, V047, and V048 will no longer be available after October 1, 2007.

D. **Long-Term Care Insurance Partnership Program and the Asset Protection Process -** This program policy is effective with any application, change, or review processed on or after 10/1/2007.

1. **Background -** Under the authority provided by the federal Deficit Reduction Act of 2005 (DRA), Kansas has established a Long-Term Care Insurance Partnership Program. Under this program, an individual who purchases a long-term care insurance policy which meets specific criteria established in the DRA, may qualify for Medicaid while retaining a greater amount of their assets than would be possible under the usual resource rules. Long-term care policies which meet these requirements are known as Qualified Plans (QP).

   Purchase of a QP would allow the individual to protect a portion of their assets in determining their eligibility for Medicaid and from the estate recovery claim. This additional amount of resource protection is known as the Asset Disregard (AD). The AD is equal to the amount of insurance benefits paid by the carrier under the policy to or for the benefit of the individual. The AD is in addition to any other disregard the individual would be eligible to receive.

2. **Qualifying Plan -** The Kansas Insurance Department (KID) is responsible for setting guidelines and certifying policies sold in the state as a QP, or a LTC Partnership Policy. Not all LTC policies sold in the state meet these requirements and each policy must be evaluated to determine if it is a QP. The eligibility worker is not responsible for determining if an insurance plan is either qualifying or non-qualifying, but should understand the basic elements of a QP. The long-term care insurance policy must meet the following requirements in order to be considered a QP:

   a. The policy (including those issued under a group insurance contract) must be tax qualified under federal tax law;

b. The policy must be issued (for new policies) or exchanged (for existing policies) after 4/1/2007, the date Kansas was approved to participate in the LTC Partnership Program;

c. The policy must contain age specific inflation protection;

d. The individual covered by the policy must have been a resident of the state when coverage first became effective; and

e. The policy must contain certain consumer protection requirements.

The Medicaid applicant/recipient is responsible for reporting the existence of any long-term care insurance policy, including those which may have exhausted benefits and are no longer in effect. All current long-term care insurance policies will continue to be listed as a Third Party Resource in MMIS. Any payment made by these policies will also continue to be treated as insurance through the MMIS billing process and are not considered income. Policy premiums continue to be allowed as a medical expense.

DOCUMENTATION REQUIREMENTS: Once the policy is reported, the eligibility worker shall investigate to determine whether or not the policy is a QP for purposes of the LTC partnership program. KID is establishing rules that would require all newly issued plans to contain a document certifying the policy as a LTC Partnership Policy, but these requirements are not yet in place. Until these standard certificates are available, the QP status of a long-term care insurance policy may be verified for each policy with an issue date on or after 4/1/2007 by any of the following documents:

An endorsement page issued with the insurance policy certifying the policy is a Partnership Policy;

• A certificate issued by the group plan carrier certifying the policy is a Partnership Policy;
• A letter from the insurance company or group plan carrier certifying the policy is a Partnership Policy; or
• A letter or other documentation from the Kansas Insurance Department certifying the policy is a Partnership Policy.

EXCHANGE POLICIES: The Kansas Insurance Department intends to establish specific protocol to allow policies purchased prior to 4/1/2007 to be exchanged for policies which will meet LTC partnership standards. Until such general requirements are established, the company may elect to reissue the policy with an effective date on or after 4/1/2007. Whether reissued or exchanged, verification is still required to establish that the policy is a QP for purposes of the LTC partnership.

3. **Affected Programs -** The following programs are impacted by the new AP provisions:

- MS
    - Independent Living (Spenddown)
    - Nursing Home
    - HCBS
- QMB
- LMB
- Expanded LMB
- Working Healthy

4. **Asset Disregard -** The Asset Disregard is a dollar-for-dollar amount of insurance benefits paid out by a QP on a reimbursement, cash benefit basis, indemnity insurance basis, or on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate. In addition, the AD applies to all insurance benefits received from a QP even if the long-term care costs would not have been covered by Medicaid.

   The AD is the amount of insurance benefits from a QP that have been received prior to the date eligibility is being determined, even if additional insurance benefits may be received in the future from the QP. The AD is in addition to the normal asset limit for the applicable program. The AD would also be disregarded from the estate recovery claim after death.

   An individual need not exhaust the benefits payable under the QP before applying for assistance. The AD is determined at the time the individual applies for assistance. Once approved for assistance, the AD may be adjusted at review or as needed due to a change in circumstances. The AD is determined by the amount of actual verified insurance benefits paid out under the QP. Under no circumstances would future prospective benefits, as yet unpaid, be counted as part of the AD.

   The AD simply increases the resource limit for the affected programs. The AD is not a resource exemption and is specific to the individual receiving insurance benefits from the QP. The individual must still meet all other Medicaid financial and non-financial eligibility criteria in order to qualify for medical assistance.

   The eligibility worker shall verify the amount of insurance benefits paid out by the QP with documentation issued by the insurance carrier. Either a written statement from the carrier or a benefits statement issued to the policyholder will be sufficient verification.

   Example 1: A single individual with a QP applies for long-term care assistance under the MS program with a resource limit of $2,000. The QP has paid out $50,000 at the time of the application. This individual would qualify for assistance if total countable resources did not exceed $52,000 ($2,000 + the AD of $50,000 = $52,000).

   Example 2: A married individual with a QP applies for long-term care assistance

under the MS program and also requests a division of assets. The QP has paid out $25,000 at the time of the application. The Community Spouse Resource Allowance (CSRA) is determined to be $50,000. This individual would qualify for assistance if total countable resources did not exceed $77,000 ($2,000 + the AD of $25,000 + the CSRA of $50,000 = $77,000).

Example 3: A married couple applies for QMB-only coverage with a resource limit of $6,000. One of the spouses has a QP that previously paid out $4,500 for a short-term nursing home stay they had a few months ago. This couple would qualify for assistance if total countable resources did not exceed $10,500 ($6,000 + the AD of $4,500 = $10,500).

Example 4: A single individual applies for Working Healthy coverage with a resource limit of $15,000. The QP previously paid out $20,000 for a 6 month nursing home stay that ended last month. This individual would qualify for assistance if total countable resources did not exceed $35,000 ($15,000 + the AD of $20,000 = $35,000).

In any of these examples, if the individual or couple had failed the resource limit, the application would have been denied due to excess resources. If the QP benefits had not been exhausted at the time of the original application, a recalculation of the AD would be required upon reapplication where additional benefits have been paid out since the initial determination.

NOTE: The determination of the CSRA would not be affected by the amount of any AD for the long-term care spouse. The community spouse would still be able to shelter countable assets in an amount equal to the CSRA. The long-term care spouse could shelter assets equal to the amount of the AD plus $2,000. And since the AD is specific to the individual, resources to be disregarded in this manner would be expected to be listed in the name of the long-term care spouse once the division of assets is completed.

5. **Effective Date -** The Long-Term Care Insurance Partnership Program became effective in Kansas on 4/1/2007. Only policies purchased or exchanged on or after that date can qualify as a QP in Kansas. Any insurance benefits paid out on a QP on or after that date count towards the amount of the AP. Any benefits paid out under a long-term care insurance policy issued in Kansas before that date are not counted towards the AP.

   Example 1: An individual with a QP applies for long-term care assistance on 9/21/2007, requesting prior medical. This individual has been in the nursing home since 6/15/2007 with benefits paid out under the QP commencing with the date of entry. The QP was purchased on 4/11/2007. The eligibility worker processes the application on 10/20/2007. Since the application is being processed after 9/30/2007, the new policy is applicable. The total amount of insurance benefits paid out of the QP since 4/11/2007 would be verified to determine the AD amount. The AD amount would be calculated separately for each of the prior months based on the total benefits paid out through the end of each particular month.

Example 2: A married individual with a QP applies for long-term care assistance on 10/20/2007. This individual has been in the nursing home since 5/5/2007 with benefits paid out under a non-qualifying long-term care plan since the date of entry. In order to take advantage of the new AD rules, the non-qualifying plan was exchanged for a QP on 8/23/2007. The benefits paid out since the date of the exchange equal the AD, while benefits paid out prior to that date under the non-qualifying plan are not counted.

Example 3: A single individual with a non-qualifying long-term care policy applies for long-term care assistance on 10/15/2007. This individual has been in a nursing home since 2/7/2007 with benefits being paid out under the plan since the date of entry. Since this individual does not have a QP, there would be no additional AD. This individual would have to meet the $2,000 resource limit to qualify for assistance.

6. **Reciprocity -** Kansas Medicaid participates in a national reciprocity agreement with other states operating a Long-Term Care Insurance Partnership Program. What this means is that a QP from another state that provides reciprocity will be deemed to be a QP in Kansas. Kansas Medicaid rules would still be used to determine the amount and application of the AD.

   Verification that the policy is a QP in the state in which it was issued would be accomplished in the same manner as for a policy issued in Kansas. The eligibility worker would obtain a copy of the insurance policy endorsement page or group plan certificate, a letter from the insurance company or group plan carrier, or a letter from the other state's Department of Insurance.

   The eligibility worker must also verify that the state in which the policy was issued has not opted out of the national reciprocity agreement. If the state is not a reciprocity state, then the policy is not recognized in Kansas as a QP and the individual would not be entitled to an AD for any benefits paid out under the policy.

   Currently there is no centralized list of states participating in the Long-Term Care Insurance Partnership Program or whether those states offer reciprocity. Until a list is developed, each out-of-state policy would be investigated to determine if it is a QP as previously described. If the policy is a QP, then the Medicaid office in the state the policy was issued would also be contacted to ascertain if it is a reciprocity state.

   Example 1: An individual moves to Kansas and applies for medical assistance. The individual has a long-term care insurance policy that is a QP in the state of issue. If the issuing state provides for reciprocity, then the policy would be deemed a QP in Kansas. Eligibility would be determined using Kansas Medicaid rules. The AD would equal the amount of benefits paid out by the QP since 4/1/2007.

   Example 2: An individual moves to Kansas and applies for medical assistance.

The individual has a long-term care insurance policy that is a QP in the state of issue. The issuing state is not a reciprocity state. Kansas does not recognize this as a QP and the individual is not entitled to an AD. The regular resource limits would apply.

7. **Documentation -** There have been no KAECSES system changes to accommodate this new policy. Existing screens and codes will be used to identify, track and document individuals and cases with a QP and the amount of any asset disregard. Documentation in the case file describing the QP/AD involvement is required.

   • A "QP/AD CASE: CHECK RESOURCES" notation shall be entered on the WOAL screen with a due date of 01/01/99.
   • Countable assets in excess of the normal resource limit shall be coded as XM on the resource screens up to the amount of the AD.
   • A screen print of the MSRD screen with a notation that this is a QP/AD case shall be retained in the case file along with verification of the insurance benefit amount paid out to document the amount of the AD.
   • Existing medical assistance notices shall be used to notify the individual of case action.

   FOR MORE INFORMATION: Individuals with specific questions concerning QP long-term care insurance policies, including how to exchange an existing policy, are referred to the Kansas Insurance Department and/or the individual's current insurance carrier. The eligibility worker is responsible for answering general questions regarding the impact of a QP on Medicaid eligibility, but shall not provide advice regarding exchange or purchase of a LTC Partnership Policy.

   The Kansas Insurance Department offers a toll-free number to consumers: 1-800-432-2484 (in Kansas only). The e-mail address is commissioner@ksinsurance.org.

For questions regarding the asset disregard or any other information addressed in this memo, contact Tim Schroeder at (785) 296-1144 or by e-mail at Tim.Schroeder@khpa.ks.gov.

V. SUCCESSFUL FAMILIES

A. **Orientation, Assessment, Referral, Safety (OARS) -** See Summary of Changes item IX, A, 1, and KEESM section 3330.8. Also see **KCSDV SFY 2008 Contract** memo from Bobbi Mariani, dated August 23, 2007.

   The SFY 2008 contract with KCSDV limits OARS services to current TAF cash recipients and former TAF recipients who lost cash eligibility within the last 12 months. Effective July 1, 2007, OARS Advocates will not accept referrals for EES customers who are not current TAF cash recipients or former TAF recipients who lost cash eligibility within the last 12 months.

   Between July 1 and September 30, 2007, OARS Advocates will transition to local DV programs those current customers who are not TAF cash recipients or former TAF

recipients who lost cash eligibility within the last 12 months.

When a TAF applicant discloses domestic violence issues prior to approval of the application for TAF cash assistance, the applicant should be referred to the subcontracting agency for DV services. When the TAF cash application is approved, the EES case manager is to send a referral (ES 4320) to the OARS Advocate.

Attachments:

A. Name Standards on Systems

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