State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

August 9, 2017

TO: ALL COUNTY WELFARE DIRECTORS Letter No.: 17-18
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY MEDS LIAISONS

SUBJECT: PERIODIC DATA MATCHING TO CONFIRM RESIDENCY

The Department of Health Care Services (DHCS) performs periodic data matching to confirm California residency. The periodic data matching detects when Medi-Cal beneficiaries appear to have an unreported change in circumstance specific to state residency. This letter provides guidance to County Welfare Departments (CWDs) on how to coordinate with DHCS regarding the state-level discontinuances of Medi-Cal eligibility that result from the periodic data matching.

Residency Verification Activities

DHCS conducts periodic data matching that has the capability to detect beneficiaries living outside of California. There are numerous detection sources, including, but not limited to, information from the Department of Defense, Social Security Administration, the Medicare program, and public records. To prevent improper payments for ineligible Medi-Cal beneficiaries, DHCS sends out residency verification letters to beneficiaries who may no longer have California residency. Beneficiaries receive instructional letters and forms to provide a current California residence address if they want to continue their Medi-Cal eligibility. The MC 215 “Request for Withdrawal and/or Waiver of Ten-Day Advance Notice” is also included with the letters. Special populations are excluded, such as students or beneficiaries leaving California for 60 days or less, as described in All County Welfare Directors Letter (ACWDL) 15-23.

DHCS sends residency verification letters to the mailing address appearing in the Medi-Cal Eligibility Data System (MEDS). The letters instruct the beneficiaries to respond within 30 days. Refer to Enclosure A for a sample of mailing contents.

DHCS discontinues Medi-Cal benefits in MEDS for those beneficiaries who confirm out-of-state residency or request to have their benefits terminated. Individuals that do not respond to DHCS or the CWD within 30 days are considered nonresponsive and are discontinued from Medi-Cal in MEDS. (Welf. & Inst. Code § 14005.39; Cal. Code Regs.

Title 22, §§ 50175, 50323.) DHCS sends Notices of Action (NOAs) to beneficiaries based on their response or nonresponse. The NOAs provide the reason for discontinuing benefits and information for requesting a fair hearing. NOAs for nonrespondents contain language for the 90-day cure period. If a beneficiary provides the requested information within the 90-day cure period and the information establishes continued eligibility, CWDs reinstate benefits back to the date of discontinuance. CWDs update the Statewide Automated Welfare System (SAWS) upon receiving the requested information. If DHCS receives the requested information, DHCS notifies CWDs of the updated information via their MEDS coordinator or designated liaison so CWDs can update SAWS. After mailing NOAs, DHCS updates MEDS by placing a "48" (loss of residency), "03" (discontinuance at recipient request), or "04" (failure to cooperate) value in the Eligibility Termination Reason field (Data Element Number 0185). See Enclosure B for sample NOAs.

CWD Coordination

Residency verification letters instruct Medi-Cal beneficiaries to return the requested information directly to DHCS. Despite this, there is a chance some Medi-Cal beneficiaries may contact the CWDs. If this happens, CWDs must update SAWS with the new information and alert DHCS by mail, fax, or secure email within ten business days of the contact. CWDs send mail to:

Department of Health Care Services
Residency Verification Program
P.O. Box 997417, MS 4607
Sacramento, CA 95899-7417

Secure emails are sent to rvp@dhcs.ca.gov. Alternatively, CWDs fax information to 916-440-5243.

DHCS provides each county with a list of discontinued beneficiaries via secure email sent to the designated liaison. The discontinuance list indicates:

- Beneficiary's name and date of birth
- Beneficiary's MEDS ID and CIN
- Beneficiary's MEDS address
- County-ID, District, and EW Code in MEDS
- Date DHCS sent NOA to beneficiary
- Type of NOA sent to the beneficiary
- MEDS termination date and reason

DHCS sends these lists quarterly. Upon receipt of the discontinuance list, CWDs must inform DHCS within 30 calendar days if a discontinued beneficiary has informed them of temporarily leaving California for any reason.

CWDs must update SAWS to reflect the discontinuances prior to the next MEDS reconciliation. DHCS notes when the next MEDS reconciliation occurs to help CWDs plan for sufficient time to update SAWS. When updating cases locally, CWDs must suppress the mailing of notices to discontinued beneficiaries since DHCS has already issued discontinuance NOAs. CWDs receive a copy of the letter and NOA sent to each beneficiary along with copies of emails, correspondences and returned forms from Medi-Cal beneficiaries. CWDs must upload these copies to the case. Any email, correspondence or returned form DHCS receives after discontinuance lists are sent will be forwarded to CWDs the following quarter.

CWDs do not need to inform DHCS once cases have been discontinued in SAWS as long as the discontinuances are completed prior to the next MEDS reconciliation. Follow established procedures for any other residency program currently in place, such as Medicare out of state alerts and other state public assistance enrollment alerts. This letter does not alter procedures of any other existing residency alerting programs. Continue to follow all existing reinstatement and appeal procedures.

Loss of residency, in some instances, will be for one individual moving out of the household but depending on the situation, could be for the entire family. When benefits for an entire family are discontinued, DHCS groups members of the same household together by County-ID on the discontinuance lists. If Medi-Cal is discontinued for one individual while the rest of the household remains in California, the household members **not** on the discontinuance lists are considered California residents. However, CWDs should determine if the change in household composition impacts eligibility for other members of the case following standard redetermination procedures outlined in Welf. & Inst. Code § 14005.37 and ACWDL 14-22. If eligibility for other family members not listed on the spreadsheet is changed, CWDs must send NOAs to these beneficiaries if appropriate. DHCS reminds CWDs that an absent beneficiary may continue to be part of the household for tax purposes and Medi-Cal eligibility determination for the remaining household members depending on each household's unique tax situation.

Thank you for your attention to these residency verification activities. These ongoing mailings prevent improper payments and reduce CWD workload by identifying and discontinuing ineligible Medi-Cal beneficiaries prior to the next annual redetermination. This residency verification program does not replace any other non-resident detection programs, such as matching beneficiaries receiving public assistance in more than one state, but instead augments efforts to identify Medi-Cal beneficiaries who no longer intend to reside in California. All other programs remain intact in their present format.

If you have any questions or comments regarding the information in this letter, please contact Ms. Leslie Nowack at (916) 327-0413 or by email at Leslie.Nowack@dhcs.ca.gov.

ORIGINAL SIGNED BY

Sandra Williams, Chief
Medi-Cal Eligibility Division

Enclosures

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
Director

JERRY BROWN
Governor

June 29, 2016

Mr. John Doe
1501 Capitol Ave.
Sacramento, CA 95814

Dear Mr. Doe:

You are receiving this letter because you are currently enrolled in Medi-Cal and possibly living outside of California. Under California law, California residency is a requirement for a person to be eligible for Medi-Cal. (Cal. Code Regs., Title 22, § 50320.) You are a resident if you live and intend to reside in California. This includes if you came to the state with a job or are looking for a job. You do not need to have a job or a fixed address to be a California resident. (Welf. & Inst. Code § 14007.15.)

In addition, it appears you or a family member is serving on active duty status with the U.S. Armed Forces. Active duty members of the military and their dependents are entitled to medical and dental care through the federal government. (10 U.S.C. §§ 1074, 1076.)

If you still live in California, please provide the address where you currently live. Please complete the enclosed "Medi-Cal Address Update" form.

If you no longer intend to live in California, you can end your Medi-Cal benefits immediately by checking the "Medi-Cal Eligibility Discontinuance" (2nd box) on the enclosed "Request for Withdrawal and/or Waiver of Ten-Day Advance Notice" (MC 215) form. If other members of your family no longer intend to reside in California, we need a form for each person. Adults must sign their own form. For any minor children, a parent or legal guardian should sign on each minor's behalf.

We have provided a return envelope for your convenience. If it's easier you can send an email to rvp@dhcs.ca.gov or fax your request to (916) 440-5243. Please contact us within **30** days of the date of this letter or your Medi-Cal eligibility will be turned off.

If you have any questions regarding this letter, send them by email to rvp@dhcs.ca.gov. You can also fax questions to (916) 440-5243 or contact your Medi-Cal eligibility worker at your county office. Thank you for your service.

MEDI-CAL
ADDRESS UPDATE FORM

Please provide your current home address (where you live the majority of the time).

HOME ADDRESS

Name(s): _____

Number/Street (including apt. number if applicable): _____

_____

City, State, ZIP: _____

Phone: (optional): _____

Email: (optional): _____

Please provide your current mailing address or check the box below.

MAILING ADDRESS

☐ **My mailing address is the same as my home address**.

Number/Street/Apt: _____

City, State, ZIP: _____

DHCS PRIVACY STATEMENT

This form is for receiving benefits through the Department of Health Care Services (DHCS). The personal and medical information you provide on it is private and confidential. DHCS needs it to identify you and the other people on this form and to administer our programs. We will share your information with other state, federal, and local agencies, contractors, health plans, and programs only to administer programs, and with other state and federal agencies as required by law.

You must answer all of the questions on this form unless they are marked “optional.” If your form is missing anything that we require, we will contact you to get it. If you do not provide it, we will not be able to make a decision on your benefits. You may have to submit a new application, or services may be discontinued.

In most cases, you have the right to see personal information about you that is in federal and state records. You can see it in an alternative format (such as large print) if you need that. For more information, contact the DHCS Information Protection Unit at:

P.O. Box 997413, MS 4721
Sacramento, CA
95899-7413
Phone: 1-866-866-0602
TTY: 1-877-735-2929

These state laws give us the right to collect and keep the information: CA Welfare and Institutions Code § 14011 and Article 3, Chapters 5 and 7, Parts 2 and 3, Division 9. We must give you this Privacy Statement under CA Civil Code § 1798.17.

State of California—Health and Human Services Agency

Department of Health Care Services
Medi-Cal Program

FOR COUNTY USE ONLY

Case Name: _____
Case Number: _____
Worker Number: _____
Telephone Number: _____

REQUEST FOR WITHDRAWAL AND/OR WAIVER OF TEN-DAY ADVANCE NOTICE

❒ MEDI-CAL APPLICATION WITHDRAWAL

I, _____, ask that my application for Medi-Cal, dated _____/_____/_____, be withdrawn because _____

_____.

I understand that my Medi-Cal eligibility will not be determined at this time. I can reapply at any time.

❒ MEDI-CAL ELIGIBILITY DISCONTINUANCE

I, _____, ask that my Medi-Cal eligibility be discontinued effective _____/_____/_____because _____

_____.

I understand that I can reapply at any time.

❒ BENEFICIARY WAIVER OF TEN-DAY NOTICE

I, _____, understand that based upon the information I have reported, effective _____/_____/_____,

❒ my Medi-Cal eligibility must be discontinued.

❒ my Medi-Cal share-of-cost must be increased.

I understand that I am supposed to be given a ten-day notice before this action becomes effective. However, since I know that the above action must be taken based on the information I reported, it is not necessary for the county to send me this notice within the ten-day limit.

I understand that the above request will not interfere with my right to a state hearing, and that I can reapply for Medi-Cal at any time. I understand that if I ask for a state hearing before the effective date of the action, the county's action will be delayed.

_____ _____
Signature of Applicant/Beneficiary Date

NOTICE OF ACTION
DISCONTINUANCE OF BENEFITS
BENEFICIARY REQUEST FOR DISCONTINUANCE

Department of Health Care Services
Residency Verification Program
P.O. Box 997417 MS 4607
Sacramento, CA 95899-7417

John Doe
1501 Capitol Ave
Sacramento, CA 95814

Notice Date: January 4, 2016

DISCONTINUANCE OF BENEFITS NOTICE FOR:

John Doe

We asked you to confirm your California residency to continue your Medi-Cal coverage. Based on your response, your Medi-Cal will be discontinued on January 31, 2016.

The reason your benefits are stopping is:

You asked the Department of Health Care Services (DHCS) to end your Medi-Cal.

Please note: Other family members with different eligibility status may receive a separate notice. Please call your county welfare department if you need additional information about this notice.

DO NOT THROW AWAY YOUR BENEFITS IDENTIFICATION CARD (BIC)
If you already have a plastic Benefits Identification Card (BIC), do not throw it away. You can use it again if you become eligible for Medi-Cal.

We used the information you gave us on your recent contact with DHCS to make our decision. If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away. You can reapply for Medi-Cal at any time.

RULES: California Code of Regulations, Title 22, §50155 is the regulation or law we used to make this decision. If you think we made a mistake, you can request a hearing. The back of this page explains how to request a hearing.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits 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, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: Cash Aid CalFresh
Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

<u>Cal-Learn</u>:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

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

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

  State Hearings Division
  P.O. Box 944243 MS 19-37
  Sacramento, CA 94244-2430

  OR
- **Call toll free: 1-800-952-5253 or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

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

Cash Aid CalFresh Medi-Cal

Other (list)_____

Here's Why:

_____

_____

_____

_____

_____

If you need more space, check here and add a page.

I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is:

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE	PHONE NUMBER

STREET ADDRESS

CITY	STATE	ZIP CODE

SIGNATURE	DATE
NAME OF PERSON COMPLETING THIS FORM	PHONE NUMBER

I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)

NAME	PHONE NUMBER

STREET ADDRESS

CITY	STATE	ZIP CODE

NOTICE OF ACTION
DISCONTINUANCE OF BENEFITS
NOT A CALIFORNIA RESIDENT

Department of Health Care Services
Residency Verification Program
P.O. Box 997417 MS 4607
Sacramento, CA 95899-7417

John Doe
1501 Capitol Ave
Sacramento, CA 95814

Notice Date: January 4, 2016

DISCONTINUANCE OF BENEFITS NOTICE FOR:

John Doe

We asked you to confirm your California residency to continue your Medi-Cal coverage. Based on your response, your Medi-Cal will be discontinued on January 31, 2016.

The reason your benefits are stopping is:

You no longer live in California. You must live in California to receive Medi-Cal benefits.

Please note: Other family members with different eligibility status may receive a separate notice. Please call your county welfare department if you need additional information about this notice.

DO NOT THROW AWAY YOUR BENEFITS IDENTIFICATION CARD (BIC)
If you already have a plastic Benefits Identification Card (BIC), do not throw it away. You can use it again if you become eligible for Medi-Cal.

We used the information you gave us on your recent contact with DHCS to make our decision. If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away. You can reapply for Medi-Cal at any time.

RULES: This action is required by California Code of Regulations, Title 22, §50320. If you think this action is incorrect, you can request a hearing. The back of this page explains how to request a hearing.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits 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, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: Cash Aid CalFresh
Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

<u>Cal-Learn</u>:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

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

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**

  State Hearings Division
  P.O. Box 944243 MS 19-37
  Sacramento, CA 94244-2430

  OR
- **Call toll free: 1-800-952-5253 or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

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

Cash Aid CalFresh Medi-Cal

Other (list) _____

Here's Why:

_____

_____

_____

_____

_____

If you need more space, check here and add a page.

I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is:

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

NOTICE OF ACTION
DISCONTINUANCE OF BENEFITS
FAILURE TO COOPERATE

Department of Health Care Services
Residency Verification Program
P.O. Box 997417 MS 4607
Sacramento, CA 95899-7417

John Doe
1501 Capitol Ave.
Sacramento, CA 95814

Notice Date: August 4, 2016

DISCONTINUANCE OF BENEFITS NOTICE FOR:

John Doe

Your Medi-Cal will end on 08/31/2016 because:

You did not confirm your California residency. You must live in California to receive Medi-Cal benefits. In order to complete our review of your Medi-Cal eligibility, we needed the following information from you:

1. Your current residence address.

We asked you for that information, but we have not received it and it is needed to process your eligibility.

You can still get Medi-Cal, but you need to give us more information. We need it within 90 days, by November 27, 2016. We can give you Medi-Cal from August 31, 2016 if you are still eligible. If we do not get the information by November 27, 2016, you must reapply for Medi-Cal. (Welfare and Institutions Code, Section 14005.37(i)).

Please note: Other family members with different eligibility status may receive a separate notice. Please call your county welfare department if you need additional information about this notice.

DO NOT THROW AWAY YOUR BENEFITS IDENTIFICATION CARD (BIC)
If you already have a plastic Benefits Identification Card (BIC), do not throw it away. You can use it again if you become eligible for Medi-Cal.

We did not have enough information to determine your California residency. You should call or write your county welfare department right away if you have any questions about this action or if the information in the notice is not correct. You can reapply for Medi-Cal at any time.

RULES: California Code of Regulations, Title 22, §50167, §50185, §50320, and §50320.1 are the regulations or laws we used to make this decision. If you think we made a mistake, you can request a hearing. The back of this page explains how to request a hearing.

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- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits 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, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

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Cash Aid CalFresh Medi-Cal

Other (list) _____

Here's Why:

_____

_____

_____

_____

_____

If you need more space, check here and add a page.

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My language or dialect is:

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE