Disability Rights California

California's protection and advocacy system
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2011 Fact Sheet # 1, Pub #F049.01

California's Budget Cuts to Developmental Disability Services & Programs Effective July 1, 2011

Annual Family Program Fee[1]

The State Legislature required the Department of Developmental Services (DDS) to reduce its budget by 174 million dollars for this fiscal year (2011-2012), in addition to the required 334 million dollar reduction effective July, 2009.[2] As a result, there are changes to the types and amounts of services that regional centers can purchase. This fact sheet describes the 2011 addition of the Annual Family Program Fee to the Lanterman Act. It also includes information about the exemptions to the fee, how the fee will be collected, and what to do if you do not agree with the amount of the fee charged.

[1] The changes are part of the Budget Trailer Bill (TBL) AB104. You may find the law at http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0101-0150/ab_104_bill_20110630_chaptered.html. Welfare and Institutions Code section 4782

[2] The new law requires DDS to obtain even greater savings if certain triggers are not met in the state budget throughout the year. Disability Rights California will discuss this on its website if the triggers are not met.

HOW THE LAW CHANGED

The Lanterman Act previously required that parents pay for out of home placements[3] and the services provided under the Family Cost Participation Program.[4] Now, families of minor regional center eligible children have to pay an annual fee under certain circumstances.[5]

A. Annual Family Program Fee

The Department of Developmental Services established a new program by which it will collect fees for children receiving regional center services. Any family whose adjusted gross income is at or above 400 percent of the federal poverty rate and that meets the following criteria will be assessed an annual fee:

1. The child is eligible for regional center services under the Lanterman Act or Early Intervention Services Act;[6]
2. The child is under 18 years of age;
3. The child lives with his/her parents;
4. The child or family receives services beyond needs assessment and service coordination;
5. The child does **not** receive Medi-Cal including Medi-Cal waiver services; and,
6. The child receives services beyond those for which a copay is being assessed under the Family Cost Participation Program.[7]

If the family's adjusted gross income is less than 400 percent of the federal poverty level, there will be **no fee**. If the family's adjusted gross income is between 400 and 800 percent of the federal poverty level, there will be a fee of $150 per family. [8] If the family's adjusted gross income is more than

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[3] Welfare and Institutions Code section 4782
[4] Welfare and Institutions Code section 4783
[5] Welfare and Institutions Code section 4785
[6] The fee will apply to children age 0-2 years only if approval is given to the state by the federal government.
[7] Welfare and Institutions Code section 4785(a); includes respite, day care, or camping costs.
[8] Welfare and Institutions Code section 4785(b)

800 percent of the federal poverty level, there will be a fee of $200 per family.

General considerations:

1. These fees are per family, regardless of the number of regional-center eligible children in the family.

2. Total adjusted gross family income means all income from both parents (even if living separately unless a court order states otherwise), including the community property portion of a stepparent's income.

3. If a noncustodial parent's income cannot be obtained, then it shall not be included.

B. Exemptions

A regional center may grant an exemption to the assessment of an annual family program fee if the parents demonstrate:

1. The exemption is necessary to maintain the child in the family home;

2. The existence of an extraordinary event that impacts the parents' ability to pay the fee or the parents' ability to meet the care and supervision needs of the child; or,

3. The existence of a catastrophic loss that temporarily limits the ability of the parents to pay and creates a direct economic impact on the family. For purposes of this subdivision, catastrophic losses may include, but are not limited to: natural disasters; accidents involving, or major injuries to, an immediate family member; and extraordinary medical expenses.[9]

[9] Welfare and Institutions Code section 4785(f)

C. Chart Showing Federal Poverty Rate

2011 HHS Poverty Guidelines[10]			
Persons in Family	**48 Contiguous States and D.C.**	**400%**	**800%**
1	$10,890	$43,560	$87,120
2	14,710	58,840	117,680
3	18,530	74,120	148,240
4	22,350	89,400	178,800
5	26,170	104,680	209,390
6	29,990	119,960	239,920
7	33,810	135,240	270,480
8	37,630	150,520	301,040
For each additional person, add	3,820		

D. Effective Date

This part of the law is effective at the time the TBL was enacted, which was July 1, 2011. However, the fee shall not be assessed until the next scheduled review or modification of your current Individual Program Plan (IPP) or at development of an initial IPP. These fees must be assessed by June 30, 2012, and annually thereafter.[11] This law will no longer be effective June 30, 2013, unless further legislation is enacted.

E. What Will Happen when the Regional Center Wants to Implement the Annual Family Program Fee?

At the IPP meeting, the regional center should give each qualifying family a form and an envelope to mail the Annual Family Program Fee to DDS. The Department of Developmental Services will report on the fees collected to each regional center quarterly.

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[10] SOURCE: *Federal Register*, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638 at http://aspe.hhs.gov/poverty/11poverty.shtml

[11] Welfare and Institutions Code section 4785(c)

F. What Will Happen if the Annual Family Program Fee Is Not Paid?

Non-payment of the Annual Family Program Fee **cannot** result in delayed or denied services for the child or family.[12] If fees are not paid, the regional center will send a letter requesting payment of the fees. If fees are still not paid, DDS can pursue collections.[13]

G. What to Do if You Do Not Agree with the Amount of the Annual Assessment

Disability Rights California believes that if you do not agree with the amount of your family's annual assessment, you are entitled to a regional center due process hearing even though the statute enacting the fee does not specifically say this. The Lanterman Act states that any applicant for or recipient of services, or authorized representative of the applicant or recipient, who is dissatisfied with any decision or action of the (regional center) which he or she believes to be illegal, discriminatory, or not in the recipient's or applicant's best interests, shall, upon filing a request within 30 days after notification of the decision or action complained of, be afforded an opportunity for a fair hearing.[14]

For more important information on how to appeal decisions by the regional center, read our fact sheet, Regional Center Due Process and Hearing Rights at http://www.disabilityrightsca.org/pubs/F02601.pdf.

[12] Welfare and Institutions Code section 4785(g)
[13] Welfare and Institutions Code section 4785 (d) and (e)
[14] Welfare and Institutions Code section 4710.5(a)

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2011 Fact Sheet # 6, Pub #F054.01

California's Budget Cuts to Developmental Disability Services & Programs Effective July 1, 2011

Use of Generic Services and Private Insurance and the Requirement to Provide Copies of Health Benefits Cards[1]

The State Legislature required the Department of Developmental Services (DDS) to reduce its budget by 174 million dollars for this fiscal year (2011-2012) in addition to the required 334 million dollar reduction effective July, 2009.[2] As a result, there are changes to the types and amounts of services that regional centers can purchase.

This fact sheet describes the 2011 change that requires that copies of health benefits' cards be provided to regional centers, includes reference to the 2009 changes involving use of generic resources and private insurance, and what will happen if the regional center wants to change your services.

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[1] The changes are part of the Budget Trailer Bill (TBL) AB 104. You may find the law at http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0101-0150/ab_104_bill_20110630_chaptered.html. Changes affecting Generic Services and Private Insurance are found in Welfare and Institutions Code, section 4659(a). Changes requiring the provision of copies of health benefits cards are found in Government Code section 95020 and Welfare and Institutions Code sections 4643 & 4646.4.

[2] The new law requires DDS to obtain even greater savings if certain triggers are not met in the state budget throughout the year. Disability Rights California will discuss this on its website if the triggers are not met.

HOW THE LAW CHANGED IN 2009

The Lanterman Act currently requires regional centers to identify other sources of funding before buying services.[3] These are sometimes called "generic" services.

In 2009, the law changed to make these requirements stronger. The changes say:

1. **Specific Generic Services You Must Apply for Before the Regional Center Can Pay**[4]

If you or your family are eligible for Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services (CHAMPUS-otherwise known as TRICARE), In-Home Support Services (IHSS), California Children's Services (CCS), private insurance, or a health care service plan, and you or your family choose not to apply for these services, then the regional center cannot purchase those services for you.

If you or your family does not meet the criteria for the generic services above, then the regional center can continue to purchase these types of services for you.

2. **Medical and Dental Services You Must Apply for (and Appeal the Denial if the Regional Center Thinks You Should) Before the Regional Center Can Pay**[5]

A regional center can only buy medical or dental services for you if you are over age three (3) and:

- You or your family show the regional center that Medi-Cal, private insurance, or a health care service plan has denied the medical or dental service; and,

- The regional center decides that an appeal would have no merit.

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[3] Welfare and Institutions Code section 4659(a)
[4] Welfare and Institutions Code section 4659(c)
[5] Welfare and Institutions Code section 4659(d)

The regional centers may pay for medical or dental services:

- While you or your family are trying to get medical or dental service from another agency or private insurance and you have not yet been given a denial;

- While you or your family are waiting for a final administrative decision and you already provided the regional center with information that you are appealing; or,

- Until Medi-Cal, private insurance, or a health care services plan begins to provide the services.

HOW THE LAW CHANGED IN 2011

Starting July 1, 2011, you must provide the regional center with copies of any health benefits cards under which you are eligible to receive health benefits, including private health insurance coverage, health service plans, Medi-Cal, Medicare, and TRICARE cards (for military families).[6] But if you, or where appropriate, your parents, legal guardians, or conservators, have no such benefits, the regional center cannot use that fact to negatively impact the services you may or may not receive from the regional center.[7]

For regional center services, the cards must be presented at assessments or development, scheduled review, or modification of the IPP. For Early Start services, the cards must be presented at the time of the intake or assessment but no later than the Individualized Family Service Plan (IFSP) meeting.

What Will Happen If the Regional Center Wants to Change Your Services?

If your regional center wants to change your services by requiring you to use a generic service or your private insurance, it must either hold an IPP meeting and reach agreement with you about the change or give you a

[6] Government Code section 95020 and Welfare and Institutions Code sections 4643 & 4646.4
[7] *Id.*

written notice.[8] The notice must be given 30 days before the change begins.[9] The notice must give you the following information:

- the action the regional center is taking;
- the basic facts about why the regional center is making its decision;
- the reason for the action;
- the effective date; and,
- the specific law, regulation or policy that supports the action.[10]

If you are already receiving the service and you disagree with the regional center's decision and want to continue to receive it, you must request a fair hearing within 10 days of receiving the notice.[11] Otherwise, the request must be made within 30 days.[12] If exemptions are available and you think you meet an exemption, remember to additionally put "I meet an exemption" into your fair hearing request.

For more important information on how to appeal decisions by the regional center, read our fact sheet, Regional Center Due Process and Hearing Rights at http://www.disabilityrightsca.org/pubs/F02601.pdf.

[8] Usually, decisions about the services you need must be decided by an IPP team. Welfare and Institutions Code section 4646.4(a)-(c). However, the law says if a regional center wants to reduce, end or change a service in your IPP without your consent, it has to give you a 30 day notice first. Welfare and Institutions Code section 4710

[9] Welfare and Institutions Code section 4710

[10] Welfare and Institutions Code section 4701. The information must also be in the language you understand.

[11] Welfare and Institutions Code section 4715

[12] Welfare and Institutions Code section 4710.5(a)