Hearing Date: February 13, 2026

ITEM 4
TEST CLAIM
PROPOSED DECISION

Penal Code Section 11171(f), Effective January 1, 2024

Statutes 2023, Chapter 841 (AB 1402)

Child Physical Abuse and Neglect Exams

24-TC-05

County of Santa Clara, Claimant

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Exhibit A

STATE of CALIFORNIA
COMMISSION ON STATE MANDATES

For CSM Use Only	
Filing Date:	RECEIVED December 31, 2024 Commission on State Mandates
TC #:	24-TC-05

TEST CLAIM FORM AND TEST CLAIM AMENDMENT FORM (Pursuant to Government Code section 17500 et seq. and Title 2, California Code of Regulations, section 1181.1 et seq.)

Section 1

Proposed Test Claim Title:

Child Physical Abuse and Neglect Exams

Section 2

Local Government (Local Agency/School District) Name:

County of Santa Clara

Name and Title of Claimant's Authorized Official pursuant to CCR, tit.2, § 1183.1(a)(1-5):

Margaret Olaiya, Director of Finance (ex-officio Auditor-Controller)

Street Address, City, State, and Zip:

70 West Hedding Street, East Wing, 2nd Floor

Telephone Number: 408-299-5201

Email Address: Margaret.Olaiya@fin.sccgov.org

Section 3 – Claimant designates the following person to act as its sole representative in this test claim. All correspondence and communications regarding this claim shall be sent to this representative. Any change in representation must be authorized by the claimant in writing, and e-filed with the Commission on State Mandates. (CCR, tit.2, § 1183.1(b)(1-5).)

Name and Title of Claimant Representative:

Rajiv Narayan, Deputy County Counsel

Organization: Office of the County Counsel, County of Santa Clara

Street Address, City, State, Zip:

70 West Hedding Street, East Wing, 9th Floor

Telephone Number: 6697864287

Email Address: rajiv.narayan@cco.sccgov.org

Section 4 – Identify all code sections (include statutes, chapters, and bill numbers; e.g., Penal Code section 2045, Statutes 2004, Chapter 54 [AB 290]), regulatory sections (include register number and effective date; e.g., California Code of Regulations, title 5, section 60100 (Register 1998, No. 44, effective 10/29/98), and other executive orders (include effective date) that impose the alleged mandate pursuant to Government Code section 17553 and check for amendments to the section or regulations adopted to implement it:

Penal Code section 11171, subd. (f), Statutes of 2023, Chapter 841 (AB 1402)

☑ Test Claim is Timely Filed on [Insert Filing Date] [select either A or B]: 12 / 31 / 2024

☑ A: Which is not later than 12 months (365 days) following [insert effective date] 01 / 01 / 2024, the effective date of the statute(s) or executive order(s) pled; or

☑ B: Which is within 12 months (365 days) of [insert the date costs were *first* incurred to implement the alleged mandate] 01 / 03 / 2024, which is the date of first incurring costs as a result of the statute(s) or executive order(s) pled. *This filing includes evidence which would be admissible over an objection in a civil proceeding to support the assertion of fact regarding the date that costs were first incurred.*

(Gov. Code § 17551(c); Cal. Code Regs., tit. 2, §§ 1183.1(c) and 1187.5.)

Section 5 – Written Narrative:

☑ Includes a statement that actual or estimated costs exceed one thousand dollars ($1,000). (Gov. Code § 17564.)

☑ Includes all of the following elements for each statute or executive order alleged **pursuant to Government Code section 17553(b)(1)**:

☑ Identifies all sections of statutes or executive orders and the effective date and register number of regulations alleged to contain a mandate, including a detailed description of the *new* activities and costs that arise from the alleged mandate and the existing activities and costs that are *modified* by the alleged mandate;

☑ Identifies *actual* increased costs incurred by the claimant during the fiscal year for which the claim was filed to implement the alleged mandate;

☑ Identifies *actual or estimated* annual costs that will be incurred by the claimant to implement the alleged mandate during the fiscal year immediately following the fiscal year for which the claim was filed;

☑ Contains a statewide cost estimate of increased costs that all local agencies or school districts will incur to implement the alleged mandate during the fiscal year immediately following the fiscal year for which the claim was filed;

Following FY: 2024 - 2025 Total Costs: $11,800,000

☑ Identifies all dedicated funding sources for this program;

State: None

Federal: None

Local agency's general purpose funds: No dedicated funding source (General Fund used to cover costs)

Other nonlocal agency funds: None

Fee authority to offset costs: None

☑ Identifies prior mandate determinations made by the Board of Control or the Commission on State Mandates that may be related to the alleged mandate:

00-TC-22, titled "Interagency Child Abuse and Neglect Investigation Reports"

☑ Identifies any legislatively determined mandates that are on, or that may be related to, the same statute or executive order: None

Section 6 – The Written Narrative Shall be Supported with Declarations Under Penalty of Perjury Pursuant to Government Code Section 17553(b)(2) and California Code of Regulations, title 2, section 1187.5, as follows:

☑ Declarations of actual or estimated increased costs that will be incurred by the claimant to implement the alleged mandate.

☑ Declarations identifying all local, state, or federal funds, and fee authority that may be used to offset the increased costs that will be incurred by the claimant to implement the alleged mandate, including direct and indirect costs.

☑ Declarations describing new activities performed to implement specified provisions of the new statute or executive order alleged to impose a reimbursable state-mandated program (specific references shall be made to chapters, articles, sections, or page numbers alleged to impose a reimbursable state-mandated program).

☐ If applicable, declarations describing the period of reimbursement and payments received for full reimbursement of costs for a legislatively determined mandate pursuant to Government Code section 17573, and the authority to file a test claim pursuant to paragraph (1) of subdivision (c) of Government Code section 17574.

☑ The declarations are signed under penalty of perjury, based on the declarant's personal knowledge, information, or belief, by persons who are authorized and competent to do so.

Section 7 – The Written Narrative Shall be Supported with Copies of the Following Documentation Pursuant to Government Code section 17553(b)(3) and California Code of Regulations, title 2, § 1187.5:

☑ The test claim statute that includes the bill number, and/or executive order identified by its effective date and register number (if a regulation), alleged to impose or impact a mandate.
Pages 48 to 53.

☑ Relevant portions of state constitutional provisions, federal statutes, and executive orders that may impact the alleged mandate. Pages 106 to 234.

☑ Administrative decisions and court decisions cited in the narrative. (Published court decisions arising from a state mandate determination by the Board of Control or the Commission are exempt from this requirement.) Pages 54 to 105.

☑ Evidence to support any written representation of fact. *Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions.* (*Cal. Code Regs., tit. 2, § 1187.5.*) Pages 21 to 46.

Section 8 – TEST CLAIM CERTIFICATION Pursuant to Government Code section 17553

☑ The test claim form is signed and dated at the end of the document, under penalty of perjury by the eligible claimant, with the declaration that the test claim is true and complete to the best of the declarant's personal knowledge, information, or belief.

Read, sign, and date this section. Test claims that are not signed by authorized claimant officials pursuant to California Code of Regulations, title 2, section 1183.1(a)(1-5) will be returned as incomplete. In addition, please note that this form also serves to designate a claimant representative for the matter (if desired) and for that reason may only be signed by an authorized local government official as defined in section 1183.1(a)(1-5) of the Commission's regulations, and not by the representative.

This test claim alleges the existence of a reimbursable state-mandated program within the meaning of article XIII B, section 6 of the California Constitution and Government Code section 17514. I hereby declare, under penalty of perjury under the laws of the State of California, that the information in this test claim is true and complete to the best of my own personal knowledge, information, or belief. All representations of fact are supported by documentary or testimonial evidence and are submitted in accordance with the Commission's regulations. (Cal. Code Regs., tit.2, §§ 1183.1 and 1187.5.)

Margaret Olaiya
Name of Authorized Local Government Official
pursuant to Cal. Code Regs., tit.2, § 1183.1(a)(1-5)

Director of Finance (ex officio Auditor-Controller)
Print or Type Title

Margaret Olaiya
Margaret Olaiya (Feb 11, 2025 17:05 PST)
Signature of Authorized Local Government Official
pursuant to Cal. Code Regs., tit.2, § 1183.1(a)(1-5)

Test Claim Form

Final Audit Report 2025-02-12

Created:	2025-01-30
By:	CSM Sign (csmsign@csm.ca.gov)
Status:	Signed
Transaction ID:	CBJCHBCAABAA29HPRe1yh6zVEGbn9C5qJbo-swI3cr2i

"Test Claim Form" History

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Signer rajiv.narayan@cco.sccgov.org entered name at signing as Rajiv Narayan
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Agreement completed.
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Adobe Acrobat Sign

Test Claim Form Sections 4-7 WORKSHEET

Complete Worksheets for Each New Activity and Modified Existing Activity Alleged to Be Mandated by the State, and Include the Completed Worksheets With Your Filing.

Statute, Chapter and Code Section/Executive Order Section, Effective Date, and Register Number:
Penal Code section 11171, subd. (f), Statutes 2023, Chapter 841 (AB 1402), eff. January 1, 2024

Activity: Mandates that "[c]osts for the medical evidentiary portion of the examination shall not be charged directly or indirectly to the victim of child physical abuse or neglect." (Penal Code, § 11171, subd. (f).)

Initial FY: 23-24 Cost: $ 221,046.00 Following FY: 24-25 Cost: $ 717,496.00

Evidence (if required): Declaration of Kiyomi Ross

All dedicated funding sources; State: 0 Federal: 0

Local agency's general purpose funds: 0

Other nonlocal agency funds: 0

Fee authority to offset costs: 0

Statute, Chapter and Code Section/Executive Order Section, Effective Date, and Register Number:

Activity:

Initial FY: ____-____ Cost: _____ Following FY: _____-_____ Cost:

Evidence (if required):

All dedicated funding sources; State: Federal:

Local agency's general purpose funds:

Other nonlocal agency funds:

Fee authority to offset costs:

Statute, Chapter and Code Section/Executive Order Section, Effective Date, and Register Number:

Activity:

Initial FY: ____-____ Cost: _____ Following FY: _____-_____ Cost:

Evidence (if required):

All dedicated funding sources; State: Federal:

Local agency's general purpose funds:

Other nonlocal agency funds:

Fee authority to offset costs:

COUNTY OF SANTA CLARA TEST CLAIM

STATUTES 2023, CHAPTER 841—ASSEMBLY BILL NO. 1402

Amending Penal Code § 11171, subd. (f) "Child Physical Abuse and Neglect Exams"

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SECTION 5: WRITTEN NARRATIVE

COUNTY OF SANTA CLARA TEST CLAIM

STATUTES 2023, CHAPTER 841—ASSEMBLY BILL NO. 1402

Amending Penal Code § 11171, subd. (f) "Child Physical Abuse and Neglect Exams"

Written Narrative

County of Santa Clara Test Claim

Statutes 2023, Chapter 841—Assembly Bill 1402

Adding Penal Code Section 11171, Subdivision (f)

"Child Physical Abuse and Neglect Exams"

I. Introduction

The County of Santa Clara ("County") seeks a decision that the State of California ("State") must reimburse the costs of implementing Assembly Bill No. 1402 (2023 Stats., ch. 841) ("AB 1402"). AB 1402, which amended Penal Code section 11171 ("Section 11171") and became effective on January 1, 2024, imposes through subdivision (f) a new program or higher level of service on counties by requiring them to pay for the cost of medical evidentiary exams for potential victims of child physical abuse and neglect whenever the State fails to provide reimbursement, as it has for the last two fiscal years.

Physical abuse and neglect exams are indispensable to investigating child abuse and neglect, protecting children, and prosecuting crimes committed against children. Through Section 11171, the State has long played a central role in defining these exams by developing rules and standards, issuing a form for notating the exam, and creating a protocol to ensure consistent and comprehensive exams.

Previously, counties billed Medi-Cal or private health insurance for physical abuse or neglect exams. AB 1402 ended this practice by adding subdivision (f) to Section 11171 ("Subdivision (f)"), thereby prohibiting direct or indirect patient billing. AB 1402 also requires that counties designate examiners who can send invoices to the California Office of Emergency Services ("CalOES"). However, the Legislature declined to appropriate funding for these reimbursements and CalOES has established no reimbursement process. Therefore, the State summarily transferred costs for physical abuse and neglect exams to counties. Moreover, since counties could previously bill Medi-Cal for some of these exams, the Legislature used AB 1402 to create an added windfall for the State, which no longer pays for these exams either through Medi-Cal *or* CalOES reimbursements.

These expenses fall into the category of mandatory costs that voters intended to require the State to reimburse when they passed Proposition 4 in 1979, amending the California Constitution to add Article XIII B, Section 6 ("Section 6"). This constitutional provision requires the State to compensate local governments for the expenses of carrying out new programs or higher levels of service compelled by State law. The County respectfully requests that the Commission on State Mandates find that Subdivision (f) imposes a reimbursable mandate under Section 6, and that the State must reimburse the compliance costs that counties would otherwise be forced to bear.

II. Background

A. Investigations Prevent and Address Child Physical Abuse and Neglect

Child physical abuse and neglect has profound and devastating consequences. (Expert Declaration of Marlene Sturm, MD, at p. 3 ("Sturm Decl.").) Severe consequences of child maltreatment include permanent brain injury, drug overdose, suicide, and death. (*Ibid*.) Child abuse and neglect may be associated with chronic and serious health conditions that persist into adulthood, including obesity, heart disease, substance abuse, chronic anxiety, depression, and suicidality. (*Ibid*.) Child maltreatment also affects whole communities such that experts characterize it as "a major public health concern with substantial economic impact." (*Ibid*.) Each year, child protection agencies in the United States investigate more than 2.4 million reports of suspected child maltreatment. (*Ibid*.) The County receives more than 20,000 child abuse reports annually. (*Ibid*.)

Early identification and intervention can not only protect abused or neglected children, but can also stop further abuse, which can be lifesaving. (*Ibid*.) Even so, it is difficult to identify child physical abuse or neglect—witnesses are rare; the injuries may be nonvisible or obscured; perpetrators tend not to admit to their actions; children harmed by abuse may be preverbal or could be too severely injured or frightened to report their harm; and where children do speak out, adults may intimidate or otherwise disbelieve them. (*Id*. at pp. 3-4.) For these reasons, physical abuse and neglect exams are necessary to ensure the safety of the child, to support effective collaboration with social services, and when appropriate, to file criminal charges. (*Id*. at p. 4.)

B. Counties Rely on Medical Evidentiary Exams to Investigate, Treat, and Prosecute Child Physical Abuse and Neglect

This test claim concerns billing practices regarding medical evidentiary exams for potential victims of child physical abuse or neglect, also known as physical abuse and neglect exams. Physical abuse and neglect exams are necessary to gather evidence and assess the presence of abuse and neglect to provide healthcare services, support child protection efforts, and investigate and prosecute crimes committed against children. (See Pen. Code, § 11171.)

The State has administered Section 11171 for two decades. In 2002, the Legislature directed the State to develop standards, protocols, training, and guidance for medical evidentiary exams. (See Stats. 2003, ch. 249, § 4 [adding Section 11171].) With Section 11171, the Legislature declared "that adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations." (Pen. Code, § 11171, subd. (a)(1).) To promote consistency, Section 11171 instructed CalOES to work with several public and private entities to "establish medical forensic forms, instructions, and examination protocols for victims of child physical abuse or neglect." (*Id*., subd. (b).)

The Legislature required the medical forensic forms to include comprehensive examination criteria. (*Id*., subd. (c).) These criteria define the content of the exam by including notation of: "[a]ny notification of injuries or any report of suspected child abuse or neglect to law enforcement authorities or children's protective services"; "[a]ddressing relevant consent issues"; "taking of a patient history of child physical abuse that includes other relevant medical history"; "performance of a physical examination for evidence of child physical abuse or neglect"; "collection or documentation of any physical evidence of child physical abuse or neglect"; "collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated"; "[p]rocedures for the preservation and disposition of evidence"; "[c]omplete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays"; and "[a]n assessment as to whether there are findings that indicate physical abuse or neglect." (*Ibid*.)

Pursuant to Section 11171, the Governor's Office of Emergency Services (the precursor office to CalOES) issued effective January 1, 2004, a form that is now titled the "CalOES 2-900 Medical Report: Suspected Child Physical Abuse and Neglect" for recording Section 11171 medical evidentiary exam results. (California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims ("Protocol"), Governor's Office of Emergency Services, State of California, 1.) Section 11171 requires that the CalOES 2-900 form "become part of the patient's medical record pursuant to guidelines established by the advisory committee of the Office of Emergency Services and subject to the confidentiality laws pertaining to the release of medical forensic examination records." (Pen. Code, § 11171, subd. (d).)

In addition to the CalOES 2-900 form, the Governor's Office of Emergency Services also issued form instructions and the Protocol, which provides "[s]tep-by-step procedures for conducting examinations opposite each page of the standard forms"; "[e]xamination protocol for child physical abuse and neglect"; "[c]ontextual information for performing examinations and implementing a multidisciplinary team approach"; and "[r]elevant and expanded information on patient consent, mandatory reporting laws, financial compensation for examinations, crime victim compensation, and evidence collection and preservation."

Prior to AB 1402, the Protocol noted that "[i]n the majority of counties in California, charges for child physical abuse and neglect examinations are billed to Medi-Cal or to the patient's private insurance." (Protocol, *supra*, at p. 9.) For uninsured and underinsured patients, the Protocol observed that "reimbursement of charges may be obtained through California Victim Compensation and Government Claims Board."

C. AB 1402 Altered the Scheme for Financing Child Physical Abuse and Neglect Exams

AB 1402 added three provisions to Section 11171. These provisions read as follows:

(f) The costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect shall be separate from diagnostic treatment and procedure costs associated with medical treatment. *Costs for the medical evidentiary portion of the examination shall not be charged directly or indirectly to the victim of child physical abuse or neglect.*

(g) Each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify the Office of Emergency Services of this designation. *The costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature.* Each county's designated SART, SAFE, or other qualified medical evidentiary examiners shall submit invoices to the Office of Emergency Service, who shall administer the program. A flat reimbursement rate shall be established. Within one year upon initial appropriation, the Office of Emergency Service shall establish a 60-day reimbursement process. The Office of Emergency Service shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years.

(h) Reimbursement shall not be subject to reduced reimbursement rates based on patient history or other reasons. Victims of child physical abuse or neglect may receive a medical evidentiary exam outside of the jurisdiction where the crime occurred and that county's approved SART, SAFE teams, or qualified medical evidentiary examiners shall be reimbursed for the performance of these exams.

(Stats. 2023, ch. 841, § 1 (emphasis added).) Although these provisions are all relevant to the Test Claim, the County pleads only Subdivision (f) as reimbursable pursuant to Section 6. As a non-urgency statute enacted in 2023, AB 1402 became effective on January 1, 2024. (Cal. Const., Art. IV, § 8, subd. (c)(1).)

As a result of Subdivision (f), county providers can no longer bill Medi-Cal or private insurance for physical abuse and neglect exams administered to children. Rather than charge Medi-Cal or private insurance for physical abuse and neglect exams, counties are now required to authorize a designee to approve providers who can perform these exams and send invoices to CalOES. (*Id*., subd. (g).) CalOES, who administers the reimbursement program under Section 11171, must reimburse counties within 60 days and adjust reimbursement rates every five years. (*Ibid*.)

Notwithstanding the mandatory reimbursement provision of AB 1402, the Legislature has failed to appropriate any funding for child physical abuse and neglect

exams. (See Stats. 2024, ch. 22, § 2.00; Stats. 2023, ch. 38; see also Sen. Comm. on Approps., Analysis of Assem. Bill No. 1402 (2023-2024 Reg. Sess.), p. 3 ["Staff notes that no funding has been included in the 2023-24 budget for these purposes."].) Nor has CalOES issued any guidance or form for AB 1402 reimbursements. (Declaration of Serena Sy, at p. 3 ("Sy Decl.")) As a result, counties are now forced to absorb the costs of physical abuse or neglect exams for children.

III. Legal Standard

Section 6 "requires the state to provide a subvention of funds to compensate local governments for the cost of a new program or higher level of service mandated by the state." (*Department of Fin. v. Comm'n on State Mandates* (2022) 85 Cal. App. 5th 535, 549.) The purpose of Section 6 "was to prevent the state from unfairly shifting the costs of government onto local entities that were ill-equipped to shoulder the task." (*County of San Diego v. Comm'n on State Mandates* (2018) 6 Cal. 5th 196, 207.)

Expenses incurred by a local government in complying with a State statute constitute reimbursable "costs mandated by the state" if: (1) the statute "compels the local agency to act," (2) "the compelled activity requires the agency to provide a new program or higher level of service," and (3) none of the statutory or constitutional exceptions to the State's responsibility to reimburse local governments applies. (*Coast Cmty. Coll. Dist. v. Comm'n on State Mandates* (2022) 13 Cal. 5th 800, 808 (citation omitted); see Gov. Code, § 17514 (defining "costs mandated by the state" as, in relevant part, "any increased costs which a local agency . . . is required to incur . . . as a result of a statute . . . which mandates a new program or higher level of service of an existing program within the meaning of [Section 6]").

Under the first prong, a statute "compels the local agency to act" where the State either *legally* compels action by "us[ing] mandatory language that requires or commands a local entity to participate in a program or service (*Coast Cmty. Coll. Dist.*, *supra,* 13 Cal. 5th at p. 815 (citation omitted)), or *practically* compels action because "an entity . . . face[s] certain and severe penalties or consequences" for noncompliance (*Department of Fin.*, *supra,* 85 Cal. App. 5th at p. 558). Under the second prong, a statute creates a new "program" if it involves *either* "(1) programs that carry out the governmental function of providing services to the public, or (2) laws which, to implement a state policy, impose unique requirements on local governments and do not apply generally to all residents and entities in the state." (*San Diego Unified Sch. Dist. v. Comm'n on State Mandates* (2004) 33 Cal. 4th 859, 874 (citation omitted).) Under the third prong, the State bears the burden of demonstrating the existence of any of the seven conditions in Government Code section 17556 or four conditions in Section 6 that free it from the requirement to reimburse local governments for the costs of carrying out a State-mandated program. (*Department of Fin. v. Comm'n on State Mandates* (2016) 1 Cal. 5th 749, 769 (2016) [holding that the State bears the burden of claiming an exception to the requirement it reimburse mandatory costs]; see also *Department of*

Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd. (2017) 7 Cal. App. 5th 628, 641 [“An exception to a statute is to be narrowly construed.”] (citation omitted).)

A local government seeking reimbursement for costs of compliance with a State law may file a test claim with the Commission on State Mandates (“Commission”). (*County of San Diego*, *supra,* 6 Cal. 5th at p. 202.) Following a hearing, the Commission determines “whether the statute that is the subject of the test claim. . . mandates a new program or an increased level of service.” (*Ibid.* [citing Gov. Code § 17551].) If the Commission concludes that the statute imposes a reimbursable mandate, “it must then ‘determine the amount to be subvened to local agencies . . . for reimbursement.’” (*Coast Cmty. Coll. Dist.*, *supra,* 13 Cal. 5th at p. 809 [quoting Gov. Code, § 17557, subd. (a)].)

IV. Argument

Through Subdivision (f), AB 1402 requires counties to fully assume the costs of providing physical abuse and neglect exams to child victims whenever the state declines to appropriate reimbursement funds. With no ability to bill or seek reimbursements, counties now have no choice but to pay for these exams by drawing down on their general fund dollars. Therefore, Subdivision (f) gives rise to reimbursable costs mandated by the State under Section 6 because it compels counties to act, the compelled activity requires the counties to provide a new program or higher level of an existing service, and the State cannot carry its burden to demonstrate any legal barriers to reimbursement. (See *Coast Cmty. Coll. Dist.*, *supra,* 13 Cal. 5th at p. 808.)

A. The Legislature Expressly Accepted Responsibility for Funding the Exams in AB 1402 But Failed to Live Up to This Requirement

The text and intent of AB 1402 indicate the State’s apparent acknowledgement that child physical abuse exams are costly such that the State itself would fill the funding gap resulting from the prohibition on billing insurance. Along with the billing prohibition in Subdivision (f), subdivision (g) unambiguously states that “[t]he costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature.” Reflecting the express intent of AB 1402, the Senate Appropriations Committee explained that:

> This bill is similar to recent legislation intended to provide no-cost medical examinations to victims of sexual and domestic violence. Rather than directly charging victims of child abuse and neglect for physical examinations, this bill would require counties to set up systems to provide examinations at no cost to the victim and then submit invoices for reimbursement to OES.

(Sen. Comm. on Approps., Analysis of Assem. Bill No. 1402 (2023-2024 Reg. Sess.), p. 2.) The State acknowledges its liability for the cost of these exams because they are indispensable services for child abuse and neglect victims. As the bill author explained:

> Despite providing reimbursement for the medical forensic examination of domestic violence, adult and pediatric sexual assault, existing law does not provide reimbursement for the medical forensic examination of suspected child physical abuse or neglect. This makes it difficult for clinics and providers to offer this service, especially in rural districts where access is scarce. For example, there is one primary provider of these exams located in Shasta County who covers the territory of seven large counties in the First Assembly District. Victims seeking these exams are forced to travel up to three hours for an exam.

(Assem. Comm. on Pub. Safety, Analysis of Assem. Bill No. 1402 (2023-2024 Reg. Sess.), p. 3.) Although AB 1402 recognizes that reimbursement for child physical abuse and neglect exams are "subject to appropriation by the Legislature," it does not contemplate that these exams are unnecessary.

B. Costs of Implementing a New Program or Higher Level of Service Mandated by Subdivision (f) Are "Costs Mandated by the State" Warranting Reimbursement Under Section 6

Subdivision (f) mandates that the County provide a new program or higher level of service, the costs for which the County is covering from its General Fund. The facts provided below, as required under subdivision (b)(1) of Government Code section 17553, demonstrate that these expenditures are reimbursable "costs mandated by the state" under Section 6. (See Gov. Code, § 17514.)

1. Subdivision (f) Requires the County to Perform a New Program or Higher Level of Service

To comply with Subdivision (f), the County can no longer bill insurance for physical abuse and neglect exams given to child victims. Instead, the County must approve providers who send invoices to CalOES. (*Id*., subd. (g).) However, AB 1402 is careful to disclaim that "costs associated with these medical evidentiary exams shall be funded by the state, *subject to appropriation by the Legislature*." (*Ibid.* (emphasis added).) Since the date of its enactment, the Legislature has made no appropriation for AB 1402. (Sy Decl. at p. 3.) In other words, the new activity mandated by Subdivision (f)—and the corresponding new program or higher level of service—is the new requirement that the County assume the full cost of providing child abuse and neglect exams free of charge whenever the State declines to reimburse these costs.

Although counties have long provided child physical abuse and neglect exams under the State's supervision, counties were never responsible for funding these exams. (See Protocol, *supra*, at p. 9.) Instead, counties would remunerate their

expenses by billing Medi-Cal and private insurance. (*Ibid*.) Because the State has declined to provide any reimbursement, the County must now perform its existing duties—provide these exams consistent with the State's guidance, protocols, and forms—*and* assume financial responsibility for these exams.

AB 1402 is reminiscent of an earlier attempt in the 1980s to shift Medi-Cal costs onto counties, which the California Supreme Court concluded was an unfunded mandate. In *County of San Diego v. State of California* (1997) 15 Cal.4th 68, San Diego sought a decision concluding that the Legislature's exclusion of medically indigent people ("MIP") from Medi-Cal in 1982 mandated a new program or higher level of service within the meaning of Section 6. With the 1982 legislative reform, the State prohibited billing Medi-Cal for a patient population whose claims were previously billable. (*Id*. at pp. 79-80.) Although the Legislature created a funding mechanism to remunerate counties for providing care to MIPs, the State decreased its funding to San Diego over time, eventually creating a shortfall for the county and a windfall for the State. (*Id*. at p. 80.) The Court concluded that "the Legislature excluded adult MIPs from Medi-Cal *knowing* and *intending* that the 1982 legislation would trigger the counties' responsibility to provide medical care as providers of last resort under section 17000. Thus, through the 1982 legislation, the Legislature attempted to do precisely that which the voters enacted section 6 to prevent: 'transfer[ ] to [counties] the fiscal responsibility for providing services which the state believed should be extended to the public.' " (*Id*. at p. 98 (citation omitted).)

When the California Supreme Court scrutinized this three-step approach—(1) prohibit counties from billing for patient care; (2) identify for counties a State funding mechanism to make them whole; and (3) decline to fully provide counties that funding—it concluded that the State's actions imposed an unfunded mandate. In a similar fashion, the Legislature through Subdivision (f) prohibited billing patients' insurance for these exams. Then, the Legislature through subdivision (g) identified a State funding mechanism for those exams. The Legislature then failed to provide that funding. As in *County of San Diego*, Subdivision (f) compels local governments to assume the full financial responsibility for these crucial exams whenever the State declines to provide reimbursement. Section 6 requires the State to reimburse these costs.

Costs. The County estimates that complying with Subdivision (f) by assuming the financial responsibility for child physical abuse exams will cost approximately $621,927 each year. (Declaration of Kiyomi Ross, at pp. 1-2 ("Ross Decl.").) On average, the County performs 15 child physical abuse and neglect exams each month and 180 exams each year. (*Ibid*.) It costs the County approximately $3,455 on average to perform each child physical abuse and neglect exam. (*Id*. at p. 1.) The County cost data for child physical abuse and neglect exams includes expenses for care provided by physicians and other medical professionals, and overhead and institutional expenses that the County incurred for providing this service. (*Ibid*.)

2. The County Incurred Approximately $221,046 to Implement Subdivision (f) in the 2023-2024 Fiscal Year

In fiscal year 2023-2024, the County incurred approximately $221,046 to implement the requirements of Subdivision (f), significantly exceeding the $1,000 established by Government Code section 17564 as the minimum threshold above which a local government may bring a test claim. (*Id.* at p. 2.) As noted above, the cost of implementing Subdivision (f) is the activity of paying for child abuse and neglect exams. This activity included the costs of 83 exams in fiscal year 2023-2024, which require the labor, supplies, and indirect costs of healthcare providers. (*Ibid*.) This sum does not reflect a full 12 months of costs, as AB 1402 became effective halfway through the fiscal year, on January 1, 2024. (*Ibid*.)

3. The County Estimates Incurring Approximately $717,496 to Implement Subdivision (f) in the 2024-2025 Fiscal Year

Pursuant to Subdivision (f), the County estimates it will incur an additional $717,496 to perform 188 child physical abuse and neglect exams during fiscal year 2024-2025. (*Ibid*.) This accounts for actual costs of $352,509 from July 2024 through November 2024 and estimated costs of $364,987 through the remainder of fiscal year 2024-2025, from December 2024 through June 2025. (*Ibid*.) These actual costs reflect 83 actual exams between July 2024 through November 2024 and the estimated costs reflect an estimated 105 exams through the remainder of fiscal year 2024-2025, from December 2024 through June 2025. (*Ibid*.)

4. Statewide Costs of Implementing Subdivision (f) in the 2024-2025 Fiscal Year Are Estimated to Reach Approximately $11.8 million.

The County estimates that it will cost local governments an aggregate and approximate $11,800,000 in the 2024-2025 fiscal year to comply with Subdivision (f), which requires absorbing the cost for child physical abuse and neglect exams whenever the State declines to reimburse those costs.

In analyzing AB 1402, the Senate Committee on Appropriations developed a statewide cost estimate for reimbursing counties for exams. (Sen. Comm. on Approps., *supra*, at p. 3.) Although this estimate is significantly lower than the County's anticipated outlay—a difference attributable to the County's relatively large population, urban make-up, and high cost of living—the County adopts $11.8 million as a reasonable estimate of the total aggregated cost of compliance for counties statewide.

To reach an estimate of overall statewide costs, the Senate Committee on Appropriations assumed that the cost of child physical abuse and neglect exams would roughly mirror the $911 that CalOES reimburses for each sexual assault exam. (*Ibid*.) Then, citing figures from a 2022 California State Auditor report, the Committee approximated that there are on average 13,000 child physical abuse and neglect exams

each year. (*Ibid*.) As a result, 13,000 exams that are each reimbursable for $911 total roughly $11.8 million annually for local reimbursements.

5. No Dedicated Funding Sources Offset Costs of Complying with Subdivision (f)

There are no dedicated funding sources available from the State, the federal government, or any nonlocal agency to offset the costs of implementing the activities mandated by Subdivision (f). (Sy Decl. at p. 3.) Indeed, the provision itself prohibits counties from billing patients "directly or indirectly" for child physical abuse and neglect exams. (Pen. Code, § 11171, subd. (f).) Although AB 1402 presumes that CalOES will reimburse county providers, the Legislature has not appropriated any funds for AB 1402 reimbursements. (See Stats. 2024, ch. 22, § 2.00; Stats. 2023, ch. 38.) Nor has CalOES issued any guidance about reimbursements. (Sy Decl. at p. 3.) Even the Senate Committee on Appropriations analysis of AB 1402 conceded that "no funding has been included in the 2023-24 budget for these purposes." (Sen. Comm. on Approps., *supra*, at p. 3.) Therefore, all costs for child physical abuse and neglect exams following the effective date of AB 1402 have been and will be paid from the County's General Fund (see Ross Decl., *supra*, at p. 2), unless the Commission determines that these costs are reimbursable pursuant to Section 6.

6. There is One Prior Mandate Determination Related to Subdivision (f)

The Commission previously rendered a decision, 00-TC-22, titled "Interagency Child Abuse and Neglect Investigation Reports." This decision partially approved reimbursement for Penal Code sections 11165.9, 11166, 11166.2, 11166.9, 11168 (formerly 11161.7), 11169, 11170, as added or amended by Statutes 1977, chapter 958, Statutes 1980, chapter 1071, Statutes 1981, chapter 435, Statutes 1982, chapters 162 and 905, Statutes 1984, chapters 1423 and 1613, Statutes 1985, chapter 1598, Statutes 1986, chapters 1289 and 1496, Statutes 1987, chapters 82, 531 and 1459, Statutes 1988, chapters 269, 1497 and 1580, Statutes 1989, chapter 153, Statutes 1990, chapters 650, 1330, 1363 and 1603, Statutes 1992, chapters 163, 459 and 1338, Statutes 1993, chapters 219 and 510, Statutes 1996, chapters 1080 and 1081, Statutes 1997, chapters 842, 843 and 844, Statutes 1999, chapters 475 and 1012, and Statutes 2000, chapter 916; and executive orders California Code of Regulations, title 11, section 903, and "Child Abuse Investigation Report" Form SS 8583.

The Commission's partial approval covered the following activities: distributing the suspected child abuse report form, reporting between local departments, investigating suspected child abuse and reporting to and from the State Department of Justice, notifications following reports to the Central Child Abuse Index, and record retention. (Statement of Decision: ICAN (00-TC-22), Commission on State Mandates (2007), 3-7.)

The 00-TC-22 decision is related to Subdivision (f) because both the 00-TC-22 test claim statutes and Subdivision (f) are encompassed by the Child Abuse and

Neglect Reporting Act ("CANRA"), codified at Penal Code section 11164 *et seq*. However, none of the 00-TC-22 test claim statutes or orders reference Section 11171, which hadn't been enacted when that test claim was filed. The Legislature suspended reimbursements for 00-TC-22 in Fiscal Years 2023-2024 and 2024-2024. (Mandated Cost Manual for Local Agencies, State Controller's Office (Oct. 2024) at 2-3.)

7. There Are No Legislatively Determined Mandates as to Subdivision (f)

The County is not aware of any legislatively determined mandate as to Subdivision (f). (Sy Decl., at p. 3.)

C. The Costs of Compliance with Subdivision (f) are Reimbursable by the State Under the California Supreme Court's Three-Prong Test

Subdivision (f) constitutes a reimbursable State mandate under Section 6 because (1) the provision compels local governments to act, (2) the compelled activity requires local governments to provide a new program or higher level of service, and (3) the state cannot carry its burden of identifying legal impediments to reimbursement. (See *Coast Cmty. Coll. Dist.*, *supra*, 13 Cal. 5th at p. 808.)

1. Subdivision (f) Practically Compels Local Governments to Act

Under Section 6, a statute "constitute[s] a state mandate" when it "establishes conditions under which the state, rather than local officials, has made the decision requiring [local entities] to incur the costs of" providing a new program. (*San Diego Unified Sch. Dist.*, *supra*, 33 Cal. 4th at p. 880.) When "an entity makes an initial discretionary decision that in turn triggers mandated costs," that entity may still be due reimbursement under Section 6. (*Department of Finance*, *supra*, 85 Cal.App.5th at p. 557 [citation omitted].) This is because local governments may be compelled "as a practical matter" to comply with a State program "when an entity or its constituents face certain and severe penalties or consequences for not participating in" the program. (*Id*. at p. 558.) The burden is on the local government to make a "concrete showing" in the record that compliance with the State program "is the only reasonable means to carry out their core mandatory functions." (*Department of Finance v. Commission on State Mandates* (2009) 170 Cal.App.4th 1355, 1368.) The County asserts that Subdivision (f) practically compels local governments to assume the full cost of child physical abuse and neglect exams whenever the State declines to provide reimbursement.

Case law and previous Commission decisions illustrate several examples of practically compelled mandates that required reimbursement under Section 6. Rejecting the argument that local governments preclude reimbursement by choosing to provide a stormwater drainage system, the Court of Appeal explained that "[t]he drainage of a city in the interest of the public health and welfare is one of the most important purposes for which the police power can be exercised," such that "deciding

not to provide a stormwater drainage system is no alternative at all." (*Department of Finance*, *supra*, 85 Cal.App.5th at p. 558 [citation omitted].)

In determining that the federal government practically compelled the State and local governments to provide unemployment insurance benefits to their employees, the Court of Appeal observed that California "businesses faced a new and serious penalty" for noncompliance, one that was "certain and severe." (*City of Sacramento v. State of California* (1990) 50 Cal.3d 51, 74.) State and local government noncompliance would invite "full, double unemployment taxation by both state and federal governments" that, "[b]esides constituting an intolerable expense against the state's economy on its face, . . . would place California employers at a serious competitive disadvantage against their counterparts in states which remained in federal compliance." (*Ibid*.)

The Commission determined that post-election manual tallies were practically compelled during the November 2008 General Election. First, the Commission noted that it is a "core mandatory function of counties . . . to conduct elections." (Post Election Manual Tally (PEMT), 10-TC-08, Statement of Decision, 37, Commission on State Mandates (2014). In this case, the claimant established that complying with the test claim regulations was "the only reasonable means to carry out its core mandatory function." (*Ibid*.) Given the compliance timeframe and with voting already underway, the Commission agreed that "counties could not, as a practical matter, stop using the already-approved electronic voting system and change to a paper ballot only voting process to avoid the test claim regulations." (*Id*. at pp. 37-38.)

Subdivision (f) compels compliance as a practical matter because counties—and more importantly, the infants and children they serve—face severe and certain consequences were counties to cease using child physical abuse and neglect exams as a tool in their child welfare investigations. "Counties are responsible for a public system of statewide child welfare services, which includes providing for the investigation of possible abuse or neglect of a child warranting removal from parental custody." (*In re Social Services Payment Cases* (2008) 166 Cal.App.4th 1249, 1256 [citing Welf. & Inst. Code, §§ 300 *et seq*.; 16500 *et seq*.].) As a practical matter, eliminating physical abuse and neglect exams to avoid incurring a mandatory cost is not a reasonable alternative.

The County conducts the vast majority of its child physical abuse and neglect exams to comply with laws and regulations governing child welfare investigations. (Sy Decl., at p. 1; Sturm Decl. at p. 4.) Some child welfare laws expressly reference child physical abuse and neglect exams. For example, where a law enforcement agency or child welfare department learn of alleged child abuse for a child taken into protective custody and they learn that a physical abuse and neglect exam is appropriate after consulting with a medical specialist, they "shall cause the child to undergo a physical examination performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, and, whenever possible, shall ensure that this examination take place within 72 hours of the time the child was taken into protective custody." (Welf. & Inst. Code, § 324.5.) Thus, the only way for a county

to ensure it does not incur costs under Subdivision (f) is to direct its law enforcement and child welfare personnel to not consult with medical specialists upon learning of alleged child abuse. That is not an acceptable alternative.

In addition, the general duty to investigate child abuse and neglect often requires these exams. Indeed, when a social worker[1] "has cause to believe that there was or is within the county, or residing in the county, a person described in [Welfare and Institutions Code] Section 300, the social worker shall immediately make any investigation the social worker deems necessary to determine whether child welfare services should be offered to the family and whether proceedings in the juvenile court should be commenced." (Welf. & Inst. Code, § 328, subd. (a).) Welfare and Institutions Code section 300 applies where a "child has suffered, or there is a substantial risk that the child will suffer, serious physical harm inflicted nonaccidentally upon the child by the child's parent or guardian." (Welf. & Inst. Code, § 300, subd. (a).) In addition to physical abuse, Section 300 expressly encompasses neglect. (See *id*., subds. (b), (f), (g).) Courts may also initiate investigations by local child welfare agencies pursuant to Welfare and Institutions Code section 328 whenever child abuse allegations are made during a child custody proceeding, after which the "agency shall report its findings to the court." (Fam. Code, § 3027.)

Child physical abuse and neglect exams are indispensable to County social workers performing their duties in the child welfare system. (Declaration of Melissa Suarez, at p. 1 ("Suarez Decl.").) Accordingly, County social workers investigating a potential case of child abuse and neglect are trained to consider a physical abuse and neglect exam in response to several concerning indicia, such as sexual assault or recent disclosure of sexual assault; bruising of the ears, neck, torso, or genitals; patterned bruising in any location; burn or bite injuries; concern for abusive head trauma; concern for inflicted abdominal trauma; concern for strangulation; bone fractures or other serious injuries without an explanation consistent with the injury; concern for medical neglect, such as malnutrition, failure to thrive, delayed or lack of medical care; domestic violence in the home; and active drug use in the home. (*Id*. at p. 3.)

Mandatory reporter laws also depend on investigations that may require a physical abuse and neglect exam. The Child Abuse and Neglect Reporting Act ("CANRA") exemplifies this. (See Pen. Code, § 11164 *et seq*.) The California Supreme Court has explained that CANRA "contemplates that these agencies will, pursuant to their 'existing duties,' investigate reported incidents of suspected child abuse, and that they will notify other agencies when they commence their investigation. (*B.H. v. County of San Bernadino* (2015) 62 Cal.4th 168, 190.) Indeed, the Legislature expressly intended "that in each county the law enforcement agencies and the county welfare or probation department shall develop and implement cooperative arrangements in order

[1] The term "social worker" includes "any social worker in a county welfare department." (Welf. & Inst. Code, § 215.)

to coordinate existing duties in connection with the investigation of suspected child abuse or neglect cases." (Pen. Code, § 11166.3, subd. (a).)

CANRA also requires that local government agencies "forward to the Department of Justice a report in writing of every case it investigates of known or suspected child abuse or severe neglect that is determined to be substantiated." (*Id*., § 11169, subd. (a).) The Department of Justice makes these reports available to county child welfare agencies and other government agencies so that they can conduct background investigations on "any applicant seeking employment or volunteer status with the agency who, in the course of his or her employment or volunteer work, will have direct contact with children who are alleged to have been, are at risk of, or have suffered, abuse or neglect." (*Id*., § 11170, subd. (b)(10).)

County social workers regularly seek child physical abuse and neglect exams in their child welfare investigations to both uncover and develop evidence for physical abuse and neglect. (Suarez Decl., at pp. 1-2.) In many cases, these exams are necessary to uncover abuse and neglect. (Sturm Decl., at p. 4.) First, the child or infant may be pre-verbal or nonverbal, developmentally delayed, or otherwise unable to communicate their injuries, nor can they inform the social worker about neglected food and care, medical attention, or adult supervision. (Suarez Decl., at p. 2; Sturm Decl., at p. 4.) Second, injuries may be invisible to the eye because they are either hidden by clothes, healed, or internal to the body, such as a brain bleed, detached retinas, or broken bones. (Suarez Decl., at p. 2; Sturm Decl., at p. 4.) Third, physical abuse and neglect exams distinguish between accidental injury and maltreatment, the latter being an indicia of abuse and neglect. (Sturm Decl., at pp. 3-4.) It is crucial for counties to uncover these injuries because social workers otherwise risk returning the child to an unsafe environment, where siblings and others may also be unsafe. (Suarez Decl. at pp. 1-2; Sturm Decl., at pp. 4-5.)

In addition to uncovering physical abuse and neglect, these exams play an important role in developing evidence for criminal investigations, prosecutions, temporary protective custody, and dependency proceedings. In each of these cases, county officials need to establish proof of child abuse or neglect to protect the child or prosecute a crime against the child. (See, e.g., Welf. & Inst. Code, § 361, subd. (c) [authorizing child removal upon showing of physical abuse or neglect]; *id*., § 305 [authorizing temporary custody of a minor with reasonable cause that child is described by Section 300]; Pen. Code, §§ 273a, 273ab, 273d [articulating crimes against children].) Without child physical abuse and neglect exams, counties risk underinclusive and overinclusive child protection actions. (Suarez Decl., at pp. 1-2; Sturm Decl., at pp. 4-5.) In underinclusive scenarios, the lack of proof due to the absence of an exam would carry severe consequences, such as permanent injury or death, because social services may not have enough evidence to place the child in protective custody. (Sturm Decl., at p. 5.)

Overinclusive scenarios also carry severe consequences because they threaten to break apart families and punish innocent adults. Erroneous decisions to place children in protective custody because of incomplete or inaccurate information break apart families and treat innocent adults as perpetrators. (*Ibid*.) Life-threatening injuries may have credible explanations or bonafide medical causes. (*Ibid*.) For example, a brain hemorrhage may reflect a blood disorder. (*Ibid*.) Or radiologic imaging (x-rays, head CT, MRI scans) may reveal characteristics of the brain hemorrhage that are consistent with accidental impact. (*Ibid*.) Such medical determinations allow the County to exclude inflicted injury as a mechanism, preserving the integrity of families and the dependency system. (*Ibid*.) Indeed, County social workers have discovered by seeking child physical abuse and neglect exams that some infants with brain bleed possessed a rare blood disorder. (Suarez Decl., at p. 1.)

Standard physical exams, such as well child visits and emergency room encounters, are not a reasonable substitute for child physical abuse and neglect exams. (Sturm Decl., at p. 5.) Child abuse pediatrics is a medical specialty within pediatrics, like pediatric cardiology or pediatric neurology. (*Id*. at p. 3.) Without specific and continuing education in child abuse pediatrics, general practitioners are not qualified to provide expert medical opinions about whether a child has endured and survived maltreatment or determine the best course of treatment. (Ibid.) Medical professionals who are not trained to identify child abuse and neglect miss opportunities for diagnosis and intervention. (*Id*. at p. 5.)

Scientific research and practice experience demonstrate the practical necessity of child abuse and neglect exams. In one study, child physical abuse exams by expert child abuse specialists reduced cases of missed abusive head trauma, the form of maltreatment associated with the highest incidence of child death. (*Id*. at p. 6.) Conversely, another study found unexpectedly low rates of abuse evaluations among bruised infants seen in non-specialized emergency departments. (*Id*. at p. 5.)

One multi-institution retrospective study evaluated 232 pediatric patients seen over 2.5 years who, ultimately, were diagnosed with abusive injury. (*Id*. at p. 5.) In this study, 31 percent of the children had a total of 120 prior evaluations by either a medical provider or a child protective services professional who missed the injuries, and/or provided an alternative and erroneous explanation for the injuries. (*Id*. at pp. 5-6.) Of the 120 prior evaluations, 98 of the missed opportunities were in a medical setting—91 in a primary care setting or an emergency department. (*Id*. at p. 6.) The remaining 22 prior evaluations were missed by child protective services. (*Ibid*.)

Moreover, the County's physician overseeing child physical abuse and neglect exams learns as often as once a week of young children with bruising and other sentinel injuries concerning for abuse who were discharged from clinics and emergency departments in the County without evaluations for maltreatment. (*Ibid*.) In these cases, the County's child physical abuse and neglect experts attempt to arrange for urgent evaluations for child abuse. (*Ibid*.)

It is also no alternative to avoid physical abuse and neglect exams and instead rely on disclosures and confessions. The experience of County social workers and medical experts make clear that child physical abuse and neglect will go undetected were governments to rely exclusively on witnesses, perpetrator confessions, and child disclosures. (*Id*. at pp. 3-4; Suarez Decl. at pp. 3-4.) In general, child disclosures are rare and rarer still for child physical abuse relative to sexual abuse. (Sturm Decl., at p. 4.) Further County social workers observe that requiring children to evidence their abuse or neglect can retraumatize them. (Suarez Decl., at p. 2.)

It is also not reasonable to rely on private institutions to provide these exams. No private institution has applied to be a provider of child physical abuse and neglect exams pursuant to AB 1402. (Sy Decl., at p. 3.) If no private institution so applies, AB 1402 provides to counties no enforcement mechanism to require any institution to provide child physical abuse and neglect exams. (See Pen. Code, § 11171, subd. (g).) If the Legislature appropriates no funds for AB 1402, it is not economically feasible for any private institution to volunteer to incur the costs for these exams. The County's physician overseeing child physical abuse and neglect exams confirms that *pro bono* child abuse evaluations do not happen in Santa Clara County or anywhere else to her knowledge. (Sturm Decl. at p. 6.)

So, it is no alternative at all for counties to avoid costs from Subdivision (f) by ceasing to provide child physical abuse and neglect exams. Although no severe consequence is guaranteed every single child welfare case, the record contains concrete evidence that such consequences are certain among the aggregate of cases. It is certain that an unacceptable number of young survivors of child abuse and neglect would have delayed diagnoses, missed diagnoses, or diagnoses after their death, on post-mortem. (*Id*. at p. 6.) It is also certain that counties would fail to accurately identify child abuse in some cases and would not adequately carry out their statutory duties to investigate. (Suarez Decl. at pp. 3-4.) Other severe consequences include: evaluations for maltreatment performed by nonspecialists in other medical settings (such as general pediatrics) could depend on the insurance status of the child and family; child welfare investigators would lack access to medical evidence to protect at-risk children and protect families; and law enforcement officials would lack medical evidence for criminal investigations. (Sturm Decl. at p. 6.)

The evidence for these outcomes comes from the catalog of legal duties that assume robust child abuse and neglect investigations; medical studies that compare child physical abuse and neglect exams to other medical encounters; the experience of County social workers, who conduct child welfare investigations daily; and the experience of County healthcare providers, who conduct child physical abuse and neglect exams year-round. The consequences of not providing these exams are so beyond the realm of practical reality for counties charged with the duty to protect children that counties will inevitably assume the full cost of providing these exams whenever the State declines to provide reimbursement.

2. Subdivision (f) Imposes a New Program or Higher Level of Service on Counties for the Purposes of Section 6

The requirement that counties assume full financial responsibility for physical abuse and neglect exams when the State declines to provide reimbursement is the very kind of mandated activity that warrants reimbursement because counties are required to perform a new program or higher level of service for the purposes of Section 6.

a) The Actions Mandated by Subdivision (f) Concern Programs for the Purposes of Section 6

The actions compelled by Subdivision (f) impose a new program or higher level of service under either prong of the Supreme Court's test because the provision (1) concerns "programs that carry out the governmental function of providing services to the public," and (2) "implement[s] a state policy, impose[s] unique requirements on local governments and do[es] not apply generally to all residents and entities in the state." (*San Diego Unified Sch. Dist.*, *supra*, 33 Cal. 4th at p. 874 (citation omitted).) "[O]nly one of these findings is necessary to trigger reimbursement." (*Carmel Valley*, *supra*, 190 Cal. App. 3d at p. 537.)

First, Subdivision (f) mandates actions that "carry out a governmental function of providing services to the public." In enacting Section 11171, the Legislature found and declared "that adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations." (Pen. Code, § 11171, subd. (a)(1).) Accordingly, the State directed CalOES to coordinate a set of public and private bodies to standardize these exams, provide training, guidance, and protocols, and establish a consistent and accessible reporting system. (See *id*., subds. (b)-(e).) These exams play a central role in promoting child welfare, as they are often necessary to carry out various statutory duties to investigate potential child abuse. (See, e.g., Welf. & Inst. Code, §§ 324.5, 328, 329; Fam. Code, § 3027; Prob. Code, § 1513; Pen. Code, §§ 11166.3, 11169.)

Courts have repeatedly found that state laws aimed at providing beneficial and protective public services create programs or higher levels of service under this prong, and accordingly involve reimbursable State mandates. For example, permitting conditions establishing heightened stormwater drainage requirements involved a program because they benefitted the public with increased pollution abatement. (*Department of Fin*., *supra*, 85 Cal. App. 5th at p. 555-56.) Similarly, a law requiring local agencies to contribute costs of educating area pupils with special needs at state schools created a program because "the education of handicapped children is clearly a governmental function providing a service to the public." (*Lucia Mar Unified Sch. Dist. v. Honig* (1988) 44 Cal. 3d 830, 835.) And a law requiring that public school districts afford hearings with specified protections to students facing expulsion created a higher level of service for an existing program because "[p]roviding public schooling clearly constitutes a governmental function, and enhancing the safety of those who attend such schools

constitutes a service to the public." (*San Diego Unified Sch. Dist.*, *supra*, 33 Cal. 4th at p. 879.) Here, likewise, Subdivision (f) concerns a program subject to Section 6 because counties provide an important service to the public, free of charge, in conducting effective and accessible physical abuse and neglect exams for victims of child physical abuse and neglect.

Second, Subdivision (f) "implement[s] a state policy, impose[s] unique requirements on local governments and do[es] not apply generally to all residents and entities in the state." (*San Diego Unified Sch. Dist.*, *supra*, 33 Cal. 4th at p. 874.) Subdivision (f) must be read along with AB 1402, which mandates that each county's board of supervisors "shall authorize a designee to approve the Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify the Office of Emergency Services of this designation." (Pen. Code, § 11171, subd. (g).) Because AB 1402 imposes unique requirements on local governments alone, the free provision of child abuse and neglect exams constitutes a program under this prong. (See, e.g., *Lucia Mar*, *supra*, 44 Cal. 3d at p. 835 [statute was a program because it "impose[d] requirements on school districts not imposed on all the state's residents"); *San Diego Unified Sch. Dist.*, *supra*, 33 Cal. 4th at p. 885 n.20 [statute mandating terms of school districts' expulsion hearings was a program because it "impose[d] unique requirements on local governments"].)

In addition to the language of Subdivision (f) itself, the provision affects an underlying set of duties that are exclusively imposed on counties. Whether they use contractors or perform physical abuse and neglect exams in-house, counties and not private entities or any other institution are ultimately accountable for investigating potential child abuse for several purposes that include public safety, child welfare, and guardianship. (See, e.g., Welf. & Inst. Code, §§ 324.5, 328, 329; Fam. Code, § 3027; Pen. Code, § 11166.3, subd. (a); Prob. Code, § 1513.) Therefore, even if private bodies are likewise subject to Subdivision (f), counties are uniquely required to assume the full cost of providing child abuse and neglect exams because they are uniquely charged with child welfare and public safety obligations.

b) The New Program or Higher Level of Service Mandated by Subdivision (f) is New

The new program or higher level of service imposed by Subdivision (f) is new "in comparison with the preexisting scheme [because it] did not exist prior to the enactment of" the bill. (*San Diego Unified Sch. Dist.*, *supra*, 33 Cal. 4th at p. 878; see, e.g. *Department of Fin.*, *supra*, 85 Cal. App. 5th at pp. 559-60 [similar].) For example, in *Lucia Mar Unified School District v. Honig* (1988) 44 Cal.3d 830, the California Supreme Court considered Education Code section 59300, a statute that required school districts to contribute funds to the education of children with disabilities. (*Id*. at p. 835.) The

Court held that the statute's "program was new insofar as plaintiffs are concerned, since at the time section 59300 became effective they were not required to contribute to the education of students from their districts at such schools." (*Ibid*.) The Court was unambiguous in this conclusion: "To hold, under the circumstances of this case, that a shift in funding of an existing program from the state to a local entity is not a new program as to the local agency would, we think, violate the intent underlying section 6 of article XIIIB." (*Ibid*.)

Prior to the enactment of Subdivision (f), county providers did not assume the full financial responsibility for child physical abuse and neglect exams. Rather, counties billed Medi-Cal and private insurance. (See Protocol, *supra*, at p. 9; see also Sy Decl. at p. 2.) Subdivision (f) imposes on counties a new program or higher level of service by mandating that counties now assume the full cost of child physical abuse and neglect exams whenever the State declines to reimburse counties, which has been the case since the enactment of AB 1402. Although Subdivision (f) itself is the provision that imposes a new program or higher level of service, the broader scheme of AB 1402 is relevant to its recent imposition. First, through Subdivision (f), AB 1402 prohibits counties from billing "directly or indirectly" for physical abuse and neglect exams. Second, AB 1402 mandates that counties identify for the State which entities will seek reimbursement from CalOES on behalf of the county. (Pen. Code § 11171, subd. (g).) And third, AB 1402 permits the State to transfer the full financial responsibility to counties by directing CalOES to make those reimbursements "subject to appropriation by the Legislature." (*Ibid*.)

Indeed, the State has set up no reimbursement scheme via CalOES, and the Legislature has appropriated no funding for AB 1402. (Sy Decl. at pp. 2-3.) As a result, there is currently no entity the County can now bill for child physical abuse and neglect exams. (Sy Decl. at p. 3.) For the foregoing reasons, the State must reimburse counties for the costs to local governments triggered by compliance with Subdivision (f).

3. No Conditions Exist That Create an Exception to the Requirement That the State Must Reimburse the County for Compliance with Subdivision (f)

None of the circumstances enumerated in Government Code section 17556 or Section 6 that create an exception to the State's requirement to reimburse local entities for State-mandated activities exists with respect to the mandates imposed by Subdivision (f) .

1. The County did not request that the State enact Subdivision (f) or grant it the legislative authority to implement the new program it creates. (Section 6, subd. (a)(1); Gov. Code, § 17556, subd. (a).)

2. Subdivision (f) does not define, create, or eliminate a crime or infraction or change the penalty for a crime or infraction or an existing definition of a crime. (Section 6, subd. (a)(2); Gov. Code, § 17556, subd. (g).)

3. Subdivision (f) was not enacted prior to January 1, 1975. (Section 6, subd. (a)(3).)

4. Subdivision (f) is not contained in the Ralph M. Brown Act or California Public Records Act. (Section 6, subd. (a)(4).)

5. Subdivision (f) does not affirm a mandate declared to be existing law by any court. (Gov. Code, § 17556, subd. (b).)

6. Subdivision (f) does not impose a requirement mandated by federal law or regulation, nor does it result in costs mandated by the federal government. (Gov. Code, § 17556, subd. (c).)

7. The County lacks the authority to levy service charges, fees, or assessments to pay for the costs of complying with Subdivision (f). (Gov. Code, § 17556, subd. (d).)

8. Subdivision (f) does not provide for offsetting savings that result in no net costs to the County or include additional revenue intended to fund the costs of the mandate in an amount sufficient to fund the cost of the mandate. (Gov. Code, § 17556, subd. (e).)

9. Subdivision (f) does not impose duties that are necessary to implement or are included in a California ballot measure approved by the voters. (Gov. Code, § 17556, subd. (f).)

V. Conclusion

For the foregoing reasons, the Commission should find that the State must compensate the County and other local governments for the costs they incur in complying with the State's mandate under Subdivision (f) .

SECTION 6: DECLARATIONS

COUNTY OF SANTA CLARA TEST CLAIM

STATUTES 2023, CHAPTER 841—ASSEMBLY BILL NO. 1402

Amending Penal Code § 11171, subd. (f) "Child Physical Abuse and Neglect Exams"

DECLARATION OF SERENA SY

1. I, Serena Sy, declare:

2. I have been employed by the County of Santa Clara (the "County") since 2011, and currently hold the title of Director of Primary Care Operations for Santa Clara Valley Healthcare ("SCVH"). I have occupied this role since 2019.

3. As Director of Primary Care Operations, I am responsible for overseeing all facets of SCVH operations over primary care clinics and programs throughout the County. This work includes oversight of facilities, staffing, and services. At least 1,000 subordinate staff report up to my position. In this role, I oversee the County's actions in carrying out the new program or enhanced level of service mandated by Statutes 2023, Chapter 841 ("AB 1402"), described in detail below. AB 1402 imposes a new program or higher level of service by requiring the County, through subdivision (f) of Penal Code section 11171 ("Subdivision (f)"), to assume the full cost of child physical abuse and neglect exams whenever the State declines to reimburse those costs.

4. I have personal knowledge of the facts set forth in this Declaration, as well as the information presented in the adjoining test claim, and if called to testify to the statements made herein, I could and would do so competently.

5. The County conducts the majority of its medical evidentiary exams for child physical abuse and neglect ("physical abuse and neglect exams") at its Children's Advocacy Center ("CAC").

6. The medical clinic that offers these exams at the CAC is one of the primary care programs within SCVH. Among other tasks, my role is to ensure that we have medical providers to conduct physical abuse and neglect exams, and that the clinic meets hospital accreditation requirements. My team is also responsible for supporting the operations that link patients to referrals and services connected to child abuse and neglect.

7. The County conducts the vast majority of physical abuse and neglect exams to comply with child welfare investigations.

8. In some cases, a healthcare provider will refer a child to the CAC for a physical abuse and neglect exam pursuant to concerns about the child's wellbeing, the system of mandatory reporting, or the healthcare provider's other existing duties.

9. Physical abuse and neglect exams are also conducted pursuant to law enforcement investigations into potential crimes against children.

10. Physical abuse and neglect exams are occasionally necessary to determining the appropriate diagnosis or treatment for a child in distress. For example, children

and infants who are preverbal or nonverbal, children with disabilities, and traumatized children may be unable to identify their abuse or neglect.

11. The County is one of only providers of physical abuse and neglect exams in its region. SCVH and the CAC frequently receive referrals from other agencies and hospitals to perform these exams for children.

12. Prior to the enactment of AB 1402, the County had the ability to bill eligible services to patients with qualifying insurance plans, including Medi-Cal or private insurance, to recoup the cost of administering medical evidentiary exams for child physical abuse or neglect.

13. AB 1402 makes several amendments to Penal Code section 11171 ("Section 11171"), some of which impose a higher level of service on the County.

    a. AB 1402 adds subdivision (f) to Section 11171, stating: "The costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect shall be separate from diagnostic treatment and procedure costs associated with medical treatment. Costs for the medical evidentiary portion of the examination shall not be charged directly or indirectly to the victim of child physical abuse or neglect."

    b. AB 1402 adds subdivision (g) to Section 11171, stating: "Each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify the Office of Emergency Services of this designation. The costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature. Each county's designated SART, SAFE, or other qualified medical evidentiary examiners shall submit invoices to the Office of Emergency Service, who shall administer the program. A flat reimbursement rate shall be established. Within one year upon initial appropriation, the Office of Emergency Service shall establish a 60-day reimbursement process. The Office of Emergency Service shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years."

14. As the County's Director of Primary Care Operations, I am familiar with the County's new activities arising from Subdivision (f) and costs incurred in carrying out these activities.

15. To comply with Subdivision (f), the County can no longer bill Medi-Cal or private insurance when it conducts physical abuse and neglect exams for child victims of physical abuse or neglect. This is a new activity that constitutes a new program

or higher level of service whenever the State declines to reimburse the cost of these exams, as in those cases Subdivision (f) requires the County to assume the full cost of these exams. Detailed information about the costs that result from Subdivision (f) are included in the Declaration of Kiyomi Ross.

16. Although not pled in the test claim as reimbursable State mandates, other elements of AB 1402 are relevant to understanding Subdivision (f). Through subdivision (g) of Section 11171 ("Subdivision (g)"), the County must designate examiners who are authorized to provide physical abuse and neglect exams and seek reimbursement for those exams from the California Office of Emergency Services ("CalOES").

17. At present, there is no entity the County can bill for child physical abuse and neglect exams. To my knowledge, CalOES has not created a reimbursement process. Moreover, for the last two fiscal years, the Legislature has not appropriated any funds to reimburse the costs of Subdivision (f) .

18. CalOES has issued no guidance for compliance with AB 1402.

19. No private institution has applied to the County to become a designated provider for physical abuse and neglect exams pursuant to Subdivision (g) and the County Board of Supervisors has not deemed any private institution a provider of physical abuse and neglect exams pursuant to Subdivision (g).

20. To the best of my knowledge, the County has not received any local, State, or federal funding and does not have a fee authority to offset the increased direct and indirect costs associated with the enhanced services mandated by Subdivision (f).

21. To the best of my knowledge, there are no legislatively determined mandates as to Subdivision (f).

22. The Commission on State Mandate's decision for test claim 00-TC-22 is related to Subdivision (f) because both the 00-TC-22 test claim statutes and Subdivision (f) are encompassed by Child Abuse and Neglect Reporting Act ("CANRA"). (Pen. Code, § 11164, *et. seq*.) However, none of the 00-TC-22 test claim statutes or orders reference Subdivision (f) or any element of Section 11171.

23. The Legislature continued to suspend reimbursements for 00-TC-22 in Fiscal Years 2023-2024 and 2024-2024. (Mandated Cost Manual for Local Agencies, State Controller's Office (Oct. 2024) at pp. 2-3.)

24. The County estimates costs to all local governments across California of approximately $11,800,000 for Fiscal Year 2024-2025. To reach an estimate of overall statewide costs, the County adopts the calculation used by the Senate Committee on Appropriations in its analysis of AB 1402 and multiplies the average number of child abuse cases (13,000 per year) by the reimbursement

amount that the CalOES currently provides for each sexual assault medical evidentiary exam ($911). (Sen. Comm. on Approps., Analysis of Assem. Bill No. 1402 (2023-2024 Reg. Sess.), p. 3.)

25. I declare under penalty of perjury that the foregoing is true and correct to the best of my personal knowledge, information, or belief.

26. Executed on 2/4/25 at San José, California.

SERENA SY
Director of Primary Care Operations
Santa Clara Valley Healthcare
County of Santa Clara

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DECLARATION OF KIYOMI ROSS

1. I, KIYOMI ROSS, declare:

2. I have been employed by the County of Santa Clara (the "County") since November 2023 and currently hold the title of Director Financial Planning and Performance. I have occupied this role since November 2023.

3. As Director, I am responsible for overseeing the County's cost accounting system integrity and use. In this role, I oversee Financial Planning and Performance for the Santa Clara County health system, including all hospitals and clinics.

4. I have personal knowledge of the facts in this Declaration and the attached exhibit, as well as the information presented in the test claim, and if called to testify to the statements made herein, I could and would do so competently.

5. As stated in the Declaration of Serena Sy, the County must comply with subdivision (f) of Penal Code section 11171 ("Subdivision (f)") by fully assuming the costs of providing child physical abuse and neglect exams whenever the State declines to reimburse these costs. This Declaration provides detailed information about the costs associated with complying with Subdivision (f). These are the costs of providing child physical abuse and neglect exams free of charge to patients and without reimbursement from the State.

6. The County calculates the cost of child physical abuse and neglect exams by reviewing the cost data for a set of medical encounters that involve the medical examination and assessment for a variety of forms of child physical abuse and neglect. To develop the data noted in this Declaration and illustrated in Exhibit A, analytics and program staff for Santa Clara Valley Healthcare provided data about child physical abuse and neglect exams to finance staff, who calculated cost data for these exams.

7. The County cost data for child physical abuse and neglect exams includes expenses for care provided by physicians and other medical professionals, and overhead and institutional expenses that the County incurred for providing this service.

8. A true and correct copy of the figures and calculations used to make the following statements is attached as Exhibit A.

9. The cost data for actual child physical abuse and neglect exams offered between January 2024 through November 2024 indicates that the average cost of each exam is $3,455. The exam count data for actual child physical abuse and neglect exams offered between January 2024 and November 2024 indicates that the County provides an average of 15 such exams each month and 180 such exams each year. Multiplying the average cost of these exams by the average

annual count of these exams yields an expected average annual cost to the County of $621,927 for child physical abuse and neglect exams.

10. The County first incurred costs as a result of Subdivision (f) on January 3, 2024. On this date, County healthcare providers performed a medical evidentiary exam for child physical abuse or neglect. The County incurred costs for this examination because it was unable to charge any entity for its expenses.

11. Because the County cannot bill any entity for physical abuse and neglect exams, the County absorbs them, meaning that the costs of physical abuse and neglect exams are ultimately drawn down from the County's General Fund.

12. In Fiscal Year 2023-2024, when AB 1402 became effective, the actual costs arising from the County's implementation of Subdivision (f) totaled approximately $221,046. During this period, the County provided an actual 83 child physical abuse and neglect exams. Because AB 1402 became effective on January 1, 2024, these figures represent cost and exam frequency data from January 2024 through June 2024.

13. In Fiscal Year 2024-2025, the year following the effective date of AB 1402, the costs of implementing Subdivision (f) are estimated to reach approximately $717,496 for 188 exams.

    a. During this period, the County incurred an actual $352,509 for child physical abuse and neglect exams between July 2024 and November 2024, and it expects to incur an additional $364,987 through the end of Fiscal Year 2024-2025, from December 2024 through June 2025.

    b. During July 2024 and November 2024, the County provided 83 actual child physical abuse and neglect exams, and it expects to provide 105 additional exams through the end of Fiscal Year 2024-2025, between December 2024 through June 2025.

14. The actual and estimated costs of implementing Subdivision (f) exceed $1,000.

15. I declare under penalty of perjury that the foregoing is true and correct to the best of my personal knowledge, information, or belief.

16. Executed on February 4, 2025 at San José, California.

KIYOMI ROSS
Director of Financial Planning and Performance
Santa Clara Valley Healthcare
County of Santa Clara

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Exhibit A

Fiscal Year	Month	Child Physical Abuse and Neglect Exams	County Costs	
2024	January	11	$22,594	Actual
2024	February	7	$10,577	
2024	March	29	$86,122	
2024	April	12	$41,248	
2024	May	14	$31,802	
2024	June	10	$28,703	
2025	July	14	$84,222	
2025	August	16	$60,703	
2025	September	23	$75,810	
2025	October	14	$67,274	
2025	November	16	$64,500	
2025	December	15	$52,141	Estimated
2025	January	15	$52,141	
2025	February	15	$52,141	
2025	March	15	$52,141	
2025	April	15	$52,141	
2025	May	15	$52,141	
2025	June	15	$52,141	

	County Costs	Child Physical Abuse and Neglect Exams
FY 2024 Actual	$221,046	83
FY 2025 Actual	$352,509	83
Total of Actuals	$573,555	166
FY 2025 Estimated	$364,987	105
FY 2025 Actuals + Estimated	$717,496	188

	Figure	Calculation	Explanation
Avg. Cost Per Exam	$3,455	$573,555 ÷ 166	Total Actual Costs ÷ Total Actual Exams
Avg. Exams Per Month	15	166 ÷ 11	Total Actual Exams ÷ Total Actual Months
Avg. Exams Per Year	180	15 x 12	Avg. Exams Per Month x 12 months
Avg. Cost Per Year	$621,900	$3,455 x 180	Avg. Cost Per Exam x Avg. Exams Per Year

DECLARATION OF MELISSA SUAREZ

1. I, Melissa Suarez, declare:

2. I have been employed by the County of Santa Clara (the "County") since July 1998. In this time, I have been employed by the Department of Family and Children's Services ("DFCS"). Prior to my current role, I have served as a social worker, case manager, and social worker supervisor for the County's child welfare system. In my various roles, I have been involved in child welfare emergency response investigations for at least 24 years.

3. I currently hold the title of Social Services Program Manager III. This title is also termed Bureau Manager for DFCS. I have occupied this role since 2020. In total, there are approximately 200 staff under me, with an estimated 125 of that staff serving as social workers for the County's child welfare system.

4. As Bureau Manager, I am responsible for overseeing a region emergency social workers that spans from South San José to the southernmost boundary of the County's jurisdiction. I also support DFCS division managers in the day-to-day work of emergency response, court, and non-court services for the County's child welfare system.

5. I have personal knowledge of the facts set forth in this Declaration, as well as the relevant information presented in the adjoining test claim, and if called to testify to the statements made herein, I could and would do so competently.

6. Several laws, rules, and regulations impose upon County social workers a duty to investigate allegations of child physical abuse and neglect so that they may determine whether child welfare services should be offered to the family and whether proceedings in the juvenile court should be commenced.

7. County social workers use medical evidentiary examinations for potential victims of child physical abuse or neglect ("physical abuse and neglect exams") to investigate the existence of child abuse or neglect, determine whether a child needs to be taken into protective temporary custody, collaborate with a law enforcement office's criminal investigation, and evidence a petition for child removal, as well as in other situations.

8. Physical abuse and neglect exams are also important to protecting families. In some cases, physical abuse and neglect can evidence where injuries that might otherwise raise concerns are not due to abuse or neglect. For example, DFCS has encountered infants whose brain bleed (which might otherwise be explained by abusive head trauma) was due to a rare blood disorder.

9. Physical abuse and neglect exams play an indispensable role in the child welfare system. These exams allow trained medical professionals to assess whether a child is a victim of physical abuse or neglect without having to depend on the

observations of witnesses or the disclosure of children. Witnesses to child abuse and neglect are rare, the adults who perpetrate abuse and neglect rarely admit to their crimes, and children may be too traumatized to disclose their injuries (or may be retraumatized by having to disclose their injuries).

10. Physical abuse and neglect exams are especially crucial where the victim or potential victim is an infant, pre-verbal, nonverbal, developmentally delayed, or otherwise unable to communicate their abuse or neglect. In these situations, the child or infant cannot inform the social worker about "invisible" injuries, such as a brain bleed, detached retinas, broken bones, injuries hidden under clothes, or injuries that have since healed. Nor can these children inform a social worker about neglected food and care, medical attention, or adult supervision. In these cases, a provider administering the physical abuse and neglect exam can use their expertise to identify present or past harm so that the social worker can take the appropriate action in a child welfare investigation.

11. Were social workers to rely on witnesses, perpetrator confessions, or child victims instead of physical abuse and neglect exams to verify physical abuse or neglect, I am certain that cases of actual abuse and neglect would be missed, which means that children and families in those cases would not receive the services they need to support children.

12. If County social workers were unable to secure child physical abuse and neglect exams, or if they had to wait unreasonably long for such exams, I am certain that more children would be at risk of additional injury or death.

13. Standard physical exams, such as well child visits, are not a substitute for physical abuse and neglect exams. County social workers seek physical abuse and neglect exams from the County's Child Advocacy Center ("CAC") because the examiners there are trained to identify and assess the presence of child abuse and neglect. Our social workers' experience is that standard physical exams do not reliably capture child abuse and neglect.

14. Where social workers are unable to substantiate a report of child physical abuse or neglect, they risk returning the child to an unsafe environment, where the siblings may also be unsafe.

15. The situations that prompt the social worker to seek a physical abuse and neglect exam include, but are not limited to, the following referrals:

    a. DFCS receives a report of child abuse or neglect from the child themselves, a witness to the abuse or neglect, a daycare, a school, or another community member.

    b. A law enforcement officer contacts DFCS and requests a physical abuse and neglect exam to assist a criminal investigation into child abuse or neglect.

c. A healthcare provider, such as an emergency department physician, contacts DFCS to request a physical abuse and neglect exam after providing treatment to a child with acute injuries.

16. When County social workers investigate a potential case of child abuse and neglect, they are trained to consider a physical abuse and neglect exam when they observe or learn of concerning indicia, which include, but are not limited to:

    a. Sexual assault or recent disclosure of sexual assault;

    b. Initial or partial disclosure of other forms of sexual abuse;

    c. Bruising of the ears, face, neck, torso, or genitals;

    d. Patterned bruising in any location;

    e. Burn or bite injuries;

    f. Concern for abusive head trauma;

    g. Concern for inflicted abdominal trauma;

    h. Concern for strangulation (choking) or disclosure of strangulation;

    i. Bone fractures or other serious injuries without an explanation consistent with the injury;

    j. Concern for medical neglect: malnutrition, failure to thrive, delayed or lack of medical care;

    k. Domestic violence in the home; and

    l. Active drug use in the home, including methamphetamine and fentanyl.

17. The County's social workers act quickly to investigate allegations of child physical abuse and neglect because time is of the essence for examining and assessing child abuse and neglect. Injuries may fade and heal, invisible injuries may worsen without treatment (e.g., brain bleeds), and the child may be at grave risk of harm the longer they remain in an unsafe environment.

18. If the County could somehow cease providing physical abuse and neglect exams, I am certain based on my own experience and that of the County's child welfare agency that several severe consequences will occur:

    a. Law enforcement officials' investigations into child abuse and neglect crimes would be severely limited;

b. Social workers would be unable to substantiate suspected cases of child physical abuse or neglect, particularly for nonverbal, pre-verbal, disabled, and developmentally delayed children;

c. Children and families who would otherwise receive support services following medical findings of abuse or neglect would not be assisted; and

d. Children whose abuse or neglect would be uncovered by a physical abuse and neglect exam would remain in dangerous situations, and in some cases, would be severely harmed or killed.

19. I declare under penalty of perjury that the foregoing is true and correct to the best of my personal knowledge, information, or belief.

20. Executed on 12/24/24 at San José, California.

Melissa Saurez

MELISSA SAUREZ
Bureau Manager
Department of Family and
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County of Santa Clara

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EXPERT DECLARATION OF MARLENE STURM, MD

1. I, Marlene Sturm, MD, declare:

2. I have been employed by the County of Santa Clara ("County") since 1992. I have practiced pediatrics at Santa Clara Valley Medical Center for more than 30 years and have supervised the County's child abuse pediatrics program since 2017. In that role, I served as Medical Director of the Center for Child Protection from 2017 until 2021 and have served as Medical Director of the Medical Clinic at the Children's Advocacy Center of Santa Clara County ("CAC") since the Center opened in April 2021. A true and correct copy of my curriculum vitae is attached as Exhibit A.

3. I completed my undergraduate education at Brown University, my medical degree at Stanford Medical School, and my residency in pediatrics at Stanford Hospital. I am board-certified by the American Board of Pediatrics and licensed by the State of California.

4. I am a member of the Helfer Society, the national society of child abuse pediatricians. Each year, I attend the most important research and practice meetings in child abuse pediatrics, including the Helfer Society Annual Meeting and the San Diego International Conference on Child and Family Maltreatment Conference hosted at Rady Children's Hospital in San Diego.

5. As Medical Director of Children's Advocacy Center, I provide direct supervision or complete personally the majority of medical evaluations for child maltreatment in Santa Clara County. We provide medical evaluations for child sexual abuse and sexual assault, child physical abuse, child neglect, burn injuries, medical child abuse, child abduction, and child torture. I also provide consultation for patients hospitalized at Santa Clara Valley Medical Center (SCVMC) with concerns for child maltreatment—on the Pediatric Ward, the Burn Unit, the Pediatric ICU (PICU) and the Neonatal ICU (NICU). At the CAC, we perform sexual assault forensic exams ("SAFE") for the County of Santa Clara, and some exams for adjacent counties, including Monterey, San Benito, and Santa Cruz Counties. I directly supervise the CAC Team of SAFE examiners. Ours is a rapidly growing program, with depth and breadth in our trauma-informed approach to children who have experienced all forms of maltreatment.

6. In my role, I work frequently with County child welfare social workers and law enforcement personnel on investigations for all forms of maltreatment. I have developed and contributed to policies, practices, and procedures for responding to child abuse and neglect across Santa Clara County.

7. I have personal knowledge of the facts concerning my medical practice set forth in this Declaration, as well as the corresponding facts presented in the adjoining test claim, and if called to testify to the statements made herein, I could and would do so competently.

8. Based on my background, training, continuing education, and experience as a child abuse pediatrician, I am familiar with the standard of care in the medical community applicable to physicians, nurses, and medical personnel who assess, diagnose, and treat child physical abuse and neglect. I am familiar with the level of education and skill possessed by most credentialed physicians, nurses, and medical personnel practicing in the same or similar specialties.

9. In forming my expert medical opinions, I review relevant materials in the medical and scientific literature and draw upon my expertise as a pediatrician with more than 30 years of clinical experience. My methodology includes careful review of the most cited and recent articles in the relevant child abuse pediatrics and pediatric radiology literature, with regards to the strength and consistency of study data collection; methodology and design of the study; and results, limitations, and inferences.

10. Among other materials, I reviewed the following studies in the course of preparing this report and my expert opinions:

    a. Christian, *The Evaluation of Suspected Child Physical Abuse* (2015) 135 Pediatrics 5 [updated in 2021 to include current data and references].

    b. Mehta et al., *Child Maltreatment and Long-Term Physical and Mental Health Outcomes: An Exploration of Biopsychosocial Determinants and Implications for Prevention* (2023) 54 Child Psychiatry & Human Dev. 421.

    c. Child Abuse Statistics, Studies and Reports, Child Abuse Prevention Council, County of Santa Clara <https://capc.santaclaracounty.gov/resources/mandated-reporter-resources/child-abuse-statistics-studies-and-reports> [as of Dec. 4, 2024].

    d. Choudhary et al., *Consensus Statement on Abusive Head Trauma in Infants and Young Children* (2018) 48 Pediatric Radiology 1048.

    e. Rush et al., *Disclosure Suspicion Bias and Abuse Disclosure: Comparisons Between Sexual and Physical Abuse* (2015) 18 Child Maltreatment 113.

    f. Hibberd et al., *Childhood Bruising Distribution Observed From Eight Mechanisms of Unintentional Injury* (2017) 102 Archives of Disease in Childhood 1103.

    g. Pierce et al., *Validation of a Clinical Decision Rule to Predict Abuse in Young Children Based on Bruising Characteristics* (2021) 4 JAMA Network Open 1.

    h. Narang et al., *American Academy of Pediatrics Policy Statement: Abusive Head Trauma in Infants and Children* (2020) 145 Pediatrics 1.

i. Hymel, et al., *A Cluster Randomized Trial to Reduce Missed Abusive Head Trauma in Pediatric Intensive Care Settings* (2021) 236 J. Pediatrics 260.

j. Pierce, et al., *The Prevalence of Bruising Among Infants in Pediatric Emergency Departments* (2016) 67 Ann. Emerg. Med. 1.

k. Letson et al., *Prior Opportunities to Identify Abuse in Children with Abusive Head Trauma* (2016) 60 Child Abuse & Neglect 36.

11. My professional experience and review of the literature confirm that child physical abuse and neglect has profound and devastating consequences. Severe consequences of child maltreatment include permanent brain injury, drug overdose, suicide, and death. Child abuse and neglect may be associated with chronic and serious health conditions that persist into adulthood, including obesity, heart disease, substance abuse, chronic anxiety, depression, and suicidality.

12. My professional experience and review of the literature also indicate that child abuse and neglect affects entire communities. Studies rightly indicate that child maltreatment is "a major public health concern with substantial economic impact." (Mehta, *supra*, at p. 423.)

13. Each year, child protection agencies in the United States investigate more than 2.4 million reports of suspected child maltreatment. (Christian, *supra*, at p. 1.)

14. The County receives more than 20,000 child abuse reports annually. (Child Abuse Statistics, County of Santa Clara, *supra*, at p. 1.)

15. My professional experience and review of the literature indicate that early identification and intervention protects abused and neglected children, and can also prevent further abuse, potentially saving the lives of vulnerable children. (See Christian, *supra*, at p. 4.)

16. My professional experience and review of the literature indicate that communities struggle to accurately and reliably identify child maltreatment without expert child abuse pediatric evaluations. In plain terms, child abuse pediatrics is a medical specialty within pediatrics, like pediatric cardiology or pediatric neurology. While most pediatricians have some knowledge in child abuse pediatrics from residency training and practice, general pediatricians—and emergency department physicians—are not child abuse pediatricians. To continue the analogy, a general pediatrician or emergency department physician may recognize that a child is having an unusual seizure or heart arrhythmia—but will consult with a specialist to complete the evaluation and determine next-steps.

17. Without specific and continuing education in child abuse pediatrics, general practitioners are not qualified to provide expert medical opinions about whether a child has endured and survived maltreatment—or determine the best course of treatment.

18. Beyond the training and experience of the medical provider, other factors complicate assessments of child maltreatment. The injuries may be invisible, internal, or obscured. The child abuse literature and my own experience argue against reliance on description by witnesses or confessions by perpetrators. (Christian, *supra*, at p. 4.) Witnesses are rare; and perpetrators typically do not disclose or admit to their actions. In general, child disclosures are infrequent, and rarer among victims of child physical abuse as compared with victims of child sexual abuse. (Rush, *supra*, at p. 113.) Patients who are severely injured may be unable to disclose. Children who are intimidated by their abusers may be afraid to disclose. Even when children do speak out, adults may discount or disbelieve their disclosures.

19. In my professional experience, expert medical evaluations for child physical abuse and neglect exams are necessary to ensure the safety of the child, to support effective collaboration with social services, and when appropriate, to file criminal charges.

20. In my professional experience, the County conducts the vast majority of child physical abuse and neglect exams to comply with child welfare investigations.

21. My professional experience and review of the literature also indicate that in many cases, expert medical evaluations for child physical abuse and neglect exams are *required* to diagnose missed cases of child abuse and neglect. Multiple factors impact the difficult diagnosis of child maltreatment. First, the infant or child may be pre-verbal, nonverbal, developmentally delayed, severely injured, or other factors may limit the child's ability to communicate. A child with limited verbal ability cannot inform the social worker about food scarcity, missed medical care, or inadequate adult supervision. Second, injuries may be invisible to the eye because the injuries are healing, obscured by clothing, or internal to the body. For example, a general pediatric examination may miss subtle fractures, injuries to internal organs, or retinal hemorrhages inside the eye. Of greatest concern, a child can have a relatively normal neurologic exam and "appear normal," yet have an evolving brain hemorrhage. Third, expert medical evaluations for child physical abuse and neglect are crucial to distinguish between abusive injuries and other types of injuries.

22. An accurate diagnosis of abuse and assessment of ongoing medical risk is crucial to ensure the child's safety. Without this information, a social worker may return a child to an unsafe environment, where siblings and others may also be unsafe. Moreover, if the child has an evolving medical condition, such as a brain hemorrhage or intra-abdominal hemorrhage, the child's condition may become more serious at home, risking permanent injury or death.

23. In my professional experience, without expert medical evaluations for child physical abuse and neglect, the County risks *underinclusive and overinclusive* child protection actions.

    a. Underinclusive Actions: Without a child abuse evaluation, social services may not have enough evidence to place the child in protective custody. The child may experience severe consequences, including permanent injury or death.

    b. Overinclusive Actions: Placing a child in protective custody because of incomplete or inaccurate information may also carry severe consequences. Erroneous decisions to place children in protective custody break apart families and treat innocent adults as perpetrators. Life-threatening injuries may have credible explanations or bonafide medical causes. For example, a brain hemorrhage may reflect a hematologic (blood) disorder. Or radiologic imaging (x-rays, head CT, MRI scans) may reveal characteristics of the brain hemorrhage that are consistent with accidental impact. Such medical determinations allow the County to exclude inflicted injury as a mechanism, preserving the integrity of families and the dependency system.

24. My professional experience and review of the literature indicate that standard physical exams—such as well child visits, and emergency room encounters—are not adequate substitutes for evaluations by a trained child abuse pediatrics expert. Medical professionals who are not trained to identify child abuse and neglect miss opportunities for diagnosis and intervention.

    a. Mary Clyde Pierce, MD, a Northwestern University professor of child abuse pediatrics and emergency department pediatrics, and leader in the field, found unexpectedly low rates of abuse evaluations among bruised infants seen in emergency departments. (Pierce (2016), *supra*, at p. 8.) In their role as consultants, child abuse pediatricians serve as guides towards evidence-based practice for their emergency department physician colleagues.

    b. Dr. Pierce's highly-regarded research documents that bruises of the **T**orso, **E**ars, and **N**eck (TEN locations) in children younger than four years old—and bruising in any location in infants 4 months old and younger—are both highly sensitive and specific for abusive injury.

    c. Another study by Letson et al. documented missed diagnoses of abusive injury. This multi-institution retrospective study evaluated 232 pediatric patients seen over 2.5 years who, ultimately, were diagnosed with abusive injury. 31 percent of the children had a total of 120 prior evaluations by either a medical provider or a child protective services professional—who missed the injuries, and/or provided an alternative and erroneous

explanation for the injuries. (Letson, *supra*, at p. 38.) Of the 120 prior evaluations, 98 of the missed opportunities were in a medical setting—91 in a primary care setting or an emergency department. (*Ibid.*) The remaining 22 prior evaluations were missed by child protective services. (*Ibid.*)

d. In study settings, child physical abuse exams by expert child abuse specialists reduce cases of missed abusive head trauma, the form of maltreatment associated with the highest incidence of child death (See, e.g., Hymel, *supra*, at p. 260.)

e. In my own practice, as often as once a week, I hear about young children with bruising and other sentinel injuries concerning for abuse who were discharged from clinics and emergency departments in our County without evaluations for maltreatment. Sometimes, we are able to arrange urgently for an outpatient evaluation at the CAC, or for hospital admission. In other cases, the CAC medical team collaborates with social workers and law enforcement to locate the child and bring them to our clinic or the hospital for urgent evaluation. I speak formally and informally to physician colleagues, Santa Clara County Department of Family and Children's Services social workers, and others once or twice a month to provide education about child abuse medical evaluations and address misinformation in our community.

25. To my knowledge, *pro bono* child abuse evaluations do not happen in Santa Clara County or anywhere else.

26. In Santa Clara County, as in other counties across California and the United States, public hospitals and government agencies provide a safety net to protect children who may have survived all forms of maltreatment.

27. In my opinion, without this safety net, it is certain that an unacceptable number of young survivors of child abuse and neglect would have delayed diagnoses, missed diagnoses, or diagnoses after their death, on post-mortem. Other severe consequences include: evaluations for maltreatment performed by nonspecialists in other medical settings (such as general pediatrics) could depend on the insurance status of the child and family; child welfare investigators would lack access to medical evidence to protect at-risk children and protect families; and law enforcement officials would lack medical evidence for criminal investigations.

28. I declare under penalty of perjury that the foregoing is true and correct to the best of my personal knowledge, information, or belief.

29. Executed on 12/25/2024 at San José, California.



Marlene A. Sturm, MD
Medical Director
Medical Clinic at the Children's Advocacy Center
Children's Advocacy Center of Santa Clara County
Santa Clara Valley HealthCare

Children's Advocacy Center of Santa County
455 O'Connor Drive, Suite 150
San José, CA 95128
(669) 299-8810

Exhibit A

CURRICULUM VITAE

Marlene A. Sturm M.D.
Contact: (408) 621-5352 direct
Email: marlene.sturm@hhs.sccgov.org

EDUCATION

1991 – 1993 Stanford University Medical Center
Residency in Pediatrics, Stanford Hospital

1990 – 1991 Stanford University Medical Center
Internship in Pediatrics, Stanford Hospital

1984 – 1990 Stanford University School of Medicine
Dean's Award for Distinguished Research in Pediatrics, 1990
March of Dimes Student Research Fellowship, 1987
Stanford Alumni Medical Scholars Research Fellowship, 1986

1978 – 1982 Brown University
Bachelor of Arts in Comparative Literature, *Magna Cum Laude*
Hope-Chatterton Award for Solo Piano, First Prize, 1982

AWARDS, LICENSES, and CERTIFICATIONS

2023 Recipient Neil Snyder Award for Outstanding Service, CAPSAC
The California Chapter of the American Professional Society on the Abuse of Children

2022 Member, Helfer Society: the National Society of Child Abuse Pediatricians

2007 Fellow, American Academy of Pediatrics; Recertified 2018
1993 Diplomate, American Board of Pediatrics; Recertified 2018
1991 Medical Board of California, License No. G71121

PROFESSIONAL EXPERIENCE

2021 – Present	Medical Director, Medical Clinic at the Children's Advocacy Center (CAC) Children's Advocacy Center of Santa Clara County Santa Clara Valley Healthcare 455 O'Connor Drive, Suite 150, San Jose, CA 95128
1993 – Present	General Pediatrician, Santa Clara Valley Healthcare Since completing residency, I have worked in our County's busy outpatient pediatric clinics, seeing children from newborns to 21 years for well-child and well-adolescent exams, newborn care, and urgent care visits.
2017 – 2021	Medical Director, Center for Child Protection. This program predated the CAC.
2017 – 2023	Medical Director, SPARK Clinic, Santa Clara Valley Healthcare The medical home for children in foster care, or with a DFCS (CPS) history 777 East Santa Clara Street, San Jose, CA 95112

1993 – 2017 Attending General Pediatrician, Department of Pediatrics
Santa Clara Valley Health Center at East Valley Clinic, an FQHC Clinic
Santa Clara Valley Healthcare

Summary of Clinical Activities
The Children's Advocacy Center (CAC) of Santa Clara County provides forensic medical examinations, forensic interviews, advocacy, and victim's services for children who are suspected victims of sexual abuse, physical abuse, or neglect. The CAC is a collaboration between Santa Clara Valley Healthcare (SCVH), the District Attorney's Office, the Department of Family and Children Services (DFCS), Law Enforcement, victim's advocates, and other community partners—to protect the health and well-being of all children at risk in Santa Clara County.
As the founding Medical Director of the Children's Advocacy Center, my responsibilities include:

- Direct supervision of CAC medical providers, with formal review of all forensic medical examinations, photographs, and written reports for child sexual abuse (SAFE exams), physical abuse, and neglect conducted at the CAC. Lead weekly case review of all patients seen at the CAC.
- Consultation for Santa Clara County DFCS: phone and in-person consultation to DFCS social workers for new and open cases of child abuse and neglect.
- Consultation at Santa Clara Valley Medical Center (County Hospital) for complex inpatient and outpatient evaluations for sexual abuse and assault, abusive head trauma, multiple injuries, burns, medical neglect, other forms of child maltreatment, and child death.
- Chair SCVMC Child Abuse Prevention Committee. This quality committee meets monthly to review cases of child maltreatment at SCVMC and affiliated hospitals and clinics.
- Collaboration with Coroner's Office regarding child death evaluations and forensic reports.
- Education of Stanford residents in pediatrics (physicians-in-training) and Stanford medical students in topics related to child physical abuse, sexual abuse, and neglect.
- Direct education and development of educational materials for use across Santa Clara Valley Healthcare regarding child abuse prevention and evaluations of child maltreatment.
- Expert witness testimony in child maltreatment in Santa Clara County Family Court and Criminal Court.

The SPARK Clinic is the Medical Home for children and youth in foster care, or with a history of connection with DFCS in Santa Clara County. SPARK patients include children and youth in foster care, children reunited with their parents, adopted children, and children receiving supervision by DFCS while in the care of their parents or extended family. As Medical Director of the SPARK Clinic through 2023, I provided direct primary care of SPARK patient, and supervised SPARK medical providers.

From 1993 until 2017, I served as a general pediatrician at East Valley Clinic, an FQHC Clinic in San Jose. I carried a full load of patients and families: approximately 60% time in primary care, and 40% in urgent care. More than half of the families I served speak Spanish primarily.

PROFESSIONAL MEMBERSHIPS and ACTIVITIES
I am a Fellow of the American Academy of Pediatrics, an admitted member of the Helfer Society, the national society of child abuse pediatricians, and a member of APSAC, the American Professional Society on the Abuse of Children.

2021 – 2023 Chair, Child Abuse Prevention Council (CAPC), Santa Clara County

2017 – Present Commissioner, Child Abuse Prevention Council, Santa Clara County,
Co-Chair, Child Sexual Abuse Task Force 2018-2019

The Santa Clara County Board of Supervisors appointed me to serve as a Commissioner of the Child Abuse Prevention Council in 2017. In 2019, I served as Co-Chair of the Child Sexual Abuse Task Force; the work of this committee culminated in the CAPC's recommendation to the Board of Supervisors to establish the Children's Advocacy Center of Santa Clara County. In June 2021, I was asked to serve as Chair of CAPC.

2017 – Present Chair, Child Abuse Prevention Committee, SCVMC
The Child Abuse Prevention Committee is the SCVMC quality committee that provides oversight for the evaluation of child abuse and neglect at SCVMC. I created and have served as committee chair since 2017.

2017 – Present Member, Child Death Review Team, Santa Clara County
The CDRT meets monthly to review and discuss all child and youth deaths in Santa Clara County.

2017 – Present Member, Ray Helfer Society of Child Abuse Pediatricians.
I was nominated and admitted to the Helfer Society in July 2022. I was a Scholar Member from 2017-2022.

2019 – Present County-wide SCAN Team, at Kaiser Santa Clara
I created and served as chair of this committee from 2019-2020. The committee meets quarterly, and includes representation from Stanford, Kaiser, and SCVMC, DFCS, law enforcement, and the DA's Office.

2017 – 2021 Children's Advocacy Center Initiative:
I initiated and co-led efforts with the District Attorney's Office to establish a Children's Advocacy Center in Santa Clara County. With the unanimous support of the Board of Supervisors, the CAC opened in April 2021. The CAC is fully funded by the Board of Supervisors of Santa Clara County.

CONTINUING PROFESSIONAL EDUCATION

October 2024	The Body Keeps the Score: Trauma Healing Through the Senses, Bessel van der Kolk, MD, PESI Anaheim, CA
May 2019	Trauma and Adversity in Early Childhood, Bruce Perry, MD Napa, CA
2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024	RADY Child Protection and Maltreatment Meetings
2017, 2019, 2021, 2022. 2023	Helfer Society Annual Meetings
2022, 2023, 2024	Stanford Child Maltreatment Conference
2023, 2024	Lurie Children's (Northwester) Maltreatment Conference
2016, 2017, 2018, 2019	CCFMTC/ Child Sexual Abuse Forensic Trainings

TEACHING 1993 – Present
As an attending in general pediatrics, I have taught Stanford medical students and residents in pediatrics (physicians-in-training) for more than thirty years. SCVMC is affiliated with the Stanford School of Medicine. Since serving as Medical Director of the County's child protection program, I have taught medical students topics related to child physical abuse, sexual abuse, and neglect; the County's child protection system; and child abuse prevention. Teaching responsibilities include: monthly conferences, frequent informal teaching sessions, and supervision of Stanford medical students and residents in pediatrics in the clinics and at the hospital. I have also taught multiple classes for foster parents through KAFTA, the Santa Clara County foster parent association. Class topics have included nutrition, parenting adolescents, and managing academics and home life during the COVID-19 pandemic.

COMMUNITY PRESENTATIONS
2023 Child Abuse Symposium, Santa Clara County
Forty Years of Child Abuse Pediatrics

2019 Keynote Speech, Special Hearing on Child Sexual Abuse, 11/20/2019
Supervisor Cindy Chavez invited me to give the keynote speech at this hearing, which led to the Board of Supervisors' unanimous vote to establish a Child Advocacy Center in Santa Clara County.

2019 Child Abuse Symposium, Santa Clara County
Building Our Children's Future: A Child Advocacy Center for Santa Clara County

2018 Child Abuse Symposium, Santa Clara County
Red Flags for Child Physical and Sexual Abuse: Moderated Panel of Child Abuse Pediatricians
2017 Child Abuse Symposium, Santa Clara County

In recent years, I have given numerous presentations to groups of SCVMC physicians, including talks and grand rounds on child abuse pediatrics to the Emergency Department, Trauma Surgery, and Burn/ Plastic Surgery groups.

I have also made formal and informal presentations to the Santa Clara County Board of Supervisors, San Jose City Council, Child Abuse Prevention Council, DFCS, and other community organizations.

RESEARCH PUBLICATIONS and PRESENTATIONS
1. Sturm MA, Conover CA, Pham H, and Rosenfeld RG. Insulin-like Growth Factor Receptors and Binding Protein in Rat Neuroblastoma Cells. *Endocrinology* 124 388-396, 1989

2. Sturm MD, Conover CA, Pham H, and Rosenfeld RG. Insulin-like Growth Factor-II (IGF-II) Receptors in Rat Neuroblastoma Cells. Western Meeting, Society for Clinical Investigation, Carmel CA, January, 1988.

3. Sturm MD, Pham H, and Rosenfeld RG. Insulin-like Growth Factor-II (IGF-II) Receptors in Rat Neuroblastoma Cells. National Meeting, Society for Pediatric Research, Anaheim CA, April, 1987.

4. Sturm, Marlene, Editor. Newsletter of the Standing Committee on Bioethics, American Medical Students Association. Issues 1-3: 1986-1987.

RESEARCH EXPERIENCE
1986 – 1988 Characterization of somatomedin receptors and somatomedin binding protein in a transformed rat neuroblastoma line.
Primary Investigator: Ron Rosenfeld, MD, Professor of Pediatrics, Stanford Medical School, Department of Pediatrics, Division of Endocrinology.

1979 – 1980 Abstract learning acquisition in adult rhesus monkeys.
Primary Investigator: William Schrier, Ph.D. Professor of Psychology, Brown University Department of Psychology.

COMMUNITY SERVICE / LEADERSHIP
2010 – 2019 Jewish Community Federation of Northern California, Board of Governors

2010 – 2012 Bureau of Jewish Education of Northern California, President, Board of Governors.
Led effort to rebrand and build endowment for oldest Jewish institution in Northern California, which supports education in preschools, day schools, synagogues, and creates forums for adult learning.

2006 – 2014 Bureau of Jewish Education of Northern California, Board/ Executive Committee Member, Board of Governors

2007 – 2009 Gideon Hausner Jewish Day School, Palo Alto CA, President, Board of Directors.
Led effort to design and construct $12 million elementary and middle school campus.

2000 – 2011 Gideon Hausner Jewish Day School, Palo Alto CA, Board/ Executive Committee Member, Board of Directors

PERSONAL
I speak English, French, and Spanish with fluency, and can converse in Hebrew and Italian.

SECTION 7: SUPPORTING DOCUMENTS

COUNTY OF SANTA CLARA TEST CLAIM

STATUTES 2023, CHAPTER 841—ASSEMBLY BILL NO. 1402

Amending Penal Code § 11171, subd. (f) "Child Physical Abuse and Neglect Exams"

STATE OF CALIFORNIA
LEGISLATIVE COUNSEL BUREAU
AUTHENTICATED
ELECTRONIC LEGAL MATERIAL

Assembly Bill No. 1402

CHAPTER 841

An act to amend Section 11171 of the Penal Code, relating to medical evidentiary examinations.

[Approved by Governor October 13, 2023. Filed with Secretary of State October 13, 2023.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1402, Megan Dahle. Medical evidentiary examinations: reimbursement.

Existing law requires the Office of Emergency Services to establish medical forensic forms, instructions, and examination protocols for victims of child physical abuse or neglect based on the guidelines for those forms as they relate to sexual assault. Existing law requires the forms to have a place for notation of specified information, including, among other things, the performance of a physical examination for evidence of child physical abuse or neglect.

This bill would require victims of child physical abuse or neglect to have access to medical evidentiary examinations, free of charge, by Local Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners. The bill would require each county's board of supervisors to authorize a designee to approve the SART, SAFE teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and to notify the office of this designation. The bill would require that the costs associated with these medical evidentiary exams be funded by the state, subject to appropriation by the Legislature, and would require the Office of Emergency Services to establish a 60-day reimbursement process within one year upon initial appropriation.

The people of the State of California do enact as follows:

SECTION 1. Section 11171 of the Penal Code is amended to read:

11171. (a) (1) The Legislature hereby finds and declares that adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations.

(2) Enhancing examination procedures, documentation, and evidence collection relating to child abuse or neglect will improve the investigation and prosecution of child abuse or neglect as well as other child protection efforts.

(b) The Office of Emergency Services shall, in cooperation with the State Department of Social Services, the Department of Justice, the California Association of Crime Lab Directors, the California District Attorneys Association, the California State Sheriffs' Association, the California Peace Officers Association, the California Medical Association, the California Police Chiefs' Association, child advocates, the California Medical Training Center, child protective services, and other appropriate experts, establish medical forensic forms, instructions, and examination protocols for victims of child physical abuse or neglect using as a model the form and guidelines developed pursuant to Section 13823.5.

(c) The forms shall include, but not be limited to, a place for notation concerning each of the following:

(1) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures.

(2) Addressing relevant consent issues, if indicated.

(3) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history.

(4) The performance of a physical examination for evidence of child physical abuse or neglect.

(5) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures.

(6) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated.

(7) Procedures for the preservation and disposition of evidence.

(8) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays.

(9) An assessment as to whether there are findings that indicate physical abuse or neglect.

(d) The forms shall become part of the patient's medical record pursuant to guidelines established by the advisory committee of the Office of Emergency Services and subject to the confidentiality laws pertaining to the release of medical forensic examination records.

(e) The forms shall be made accessible for use in an electronic format.

(f) The costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect shall be separate from diagnostic treatment and procedure costs associated with medical treatment. Costs for the medical evidentiary portion of the examination shall not be charged directly or indirectly to the victim of child physical abuse or neglect.

(g) Each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify the Office of Emergency Services of this designation. The costs associated with these medical

evidentiary exams shall be funded by the state, subject to appropriation by the Legislature. Each county's designated SART, SAFE, or other qualified medical evidentiary examiners shall submit invoices to the Office of Emergency Service, who shall administer the program. A flat reimbursement rate shall be established. Within one year upon initial appropriation, the Office of Emergency Service shall establish a 60-day reimbursement process. The Office of Emergency Service shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years.

(h) Reimbursement shall not be subject to reduced reimbursement rates based on patient history or other reasons. Victims of child physical abuse or neglect may receive a medical evidentiary exam outside of the jurisdiction where the crime occurred and that county's approved SART, SAFE teams, or qualified medical evidentiary examiners shall be reimbursed for the performance of these exams.

O

West's Annotated California Codes
Penal Code (Refs & Annos)
Part 4. Prevention of Crimes and Apprehension of Criminals (Refs & Annos)
Title 1. Investigation and Control of Crimes and Criminals (Refs & Annos)
Chapter 2. Control of Crimes and Criminals (Refs & Annos)
Article 2.5. Child Abuse and Neglect Reporting Act (Refs & Annos)

West's Ann.Cal.Penal Code § 11171

§ 11171. Legislative findings and declarations; establishment of medical forensic forms, instructions and examination protocols for victims of child physical abuse or neglect; contents of form; confidentiality; electronic access; costs of medical evidentiary exams and reimbursement

Effective: January 1, 2024
Currentness

(a)(1) The Legislature hereby finds and declares that adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations.

(2) Enhancing examination procedures, documentation, and evidence collection relating to child abuse or neglect will improve the investigation and prosecution of child abuse or neglect as well as other child protection efforts.

(b) The Office of Emergency Services shall, in cooperation with the State Department of Social Services, the Department of Justice, the California Association of Crime Lab Directors, the California District Attorneys Association, the California State Sheriffs' Association, the California Peace Officers Association, the California Medical Association, the California Police Chiefs' Association, child advocates, the California Medical Training Center, child protective services, and other appropriate experts, establish medical forensic forms, instructions, and examination protocols for victims of child physical abuse or neglect using as a model the form and guidelines developed pursuant to Section 13823.5.

(c) The forms shall include, but not be limited to, a place for notation concerning each of the following:

(1) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures.

(2) Addressing relevant consent issues, if indicated.

(3) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history.

(4) The performance of a physical examination for evidence of child physical abuse or neglect.

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(5) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures.

(6) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated.

(7) Procedures for the preservation and disposition of evidence.

(8) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays.

(9) An assessment as to whether there are findings that indicate physical abuse or neglect.

(d) The forms shall become part of the patient's medical record pursuant to guidelines established by the advisory committee of the Office of Emergency Services and subject to the confidentiality laws pertaining to the release of medical forensic examination records.

(e) The forms shall be made accessible for use in an electronic format.

(f) The costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect shall be separate from diagnostic treatment and procedure costs associated with medical treatment. Costs for the medical evidentiary portion of the examination shall not be charged directly or indirectly to the victim of child physical abuse or neglect.

(g) Each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify the Office of Emergency Services of this designation. The costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature. Each county's designated SART, SAFE, or other qualified medical evidentiary examiners shall submit invoices to the Office of Emergency Service, who shall administer the program. A flat reimbursement rate shall be established. Within one year upon initial appropriation, the Office of Emergency Service shall establish a 60-day reimbursement process. The Office of Emergency Service shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years.

(h) Reimbursement shall not be subject to reduced reimbursement rates based on patient history or other reasons. Victims of child physical abuse or neglect may receive a medical evidentiary exam outside of the jurisdiction where the crime occurred and that county's approved SART, SAFE teams, or qualified medical evidentiary examiners shall be reimbursed for the performance of these exams.

Credits

(Added by Stats.2002, c. 249 (S.B.580), § 4. Amended by Stats.2003, c. 62 (S.B.600), § 235; Stats.2003, c. 468 (S.B.851), § 20; Stats.2003, c. 229 (A.B.1757), § 18; Stats.2004, c. 183 (A.B.3082), § 274; Stats.2004, c. 405 (S.B.1796), § 18; Stats.2010,

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c. 618 (A.B.2791), § 209; Stats.2013, c. 352 (A.B.1317), § 421, eff. Sept. 26, 2013, operative July 1, 2013; Stats.2023, c. 841 (A.B.1402), § 1, eff. Jan. 1, 2024.)

West's Ann. Cal. Penal Code § 11171, CA PENAL § 11171
Current with Ch. 1 of 2023-24 2nd Ex.Sess, and all laws through Ch. 1017 of 2024 Reg.Sess.

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62 Cal.4th 168
Supreme Court of California

B.H., a Minor, etc., Plaintiff and Appellant,
v.
COUNTY OF SAN BERNARDINO
et al., Defendants and Respondents.

No. S213066
|
Nov. 30, 2015.

Synopsis

Background: Child, through guardian ad litem, brought action against county, deputy sheriff, and others for failing to cross-report initial child abuse allegations to child welfare agency, in violation of the Child Abuse and Neglect Reporting Act (CANRA). The Superior Court, San Bernardino County, No. CIVDS913403, Donald R. Alvarez, J., granted county's and deputy sheriff's motion for summary judgment based on immunity. Child appealed, and the Court of Appeal affirmed. The Supreme Court granted review, superseding the opinion of the Court of Appeal.

Holdings: The Supreme Court, Chin, J., held that:

[1] county sheriff's department had a duty under CANRA to inform child welfare agency of initial 911 emergency phone call in which nonmandated reporter noted possible abuse of child, and

[2] deputy sheriff investigating initial report of potential child abuse did not have a duty as a mandated reporter under CANRA to make additional reports about the same incident, disapproving *Alejo v. City of Alhambra*, 75 Cal.App.4th 1180, 89 Cal.Rptr.2d 768.

Affirmed in part, reversed in part, and remanded.

Liu, J., concurred in part and dissented in part with opinion.

Opinion, 2013 WL 3865354, vacated.

Procedural Posture(s): On Appeal; Petition for Discretionary Review; Motion for Summary Judgment.

West Headnotes (21)

[1] **Summary Judgment** In conjunction with right to judgment as matter of law

Defendants are entitled to summary judgment only if all the papers submitted show that there is no triable issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

7 Cases that cite this headnote

[2] **Appeal and Error** Plenary, free, or independent review

Appeal and Error Evidence or Other Material Not Considered Below

Appeal and Error Summary Judgment

To determine whether triable issues of fact do exist, the Supreme Court independently review the record that was before the trial court when it ruled on defendants' motion for summary judgment; in so doing, Supreme Court views the evidence in the light most favorable to plaintiffs as the losing parties, resolving evidentiary doubts and ambiguities in their favor.

7 Cases that cite this headnote

[3] **Municipal Corporations** Duties absolutely imposed

The first question when considering public entity immunity always is whether there is liability for breach of a mandatory duty; if there is no liability, the issue of immunity never arises. West's Ann.Cal.Gov.Code § 815.6.

17 Cases that cite this headnote

[4] **Infants** Public authorities and agencies in general

County sheriff's department had a duty under the Child Abuse and Neglect Reporting Act (CANRA), separate and independent from responding deputy's duty, to inform child welfare agency of initial 911 emergency phone call

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in which nonmandated reporter noted possible abuse of child. West's Ann.Cal.Gov.Code § 815.6; West's Ann.Cal.Penal Code § 11166(k).

1 Case that cites this headnote

[5] **Appeal and Error** Sufficiency and scope of motion

Child properly raised issue of whether county law enforcement agencies were liable for failure under the Child Abuse and Neglect Reporting Act (CANRA) to cross-report to the county welfare or probation department "every known or suspected instance of child abuse or neglect reported to it which is alleged to have occurred as a result of the action of a person responsible for the child's welfare," and thus did not forfeit the issue, where child pleaded a cause of action based on the direct liability of the county agencies and alleged that they breached their mandatory duties under that section of the CANRA, child raised the same argument in his opposition to county defendants' motion for summary judgment, in his opposition to the defendants' proposed order, and during the summary judgment hearing, and defendants responded on the merits to child's claim in their reply to child's opposition to defendants' motion for summary judgment. West's Ann.Cal.Penal Code § 11166(k).

3 Cases that cite this headnote

[6] **Appeal and Error** Nature or subject-matter in general

Supreme Court considering grant of summary judgment to county defendants, on immunity grounds, on child's tort claim based on failure to comply with reporting requirements of the Child Abuse and Neglect Reporting Act (CANRA) would decline to consider whether child failed to raise the CANRA claim in his government claim and thus failed to comply with required procedures, as, although defendants asserted the failure to comply with government claims procedures as an affirmative defense in their answer, they did not raise that defense as a basis for the grant of summary judgment. West's Ann.Cal.Gov.Code §§ 945.4, 945.6; West's Ann.Cal.Penal Code § 11166(k).

More cases on this issue

[7] **Municipal Corporations** Duties absolutely imposed

Municipal Corporations Discretionary powers and duties

The first element of public entity liability based on an enactment requires that the enactment at issue be obligatory, rather than merely discretionary or permissive, in its directions to the public entity; it must require, rather than merely authorize or permit, that a particular action be taken or not taken. West's Ann.Cal.Gov.Code § 815.6.

5 Cases that cite this headnote

[8] **Municipal Corporations** Duties absolutely imposed

Municipal Corporations Discretionary powers and duties

To impose public entity liability based on an enactment, it is not enough that the public entity or officer have been under an obligation to perform a function if the function itself involves the exercise of discretion. West's Ann.Cal.Gov.Code § 815.6.

19 Cases that cite this headnote

[9] **Municipal Corporations** Duties absolutely imposed

Municipal Corporations Discretionary powers and duties

Whether a particular statute is intended to impose a mandatory duty, rather than a mere obligation to perform a discretionary function, is a question of statutory interpretation for the courts considering whether the enactment imposes public entity liability. West's Ann.Cal.Gov.Code § 815.6.

6 Cases that cite this headnote

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[10] **Municipal Corporations** Duties absolutely imposed

Municipal Corporations Discretionary powers and duties

Court considering whether a particular statute is intended to impose a mandatory duty, for purposes of public entity liability, rather than a mere obligation to perform a discretionary function, examines the language, function, and apparent purpose of each cited enactment to determine if any or each creates a mandatory duty designed to protect against the injury allegedly suffered by plaintiff. West's Ann.Cal.Gov.Code § 815.6.

23 Cases that cite this headnote

[11] **Infants** Public authorities and agencies in general

County deputy investigating initial report of potential child abuse received by County Sheriff's Department did not have a duty as a mandated reporter under the Child Abuse and Neglect Reporting Act (CANRA) to make additional reports about the same incident; deputy's findings, observations, and duties regarding the investigation of the reported incident of abuse were not governed by the duties of a mandated reporter but were instead governed by CANRA's provisions setting forth various obligations and procedures related to investigations; disapproving *Alejo v. City of Alhambra*, 75 Cal.App.4th 1180, 89 Cal.Rptr.2d 768. West's Ann.Cal.Penal Code § 11166(a).

3 Cases that cite this headnote

[12] **Infants** Requisites and responsibilities as to reporting; form and information

Child Abuse and Neglect Reporting Act (CANRA) only requires mandated reporters to make reports if the reporter, in his or her professional capacity or within the scope of his or her employment, knows or reasonably suspects child abuse or neglect; there is no requirement of a followup investigation to confirm any suspicions. West's Ann.Cal.Penal Code § 11166(a).

8 Cases that cite this headnote

[13] **Infants** Child abuse reports and investigations

Infants Requisites and responsibilities as to reporting; form and information

In regard to investigating whether child abuse or neglect has occurred, the assessments of mandated reporters and the agencies receiving child abuse reports are not the same and are governed by different standards under the Child Abuse and Neglect Reporting Act (CANRA). West's Ann.Cal.Penal Code § 11166.

13 Cases that cite this headnote

[14] **Appeal and Error** Statutory or legislative law

The meaning and construction of a statute is a question of law, which Supreme Court decides independently.

9 Cases that cite this headnote

[15] **Statutes** Construing together; harmony

Court is required to harmonize the various parts of a statutory enactment by considering the particular section in the context of the statutory framework as a whole.

7 Cases that cite this headnote

[16] **Statutes** Language and intent, will, purpose, or policy

Ordinarily, the words of the statute provide the most reliable indication of legislative intent.

5 Cases that cite this headnote

[17] **Statutes** Relation to plain, literal, or clear meaning; ambiguity

A statute's literal terms will not be given effect if to do so would yield an unreasonable or mischievous result.

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4 Cases that cite this headnote

[18] **Infants** Requisites and responsibilities as to reporting; form and information

Child Abuse and Neglect Reporting Act (CANRA) requires persons in positions where abuse is likely to be detected to report promptly all suspected and known instances of child abuse to authorities for follow-up investigation. West's Ann.Cal.Penal Code § 11166.

7 Cases that cite this headnote

[19] **Infants** Requisites and responsibilities as to reporting; form and information

Once a report is made under the Child Abuse and Neglect Reporting Act (CANRA), responsibilities shift and governmental authorities take over. West's Ann.Cal.Penal Code § 11166(a).

3 Cases that cite this headnote

[20] **Infants** Conduct subject to duty to report in general

A mandatory reporter's duty to report under the Child Abuse and Neglect Reporting Act (CANRA) arises not on the basis of the mandated reporter's personal assessment of the facts known to her but on the basis of what a reasonable person would suspect based on those facts. West's Ann.Cal.Penal Code § 11166(a).

8 Cases that cite this headnote

[21] **Infants** Child abuse reports and investigations

Infants Conduct subject to duty to report in general

When circumstances giving rise to a reasonable suspicion of abuse exist, the Child Abuse and Neglect Reporting Act (CANRA) does not permit a mandated reporter to investigate and determine that no abuse occurred; the existence of such circumstances triggers the mandatory duty to report the circumstances to a designated outside agency, and it is the responsibility of the outside agency to investigate all reports of suspected abuse and to determine whether abuse occurred. West's Ann.Cal.Penal Code § 11166(a).

3 Cases that cite this headnote

Attorneys and Law Firms

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Jennifer B. Henning, for California State Association of Counties and League of California Cities as Amici Curiae on behalf of Defendants and Respondents.

Opinion

CHIN, J.

*174 **321 The intent and purpose of the Child Abuse and Neglect Reporting Act (CANRA; Pen.Code § 11164 et seq.) is to protect children from abuse and neglect. (Pen.Code § 11164, subd. (b).)[1] One of the stated fundamental goals of CANRA is to increase communication and the sharing of information relating to child abuse and neglect among the agencies responsible for the welfare of children. (§ 11166.3, subd. (a).) To accomplish this, CANRA designates certain agencies to accept reports of alleged child abuse or neglect and to cross-report the information contained therein to other agencies. (§ 11166.)

1 All further statutory references are to the Penal Code unless otherwise indicated.

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****322** Here, a private citizen called a 911 operator to report an incident of suspected child abuse during the child's visit with his father. The operator relayed the report to the San Bernardino County Sheriff's Department (Sheriff's Department). A deputy sheriff was dispatched to investigate the report. The officer determined that there was an ongoing custody dispute between the parents, the child was not a victim of child abuse, and there was no need for further investigation. Neither the Sheriff's Department nor the officer cross-reported the initial 911 report to the county child welfare agency. About three weeks later, the child suffered extensive head injuries during a visit with his father.

The child, through a guardian ad litem, sued the county and the deputy sheriff, among others, for failing to cross-report the initial child abuse allegations to the child welfare agency, in violation of CANRA. The trial court granted defendants' motion for summary judgment finding there was no duty to cross-report and defendants were immune from liability. The Court of Appeal affirmed the trial court's ruling.

This case presents two issues for our review: (1) whether CANRA imposed a mandatory duty on the Sheriff's Department to cross-report the child abuse allegations to the relevant child welfare agency when it received the 911 report and (2) whether CANRA imposed a mandatory duty on the investigating deputy sheriff to report the child abuse allegations and her investigative findings to the relevant child welfare agency despite her conclusion of no child abuse.

***175** We conclude that the Sheriff's Department had a mandatory and ministerial duty to cross-report the child abuse allegations made to the 911 operator to the child welfare agency and that the failure to cross-report can support a finding of breach of a mandatory duty, elements required to establish public entity liability. (§ 11166, subd. (k); Gov.Code § 815.6.) We further conclude that the officer had no duty to report the child abuse allegations and her investigative findings to the child welfare agency. (§ 11166, subd. (a).)

*****224** Accordingly, we affirm the judgment of the Court of Appeal in part and reverse in part.

FACTS AND PROCEDURAL HISTORY

Plaintiff, B.H., was born in August 2006. At all times after plaintiff's birth, mother Lauri H. and father Louis Sharples lived apart. Starting in February or March 2008, Lauri H. and Sharples informally agreed that Sharples could begin to take physical custody of plaintiff for periods of a few days, which eventually occurred every weekend.

In July 2008, Lauri H. and Sharples began to have custody disputes over plaintiff. Over the Fourth of July holiday, Sharples was scheduled to take plaintiff for five days. After plaintiff was dropped off, Sharples called the Sheriff's Department on July 2 and reported he noticed plaintiff frequently had bruises when he arrived for his visits. Sharples also reported that on this particular visit, plaintiff "ha[d] bruises around his neck" and "it look[ed] like somebody choked him." This prompted Lauri H. to call the county department of children and family services (DCFS) the following day to report that Sharples had made a false report of child abuse. Lauri H. reported that she noticed that plaintiff often returned from visits with various injuries.

Both Sharples's report to the Sheriff's Department and Lauri H.'s report to DCFS were subsequently investigated. The officer responding to Sharples's report interviewed both parties and found the allegations inconclusive. Likewise, DCFS social worker Leann Ashlock met with both parties and urged them to reconcile their differences. Ashlock coordinated a supervised visit so Lauri H. could see plaintiff on July 28. The parties decided to continue sharing custody of plaintiff until they could settle their matters before a family law court.

On September 17, 2008, a family law court granted Sharples one midweek visit and custody of plaintiff every weekend. During the following weekend, on September 22, Lauri H. picked up plaintiff after a visit with Sharples and noticed a scratch and bruises on his face. When Lauri H. returned home with plaintiff, she discussed the injuries with Christy Kinney, the woman who ***176** raised Lauri H. and with whom she and plaintiff were ****323** living. Kinney advised Lauri H. to photograph plaintiff's injuries. Lauri H. took photographs of plaintiff's face and body before she left for school. At 10:14 that evening, while Lauri H. was out for an evening class and party, and without Lauri H.'s knowledge, Kinney called 911 to report her suspicions of child abuse to the Sheriff's Department. During the call, Kinney reported that Sharples said plaintiff "fell out of the car or the truck" but that Sharples's "girlfriend said he fell down the stairs" at a local fast food restaurant. The 911 operator recorded the information as a child abuse report, dispatched it to the Sheriff's Department computer-aided dispatch system, and requested that an officer look into the matter.

Deputy Sheriff Kimberly Swanson responded to the residence shortly before midnight and spoke with Kinney. At this time, plaintiff was asleep and in Kinney's care. Kinney woke plaintiff for Deputy Swanson to observe him. For about 20 minutes, Swanson spoke with Kinney and attempted to examine plaintiff, who was crying and unresponsive because Kinney had just awakened him. Afterwards, Deputy Swanson returned to her patrol vehicle and conducted a computer record check on both Lauri H. and Sharples. She returned to the house, gave Kinney her contact information, and requested that Lauri H. ***225 contact her when she returned home. Deputy Swanson never heard from either Lauri H. or Kinney.

Three days later, Deputy Swanson wrote a report about the incident. Deputy Swanson cleared the case, concluding that there was an ongoing custody dispute between plaintiff's parents, and that the case was "for information only at this time and forward to station files." Swanson noted that Kinney saw that plaintiff "had a cut and bruising above his right eye" when he returned from his weekend visit with his father. Swanson also noted that plaintiff "had small bruises, which appeared to be old, on his upper right arm and on his back" and that Kinney had contacted Sharples, who told her plaintiff had fallen and bumped his head. Sergeant Jeff Bohner, Deputy Swanson's supervisor, reviewed and approved the report.

Lauri H. did not allow plaintiff to visit Sharples again until October 10 or 11, 2008. During the following weekend's visit, Sharples called his girlfriend and said that plaintiff had fallen, hit his head, and would not wake up. Sharples's girlfriend rushed home, noticed that plaintiff was "stiff," and asked if Sharples had called 911. When Sharples responded that he had not, his girlfriend instructed him to call 911, while she notified Lauri H. Emergency personnel responded and transported plaintiff to Loma Linda University Medical Center. Plaintiff, unconscious and suffering from seizures, was treated for severe head trauma and was given a craniectomy, in which a portion of the skull is removed in order to relieve pressure on the brain *177 caused by swelling. Plaintiff suffered subdural hematoma, cerebral edema, and subfalcine herniation caused by intracranial pressure. A consulting forensic pediatrician determined that the injuries were caused by child abuse, most likely "shaken baby syndrome."

Plaintiff filed a complaint, through his mother Lauri H. as guardian ad litem, against the County of San Bernardino, the City of Yucaipa, Deputy Swanson, Sergeant Bohner (collectively, defendants), and Sharples.[2] The complaint alleged two causes of action against defendants: (1) breach of a public entity's mandatory duty to report or cross-report child abuse allegations, under Government Code section 815.6, and (2) negligence by an employee within the scope of employment, under Government Code section 815.2, subdivision (a).

2 The complaint's third cause of action involved only Sharples. Sharples failed to answer the complaint and a default was entered against him.

Defendants filed a motion for summary judgment on the ground they did not breach a mandatory statutory duty owed to plaintiff and were entitled to governmental immunities under Government Code sections 815.2, subdivision (b), 820.2, and 821.6. The trial court found that because the decision not to cross-report was based on the officer's investigatory findings and her discretionary determination of no child abuse, defendants were **324 immune from liability. It granted the motion for summary judgment.

In an unpublished opinion, the Court of Appeal affirmed the trial court's order granting the summary judgment motion. The court held that Deputy Swanson, having conducted an investigation, was not required under section 11166, subdivision (a), to report the child abuse allegations to the child welfare agency because she concluded "there was no child abuse." The court reasoned that because the officer's decision not to report was based on her "judgment, expertise and discretion" and was "tantamount to a decision not to prosecute, where it was the product of an ***226 investigation," her investigation was immunized under Government Code section 821.6. It determined that, consequently, the Sheriff's Department was not vicariously liable under Government Code section 815.2, subdivision (b). The Court of Appeal further held that the Sheriff's Department did not have a separate and independent mandatory duty to cross-report under Penal Code section 11166, subdivision (k) and therefore was not directly liable as a public entity under Government Code section 815.6.

We granted plaintiff's petition for review to decide whether Deputy Swanson and the Sheriff's Department had mandatory duties to report and to cross-report under section 11166, subdivisions (a) and (k).

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***178 DISCUSSION**

CANRA sets forth several different reporting requirements once child abuse or neglect is suspected. (§ 11166.) Certain types of professionals known as "mandated reporters" (§ 11165.7) "shall" report to law enforcement agencies or county welfare departments any known or suspected instance of child abuse or neglect. (§§ 11165.9, 11166, subd. (a).) "Any other person" "may" report to law enforcement agencies or county welfare departments any known or suspected instance of child abuse or neglect. (§§ 11165.9, 11166, subd. (g).) Certain designated agencies, such as a police department, sheriff's department, or county welfare department, "shall" accept such reports made by a "mandated reporter or another person." (§ 11165.9.) In addition, law enforcement agencies "shall" cross-report to the county welfare or probation department "every known or suspected instance of child abuse or neglect reported to it which is alleged to have occurred as a result of the action of a person responsible for the child's welfare." (§ 11166, subd. (k).) Reciprocal duties of cross-reporting to law enforcement agencies are imposed on the county welfare or probation department. (§ 11166, subd. (j).)

Plaintiff claims that the Court of Appeal's decision was incorrect in several respects. First, he argues that section 11166, subdivision (k) imposed on the Sheriff's Department an independent and mandatory duty to inform the child welfare agency of the initial 911 report, which was separate from Deputy Swanson's duty to investigate and cross-report. Second, he argues that section 11166, subdivision (a) imposed on Deputy Swanson, as a mandated reporter, a duty to report an objectively reasonable suspicion of child abuse. Plaintiff contends that because the parties disagreed on the appearance of plaintiff when Deputy Swanson examined him, the reasonableness of her conclusion of no child abuse presented a disputed issue of material fact. On the other hand, defendants argue that plaintiff forfeited the section 11166, subdivision (k) claim for failing to raise the issue below. In any event, they assert, the Court of Appeal correctly concluded that they are immune from liability.

A. Standard of Review

[1] **[2]** " 'This case comes to us on review of a summary judgment. Defendants are entitled to summary judgment only if "all the papers submitted show that there is no triable issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." [Citation.] To determine whether triable issues of fact do exist, we independently review the record that was before the trial court when it ruled on defendants' motion. [Citations.] In so doing, we view the evidence in the light most favorable to plaintiffs as the losing parties, resolving evidentiary doubts and ambiguities in their favor.' " (****325** *****227** *Elk Hills Power, LLC v. Board of Equalization* (2013) 57 Cal.4th 593, 605–606, 160 Cal.Rptr.3d 387, 304 P.3d 1052.)

***179 B. California Government Claims Act**

Under the California Government Claims Act (Gov.Code § 810 et seq.), governmental tort liability must be based on statute. "Except as otherwise provided by statute: [¶] [a] public entity is not liable for an injury, whether such injury arises out of an act or omission of the public entity or a public employee or any other person." (Gov.Code § 815, subd. (a); see *Miklosy v. Regents of University of California* (2008) 44 Cal.4th 876, 899, 80 Cal.Rptr.3d 690, 188 P.3d 629.) Relevant to this case, Government Code section 815.6 provides a statutory exception to the general rule of public entity immunity: "Where a public entity is under a mandatory duty imposed by an enactment that is designed to protect against the risk of a particular kind of injury, the public entity is liable for an injury of that kind proximately caused by its failure to discharge the duty unless the public entity establishes that it exercised reasonable diligence to discharge the duty." (Gov.Code § 815.6.)

[3] In *Guzman v. County of Monterey* (2009) 46 Cal.4th 887, 95 Cal.Rptr.3d 183, 209 P.3d 89 (*Guzman*), we explained that Government Code section 815.6 has three elements that must be satisfied to impose public entity liability: (1) a mandatory duty was imposed on the public entity by an enactment; (2) the enactment was designed to protect against the particular kind of injury allegedly suffered; and (3) the breach of the mandatory statutory duty proximately caused the injury. Even when a duty exists, California has enacted specific immunity statutes that, if applicable, prevail over liability provisions. (*Creason v. Department of Health Services* (1998) 18 Cal.4th 623, 635, 76 Cal.Rptr.2d 489, 957 P.2d 1323.) The first question always is whether there is liability for breach of a mandatory duty. (*Creason,* at p. 630, 76 Cal.Rptr.2d 489, 957 P.2d 1323.) If there is no liability, the issue of immunity never arises. (*Ibid.; Guzman,* at p. 911, fn. 16, 95 Cal.Rptr.3d 183, 209 P.3d 89.)

In addition to liability under Government Code section 815.6, the complaint alleged that defendants were negligent under

Government Code section 815.2. Section 815.2 provides: "(a) A public entity is liable for injury proximately caused by an act or omission of an employee of the public entity within the scope of his employment if the act or omission would, apart from this section, have given rise to a cause of action against that employee or his personal representative. [¶] (b) Except as otherwise provided by statute, a public entity is not liable for an injury resulting from an act or omission of an employee of the public entity where the employee is immune from liability."

Generally, a public employee is "liable for injury caused by his act or omission to the same extent as a private person." (Gov.Code § 820, subd. (a).) However, as relevant here, "a public employee is not liable for an ***180** injury resulting from his act or omission where the act or omission was the result of the exercise of the discretion vested in him, whether or not such discretion be abused." (Gov.Code § 820.2.) In addition, "[a] public employee is not liable for injury caused by his instituting or prosecuting any judicial or administrative proceeding within the scope of his employment, even if he acts maliciously and without probable cause." (Gov.Code § 821.6.)

C. Section 11166, Subdivision (k)

[4] **[5]** **[6]** We first determine whether section 11166, subdivision (k) imposed on the *****228** Sheriff's Department an independent and mandatory duty to inform the child welfare agency of the initial 911 report. [3]

[3] Preliminarily, defendants claim that plaintiff has forfeited the issue relating to the direct liability of the county agencies, pursuant to Penal Code section 11166, subdivision (k) because he failed to raise it in the trial court. Our review of the record reveals that plaintiff properly raised the issue in the trial court. In the complaint, plaintiff pleaded a cause of action based on the direct liability of the county agencies under Government Code section 815.6 and alleged that they breached their mandatory duties pursuant to section 11166, subdivision (k). Plaintiff raised the same argument in his opposition to defendants' motion for summary judgment, in his opposition to the defendants' proposed order, and during the summary judgment hearing. Significantly, defendants responded on the merits to plaintiff's claim in their reply to plaintiff's opposition to defendants' motion for summary judgment.

Defendants further argue that plaintiff failed to raise the Penal Code section 11166, subdivision (k) claim in his government claim and thus, failed to comply with the procedures required by Government Code sections 945.4 and 945.6. Although defendants asserted, as an affirmative defense, the failure to comply with government claims procedures in their answer, they did not raise that defense as a basis for the grant of summary judgment.

Finally, in this court, defendants failed to file an answer to the petition for review requesting that we limit the issues by excluding the one related to section 11166, subdivision (k). Consequently, that issue is properly before us.

****326** **[7]** **[8]** The first element of liability under Government Code section 815.6 requires that " 'the enactment at issue be *obligatory,* rather than merely discretionary or permissive, in its directions to the public entity; it must *require,* rather than merely authorize or permit, that a particular action be taken or not taken. [Citation.] It is not enough, moreover, that the public entity or officer have been under an obligation to perform a function if the function itself involves the exercise of discretion. [Citation.]' [Citation.] Courts have construed this first prong rather strictly, finding a mandatory duty only if the enactment 'affirmatively imposes the duty and provides implementing guidelines.' " (*Guzman, supra,* 46 Cal.4th at p. 898, 95 Cal.Rptr.3d 183, 209 P.3d 89.)

[9] **[10]** " 'Whether a particular statute is intended to impose a mandatory duty, rather than a mere obligation to perform a discretionary function, is a question of statutory interpretation for the courts.' [Citations.] We examine ***181** the 'language, function and apparent purpose' of each cited enactment 'to determine if any or each creates a mandatory duty designed to protect against' the injury allegedly suffered by plaintiff." (*Guzman, supra,* 46 Cal.4th at p. 898, 95 Cal.Rptr.3d 183, 209 P.3d 89.)

Section 11166, subdivision (k) provides: "A law enforcement agency *shall immediately, or as soon as practicably possible, report* by telephone, fax, or electronic transmission to the agency given responsibility for investigation of cases under Section 300 of the Welfare and Institutions Code and to the district attorney's office *every known or suspected instance* of child abuse or neglect *reported to it,* except acts or omissions

coming within subdivision (b) of Section 11165.2, which shall be reported only to the county welfare or probation department. A law enforcement agency *shall report* to the county welfare or probation department *every known or suspected* instance of child abuse or neglect *reported to it which is alleged* to have occurred as a result of the action of a person responsible for the child's welfare, or as the result of the failure of a person responsible for the child's welfare to adequately protect the minor from abuse when the person responsible for the child's *****229** welfare knew or reasonably should have known that the minor was in danger of abuse. A law enforcement agency also *shall* send, fax, or electronically transmit a written report thereof *within 36 hours of receiving the information concerning the incident* to any agency to which it makes a telephone report under this subdivision." (Italics added.)

Section 11166, subdivision (k) imposes an obligatory duty, and not merely a discretionary or permissive authorization, upon law enforcement agencies to cross-report the child abuse or neglect reports that it receives. First, the plain language of the statute commands that a law enforcement agency "*shall* immediately, or as soon as practicably possible, report ... every known or suspected instance of child abuse or neglect reported to it." (§ 11166, subd. (k), italics added.) Regarding persons responsible for the child's welfare, the statute directs that a law enforcement agency "*shall* report ... every known or suspected instance of child abuse or neglect reported to it which is *alleged* to have occurred." (*Ibid.,* italics added.)

The term "child abuse or neglect" is clearly defined. (§§ 11165.1, 11165.2, 11165.3, 11165.4, 11165.6.) Although in some instances it may require the exercise of judgment to identify whether a report involves child abuse or neglect, such a determination does not involve the exercise of discretion. Deciding if conduct falls into a defined category does not require the consideration of a host ****327** of potentially competing factors that is the hallmark of discretion.

***182** In addition, subdivision (k) sets forth implementing guidelines. The law enforcement agency is required initially to cross-report instances of child abuse "immediately, or as soon as practicably possible ... by telephone, fax, or electronic transmission" to a child welfare agency, and then submit a "written report" within "36 hours of receiving the information" if it initially made a telephone report. (§ 11166, subd. (k).)

Second, within section 11166 itself, the Legislature used both the words "shall" and "may," depending on the duties imposed on various persons and governmental agencies. For example, section 11166, subdivision (a) provides that mandated reporters, various designated professionals (§ 11165.7), "shall" report to law enforcement agencies, county probation departments, or county welfare departments any known or suspected instance of child abuse or neglect. (§§ 11165.9, 11166, subd. (a).) On the other hand, section 11166, subdivision (g) provides that "[a]ny other person" (i.e., nonmandated reporters) "may" report to those same agencies any known or suspected instance of child abuse or neglect. Similarly, section 11166, subdivision (h) provides that if two or more persons are required to report a known or suspected instance of child abuse or neglect, a single report "may" be made by one person by mutual agreement. It further provides that if any of those persons knows that the designee has failed to report, he or she "shall" make the report. Further, section 11166, subdivision (d)(3)(A) provides that clergy members "may" report to those same agencies any known or suspected instance of child sexual abuse. Moreover, another section of CANRA, section 11165.9, states that designated agencies (i.e., police, sheriff's, probation, or welfare departments) "shall accept a report of suspected child abuse or neglect whether offered by a mandated reporter or another person." These provisions indicate that the Legislature was aware of the difference between the two terms "shall" and "may," using the term "shall" to convey an obligatory requirement and "may" to indicate *****230** merely a discretionary or permissive authorization.

Although the use of the word "shall" does not necessarily determine the mandatory nature of the duty imposed (*Guzman, supra,* 46 Cal.4th at p. 899, 95 Cal.Rptr.3d 183, 209 P.3d 89), the statute's legislative history further indicates the Legislature's intent to impose a mandatory duty on law enforcement to inform other designated agencies of its receipt of child abuse or neglect reports. Also, regarding the second prong of *Guzman* 's test, the legislative history reflects that the duty described in section 11166, subdivision (k) was designed to protect against the particular kind of injury plaintiff suffered in this case.

The purpose of CANRA, of which section 11166, subdivision (k) is a part, is to protect children from abuse and neglect. (§ 11164, subd. (b).) California's child abuse reporting law was reenacted in 1980 to overhaul an earlier ***183** reporting scheme, with the goal of "increasing the likelihood that child abuse victims would be identified. (Stats. 1980, ch.

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1071, § 4, pp. 3420 et seq.)" (*Ferraro v. Chadwick* (1990) 221 Cal.App.3d 86, 90, 270 Cal.Rptr. 379.) The Legislature explained that "[i]n reenacting the child abuse reporting law, it is the intent of the Legislature to clarify the duties and responsibilities of those who are required to report child abuse. The new provisions are designed to foster cooperation between child protective agencies and other persons required to report. Such cooperation will insure that children will receive the collective judgment of all such agencies and persons regarding the course to be taken to protect the child's interest." (Stats. 1980, ch. 1071, § 5, p. 3425.)

The Attorney General, the drafter of the bill, had emphasized the need for cooperation and communication between law enforcement and child welfare agencies. At an interim hearing before the Assembly Committee on Criminal Justice, Deputy Attorney General Michael Gates testified that "if a policeman or social worker makes that decision [to investigate] by themselves, they do not have the expertise that is required by all of these agencies collectively to make that decision. [¶] ... [¶] I want alternative reporting in the ****328** sense that either agency, if the police gets the report first, we provide that they immediately advise [child welfare services], and vice versa. If [child welfare services] gets it, they immediately advise the police." (Assem. Com. on Criminal Justice, transcript of hearing, "Child Abuse Reporting" (Nov. 21, 1978) pp. 7, 11 (Transcript of Assembly Public Hearing).)

Thus, the legislative history reflects that the Legislature, in reenacting the child abuse reporting law, intended to rectify the problem of inadequate child abuse reporting by mandating cross-reporting between law enforcement and child welfare agencies. (See *Krikorian v. Barry* (1987) 196 Cal.App.3d 1211, 1217, 242 Cal.Rptr. 312 (*Krikorian*).) Moreover, courts have understood the reporting scheme to be mandatory. For example, in explaining the mandatory nature of the reporting scheme, the court in *Planned Parenthood Affiliates v. Van de Kamp* (1986) 181 Cal.App.3d 245, 226 Cal.Rptr. 361 (*Planned Parenthood*), stated: "The child protective agency receiving the initial report must share the report with all its counterpart child protective agencies by means of a system of cross-reporting. An initial report to probation or welfare department is shared with the local police or sheriff's department, and vice versa. Reports are cross-reported in almost all cases to the office of the district attorney.... [¶] A child protective agency receiving the initial child abuse report then conducts an investigation. The Legislature intends an investigation *****231** be conducted on every report received." (*Id.* at pp. 259–260, 226 Cal.Rptr. 361; see *James W. v. Superior Court* (1993) 17 Cal.App.4th 246, 254, 21 Cal.Rptr.2d 169 [reciprocal duties of law enforcement and county welfare departments to cross-report immediately or as soon as practicably possible after receiving initial report of suspected child abuse].)

***184** The Court of Appeal improperly linked the duties designated in section 11166, subdivision (k) with those designated in subdivision (a) of that section. Subdivision (a) requires mandated reporters, which includes a police officer or sheriff's deputy (§ 11165.7, subd.(a)(34)), to report any known or suspected instance of child abuse or neglect to law enforcement agencies or child welfare agencies (§ 11165.9). [4]

4 Subdivision (a) of section 11166 states, in relevant part: "a mandated reporter shall make a report to an agency specified in Section 11165.9 whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. The mandated reporter shall make an initial report by telephone to the agency immediately or as soon as is practicably possible, and shall prepare and send, fax, or electronically transmit a written followup report within 36 hours of receiving the information concerning the incident. The mandated reporter may include with the report any nonprivileged documentary evidence the mandated reporter possesses relating to the incident."

The Court of Appeal concluded that a law enforcement agency's duty to cross-report under section 11166, subdivision (k) depends, not just on the receipt of a child abuse or neglect report, but on its employee's fulfillment of its duties under section 11166, subdivision (a). The court reasoned that subdivision (a) imposes both a duty on the officer to report and investigate, and that a law enforcement agency's and an officer's reporting duties do not arise in the absence of an investigation, since such a report depends on the officer's investigative findings. In other words, "the duty to cross-report [under section 11166, subdivision (k)] arises only after an investigation results in the determination that abuse is known or that it is objectively reasonable for a person to entertain a suspicion, based on facts that could cause a reasonable person to suspect child abuse or neglect. (Pen.Code § 11166, subd. (a)(1).)"

The Court of Appeal incorrectly determined that a law enforcement agency's duty to cross-report under section 11166, subdivision (k) is contingent on its employee's duty, arising as a mandated reporter, to report and investigate under subdivision (a). First, the language of section 11166, subdivisions (k) and (a) reflects that the duties specified in each provision are not dependent on each other and are not the same. Section 11165.9 specifies that law enforcement agencies and the county welfare department "shall accept a report of suspected child abuse or neglect whether offered by a mandated reporter or ****329** another person, or referred by another agency." In turn, section 11166, subdivision (k) requires law enforcement agencies to cross-report to other agencies those reports *received* by them from mandated reporters or another person (i.e., nonmandated reporters). (§ 11166, subds. (a), (k), (g).)

***185** On the other hand, section 11166, subdivision (a) requires mandated reporters to *make* reports of known or suspected instances of child abuse or neglect to the agencies specified in section 11165.9. The definition of a mandated reporter consists of a list of 44 classes of professionals, including teachers, health practitioners, coroners, clergy members, and police officers, who are, broadly, "individuals whose professions bring them into contact with *****232** children." (*Planned Parenthood, supra,* 181 Cal.App.3d at p. 258, 226 Cal.Rptr. 361; see § 11165.7.) Contrary to the Court of Appeal's assertion, a law enforcement agency's duty to cross-report under section 11166, subdivision (k) is contingent only on *receipt* of a child abuse report, including those reports made by a police officer in his or her capacity as a mandated reporter. Such reports are made if the mandated reporter, not the law enforcement agency, "knows or reasonably suspects [a child] has been the victim of child abuse or neglect." (§ 11166, subd. (a).)

Second, nothing in section 11166, subdivision (k) indicates that a law enforcement agency must first investigate the matter before cross-reporting an initial report of abuse. Neither subdivision (a) nor subdivision (k) of section 11166 states that the duty to report and cross-report arises only after the completion of an investigation. Both subdivisions (a) and (k) specify that a mandated reporter or law enforcement agency can make an initial report by telephone immediately or as soon as practicably possible, and must then follow up with a written report within 36 hours of receiving the information concerning the incident. This timeframe is clearly insufficient to conduct and complete an investigation. Moreover, many of the professionals who are mandated reporters, such as doctors, coroners, or teachers, do not have the capacity to conduct followup investigations of known or suspected child abuse or neglect.

Third, other provisions of CANRA specify different obligations and procedures for the reporting of investigations. (§§ 11166.3, subd. (a), 11169, subd. (a).) These provisions indicate that a law enforcement agency's duty to cross-report the receipt of an initial child abuse or neglect report is separate from its investigative duties.

The statutory provisions considered as a whole reflect that the Legislature intended that the various law enforcement and child welfare agencies immediately communicate to each other information received on alleged child abuse or neglect so that they may in turn coordinate their investigative procedures. (§ 11166.3, subd. (a); Cal.Code Regs. tit. 11, § 900.) Here, it is undisputed that the Sheriff's Department did not cross-report the initial 911 report of child abuse made by Kinney, a nonmandated reporter. The Court of Appeal affirmed the trial court's grant of summary judgment, concluding that the county defendants were not liable under Government Code section 815.6 ***186** because Penal Code section 11166, subdivision (k) does not create a mandatory duty that is separate and independent from the officer's duty to report. Accordingly, the Court of Appeal incorrectly ruled on the first two *Guzman* elements.

D. Section 11166, Subdivision (a)

[11] In his opening and reply briefs, plaintiff contends that Deputy Swanson, as a mandated reporter, had a mandatory duty, under section 11166, subdivision (a) both (1) to report Kinney's 911 report of child abuse to a child welfare agency and (2) to investigate and report her investigative findings, including her observations, to a child welfare agency because it was objectively reasonable to suspect child abuse. In their answer brief, defendants agree that Deputy Swanson had a mandatory duty, under section 11166, subdivision (a), to investigate Kinney's report of child abuse, but that because her investigatory findings were subject to her discretion, her decision not to report was immune from liability. The Court of Appeal agreed with defendants as to the applicability of section 11166, subd. (a). However, contrary ****330** to the parties' and the court's underlying premise, *****233** section 11166, subdivision (a) does not require a law enforcement officer conducting an investigation of an initial report of child abuse that has been received by an agency to make additional reports about the same incident.

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Section 11166, subdivision (a) requires a mandated reporter to make a report to a law enforcement agency or a county welfare department "whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect." A mandated reporter has a "reasonable suspicion" when "it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. 'Reasonable suspicion' does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any 'reasonable suspicion' is sufficient." (§ 11166, subd. (a)(1).)

The Court of Appeal agreed with the parties that section 11166, subdivision (a) imposes a duty to investigate, but concluded that it does not create a mandatory duty "to take further action" (i.e., to report) where child abuse is not suspected. It reasoned that Deputy Swanson's decision not to report was grounded on her "judgment, expertise and discretion" and was "tantamount to a decision to not prosecute, where it was the product of an investigation." It further noted that "[h]aving investigated the incident, it was objectively ***187** reasonable for Deputy Swanson to conclude the situation did not involve child abuse, even if that conclusion, in the exercise of Deputy Swanson's judgment, was in error."

Plaintiff responds that the Court of Appeal incorrectly used a subjective standard to conclude that Deputy Swanson had no duty to report because she personally did not suspect child abuse. He contends that discretionary immunity is inapplicable where an officer has a mandatory duty to report based on an objective standard. Plaintiff argues that because the extent of his injuries when Deputy Swanson saw him was in dispute, there was a material issue of fact as to whether a reasonable person in Swanson's position would have suspected child abuse or neglect.

The parties' and the court's underlying assumption—that section 11166, subdivision (a) applies when an officer follows up on a reported incident of child abuse—is based on *Alejo v. City of Alhambra* (1999) 75 Cal.App.4th 1180, 89 Cal.Rptr.2d 768 (*Alejo*).[5] There, the plaintiff sued the City of Alhambra and one of its police officers for the negligent failure to investigate or report child abuse under CANRA. *****234** The plaintiff's father, suspecting that the plaintiff's mother and her boyfriend were abusing the plaintiff, went to the police to report the matter. The police department and the officer who spoke with the father failed to cross-report the father's initial report to other governmental agencies and to conduct any investigation into the alleged abuse. Six weeks later, the mother's boyfriend severely beat the plaintiff. (*Id.* at pp. 1183–1184, 89 Cal.Rptr.2d 768.)

5 Plaintiff never contested that Deputy Swanson was acting as an investigating officer within the meaning of CANRA, until after the parties filed their initial briefs when we asked for supplemental briefing on whether *Alejo* should be disapproved. (See post, p. 22, fn. 6.) Here, the trial court found that Deputy Swanson was investigating the third party report of suspected child abuse. Similarly, the Court of Appeal opinion stated, "it is undisputed that Deputy Swanson investigated the report of suspected abuse." In the Court of Appeal, plaintiff filed a rehearing petition and contested several statements in the opinion as misstatements of fact and others as misstatements of law. However, he did not contest the statement about Deputy Swanson's investigative duties in this case. Indeed, his arguments up until he changed his position were predicated on the point that Deputy Swanson was dispatched to investigate Kinney's 911 report, under section 11166, subdivision (a).

Addressing an earlier, similar version of section 11166, subdivision (a) (as amended by Stats.1996, ch. 1081, § 3.5, p. 7410), the *Alejo* court held that that provision imposed two mandatory duties on law enforcement officers ****331** who received a report of child abuse: (1) "a duty to investigate" and (2) "a duty to take further action when an objectively reasonable person in the same situation would suspect child abuse." (*Alejo, supra,* 75 Cal.App.4th at p. 1186, 89 Cal.Rptr.2d 768.) The court acknowledged that former section 11166, subdivision (a) did not use the term " investigate." However, it reasoned that the statute ***188** "clearly envisions some investigation in order for an officer to determine whether there is reasonable suspicion to support the child abuse allegation and to trigger a report to the county welfare department and the district attorney" and "to the Department of Justice under section 11169, subdivision (a)." (*Alejo,* at p. 1186, 89 Cal.Rptr.2d 768.) The court noted that "[a]n officer is only required to investigate and report an account of child abuse when '... it is objectively reasonable

for a person to entertain a suspicion,' " and need not " pass on an 'unfounded report,' i.e., one which he or she determines to be false" as defined by the statute. (*Alejo,* at pp. 1188–1189, 89 Cal.Rptr.2d 768.)

The *Alejo* court held that the trial court erred in sustaining the defendants' demurrer without leave to amend; the plaintiff's complaint pled a cause of action for the negligent failure to investigate or report under former section 11166, subdivision (a). (*Alejo, supra,* 75 Cal.App.4th at p. 1184, 89 Cal.Rptr.2d 768.)

[12] *Alejo* conflates an officer's mandatory reporting duties with those of an officer investigating a reported instance of alleged child abuse or neglect. It failed to recognize that there is "a dichotomy between reporter and reportee, i.e., differentiating between those who make the initial report and the officials who come later" in performing their investigatory or prosecutorial functions. (*James W. v. Superior Court, supra,* 17 Cal.App.4th at p. 257, 21 Cal.Rptr.2d 169.) As noted above, "mandated reporter" includes 44 classes of professionals, most of whom are not involved in and lack the capacity to perform law enforcement activities, including investigations. (§ 11165.7.) Accordingly, section 11166, subdivision (a) only requires mandated reporters to *make* reports if the reporter, in his or her professional capacity or within the scope of his or her employment, knows or reasonably suspects child abuse or neglect. There is no requirement of a followup investigation to confirm any suspicions. (*People ex rel. Eichenberger v. Stockton Pregnancy Control Medical Clinic, Inc.* (1988) 203 Cal.App.3d 225, 239–240, 249 Cal.Rptr. 762 ["nothing in the Act requires professionals such as health care practitioners to obtain information they would not ordinarily obtain in the course of providing care or treatment"]; see *People v. Davis* (2005) 126 Cal.App.4th 1416, 1426, 25 Cal.Rptr.3d 92 (*Davis*) ["[t]he duty to investigate and the authority to determine whether abuse actually did occur are vested in outside agencies," separate from mandated reporters].) [6]

6 We disapprove *Alejo v. City of Alhambra, supra,* 75 Cal.App.4th 1180, 89 Cal.Rptr.2d 768, to the extent it is inconsistent with this opinion. In amending CANRA in 2000, the Legislature declared: "This act is not intended to abrogate the case of *Alejo v. City of Alhambra* (1999) 75 Cal.App.4th 1180 [89 Cal.Rptr.2d 768]." (Stats.2000, ch. 916, § 34, p. 6838.) The 2000 amendment clarified the various parties subject to the provisions of CANRA. (Stats.2000, ch. 916, § 5, pp. 6813–6815.) Similarly, in the 1980 enactment, the Legislature declared: "[I]n reenacting the Child Abuse Reporting Law ..., it is not the intent of the Legislature to alter the holding in the decision of *Landeros v. Flood* (1976) 17 Cal.3d 399 [131 Cal.Rptr. 69, 551 P.2d 389], which imposes civil liability for a failure to report child abuse." (Stats.1980, ch. 1071, § 5, p. 3425.) "Thus, in both of these instances, the Legislature recognized case law that had permitted a civil suit for injury to a child where there was a breach of the mandated reporter's duty to report child abuse." (*All Angels Preschool/Daycare v. County of Merced* (2011) 197 Cal.App.4th 394, 405, 128 Cal.Rptr.3d 349.) From that brief statement regarding *Alejo,* it appears that the Legislature was endorsing *Alejo* to the extent that it allowed such civil suits in general and was not sanctioning all aspects of the opinion. The Legislature has also imposed criminal sanctions against mandated reporters for failing to report. (§ 11166, subd. (c) ["misdemeanor punishable by up to six months confinement in a county jail or by a fine of one thousand dollars ($1,000) or by both that imprisonment and fine"].)

***235 *189 **[13]** In regard to investigating whether child abuse or neglect has occurred, the assessments of mandated reporters and the agencies receiving child abuse reports are not the same and are governed by different standards. As explained below, Deputy **332 Swanson did not have a duty to report under section 11166, subdivision (a). Deputy Swanson, acting on behalf of the Sheriff's Department —as the recipient of a child abuse report made by a third party—was dispatched to fulfill the Sheriff's Department's function of investigating a specific reported incident of child abuse. Deputy Swanson's findings, observations, and duties regarding the investigation of the reported incident of abuse were not governed by section 11166, subdivision (a), but were instead governed by CANRA's provisions setting forth various obligations and procedures related to investigations.

[14] **[15]** **[16]** **[17]** The meaning and construction of a statute is a question of law, which we decide independently. (*People ex rel. Lockyer v. Shamrock Foods Co.* (2000) 24 Cal.4th 415, 432, 101 Cal.Rptr.2d 200, 11 P.3d 956.) We are required to harmonize the various parts of a statutory enactment by considering the particular section in the context of the statutory framework as a whole. (*Palos Verdes Faculty Assn. v. Palos Verdes Peninsula Unified School Dist.* (1978)

21 Cal.3d 650, 659, 147 Cal.Rptr. 359, 580 P.2d 1155.) Ordinarily, the words of the statute provide the most reliable indication of legislative intent. (*Pacific Gas & Electric Co. v. County of Stanislaus* (1997) 16 Cal.4th 1143, 1152, 69 Cal.Rptr.2d 329, 947 P.2d 291.) However, a statute's literal terms will not be given effect if to do so would yield an unreasonable or mischievous result. (See *Friends of Mammoth v. Board of Supervisors* (1972) 8 Cal.3d 247, 259, 104 Cal.Rptr. 761, 502 P.2d 1049.)

CANRA defines "an employee of any police department, county sheriff's department, county probation department, or county welfare department" as a "mandated reporter," without any express exceptions. (§ 11165.7, subd. (a)(34).) Also, there is no dispute that Deputy Swanson was an employee of a county sheriff's department. Because Deputy Swanson is designated a mandatory reporter, but was dispatched to investigate a third party report of an instance of suspected child abuse (a task that most ***190** mandated reporters do not perform), there is an ambiguity *****236** in Deputy Swanson's role within CANRA's comprehensive statutory scheme. In such circumstances, we may consider CANRA's structure, goals, legislative history, and the wider historical circumstances of the statute's enactment and select the construction that comports most closely with the intent of the Legislature, with a view to promoting the general purpose of the statute and avoiding an interpretation that would lead to absurd consequences. (*Day v. City of Fontana* (2001) 25 Cal.4th 268, 272, 105 Cal.Rptr.2d 457, 19 P.3d 1196.)

[18] **[19]** CANRA was enacted to rectify the problem that many instances of child abuse were still going unreported. (*Krikorian, supra,* 196 Cal.App.3d at pp. 1216–1217, 242 Cal.Rptr. 312; *Davis, supra,* 126 Cal.App.4th at p. 1428, 25 Cal.Rptr.3d 92.) It "requires persons in positions where abuse is likely to be detected to report promptly all suspected and known instances of child abuse to authorities for follow-up investigation." (*Ferraro v. Chadwick, supra,* 221 Cal.App.3d at p. 90, 270 Cal.Rptr. 379.) As noted above, the statutory framework imposes specific duties on mandated reporters to report known or suspected instances of child abuse within expedited timeframes and defines what must be reported, and when, how, and to whom it must be reported. (§§ 11166, subd. (a), 11167, subd. (a).) "Once a report is made, responsibilities shift and governmental authorities take over." (*James W. v. Superior Court, supra,* 17 Cal.App.4th at p. 254, 21 Cal.Rptr.2d 169.) For example, CANRA imposes on law enforcement agencies the duty to cross-report reports they receive to other agencies. (§ 11166, subd. (k).) CANRA further contemplates that these agencies will, pursuant to their "existing duties," investigate reported incidents of suspected child abuse, and that they will notify other agencies when they commence their investigation. (§ 11166.3; cf. *Planned Parenthood, supra,* 181 Cal.App.3d at p. 259, 226 Cal.Rptr. 361 [a "child protective agency receiving the initial child abuse report then conducts an investigation"].) Oftentimes, reporting by third parties is the only way the proper authorities become aware of an incident of child abuse. (Transcript of Assem. Public Hearing, *supra,* p. 17.) In this way, the statutory scheme sets up "a dichotomy between reporter and ****333** reportee." (*James W. v. Superior Court, supra,* 17 Cal.App.4th at p. 257, 21 Cal.Rptr.2d 169.)

June Sherwood, as the director of the Attorney General's crime prevention unit, worked with local government in the area of child abuse. In the 1978 interim Assembly hearing, in support of enhanced reporting legislation, she explained that the role of law enforcement, as a child protective agency, in handling child abuse cases was the same as other child protective agencies, such as county welfare departments. In emphasizing the importance of interagency cooperation in child abuse "decision-making," she stated:

"It is clear that it may not be appropriate in any instant case to respond with traditional crime and punishment approaches. However, since the immediate protection of the child is the paramount concern and since early intervention is vital due to the recidivist and escalatory nature of the crime of child abuse, ***191** law enforcement must be involved in *decision-making* along with the other disciplines. [¶] Indeed, the nature of law enforcement's role and training brings unique qualifications to the handling of child abuse cases, and *which must be part of interagency decision making, particularly in the initial response.* [¶] Under California child abuse reporting statutes and law, police play a central role in crisis intervention and in initial investigation and handling of child abuse cases with the following functions: *****237** [¶] 1. Protection of the child [¶] 2. Collection of evidence and investigation; and [¶] 3. Determination, with other agencies, of resources available in the community." (Transcript of Assem. Public Hearing, *supra,* p. 33, italics added.)

Ms. Sherwood further explained that law enforcement agencies are uniquely qualified to handle child abuse cases: (1) the "[p]olice are the only 24–hour field service child protective agency with investigatory and arrest authority," are "the only round-the-clock branch of government that can provide immediate response," and "are the only agency

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empowered to take a child into immediate protective custody"; (2) "[c]ompared to other involved disciplines, police are better trained to ensure constitutional rights and due process procedures in the investigation of cases"; and (3) "police response is *immediate* within a time frame of 3–30 minutes, whereas, because of public social worker heavy caseload and limited staff, their time response varies from within 2 hours to 2 days." (Transcript of Assem. Public Hearing, *supra,* pp. 34–35.)

In response, the Legislature defined a "child protective agency" as "a police or sheriff's department, a county probation department, or a county welfare department." (Stats.1980, ch. 1071, § 4, pp. 3420, 3422, amending former § 11165, subd. (k).) [7] Thus, the Legislature considers law enforcement agencies, along with child welfare agencies, to be child protective agencies that are designated to accept reports of child abuse (§ 11165.9) and to investigate child abuse reports (§ 11166.3).

7 When reenacted in 1980, the child abuse reporting law required four categories of professionals to report known or suspected incidents of child abuse to a child protective agency: (1) child care custodians; (2) medical practitioners; (3) nonmedical practitioners; and (4) employees of a child protective agency. (Stats.1980, ch. 1071, § 4, pp. 3421–3422, amending former §§ 11165, subds. (h)-(k), 11166, subd. (a).) Of these four broadly defined groups, only child protective agency employees performed the agency function of investigating specific reported incidents of child abuse.
In 2000, the Legislature reorganized and recast the list of specified persons required to report by designating them as mandated reporters and defining them by each individual occupation. (Stats.2000, ch. 916, § 5, p. 6813; Legis. Counsel's Dig., Assem. Bill No. 1241 (1999–2000 Reg. Sess.) 6 Stats.2000, Summary Dig., p. 422.)

The Courts of Appeal have held that the decisions of child welfare agency employees—regarding determinations of child abuse, the potential risk to a ***192** child, placement of a child, removal of a child, and other resultant actions —are subjective *discretionary* ones that are incidental to the employees' investigations. (See, e.g., *Christina C. v. County of Orange* (2013) 220 Cal.App.4th 1371, 1381, 164 Cal.Rptr.3d 43; *Ortega v. Sacramento County Dept. of Health & Human Services* (2008) 161 Cal.App.4th 713, 727–728, 74 Cal.Rptr.3d 390 (*Ortega*); ****334** *Jacqueline T. v. Alameda County Child Protective Services* (2007) 155 Cal.App.4th 456, 468, 66 Cal.Rptr.3d 157 (*Jacqueline T.*); *Alicia T. v. County of Los Angeles* (1990) 222 Cal.App.3d 869, 882–883, 271 Cal.Rptr. 513 (*Alicia T.*).)

These holdings are supported by the legislative history, as well as the statutory structure. Deputy Attorney General Gates explained that the determinations of child protective agency investigators about how to follow up on a report of a suspected incident of child abuse are governed by a subjective standard: "What you have by an investigating agency that receives a report, in every case a judgment call. Do I proceed informally and handle this thing and work with the family, or do I proceed formally? Do I proceed formally in a civil *****238** sense in terms of filing a [Welfare and Institutions Code section] 300d petition, or should the District Attorney file a complaint depending upon the seriousness of the injuries involved? All of these things have to be made by a collective judgment, and by having a complete, accurate index, a central index, then this assists those people who make judgments in terms of how they are going to proceed with that judgment." (Transcript of Assem. Public Hearing, *supra,* pp. 43–44.)

The statutory provisions reflect that when an employee of a child protective agency is dispatched to investigate a child abuse incident report received by the agency, the various provisions governing reporting by child protective agencies apply. The child protective agency then has a duty to report to other child protective agencies that it is investigating the case within 36 hours after *starting* its investigation. (§ 11166.3, subd. (a).) Under the version of CANRA in effect at the time of the incident at issue here, the investigating agency was required to report its investigative findings to the Department of Justice if it determined the child abuse or neglect allegations not to be "unfounded, as defined in Section 11165.12." (§ 11169, former subd. (a), as amended by Stats.2004, ch. 842, § 17, p. 6410.) [8] Section ***193** 11165.12 defines reports as unfounded, substantiated, or inconclusive in terms of the investigator's subjective findings. [9]

8 Current section 11169 states, in pertinent part:
"(a) An agency specified in Section 11165.9 shall forward to the Department of Justice a report in writing of every case it investigates of known or suspected child abuse or severe neglect that is determined to be substantiated .... An agency shall

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not forward a report to the Department of Justice unless it has conducted an active investigation and determined that the report is substantiated, as defined in Section 11165.12....
"(b) On and after January 1, 2012, a police department or sheriff's department specified in Section 11165.9 shall no longer forward to the Department of Justice a report in writing of any case it investigates of known or suspected child abuse or severe neglect...."

9 Section 11165.12 states:
"As used in this article, the following definitions shall control:
"(a) 'Unfounded report' means a report that is determined by the investigator who conducted the investigation to be false, to be inherently improbable, to involve an accidental injury, or not to constitute child abuse or neglect, as defined in Section 11165.6.
"(b) 'Substantiated report' means a report that is determined by the investigator who conducted the investigation to constitute child abuse or neglect, as defined in Section 11165.6, based upon evidence that makes it more likely than not that child abuse or neglect, as defined, occurred. A substantiated report shall not include a report where the investigator who conducted the investigation found the report to be false, inherently improbable, to involve an accidental injury, or to not constitute child abuse or neglect as defined in Section 11165.6.
"(c) 'Inconclusive report' means a report that is determined by the investigator who conducted the investigation not to be unfounded, but the findings are inconclusive and there is insufficient evidence to determine whether child abuse or neglect, as defined in Section 11165.6, has occurred."

[20] **[21]** Nevertheless, there is a tension in the statutory scheme; employees of child protective agencies, who perform investigatory functions on behalf of their employer, are designated mandatory reporters. (§ 11165.7, subd. (a)(34).) Mandated reporters have *mandatory* reporting duties which are governed by an objective standard. (§ 11166, subd. (a); *Krikorian, supra,* 196 Cal.App.3d at pp. 1216–1217, 242 Cal.Rptr. 312.) That is, "the duty to report arises not on the basis of the mandated reporter's personal assessment of the facts known to her, but on the basis of what a reasonable person would suspect based on those facts." (***239** *Davis, supra,* 126 Cal.App.4th at p. 1430, 25 Cal.Rptr.3d 92 [duties of mandated reporter ****335** under elder abuse law and CANRA are the same].) "[W]hen circumstances giving rise to a reasonable suspicion of abuse exist, the Act does not permit a mandated reporter to investigate and determine that no abuse *occurred*.... [T]he existence of such circumstances triggers the mandatory duty to report the circumstances to a designated outside agency. *It is the responsibility of the outside agency to investigate all reports of suspected abuse and to determine whether abuse occurred.*" (*Id.* at pp. 1431–1432, 25 Cal.Rptr.3d 92, italics added, fn. omitted.)

The Legislature imposed an objective standard—while granting concomitant broad immunities for those mandated reporters who report suspected instances of child abuse—to rectify the problem of inadequate child abuse reporting, to broaden the circumstances under which reporting is required, and to encourage mandated reporters to report reasonable suspicions of child abuse. (§ 11172, subd. (a) [providing absolute immunity for mandated reporters who report]; *Davis, supra,* 126 Cal.App.4th at p. 1429, 25 Cal.Rptr.3d 92; *Krikorian, supra,* 196 Cal.App.3d at pp. 1217, 1219, 242 Cal.Rptr. 312.) After commenting on the problem of under-reporting, Deputy Attorney General Gates testified that "we have to rely on third parties reporting child abuse who come into contact with children and are able to observe potential injuries and potential cases of child abuse. ***194** So, it is imperative that third parties report, and it is imperative that they report completely and not just subjectively or let their own philosophy interfere with their legal duties." (Transcript of Assem. Public Hearing, *supra,* p. 4.)

We conclude that Deputy Swanson did not have a duty to file a report of a suspected incident of child abuse in this case for several reasons. First, imposing section 11166, subdivision (a)'s reporting duties on Deputy Swanson in the circumstance of this case would not further CANRA's goals. The Legislature intended that all reasonably suspected *instances* of child abuse be identified and reported to the designated local authorities and that they in turn be cross-reported to other designated agencies. (Legis. Counsel's Dig., Sen. Bill No. 781 (1979–1980 Reg. Sess.) 4 Stats.1980, Summary Dig., p. 333; §§ 11166, subds. (a) [mandated reporter shall make "a written followup report within 36 hours of receiving the information concerning the *incident* " (italics added)], (k) [law enforcement agency shall report to other designated agencies "every known or suspected *instance* of child abuse or neglect reported to it" (italics added)], (g) [nonmandated reporter "may report the known or suspected

instance of child abuse or neglect" (italics added)], 11170, subd. (b) [Dept. of Justice required to notify reporting agency of any information relevant to the "known or suspected *instance* of child abuse or severe neglect" (italics added)], 11167, subd. (c) [information relevant to "*incident* of child abuse or neglect" may be given to licensing agency (italics added)]; see *James W., supra,* 17 Cal.App.4th at p. 255, 21 Cal.Rptr.2d 169.)

Here, Kinney's 911 report notified the Sheriff's Department of the suspected *instance* or *incident* of child abuse. If the Sheriff's Department had cross-reported the incident to DCFS and the district attorney's office, as it was required to, all of the proper authorities would have been notified of that operative incident. In her investigation in response to the report, Deputy Swanson did not identify a different instance of child abuse, but gathered information concerning the one that had already been reported. Thus, the child welfare agency lacked awareness of the suspected incident of child abuse, not because *****240** it failed to receive Deputy Swanson's investigative report, but because the Sheriff's Department had failed in its cross-reporting duties. The Sheriff's Department was further required to notify the child welfare agency of its investigation within 36 hours after its inception. (§ 11166.3, subd. (a).) Once notified of the suspected child abuse incident, the child welfare agency was required to evaluate the report within 10 calendar days. (Welf. and Inst.Code § 16501, subd. (f).) If DCFS had been notified of Kinney's initial report and the Sheriff's Department's investigation, it could have readily requested Deputy Swanson's investigative report as part of its evaluation.

***195** ****336** Second, there would be other oddities in the statutory scheme if we were to conclude that a law enforcement officer investigating a report of suspected child abuse must file a report under section 11166, subdivision (a). Section 11170, subdivision (b)(2) requires that on completion of the investigation, the investigating agency shall inform the mandated reporter of the results of the investigation and of any action the agency is taking with regard to the child or family. Certainly in some cases multiple actors and multiple agencies may be involved in an investigation and in the ultimate decision about what steps to take with regard to the child or family. But at least where an officer sees an investigation of a previously reported incident of child abuse through to its conclusion, the officer presumably would know the results of his or her own investigation and would not need notification by his or her own agency.

Third, Courts of Appeal have held that preliminary determinations of the potential risk to the child and the necessity of intervention made by employees of child protective agencies based on their investigative findings are not ministerial duties; these decisions are subjective, "involve a formidable amount of discretion" and are entitled to immunity. (*Ortega, supra,* 161 Cal.App.4th at p. 728, 74 Cal.Rptr.3d 390; see *Jacqueline T., supra,* 155 Cal.App.4th at p. 468, 66 Cal.Rptr.3d 157; *Christina C., supra,* 220 Cal.App.4th at p. 1381, 164 Cal.Rptr.3d 43; see also *Thompson v. County of Alameda* (1980) 27 Cal.3d 741, 749, 167 Cal.Rptr. 70, 614 P.2d 728 ["[t]he decision, requiring as it does, comparisons, choices, judgments, and evaluations, comprises the very essence of the exercise of 'discretion' "].) Otherwise, such employees' independence " 'would be compromised' " by their " 'constant[ ] fear that a mistake could result in a time-consuming and financially devastating civil suit.' " (*Alicia T., supra,* 222 Cal.App.3d at p. 880, 271 Cal.Rptr. 513; *id.* at p. 881, 271 Cal.Rptr. 513 ["state's interest in preventing child abuse will be diminished due to fear of retaliatory suits"].) Any benefit obtained from imposing liability on child protective agency personnel making discretionary decisions relating to the child's best interests must be carefully balanced against the burden of potential liability, including the risk of being second-guessed years later in a lawsuit.[10] (See *Weirum v. RKO General, Inc.* (1975) 15 Cal.3d 40, 46, 123 Cal.Rptr. 468, 539 P.2d 36 [foreseeable risk of harm "is a question of fact for the jury"]; *Storch v. Silverman* (1986) 186 Cal.App.3d 671, 678, 231 Cal.Rptr. 27 ["issue of the *****241** reasonableness of the reporter's suspicions would potentially exist in every reported case"].) We recognize that B.H.'s claim is based on an allegation that Deputy Swanson ***196** failed to make a *mandatory* report under a standard of *objective reasonableness*. But the difference between the subjective, discretionary nature of decisions made in the course of following up on a reported incident of child abuse and the mandatory, objective nature of the section 11166, subdivision (a) reporting duty reinforces the point that Deputy Swanson was not required to report under subdivision (a) when she was dispatched in response to a previously reported incident of suspected child abuse.

10 Deputy Attorney General Gates explained that the mandated reporter's liability for foreseeable injuries from the failure to report an objectively reasonable suspicion of child abuse or neglect "would be really after the fact when it was somehow discovered down the line that ... by virtue

> of the fact there wasn't a report, the child went back into the home, was re-injured and somebody else reported it....” (Transcript of Assem. Public Hearing, supra, p. 13.)

Fourth, the different statutory immunities conferred on mandated reporters and on investigators demonstrate that the Legislature distinguished between the two separate functions of reporting and investigating an incident of abuse. (See § 11172, subd. (a) [providing absolute immunity for mandated reporters from liability based on filing a report].) The Court of Appeal opinions in *Newton v. County of Napa* (1990) 217 Cal.App.3d 1551, 266 Cal.Rptr. 682 (*Newton*) and *James W., supra,* 17 Cal.App.4th 246, 21 Cal.Rptr.2d 169 illustrate the scope of the distinction.

In *Newton, supra,* 217 Cal.App.3d at page 1558, 266 Cal.Rptr. 682, officers of four county agencies, including the Napa County Sheriff's Department and Napa County Child Protective Services, went to the plaintiffs' ****337** house after receiving a report that the plaintiffs were abusing their children. The officials informed the plaintiffs they had come to investigate a child abuse report and took each of the children, without parental consent, to the bathroom where they were required to disrobe. They searched each child's body for signs of abuse, found no signs of abuse, and acknowledged to the plaintiffs that the report of child abuse was “unfounded.” The plaintiffs sued the four county agencies for various causes of action in connection with the investigation of suspected child abuse.

The Court of Appeal held that the unqualified immunity conferred on mandated reporters, including those who are employees of child protective agencies (former § 11172, subd. (a), as amended by Stats.1981, ch. 435, § 6, p. 1673), “extends only to persons reporting child abuse to governmental authorities; it does not apply to actions taken by officials who receive such reports of abuse. The duties and immunities of such officials are to be found rather in [different statutory provisions].” (*Newton, supra,* 217 Cal.App.3d at pp. 1558–1559, 266 Cal.Rptr. 682.) Thus, the Court of Appeal recognized that law enforcement officers and child welfare agency employees perform different functions at various times and that their immunity—either as a mandated reporter or investigator—depends on the particular circumstances alleged to give rise to liability.

Similarly, in *James W., supra,* 17 Cal.App.4th at page 256, 21 Cal.Rptr.2d 169, the Court of Appeal held that defendants, foster parents and a private family counselor, were not entitled to the absolute immunity afforded to ***197** mandated reporters. (Former § 11172, subd. (a), as amended by Stats.1987, ch. 1459, § 23.) Although the defendants were designated reporters, they were not acting in that capacity —identifying or reporting child abuse—and thus, could not “take advantage of the reporting act immunity.” (*James W., supra,* 17 Cal.App.4th at p. 256, 21 Cal.Rptr.2d 169; see *id.* at pp. 253, fns. 10 & 11, 21 Cal.Rptr.2d 169.) The Court of Appeal stated: “We believe recognition of a dichotomy between reporter and reportee, i.e., differentiating between those who make the initial report and the officials who come later, is a healthy distinction.” *****242** (*Id.* at p. 257, 21 Cal.Rptr.2d 169.) Thus, the Court of Appeal recognized that law enforcement officers and child welfare agency employees perform both investigative and reporting functions and that their immunity turns on the specific acts or omissions alleged to have given rise to liability.

Finally, although Deputy Swanson did not have a duty to report in this case, we note that in other circumstances a law enforcement officer would have that duty with the concomitant obligations, liabilities, and immunities. Law enforcement officers, although considered to be employees of child protective agencies, have numerous duties other than investigating child abuse reports and determining a child's best interest based on that investigation. Deputy Swanson would be required to report in the first instance if she encountered a child while patrolling the streets or working a case for whom no report of suspected abuse or neglect had been made in a situation that would sustain an objectively reasonable suspicion of child abuse or neglect. For example, if Deputy Swanson were dispatched to investigate a reported residential burglary and observed evidence that would sustain an objective suspicion of child abuse, she would be required to report under section 11166, subdivision (a). Deputy Swanson also would have been required to report were she dispatched to investigate a report of a suspected incident of child abuse and observed evidence that would sustain an objective suspicion that a different, previously unreported incident or instance of child abuse had occurred. (Cf. *People v. Stritzinger* (1983) 34 Cal.3d 505, 513, 194 Cal.Rptr. 431, 668 P.2d 738 [psychotherapist was “under no statutory obligation to make a second report” concerning previously reported incidents of abuse, but “[h]ad he learned ... of possible further abuse—whether additional incidents involving [the same victim], or other incidents with another child—he would, of course, have been required to report these new suspicions.”].) In turn, the Sheriff's Department would be required to cross-report under section 11166, subdivision (k).

****338** The Court of Appeal reached the same result by a different route: it concluded that although section 11166, subdivision (a) imposed a mandatory duty on Deputy Swanson to investigate, it did not impose a mandatory duty on her to report her investigative findings and conclusion of no child abuse. Because Deputy Swanson did not have a mandatory duty to report under section 11166, subdivision (a), she is not directly liable under that statutory ***198** provision and thus, the county defendants are not derivatively liable under Government Code section 815.2, subdivision (a). Accordingly, the trial court and Court of Appeal properly determined defendants were entitled to judgment as a matter of law regarding the negligence cause of action based on section 11166, subdivision (a). Despite the Court of Appeal's flawed reasoning, it correctly affirmed the trial court's order granting summary judgment as to that cause of action.

CONCLUSION

The Court of Appeal erred in affirming the trial court's grant of summary judgment as to the cause of action relating to Government Code section 815.6 and Penal Code section 11166, subdivision (k). However, the Court of Appeal correctly affirmed the trial court's grant of summary judgment as to the cause of action relating to section 11166, subdivision (a). Accordingly, we reverse its judgment in part, affirm its judgment in part, and remand to that court for further proceedings consistent with this opinion.

*****243** WE CONCUR: CANTIL–SAKAUYE, C.J., WERDEGAR, CORRIGAN, CUÉLLAR, and KRUGER, JJ.

Concurring and Dissenting Opinion by LIU, J.

I agree with today's opinion that the Child Abuse and Neglect Reporting Act (CANRA) imposed on the San Bernardino County Sheriff's Department (Sheriff's Department) a mandatory duty to inform the county child welfare agency of Christy Kinney's 911 report of child abuse. (Pen.Code § 11166, subd. (k); all undesignated statutory references are to this code.) But I do not agree that the officer sent to investigate the incident, Deputy Sheriff Kimberly Swanson, had no duty to report under section 11166, subdivision (a) (section 11166(a)).

There is no dispute that Deputy Swanson was a mandated reporter under CANRA. (§ 11165.7, subd. (a)(34).) Section 11166(a) provides that "a mandated reporter *shall* make a report to [a child protective agency] *whenever* the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect." (Italics added.) I would apply the unambiguous terms of section 11166(a) as written and conclude that Deputy Swanson was required to make a report if her observations of B.H. gave rise to a reasonable suspicion of child abuse.

Instead of following this straightforward analysis, today's opinion holds that section 11166(a) "does not require a law enforcement officer conducting an investigation of an initial report of child abuse that has been received by ***199** an agency to make additional reports about the same incident." (Maj. opn., *ante,* 195 Cal.Rptr.3d at p. 233, 361 P.3d at p. 330.) In so holding, the court departs from the plain language of the statute and fashions a judicially invented exception that no party to this litigation has urged.

"Ordinarily, the words of the statute provide the most reliable indication of legislative intent." (*Pacific Gas & Electric Co. v. County of Stanislaus* (1997) 16 Cal.4th 1143, 1152, 69 Cal.Rptr.2d 329, 947 P.2d 291.) Today's opinion does not identify any ambiguous language in the reporting requirement of section 11166(a). Instead, the court says there is "a tension in the statutory scheme" due to the fact that "employees of child protective agencies, who perform investigatory functions on behalf of their employer, are designated mandatory reporters." (Maj. opn., *ante,* 195 Cal.Rptr.3d at p. 238, 361 P.3d at p. 334.) The court then resolves the "tension" by holding that such employees, though designated as mandatory reporters, have no duty to report when investigating an already reported incident of suspected child abuse.

****339** But the "tension" posited by the court exists only on the premise that a child protective agency employee who is following up on an initial report of suspected child abuse must be performing *either* an investigative function *or* a reporting function and cannot be performing both at the same time. The court makes four arguments in defense of this premise, but none is persuasive.

First, the court says "imposing section 11166, subdivision (a)'s reporting duties on Deputy Swanson in the circumstance

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of this case would not further CANRA's goals" because the Legislature intended only that "reasonably suspected *instances* of child abuse be identified and reported." (Maj. opn., *ante,* 195 Cal.Rptr.3d at p. 239, 361 P.3d at p. 335; see *id.* at pp. 239–240, 361 P.3d at pp. 335–336 [citing CANRA's ***244** use of the terms "instance" and "incident" of child abuse].) "Here, Kinney's 911 report notified the Sheriff's Department of the suspected *instance* or *incident* of child abuse," and "Deputy Swanson did not identify a different instance of child abuse, but gathered information concerning the one that had already been reported." (Maj. opn., *ante,* at p. 239, 361 P.3d at p. 335.) Thus, the court contends, an additional report by Deputy Swanson would not further CANRA's goal of ensuring the identification and reporting of each suspected instance or incident of child abuse.

But the court's narrow reading of the purpose of reporting under CANRA is belied by the statute's reporting requirements, which go well beyond merely flagging each instance or incident of suspected child abuse. Section 11167, subdivision (a) requires mandated reports to include "the information that gave rise to the reasonable suspicion of child abuse or neglect and the source or sources of that information. If a report is made, the following *200 information, if known, shall also be included in the report: the child's name, the child's address, present location, and, if applicable, school, grade, and class; the names, addresses, and telephone numbers of the child's parents or guardians; and the name, address, telephone number, and other relevant personal information about the person or persons who might have abused or neglected the child." In addition, "[a]ny mandated reporter who knows or reasonably suspects that the home or institution in which a child resides is unsuitable for the child because of abuse or neglect of the child shall bring the condition to the attention of the [child protective] agency" in the mandated report. (§ 11166, subd. (f).) The reporting form derived from this statute requires the mandated reporter to describe "what [the] victim said, ... what the mandated reporter observed, ... [and] what [the] person accompanying the victim(s) said ... [or] similar or past incidents involving the victim(s) or suspect."

If the purpose of reporting under CANRA were only to flag each instance of suspected child abuse, there would have been no need for the statute to require such detailed information. The Legislature plainly intended the task of reporting to provide relevant agencies with all information known to a mandated reporter regarding an incident of suspected child abuse. This sensibly ensures that child protective agencies will have the most complete information available when setting priorities, allocating resources, and conducting investigations.

Here, Deputy Swanson received the 911 dispatch report in which Kinney reported that B.H. "was at his father[']s house for the weekend and came home with bruises on his forehead." This was the extent of the information Deputy Swanson had about B.H.'s injuries when she arrived at the home. In her police report, Deputy Swanson wrote that B.H. had a "cut and bruising above his right eye. He also had small bruises, which appeared to be old, on his upper right arm and on his back." Even if the Sheriff's Department had reported the incident to the child welfare agency upon receiving the 911 call, as required by section 11166, subdivision (k), an additional mandated report with Deputy Swanson's observations (assuming those observations gave rise to reasonable suspicion of child abuse) would have advanced the informational objectives of the statutory reporting requirement.

Moreover, even accepting the court's view that CANRA's reporting requirements are concerned only with "instances" or "incidents" **340 of child abuse, I would find the trial court's grant of summary judgment improper. Today's opinion says ***245 Deputy Swanson "would have been required to report were she dispatched to investigate a report of a suspected incident of child abuse and observed evidence that would sustain an objective suspicion that a different, previously unreported incident or instance of child abuse had occurred." *201 (Maj. opn., *ante,* 195 Cal.Rptr.3d at p. 242, 361 P.3d at p. 337.) As noted, Deputy Swanson's police report observed that B.H. "had small bruises, *which appeared to be old,* on his upper right arm and on his back." (Italics added; cf.*People v. Mills* (1991) 1 Cal.App.4th 898, 911, 2 Cal.Rptr.2d 614 [bruises of various ages on a child is, among other indicators, evidence of past child abuse].) The presence of old bruises on B.H.'s body arguably gave rise to reasonable suspicion of a *past* unreported incident of child abuse. This triable issue of material fact precludes summary judgment.

Second, the court says it would be an "oddit[y]" if an officer dispatched to investigate a report of child abuse were herself required to make a report. (Maj. opn., *ante,* 195 Cal.Rptr.3d at p. 240, 361 P.3d at p. 336.) "Section 11170, subdivision (b)(2) requires that on completion of the investigation, the investigating agency shall inform the mandated reporter of the results of the investigation and of any action the agency is taking with regard to the child or family." (*Ibid.*) Thus, "at

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least where an officer sees an investigation of a previously reported incident of child abuse through to its conclusion, the officer presumably would know the results of his or her own investigation and would not need notification by his or her own agency." (*Ibid.*)

But this supposed oddity assumes that after an officer makes a mandated report, only that officer will initiate and complete an investigation. Here, if Deputy Swanson had filed a mandated report on top of an initial mandated report filed by the Sheriff's Department, the child welfare agency might have opened its own investigation. As the court notes, "multiple actors and multiple agencies may be involved in an investigation and in the ultimate decision about what steps to take with regard to the child or family." (Maj. opn., *ante,* 195 Cal.Rptr.3d at p. 240, 361 P.3d at p. 336.) The results of the child welfare agency's investigation would provide helpful follow-up to the officer who made the mandated report, confirming or controverting the officer's own conclusion as to whether the initial report of suspect abuse was well founded. There is nothing odd about this feedback loop.

Third, the court says that "preliminary determinations of the potential risk to the child and the necessity of intervention made by employees of child protective agencies based on their investigative findings are not ministerial duties; these decisions are subjective, 'involve a formidable amount of discretion' and are entitled to immunity." (Maj. opn., *ante,* 195 Cal.Rptr.3d at p. 240, 361 P.3d at p. 336.) This is true but beside the point. Even if Deputy Swanson, as a child protective agency employee, was performing investigative duties that required discretionary judgment entitled to immunity, she was also a mandated reporter with duties that did not require subjective judgment but rather an objective determination of reasonable suspicion. As the court notes, "B.H.'s claim is based on an allegation that Deputy Swanson failed to make a *mandatory* ***202** report under a standard of *objective reasonableness* " (maj. opn., *ante,* at p. 241, 361 P.3d at p. 336); B.H. does not claim that Deputy Swanson failed to properly investigate.

Fundamentally, the court does not explain why Deputy Swanson could not have been subject to investigatory and reporting *****246** duties at the same time. In enacting CANRA, the Legislature was aware that law enforcement officers would have dual roles as investigators of reported incidents of child abuse and as mandated reporters obligated to file their own reports. If the Legislature had intended one role to take precedence over the other when an officer is following up on a reported incident of suspected child abuse, presumably it would have said so. But no such indication appears in the statute, and nothing suggests it is absurd or impossible for an officer to act in both capacities simultaneously. Indeed, no party in this case contends that Deputy Swanson, though a mandated reporter, had ****341** no duty to report in these circumstances. I would apply the plain text of section 11166(a) instead of inventing an exception to the statute as the court does today.

Finally, the court observes that "the different statutory immunities conferred on mandated reporters and on investigators demonstrate that the Legislature distinguished between the two separate functions of reporting and investigating an incident of abuse." (Maj. opn., *ante,* 195 Cal.Rptr.3d at p. 241, 361 P.3d at p. 336.) But again, the fact that reporting and investigating are separate functions, with different standards governing an officer's duties, does not mean the exercise of one function precludes exercise of the other. And the fact that an officer's "immunity—either as a mandated reporter or investigator—depends on the particular circumstances alleged to give rise to liability" (*id.* at p. 241, 361 P.3d at p. 337) does not mean the officer must be understood to act in only one capacity at a time. An officer's entitlement to immunity as well as the scope of that immunity will depend on the officer's specific acts or omissions measured against the standards applicable to each duty, whether as investigator or as mandated reporter. (Compare *Newton v. County of Napa* (1990) 217 Cal.App.3d 1551, 1561–1562, 266 Cal.Rptr. 682 [county was immune for conduct relating to investigation of reported child abuse] with § 11172, subd. (a) [absolute immunity for mandated reporters who comply with duties] and § 11166, subd. (c) [criminal liability for mandated reporters who do not comply with duties].) But there is no reason why more than one set of legal duties and immunities cannot govern an officer's conduct in this context at the same time.

To be sure, a straightforward application of section 11166(a) may result in the same instance of suspected child abuse being reported more than once. But CANRA contemplates a layered reporting system to protect children from abuse. For example, a mandated reporter who has reasonable suspicion of ***203** child abuse must make a report even if she has conveyed the information to her employer, supervisor, or another mandated reporter. (§ 11166, subd. (i)(3).) In addition, a mandated reporter must report even when another person who is not a mandated reporter has already done so. (§ 11166, subd. (g); cf. § 11166, subd. (h) [two or more mandated reporters

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who "jointly have knowledge" of a suspected instance of child abuse may form a "reporting team" and file "a single report"].) The potential benefit of this layered reporting system is apparent in this case: If Deputy Swanson had filed a mandated report, her report would have provided the child welfare agency with more information than what the 911 dispatch report contained.

On the facts here, it is arguable whether Deputy Swanson should have had a reasonable suspicion of child abuse. For purposes of section 11166(a), " 'reasonable suspicion' means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. 'Reasonable suspicion' does not require certainty that child abuse or ***247 neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any 'reasonable suspicion' is sufficient." (§ 11166, subd. (a)(1).) Applying this standard to what Deputy Swanson observed when she visited B.H., I believe there is a triable issue of material fact as to whether Deputy Swanson's observations gave rise to a reasonable suspicion of child abuse and, if so, whether she fulfilled her duty to report under section 11166(a). Accordingly, I would reverse the grant of summary judgment in favor of Deputy Swanson and the Sheriff's Department. Although the Court of Appeal held that Government Code section 821.6 immunized Deputy Swanson from any reporting liability, I see no need to opine on immunity in advance of a proper determination of whether Deputy Swanson did not comply with section 11166(a).

In all other respects, I join the court's opinion.

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7 Cal.App.5th 628
Court of Appeal, Third District, California.

DEPARTMENT OF ALCOHOLIC BEVERAGE CONTROL, Petitioner,
v.
ALCOHOLIC BEVERAGE CONTROL APPEALS BOARD, Respondent;
Garfield Beach CVS, LLC et al., Real Parties in Interest.

C078574
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Filed 1/17/2017

Synopsis

Background: Department of Alcoholic Beverage Control appealed decision of the Alcoholic Beverage Control Appeals Board, No. AB9434, which reversed suspension of store's off-sale general license for selling alcohol to a minor decoy.

Holdings: The Court of Appeal, Hoch, J., held that:

[1] Alcoholic Beverage Control rule which required that minor decoys "truthfully answer any questions about his or her age," did not require minor decoy to truthfully respond to clerk's statement, after looking at driver's license, that "I would not have guessed it, you must get asked a lot," as rule only required decoys to answer questions, and

[2] rule did not impose affirmative duty on minor decoy to speak up in order to clarify any mistake regarding age articulated by sales clerk.

Annulled; reinstated and remanded.

West Headnotes (15)

[1] **Alcoholic Beverages** Discretion of decisionmaker below

In the absence of a clear abuse of discretion, the courts will uphold the decision of the Department of Alcoholic Beverage Control to suspend a liquor license for violation of the liquor laws. Cal. Const. art. 20, § 22.

[2] **Alcoholic Beverages** Agencies, Boards, Commissions, and Departments

Alcoholic Beverages Powers, duties, and liabilities

Alcoholic Beverages Finality; interlocutory review

The administration of the Alcoholic Beverage Control Act, within the scope of the purposes of that act, is initially vested in the Department of Alcoholic Beverage Control; its decisions, however, are subject to administrative review by the Alcohol Beverage Control Appeals Board, and a final order of the Board is, in turn, subject to judicial review. Cal. Bus. & Prof. Code § 23000 et seq.

1 Case that cites this headnote

[3] **Alcoholic Beverages** Proceedings concerning violations and discipline

Alcoholic Beverages Scope, Standard, and Extent of Review

The scope of review of the decisions of the Department of Alcoholic Beverage Control is the same in the Alcohol Beverage Control Appeals Board and the Court of Appeal. Cal. Bus. & Prof. Code § 23090.2.

1 Case that cites this headnote

[4] **Alcoholic Beverages** Administrative construction of statutes and regulations; judicial deference

Court of Appeal defers to the Department of Alcoholic Beverage Control's interpretation of its own rules, since the agency is likely to be intimately familiar with regulations it authored and sensitive to the practical implications of one interpretation over another. Cal. Bus. & Prof. Code § 23090.2.

2 Cases that cite this headnote

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[5] **Alcoholic Beverages** Administrative construction of statutes and regulations; judicial deference

Courts generally will not depart from the Department of Alcoholic Beverage Control's contemporaneous construction of a rule enforced by the Department unless such interpretation is clearly erroneous or unauthorized. Cal. Bus. & Prof. Code § 23090.2.

2 Cases that cite this headnote

[6] **Alcoholic Beverages** Scope, Standard, and Extent of Review

Decisions of the Department of Alcoholic Beverage Control are subject to review only for insufficiency of the evidence, excess of jurisdiction, errors of law, or abuse of discretion. Cal. Bus. & Prof. Code § 23090.2.

2 Cases that cite this headnote

[7] **Alcoholic Beverages** Undercover, decoy, or "sting" operations

Alcoholic Beverage Control rule which required that minor decoys "truthfully answer any questions about his or her age," did not require minor decoy to truthfully respond to clerk's statement, after looking at driver's license, that "I would not have guessed it, you must get asked a lot," as rule only required decoys to answer questions. Cal. Bus. & Prof. Code § 25658(a); Cal. Code Regs. tit. 4, § 141(b)(4).

[8] **Alcoholic Beverages** Undercover, decoy, or "sting" operations

Under Department of Alcoholic Beverage Control rule providing that "a decoy shall answer truthfully any questions about his or her age," minor decoys do not need to respond to statements of any kind, nor do they need to respond truthfully to questions other than those concerning their ages. Cal. Bus. & Prof. Code § 25658(a); Cal. Code Regs. tit. 4, § 141(b)(4).

[9] **Alcoholic Beverages** Undercover, decoy, or "sting" operations

Department of Alcoholic Beverage Control rule providing that "a decoy shall answer truthfully any questions about his or her age" does not require minor decoys to correct mistakes articulated by licensed alcohol sellers; instead, the decoys need to respond truthfully only to questions about their ages. Cal. Bus. & Prof. Code § 25658(a); Cal. Code Regs. tit. 4, § 141(b)(4).

[10] **Alcoholic Beverages** Undercover, decoy, or "sting" operations

Alcoholic Beverage Control rule regarding use of minor decoys, which allowed law enforcement to use decoys "in a fashion that promotes fairness," did not impose affirmative duty on minor decoy to speak up in order to clarify any mistake regarding age articulated by sales clerk who stated, after looking at driver's license, that "I would not have guessed it, you must get asked a lot"; rule implement goal of fairness by imposing five specific requirements, minor decoy did not say anything untrue but rather presented accurate information in the form of his driver license, and minor decoy's silence did not involve any attempt to pressure or encourage the sale of an alcoholic beverage to him. Cal. Bus. & Prof. Code § 25658(a); Cal. Code Regs. tit. 4, § 141.

[11] **Alcoholic Beverages** Decisions Reviewable

Court of Appeal may take judicial notice of decisions of the Alcoholic Beverage Control Appeals Board.

1 Case that cites this headnote

[12] **Alcoholic Beverages** Administrative construction of statutes and regulations; judicial deference

Although not bound by the decisions of the Alcoholic Beverage Control Appeals Board,

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Court of Appeal would take judicial notice of their decisions and consider their reasoning for persuasive value when determining whether rule regarding use of minor decoys, which required law enforcement to use minor decoys "in a fashion that promotes fairness," was ambiguous. Cal. Code Regs. tit. 4, § 141(a).

3 Cases that cite this headnote

[13] **Statutes** Exceptions, Limitations, and Conditions

An exception to a statute is to be narrowly construed.

[14] **Statutes** Exceptions, Limitations, and Conditions

When a statute specifies an exception, no others may be added under the guise of judicial construction.

[15] **Alcoholic Beverages** Proceedings concerning violations and discipline

Minor decoy's testimony in proceedings to suspend liquor store's off-sale general license was sufficient to support finding that store clerk's words regarding liquor purchase were a statement, rather than a question about decoy's age to which decoy was required to respond truthfully; decoy's testimony, including that clerk stated "I would not have guessed it, you must get asked a lot," or words to that effect, was clear and credible. Cal. Bus. & Prof. Code § 25658(a); Cal. Code Regs. tit. 4, § 141(b)(4).

****132** ORIGINAL PROCEEDING: Petition for writ of review. Petition granted. Alcoholic Beverage Control Appeals Board No. AB9434.

Attorneys and Law Firms

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****133** Solomon, Saltsman & Jamieson, Stephen Warren Solomon, Ralph Barat Saltsman, Stephen Allen Jamieson, R. Bruce Evans, Ryan M. Kroll, Jennifer L. Oden, Los Angeles, and Margaret Warner Rose for Real Parties in Interest.

Opinion

HOCH, J.

***630** California Constitution, article XX, section 22, prohibits the sale of alcoholic beverages to persons under 21 years of age. (See also Bus. & Prof. Code, § 25658, subd. (a)), [1] [making it a misdemeanor to sell alcohol to a person under 21 years of age]. Here, the Department of Alcoholic Beverage ***631** Control (Department) issued a 15–day suspension of an off-sale general license held by the Garfield Beach CVS LLC Longs Drug Stores California LLC, doing business as CVS Pharmacy Store 9174 (CVS) after an administrative law judge found the store clerk sold alcohol to a minor decoy. [2] The Alcoholic Beverage Control Appeals Board (Appeals Board) reversed the suspension based on California Code of Regulations, title 4, section 141 (Rule 141), which allows a law enforcement agency to use an underage decoy only "in a 'fashion that promotes fairness.' (*Id.*, subd. (a).) In the Appeals Board's view, the suspension was unfair because the minor decoy did not respond about his age when the store clerk looked at his driver license and remarked, "I would never have guessed it, you must get asked a lot." To challenge the reversal of the license suspension, the Department petitioned for a writ of review in this court. (§ 23090.)

1 Undesignated statutory references are to the Business and Professions Code.

2 The license is held by Garfield Beach CVS LLC Longs Drug Stores California LLC, doing business as CVS Pharmacy Store 9174.

The Department contends it correctly interprets Rule 141 to require minor decoys to answer only questions about their ages. Based on the administrative law judge's finding in this case that the store clerk's remark constituted a statement rather than a question, the Department argues its decision was legally correct and supported by substantial evidence. The Appeals Board counters Rule 141 is ambiguous and results "in confusion and manifest unfairness." CVS

argues the Department's interpretation of Rule 141 unfairly allows decoys to remain silent in the face of mistaken statements about age. According to CVS, affirming the license suspension would allow deceptive and misleading silence in the face of a store clerk's explicit mistake about the minor decoy's age.

We conclude Rule 141 is not ambiguous in requiring minor decoys to answer truthfully only questions about their ages. Because substantial evidence supports the administrative law judge's factual finding the decoy in this case was not questioned about his age, we determine as a matter of law that Rule 141 does not provide CVS with a defense to the accusation it sold an alcoholic beverage to an underage buyer. Accordingly, we annul the Appeals Board's decision.

BACKGROUND

The Department's Imposition of a 15–day License Suspension

In October 2013, the Department accused CVS of selling alcohol to an underage person at its Garfield Beach store. An administrative hearing was ***632** held in February 2014, in which the administrative law judge made the following findings of fact:

CVS has held an off-sale general license to sell alcohol since June 2009, with no prior record of discipline by the Department. On June 3, 2013, Joseph Childers was 18 years old and had the appearance and mannerisms of a person under the age of 21. On that date, Childers accompanied ****134** Department agents and law enforcement officers to conduct an alcoholic beverage decoy operation at the Garfield Beach CVS store. Childers entered the store at 2:30 p.m., went to the beer cooler where he selected a 24–ounce bottle of beer, and took the beer to the checkout line. The CVS store clerk scanned the bottle of beer and asked Childers for identification. Childers handed his California driver license to the clerk. The driver license indicated Childers's date of birth and had a red stripe with white letters that stated, "AGE 21 IN 2015." In addition, the driver license had a blue stripe with white letters that stated, "PROVISIONAL UNTIL AGE 18 IN 2012."

The administrative law judge made the following factual findings: "The clerk looked at Childers's [driver license], tried to scan it, and looked at the [license] again. She then stated, 'I would never have guessed it, you must get asked a lot,' or words to that effect. The clerk's remark was framed as a statement not a question. The decoy did not say anything to the clerk in response to her remark. He thought the clerk's statement was 'casual conversation.' The decoy also testified the statement might or might not have been related to his age. Thus, in his mind it was unclear what the clerk meant by her statement. [¶] The clerk sold Childers the 24-ounce bottle of Corona beer. At no time during the transaction did the clerk ask Childers how old he was or his age. Following the sale of the beer, the decoy exited the premises." The administrative law judge found Childers's testimony at the hearing to be clear, concise, and credible. On this basis, the administrative law judge decided there was cause to suspend CVS's off-sale general license for 15 days.

In April 2014, the Department adopted the administrative law judge's proposed decision as its decision in this case. CVS appealed the decision to the Appeals Board.

The Appeals Board's Reversal of License Suspension

In January 2015, the Appeals Board issued its decision. The Appeals Board's decision relied upon its prior decision to conclude Rule 141 required the decoy to respond to the store clerk's statement upon looking at his driver license. The Appeals Board's decision emphasized the following testimony by the decoy at the administrative hearing:

***633** "[Counsel for CVS]: [A]fter the clerk made that statement to you, what did you take that statement to mean?

"A. [Childers]: Casual conversation.

"Q. And [in] that casual conversation did you see it related in any way to your age?

"A. Yes and no.

"Q. When you say 'Yes and no,' what do you mean?

"A. Yes, that maybe *I looked younger*. No, because she *thought I was older* or thought that I do it a lot, you know."

The Appeals Board reasoned that "[w]hen the decoy believes, as here, that a clerk's remarks are ambiguous as to his or her age, the decoy has an obligation to respond verbally and truthfully. That is the plain meaning of rule 141(a)'s language

instructing that minor decoy operations must be conducted in a 'fashion that promotes fairness.' " (Italics omitted.) The Appeals Board further stated that whenever "the decoy him or herself interprets a seller's comments to *in any way* pertain to the decoy's age, the Department should insist that decoy err on the side of responding with clarification." On these grounds, the Appeals Board reversed the Department's decision and rescinded the ****135** suspension of CVS's off-sale general license.

Petition for Writ of Review

In February 2015, the Department filed in this court a petition for writ of review from the decision of the Appeals Board. We issued a writ of review in March 2015. (§ 23090.)

DISCUSSION

I

Standard of Review

[1] **[2]** In addition to prohibiting the sale of alcohol to minors, the California Constitution "vests the Department with broad discretion to revoke or suspend liquor licenses 'for good cause' if continuing the license would be 'contrary to public welfare or morals.' (Cal. Const., art. XX, § 22.) In the ***634** absence of a clear abuse of discretion, the courts will uphold the Department's decision to suspend a license for violation of the liquor laws. (E.g., *Martin v. Alcoholic Bev. etc. Appeals Bd.* (1959) 52 Cal.2d 238, 248–249 [340 P.2d 1].)" (*Provigo Corp. v. Alcoholic Beverage Control Appeals Bd.* (1994) 7 Cal.4th 561, 566, 28 Cal.Rptr.2d 638, 869 P.2d 1163 (*Provigo*).) " 'The administration of the Alcoholic Beverage Control Act, within the scope of the purposes of that act, is initially vested in the department. Its decisions, however, are subject to administrative review by the board and a final order of the board is, in turn, subject to judicial review.' " (*Caressa Camille, Inc. v. Alcoholic Beverage Control Appeals Bd.* (2002) 99 Cal.App.4th 1094, 1099, 121 Cal.Rptr.2d 758, quoting *Walsh v. Kirby* (1974) 13 Cal.3d 95, 102, 118 Cal.Rptr. 1, 529 P.2d 33.)

[3] The scope of review of the Department's decisions is the same in the Appeals Board and this court. (*Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd.* (2002) 100 Cal.App.4th 1066, 1071, 123 Cal.Rptr.2d 278 (*Deleuze*).) Section 23090.2 provides that review "shall not extend further than to determine, based on the whole record of the department as certified by the board, whether: [¶] (a) The department has proceeded without or in excess of its jurisdiction. [¶] (b) The department has proceeded in the manner required by law. [¶] (c) The decision of the department is supported by the findings. [¶] (d) The findings in the department's decision are supported by substantial evidence in the light of the whole record. [¶] (e) There is relevant evidence which, in the exercise of reasonable diligence, could not have been produced or which was improperly excluded at the hearing before the department." Section 23090.2 also excludes the power to make findings of fact from the scope of review. (*Ibid.*)

[4] **[5]** **[6]** In conducting our review, " '[w]e defer to the Department's interpretation of its own rules, since the agency is likely to be intimately familiar with regulations it authored and sensitive to the practical implications of one interpretation over another.' (*Yamaha Corp. of America v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 12 [78 Cal.Rptr.2d 1, 960 P.2d 1031], (*Yamaha Corp.*).) Courts generally will not depart from the Department's contemporaneous construction of a rule enforced by the Department unless such interpretation is clearly erroneous or unauthorized. (*Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd.* (2003) 109 Cal.App.4th 1687, 1696 [1 Cal.Rptr.3d 339] ....)" (*Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd.* (2005) 128 Cal.App.4th 1195, 1205, 27 Cal.Rptr.3d 766.) In short, the Department's decisions are ****136** "subject to review only for insufficiency of the evidence, excess of jurisdiction, errors of law, or abuse of discretion." (*Deleuze*, at p. 1072, 123 Cal.Rptr.2d 278.)

***635** II

Rule 141

The Department contends it correctly rejected CVS's reliance on Rule 141 as providing a defense to its sale of alcohol to the underage decoy in this case. We agree.

A.

The Department's Reliance on Minor Decoys

The Department relies on minor decoy operations as an integral part of its enforcement of the constitutional and statutory prohibitions on sales of alcohol to persons under 21 years of age. (Cal. Const., art. XX, § 22; § 25658, subd. (a).) The California Supreme Court has approved of the practice, noting that "[t]he use of underage decoys to enforce laws against unlawful sales to minors clearly *promotes* rather than hinders" the California constitutional and statutory prohibitions on sales of alcoholic beverages to minors. (*Provigo*, *supra*, 7 Cal.4th at p. 567, 28 Cal.Rptr.2d 638, 869 P.2d 1163.)

The Business and Professions Code provides that "[p]ersons under 21 years of age may be used by peace officers in the enforcement of this section to apprehend licensees, or employees or agents of licensees, or other persons who sell or furnish alcoholic beverages to minors." (§ 25658, subd. (f).) In pertinent part, subdivision (f) of section 25658 further provides: "Guidelines with respect to the use of persons under 21 years of age as decoys shall be adopted and published by the department in accordance with the rulemaking portion of the Administrative Procedure Act ...." To comply with subdivision (f) of section 25658, the Department promulgated Rule 141. (*Acapulco Restaurants, Inc. v. Alcoholic Beverage Control Appeals Bd.* (1998) 67 Cal.App.4th 575, 579, 79 Cal.Rptr.2d 126 (*Acapulco Restaurants*).) In its entirety, Rule 141 states:

"(a) A law enforcement agency may only use a person under the age of 21 years to attempt to purchase alcoholic beverages to apprehend licensees, or employees or agents of licensees who sell alcoholic beverages to minors (persons under the age of 21) and to reduce sales of alcoholic beverages to minors in a fashion that promotes fairness.

"(b) The following minimum standards shall apply to actions filed pursuant to Business and Professions Code Section 25658 in which it is alleged that a minor decoy has purchased an alcoholic beverage: [¶] (1) At the time of the operation, the decoy shall be less than 20 years of age; [¶] (2) The decoy ***636** shall display the appearance which could generally be expected of a person under 21 years of age, under the actual circumstances presented to the seller of alcoholic beverages at the time of the alleged offense; [¶] (3) A decoy shall either carry his or her own identification showing the decoy's correct date of birth or shall carry no identification; a decoy who carries identification shall present it upon request to any seller of alcoholic beverages; [¶] (4) *A decoy shall answer truthfully any questions about his or her age*; [¶] (5) Following any completed sale, but not later than the time a citation, if any, is issued, the peace officer directing the decoy shall make a reasonable attempt to enter the licensed premises and have the minor decoy who purchased alcoholic beverages make a face to face identification of the alleged seller of the alcoholic beverages.

****137** "(c) Failure to comply with this rule shall be a defense to any action brought pursuant to Business and Professions Code Section 25658." (Italics added.)

B.

Availability of the Rule 141 Defense

[7] The Appeals Board contends subdivision (b)(4) of Rule 141 required the minor decoy in this case to truthfully respond to the clerk's statement, "I would never have guessed it, you must get asked a lot." Similarly, CVS argues the minor decoy's lack of response violated Rule 141 and provided a defense to the Department's accusation. The Department counters by noting the administrative law judge made the factual finding that the CVS clerk's words to the minor decoy constituted a statement rather than a question. On this basis, the Department argues the defense supplied by Rule 141 does not apply here. Resolving these contentions requires us to construe the meaning of Rule 141.

As this court has previously explained, "Generally, the same rules governing the construction and interpretation of statutes apply to the construction and interpretation of administrative regulations. (*In re Richards* (1993) 16 Cal.App.4th 93, 97–98, 19 Cal.Rptr.2d 797.) Accordingly, ' "we begin with the fundamental rule that a court should ascertain the intent of the Legislature so as to effectuate the purpose of the law." ' [Citations.] 'An equally basic rule of statutory construction is, however, that courts are bound to give effect to statutes according to the usual, ordinary import of the language employed in framing them.' [Citations.] Although a court may properly rely on extrinsic aids, it should first turn to the words of the statute to determine the intent of the Legislature. [Citations.] 'If the words of the statute are clear, the court should not add to or alter them to accomplish a ***637** purpose that does not appear on the face of the statute or from its legislative history.' (*California Teachers Assn. v. San Diego*

Community College Dist. (1981) 28 Cal.3d 692, 698 [170 Cal.Rptr. 817, 621 P.2d 856].)" (*Schmidt v. Foundation Health* (1995) 35 Cal.App.4th 1702, 1710–1711, 42 Cal.Rptr.2d 172.) " 'The construction of an administrative regulation and its application to a given set of facts are matters of law.' " (*Ibid.*, quoting *Auchmoody v. 911 Emergency Services* (1989) 214 Cal.App.3d 1510, 1517, 263 Cal.Rptr. 278.)

In enacting the Alcoholic Beverage Control Act (Act) (§ 23000 et seq.), the Legislature declared the Act "involves in the highest degree the economic, social, and moral well-being and the safety of the State and of all its people." (§ 23001.) The Act establishes the Department "to provide a governmental organization which will ensure a strict, honest, impartial, and uniform administration and enforcement of the liquor laws throughout the State." (§ 23049.) To that end, section 23001 declares that "[a]ll provisions of this division shall be liberally construed for the accomplishment of these purposes."

[8] **[9]** Rule 141, subdivision (b)(4) provides that "[a] decoy shall answer truthfully any questions about his or her age." The Rule's guidance is clear and unambiguous. Minor decoys do not need to respond to *statements* of any kind nor do they need to respond truthfully to *questions* other than those concerning their ages. Thus, Rule 141 does not require minor decoys to correct mistakes articulated by licensed alcohol sellers. Instead, the minor decoys need to respond truthfully only to questions about their ages. In short, Rule 141 sets forth clear, unambiguous, and fair guidance for minor decoys to follow during the Department's operations. Consequently, the Department properly construed the ****138** plain language of Rule 141 in determining the minor decoy in this case was not required to respond to the clerk's statement that might have related to the decoy's age.

The Appeals Board disagrees with the Department's plain-meaning interpretation of Rule 141, asserting the Rule is ambiguous and unfair. The Appeals Board argues that "the language of Rule 141[(b)(4)] is ambiguous, and decoys lack the expertise to make a fair decision about whether a clerk's words are a 'question' 'about his or her age.' " The Appeals Board bases its argument on the assertion that "[t]he word 'question' is, especially when uttered vocally as opposed to being written, not free from doubt." In support, the Appeals Board argues the ambiguity of the word "question" is demonstrated by the need for an evidentiary hearing to determine the nature of the store clerk's communication to the minor decoy. We reject the argument.

Courts have long resolved factual issues concerning whether a spoken communication constitutes a question that invited an answer. In ***638** *Rhode Island v. Innis* (1980) 446 U.S. 291, 100 S.Ct. 1682, 64 L.Ed.2d 297, the United States Supreme Court articulated a test for determining when *Miranda* advisements must be given to a suspect that "come[s] into play whenever a person in custody is subjected to either express questioning or its functional equivalent." (*Id.* at pp. 300–301, 100 S.Ct. 1682.) The test under *Rhode Island v. Innis* requires that police officers understand not only whether they are engaging in "express questioning," but also when their words or actions "are reasonably likely to elicit an incriminating response from the suspect." (*Id.* at p. 301, 100 S.Ct. 1682. fn. omitted.) The United States Supreme Court's decision establishes the unproblematic nature of distinguishing between oral communications constituting questions (and even their functional equivalents) and statements not reasonably likely to elicit an incriminating answer. Courts even require law enforcement officers to distinguish between suggestive and nonsuggestive questions. (*People v. Saracoglu* (2007) 152 Cal.App.4th 1584, 1590, 62 Cal.Rptr.3d 418.) Here, the determination required of minor decoys is more clear than the *Rhode Island v. Innis* test or the distinction between suggestive and nonsuggestive questions because subdivision (b)(4) of Rule 141 applies *only* to questions relating to age. "Question" is not an ambiguous term and does not lead to confusion in limiting spoken communications to those involving inquiries that contemplate answers.

[10] We also reject the Appeals Board's contention Rule 141 is ambiguous because "no definition is provided as to what 'fairness' means or how it is to be determined." The lack of a definition of fairness, by itself, does not render Rule 141 ambiguous. (Cf. *Nava v. Mercury Cas. Co.* (2004) 118 Cal.App.4th 803, 805, 13 Cal.Rptr.3d 816 [lack of definition does not render a term ambiguous].) Contrary to the Appeals Board's contention, Rule 141 provides specific guidance regarding how to preserve fairness in minor decoy operations. Subdivision (b) of Rule 141 implements the goal of fairness by imposing five specific requirements for every minor decoy operation. Decoys must be under the age of 20; have the appearance of a person under 21; carry their own actual identification and present that identification upon request; truthfully answer any questions about their ages; and make face-to-face identifications of the persons who sold the alcoholic beverages. (Rule 141, subd. (b)(1)-(5).) Fairness under Rule 141 is assured by a set of five expressly defined

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safeguards, all of which must be fulfilled during a minor decoy operation. ****139** (*Acapulco Restaurants, supra,* 67 Cal.App.4th at p. 580, 79 Cal.Rptr.2d 126.) Consequently, Rule 141's use of the word "fairness" does not render the rule ambiguous or confusing.

[11] **[12]** In support of the Appeals Board's argument Rule 141 is ambiguous regarding what constitutes fairness, it points to its earlier decisions in *7–Eleven, Inc. & Johal Stores, Inc.* (Oct. 1, 2014) AB–9403 (*7–Eleven*), *Equilon Enterprises, LLC* (July 26, 2002) AB–7845 (*Equilon*), *Lucky Stores, Inc*. (Oct. 13, 1999) AB–7227 (*Lucky*), *Southland Corp. & Dandona* (Apr. ***639** 16, 1999) AB–7099 (*Southland*), and *Thrifty Payless, Inc*. (Dec. 30, 1998) AB–7050 (*Thrifty*). We may take judicial notice of decisions of the Appeals Board. (*Department of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd*. (2005) 128 Cal.App.4th 1195, 1208, fn. 5, 27 Cal.Rptr.3d 766; accord *Reimel v. Alcoholic Beverage Control Appeals Bd*. (1967) 254 Cal.App.2d 340, 62 Cal.Rptr. 54.) Thus, although we are not bound by the Appeals Board's decisions, we take judicial notice of the cited decisions and consider their reasoning for persuasive value.

Regarding agency decisions, the California Supreme Court has noted that "[w]here the meaning and legal effect of a statute is the issue, an agency's interpretation is one among several tools available to the court. Depending on the context, it may be helpful, enlightening, even convincing. It may sometimes be of little worth. [Citation.] Considered alone and apart from the context and circumstances that produce them, agency interpretations are not binding or necessarily even authoritative." (*Yamaha Corp. of America v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 7–8, 78 Cal.Rptr.2d 1, 960 P.2d 1031.) Based on our review, we conclude the Appeals Board's cited decisions vary in their persuasiveness and fidelity to Rule 141.

In *7–Eleven*, *supra,* AB–9403, the Appeals Board affirmed the suspension of an off-sale license based on sale to a minor decoy after the store clerk looked at the minor decoy's identification and stated, "oh, you are so young." (*7–Eleven*, at pp. 2, 14.) In affirming the suspension, the Appeals Board concluded the minor decoy was not required to respond because the store clerk did not ask a question or indicate a mistake as to the minor decoy's age. The Appeals Board reasoned that "[t]he wor[d] 'young' is a subjective term, and gives no indication that the clerk has made a miscalculation and as a result believes the decoy to be over 21" years of age. (*Id.* at p. 12.) Under the reasoning of *7–Eleven*, the Appeals Board should have affirmed the license suspension in this case as well. Here, the administrative law judge found the store clerk did not ask a question of the minor decoy. And the store clerk did not clearly demonstrate confusion as to the minor's age in the statement, "I would never have guessed it, you must get asked a lot." The minor decoy testified he thought the statement might mean either that "she thought I was older *or thought that I do it a lot* ...." (Italics added.) Because the store clerk in this case made a statement akin to that in *7–Eleven*, the reasoning employed in *7–Eleven* should have led the Appeals Board to affirm the Department's decision.

We reject the reasoning contained in the remainder of the Appeals Board's earlier decisions because the reasoning in each would require minor decoys to speak up to clarify any mistake about their ages even in the absence of a question. (*Equilon,* supra, AB-7845, at p. 2 [concluding Rule 141 "was ***640** violated when the decoy failed to respond to a statement by the clerk which implied that she was 21 years of age or older"], *Lucky*, supra, AB-7227, at p. 4 [same where minor decoy did not respond to mistaken statement, "1978. You are 21"], and *Southland*, supra, AB-7099, at pp. 6, 7 [same where decoy did not respond to statement, "You are 21"]. In each of these decisions, ****140** the Appeals Board relied on the notion of fairness to craft a new requirement for Rule 141, namely the obligation of a minor decoy to respond to any indication of mistake regarding age even in the absence of a question. Rule 141, however, expressly requires minor decoys only to answer questions relating to their ages. (Rule 141, subd. (b)(4).) The Appeals Board lacks the power to add a new defense to Rule 141.

The Appeals Board's decision in *Thrifty, supra,* AB–7050 involved a reversal of the Board's decision based on the minor decoy's silent tendering of a driver license rather than answering the clerk's question about her age. (See *Thrifty*, at p. 6 [speculating about the minor decoy's motivation in offering her identification rather than answering about her age].) Unlike this case, *Thrifty* involved an actual question by the clerk about the minor decoy's age and is therefore inapposite in this case where the administrative law judge determined the clerk did not ask any questions. (*Id.* at pp. 5–6.) Consequently, we need not consider whether *Thrifty* was correctly decided in harmony with Rule 141.

Ultimately, we are not persuaded by the Appeals Board's prior decisions that Rule 141 is ambiguous in requiring decoys to answer truthfully only questions relating to their ages.

Next, the Appeals Board argues the principle of fairness upon which Rule 141 is founded imposes an affirmative duty on minor decoys to speak up in order to clarify any mistake regarding age articulated by the vendor. If the Department had wanted to provide license holders with a defense for mistakes about a minor decoy's age or based on a minor decoy's failure to respond to a statement by the clerk, the Department could have done so by including express language to that effect in Rule 141. However, as we explained above, the language of Rule 141 requires minor decoys to respond only to questions about their ages. We reject the Appeals Board's attempt to add a new defense to Rule 141 that is not expressed in the rule. (*Acapulco Restaurants*, *supra*, 67 Cal.App.4th at p. 580, 79 Cal.Rptr.2d 126.)

Acapulco Restaurants involved a minor decoy operation in which the Department did not comply with Rule 141's requirement the minor decoy make a face-to-face identification of the clerk who sold the alcoholic beverage. (Acapulco Restaurants, supra, 67 Cal.App.4th at p. 577, 79 Cal.Rptr.2d 126; see also Rule 141, subd. (b)(5).) Despite the failure to follow this express requirement ***641** of Rule 141, the Department imposed and the Appeals Board affirmed a 15–day license suspension on grounds a law enforcement officer witnessed the entire transaction. (*Acapulco Restaurants,* at p. 577, 79 Cal.Rptr.2d 126.) However, the *Acapulco Restaurants* court reversed, explaining, "[t]o ignore a rule and the defense that arises from law enforcement's failure to comply with that rule is not a matter of 'interpretation.' What the Department has done is to unilaterally decide that rule 141[ ](b)(5) applies in some situations but not others, a decision that exceeds the Department's power. By its refusal to apply rule 141[ ](b)(5) when a police officer is present at the time of the sale, the Department has crossed the line separating the interpretation of a word or phrase on one side to the legislation of a different rule on the other, thereby substituting its judgment for that of the rulemaking authority. It might as well have said that rule 141[ ](b)(5) applies on Mondays but not Thursdays." (*Acapulco Restaurants*, *supra*, 67 Cal.App.4th at p. 580, 79 Cal.Rptr.2d 126.)

[13] **[14]** The result in *Acapulco Restaurants* followed the well-established rule that " '[a]n exception to a statute is to be narrowly construed. (Citation.) When a statute specifies an exception, no others ****141** may be added under the guise of judicial construction. (Citations.)' " (*Kirby v. Alcoholic Beverage Control Appeals Bd.* (1968) 267 Cal.App.2d 895, 898, 73 Cal.Rptr. 352, quoting *Lacabanne Properties, Inc. v. Department of Alcoholic Beverage Control* (1968) 261 Cal.App.2d 181, 189, 67 Cal.Rptr. 734.) Fairness does not require the new exception to be judicially grafted into Rule 141 to provide additional defenses that require a minor decoy to speak up in the absence of a question by the store clerk. As the California Supreme Court has noted, "licensees have a ready means of protecting themselves from liability by simply asking any purchasers who could possibly be minors to produce bona fide evidence of their age and identity." (*Provigo*, *supra*, 7 Cal.4th at p. 570, 28 Cal.Rptr.2d 638, 869 P.2d 1163.)

Likewise, we reject the argument made by CVS that the minor decoy's silence in response the clerk's statement about his youthful appearance was "deceptive and misleading." As this court has previously noted in a case involving a claim a governmental agency engaged in fraudulent concealment, "Courts uniformly distinguish between the misleading half-truth, or partial disclosure, and the case in which defendant says nothing at all. The general rule is that silence alone is not actionable." (*Wiechmann Engineers v. State of California ex rel. Dept. Pub. Wks.* (1973) 31 Cal.App.3d 741, 751, 107 Cal.Rptr. 529.)

Here, the minor decoy did not say anything untrue. To the contrary, the minor decoy presented accurate information in the form of his driver license. Thus, the minor decoy did not engage in deceptive and misleading communication with the clerk. Notably, the California Supreme Court has rejected a claim the use of a "mature-looking" decoy constitutes an unfair practice by ***642** the Department in a case in which a minor decoy "simply bought beer and wine, *without attempting to pressure or encourage the sales in any way*." (*Provigo*, *supra*, 7 Cal.4th at p. 569, 28 Cal.Rptr.2d 638, 869 P.2d 1163, italics added.) The same reason applies here. The minor decoy's silence in this case did not involve any attempt to pressure or encourage the sale of an alcoholic beverage to him. The minor decoy's silence did not render the Department's operation unfair.

CVS's argument its clerk was deceived and misled by the minor decoy in this case is based on the same premise as that advanced by the Appeals Board, namely a minor decoy has a duty to speak up in response to a statement indicating a mistaken calculation of age. However, as we have explained, Rule 141 does not supply a defense based on a minor decoy's failure to respond to statements made by the clerk. Consequently, we conclude the Department properly

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rejected CVS's argument the minor decoy's silence rendered the operation unfair under Rule 141.

C.

Substantial Evidence Supports the Department's Decision

[15] As part of its argument Rule 141 is ambiguous, the Appeals Board asserts the minor decoy's testimony during the hearing was equally uncertain. Specifically, the Appeals Board asserts that "[t]he decoy's testimony is as ambiguous as [Rule 141], and certainly does not support the conclusion, reached by the Department, that the clerk's words were '[i]ndisputably a statement' falling outside the Rule." In light of the administrative law judge's factual finding, we disagree.

Viewed in the light most favorable to the Department's decision, we conclude substantial evidence supports the administrative law judge's decision. As the administrative law judge found, the minor decoy's ****142** testimony was clear and credible. The administrative law judge also expressly found the testimony established the store clerk's communication to the minor decoy was a statement and not a question. Under section 23090.2, the Appeals Board lacks power to disregard the Department's factual findings, which includes findings made by the administrative law judge. (*Hasselbach v. Department of Alcoholic Beverage Control* (1959) 167 Cal.App.2d 662, 667, 334 P.2d 1058 ["The statement made in the opinion of the appeals board was not a finding of fact for that board is without power to make findings of fact"].) Accordingly, we reject the Appeals Board's argument the store clerk's statement might have been a question instead of a statement.

***643** DISPOSITION

The decision of the Alcohol Beverage Control Appeals Board is annulled. The decision of the Department of Alcoholic Beverage Control is reinstated and the case is remanded to the Alcohol Beverage Control Appeals Board for further proceedings consistent with this opinion.

We concur:

BLEASE, Acting P.J.

RENNER, J.

All Citations

7 Cal.App.5th 628, 213 Cal.Rptr.3d 130, 17 Cal. Daily Op. Serv. 384, 2017 Daily Journal D.A.R. 402

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166 Cal.App.4th 1249
Court of Appeal, Second District, Division 2, California.

SOCIAL SERVICES PAYMENT CASES.

No. B200788.
|
Sept. 16, 2008.
|
Review Denied Dec. 17, 2008.

Synopsis

Background: Developmentally disabled foster children and their foster families brought putative class action against California Department of Social Services, its director, and counties for underpayment of social services, declaratory relief, injunctive relief, and writ of mandate. The Superior Court, Los Angeles County, JCCP No. 4439, Carolyn B. Kuhl, J., sustained demurrer without leave to amend. Plaintiffs appealed.

Holdings: The Court of Appeal, Todd, J., held that:

[1] community care facilities for developmentally disabled foster children must be vendorized in order to be eligible for Alternative Residential Model (ARM) rates;

[2] requirement of vendorization by a regional center does not violate federal requirement that a single state agency administer foster care program; and

[3] defendants were not equitably estopped from denying payment of ARM rates.

Affirmed.

West Headnotes (22)

[1] Public Assistance Payment; payees

A "vendorized" community care facility is one that has been approved, by a regional center established by the Lanterman Developmental Disabilities Act, to provide the services and supports a developmentally disabled child has been assessed to need. West's Ann.Cal.Welf. & Inst.Code § 4681.1(a); 17 CCR §§ 54302(a)(55), 56002(a)(15).

[2] Appeal and Error Defects, objections, and amendments

The Court of Appeal would treat an appeal taken from a nonappealable order sustaining a demurrer without leave to amend as a premature but valid notice of appeal from the subsequently entered judgment. Cal.Rules of Court, Rule 8.104(e)(2).

13 Cases that cite this headnote

[3] Appeal and Error Objections and exceptions; demurrer

In reviewing the sustaining of a demurrer without leave to amend, the Court of Appeal may disregard allegations which are contrary to law or to a fact of which judicial notice may be taken.

10 Cases that cite this headnote

[4] Appeal and Error Objections and exceptions; demurrer

On appeal of a grant of a demurrer without leave to amend, the appellants bear the burden of demonstrating the trial court erred in sustaining the demurrer or abused its discretion in denying leave to amend.

8 Cases that cite this headnote

[5] Statutes Literal, precise, or strict meaning; letter of the law

Statutes Construing together; harmony

The "plain meaning" rule does not prohibit a court from determining whether the literal meaning of a statute comports with its purpose or whether such a construction of one provision is consistent with other provisions of the statute.

[6] Statutes Policy considerations; public policy

Statutes Construction in View of Effects, Consequences, or Results

In construing a statute, courts may consider the impact of a interpretation on public policy, for where uncertainty exists, consideration should be given to the consequences that will flow from a particular interpretation.

2 Cases that cite this headnote

[7] **Infants** Public stipends and subsidies

The eligibility of a licensed community care facility, including an individual foster home, for Alternative Residential Model (ARM) rates for foster children who are also developmentally disabled, is contingent upon a regional center established by the Lanterman Developmental Disabilities Act vendorizing the facility, even if payment for "care and supervision" in the facility is funded through the Aid to Families with Dependent Children–Foster Care (AFDC–FC) program rather than through regional centers. 17 CCR § 54302; West's Ann.Cal.Welf. & Inst.Code §§ 4648, 4681.1, 4684; § 11464 (Repealed).

[8] **Administrative Law and Procedure** Contemporaneous or subsequent construction in general

Administrative Law and Procedure Erroneous or unreasonable construction; conflict with statute

Contemporaneous administrative construction of a statute by the agency charged with its enforcement and interpretation, while not necessarily controlling, is of great weight, and courts will not depart from such construction unless it is clearly erroneous or unauthorized.

[9] **Infants** Public stipends and subsidies

Public Assistance Payment; payees

Statute requiring that state Department of Social Services (DSS) use the Alternative Residential Model (ARM) residential facility rates established by state Department of Developmental Services (DDS) to determine rates to be paid for 24–hour out-of-home nonmedical care and supervision of foster children who are also developmentally disabled requires the DSS to use not only the monetary component of the rate but also the framework governing the setting and payment of the ARM rates. West's Ann.Cal.Welf. & Inst.Code § 11464 (Repealed).

[10] **Infants** Public stipends and subsidies

The requirement that a licensed community care facility for developmentally disabled foster children, including an individual foster home, be vendorized by a regional center established by the Lanterman Developmental Disabilities Act in order to obtain Alternative Residential Model (ARM) rates, does not violate the federal Aid to Families and Dependent Children–Foster Care (AFDC–FC) requirement that a single state agency administer the foster care program, since vendorization does not interfere with Department of Social Services (DSS) placement decisions. Social Security Act, § 401 et seq., 42 U.S.C.A. § 601 et seq.; 45 C.F.R. § 205.100(a)(1)(ii) & (b)(1); West's Ann.Cal.Welf. & Inst.Code §§ 4684, 11400(b), 11404(a); § 11464 (Repealed).

See Annot., Construction and Application by State Courts of the Federal Adoption and Safe Families Act and Its Implementing State Statutes (2006) 10 A.L.R.6th 173; Cal. Jur. 3d, Public Aid and Welfare, § 15.

[11] **Infants** Public stipends and subsidies

The federal Aid to Families and Dependent Children–Foster Care (AFDC–FC) requirement that a single state agency administer the foster care program does not prohibit various state agencies from working in tandem and utilizing each other's expertise. Social Security Act, § 401 et seq., 42 U.S.C.A. § 601 et seq.; 45 C.F.R. § 205.100.

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[12] **Evidence** Official Opinions, Guidelines, and Policy Statements

Trial court acted within its discretion in taking judicial notice of "All County Letters" issued by state Department of Social Services (DSS), stating the Department's statutory interpretation that a licensed community care facility, including an individual foster home, must be vendorized by a regional center established by the Lanterman Developmental Disabilities Act in order to be eligible for Alternative Residential Model (ARM) rates for foster children who are also developmentally disabled, even though the letters were not rendered in accordance with the Administrative Procedure Act, since the letters were official acts of the state's executive department. Government Code § 11340 et seq.; Evid.Code, § 452(c); West's Ann.Cal.Welf. & Inst.Code § 4684; § 11464 (Repealed).

5 Cases that cite this headnote

[13] **Administrative Law and Procedure** Supplemental security income; disability benefits

Public Assistance Construction

Trial court was entitled to accord great weight and respect to state Department of Social Services (DSS) interpretation of statutes requiring that licensed community care facilities be vendorized by a regional center established by the Lanterman Developmental Disabilities Act in order to be eligible for Alternative Residential Model (ARM) rates for foster children who are also developmentally disabled, since the DSS possessed expertise in dealing with the needs of developmentally disabled foster children, and "All County Letters" issued by the DSS indicated that senior DSS officials had carefully considered how responsibility for addressing those needs should be handled by county welfare departments in coordination with regional centers. West's Ann.Cal.Welf. & Inst.Code § 4684; § 11464 (Repealed).

[14] **Estoppel** Estoppel Against Public, Government, or Public Officers

While the doctrine of equitable estoppel may be applied against the government where justice and right require, it will not be applied if doing so would effectively nullify a strong rule of policy, adopted for the benefit of the public.

1 Case that cites this headnote

[15] **Estoppel** Essential elements

To apply the equitable estoppel doctrine, four elements must be present: (1) the party to be estopped must be apprised of the facts; (2) he must intend that his conduct shall be acted upon, or must so act that the party asserting the estoppel had a right to believe it was so intended; (3) the other party must be ignorant of the true state of facts; and (4) he must rely upon the conduct to his injury.

1 Case that cites this headnote

[16] **Estoppel** Estoppel Against Public, Government, or Public Officers

If the elements of estoppel are established against the government, the court must then balance the burden on the party asserting estoppel if the doctrine is not applied against the public policy that would be affected by the estoppel.

1 Case that cites this headnote

[17] **Infants** Public stipends and subsidies

Public Assistance Payment; payees

California Department of Social Services, its director, and counties were not apprised of the facts related to denial of Alternative Residential Model (ARM) rates for developmentally disabled foster children living in non-vendorized individual foster homes, and thus were not equitably estopped from denying payment of the ARM rates to the children and their foster parents, even if DSS placed eligible developmentally disabled children into non-vendorized community care facilities, paid ARM rates to non-vendorized facilities, and failed

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to notify foster parents of ARM rates or the requirement that they vendorize their homes to obtain ARM rates, absent evidence that DSS was aware that the non-vendorized foster homes were ineligible to receive ARM rates; vendorization requirement did not preclude DSS from placing developmentally disabled children in facilities ineligible for ARM rates. West's Ann.Cal.Welf. & Inst.Code § 4684; § 11464 (Repealed).

[18] **Estoppel** Particular state officers, agencies or proceedings

Developmentally disabled foster children and their foster parents failed to allege how Department of Social Services (DSS) intended for any conduct in which DSS engaged to be acted upon by them, as required for DSS, its director, and counties to be equitably estopped from denying payment of the Alternative Residential Model (ARM) rates to foster parents and children in non-vendorized foster homes. West's Ann.Cal.Welf. & Inst.Code § 4684; § 11464 (Repealed).

[19] **Estoppel** Particular state officers, agencies or proceedings

Developmentally disabled foster children and their foster parents failed to allege they were ignorant of Alternative Residential Model (ARM) rates or of the vendorization requirement to become eligible for ARM rates, as required for Department of Social Services (DSS), its director, and counties to be equitably estopped from denying payment of the ARM rates to foster parents and children in non-vendorized foster homes. West's Ann.Cal.Welf. & Inst.Code § 4684; § 11464 (Repealed).

[20] **Estoppel** Particular state officers, agencies or proceedings

Developmentally disabled foster children and their foster parents failed to allege that parents relied on any action or inaction on the part of the Department of Social Services (DSS) in accepting placement of children in foster parents' non-vendorized homes, as required for Department of Social Services (DSS), its director, and counties to be equitably estopped from denying payment of Alternative Residential Model (ARM) rates to foster parents and children in non-vendorized foster homes. West's Ann.Cal.Welf. & Inst.Code § 4684; § 11464 (Repealed).

[21] **Estoppel** Particular state officers, agencies or proceedings

Even if elements of equitable estoppel were otherwise satisfied, trial court acted within its discretion in declining to apply equitable estoppel to preclude California Department of Social Services, its director, and counties from denying payment of Alternative Residential Model (ARM) rates to developmentally disabled foster children living in non-vendorized individual foster homes, since application of estoppel would thwart the public policy considerations served by requiring vendorization; vendorization served as a safeguard to help assure that the developmentally disabled were receiving appropriate services and supports from qualified vendors. West's Ann.Cal.Welf. & Inst.Code §§ 4684, 11464; 17 CCR §§ 54320, 54322, 56046 et seq.

[22] **Appeal and Error** Complaint, petition, or other initial pleading

To demonstrate on appeal that the trial court abused its discretion in denying leave to amend the complaint, plaintiffs must show in what manner they can amend their complaint and how that amendment will change the legal effect of their pleading.

7 Cases that cite this headnote

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Opinion

DOI TODD, J.

[1] ***1254** Plaintiffs and appellants, a proposed class of individuals representing developmentally disabled foster children and their foster families throughout California, appeal from a judgment entered following the trial court's order sustaining a demurrer without leave to amend filed by defendants and respondents the California Department of Social Services and its director John A. Wagner (collectively the DSS). Appellants sought reimbursement of additional foster care benefits allegedly available for the children. The trial court ruled that appellants failed to state a claim, as the additional rates are available only to facilities that have been "vendorized," or approved to ***1255** provide the services and supports a developmentally disabled child has been assessed to need, and appellants failed to allege they could meet this requirement.

We affirm. The language of the statutory and regulatory scheme governing developmentally disabled foster children and the policy considerations underlying that scheme require that the facilities into which developmentally disabled foster children are placed be vendorized in order to receive the additional rates referenced in Welfare and Institutions Code sections 4684 and 11464. [1]

1 Unless otherwise indicated, all further statutory references are to the Welfare and Institutions Code.

****439 FACTUAL AND PROCEDURAL BACKGROUND**

In reviewing a trial court's order sustaining a demurrer, we assume the truth of all facts properly pleaded in the complaint, but we do not assume the truth of contentions, deductions or conclusions of law. (*Moore v. Regents of University of California* (1990) 51 Cal.3d 120, 125, 271 Cal.Rptr. 146, 793 P.2d 479; *Fleming v. State of California* (1995) 34 Cal.App.4th 1378, 1381, 41 Cal.Rptr.2d 63.)

The Statutory Scheme.

Appellants' allegations are premised on the applicable statutory and regulatory scheme governing the public benefits provided to foster children with developmental disabilities. California provides foster care benefits to eligible children under a program funded by the state and federal governments. Title IV–E of the Social Security Act, Title 42 United States Code section 601 et seq., authorizes the Aid to Families and Dependent Children–Foster Care (AFDC–FC) program. (See generally *State of Cal. Dept. of Social Servs. v. Thompson* (9th Cir.2003) 321 F.3d 835, 839.) The federal government's contribution of funds is dependent on the state's implementation of and compliance with a "State plan" that meets the requirements of federal law. (42 U.S.C. §§ 671, 672; 45 C.F.R. §§ 1355.21, 1356.10 et seq.)

One requisite element of the state plan is the designation of a "single State agency with authority to administer or supervise the administration of the plan." (45 C.F.R. § 205.100(a)(1)(i); see also 45 C.F.R. § 1355.30(p)(4).) The designated single state agency must have authority to make rules and regulations governing the administration of the plan and may not delegate its authority to exercise discretion in the administration and supervision of the plan. (45 C.F.R. § 205.100(a)(1)(ii) & (b)(1).) Though other state ***1256** and local agencies may perform services for the single state agency, they do "not have authority to review, change, or disapprove any administrative decision of the single State agency, or otherwise substitute their judgment for that of the agency as to the application of policies, rules, and regulations promulgated by the State agency." (45 C.F.R. § 205.100(b)(3).)

Having elected to participate in the AFDC–FC program, California has submitted a state plan and enacted a statutory scheme designed to comply with the federal requirements. (See § 10000 et seq.; see also *County of Alameda v. Carleson* (1971) 5 Cal.3d 730, 738–739, 97 Cal.Rptr. 385, 488 P.2d 953.) Under the state plan, the DSS is designated as the "single state agency with full power to supervise every phase of the administration of public social services ...." (§ 10600.) Such services include the provision of foster care. (*Scott v. County of Los Angeles* (1994) 27 Cal.App.4th 125, 143, 32 Cal.Rptr.2d 643.) Accordingly, the DSS is also charged with the authority to make "rules and regulations for the proper maintenance and care of needy children and for the administration of Aid to Families with Dependent Children." (§ 11209.)

The Legislature has determined that the provision of public social services, including foster care, is a county function and responsibility subject to any applicable state and federal statutes and regulations. (§ 10800.) Counties are responsible for a public system of statewide child welfare services, which includes providing for the investigation of possible abuse or neglect of a child warranting removal from parental custody. (§§ 300 et seq. & 16500 et seq.) A child removed from his or her home pursuant to the dependency statutes and placed in foster care becomes eligible to receive AFDC–FC benefits. (****440** §§ 11400, subd. (a), 11401, 11460.) According to section 11404, subdivision (a), "a child is not eligible for AFDC–FC unless responsibility for placement and care of the child is with the county welfare department ...." Eligibility for AFDC–FC is also dependent on the agency with the responsibility for the child's placement and care developing a case plan for the child, defined in pertinent part as a "written document that, at a minimum, specifies the type of home in which the child shall be placed, the safety of that home, and the appropriateness of that home to meet the child's needs. It shall also include the agency's plan for ensuring that the child receive proper care and protection in a safe environment, and shall set forth the appropriate services to be provided to the child, the child's family, and the foster parents, in order to meet the child's needs while in foster care, and to reunify the child with the child's family." (§§ 11400, subd. (b), 11404, subd. (b).)

"Foster care providers shall be paid a per child per month rate in return for the care and supervision of the AFDC–FC child placed with them." (§ 11460, subd. (a).) Section 11460 further defines "care and supervision" to include ***1257** "food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation." (§ 11460, subd. (b).) The DSS has the duty to administer a state system for establishing rates for the AFDC–FC program. (§ 11460, subd. (a).) The basic foster care rates are described by statute, including sections 11461 (licensed or approved family homes), 11462 (group homes and public child care institutions) and 11463 (foster family agencies).

The California Department of Developmental Services (DDS) is responsible for the execution of laws and the establishment of rules and regulations relating to the care, custody and treatment of developmentally disabled persons. (§§ 4416, 4417.) The Lanterman Developmental Disabilities Act (Lanterman Act), section 4500 et seq., contains provisions affording assistance to developmentally disabled individuals; such services are governed by a separate state plan. (§§ 4561–4568, 4675.) For purposes of the Lanterman Act, a developmental disability is one that originates before an individual is 18 years old, continues or can be expected to continue indefinitely, constitutes a substantial disability, and includes "mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature." (§ 4512, subd. (a); see also Cal.Code Regs., tit. 17, § 54000, subds. (a) & (b).)

A county social worker may refer a foster child believed to have developmental disabilities to a "regional center" for evaluation. Established by the Lanterman Act, regional centers are private, nonprofit corporations that contract with the DDS to help the state carry out its responsibilities to developmentally disabled persons and their families. (§§ 4620–4622, 4269.) To be eligible for regional center services, an individual must have a developmental disability that falls within the definition provided by section 4512, subdivision (a). (§§ 4643, subd. (b), 4643.5; Cal.Code Regs., tit. 17, § 54010, subd. (b).) Regional centers develop individual program plans for eligible individuals that are designed to address identified goals and objectives through the provision of specified services and supports. (§§ 4646, 4646.5, 4648.)

****441** As directed by statute, the DDS has "adopt[ed] regulations that specify rates for community care facilities serving persons with developmental disabilities." (§ 4681.1, subd. (a).) According to the regulations, a " '[f]acility' means a licensed community care facility as defined in Health and Safety Code Section 1502(a)(1), (4), (5) or (6); ... which has been vendorized as a residential facility by a regional center ...." (***1258** Cal.Code Regs., tit. 17, § 56002, subd. (a)(15); see also Cal.Code Regs., tit. 17, § 54302, subd. (a)(55).)[2] Vendorization "is the process for identification, selection, and utilization of service vendors or contractors, based on the qualifications and other requirements necessary in order to provide the service." (§ 4648, subd. (a)(3)(A); see also Cal.Code Regs., tit. 17, § 54302, subd. (a)(78) [" 'Vendorization' means the process used to: [¶] (A) Verify that an applicant meets all of the requirements and standards pursuant to Section 54320(b) of these regulations prior to the provision of services to consumers; and [¶] (B) Assign vendor identification numbers, service codes and subcodes, for the purpose of identifying vendor expenditures"].)

[2] A " '[c]ommunity care facility' means any facility, place, or building that is maintained and operated to provide nonmedical residential care, day treatment, adult day care, or foster family agency services for children, adults, or children and adults, including, but not limited to, the physically handicapped, mentally impaired, incompetent persons, and abused or neglected children, and includes" a residential facility, foster family agency, foster family home and small family home. (Health & Saf.Code, § 1502, subds. (a)(1), (4), (5) & (6).)

The facility rates specified in section 4681.1 are referred to as "ARM rates" because they are premised on the model identified in the DDS's April 1987 report entitled Alternative Residential Model. (See former § 4681.1, subd. (c), added by Stats.1988, c. 85, § 2, eff. April 22, 1988.) The ARM rates correspond to a facility's service level. (Cal.Code Regs., tit. 17, §§ 56902, 56910–56915.) A facility's " '[s]ervice [l]evel' means one of a series of 4 levels which has been approved for each facility by a regional center. Service Levels 2, 3 and 4 have a specified set of requirements that a facility must meet which addresses the direct supervision and special services for consumers within that facility." (Cal.Code Regs., tit. 17, § 56002, subd. (a)(44).) Service level 1 through 4 facilities must possess a valid community care facility license issued by the DSS and "shall be vendorized by a regional center pursuant to the requirements of Title 17, California Code of Regulations, Chapter 3, Subchapter 2." (Cal.Code Regs., tit. 17, § 56004, subds. (a) & (b).)

A foster child who is eligible to receive regional center services is commonly referred to as a "dual agency child." Section 4684 addresses funding for out-of-home nonmedical care and supervision of dual agency children and, prior to its 2007 amendments, provided: "Notwithstanding any other provision of law, the cost of providing 24–hour out-of-home nonmedical care and supervision in licensed community care facilities shall be funded by the Aid to Families with Dependent Children–Foster Care (AFDC–FC) program pursuant to Section 11464, for children who are both AFDC–FC recipients and regional center clients. [¶] Regional centers shall pay the cost of services which they authorize for AFDC–FC recipients but which are not allowable under state or federal AFDC–FC program requirements. Regional centers shall accept referrals for evaluation of AFDC–FC eligible children ***1259** and assist county welfare and probation departments in identifying appropriate placement resources ****442** for children who are eligible for regional center services." [3]

[3] Both section 4684 and section 11464 were amended in 2007 to provide specified rates for care and supervision provided to dual agency children in non-vendorized placements and to unambiguously establish the requirement of vendorization for a facility seeking receipt of the ARM rates. (See §§ 4684 & 11464, amended by Stats.2007, c. 177 (S.B. 84), eff. Aug. 24, 2007.) Appellants' claims are based on the prior versions of the statutes and are not affected by the amendments.

In turn, prior to its amendment in 2007, section 11464 addressed the rates for dual agency children, stating: "Notwithstanding any other provision of law, the State Department of Social Services shall use the residential facility rates established by the State Department of Developmental Services to determine rates to be paid for 24–hour out-of-home nonmedical care and supervision of children who are both regional center clients pursuant to Section 4684 and AFDC–FC recipients under the provisions of this chapter and placed in licensed community care facilities. [¶] Any services authorized by a regional center for AFDC–FC recipients that are not allowable under state or federal AFDC–FC program requirements shall be paid pursuant to Section 4684."

The Trial Court Proceedings.

Appellants are an uncertified class comprised of current and former foster children and their foster families who contend that they were entitled to receive additional benefits in the form of payment of the ARM rates because of the children's developmental disabilities. Appellants fall into one of three subclasses: (1) Dual agency children under age 18 who at any time since 1987 were placed in licensed community care facilities that did not receive the ARM rates; (2) dual agency children over age 18 who were placed in licensed community care facilities that did not receive the ARM rates at any point within the applicable limitations period; and (3) persons who were foster parents of the children identified within the foregoing groups at any point within the applicable limitations period.

In 2005, appellants filed approximately ten identical class action lawsuits in various counties throughout California, alleging an underpayment of foster care benefits to dual agency children. They contended the statutory scheme did not require a licensed community care facility into which a

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dual agency child had been placed to be vendorized by a regional center in order to receive the ARM rates. The Judicial Council of California coordinated the actions pursuant to California Rules of Court, rule 3.550, assigning a single judge, the caption "Social Services Payment Cases" and case ***1260** number JCCP No. 4439. In March 2006, the trial court sustained a demurrer with leave to amend brought by nine California counties (Counties) in the coordinated action. The trial court directed appellants to combine the coordinated actions into a single complaint and to plead more specifically the applicable statutory and regulatory schemes.

In April 2006, appellants filed their master complaint against the DSS and its director, and the Counties, including Los Angeles County (County). They alleged causes of action for underpayment of social services, declaratory relief, injunctive relief and writ of mandate on the ground that DSS had improperly denied payment of the ARM rates to licensed community care facilities providing nonmedical care and supervision for dual agency children. The DSS demurred, as did the Counties. The County also filed a supplemental demurrer in which several other Counties ****443** joined. They argued that the applicable statutes and regulations, when read together, demonstrated vendorization was a prerequisite for a licensed community care facility's receipt of the ARM rates and that, therefore, non-vendorized facilities were ineligible to receive the ARM rates.

Appellants opposed, asserting that no statute or regulation required that the ARM rates be paid only to a vendorized provider and that imposing such a requirement improperly delegated placement authority to the regional centers in violation of the "single state agency" rule.

Following an August 2006 hearing, the trial court filed an order on November 1, 2006, which sustained the demurrers with leave to amend as to the DSS and without leave to amend as to the Counties. It ruled: "Just as foster parents and foster homes must be licensed in order to receive AFDC–FC benefits, state regulations require foster parents and foster homes to be 'vendorized' in order to receive the additional benefits for care of developmentally disabled children authorized by Welfare and Institutions Code sections 4684 and 11464. These regulations are not contrary to statute and must be given deference by the court." Finding ambiguity in the statutory scheme as to whether a licensed community care facility, including an individual foster home, must be vendorized in order to qualify for receipt of the ARM rates, the trial court turned to agency regulations for guidance and reasoned that the applicable regulations supported a vendorization requirement. It further found that its interpretation of the statutory scheme did not violate the single state agency rule, as the vendorization requirement did not interfere with a county's placement decisions. With respect to the Counties, the trial court concluded they were not proper parties to the litigation because their administration of foster care benefits depended on a delegation from the DSS and they were not permitted to act independently of or contrary to the DSS's instructions. With respect to the DSS, the trial court granted ***1261** appellants leave to amend to allow claims to be brought by "dual agency children who have been placed in vendorized licensed community care facilities."

Thereafter, in January 2007 appellants filed a first amended master complaint (FAMC). Appellants did not comply with the trial court's prior order by alleging more limited claims or alleging claims on behalf of a more limited group of caregivers. Rather, they continued to challenge the vendorization requirement through allegations such as: "Interpreting sections 4684 and 11464 of the Welfare and Institutions Code to mean that a regional center must approve a county's placement decision before a given rate of AFDC–FC funding can be paid to a dual agency child would be inconsistent with the Legislature's intent to comply with federal funding requirements"; "[r]equiring regional centers to approve or disapprove foster care providers or the eligibility for benefits (through vendorization) would be inconsistent with the requirement that a 'single state agency' be in charge of foster care"; and "[n]o California statute or regulation expressly states that a licensed community care facility in which a dual agency child has been placed must be vendorized before the foster care rate specified in Welfare and Institutions Code section 11464 can be paid on behalf of the child." Their only new allegation was that the DSS had acted inconsistently with its current interpretation of the vendorization requirement by placing "hundreds of dual agency children" in non-vendorized placements, paying the ARM rates to numerous dual agency children in those placements, and failing to notify other dual agency children in those placements of the availability of the ARM ****444** rates. Appellants sought payment of rates equal to the ARM rates for care and supervision provided by licensed community care facilities to dual agency children since July 1987.

The DSS again demurred. It asserted that appellants were not entitled to any relief as a matter of law because they failed to allege they were placed in or operated a licensed community

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care facility that was vendorized by or contracted with a regional center. For the most part, its arguments mirrored the bases for the trial court's previous order sustaining the demurrer. In support of its demurrer, the DSS requested the trial court to take judicial notice of two "All County Letters", as well as the memorandum of points and authorities filed by the Counties in support of the previous demurrer. The DSS issued All County Letter No. 87–64 (ACL 87–64) on April 30, 1987, "to provide further information and instructions to counties regarding the implementation of AB 2520 (Chapter 355, Statutes of 1986)." Under the heading "Eligible Population and Eligible Facilities," ACL 87–64 provided: "All AFDC–FC recipients who are also receiving services as regional center clients shall be eligible for the rate of payment established by SDDS for 24–hour out-of-home nonmedical care and supervision. The majority of regional center placements are made into facilities of the small family home category, ***1262** however, regional center placements may also be made into licensed foster family homes and group homes. The provisions of this statute apply to AFDC–FC children placed in any of these facilities having a 'vendorized' or contractual relationship with the regional centers." The DSS issued All County Letter No. 98–28 (ACL 98–28) over ten years later, superseding ACL 87–64. The purpose of ACL 98–28 was "to inform counties of federal and state requirements regarding funding for foster children who are regional center clients." It discussed the rate system that had been implemented since the issuance of ACL 87–64, explaining: "Effective January 1, 1991 the CDDS implemented the Alternative Residential Model (ARM) for setting rates to cover the cost of care and supervision for regional center clients, including dual agency children. The ARM rates are based on the level of services provided by a facility. The regional center 'vendorizes' each licensed facility and approves a facility service level, which then corresponds to an established facility rate." ACL 98–28 further reiterated that "[t]he provisions of WIC Section 11464 apply to AFDC–FC children placed in any of these facilities having a 'vendorized' or contractual relationship with the regional centers." The DSS argued that its interpretation of the applicable statutes promulgated in the All County Letters should control over any anecdotal conduct to the contrary.

This time, the trial court sustained the demurrer without leave to amend. To the extent the FAMC reiterated the allegations in the master complaint that were previously found to be deficient, the trial court adopted the reasoning of its prior order sustaining the DSS's demurrer. Assuming the truth of the new allegations that the DSS had previously not enforced the vendorization requirement, the trial court found that those allegations did not undermine the DSS's reliance on its policy requiring vendorization nor did they create any basis for an estoppel to deny the policy.

[2] The trial court thereafter entered judgment in favor of the DSS and this appeal followed. [4]

[4] Although the appeal was taken from the nonappealable order sustaining the demurrer, we treat the notice of appeal as a premature but valid notice of appeal from the subsequently entered judgment. (See Cal. Rules of Court, rule 8.104(e)(2).)

****445 DISCUSSION**

Appellants maintain that the trial court erred in sustaining the DSS's demurrer without leave to amend, asserting that the trial court's reasoning finds no support in the statutory scheme. They contend that the imposition of a vendorization requirement violates the single state agency rule by improperly delegating authority to the regional centers, that the provisions of the ***1263** Lanterman Act have no application to dual agency children, and that the trial court improperly relied on the All County Letters to interpret the relevant statutes. Alternatively, they assert the DSS is estopped to deny payment of the ARM rates to non-vendorized licensed community care facilities.

I. Standard of Review.

[3] A demurrer tests the legal sufficiency of the complaint. (*Hernandez v. City of Pomona* (1996) 49 Cal.App.4th 1492, 1497, 57 Cal.Rptr.2d 406.) On appeal from a judgment of dismissal following an order sustaining a demurrer, we examine the complaint de novo in order to ascertain "whether it alleges facts sufficient to state a cause of action under any legal theory, such facts being assumed true for this purpose." (*McCall v. PacifiCare of Cal., Inc.* (2001) 25 Cal.4th 412, 415, 106 Cal.Rptr.2d 271, 21 P.3d 1189.) We give the complaint a reasonable interpretation, reading it as a whole and viewing its parts in context. (*Quelimane Co. v. Stewart Title Guaranty Co.* (1998) 19 Cal.4th 26, 38, 77 Cal.Rptr.2d 709, 960 P.2d 513; *Blank v. Kirwan* (1985) 39 Cal.3d 311, 318, 216 Cal.Rptr. 718, 703 P.2d 58.) We assume the truth of the properly pleaded factual allegations, facts that can be reasonably inferred from those pleaded, and facts of which judicial notice can be taken.

(*Schifando v. City of Los Angeles* (2003) 31 Cal.4th 1074, 1081, 6 Cal.Rptr.3d 457, 79 P.3d 569.) But we do not assume the truth of pleaded contentions and legal conclusions. (*Moore v. Regents of University of California, supra,* 51 Cal.3d at p. 125, 271 Cal.Rptr. 146, 793 P.2d 479; *Cochran v. Cochran* (1997) 56 Cal.App.4th 1115, 1120, 66 Cal.Rptr.2d 337.) And we may disregard allegations which are contrary to law or to a fact of which judicial notice may be taken. (*Wolfe v. State Farm Fire & Casualty Ins. Co.* (1996) 46 Cal.App.4th 554, 559–560, 53 Cal.Rptr.2d 878.)

[4] We review the trial court's denial of leave to amend for an abuse of discretion. (*Blank v. Kirwan, supra,* 39 Cal.3d at p. 318, 216 Cal.Rptr. 718, 703 P.2d 58; *Hernandez v. City of Pomona, supra,* 49 Cal.App.4th at pp. 1497–1498, 57 Cal.Rptr.2d 406.) "When a demurrer is sustained without leave to amend, we determine whether there is a reasonable probability that the defect can be cured by amendment. [Citation.]" (*V.C. v. Los Angeles Unified School Dist.* (2006) 139 Cal.App.4th 499, 506, 43 Cal.Rptr.3d 103.) Appellants bear the burden of demonstrating the trial court erred in sustaining the demurrer or abused its discretion in denying leave to amend. (*Blank v. Kirwan, supra,* at p. 318, 216 Cal.Rptr. 718, 703 P.2d 58; *V.C. v. Los Angeles Unified School Dist., supra,* at pp. 506–507, 43 Cal.Rptr.3d 103.)

II. The Trial Court Properly Sustained the Demurrer Without Leave to Amend.

The trial court's order sustaining the DSS's demurrer without leave to amend incorporated the reasoning of its prior order sustaining the demurrer ***1264** with ****446** leave to amend. In the prior order, the trial court found the language of section 11464 ambiguous to the extent the statute did not include an express vendorization requirement. In view of this ambiguity, the trial court examined the statutory scheme as a whole, regulations enacted by the DDS relating to the establishment of ARM rates and the DSS's and the DDS's past practices to determine that licensed community care facilities must be vendorized by a regional center to be eligible to receive the ARM rates established by the DDS. We see no basis to disturb the trial court's interpretation of section 11464.

A. Statutory Interpretation Principles.

[5] The objective of statutory interpretation is to ascertain and effectuate the intent of the Legislature. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 775, 72 Cal.Rptr.2d 624, 952 P.2d 641.) The first step in determining legislative intent is to analyze the statutory language, giving the words of the statute a plain and common sense meaning. (*Ibid.*) If the statutory language is unambiguous, a court must presume that the Legislature meant what it said, and the plain meaning of the statute governs. (*Lennane v. Franchise Tax Bd.* (1994) 9 Cal.4th 263, 268, 36 Cal.Rptr.2d 563, 885 P.2d 976.) Nonetheless, "the 'plain meaning' rule does not prohibit a court from determining whether the literal meaning of a statute comports with its purpose or whether such a construction of one provision is consistent with other provisions of the statute. The meaning of a statute may not be determined from a single word or sentence; the words must be construed in context, and provisions relating to the same subject matter must be harmonized to the extent possible. [Citation.]" (*Lungren v. Deukmejian* (1988) 45 Cal.3d 727, 735, 248 Cal.Rptr. 115, 755 P.2d 299.)

[6] "When the plain meaning of the statutory text is insufficient to resolve the question of its interpretation, the courts may turn to rules or maxims of construction 'which serve as aids in the sense that they express familiar insights about conventional language usage.' [Citation.]" (*Mejia v. Reed* (2003) 31 Cal.4th 657, 663, 3 Cal.Rptr.3d 390, 74 P.3d 166.) Accordingly, "when the statutory language is ambiguous and susceptible to more than one reasonable interpretation, 'we look to a variety of extrinsic aids, including the ostensible objects to be achieved, the evils to be remedied, the legislative history, public policy, contemporaneous administrative construction, and the statutory scheme of which the statute is a part.' (*Nolan v. City of Anaheim* (2004) 33 Cal.4th 335, 340[, 14 Cal.Rptr.3d 857, 92 P.3d 350].)" (*Forrest v. Department of Corporations* (2007) 150 Cal.App.4th 183, 205, 58 Cal.Rptr.3d 466.) The court may also consider the impact of an interpretation on public policy, for "[w]here uncertainty exists consideration should be given to the consequences that will flow from a particular interpretation." ***1265** (*Dyna–Med, Inc. v. Fair Employment & Housing Com.* (1987) 43 Cal.3d 1379, 1387, 241 Cal.Rptr. 67, 743 P.2d 1323.)

B. The Statutory Scheme Governing Dual Agency Children Must Be Construed to Require Vendorization for a Licensed Community Care Facility to Receive the ARM Rates.

Separate parts of the Welfare and Institutions Code address services for the developmentally disabled (§ 4500 et seq.) and the provision of AFDC–FC (§ 11400 et seq.). One statute in each of those sections intersects with and cross-references the other to address payment for services ****447** provided to developmentally disabled foster children. Former

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section 4684 provided that "the cost of providing 24–hour out-of-home nonmedical care and supervision in licensed community care facilities shall be funded by the Aid to Families with Dependent Children–Foster Care (AFDC–FC) program pursuant to Section 11464, for children who are both AFDC–FC recipients and regional center clients." Former section 11464 required that "the State Department of Social Services shall use the residential facility rates established by the State Department of Developmental Services to determine rates to be paid for 24–hour out-of-home nonmedical care and supervision of children who are both regional center clients pursuant to Section 4684 and AFDC–FC recipients under the provisions of this chapter and placed in licensed community care facilities." To the extent that a regional center authorizes services for a dual agency child that are not payable by AFDC–FC, the regional centers are responsible to pay the cost of those services. (§ 4684.) Both provisions apply "[n]otwithstanding any other provision of law ...." (§§ 4684, 11464.)

[7] The question before us is whether a licensed community care facility's receipt of the ARM rates specified in section 11464 is contingent upon a regional center vendorizing the facility, notwithstanding that payment for "care and supervision" is funded through the AFDC–FC program as opposed to the regional centers. To answer this question, we are guided by *DeVita v. County of Napa* (1995) 9 Cal.4th 763, 778–779, 38 Cal.Rptr.2d 699, 889 P.2d 1019, where the court declared: "When two statutes touch upon a common subject, they are to be construed in reference to each other, so as to 'harmonize the two in such a way that no part of either becomes surplusage.' [Citations.] Two codes ' "must be read together and so construed as to give effect, when possible, to all the provisions thereof." ' [Citation.]" (Accord, *Mejia v. Reed, supra,* 31 Cal.4th at p. 663, 3 Cal.Rptr.3d 390, 74 P.3d 166.) Harmonizing the text of section 4684 and section 11464 so that each word has significance, we must conclude that in order for the DSS to "use the residential facility rates established by" the DDS to determine the rates to be paid for the care of dual agency children placed in licensed community care facilities ***1266** § 11464), the DSS must take into account the statutory and regulatory conditions which are critical components of the ARM rates.

Dual agency children fall within the Lanterman Act; they are defined as "regional center clients," which means they have been determined to suffer from a developmental disability that makes them eligible for regional center services. (§§ 4643, subd. (b), 4643.5, 4684, 11464; Cal.Code Regs., tit. 17, §§ 54000, subd. (a), 54010, subd. (b).) Under the Lanterman Act, the state has accepted responsibility for these individuals, declaring that it has an obligation to provide an "array of services and supports ... to meet the needs and choices" of the developmentally disabled. (§ 4501.) To fulfill the state's obligation, the Legislature has directed the regional centers to conduct a number of specified activities for the developmentally disabled—primary among those is "[s]ecuring needed services and supports." (§ 4648, subd. (a).) In order to "secure services and supports that meet the needs of the consumer, as determined in the consumer's individual program plan," a regional center may purchase services "pursuant to vendorization or a contract ...." (§ 4648, subds. (a)(1) & (3); see also *Morohoshi v. Pacific Home* (2004) 34 Cal.4th 482, 490, 20 Cal.Rptr.3d 890, 100 P.3d 433 [holding that regional centers have no obligation to provide services themselves, noting that "the only choice facing regional ****448** centers, except in emergencies, is which vendor to hire, not whether to hire a vendor at all"].) As outlined in section 4648, subdivision (a)(3)(A), "[v]endorization or contracting is the process for identification, selection, and utilization of service vendors or contractors, based on the qualifications and other requirements necessary in order to provide the service."

With respect to payment for services and supports provided to individuals in out-of-home placements, the Legislature's expressed goal was to develop a payment system consistent with its obligation to meet the needs of the developmentally disabled: "In order to assure the availability of a continuum of community living facilities of good quality for persons with developmental disabilities, and to ensure that persons placed out of home are in the most appropriate, least restrictive living arrangement, the department shall establish and maintain an equitable system of payment to providers of such services. The system of payment shall include provision for a rate to ensure that the provider can meet the special needs of persons with developmental disabilities and provide quality programs required by this article." (§ 4680; see also § 4648, subd. (a)(5).)

By statute, rates for licensed community care facilities serving persons with a developmental disability—the ARM rates—are "calculated on the basis of a cost model designed by the [DDS] which ensures that aggregate facility payments support the provision of services to each person in accordance with his or her individual program plan and applicable program ***1267** requirements." (§ 4681.1, subd. (a).) The cost model is designed to reflect a number of elements

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including, but not limited to, basic living needs, direct care, special services, indirect costs and property costs. (§ 4681.1, subds. (a)-(c).) Also by statute, the Legislature directed the DDS to prepare regulations to implement the community care facility rates in accordance with the cost model. (§ 4681.1, subd. (e).)

The statutorily-mandated regulations unambiguously make vendorization an inextricable element of the cost model. California Code of Regulations, title 17, section 56001 et seq. describes the facility service levels and approval process for a licensed community care facility to provide services at the specified 1 through 4 levels. According to California Code of Regulations, title 17, section 56004, subdivision (b): "Service Level 1 through 4 facilities shall be vendorized by a regional center pursuant to the requirements of Title 17, California Code of Regulations, Chapter 3, Subchapter 2." (See also Cal.Code Regs., tit. 17, § 56001 ["Use of the word 'shall' denotes mandatory conduct"].) The regulations provide a " '[f]acility' means a licensed community care facility as defined in Health and Safety Code Section 1502(a)(1), (4), (5) or (6); ... which has been vendorized as a residential facility by a regional center pursuant to the requirements of Title 17, California Code of Regulations, Division 2, Chapter 3, Subchapter 2." (Cal.Code Regs., tit. 17, § 56002, subd. (a)(15).) Likewise, a "[r]esidential service provider" is defined as "an individual or entity which has been licensed by the Department of Social Services as a community care facility pursuant to Health and Safety Code Section 1502(a)(1), (4), (5) or (6); ... has completed the vendorization process pursuant to Title 17, California Code of Regulations, Division 2, Subchapter 2; and has been assigned a vendor identification number beginning with the letter 'H' pursuant to Title 17, California Code of Regulations, Section 54340(a)(1)." (Cal.Code Regs., tit. 17, § 56002, subd. (a)(41).) Only a "residential service provider" is eligible to receive the ARM rates developed by the DDS pursuant to ****449** California Code of Regulations, title 17, section 56900 et seq. (Cal.Code Regs., tit. 17, § 56917.)

[8] **[9]** "We adhere to 'the well-established principle that contemporaneous administrative construction of a statute by the agency charged with its enforcement and interpretation, while not necessarily controlling, is of great weight; and courts will not depart from such construction unless it is clearly erroneous or unauthorized.' [Citation.]" (*State Compensation Ins. Fund v. Workers' Comp. Appeals Bd.* (1995) 37 Cal.App.4th 675, 683, 43 Cal.Rptr.2d 660.) As directed by the Lanterman Act, the DDS adopted regulations that require a licensed community care facility to be vendorized by a regional center in order to receive the ARM rates. In view of the statutory and regulatory scheme, we construe the phrase "use the residential facility rates established by the State Department of Developmental Services" in former section 11464 to require the DSS to use not only the monetary component of ***1268** the rate but also the framework governing the setting and payment of the ARM rates. This construction harmonizes section 4684 and section 11464 so that no part of either statute is surplusage and establishes a "compatible interplay" between the statutes. (*Mar v. Sakti Internat. Corp.* (1992) 9 Cal.App.4th 1780, 1784, 12 Cal.Rptr.2d 388 [Code of Civil Procedure provision that permitted right of intervention under provision of law upon timely application deemed to incorporate the time limits of the Labor Code provision governing right of intervention].)

Public policy considerations further warrant construing the reference in section 11464 to the residential facility rate to incorporate a vendorization requirement. (See *Behan v. Alexis* (1981) 116 Cal.App.3d 403, 406, 172 Cal.Rptr. 132 [courts should interpret statutes to accomplish their legislative objective while accommodating important statutory and policy considerations].) The Legislature developed an equitable system of payments for developmentally disabled persons in out-of-home facilities and directed that the rate of payment "ensure that the provider can meet the special needs of persons with developmental disabilities and provide quality programs required by this article." (§ 4680.) The ARM rates take into account multiple components of a developmentally disabled individual's care, including basic living needs, direct supervision, and special services—the latter of which encompasses "specialized training, treatment, supervision, or other services which the individual program plan of each person requires to be provided by the residential facility in addition to the direct supervision provided pursuant to the person's individual program plan in subdivision (b)." (Former § 4681.1, subd. (b)(3).)

The applicable regulations specify the program design and staffing ratios that service level 1 through 4 facilities must possess in order to be approved to provide direct supervision and special services at a specified level. (Cal.Code Regs, tit. 17, §§ 56002, subds. (a)(14), (44) & (48), 56004–56005.) The ARM rates paid to these facilities are calculated on the basis of multiple factors relating to the services provided by and the service level of the facility. (Cal.Code Regs, tit. 17, §§ 56910–56915.) Service level 1 through 4 facilities must be vendorized by a regional

center. (Cal.Code Regs, tit. 17, § 56004, subd. (b).) One purpose of the vendor application is to confirm that the facility is capable of providing, and certified or licensed to perform, the services it seeks to provide. (Cal.Code Regs, tit. 17, § 54310.) A regional center's review of the vendor application, approval or denial of the application, and subsequent quality assurance monitoring and evaluation of the vendor ****450** serve as safeguards to help assure that the developmentally disabled are receiving appropriate services and supports from qualified vendors. (Cal.Code Regs, tit. 17, §§ 54320, 54322, 56046–56056.) Dispensing with the vendorization requirement would eliminate these safeguards, to the detriment of developmentally disabled individuals for whom the state is responsible.

[10] ***1269** Construing section 11464 to incorporate the requirements necessary for a licensed community care facility to receive the ARM rates does not violate any principle of law or policy. We—as did the trial court—reject appellants' argument that regional center vendorization contravenes the federal AFDC–FC requirement that a single state agency administer the foster care program. (See 45 C.F.R. § 205.100(a)(1)(ii) & (b)(1).) Appellants argue that requiring a regional center to vendorize a facility before it will receive a particular rate payable through AFDC–FC is an improper delegation of the DSS's responsibility for the placement and care of foster children. (See § 11404, subd. (a).) To contrast the regional center's role, they cite *Arizona St. Dept. of Pub. W. v. Department of Health, E. & W.* (9th Cir.1971) 449 F.2d 456, 472, where the court observed that the establishment of a federally-mandated advisory committee did not violate the single state agency rule, as "[w]ith or without the advisory committee, the responsibility for making the actual administrative decisions and for implementing them rests in a single set of hands—those of the state agency."

Appellants' authority, however, serves only to highlight that the vendorization requirement does nothing to usurp the DSS's role as the single state agency responsible for administering foster care. Vendorization does not interfere with the DSS's placement decisions. As the trial court noted in its prior order sustaining the DSS's demurrer with leave to amend, county welfare departments retain discretion to place a dual agency child in a licensed community care facility that has not been vendorized; the consequence of doing so is not that the child is removed but simply that the facility does not receive the ARM rates. Indeed, nothing about the vendorization requirement precludes a county social worker from developing a case plan that specifies a non-vendorized placement for a dual agency child. (See § 11400, subd. (b).) Correspondingly, nothing precludes a licensed community care facility where a dual agency child is placed from seeking vendorization. (See Cal.Code Regs., tit. 17, § 56003, subd. (a) [regional center is mandated to provide periodic residential services orientations "for all persons who wish to become vendorized to provide services pursuant to Subchapter 4"].)

Moreover, the DSS continues to be the department "designated the single organizational unit whose duty it shall be to administer a state system for establishing rates in the AFDC–FC program." (§ 11460, subd. (a).) Foster care rates are designed to cover the "care and supervision" of a foster child, which "includes food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable ***1270** travel to the child's home for visitation."[5] (§ 11460, subd. (b).) The ARM rates, on the other hand, are designed to compensate licensed community care facilities for the provision ****451** of direct supervision and specialized services tailored to meet the objectives of an individual program plan. (§ 4861.1.) A regional center's vendorization of a licensed community care facility provides assurance that the facility can provide such services above and beyond care and supervision. (See Cal.Code. Reg., tit. 17, §§ 54310–54326.) It constitutes an integral part of the rates "established" by the DDS that are incorporated as foster care rates pursuant to section 11464.

5 Notwithstanding the statutes governing dual agency children, the DSS retains discretion to pay a " 'specialized care increment,' " which "means an approved amount paid with state participation on behalf of an AFDC–FC child requiring specialized care to a home listed in subdivision (a) in addition to the basic rate." (§ 11461, subd. (e)(1).)

[11] Indeed, the single state agency requirement does not prohibit various state agencies from working in tandem and utilizing each other's expertise. For example, in *Giles v. Horn* (2002) 100 Cal.App.4th 206, 239–240, 123 Cal.Rptr.2d 735, the court determined that a county's contracting out certain case management work under the CalWORKS program did not violate the single state agency rule. Relevant here, the court discussed the legislative history of 45 Code of Federal Regulations part 205.100 contained in 54 Federal Register 42146, which states in part: " 'The single State agency principle does not preclude the purchase of services from other State agencies, nor is it designed to set aside the

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cooperative relationships that are normal and proper within a State. Purchase of services and working cooperatively with other agencies are, however, different from delegating administrative responsibility for performance of functions required under State and Federal laws to other agencies or individuals. The State may make use of the expertise of other agencies as long as the State IV–A agency does not delegate administrative decision-making authority.' " (*Giles v. Horn, supra,* at p. 240, 123 Cal.Rptr.2d 735; see also *RCJ Medical Services, Inc. v. Bontá* (2001) 91 Cal.App.4th 986, 1008–1013, 111 Cal.Rptr.2d 223 [Department of Health Service's delegating audit authority to State Controller's office did not violate federal Medicaid Act's single state agency requirement].) The DSS's requiring vendorization for facilities seeking payment of the ARM rates under section 11464 is not a delegation of its authority, but rather, constitutes part of the cooperative relationship between the DSS and DDS that is necessary to meet the needs of dual agency children. (See former § 4684 ["Regional centers shall accept referrals for evaluation of AFDC–FC eligible children and assist county welfare and probation departments in identifying appropriate placement resources for children who are eligible for regional center services"].)

We likewise reject appellants' related contention that the trial court improperly relied on provisions of the Lanterman Act to require vendorization ***1271** of facilities seeking the ARM rates pursuant to section 11464. Appellants contend that because section 11464 addresses foster care rates, "use" of the ARM rates is limited only to the considerations governing foster care rates set forth in sections 11460 and 11461. We cannot read section 11464 in a vacuum. (E.g., *Moore v. Panish* (1982) 32 Cal.3d 535, 541, 186 Cal.Rptr. 475, 652 P.2d 32 ["every statute should be construed with reference to the whole system of law of which it is a part, so that all may be harmonized and have effect"]; *Hicks v. E.T. Legg & Associates* (2001) 89 Cal.App.4th 496, 505, 108 Cal.Rptr.2d 10 [" 'a statute is not to be read in isolation; it must be construed with related statutes and considered in the context of the statutory framework as a whole' "].) In enacting the Lanterman Act, the Legislature recognized that the needs of the developmentally disabled should be paramount, stating "[t]he complexities of providing services and supports to persons with developmental disabilities requires *[sic]* the coordination of services of many state departments and community agencies to ensure that no gaps occur in communication or provision ****452** of services and supports." (§ 4501.) The plain language of section 11464 refers directly to the Lanterman Act, providing that the dual agency children covered by that statute are "regional center clients," which means they have been assessed to have a developmental disability that renders them eligible for regional center services. (See § 4648; Cal.Code Regs., tit. 17, § 54010, subd. (b).) It is only because those children are eligible for regional center services under the Lanterman Act that the issue of the ARM rates arises in the first instance. (§ 4648; Cal.Code Regs., tit. 17, § 54302, subd. (a)(54).) Construing section 11464 to incorporate the use of the ARM rates but not the balance of the statutory and regulatory scheme governing them would eviscerate the purpose of the ARM rates to assure that a dual agency child will in fact receive needed services and supports.

[12] Finally, the trial court's reliance on the All County Letters affords no basis for reversal of the order sustaining the demurrer. In taking judicial notice of ACL 87–64 and ACL 98–28, the trial court concluded they were relevant because they disclosed a consistent, long-standing practice by the DSS to require that licensed community care facilities be vendorized to receive the ARM rates. It expressly ruled that the letters were not independently entitled to judicial deference because they were not issued in accordance with the Administrative Procedure Act, Government Code section 11340 et seq. (See *Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557, 570–571, 59 Cal.Rptr.2d 186, 927 P.2d 296.) But the trial court properly exercised its discretion in taking judicial notice of the All County Letters. (See *Salazar v. Upland Police Dept.* (2004) 116 Cal.App.4th 934, 946, 11 Cal.Rptr.3d 22 [judicial notice ruling reviewed for abuse of discretion]; *Washington v. County of Contra Costa* (1995) 38 Cal.App.4th 890, 901, 45 Cal.Rptr.2d 646 [same].) As official acts of the state's executive department, ALC 87–64 and ***1272** ACL 98–28 were proper subjects of judicial notice. (Evid.Code, § 452, subd. (c); *California Advocates for Nursing Home Reform v. Bontá* (2003) 106 Cal.App.4th 498, 515–516, fn. 8, 130 Cal.Rptr.2d 823 [judicial notice of All County Letters].)

[13] Moreover, the trial court was entitled to "accord 'great weight and respect' " to the DSS's interpretation of sections 4684 and 11464, as the DSS possessed expertise in dealing with the needs of dual agency children and the All County Letters indicated that senior officials had carefully considered how responsibility for addressing those needs should be handled by the county welfare departments in coordination with the regional centers. (*Sharon S. v. Superior Court* (2003) 31 Cal.4th 417, 436, 2 Cal.Rptr.3d 699, 73 P.3d 554 [court deferred to the DSS's interpretation of adoption law expressed

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in an All County Letters]; see also *Megrabian v. Saenz* (2005) 130 Cal.App.4th 468, 486, 30 Cal.Rptr.3d 262 [evidence of long-standing DSS interpretation of regulation entitled to deference].)

In any event, the trial court's reliance on the All County Letters was unnecessary to its conclusion that the statutory scheme governing dual agency children requires that the licensed community care facilities into which those children are placed by the DSS through the county welfare departments must be vendorized by a regional center to receive the ARM rates created by the Lanterman Act. The All County Letters merely confirmed that the DSS has acted in conformity with the applicable statutory and regulatory scheme.

C. Appellant's Allegations Failed to Establish that the DSS Was Estopped to Rely on the Statutory Scheme.

In the FAMC, appellants sought to establish that the DSS was estopped to deny ****453** payment of the ARM rates. They alleged that, despite the DSS's asserted policy and practice of requiring vendorization for receipt of the ARM rates, "over the years" the DSS had placed "hundreds of dual agency children" in non vendorized licensed community care facilities; it had paid the ARM rates on behalf of dual agency children placed in nonvendorized licensed community care facilities; and it had failed to notify other non-vendorized facilities of the availability of the ARM rates or how to obtain them. The trial court summarily rejected appellants' contention that these facts formed the basis for an argument that the DSS was estopped to deny payment of the ARM rates to non-vendorized facilities. The trial court ruled: "Plaintiffs' 'estoppel' argument really is nothing more than a restatement of their contention that, when a county welfare department decides to place a dual agency child in a foster family home, DSS is required to pay the additional section 11464 rates automatically because the placement has been determined ***1273** to be appropriate. This argument is contrary to the statutory and regulatory scheme, as explained at length in this court's prior Opinion and Order." We find no error.

[14] **[15]** **[16]** While the doctrine of equitable estoppel may be applied against the government where justice and right require, it will not be applied if doing so would effectively nullify a strong rule of policy adopted for the benefit of the public. (*City of Long Beach v. Mansell* (1970) 3 Cal.3d 462, 493, 91 Cal.Rptr. 23, 476 P.2d 423.) To apply the equitable estoppel doctrine, four elements must be present: " '(1) the party to be estopped must be apprised of the facts; (2) he must intend that his conduct shall be acted upon, or must so act that the party asserting the estoppel had a right to believe it was so intended; (3) the other party must be ignorant of the true state of facts; and (4) he must rely upon the conduct to his injury.' " (*Id.* at p. 489, 91 Cal.Rptr. 23, 476 P.2d 423.) If those elements are established against the government, the court must then balance the burden on the party asserting estoppel if the doctrine is not applied against the public policy that would be affected by the estoppel. (*Lentz v. McMahon* (1989) 49 Cal.3d 393, 400–401, 261 Cal.Rptr. 310, 777 P.2d 83.)

[17] **[18]** **[19]** **[20]** Appellants' allegations satisfied none of the requisite elements. With respect to the DSS's knowledge of the facts, appellants alleged that the DSS placed dual agency children into non-vendorized facilities. But the vendorization requirement dictates whether the licensed community care facility is eligible to receive the ARM rates, not whether the DSS may place a dual agency child in the facility. Second, appellants did not allege how the DSS intended for any conduct in which it engaged to be acted upon by them. Third, appellants failed to allege they were ignorant of the ARM rates or of the vendorization requirement. Finally, appellants failed to allege that they relied on any action or inaction on the part of the DSS in accepting placement of dual agency children. Appellants' allegations stand in sharp contrast to the undisputed facts in *Canfield v. Prod* (1977) 67 Cal.App.3d 722, 731–733, 137 Cal.Rptr. 27, in which the court found the estoppel elements satisfied where the plaintiff, who was subject to a tax lien and faced losing her home, was unaware of her obligation to pay social security taxes and her entitlement to receive additional benefits because of that obligation, and the public agency was aware of such requirements and failed to fulfill its responsibility to notify her of her rights.

[21] Even if there were some manner in which we could construe appellants' allegations ****454** to satisfy the elements of equitable estoppel, we would conclude the trial court properly declined to apply the doctrine to save the FAMC because its application would thwart the public policy considerations served by requiring vendorization. *Lentz v. McMahon, supra,* 49 Cal.3d at pages 401, 261 Cal.Rptr. 310, 777 P.2d 83 to 402 does not compel a different result. There, the court concluded that ***1274** estoppel may be appropriate against a public welfare agency where it negligently or intentionally caused a claimant to fail to comply with a procedural precondition to eligibility, and the failure to apply estoppel would therefore constitute a significant hardship to the claimant. Notably, the *Lentz* court

expressly distinguished the type of estoppel appellants seek to invoke here, observing that "[a] more difficult question is posed, however, when estoppel is asserted against the government to defeat *substantive* limitations on eligibility for public benefits. To bar recoupment of benefits from a person whose circumstances did not qualify him for such benefits under applicable substantive eligibility rules might amount to a bestowal of benefits not contemplated by the Legislature." (*Id.* at p. 402, 261 Cal.Rptr. 310, 777 P.2d 83.)

The trial court correctly determined that appellants failed to allege the elements of estoppel and that, in any event, their estoppel argument was contrary to the statutory and regulatory scheme.

D. The Trial Court Properly Exercised its Discretion in Denying Leave to Amend.

In its order sustaining the demurrer to the FAMC without leave to amend, the trial court reiterated the limitation of its prior order, explaining that it had permitted appellants "to 'amend their complaint to limit this action to a class of dual agency children who have been placed in vendorized licensed community care facilities ....' " Appellants did not amend their complaint so as to limit the class of individuals and facilities seeking relief; instead they added allegations to support their equitable estoppel theory.

[22] Appellants have the burden to demonstrate that the trial court abused its discretion in denying leave to amend. (*Goodman v. Kennedy* (1976) 18 Cal.3d 335, 349, 134 Cal.Rptr. 375, 556 P.2d 737.) They must show in what manner they can amend their complaint and how that amendment will change the legal effect of their pleading. (*Ibid.*) Appellants have not suggested that they can amend their complaint to conform with the trial court's prior order nor indicated that there is any other manner in which they can amend their complaint to allege claims for relief that are consistent with the statutory and regulatory scheme requiring vendorization. Accordingly, they have failed to meet their burden to show the trial court abused its discretion in denying leave to amend. (See, e.g., *Reynolds v. Bement* (2005) 36 Cal.4th 1075, 1091, 32 Cal.Rptr.3d 483, 116 P.3d 1162; *Rakestraw v. California Physicians' Service* (2000) 81 Cal.App.4th 39, 43, 96 Cal.Rptr.2d 354.)

*1275 DISPOSITION

The judgment of dismissal is affirmed. The DSS is entitled to its costs on appeal.

We concur: BOREN, P.J., and ASHMANN–GERST, J.

All Citations

166 Cal.App.4th 1249, 83 Cal.Rptr.3d 434, 08 Cal. Daily Op. Serv. 12,300, 2008 Daily Journal D.A.R. 14,579

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40 Cal.2d 772, 256 P.2d 1
Supreme Court of California

ALFRED K. WEISS et al., Appellants,
v.
STATE BOARD OF
EQUALIZATION et al., Respondents.

L. A. No. 22697.
Apr. 28, 1953.

HEADNOTES

(1)
Intoxicating Liquors § 9.4--Licenses--Discretion of Board.
In exercising power which State Board of Equalization has under Const., art. XX, § 22, to deny, in its discretion, "any specific liquor license if it shall determine for good cause that the granting ... of such license would be contrary to public welfare or morals," the board performs a quasi judicial function similar to local administrative agencies.

See **Cal.Jur.2d,** Alcoholic Beverages, § 25 et seq.; **Am.Jur.,** Intoxicating Liquors, § 121.

(2)
Licenses § 32--Application.
Under appropriate circumstances, the same rules apply to determination of an application for a license as those for its revocation.

(3)
Intoxicating Liquors § 9.4--Licenses--Discretion of Board.
The discretion of the State Board of Equalization to deny or revoke a liquor license is not absolute but must be exercised in accordance with the law, and the provision that it may revoke or deny a license "for good cause" necessarily implies that its decision should be based on sufficient evidence and that it should not act arbitrarily in determining what is contrary to public welfare or morals.

(4)
Intoxicating Liquors § 9.4--Licenses--Discretion of Board.
3While the State Board of Equalization may refuse an on-sale liquor license if the premises are in the immediate vicinity of a school (Alcoholic Beverage Control Act, § 13), the absence of such a provision or regulation by the board as to off-sale licenses does not preclude it from making proximity of the premises to a school ***773** an adequate basis for denying an off-sale license as being inimical to public morals and welfare.

(5)
Intoxicating Liquors § 9.4--Licenses--Discretion of Board.
It is not unreasonable for the State Board of Equalization to decide that public welfare and morals would be jeopardized by the granting of an off-sale liquor license within 80 feet of some of the buildings on a school ground.

(6)
Intoxicating Liquors § 9.4--Licenses--Discretion of Board.
Denial of an application for an off-sale license to sell beer and wine at a store conducting a grocery and delicatessen business across the street from high school grounds is not arbitrary because there are other liquor licenses operating in the vicinity of the school, where all of them, except a drugstore, are at such a distance from the school that it cannot be said the board acted arbitrarily, and where, in any event, the mere fact that the board may have erroneously granted licenses to be used near the school in the past does not make it mandatory for the board to continue its error and grant any subsequent application.

(7)
Intoxicating Liquors § 9.4--Licenses--Discretion of Board.
Denial of an application for an off-sale license to sell beer and wine at a store across the street from high school grounds is not arbitrary because the neighborhood is predominantly Jewish and applicants intend to sell wine to customers of the Jewish faith for sacramental purposes, especially where there is no showing that wine for this purpose could not be conveniently obtained elsewhere.

SUMMARY

APPEAL from a judgment of the Superior Court of Los Angeles County. Frank G. Swain, Judge. Affirmed.

Proceeding in mandamus to compel State Board of Equalization to issue an off-sale liquor license. Judgment denying writ affirmed.

COUNSEL

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Riedman & Silverberg and Milton H. Silverberg for Appellants.
Edmund G. Brown, Attorney General, and Howard S. Goldin, Deputy Attorney General, for Respondents.

CARTER, J.

Plaintiffs brought mandamus proceedings in the superior court to review the refusal of defendant, State Board of Equalization, to issue them an off- sale beer and wine license at their premises and to compel the issuance of such a license. The court gave judgment for the board and plaintiffs appeal. ***774**

Plaintiffs filed their application with the board for an off-sale beer and wine license (a license to sell those beverages to be consumed elsewhere than on the premises) at their premises where they conducted a grocery and delicatessen business. After a hearing the board denied the application on the grounds that the issuance of the license would be contrary to the "public welfare and morals" because of the proximity of the premises to a school.

According to the evidence before the board, the area concerned is in Los Angeles. The school is located in the block bordered on the south by Rosewood Avenue, on the west by Fairfax Avenue, and on the north by Melrose Avenue- an 80-foot street running east and west parallel to Rosewood and a block north therefrom. The school grounds are enclosed by a fence, the gates of which are kept locked most of the time. Plaintiffs' premises for which the license is sought are west across Fairfax, an 80-foot street, and on the corner of Fairfax and Rosewood. The area on the west side of Fairfax, both north and south from Rosewood, and on the east side of Fairfax south from Rosewood, is a business district. The balance of the area in the vicinity is residential. The school is a high school. The portion along Rosewood is an athletic field with the exception of buildings on the corner of Fairfax and Rosewood across Fairfax from plaintiffs' premises. Those buildings are used for R.O.T.C. The main buildings of the school are on Fairfax south of Melrose. There are gates along the Fairfax and Rosewood sides of the school but they are kept locked most of the time. There are other premises in the vicinity having liquor licenses. There are five on the west side of Fairfax in the block south of Rosewood and one on the east side of Fairfax about three-fourths of a block south of Rosewood. North across Melrose and at the corner of Melrose and Fairfax is a drugstore which has an off-sale license. That place is 80 feet from the northwest corner of the school property as Melrose is 80 feet wide and plaintiffs' premises are 80 feet from the southwest corner of the school property. It does not appear when any of the licenses were issued, with reference to the existence of the school or otherwise. Nor does it appear what the distance is between the licensed drugstore and any school buildings as distinguished from school grounds. The licenses on Fairfax Avenue are all farther away from the school than plaintiffs' premises.

Plaintiffs contend that the action of the board in denying them a license is arbitrary and unreasonable and they particularly ***775** point to the other licenses now outstanding on premises as near as or not much farther from the school.

The board has the power "in its discretion, to deny ... any specific liquor license if it shall determine for good cause that the granting ... of such license would be contrary to public welfare or morals." (Cal. Const., art. XX, § 22.) (1) In exercising that power it performs a quasi judicial function similar to local administrative agencies. (*Covert v. State Board of Equalization,* 29 Cal.2d 125 [173 P.2d 545]; *Reynolds v. State Board of Equalization,* 29 Cal.2d 137 [173 P.2d 551, 174 P.2d 4]; *Stoumen v. Reilly,* 37 Cal.2d 713 [234 P.2d 969].) (2) Under appropriate circumstances, such as we have here, the same rules apply to the determination of an application for a license as those for the revocation of a license. (*Fascination, Inc. v. Hoover,* 39 Cal.2d 260 [246 P.2d 656]; Alcoholic Beverage Control Act, § 39; Stats. 1935, p. 1123, as amended.) (3) In making its decision "The board's discretion ... however, is not absolute but must be exercised in accordance with the law, and the provision that it may revoke [or deny] a license 'for good cause' necessarily implies that its decisions should be based on sufficient evidence and that it should not act arbitrarily in determining what is contrary to public welfare or morals." (*Stoumen v. Reilly, supra,* 37 Cal.2d 713, 717.)

(4) Applying those rules to this case, it is pertinent to observe that while the board may refuse an on-sale license if the premises are in the immediate vicinity of a school (Alcoholic Beverage Control Act, *supra,* § 13) there is no such provision or regulation by the board as to off-sale licenses. Nevertheless, proximity of the licensed premises to a school may supply an adequate basis for denial of a license as being inimical to public morals and welfare. (See *Altadena Community Church v. State Board of Equalization,* 109 Cal.App.2d 99 [240 P.2d 322]; *State v. City of Racine,* 220 Wis. 490 [264 N.W. 490]; *Ex parte Velasco,* (Tex.Civ.App.) 225 S.W. 2d 921; *Harrison v. People,* 222 Ill. 150 [78 N.E. 52].)

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The question is, therefore, whether the board acted arbitrarily in denying the application for the license on the ground of the proximity of the premises to the school. No question is raised as to the personal qualifications of the applicants. (5) We cannot say, however, that it was unreasonable for the board to decide that public welfare and morals would be jeopardized by the granting of an off-sale license at premises ***776** within 80 feet of some of the buildings on a school ground. As has been seen, a liquor license may be refused when the premises, where it is to be used, are in the vicinity of a school. While there may not be as much probability that an off-sale license in such a place would be as detrimental as an on-sale license, yet we believe a reasonable person could conclude that the sale of any liquor on such premises would adversely affect the public welfare and morals.

(6) Plaintiffs argue, however, that assuming the foregoing is true, the action of the board was arbitrary because there are other liquor licensees operating in the vicinity of the school. All of them, except the drugstore at the northeast corner of Fairfax and Melrose, are at such a distance from the school that we cannot say the board acted arbitrarily. It should be noted also that as to the drugstore, while it is within 80 feet of a corner of the school grounds, it does not appear whether there were any buildings near that corner, and as to all of the licensees, it does not appear when those licenses were granted with reference to the establishment of the school.

Aside from these factors, plaintiffs' argument comes down to the contention that because the board may have erroneously granted licenses to be used near the school in the past it must continue its error and grant plaintiffs' application. That problem has been discussed: “Not only does due process permit omission of reasoned administrative opinions but it probably also permits substantial deviation from the principle of stare decisis. Like courts, agencies may overrule prior decisions or practices and may initiate new policy or law through adjudication. Perhaps the best authority for this observation is *FCC v. WOKO* [329 U.S. 223 (67 S.Ct. 213, 91 L.Ed. 204).] The Commission denied renewal of a broadcasting license because of misrepresentations made by the licensee concerning ownership of its capital stock. Before the reviewing courts one of the principal arguments was that comparable deceptions by other licensees had not been dealt with so severely. A unanimous Supreme Court easily rejected this argument: 'The mild measures to others and the apparently unannounced change of policy are considerations appropriate for the Commission in determining whether its action in this case is too drastic, but we cannot say that the Commission is bound by anything that appears before us to deal with all cases at all times as it has dealt with some that seem comparable.' ***777** In rejecting a similar argument that the SEC without warning had changed its policy so as to treat the complainant differently from others in similar circumstances, Judge Wyzanski said: 'Flexibility was not the least of the objectives sought by Congress in selecting administrative rather than judicial determination of the problems of security regulation. ... The administrator is expected to treat experience not as a jailer but as a teacher.' Chief Justice Vinson, speaking for a Court of Appeals, once declared: 'In the instant case, it seems to us there has been a departure from the policy of the Commission expressed in the decided cases, but this is not a controlling factor upon the Commission.' Other similar authority is rather abundant. Possibly the outstanding decision the other way, unless the dissenting opinion in the second Chenery case is regarded as authority, is *NLRB v. Mall Tool Co.* [119 F.2d 700.] The Board in ordering back pay for employees wrongfully discharged had in the court's opinion departed from its usual rule of ordering back pay only from time of filing charges, when filing of charges is unreasonably delayed and no mitigating circumstances are shown. The Court, assuming unto itself the Board's power to find facts, said: 'We find in the record no mitigating circumstances justifying the delay.' Then it modified the order on the ground that 'Consistency in administrative rulings is essential, for to adopt different standards for similar situations is to act arbitrarily.' From the standpoint of an ideal system, one can hardly disagree with the court's remark. But from the standpoint of a workable system, perhaps the courts should not impose upon the agencies standards of consistency of action which the courts themselves customarily violate. Probably deliberate change in or deviation from established administrative policy should be permitted so long as the action is not arbitrary or unreasonable. This is the view of most courts.” (Davis, Administrative Law, § 168; see also Parker, Administrative Law, pp. 250-253; 73 C.J.S., Public Administrative Bodies and Procedure, § 148; *California Emp. Com. v. Black-Foxe M. Inst.,* 43 Cal.App.2d Supp. 868 [110 P.2d 729].) Here the board was not acting arbitrarily if it did change its position because it may have concluded that another license would be too many in the vicinity of the school.

(7) The contention is also advanced that the neighborhood is predominantly Jewish and plaintiffs intend to sell wine to customers of the Jewish faith for sacramental purposes. We fail to see how that has any bearing on the issue. The wine

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*778 to be sold is an intoxicating beverage, the sale of which requires a license under the law. Furthermore, it cannot be said that wine for this purpose could not be conveniently obtained elsewhere.

The judgment is affirmed.

Gibson, C. J., Shenk, J., Edmonds, J., Traynor, J., Schauer, J., and Spence, J., concurred.
Appellants' petition for a rehearing was denied May 21, 1953.

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Date of Hearing: April 25, 2023
Counsel: Cheryl Anderson

ASSEMBLY COMMITTEE ON PUBLIC SAFETY
Reginald Byron Jones-Sawyer, Sr., Chair

AB 1402 (Megan Dahle) – As Amended March 30, 2023

SUMMARY: Prohibits costs for the medical evidentiary portion of a child abuse or neglect examination from being charged directly or indirectly to the victim. Specifically, **this bill**:

1) Requires the costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect to be separate from diagnostic treatment and procedure costs associated with medical treatment.

2) Prohibits costs for the medical evidentiary portion of the examination from being charged directly or indirectly to the victim of child physical abuse or neglect.

3) Provides that each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Team (SART), Sexual Assault Forensic Exam (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services (OES) for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify OES of this designation.

4) States that the costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature.

5) Requires each county's designated SART, SAFE, or other qualified medical evidentiary examiners to submit invoices to OES, who shall administer the program. A flat reimbursement rate shall be established.

6) Specifies that within one year upon initial appropriation, OES shall establish a 60-day reimbursement process. OES shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years.

7) Prohibits reduced reimbursement rates based on patient history or other reasons.

8) Allows victims of child physical abuse or neglect to receive a medical evidentiary exam outside of the jurisdiction where the crime occurred and requires that county's approved SART, SAFE teams, or qualified medical evidentiary examiners to be reimbursed for the performance of these exams.

EXISTING LAW:

1) Requires OES to, in cooperation with the State Department of Social Services, the Department of Justice, the California Association of Crime Lab Directors, the California

District Attorneys Association, the California State Sheriffs' Association, the California Peace Officers Association, the California Medical Association, the California Police Chiefs' Association, child advocates, the California Medical Training Center, child protective services, and other appropriate experts, to establish medical forensic forms, instructions, and examination protocols for victims of child physical abuse or neglect using as a model the form and guidelines developed for sexual assault medical evidentiary examinations. (Pen. Code, § 11171, subd. (b).)

2) Specifies that the forms shall include, but not be limited to, a place for notation concerning each of the following:

   a) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures;

   b) Addressing relevant consent issues, if indicated;

   c) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history;

   d) The performance of a physical examination for evidence of child physical abuse or neglect;

   e) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures;

   f) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated;

   g) Procedures for the preservation and disposition of evidence;

   h) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays; and,

   i) An assessment as to whether there are findings that indicate physical abuse or neglect. (Pen. Code, § 11171, subd. (c).)

3) Provides that the forms shall become part of the patient's medical record pursuant to guidelines established by the advisory committee of OES and subject to the confidentiality laws pertaining to the release of medical forensic examination records. (Pen. Code, § 11171, subd. (d).)

4) Requires that the forms be made accessible for use on the Internet. (Pen. Code, § 11171, subd. (e).)

5) Makes sexual assault forensic medical examinations reimbursable. (Pen. Code, § 13823.95.)

6) Makes domestic violence forensic medical examinations reimbursable. (Pen. Code, § 11161.2.)

FISCAL EFFECT: Unknown

COMMENTS:

1) **Author's Statement**: According to the author, "AB 1402 continues the important work accomplished in AB 925 (M. Dahle) which authorized the appropriate local law enforcement agency to seek reimbursement from the Office of Emergency Services (OES), using the specified federal funds for the cost of conducting the medical evidentiary examination of a sexual assault victim. AB 1402 would simply allow child abuse exams to also be eligible for reimbursement."

2) **Need for this Bill:** According to information provided by the author's office, "Despite providing reimbursement for the medical forensic examination of domestic violence, adult and pediatric sexual assault, existing law does not provide reimbursement for the medical forensic examination of suspected child physical abuse or neglect. This makes it difficult for clinics and providers to offer this service, especially in rural districts where access is scarce. For example, there is one primary provider of these exams located in Shasta County who covers the territory of seven large counties in the First Assembly District. Victims seeking these exams are forced to travel up to three hours for an exam."

3) **Reimbursement for the Cost of Sexual Assault and Domestic Violence Medical Evidentiary Exams:** The Violence against Women Act (VAWA) affords sexual assault victims the right to obtain a medical evidentiary examination after a sexual assault. The victim may not be charged for the exam. The costs are charged to the local law enforcement agency. Law enforcement can seek reimbursement for cases where the victim is undecided whether to report to the assault to law enforcement. The OES uses discretionary funds from various federal grants to offset the costs of the examination. OES makes a determination on how much the reimbursement shall be under these circumstances and can reassess the reimbursement every 5 years. Law enforcement can also seek reimbursement to offset the costs of conducting an examination when the victim has decided to report the assault to law enforcement. OES makes a determination on how much the reimbursement shall be under these circumstances. OES is to provide reimbursement from funds to be made available upon appropriation for this purpose. (Pen. Code, § 13823.95).

   In AB 2185 (Weber), Chapter 557, Statutes of 2022, the Legislature provided domestic violence victims access to medical evidentiary exams, free of charge, by SART, SAFE teams, or other qualified medical evidentiary examiners. Each county's board of supervisors is required to authorize a designee to approve the SART, SAFE teams, or other qualified medical evidentiary examiners to receive reimbursement through OES for the performance of medical evidentiary examinations for victims of domestic violence. Costs incurred for the medical evidentiary portion of the examination cannot be charged directly or indirectly to the victim. The costs associated with these medical evidentiary exams are to be funded by the state, subject to appropriation by the Legislature, and require the OES to establish a 60-day reimbursement process within one year upon initial appropriation. (Pen. Code, § 11161.2.)

This bill mirrors the process set forth by AB 2185, to provide free medical evidentiary examinations for a victim of child physical abuse or neglect.

4) **Argument in Support**: None on file.

5) **Argument in Opposition**: None on file.

6) **Prior Legislation**:

a) AB 2185 (Weber), Chapter 557, Statutes of 2022, provided domestic violence victims access to medical evidentiary exams, free of charge, by SART, SAFE teams, or other qualified medical evidentiary examiners.

b) AB 145 (Committee on Budget), Chapter 80, Statutes of 2021, authorized reimbursements from OES for the costs of conducting medical evidentiary examinations of sexual assault survivors regardless of whether they have decided to report the assault to law enforcement.

c) AB 925 (Dahle), of the 2021-2022 Legislative Session, would have authorized a law enforcement agency to seek reimbursement from OES, to offset the costs of a medical evidentiary exam of a sexual assault victim who at the time of the examination has decided not to report to law enforcement, and reimburses the law enforcement agency at the same established rate for victims who have decided to report an assault at the time of the examination. AB 925 was not heard in the Senate Appropriations Committee.

d) AB 334 (Cooper), of the 2017-2018 Legislative Session, would have made a number of changes to existing law regarding sexual assault forensic medical examinations, including the reimbursement rate for exams of survivors who do not aid or otherwise participate with law enforcement. AB 334 was not heard in the Senate Public Safety Committee at the request of the author.

e) SB 580 (Figueroa), Chapter 249, Statutes of 2003, required the Office of Criminal Justice Planning (OCJP) to develop a standard form for health practitioners to report any physical injury resulting from suspected abusive conduct, and another standard form for the forensic examination of victims of child abuse or neglect.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file

Opposition

None on file

Analysis Prepared by: Cheryl Anderson / PUB. S. / (916) 319-3744

CALIFORNIA MEDICAL PROTOCOL FOR EXAMINATION OF CHILD PHYSICAL ABUSE AND NEGLECT VICTIMS



State of California
Governor's Office of
Emergency Services
www.caloes.ca.gov

PREFACE

Pioneers in the field of child physical abuse and neglect began in the field of medicine. They were subsequently joined by the disciplines of social work, nursing, law enforcement, psychology, psychiatry, and child development.

The history of this intervention movement is characterized by peaks and plateaus as the larger community assimilated new developments lead by the pioneering disciplines. Medicine began the movement with published observations by a pediatric radiologist, Dr. John Caffey, in the 1940's. Dr. Henry Kempe, a pediatrician, galvanized the movement by establishing the concept of the "battered child syndrome" in 1962. He took his concerns to Congress and by 1965, most states had enacted child abuse reporting laws.

Issuance of the CalOES 2-900 Medical Report for Suspected Child Physical Abuse and Neglect Examinations and Protocol takes the field to a new level. In 2002, the California Legislature and Governor declared that adequate protection of victims of child physical abuse and neglect has been hampered by the lack of consistent and comprehensive medical examinations. The Legislature enacted and the Governor signed SB 580, Statutes of 2002 (Figueroa), into law to address this need by establishing a standardized medical report form and protocol.

Many deserve recognition for the vision captured in these documents. The Children's Justice Act Task Force recommended the allocation of funds to accomplish this project; the Child Physical Abuse and Neglect Advisory Committee contributed wisdom, consultation, and guidance; and, the California Clinical Forensic Medical Training Center is commended for strong work, expertise, and dedication to the production of the form, instructions, and protocol. This collective effort moves the field forward on behalf of children.

The California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect Victims provides recommended methods for meeting the minimum legal standards established by Penal Code Section 11171 for performing medical examinations of physically abused and neglected children. This protocol contains the following information:

- Standard medical report form (CalOES 2-900) for documentation of findings from suspected child physical abuse and neglect examinations;
- Step-by-step procedures for conducting examinations opposite each page of the standard forms;
- Examination protocol for child physical abuse and neglect;
- Contextual information for performing examinations and implementing a multi-disciplinary team approach; and
- Relevant and expanded information on patient consent, mandatory reporting laws, financial compensation for examinations, crime victim compensation, and evidence collection and preservation.

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CHAPTER I

USE OF STANDARDIZED FORMS AND TRAINING

In 2002, the California Legislature enacted and the Governor signed SB 580 Statutes of 2002 (Figueroa) into law to amend the penal code pertaining to the performance of medical examinations for physically abused and neglected children. See **Appendix A** for a copy of this penal code section. The Legislature declared that:

- Adequate protection of victims of child physical abuse and neglect has been hampered by the lack of consistent and comprehensive medical examinations; and

- Enhancing examination procedures, documentation, and evidence collection relating to child abuse and neglect will improve the investigation of child abuse and neglect as well as other child protection efforts.

A. CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATIONS

As a result, the Governor's Office of Emergency Services issued effective January 1, 2004 the CalOES 2-900 Medical Report: Suspected Child Physical Abuse and Neglect Examination for recording the results of medical examinations.

CalOES 2-900	**Medical Report: Suspected Child Physical Abuse and Neglect Examination** • Suspected child physical abuse and neglect • Examination of children and adolescents under age 18

B. CHILD SEXUAL ABUSE EXAMINATIONS

In 1984, the California Legislature enacted legislation to establish standardized procedures for the performance of child sexual abuse and sexual assault medical evidentiary examinations. California Penal Code Section 13823.5 requires the use of these standard forms for examinations of victims of child sexual abuse and adult and adolescent sexual assault.

Required Standard State Forms for Child Sexual Abuse and Sexual Assault Exams

CalOES 923	**Forensic Medical Report: Acute (<72 hours) Adult/Adolescent Sexual Assault Examination**
CalOES 925	**Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination**
CalOES 930	**Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination**

Recommended Standard State Form

CalOES 950	**Forensic Medical Report: Sexual Assault Suspect Examination**

Key terms for Sexual Assault and Child Sexual Abuse Examinations
These terms are used to describe time frames. They are not intended to suggest that, after 72 hours, a complete examination should not be done. It is not uncommon to detect physical findings after 72 hours.

Acute	**Less than 72 hours have passed since the incident (<72 hours)**
Nonacute	**More than 72 hours have passed since the incident (>72 hours)**

C. SUGGESTED USE OF THE STANDARD STATE FORMS: FOLLOW LOCAL POLICY

CalOES 923	**Forensic Medical Report: Acute (<72 hours) Adult/Adolescent Sexual Assault Examination** • History of **acute sexual assault** (<72 hours) • Examination of adults (age 18 and over) and adolescents (ages 12-17)
CalOES 925	**Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination** • History of **nonacute sexual abuse** (>72 hours) • Examination of children and adolescents under age 18
CalOES 930	**Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination** • History of **chronic sexual abuse (incest) and recent incident** (<72 hours) • Examination of children and adolescents under age 18
CalOES 950	**Forensic Medical Report: Sexual Assault Suspect Examination** • Examination of person(s) suspected of sexual assault or child sexual abuse

D. TRAINING

The California Clinical Forensic Medical Training Center (CCFMTC) was established by Penal Code Section 13823.93 and is grant funded to provide training for physicians and nurses on how to perform medical evidentiary examinations for victims of:

- Child physical abuse and neglect;
- Child sexual abuse;
- Sexual assault;
- Domestic violence; and
- Elder and dependent adult abuse and neglect.

Training is also provided to criminal justice and investigative social services personnel on the interpretation of medical findings for use in case investigations, prosecution, and for others involved in the evaluation of medical evidence. See **Appendix B** for information on how to contact the California Clinical Forensic Medical Training Center.

The California Clinical Forensic Medical Training Center developed the CalOES 2-900 form, instructions and examination protocol under an additional grant from the Governor's Office of Criminal Justice Planning (now the California Office of Emergency Services).

CHAPTER II

MANDATORY REPORTING AND CONFIDENTIALITY OF REPORTS

A. MANDATORY REPORTING

The Child Abuse and Neglect Reporting Act is contained in Penal Code Section 11164-11174.4. The intent and purpose of the mandatory reporting law is to protect children from abuse and neglect. As used in this section, a child means a person under the age of 18.

1. Health practitioners are mandated reporters

There are 35 categories of professionals, paraprofessionals and employees of institutions, organizations, and commercial film and photographic print processing companies required to report suspected child abuse and neglect pursuant to Penal Code Section 11165.7. See **Appendix C** for a list of these categories.

Health practitioners are required to report known or suspected child abuse and neglect **immediately by telephone and to submit a written report within 36 hours** to a child protective agency.

- A health practitioner means a physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code (Penal Code Section 11165.7).

- Related categories include emergency medical technicians I or II, paramedics, or other persons certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a coroner, and a medical examiner.

- A child protective agency means a law enforcement agency, the county department of social services, or the county probation department.

- The obligation of mandated reporters to make a report to a child protective agency arises when they, in their professional capacity or within the scope of their employment, have knowledge of or observe a child who they know or reasonably suspect has been the victim of child abuse (Penal Code Section 11166).

- The term “reasonable suspicion” means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate, on his or her training and

experience, to suspect child abuse and neglect. For the purpose of this article, the pregnancy of a minor does not, in and of itself, constitute a reason for a reasonable suspicion of child sexual abuse (Penal Code Section 11166).

- For purposes of this article, a positive toxicology screen at the time of the delivery of an infant is not in and of itself, a sufficient basis for reporting child abuse and neglect. However, any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child pursuant to Section 123605 of the Health and Safety Code. If other factors are present that indicate risk to a child, then a report shall be made. However, a report based on risk to a child which relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse shall be made only to a county welfare or probation department, and not to a law enforcement agency (Penal Code Section 11165.3).

- No supervisor or administrator may impede or inhibit these reporting duties and no person making such a report shall be subject to any sanction for making the report (Penal Code Section 11166).

2. Criminal penalties for failure to report child abuse or neglect

The failure of a mandated reporter to report known or suspected child abuse or neglect is punishable by a fine not to exceed $1,000, by imprisonment in the county jail for a period not to exceed six months, or both (Penal Code Section 11166).

3. Telephone and written report requirements (Penal Code Sections 11165-11168)

- Make an immediate telephone report to a child protective agency and include the following information:
  - Name of the person making the report;
  - Name of the child;
  - Present location of the child;
  - Nature and extent of the injury; and
  - Other information requested by the child protective agency.

- Submit a written report to a child protective agency within 36 hours, using the Suspected Child Abuse Report Form (DOJ SS 8572). See **Appendix D** for a copy of this form. See **Appendix E** for a list of Child Protective Services (CPS) agencies for every county in California to obtain information and training on the use of the form.

- When two or more persons, who are required to report, jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the telephone report may be made by a member of the

team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report (Penal Code Section 11166).

4. Immunity from civil or criminal liability for complying with the child abuse reporting law

- Health practitioners and others required to report known or suspected child abuse cannot be held civilly or criminally liable for any report required or authorized by the child abuse reporting law (Penal Code Section 11172).

- Physicians and hospitals may be held liable for injuries sustained by a child for failure to diagnose and report child abuse to authorities resulting in the child being returned to the parents and receiving further injuries by them (Landeros v. Flood, (1926) 131 CAL. RPTER 69, 551 P.2d 389, 17 C.3d 399, 97 A.L.R. 3d 324).

5. Definitions of unfounded, substantiated, and inconclusive reports used by child protective agencies (Penal Code Section 11165.12)

Unfounded Report
Unfounded report means a report that is determined by the investigator who conducted the investigation to be false, to be inherently improbable, to involve an accidental injury, or not to constitute child abuse or neglect, as defined in Penal Code Section 11165.6.

Substantiated Report
Substantiated report means a report that is determined by the investigator who conducted the investigation, based upon some credible evidence, to constitute child abuse or neglect, as defined in Penal Code Section 11165.6.

Inconclusive Report
Inconclusive report means a report that is determined by the investigator who conducted the investigation not to be unfounded, but one in which the findings are inconclusive and there is insufficient evidence to determine whether child abuse or neglect, as defined in Section 11165.6, has occurred.

B. CONFIDENTIALITY OF REPORTS

1. Confidentiality of suspected child abuse and neglect report forms
Written reports required by the child abuse reporting law are confidential and can only be released to agencies receiving or investigating mandated reports (law enforcement or child protective services); to the district attorney involved in a

criminal prosecution; counsel appointed pursuant to subdivision (c) of Section 317 of the Welfare and Institutions Code; county counsel; a county or state licensing agency when abuse or neglect in out-of-home care is reasonably suspected; coroners; medical examiners; and multi-disciplinary personnel teams as defined in Section 18951 of the Welfare and Institutions Code; Hospital SCAN Teams; and other specified institutional entities (Penal Code Section 11167.5). Any violation of confidentiality is punishable by up to six months in jail, by a fine of $500, or both (Penal Code Section 11167.5).

- **Multi-disciplinary Team**
  Multi-disciplinary personnel, defined in Welfare and Institutions Code Section 18951, means any team of three or more persons who are trained in the prevention, identification, and treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child abuse.

  The team may include, but not be limited to:
  - Psychiatrists, psychologists, or other trained counseling personnel;
  - Police officers or other law enforcement agents;
  - Medical personnel with sufficient training to provide health services;
  - Social workers with experience or training in child abuse prevention; and
  - Any public or private school teacher, administrative officer, supervisor of child welfare attendance, or certified pupil personnel employee.

- **Hospital SCAN Team**
  A hospital SCAN (Suspected Child Abuse and Neglect) team means a team of three or more persons established by a hospital, or two or more hospitals in the same county, consisting of health care professionals and representatives of law enforcement and child protective services, the members of which are engaged in the identification of child abuse or neglect. The disclosure authorized by this section includes disclosure among all hospital SCAN teams (Penal Code Section 11167.5).

2. **Release of medical reports of suspected child abuse and neglect**
   Medical report(s) are subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Penal Code 11164-11174.4 or privilege), the Medical Information Act (Civil Code Section 58 et seq.), the Physician-Patient Privilege (Evidence Code Section 990), and the Official Information Privilege (Evidence Code Section 1040). They can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services social worker, a child abuse and neglect multi-disciplinary team member, county licensing agency, and coroner. Medical reports can only be released to the defense counsel through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

CHAPTER III

CONSENT ISSUES

A. CHILDREN/MINORS

1. Suspected child abuse: non-consenting parents

Parental consent is not required to examine, treat, or collect evidence for suspected child abuse. In the absence of parental consent or in the case of parental refusal, children must be taken into protective custody by a child protective agency (e.g., law enforcement agency or child protection services) to perform the examination. Follow local policy regarding placement of children in protective custody.

2. Photographs of injuries

Penal Code Section 11171.2

A physician, surgeon, or dentist or their agents and by their direction may take skeletal x-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of the child abuse or neglect.

Penal Code Section 11171.5

If a peace officer, in the course of an investigation of child abuse or neglect, has reasonable cause to believe that the child has been the victim of physical abuse, the officer may apply to a magistrate for an order directing that the victim be x-rayed without parental consent. Any x-ray taken pursuant to this subdivision shall be administered by a physician, surgeon, or dentist or their agents.

With respect to the cost of an x-ray taken by the county coroner or at the request of the county coroner in suspected child abuse or neglect cases, the county may charge the parent or legal guardian of the child-victim the costs incurred by the county for the x-ray.

No person who administers an x-ray pursuant to this section shall be entitled to reimbursement from the county for an administrative cost that exceeds 5 percent of the cost of the x-ray.

B. MINORS DEFINED BY STATUTE AS 12 YEARS OF AGE OR OLDER

1. Consent to medical treatment

- Minors may give consent to the provision of medical care related to the diagnosis or treatment of a sexual assault and the collection of evidence (Family Code Sections 6927 and 6928).
- Minors may give consent to the provision of medical care related to the prevention or treatment of pregnancy (Family Code Section 6925).
- Minors may give consent to the provision of medical care related to the diagnosis or treatment of sexually transmitted diseases (Family Code Section 6926).
- Consent given by a minor is not subject to disaffirmance because of minority (Family Code Section 6921).

2. Consent to mental health treatment, residential shelter services, or drug and alcohol counseling services

- Minors may consent to mental health treatment, counseling on an out-patient basis or residential shelter services if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services; the minor would present danger of serious physical or mental health harm to self or to others without the mental health treatment or counseling or residential treatment services; or, is the alleged victim of incest or child abuse (Family Code Section 6924).
- Minors may consent to medical care and counseling related to the diagnosis and treatment of a drug or alcohol related problem (Family Code Section 6929).

CHAPTER IV

REIMBURSEMENT FOR EXAMINATIONS

A. CHILD PHYSICAL ABUSE AND NEGLECT MEDICAL EXAMINATION REIMBURSEMENTS

In the majority of counties in California, charges for child physical abuse and neglect examinations are billed to Medi-Cal or to the patient's private insurance. Standard diagnostic and procedural coding manuals are used to generate charges. For patients without insurance, or who are underinsured, reimbursement of charges may be obtained through California Victim Compensation and Government Claims Board. See Chapter V Crime Victim Compensation and Victim Assistance Programs.

Some counties have contracts with private hospitals for various medical services (e.g., indigent care) and include a provision for payment of these examinations if there is no public or private insurance reimbursement. Follow local policy.

A direction for the future to support the development of local medical experts in the evaluation of child physical abuse and neglect examinations is to develop a fee structure for rendering an expert opinion.

B. CHILD SEXUAL ABUSE AND SEXUAL ASSAULT MEDICAL EVIDENTIARY EXAMINATION REIMBURSEMENTS (PENAL CODE SECTION 13823.95)

No costs incurred by a qualified health care professional, hospital, or other emergency medical facility for the examination of a victim of a sexual assault or child sexual abuse, as described in the protocol developed pursuant to Penal Code Section 13823.5, when the examination is performed, pursuant to Sections 13823.5 and 13823.7, for the purposes of gathering evidence for possible prosecution, shall be charged directly or indirectly to the victim of the assault. These costs shall be treated as local costs and charged to the local governmental agency in whose jurisdiction the alleged offense was committed.

Charges for the forensic medical examination, not medical treatment, shall be submitted to the law enforcement agency requesting the examination. See California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims published by the Governor's Office of Emergency Services (www.CalOES.ca.gov).

CHAPTER V

CRIME VICTIM COMPENSATION AND VICTIM ASSISTANCE PROGRAMS

A. VICTIM COMPENSATION PROGRAM (VCP)

The Victim Compensation Program (VCP) can help victims of violent crime and their families deal with the emotional, physical, and financial aftermath of crime. Victims can apply for compensation by filing an application with the California Victim Compensation and Government Claims Board, which administers VCP.

1. Eligibility

- A California resident or out-of-state resident injured in California who suffers physical injury and/or threat of physical injury, or death. Victims of sexual assault and child sexual abuse are presumed to have suffered physical injury;
- A person who is physically injured or threatened with physical injury as a result of a crime or act of terrorism that occurred in the State of California;
- A California resident or member of the military stationed in California who is a victim of a qualifying crime, wherever it occurs;
- An eligible family member or other specified persons who were legally dependent on the victim;
- A parent, sibling, spouse, or child of the victim;
- The fiancé(e) of the victim at the time of the crime or another family member of the victim who witnessed the crime;
- A grandparent or grandchild of the victim at the time of the crime, or a person living with the victim at the time of the crime, or who had previously lived with the victim for at least two years in a relationship similar to a parent, grandparent, spouse, sibling, child, or grandchild of the victim;
- A minor who witnesses a crime of domestic violence or who resides in a home where domestic violence occurs;
- Anyone who pays or assumes legal liability for a deceased victim's medical, funeral, or burial expenses, or anyone who pays for the costs of crime scene clean-up for a homicide that occurred in a residence; and
- A person who is the primary caretaker of a minor victim when treatment is rendered.

2. Expenses that are eligible for reimbursement

- Medical and medical-related expenses for the victim, including dental expenses;
- Outpatient mental health treatment or counseling;
- Inpatient psychiatric hospitalization costs under dire or exceptional circumstances;
- Funeral and burial expenses;

- Wage or income loss;
- Loss of financial support for legal dependents of a deceased or injured victim;
- Job retraining expenses;
- Relocation expenses up to $1000 per household;
- Home security installation or improvements up to $1000, if the crime occurred in the victim's home;
- Crime scene clean-up to $1000, if the victim dies as a result of a crime in the residence; and
- Medically necessary renovation or retrofitting of a home or vehicle for a person permanently disabled as a result of the crime.

3. Reimbursable expenses

For crimes that occurred prior to January 1, 2001, the maximum amount that can be reimbursed is $46,000. For crimes that occurred after January 1, 2001, the maximum amount that can be reimbursed is $70,000. Expenses for psychological counseling are also reimbursable, but are generally limited to 40 sessions. Additional sessions may be authorized upon request.

4. Examples of eligible victims

- Child physical abuse victims
- Child sexual abuse victims
- Child endangerment or abandonment
- Domestic violence victims (e.g. spouses, cohabitants) including children in domestic violence households
- Stalking
- Elder and dependent adult abuse victims
- Sexual assault victims
- Survivors of homicide victims
- Assault and battery victims
- Robbery victims
- Hit and run victims
- Victims of acts of terrorism
- Victims of drivers under the influence of drugs and/or alcohol

5. Definition of a victim, injury, and derivative victims

- A victim is defined as a person who suffers injury or death as a direct result of a crime.

- An injury means either a physical injury or an emotional injury if the victim also suffered physical injury or threat of physical injury. Specified victims, including child victims of neglect and of most sex crimes, are presumed to have sustained physical injury.

- A derivative victim is defined as a person who has any of the following characteristics:

- At the time of the crime was the parent, grandparent, sibling, spouse, or child/grandchild of the victim;
- At the time of the crime was living in the household of the victim;
- A person who has previously lived in the household of the victim for a period of not less than two years in a relationship substantially similar to that of a parent, sibling, spouse, or child of the victim; or,
- A family member of the victim, including the victim's fiancé, and who witnessed the crime.

6. Requirements

- The crime must be reported to a law enforcement agency or to Child or Adult Protective Services. In some domestic violence cases, a restraining order may suffice.

- The victim must cooperate with law enforcement in the investigation and prosecution of any known suspect(s). If the victim is a child who has been confirmed as abused, the child may qualify with or without the child's legal guardian's cooperation with the authorities, or the identification or prosecution of any known suspects.

- The victim must not have knowingly and willingly participated in the commission of the crime or engaged in conduct that causes or leads to the crime. This provision does not apply to children.

- Victims (18 years or older at the time of the crime) must file an application with the State Victim Compensation Program within one year from the date of the crime. Victims (under 18 years of age at the time of the crime) must file the application before their 19th birthday. Late claims may be accepted if "good cause" is provided.

- Eligibility for program benefits will be limited if the victim/claimant was convicted of a felony committed on or after January 1, 1989, and has not been discharged from probation, parole, or released form a correctional institution at the time of the incident (Government Code Section 13956 (d)).

7. Responsibilities of hospitals

- **Display posters in the emergency room**
  Licensed hospitals in the state of California must prominently display posters in the Emergency Department notifying crime victims of the availability of victim compensation and the existence and location of the local county victim/witness assistance center (Government Code Section 13962).
- **Provision of crime victim compensation claim forms**
  County hospitals must provide Application for Crime Victim Compensation forms to sexual assault victims (Health and Safety Code Section 1492).

8. Application for compensation

Information on crime victim compensation can be obtained by contacting local county victim/witness assistance centers or the State Victim Compensation Program administered by the Victim Compensation and Government Claims Board (www.boc.ca.gov/victims.htm). Local county victim/witness assistance centers provide assistance to victims in the preparation and submission of these applications for compensation.

Claims can also be submitted directly to the State by completing an application form and mailing it to:

Victim Compensation Program
P.O. Box 3036
Sacramento, CA 95812

The application can be completed online at www.boc.ca.gov/victims.htm. Directions are provided on the website.

Victims may also be assisted by a private attorney in filing claims. California Government Code Section 13957.7(g) provides that the Board shall pay private attorney fees of 10 percent of the approved award up to a maximum of $500, and these fees are not deducted from the applicant's award.

9. Limitations

The Victim Compensation Program (VCP) is the "payer of last resort." Other sources of reimbursement such as health or disability insurance must be used first.

B. VICTIM ASSISTANCE PROGRAMS

County victim/witness assistance centers, child abuse treatment programs, domestic violence shelters, and special crime victim counseling centers exist in California to provide counseling and other forms of assistance to crime victims. Contact the county victim/witness assistance center for information on local resources. See **Appendix F** for a list of victim/witness assistance centers. Or, call the State Victim Compensation Program at 1-800-777-9229 or 1-800-735-2929 for the hearing impaired.

CHAPTER VI

KNOWLEDGE AND SKILLS NEEDED BY MEDICAL PERSONNEL IN THE PERFORMANCE OF EXAMINATIONS

A. KNOWLEDGE

Medical personnel performing medical examinations of physically abused and neglected children should be knowledgeable about:

- Health professionals' responsibilities as "mandated reporters";
- Roles of law enforcement, child protective services, county counsel, deputy district attorneys, crime laboratories, attorneys appointed for court dependent children, and CASA (Court Appointed Special Advocates);
- Importance of scene investigation by law enforcement, particularly in the forensic evaluation of burn injuries;
- Epidemiology and clinical presentations of common accidental injuries in children;
- Pathophysiology of traumatic injury to the cutaneous, skeletal, visceral, central nervous system, and ocular areas of children;
- Injuries to children that are highly specific for physical abuse;
- Medical conditions and accidental injuries that can mimic physical abuse injuries;
- Types of child neglect, clinical presentation, and differential diagnosis;
- Differential diagnosis of failure to thrive;
- Role of radiology in the evaluation of physically abused children;
- Role of laboratory tests in the evaluation of injuries that may represent abuse;
- Role of pediatric subspecialists in the evaluation of children alleged to have been abused; and
- Role of the juvenile or family, and superior court system.

B. SKILLS

Medical personnel must be able to:

- Take a complete history from a parent or guardian about the circumstances of the child's injury, past medical conditions, and birth history;
- Perform a detailed and careful physical examination of an infant, child, or adolescent;
- Document cutaneous injuries clearly in writing and by proper use of photographic equipment;
- Make an assessment of the injury as to the likelihood of abuse based upon the history, physical examination, and laboratory and radiologic evaluation;
- Make an assessment of child neglect;
- Communicate clearly and in lay terms with non-medical personnel about the medical findings;
- Communicate in a non-adversarial manner with parents and/or guardian about the responsibilities of medical professionals to report suspected child abuse; and
- Testify in court as to one's objective findings and assessment of injuries.

CHAPTER VII

EXAMINATION PROTOCOL: CHILD PHYSICAL ABUSE

A. STEP ONE: RECOGNIZE A PATIENT HISTORY THAT DOES NOT MATCH FINDINGS

1. Patient history patterns suggestive of possible child maltreatment

- No explanatory history for significant trauma or trauma in a highly supervised age.
- Inconsistent history given:
  - History fails to explain the nature, severity, or pattern of the injury;
  - History of the logistics or mechanics of the injury do not match the injury;
  - History of minor or common trauma to explain severe or unusual injuries;
  - History describes child actions that are inconsistent with developmental abilities;
  - History blames or suggests a third party; and
  - Injuries are indicative of an object (e.g. belt buckle not included in history).
- History changes with retelling or provider probing.
- History blames the child for injuring himself or herself.
- History blames another child for causing the injury.
- History suggests neglect and/or lack of supervision.

2. Patient history with discrepancies

Care providers falsify histories to protect themselves and others from culpability associated with the true events. When health practitioners point out the inconsistency of the given or absent history, care providers may alter their story in an attempt to satisfy the practitioner. When detailed histories are taken from two historians, or at different times, discrepancies may appear as on-the-spot falsification of events occurs. Discrepancies that cannot be resolved are a strong indication of falsification and the culpability it implies.

B. STEP TWO: RECOGNIZE MEDICAL EVIDENCE OF POSSIBLE PHYSICAL ABUSE

Physical abuse is characterized by inflicting physical injury by slapping, hitting, punching, beating, kicking, throwing, biting, burning, or otherwise physically harming a child. The injury may be the result of a single episode or of repeated episodes. The physical trauma can range in severity from minor bruising, abrasions, lacerations, burns, eye injuries, and fractures to damage to the brain and internal organs (liver, spleen, abdomen, pancreas, and kidneys). Head and internal injuries are the leading causes of child

abuse-related deaths. This form of abuse also includes extreme forms of punishment such as torture or confinement of children in dark closets, boxes, or rooms for days, months, or even years at a time.

1. **Cutaneous patterns suggestive of possible child maltreatment**
   - Bruises or burns shaped like recognizable objects;
   - Repeated but unrecognizable patterned bruises or burns;
   - Bruises in children who are not pulling themselves up, and walking along furniture;
   - Buttock bruises in children wearing diapers;
   - Two or more facial bruises without clear explanation;
   - "High tide mark" burn distribution;
   - Symmetrical lesions;
   - Burns with no evidence of motion effect;
   - Evidence of untreated healing fractures; and
   - New fractures on old.

2. **Skeletal injuries suggestive of possible child maltreatment**
   - Rib fractures in young children, particularly when posterior;
   - Metaphyseal corner fractures;
   - Fractures in infants other than simple skull and clavicle fractures;
   - High energy fractures without serious accidents (e.g., long distance fall, MVA); and
   - Multiple fracture sites without serious accidents (e.g., long distance fall, MVA).

3. **Signs and symptoms of dentofacial trauma**
   - Avulsed teeth;
   - Lip lacerations;
   - Tongue injuries;
   - Frenulum injuries; and
   - Jaw and facial fractures.

4. **Syndromes of possible child maltreatment**
   - **Battered Child Syndrome**
     - Multiple distinct injuries, separated by time or cause; and
     - Inadequate explanation by disease, accident, or typical childhood injury.
   - **Shaken Baby Syndrome also called Abusive Head Trauma**
     - Intra-cranial injury;
     - Absence of verified severe trauma (e.g., MVA, long distance fall);
     - Additional findings of rib fracture, metaphyseal fractures, other injuries; and
     - Retinal hemorrhages.

Syndromes are patterns of associated findings, which suggest an etiology. Two syndromes have become well established in the abuse literature. The **Battered Child**

Syndrome can be defined as the presence of multiple separate injuries with inadequate explanation. The injuries must be distinct enough in age, location and mechanism, so that they were separately caused. Explanation by disease state, adequate history of accidental injury, and typical events of childhood, must be excluded. Once these conditions are met, inflicted injury is the most likely cause. The concept of multiple injuries in time and space is included in discussions of many of the specific abuse entities, and is a basic principle with high predictive value in child abuse. Once the whole story is known, this theme is seen again in the abuser's tendency to use violence on multiple family members, and even family pets. For many abusers, violence or losing control is a habit identified in child abuse cases.

The other major syndrome of child abuse is the **Shaken Baby Syndrome also called Abusive Head Trauma**. Originally described as the co-occurrence of long bone fractures and sub-dural hematoma, it is now known that fractures of the ribs or metaphyses are present about half of the time, and retinal hemorrhages are present about eighty percent of the time. The finding of retinal hemorrhages has been particularly well studied, and almost always signifies child abuse. Due to controversies in understanding the basic mechanism of injury, many authors now simply refer to Abusive Head Trauma. Identifying abusive head trauma rests on another basic principle of child abuse. The presence of intra-cranial traumatic injury, without a history of severe trauma identifies probable abuse. This principle of severe injury with trivial history has been noted in fractures, and is also found in abdominal and other internal injuries.

5. **Disclosure and findings associated with child sexual abuse**
   - Child discloses sexual abuse;
   - Sexually obsessive, aggressive or coercive behavior;
   - Sexually transmitted diseases;
   - Acute anogenital injuries without clear accidental cause; and
   - Absence or interruption of the posterior hymen.

   For further discussion, consult the California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims available at www.CalOES.ca.gov.
6. **Other findings suggestive of possible child maltreatment**
   - Child does not gain weight as expected;
   - Child's development and behavior is disturbed;
   - Child has too many accidents;
   - Illnesses are more severe or prolonged than expected;
   - Illnesses defy diagnosis;
   - Medical treatments are not effective;
   - Illnesses are found to be due to poisoning or occult trauma; and
   - Accidental or non-accidental illicit drug ingestion.

C. STEP THREE: EVALUATE THE CHILD FOR POSSIBLE ABUSE

1. **Obtain history from the patient (separately if possible) and caregivers**
   - **Extensively probe the history of explanatory events**
     - Do not accept absent history;
     - Challenge inadequate histories;
     - Note changes in history and when they occur; and
     - Push for details consistent with the apparent mechanism of injury.
   - **Conduct review of systems**
     - Evaluate medical history suggesting alternate diagnoses;
     - Evaluate medical history of significant concurrent illness; and
     - Obtain information on immunization and developmental status.

2. **Perform comprehensive physical examination**
   - **Record height and weight, and plot against age-based norms. For children under age two, record head circumference and percentile.**
   - **Assess developmental abilities, particularly speech**
   - **Perform multisystem total body exam**
   - **Give special scrutiny to important abuse areas**
     - Scalp;
     - Behind ears, in folds of pinna, and along top edge of pinna;
     - Mouth, labial and lingual frenula, tonsillar pillars, posterior pharynx; and
     - Palms of hands and soles of feet.
   - **Perform genital exam**
     - Traction of labia majora; and
     - Knee chest exam.

3. **Request ancillary studies, if indicated**
   - **Radiology**
     - Skeletal survey on children less than two; and
     - CT scan of the head for abused children with any neurologic signs.
   - **Laboratory**
     - CBC, PT, PTT, bleeding time for abusive bruises; and
     - Urinalysis, amylase and transaminases for occult abdominal injury.
   - **Consultative examinations**
     - Indirect ophthalmoscopy for any suspicion of Shaken Baby Syndrome also known as Abusive Head Trauma.

4. **Obtain a history from the child and caregiver**

   - **Obtain history from the child, if verbal; and separate from the caregiver, if possible.**
     If the child is verbal, the medical practitioner should take the history separate from the caregiver, if possible. The child may be able to tell the practitioner the true history, or may produce significant inconsistencies to protect the caregiver, which should be noted. Other reasons exist to speak with the child. Many children from abusive and neglectful homes are developmentally delayed. Careful listening to the child's speech, and general questioning about their life may lead to diagnoses of developmental delay, depression, or anxiety.

   - **Obtain history from caregiver.**
     When an injured child presents with a responsible care provider, the practitioner must take the opportunity to request an explanation of the injuries. Bruises on young infants, and patterned bruises on older children should not be bypassed without comment or question. In most cases of abuse, diagnosis rests with the lack of adequate explanatory history. Careful, persistent questioning, pursuing areas of apparent inconsistency, may produce a true abuse disclosure, or serve to further demonstrate the inconsistency. On the other hand, failure to accept the initial, inconsistent history, may force the caretaker to reveal details of an unusual accident, which they were too embarrassed, upset, or confused to disclose when questioned. When the practitioner has a strong sense of how the injuries occurred, he or she may choose to reveal this in questioning. Before doing so, it is important to carefully note the caretaker's first response, as abusers may incorporate your suggestions into their defensive falsehoods. Documenting this changing history may become important in identifying child abuse. Similarly, the medical practitioner must take a history that probes for possible exonerating differential diagnoses. It is best that these questions be asked neutrally, and answers examined critically, so as to avoid providing an excuse for the guilty, or missing innocent explanations. The format of a traditional review of systems and family history is excellent in that it is familiar to practitioners, seeks all information pertinent to the care of the child, and reviews a wide range of information, the significance of which may only be grasped later.

5. **Perform a comprehensive medical examination**
   Perform a comprehensive "head-to-toe" medical examination. Certain elements of the examination take on particular importance in the setting of possible child abuse. As the most common target for abusive injury, all surfaces of the skin deserve special scrutiny. The scalp is often difficult to see due to long or dense hair. Contusions, lacerations, scars or even tattoos may be hidden by hair. The external ears are often overlooked. Looking behind the ears may reveal fingernail marks

or other injuries. Small subtle bruises may be found within the folds or along the top of the pinna, which are strong evidence of abusively striking or pulling the ears. Other less commonly seen surfaces of the skin, including the perineum and bottoms of the feet should be viewed, searching for injuries.

- **Areas of injury**
  Special attention should be paid to areas of injury. Providers should carefully look at injuries for pattern or shape, evidence of healing or delayed care seeking, and possible alternate explanation. Red marks should be pressed or stretched to see if they blanche, in order to distinguish vascular markings from bruises. Follow up examination may be required to completely evaluate skin findings. Fresh bruises often become more prominent. Injuries such as bruises and lacerations are expected to heal over a predictable period of time. Following them through healing may help to distinguish trauma from other findings such as nevi, vascular lesions, and “mongolian” spots. All injuries should be measured, described, drawn, and, where possible, photographed with a size standard in the photo. Use a 35mm or a digital camera. Follow local policy. See Chapter X Photography.

- **Head, eyes, and mouth**
  Other structures of the head should be examined more closely than in typical well child checks. Petechiae of the conjunctiva are seen both with direct trauma, and with strangulation or suffocation. Retinal hemorrhages are sometimes seen during direct ophthalmoscopy, and are significant both as signs of abuse, and probable neurologic injury. The mouth requires careful attention. Bruises, lacerations or impressions inside the lips may occur when a child is struck in the face. Tearing of the labial or lingual frenula may occur during blows to the mouth, or forced feeding. Lacerations of the posterior pharynx have also occurred during forced feeding, and may result in serious medical complication. The abdomen and head are the most common sites for severe and fatal injuries to children. The examiner must be certain that the belly is benign, and the child’s neurological status is clear.

- **Musculoskeletal system**
  The musculoskeletal system, as another commonly injured system, also receives greater scrutiny than in typical general physical exams. Observe the child for deformity. See if a limb is favored, or seems painful. The chest and extremities should be palpated, feeling for tenderness, mass, or crepitance. Any signs of possible trauma require examination in greater detail, and radiological assessment.

A skeletal survey is recommended when evaluating possibly abused children below age two. Unfortunately, as suggested previously, child abuse is an event that is likely to be repeated, with children held back from medical attention. Skeletal injuries may be clinically inapparent because they have begun to heal. Many fractures found in child abuse settings are clinically unexpected. Inexperienced facilities may obtain whole body views or “baby grams” when a skeletal survey is requested. This is inadequate. Properly posed and exposed views of the ribs, spine, head, upper extremities, lower extremities, hands and feet are required. Two views of the ankles, knees, shoulders and elbow, will help to detect metaphyseal fractures. When rib fractures are suspected, oblique views may help to detect them.

- **Genitals and anus**
  Putting the child on his or her knees, with the buttocks in the air, chest on the table, and back in a lordotic posture makes this examination much easier. Evaluation of the anus and genitals may require special techniques, which are easily learned by general medical examiners. Separation of the buttocks in this posture gives a clear view of the anus. Lifting and separating the buttocks exposes the female genitalia giving the best view for evaluating the hymen. Female genitalia may also be evaluated with the child on her back with the legs abducted and externally rotated. Grasping and drawing outward on the labia majora will open the vestibule and vaginal orifice for better inspection.

- **Laboratory testing**
  Laboratory testing is ordered based on the practitioner’s assessment of the child. A complete blood count will screen for anemia, which is commonly found in neglected children. The platelet count will also help to rule out causes of easy bleeding. A prothrombin and partial thromboplastin time, and possibly a Von Willebrand’s Panel will complete this screen in children with bruises. If there is suspicion of abdominal trauma, but the patient does not appear to require imaging or surgery, urinalysis, amylase and liver transaminases will increase the likelihood of detecting milder internal injuries. Children who have neurologic injury, and those with rib or metaphyseal fractures, should have a dilated indirect ophthalmoscopy exam. Direct ophthalmoscopy, even with dilation, is inadequate to completely rule out retinal hemorrhages. Any child with signs of abuse, such as facial bruises, and even mild neurologic signs, such as vomiting without diarrhea, irritability or somnolence deserves a CT scan of the head. Milder forms of abusive head injury have been overlooked, and children returned with complications from the delay, in similar situations.

- **Screen for developmental, behavioral, and emotional problems**
  The physical examination of an abused or neglected child must evaluate all body systems. A high percentage of abused and neglected children have been found to have medical problems. A good well child examination serves as the basis for a sound child maltreatment evaluation. Such an examination begins with a developmental assessment. The behavioral, mental, and physical development should be compared against age based norms. A Denver Developmental Screening Test (DDST) or similar developmental inventory will begin to screen for delays in language and motor development. An experienced practitioner will have an experience with similar aged children, and should comment on important departures in the child's behavior. Accurate height, weight, and head circumference must be obtained and plotted on appropriate growth charts. Small children may be further evaluated by having a body mass index, or weight for height checked. Single points in developmentally or growth delayed children are of limited value. When the initial assessment is concerning, follow up evaluation and more in depth assessment will be necessary.

6. **Report suspected child abuse and neglect and refer for consultation**
   Once the medical practitioner has completed the evaluation, the decision must be made if there is reasonable suspicion of child maltreatment. Many practitioners feel that they must prove abuse prior to reporting. This is not true. The legal statute for mandated reporters in the state of California requires a report for a reasonable suspicion of abuse or neglect. If the practitioner has a genuine concern for child maltreatment, and has not eliminated it through their own evaluation, an immediate telephone report must be made to the county children's protective services, or local law enforcement agency, and a written report filed within 36 hours. If a practitioner recognizes one of the medical findings detailed above, and fails to find a reasonable explanation, suspicion is reasonable regardless of the social circumstances and reporting should occur.

   A report is not treated as proof of abuse. The appropriate agencies will investigate the family situation, often finding important information of which the practitioner is not aware. The investigation may request more medical information from the practitioner, or consult a medical child abuse expert. Sometimes cases are unsubstantiated, because the investigation finds other explanatory evidence, or cannot adequately establish that abuse has occurred.

   Practitioners sometimes fail to report cases of child maltreatment. Usually, this is because they have failed to acknowledge the possibility, missed medical signs, or consciously chosen to set aside concerns of abuse. Child abuse experts at tertiary medical centers are usually willing to discuss cases by phone, or take direct referrals to help resolve these difficult cases. It is helpful to consider the legally required telephone and written report as a mandatory consultation.

Whether the practitioner makes a report of a suspicious situation, or refers the patient to a medical expert, addressing the reporting issue is central to providing adequate medical care for these children. Approximately 70% of children dying from abusive injuries have evidence of earlier abuse that could have been detected, possibly saving the child's life. By acknowledging the possibility of abuse, recognizing medical evidence, thoroughly evaluating, and then reporting suspicions, medical practitioners can fulfill their obligation to the state and the children they serve.

This chapter is a condensed version of the article entitled "Abuse, Detection, and Screening" by Stephen Boos, M.D. from the book Child Abuse and Neglect: Guidelines for Identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment and case management of various forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor's Office of Criminal Justice Planning (now the Governor's Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

CHAPTER VIII

EXAMINATION PROTOCOL: CHILD NEGLECT

A. EVALUATION OF CHILD NEGLECT

1. **Obtain a complete medical history in children presenting with any condition suspected of being the result of neglect**
   - Obtain the birth history and weight at birth.
   - Ask whether the mother received prenatal care.
   - What immunizations has the child had?
   - Has the child received the appropriate health care over his/her lifetime?
   - Does the child have a primary care provider?
   - What is the baby's diet? Does the family have sufficient resources to meet everyone's nutritional needs? Do they receive food stamps? How often does the family skip a meal because of inadequate resources?
   - Obtain a history of developmental milestones.
   - Obtain information about schooling and school attendance. How often have children missed school during the previous six months? What school do they attend and what is their school performance?
   - Where does the family live? Who else lives in the household?
   - Obtain a social history, including economic resources, educational level of parents, substance abuse and incarceration. Who cares for the child when the parents are not available? Is extended family available?

2. **Perform a complete physical examination**
   - Weigh and measure the child, and plot measurements for gender and age on appropriate growth curves. When possible, review all prior growth parameters to determine whether growth impairment, if present, has been chronic or is of recent onset.
   - Assess nutrition and hygiene. Evidence of substandard nutrition can be noted on physical examination in the form of diminished subcutaneous tissue.
   - Assess bruises, scars, untreated injuries. Neglected children are at increased risk of physical abuse and for accidental injuries because of a general lack of supervision.
   - Screen for sexual abuse. Neglected and homeless children are at risk for sexual victimization.
   - Assess hygiene and absence of appropriate clothing (e.g. , cleanliness, smelling of urine or stool, or lack of shoes and clothing).

- Assess healthcare history.
  - Has there been lack of care for accidental injuries?
  - If there is a chronic medical condition, has there been treatment?
  - What are physical findings relevant to the condition?
- Review immunizations to ascertain whether the child is up to date. Depending upon the circumstances of the case, records may need to be obtained from schools, other hospitals and clinics, the local CHDP (Child Health, Disability, and Prevention Program), or the CWS/CMS system (a computerized database for managing information about children in the California child welfare system).
- Note clingy, aggressive, or overly-compliant behavior when experiencing painful procedures.

3. **Screen for dental problems**
   Unattended dental cavities are frequently present in neglected children. Signs and symptoms of dental neglect include untreated, rampant cavities; untreated pain, infection, bleeding, or trauma; and/or lack of continuity of care once informed that the above conditions exist.

4. **Screen for developmental problems (e.g., motor skills, speech and language delay)**
   This screening should include the following areas: developmental milestones and history, sensorymotor abilities, speech and language acquisition, fine and gross motor skills, socio-emotional functioning, and adapative skills (e.g., eating patterns, sleeping, etc.).

5. **Order laboratory testing, if indicated**
   Laboratory tests should be ordered to diagnose and evaluate untreated and/or chronic medical conditions and to ascertain whether there are conditions which may be mistaken for neglect. In general, a hemoglobin is an appropriate study to obtain to determine if the child is anemic. Obtaining lead levels for children under six years of age is recommended.

6. **Order imaging studies, if indicated**
   Skeletal trauma series are indicated in children under the age of two years who have signs of severe neglect. The purpose of these studies is to detect the presence of occult fractures.

   Additional imaging studies are rarely needed in the assessment of the child who has been physically neglected unless there is some underlying medical condition that warrants such an evaluation. For instance, the child with recurrent urinary tract infections who has not been given the prophylactic antibiotics might need a renal scan to determine the extent of renal scarring that has developed.

7. **Assess whether the mother or caretaker will follow through to ensure that the medical problems will be addressed**
   - Has the mother been reliable in the past on medical follow-up?
   - Has anything new developed to prevent the mother from following up on recommended treatment (e.g. alcohol or drug problems, domestic violence, abusive, controlling boyfriend, or mental health problems)?
   - What resources does the family need to ensure compliance (e.g., transportation)?
   - Is the neglect representative of an isolated incident that occurred because of an unusual set of circumstances that has since been remedied? Or, are there risk factors which suggest that the child is at continued risk in their environment? Is the family in need of community resources that require the mobilization of social service agencies?
   - Evaluate whether Children's Protective Services should be involved. Most cases of neglect require an evaluation not only by medical personnel, but also by social services because there are many factors which contribute to a child being neglected. An extensive medical and psychosocial evaluation is key to assuring a good outcome.

B. LEGAL DEFINITIONS: SEVERE AND GENERAL NEGLECT

Neglect means the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person. Severe and general neglect are defined below by Penal Code Section 11165.2.

1. **Severe neglect**
   Severe neglect means the negligent failure of a person having the care or custody of a child to protect the child from severe malnutritionor medically diagnosed non-organic failure to thrive. Severe neglect also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as proscribed by Penal Code Section 11165.3, including the intentional failure to provide adequate food, clothing, shelter, or medical care.

2. **General neglect**
   General neglect means the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred.

   For the purposes of this chapter, a child receiving treatment by spiritual means as provided in Section 16509.1 of the Welfare and Institutions Code, or not receiving specified medical treatment for religious reasons, shall not for that reason alone be

considered a neglected child. An informed and appropriate medical decision made by the parent or guardian after consultation with a physician or physicians who have examined the minor does not constitute neglect.

C. CLINICAL PRESENTATION OF NEGLECT

1. General Neglect

Children who are neglected may come to medical attention for a variety of reasons. Sometimes they are brought to the physician for an unrelated infectious illness, and evidence of neglect is apparent on physical examination. For instance, the child may appear dirty, smell of urine or stool, and be underweight. Other times, neglect may result in children sustaining a serious injury, such as being burned or drowned because of inadequate supervision. Children who receive inadequate food may present with growth impairment. Children with emotional neglect may experience behavioral or conduct problems in school. Some children die as a result of neglect, and these cases are usually evaluated by the medical examiner's office.

2.

Physical Neglect Refusal of Health Care	Failure to provide or allow needed care in accordance with recommendations of a competent health care professional for a physical injury, illness, medical condition, or impairment.
Delay in Health Care	Failure to seek timely and appropriate medical care for a serious health problem which any reasonable person would have recognized as needing professional medical attention.
Abandonment	Desertion of a child without arranging for reasonable care and supervision. This category includes cases in which children are not claimed within two days, and when children are left by parents/substitutes who give no (or false) information about their whereabouts.
Drug Endangered Children (DEC)	Children removed from drug manufacturing homes or homes with extensive drug use are often subject to severe neglect and accidental drug ingestion through common food and drink products in the home and exposure to trays of drug powder or crystals and residue.

Expulsion	Other blatant refusals of custody, such as permanent or indefinite expulsion of a child from the home without adequate arrangement for care by others, or refusal to accept custody of a returned runaway.
Other Custody Issues	Custody-related forms of inattention to the child's needs other than those covered by abandonment or expulsion. For example, repeated shuttling of a child from one household to another due to unwillingness to maintain custody, or chronically and repeatedly leaving a child with others for days/weeks at a time.
Other Physical Neglect	Conspicuous inattention to avoidable hazards in the home; inadequate nutrition, clothing, or hygiene; and, other forms of reckless disregard for the child's safety and welfare, such as driving with the child while under the influence of drugs or alcohol, or leaving a young child unattended in a motor vehicle.
3. Inadequate Supervision	Child left unsupervised or inadequately supervised for extended periods of time or allowed to remain away from home overnight without the parent/substitute knowing (or attempting to determine) the child's whereabouts.
4. Emotional Neglect	
Inadequate Nurturance/ Affection	Marked inattention to the child's needs for affection, emotional support, attention, or competence.
Chronic/Extreme Abuse or Domestic Violence	Chronic or extreme spouse abuse or other domestic violence.
Permitted Drug/ Alcohol Abuse	Encouraging or permitting drug or alcohol use by the child, or cases where parent/guardian was informed of the problem and did not attempt to intervene.
Refusal of Psychological Care	Refusal to allow needed and available treatment for a child's emotional or behavioral impairment or problem in accord with competent professional recommendation.

Delay in Psychological Care	Failure to seek or provide needed treatment for a child's emotional or behavioral impairment or problem which any reasonable person would have recognized as needing professional psychological attention (e.g., severe depression, suicide attempt).
Other Emotional Neglect	Other inattention to the child's developmental/emotional needs not classifiable under any of the above forms of emotional neglect (e.g., markedly overprotective restrictions which foster immaturity or emotional overdependence, chronically applying expectations clearly inappropriate in relation to the child's age or level of development, etc.).

5. Educational Neglect

Permitted Chronic Truancy	Habitual truancy averaging at least five days a month is classifiable under this form of maltreatment, if the parent/guardian has been informed of the problem, and has not attempted to intervene.
Failure to Enroll/ Other Truancy	Failure to register or enroll a child of mandatory school age, causing the school-aged child to remain at home for nonlegitimate reasons (e.g., to work, to care for siblings) an average of at least three days a month.
Inattention to Special Education Needs	Refusal to allow or failure to obtain recommended remedial educational services, or neglect in obtaining or following through with treatment for a child's diagnosed learning disorder, or other special educational needs without reasonable cause.

6. Additional commentary on definitions

Medical neglect

Medical neglect may occur for acute problems, such as burns or injuries that are sustained accidentally; acute illnesses, such as gastroenteritis; or, for routine health maintenance. Some parents do access health care when their children have chronic problems, but then fail to follow the recommendations of the physician. For instance, a child with asthma may be prescribed several medications none of which are administered. As a result, the child may require repeated hospitalizations including admission to an intensive care unit.

Parents may utilize nontraditional medicine to treat their child's ailment. Examples of such practices include cao gio, or coining and moxibustion. Residual bruises from these practices may be mistaken for inflicted trauma. The use of non-traditional medicine is not condemned so long as it does not interfere with the child receiving appropriate medical care, and does not harm the child.

Child abandonment

Abandonment may involve frank abandonment, such as when a child is left in a trash dumpster, or, left alone, unprotected in a house or apartment without any adult supervision. Abandonment also occurs when a parent leaves the child in the care of others and then fails to return at an appointed time. Inadequate supervision is another form of abandonment as well as cases where both parents renege on their responsibilities as parents. Adolescents who are expelled from the home because of "misbehavior" are abandoned. These adolescents are frequently referred to as "throwaways."

Delay in accessing medical care

- Parents may not have the financial means to pay for healthcare, and they delay seeking treatment in the hope that the illness will resolve on its own;
- Parents are unsophisticated and do not appreciate the seriousness of the illness;
- Parents are overtly negligent, and simply do not provide for their child's health care needs;
- Parents are developmentally disabled or mentally ill and cannot properly care for their child; or,
- Parents whose child has been physically and/or sexually abused and they are trying to prevent this matter from coming to the attention of authorities.

Lack of supervision

Children who are left unsupervised may die as a result of such neglect. Common examples include children who die in house fires, from drowning, starvation, or inadequate medical care.

Religious beliefs

Some parents refuse medical care because of religious beliefs. Consult with Child Protective Services (CPS) and follow local protocol.

E. PATHOPHYSIOLOGY

There are many factors that contribute to neglect. Parental factors include maternal depression, parental substance abuse, maternal developmental delay or retardation, and lack of education. There are also features in the child that place additional stress on the parent-child relationship. Children with chronic disabilities may strain the resources of a family. Similarly, infants who have been born prematurely are at increased risk of being neglected or abused. Bonding between a mother and her premature infant may be interrupted because of the separation between the two during the early period after birth. Sometimes the “goodness of fit” between the infant and mother is lacking, and the pair do not act as a reciprocal dyad.

Certain family features are also associated with neglect. These include absent or negative interactions between family members. Poor parenting skills may also be noted. There is frequently social isolation and a single parent struggling with stressors such as unemployment, illness (including mental illness), prison, and eviction. On a more global scale, community and societal factors also contribute to the risk of neglect. The lack of child care in a community means that single parents may leave young children inadequately supervised in order to go to work. The lack of convenient public transportation may impact access to medical care. Poverty, violence, and substandard educational resources all contribute to neglect within certain populations. For instance, in neighborhoods perceived to be unsafe, children are frequently prohibited from playing outdoors and forming normal friendships because of safety concerns.

F. DIFFERENTIAL DIAGNOSIS

In any child who presents with a medical condition that may be related to neglect, healthcare providers must explore other explanations that could account for the findings. Children who appear to be malnourished may suffer from a number of medical problems that affect their ability to grow and gain weight. Children who present with injuries need to be evaluated for the circumstances surrounding the injury. Did the parent’s action contribute to the child being injured? Were these actions substandard, or would other parents have acted in a similar manner? For instance, if a child accidentally drowns in a bathtub, what reasons were given for leaving the child unattended?

The differential diagnosis of physical neglect depends on the presenting complaint. Children who are inadequately clothed may present with hypothermia. The differential diagnosis would include overwhelming sepsis, drug-exposure (COOLS - carbon monoxide, opiates, oral hypoglycemics [insulin], liquor, sedative-hypotics), or

environmental exposure. Children with refractory medical conditions such as intractable asthma or unstable diabetes may be viewed as medically fragile, if the issue of non-compliance is not raised. Failure to obtain medical care in a timely manner may result in disease progression to a point where diagnosis and medical intervention are more difficult.

This chapter is a condensed version of the article entitled "Child Neglect" by Carol Berkowitz, M.D. from the book Child Abuse and Neglect: Guidelines for Identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment and case management of various forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor's Office of Criminal Justice Planning (now the Governor's Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

CHAPTER IX

IMPORTANT CONSIDERATIONS IN THE COLLECTION AND PRESERVATION OF EVIDENCE

A. CRIME LABORATORIES

Crime laboratories analyze and interpret evidence collected during the medical evidentiary examination. There are 31 public crime laboratories in California: 19 city and county laboratories and 12 California Department of Justice laboratories. There are also a number of privately operated crime laboratories. Crime laboratories have slightly different requirements for the collection and disposition of some types of evidence.

B. ENSURING EVIDENCE INTEGRITY

1. Key components of proper evidence handling are:

- Placing items in appropriate evidence containers;
- Labeling the evidence containers;
- Sealing the evidence containers;
- Storing evidence in a secure area; and
- Maintaining the chain of custody.

2. Use appropriate evidence containers to ensure that evidence cannot leak through the container, be lost, or deteriorate.

• Slide mailers	To protect slides.
• Bindles and other small containers	To protect items that can be easily lost such as crusted materials, soil, and small fibers. Bindles and other small protective containers are then placed into the evidence collection envelopes or boxes described below.
• Envelopes or boxes	To protect evidence such as swabs, reference hair samples, and foreign materials, and to hold the small containers listed above.
• Evidence kit container	A larger envelope or box to hold the individual evidence collection envelopes, small boxes, and slide mailers. The outside of the evidence kit container must have a chain of custody form printed on it or securely attached.
• Paper bags	To hold clothing.

The following chart, not meant to be all-inclusive, is a list of suggested containers for different types of evidence:

Items	Suggested Containers
• Swabs (dried)	• Envelopes • Boxes
• Slides (dried)	• Slide mailers
• Large foreign materials (e.g., hairs, grass)	• Envelopes
• Small or loose foreign materials (e.g., soil, paint, splinters, glass, fibers)	• Bindles placed into envelopes • Tapelifts in clear plastic containers
• Matted hair bearing crusted material	• Bindles placed into envelopes
• Fingernail scrapings or cuttings	• Paper bindles placed into envelopes • Sealable boxes
• Reference blood samples, liquid	• Lavender and/or yellow stoppered evacuated blood collection vials (according to local policy) placed in envelopes
• Saliva reference sample (dried)	• Envelopes
• Clothing	• Paper bags (not plastic)
• Toxicology samples Blood alcohol/toxicology Urine toxicology	• Gray stoppered evacuated blood collection vials • Tightly sealed clean plastic or glass container for urine samples

3. **Label evidence containers**
   Clearly label evidence to enable the person collecting it to later identify it in court and to ensure that the chain of custody is maintained. Many emergency departments use addressograph machines or computerized label generators to expedite labeling of evidence. Label envelopes or boxes with the following information:

   - Full name of patient;
   - Date of collection;
   - Description of the evidence including the location from which it was collected; and
   - Signature or initials of the person who collected the evidence and placed it in the container.

4. **Seal evidence containers**
   Properly seal evidence containers to ensure that contents cannot escape and that nothing can be added or altered by:

   - Securely taping the container (do not lick the adhesive seal); and
   - Initialing and dating the seal by writing over the tape onto the evidence container. Stapling is not considered a secure seal.
   - See **Appendix G**: Sealed Evidence Envelope for an example of proper sealing.

5. **Store evidence in a secure area**
   Evidence must be kept in a secure area when not directly in the possession of a person listed in the chain of custody.

6. **Maintain the chain of custody**
   The chain of custody documents the handling, transfer, and storage of evidence beginning with the collection of the evidence at the medical facility. It continues with each transfer of the evidence to law enforcement, the crime laboratory, and others. Complete documentation of the chain of custody information ensures there has been no loss or alteration of evidence prior to trial.

   - **Document all transfers of evidence with the following information:**
     - Name of person transferring custody;
     - Name of person receiving custody;
     - Date of transfer; and
     - Some jurisdictions also require documentation of time of evidence transfer. Consult your local crime laboratory for their requirements.

- **Chain of custody information can be:**
  - Printed by hand on an evidence envelope or box;
  - Securely attached to an evidence envelope or box; or
  - Preprinted on special envelopes, boxes and/or forms.
  - See **Appendix H** for a sample of the Chain of Custody Form.

C. COLLECTION OF CLOTHING

1. Collect clothing worn by the patient upon arrival at the hospital, if indicated.

2. Types of evidence on clothing

Clothing worn at the time of the assault may contain useful evidence:

- Rips, tears or other damage sustained as a result of the assault;
- Blood and other body fluids from the patient; and
- Foreign materials such as fibers, grass, soil, and other debris.

3. Collection procedures

- **Have patients remove their shoes first, then disrobe on two sheets of paper placed on top of one another on the floor.**
  The purpose of the bottom sheet is to protect the top sheet from dirt and debris on the floor. The purpose of the top sheet is to collect loose trace evidence which may fall from the clothing during disrobing. Using the disposable paper from examination tables is acceptable for this purpose.

- **Shoes**
  The shoes may be collected and packaged separately, if requested by the investigating agency or if indicated by the assault history.

- **Hairs, fibers, and debris**
  Collect loose hairs, fibers, and debris that fall from the clothing on the top sheet of paper placed on the floor for this purpose. After the clothing has been collected, fold the top sheet of paper (from the two sheets on the floor) into a large bindle to ensure that all foreign materials are contained inside. Label and seal to ensure that the contents cannot escape. Place into a large paper bag. The bottom sheet should be discarded.

- **Folding garments**
  Fold each garment as it is removed to prevent body fluid stains or foreign materials from being lost or transferred from one garment to another. Avoid folding the clothing across possible body fluid stains.

- **Wet clothing**
  It is preferable to dry clothing before packaging. If drying is not possible, wet clothing can be folded sandwiched between sheets of paper. After placing the item in a paper bag, clearly label the bag as containing a wet item and notify the law enforcement officer. Consult your local crime laboratory for additional recommendations.

- **Containers for clothing**
  Package each item of clothing in an individual paper bag. **Do not use plastic bags**. Plastic retains moisture which can result in mold and deterioration of biological evidence.

4. **Securely seal and label each clothing bag with the following information:**
   - Full name of patient;
   - Date of collection;
   - Brief description of item; and
   - Signature or initials of the person who collected the evidence and placed it in the container.

5. **Place small bags of clothing and the large paper bindle (from the floor) into large bag(s)**
   Place all bags (except those containing wet evidence) and the bindle made from the top sheet of paper into a large paper bag which has a chain of custody form printed on it or firmly attached. Multiple large bags may be used, if necessary.

D. PROCEDURES FOR BITE MARKS

1. **Photographing bite marks**
   Individuals can be identified by the size and shape of their bite marks. Properly taken photographs of bite marks and bruises can assist in the identification of the person who inflicted the injury. See Chapter X on Photography.

2. **Collecting saliva from bite marks after photo documentation**
   This sample can be examined by the crime laboratory for the presence of saliva and can be genetically typed and compared to potential suspects. Follow these procedures:

   - Swab the general area of trauma with a swab moistened with distilled, deionized or sterile water.

   - **Note:** If the patient history indicates a bite and there are no visible findings, swab the indicated area.

- Collect a control swab from an unbitten atraumatic area adjacent to the suspected saliva stain.

- Label, air dry, and package the evidence and control swabs separately.

3. Casting bite marks

- If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
- A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
- Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

E. BRUISING AND AGING OF INJURIES

Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.

- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in one to two days after the bruising develops more fully.

F. TOXICOLOGY

In addition to clinical implications, the presence of drugs in the patient's blood or urine may have legal significance.

1. Collect toxicology samples if the patient:

- Is unconscious;
- Exhibits abnormal vital signs;
- Reports ingestion of drugs or alcohol;
- Exhibits signs of memory loss, dizziness, confusion, drowsiness, impaired judgment;
- Shows signs of impaired motor skills;
- Describes loss of consciousness, memory impairment or memory loss;
- Reports nausea; and/or
- Exhibits other unexplained neurologic findings such as seizures.

2. Use these containers for toxicology samples:

Blood samples	Gray stoppered evacuated blood collection vials
Urine Samples	Tightly sealed clean plastic or glass container
Note: Refrigeration of toxicology samples is recommended.	

3. Collect toxicology samples as soon as possible

Alcohol metabolizes rapidly. Many drugs are also quickly eliminated from the body.

For alcohol analysis, collect a blood sample (5cc).
• Some drugs may also be detected in this sample if it is collected within 24 hours of ingestion. If this is a consideration, collect additional blood for drug analysis. • Be sure to cleanse the arm with a non-alcoholic solution.

If ingestion of drugs is suspected within 96 hours of the examination, collect the first available urine specimen.
• If the patient must urinate prior to the medical examination, the urine specimen for toxicology should be collected at that time. • "Clean catch" or "mid-stream" sampling methods are unsuitable for urine toxicology specimens. • Consult your local crime laboratory for recommended collection methods.

CHAPTER X

PHOTOGRAPHY

A. POLICIES AND CONSIDERATIONS

Photographs are recommended to supplement documentation of history and physical findings. They may be the only way to adequately document findings such as bite marks, bruises, or massive injuries.

- Photograph every potentially significant injury or finding.
- Photographs may be taken by trained medical forensic examination team members or be arranged with the local law enforcement agency.
- Patients may be concerned about privacy and modesty during photography. Sensitivity to these concerns should be exercised when deciding whether hospital personnel, a male or female law enforcement officer, or crime scene investigator takes the photographs.

B. PHOTOGRAPHIC PROCEDURES

Any good quality camera may be used as long as it can be focused for undistorted, close-up photographs and provides an accurate color rendition.

- Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
- Digital imaging is gaining acceptance in some jurisdictions as long as certain safeguards are in place. Consult with the local District Attorney's Office.
- Use adequate lighting whether the source is natural, flood, or flash.
- Take close-up photographs of bite marks and other wounds with the film plane as parallel to the subject area as possible. Minimize tilting of the camera to avoid distortion of the pictures.
- Include an accurate ruler or scale for size reference in the photograph. The scale should be in close proximity to and in the same plane as the injury or item being photographed. (A right-angle ruler, available commercially from police supply companies, is recommended. Consult your crime laboratory for vendors).
- Include a color bar in the photograph in the first image of the roll or series to ensure accurate color reproduction.

- Link the patient's identity and the examination date to the photographs of injuries and/or findings. This can be accomplished by:

  - Including a picture of the patient's identification card on the roll; or

  - Using a camera databack that can be programmed with the patient's medical record number or another non-duplicative numbering system.

- Avoid obscuring the injury with the ruler, identification label, or color bar. At least one or two photographs should be taken without the scale and/or color bar to orient the injury and to demonstrate that important evidence was not covered up.

- Additional photographs taken with a tangential light source (flash) may be used to enhance textured or irregular surface findings (e.g., bite marks, focal swelling, etc.).

C. GENERAL FORENSIC PHOTOGRAPHIC TECHNIQUES

At least three photographs of findings are required. These principles may be modified or adapted if multiple findings are in the same area.

- First, a "regional" or "orientation" photograph(s) showing the body part and the finding. (This shows the finding in the total context of the body region involved, as well as the anatomical orientation of the finding);

- Second, a close-up shot showing the whole finding; and

- Third, a second close-up using the scale to document size and camera position relative to the finding.

D. FORENSIC PHOTOGRAPHY COURSES

The California Clinical Forensic Medical Training Center (CCFMTC) offers courses on forensic photography. See **Appendix B** for information on how to access CCFMTC courses.

CHAPTER XI

CONSULTATION THROUGH TELEMEDICINE AND TECHNOLOGY

Telemedicine and telecourses are evolving rapidly through technology. Various types and resources are listed below:

A. POTS (PLAIN OLD TELEPHONE SYSTEM) AND POMS (PLAIN OLD MAIL SYSTEM)

Telemedicine began with POTS and POMS. Case consultation began through telephone consultation and using the mail system to send photographs of injuries to experts at other locations for assistance in interpretation and case management. This is the current most common method for obtaining consultation.

B. TWO TYPES OF VIDEO CONSULTATION: REAL TIME AND STORE AND FORWARD

1. Real time consultation

The term "real time" refers to live, clinician to clinician consultation most often between a tertiary hospital and an outlying clinic in a rural area. The rural clinician may need back up in a particular specialty, for example, obstetrics or dermatology. A clinic is scheduled for certain times and days of the week and the tertiary hospital physician is scheduled to consult with the rural clinician at that time. Video cameras are permanently set up and the tertiary center clinician monitors the examination and observes the findings at the same time as the rural clinician.

2. Store and forward consultation

The term "store and forward" means to photograph or videotape the examination, to save or "store" the videotape or photograph, and to forward it to a specialist or expert at a tertiary center for consultation. Software exists to transmit photographic and videotaped images over telephone lines. Hardware requirements include a computer, monitor, and VCR at both sites. Confidentiality and the transmission of medical records have been addressed in the development of this software.

Store and Forward has been found to be most practical in the field of forensic medicine to evaluate child physical and sexual abuse cases. First, the timing of forensic exams is unpredictable and given the low volume in rural areas the "scheduled clinic" approach is more difficult to implement. Second, the time demands are high upon the few forensic medical experts in child abuse and sexual assault. A Store and Forward system makes it easier to view transmitted photographs and videotapes on a time schedule that works for the forensic expert. See **Appendix B** on how to contact the California Clinical Forensic Medical Training Center for further information.

3. **Interactive video consultation**
   Video consultation is generally focused on one or more case studies and is handled through point-to-point computer transmissions. This type of consultation is held around a computer monitor and four to six professionals (or more depending on the size of the monitor or screen) can be accommodated at each site. Point-to-point refers to a connection between a tertiary hospital and one or more outlying areas. A simultaneous telephone connection on a speaker phone is set up and visual images are transmitted on the computer monitor.

4. **Telecourses or distance learning through satellite transmissions**
   These terms are used to refer to courses transmitted simultaneously to different sites to a live audience. A tertiary center broadcasts the course to predetermined sites.

C. CD ROM COURSES

Reference materials and courses are now being developed on CD ROM. See **Appendix B** on how to contact the California Clinical Forensic Medical Training Center for further information.

CHAPTER XII

HOSPITAL SCAN TEAM MODELS

SCAN (Suspected Child Abuse and Neglect) Teams are multi-disciplinary teams involved in the identification and treatment of child victimization. The mission of these teams is to enhance the identification, reporting, and case management of child abuse and neglect cases through a multi-disciplinary approach.

A. HISTORY OF SCAN TEAMS

The first hospital-based child protection teams were established in the late 1950's at Pittsburgh Children's Hospital, the University of Colorado Medical Center, and Children's Hospital in Los Angeles.

Tasks of SCAN Teams include, but are not limited to:

- Performing case review of all child abuse and neglect reports;
- Reviewing medical reports for evaluation, follow-up and referrals;
- Coordination of treatment planning;
- Maintaining a central log of cases and/or a data system;
- Preparing an annual summary report;
- Providing training and education to the various disciplines and professionals involved in cases;
- Providing expert testimony in court; and,
- Providing a focus for research.

B. PRIMARY CARE FACILITY TEAMS

1. Team membership

A physician and medical social worker and/or nurse are designated as resource specialists in the area of child maltreatment.

2. Roles and responsibilities

- Case consultation to other health care providers in their setting regarding the assessment of child maltreatment and the development of an adequate information base for diagnosis;
- Guidance on making the required telephone and written reports;
- Consultation on developing a treatment plan for follow-up with the family;
- Serve as liaison with area hospitals, law enforcement agencies, child protective services, and other public agencies in all cases of child abuse and neglect seen at the facility;
- Provision of training and education for the staff at the facility;
- Developing reporting protocols and procedures; and,
- Case follow-up.

C. SECONDARY LEVEL FACILITY TEAMS

1. Team membership

These teams have a core group of professionals such as physicians, mid-level practitioners, nurses, social workers, child development and mental health specialists, and psychiatrists. Team members have specialized training and expertise in the recognition of child maltreatment, assessment and evaluation, the mechanics of reporting and public agency response, and community resources for treatment and follow-up. Other specialists may be called upon as needed for consultation, such as radiologists, ophthalmologists, and dentists. At this level, a representative from the local child protective services and/or law enforcement agency is usually a member.

2. Roles and responsibilities

- Availability of 24-hour consultation to hospital staff in order to provide immediate assistance on cases. The consultation service approach does not require the SCAN Team to take over the case from the treatment team, but rather, consultation is provided by telephone or in person. Referrals typically come from the Emergency Department, newborn nurseries, inpatient pediatric ward, burn unit, and primary care clinics, such as pediatrics, family medicine, and prenatal care.
- Consultation may also be provided to the psychiatric unit and dental clinics. In many hospitals, consultation with a member of the SCAN Team is required. Any faculty or staff, regardless of discipline, is required to seek consultation with the Team whenever there is concern about maltreatment.
- Guidance for interviewing the child and parents.
- Case management with law enforcement and Child Protective Services (CPS).
- Consultation on clinical studies needed to assist in making the diagnosis.
- Forensic medical evidence collection, related consent issues, dealing with the family, and making the reports.
- Case reviews at regularly scheduled multi-disciplinary meetings.
- Provision of expert testimony in Juvenile and Superior Court.

Some teams meet weekly and review every case referred, regardless of whether a report was made. Other teams review only complex cases in which the diagnosis is more difficult. These case reviews are usually more effective when the treating physician, nurse, social worker, and other relevant staff attend and present their cases, rather than having a “paper review” of the case. Cases where reporting was recommended and completed are reviewed for follow-up. Cases that do not result in reporting are also reviewed to determine other case management alternatives. Multi-disciplinary case reviews are particularly helpful in very complex

and difficult to sort out cases such as those involving medically fragile/chronically ill children with issues of medical noncompliance, failure-to-thrive, abusive head trauma, sexual abuse, medically fragile/chronically ill children where there is noncompliance, and Munchausen by Proxy.

The need to consider complex medical, developmental, social, and psychological data may require a separate meeting on a given case. Recommendations made by the SCAN Team are documented.

3. **Case follow-up**
   Follow-up reporting on case disposition is important to inform the SCAN Team about the response of the child protection system to the case, to know whether the Team's recommendations were acted upon by the public agencies and whether the recommended intervention, services, and treatment plan were put into place. Follow-up also involves the SCAN Team to ensure that all procedures are followed and reports are completed. Without follow-up, the Team is ineffective and risks being perceived as unrealistic and impractical by child protection and other community agencies.

4. **Centralized log of all referred cases**
   A patient identification code, the child's age, gender, referral source, and type of suspected maltreatment are basic elements of the database. The database allows for identification of major trends such as an increase/decrease in the number of reports of specific types of abuse and an increase in the overall referrals from the Emergency Department, law enforcement, and CPS. Depending upon the scope of data collected and recorded, other trends may be identified and lead to further clinical investigation (e.g., an increase in the number of babies delivered exposed to methamphetamines or cocaine, more cases from a particular part of the institution's geographic service area, etc). Documenting trends can assist in garnering support for additional community resources or changes in service-delivery.

   An annual summary report is useful to document the volume of cases referred, trends, and other activities required of, or undertaken by the SCAN Team. Teaching, research, and quality assurance activities are included in this report. Progress on grants obtained and updates on hospital programs addressing child abuse prevention and treatment issues are also included.

5. **Training and education for mandated reporters**
   A master calendar of annual training programs for medical and hospital staff to provide regular updates on child abuse topics is particularly helpful in teaching hospital institutions where there is continual influx of new faculty and staff or for use

in Grand Rounds educational presentations. SCAN Teams provide valuable training to child protection social workers, law enforcement, and criminal and dependency court personnel on medical evidentiary exam findings, and updates from the scientific literature. These training programs are opportunities for communication to increase understanding and appreciation of each discipline's role and methodology for assessment/investigation.

6. Consultation to community agencies

Child Protective Services (CPS), law enforcement, prosecutors, and the courts seek consultation and expert opinion. CPS may seek consultation from the Team on a case of a child who has never been seen at the hospital. SCAN Teams afford access to physicians and other health care providers with expertise in diagnosing child abuse and neglect.

7. Prevention activities

Child abuse prevention activities include: sponsoring awareness-raising campaigns in the hospital and community during Child Abuse Prevention Month; sponsoring annual conferences; developing and distributing materials at patient visits and in public areas of the hospital and community on various topics; providing parenting classes and support groups; providing educational materials to parents of newborns; and conducting child safety campaigns.

Many hospital administrations recognize the role SCAN Teams play in reducing and managing risk. Another value-added element is economy of labor – expert consultation results in improved documentation of cases, which in turn, reduces the volume and time spent on communications with investigating agencies and court appearances. If the situation does not warrant a mandated report, the team may contribute other strategies to use to address the family's problems, or suggest treatment resources.

D. TERTIARY FACILITY TEAMS

1. Coordinated approach to patient care

Some communities are developing highly trained specialized examiner programs using physicians, mid-level practitioners (nurse practitioners and physician assistants), and nurses within their scope of practice. Each model has a physician medical director. Referrals are received from throughout the region or county. There are various acronyms for these teams: SCAN (Suspected Child Abuse and Neglect), CARE (Child Abuse Response Examiners) and CAST (Child Abuse Services Team).

2. **Key features of tertiary teams**
   - Medical leadership in the community, region, and statewide;
   - Regional resource center;
   - Coordinated team approach;
   - Prompt forensic medical examinations for acute cases and consultation;
   - Highly trained medical personnel;
   - Defined areas of expertise in either child physical or sexual abuse, or both;
   - Pre-authorization for reimbursement based upon negotiated contracts;
   - Dedicated exam space and equipment;
   - Immediate patient support and advocacy;
   - Coordinated medical and law enforcement interviews;
   - Specialized training for all team members;
   - Peer review;
   - Continuous quality improvement;
   - Collaboration and cooperation with community resources;
   - Utilization of best practice standards;
   - Inclusion of public agencies in team membership (e.g., law enforcement, child protective services, Multi-Disciplinary Interview Center, and public health nurses);
   - Provision of expert testimony throughout the region, state, and nationally;
   - Participation in public policy committees and initiatives at the state and national levels;
   - Telemedicine consultation and resource center;
   - Mental health diagnostic and treatment services;
   - Coordination for regional CQI, photo and case review meetings for other examiners to expand expertise;
   - Research and publication in peer reviewed journals; and,
   - Major conferences, symposia, and training programs.

3. **Continuing quality improvement (CQI) and photo review**
   Formal CQI review is an essential standard of practice for medical evidentiary examination teams. Some community hospitals have developed CQI for the medical team operations and participate in regular CQI with the local law enforcement agencies and Children's Protective Services. CQI sometimes includes brief evaluation forms from the crime laboratory regarding the quality of evidence collection, preservation, and handling for the examination team on a per case basis. See **Appendix B** on how to contact the California Clinical Forensic Medical Training Center for further information.

E. HOSPITAL SCAN TEAMS: HISTORY OF SPAWNING NEW PROGRAMS

1. Development of Child Protection Centers

The early SCAN Teams opened up lines of communication between medical facilities and investigative agencies; increased awareness about child abuse and neglect; provided community education; developed cooperative agency partnerships; provided professional training for law enforcement officers, prosecutors, and investigative social workers on how to interpret medical evidentiary exam findings; and, in many instances, established foundational leadership in the community to address the problem of child abuse and neglect.

Beginning in the 1980's, Child Protection Centers emerged out of SCAN Teams, and built upon the foundation established by the SCAN Team model. The hospital-based centers began to operate on a much larger multi-disciplinary scale. These programs first developed in response to the need for specialized child sexual abuse medical evidentiary examinations and the higher level of collaboration required with investigative agencies. From this foundation, other services began to be developed and offered such as foster care health programs providing clearance and comprehensive medical exams with screening for medical, developmental, dental, and mental health problems; comprehensive mental health programs including individual, group, and family therapy; research; and more formalized regional and statewide conferences and training programs.

These programs are often extensively involved in addressing larger child protection system policy issues; initiating system change to improve intervention services; developing interagency protocols for case management; and engaging in legislative and public policy advocacy at the State and Federal level.

2. Multi-Disciplinary Interview Centers (MDICs) or Multi-Disciplinary Interview Teams (MDIT)

MDICs and MDITs arose from local multi-disciplinary teams and coordinating councils and, in many instances, the original SCAN Team. These programs ensure coordinated case investigations and involve commitments from agencies to participate in a multi-disciplinary, multi-agency approach to interview children utilizing child interview specialists.

These programs are often called Multi-Disciplinary Interview Centers (MDICs) or Multi-Disciplinary Interview Teams (MDITs). In some cases, the MDIC/MDIT is located at the hospital. In most instances, the MDIC/MDIT is located at a public agency such as the District Attorney's Office or Child Protective Services, and makes referrals to the hospital's child abuse specialists for forensic medical exams.

Information from this chapter is based on the article entitled “Hospital SCAN (Suspected Child Abuse and Neglect) Team Models” by Nancy C. Hayes, L.C.S.W. from the book Child Abuse and Neglect: Guidelines for identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment, and case management of carious forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor’s Office of Criminal Justice Planning (now the Governor’s Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

CHAPTER XIII

CHILD DEATH REVIEW TEAMS

A. PURPOSES OF CHILD DEATH REVIEW TEAMS

Child Death Review Teams (CDRTs) are multi-agency, multi-disciplinary state and/or local teams that systematically review child deaths within a specific geographic area. They play a critical role in helping to identify child abuse and neglect fatalities and other preventable child deaths. Local CDRTs are often involved in the case management of child death investigations. State teams primarily serve the local teams or gather data for systems management and policy interventions. Many benefits have accrued from the work of CDRTs, including more accurate identification of child deaths due to child maltreatment, more effective determination of the underlying cause of suspicious deaths, identification of gaps and breakdowns in agencies and systems designed to protect children, and implementation of various prevention interventions.

1. Penal Code Section 11166.7 establishes County Child Death Review Teams

Each county may establish an interagency child death team to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases. Interagency child death teams have been used successfully to ensure that incidents of child abuse or neglect are recognized and other siblings and nonoffending family members receive the appropriate services in cases where a child has expired.

Each county may develop a protocol that may be used as a guideline by persons performing autopsies on children to assist coroners and other persons who perform autopsies in the identification of child abuse or neglect, in the determination of whether child abuse or neglect contributed to death, or whether child abuse or neglect had occurred prior to but was not the actual cause of death, and in the proper written reporting procedures for child abuse or neglect, including the designation of the cause and mode of death.

In developing an interagency child death team and an autopsy protocol, each county, working in consultation with local members of the California State Coroner's Association and county child abuse prevention coordinating councils, may solicit suggestions and final comments from persons, including but not limited to, the following:

- Experts in the field of forensic pathology;
- Pediatricians with expertise in child abuse;
- Coroners and medical examiners;

- Criminologists;
- District Attorneys;
- Child Protective Services staff;
- Law enforcement personnel;
- Representatives of local agencies involved with child abuse or neglect reporting;
- County health department staff who deal with children's health issues; and
- Local associations of professionals listed above.

2. Roles and responsibilities of Child Death Review Teams

Child Death Review Teams may perform any or all of the following tasks:

- Review and assess whether child deaths are homicides associated with abuse or neglect;
- Review and assess the causes of all child deaths with the intent of identifying circumstances surrounding preventable deaths;
- Improve the criminal investigation and prosecution of child abuse homicides;
- Improve dependency investigations and the protection of surviving siblings;
- Serve as a quality assurance team for death investigations;
- Design and implement cooperative protocols for investigation of child deaths;
- Improve linkages, communication and coordination among law enforcement, social services, local health agencies, the District Attorney's Office, the coroner and others;
- Provide a forum for agencies to resolve conflicts;
- Collect uniform and accurate statistics on child deaths; and,
- Identify public health issues and make recommendations to county and state policymakers and legislators.

3. Team Membership

Core members:

- County Medical Examiner or Coroner;
- Law Enforcement Agencies;
- Child Protective Services;
- District Attorney's Office; and
- Pediatrician (preferably with experience in child abuse evaluations).

Additional members:

- Child advocate;
- School representative;
- Fire Department or Emergency Medical Services;
- Mental Health representative;

- Liaison with the California Highway Patrol (CHP) (if available);
- Epidemiologist or data analyst (e.g., Office of Vital Statistics;
- Probation Officer; and
- Injury Control Specialist.

4. Selection criteria

CDRTs systematically select child deaths for review using predetermined criteria. Usually cases are drawn either from the deaths reported to the coroner or from vital statistics death certificates. Many counties (e.g., small and mid-sized counties) review all child deaths, whereas larger counties may have more selective review criteria (e.g., only coroner cases). Age criteria usually range from selecting only children under 7 to selecting all children under 20. The most common age criterion is children under 18 years of age.

Examples of review criteria used by various teams:

- All children under age 18;
- Coroner's cases of all children's deaths;
- "Unexpected", "unexplained", or "suspicious" deaths;
- Deaths under a certain age;
- Deaths of children known to Child Protective Services; and
- Deaths from certain causes.

Recommended minimum criteria:

- All coroner child death cases; and
- All children under 18 years of age.

5. Recommended "best practice" procedures

- Systematic intake and review of cases drawn by protocol from the coroner and/or vital statistics records;
- Teams function as a peer review, respecting confidentiality and sharing information across agency lines;
- Authentic peer review with no agency controlling or censuring the information, discussion, or activity of another;
- Multi-disciplinary team membership of investigative agencies with administrative support to collect, analyze, publish, and distribute the data locally for the Board of Supervisors, directors of public agencies, and in newspaper(s) for the public; and
- Capability for promoting and implementing basic or advanced procedures, policies, and prevention programs through team member agencies (e.g. , County Health Department or Child Abuse Prevention Council) or other community resources.

B. ROLE OF THE STATE CHILD DEATH REVIEW COUNCIL

The California State Child Death Review Council (CSCDRC), established under the auspices of the Department of Justice (DOJ), was organized to establish leadership at the state level with representatives from key state agencies and associations. This statewide council was established pursuant to Penal Code Section 11166.9. According to the legislative mandate, it shall be the duty of the CSCDRC to oversee the statewide coordination and integration of state and local efforts to address fatal child abuse and neglect, and to create a body of information to prevent child death. Goals of the State Council include:

- Create and maintain an integrated, automated statewide data system for all counties and relevant state agencies;
- Promote the use of standardized forms and data collection protocols;
- Foster communication between state and local teams, other states, federal agencies and national associations, including dissemination of data and a statewide directory;
- Address local, state, and federal policy legislation issues and guidelines;
- Seek additional resources and funding for county team efforts;
- Support the development of domestic violence death review teams;
- Promote increased awareness of the relationship between domestic violence and child abuse;
- Promote development of a model for small counties (e.g., multi-county teams or cluster groups for counties with populations under 20,000);
- Raise visibility of child deaths and child death review teams through public education programs and the annual state report;
- Promote education and training for child death review team members;
- Develop an evaluation process to assess team effectiveness;
- Encourage continued research efforts at the state and federal level regarding child deaths and related issues; and
- Provide training and technical assistance to local teams.

This chapter is a condensed version of the articles entitled “Child Death Review Teams” by Michael Durfee, M.D. and Stephen J. Wirtz, Ph.D. from the book Child Abuse and Neglect: Guidelines for Identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment and case management of various forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor’s Office of Criminal Justice Planning (now the Governor’s Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

CHAPTER XIV

MENTAL HEALTH AND DEVELOPMENT ISSUES AND REFERRALS

A. PSYCHOLOGICAL AND BEHAVIORAL OUTCOMES ASSOCIATED WITH CHILD PHYSICAL ABUSE

1. Psychological and Social Problems Associated with Physically Abused Children

- Post-traumatic Stress Disorder (PTSD);
- Generalized anxiety;
- Depression;
- Withdrawal;
- Feeling different from others and socially isolated;
- Poor interpersonal social skills; and
- Poor school performance and/or underachieving

2. Behavioral problems associated with physically abused children

- Difficult or aggressive behavior;
- Oppositional and/or defiant behavior;
- School problems; and
- Bullying and fighting behavior

3. Recommended mental health treatment modalities

- Individual therapy;
- Group therapy;
- Parent-Child Interaction Therapy (PCIT); and
- Home visiting programs

B. PSYCHOLOGICAL AND BEHAVIORAL OUTCOMES ASSOCIATED WITH CHILD NEGLECT

1. Psychological, developmental, and behavioral outcomes associated with child neglect

- Poor impulse control and creativity;
- Poor academic performance;
- Poor interpersonal social skills;
- Poor language comprehension;
- Speech delays;
- Lower IQ scores;
- Not “ready to learn” in school;
- Withdrawn and reticent to participate in activities;
- Depression;

- Anxiety; and
- Vulnerability for developing alcohol and drug abuse problems and for developing significant mental health problems

2. Recommended treatment modalities

- Home visiting programs;
- Individual therapy; and
- Group therapy

C. MENTAL HEALTH TREATMENT

1. Indicators for mental health treatment for abused and neglected children

- History of neglect, physical and sexual abuse;
- Death of a sibling or a parent;
- Child or parent history of alcohol and/or drug abuse;
- Depression, sadness, withdrawal and avoidance of others, fearful;
- Angry, agitated;
- Signs of stress (e.g., unable to go to sleep, wakes during the night, eating problems, quick temper, easily frustrated);
- Acting out behavior (e.g., aggressive with peers, caregivers, teachers);
- History of torture;
- Mistreatment of animals;
- Firesetting;
- School problems (e.g., poor grades, poor concentration, little participation in activities);
- Change or deterioration of behavior;
- Suicidal ideation;
- Risk of placement disruption due to behavioral difficulties;
- Difficulties with self-care not due to developmental disability;
- Hallucinations or delusions; and
- History of receiving psychotropic medication.

2. **Purpose and types of mental health treatment**
   The purpose of mental health treatment is to alleviate psychological and behavior symptoms and to facilitate the development and maintenance of healthy functioning across an individual's life domains (e.g. home, work, or school). The primary treatment modalities are:

   - Individual therapy (e.g., various psychodynamic therapeutic models, sand tray, cognitive-behavioral therapy, and play therapy);
   - Dyadic therapy (e.g., Parent-Child Interaction Therapy);
   - Group therapy; and
   - Family therapy.

   Home-based and family-centered service approaches may also be helpful in supporting children and families. Home visiting programs, family resource centers, family conferencing, and wraparound social service support models are being developed in many communities to enhance existing systems of care.

3. **Indicators for a psychological evaluation**
   Sometimes the clinical or psychosocial assessment indicates a need for a psychological evaluation to obtain more detailed information regarding the child's psychological functioning or when the diagnosis is unclear. For a treatment plan to be successful, it is important to know, for example, whether the child is suffering from Post Traumatic Stress Disorder (PTSD) or has Attention Deficit Hyperactivity Disorder (ADHD) because the symptoms can be similar but the treatment plans are different.

   Psychologists are the only mental health professionals accredited to perform psychological testing and evaluation, and they employ a battery of tests that evaluate:

   - **Cognitive functioning**
     Processing information, learning strengths and weaknesses, memory, verbal and nonverbal abilities, and academic abilities.

   - **Affective functioning**
     Emotions, fantasies, and feelings.

   - **Adaptive functioning**
     How an individual functions in the world in areas such as communication, daily living skills and socialization.

- **Pathological functioning**
  Ways in which the individual's internal conflicts and drives distort or overwhelm the ability to deal effectively with the demands of external reality.

- **Personality**
  Clinical symptoms, personality traits and patterns, and interpersonal functioning.

- **Developmental functioning**
  Cognitive, communication, social, adaptive, and/or motor development.

4. Psychological testing

Psychological testing can address these questions about an individual:

- What are the client's intellectual strengths and limitations?
- Is there evidence of neurological immaturity or impairment?
- What is the nature of past knowledge and achievements, interests, and aptitudes?
- How adequate is reality testing?
- What is the quality of interpersonal relationships?
- What are the adaptive strengths (application of assets and liabilities to new problems, flexibility of approach, persistence, frustration tolerance, and reaction to novelty)?
- To what degree are impulses maintained under control (under-controlled or over-controlled)?
- How does the person defend psychologically (protect the self from feelings, ideas, and experiences that create anxiety through avoidance, repression, fighting or aggression, etc.) against unacceptable internal needs and demands or external experiences? How rigid are the client's defenses?
- What are the areas of conflict?
- Does the child have a psychiatric disorder?
- What is the child's developmental functioning?
- What treatment strategies and services would be most effective in improving functioning?
- What support services would be helpful to the parents or caregivers?

5. Indicators for a psychiatric evaluation

Psychiatric evaluations are sometimes needed to evaluate complex issues that may need to be resolved with hospitalization or medication support for relief of symptoms. Psychiatric evaluations are helpful with parents and children in cases involving:

- Previous psychiatric history;
- Psychotic symptoms such as hallucinations (e.g. , hearing voices), delusional thinking (odd or magical beliefs) or bizarre ideation;
- Suicidal ideation or attempts or self-destructive behaviors;
- Significant anxiety (fears/worrying) and depression (sadness/withdrawal/anger/passivity);
- Episodes of dissociation, (i.e. “spacing out”);
- Inattention, forgetfulness, distractibility, or difficulty concentrating;
- Aggressive outbursts (whether toward others or animals) or firesetting;
- Hyperactivity or excessive energy;
- Changes in sleeping or eating patterns;
- Pain or any medical symptom that does not have medical basis;
- Regressed behaviors (e.g., bedwetting in a previously “dry” child);
- Inappropriate sexualized behaviors; and/or,
- Obsessive thoughts or compulsive behaviors.

D. CHILD DEVELOPMENT EVALUATIONS

1. Indicators for making a referral for a developmental evaluation

Early diagnosis gives the child with developmental disorders an important head start in school or identifies reasons behind school problems. It is especially critical that a treatment plan be determined and implemented before or during the child’s early school years. Guidelines for referral for a developmental evaluation include:

- Delays in reaching early developmental milestones (such as sitting, crawling, babbling or using words, and learning new social or play skills);
- Language delay, cognitive delay, fine and gross motor skill delay;
- Hyperactivity or behavior problems;
- Regression (loss) of skills;

- School or learning problems;
- Atypical behaviors (e.g., inability to interact or play with other children, inattention, daily living skill and self-care deficits);
- History of prenatal drug exposure, low birth weight or prematurity;
- Inability to understand or follow directions, or inability to explain ideas or speak clearly; and/or
- Children with histories of child abuse and neglect.

2. Formal Developmental Evaluation

A formal child developmental evaluation requires a multi-disciplinary team which includes a clinical psychologist with specialized training in child development and developmental disorders, a Developmental-Behavioral Pediatrician, and a social worker with training in child development. Assessment requires knowledge of typical and atypical development, cultural and social aspects of behavior, psychometric concepts, multiple diagnostic measures and techniques, ethnical/legal issues and an understanding of the child welfare and other intervention service systems.

This chapter is a condensed version of the article entitled "Developmental Issues in Abused and Neglected Children" by Theresa Witt, Ph.D. and Robin Lee Hansan, M.D. from the book Child Abuse and Neglect: Guidelines for Identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment and case management of various forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor's Office of Criminal Justice Planning (now the Governor's Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

APPENDICES

APPENDIX A
California Penal Code Section 11171

This legislation was introduced by Senator Figueroa and signed into state statute August 2002.

11171. (a) (1) The Legislature hereby finds and declares that adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations.

(2) Enhancing examination procedures, documentation, and evidence collection relating to child abuse or neglect will improve the investigation and prosecution of child abuse or neglect as well as other child protection efforts.

(b) The agency or agencies designated by the Director of Finance pursuant to Section 13820 shall, in cooperation with the State Department of Social Services, the Department of Justice, the California Association of Crime Lab Directors, the California State District Attorneys Association, the California State Sheriffs
Association, the California Peace Officers Association, the California Medical Association, the California Police Chiefs' Association, child advocates, the California Clinical Forensic Medical Training Center, child protective services, and other appropriate experts, establish medical forensic forms, instructions, and examination protocol for victims of child physical abuse or neglect using as a model the form and guidelines developed pursuant to Section 19823.5.

(c) The form shall include, but not be limited to, a place for notation concerning each of the following:

(1) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures.

(2) Addressing relevant consent issues, if indicated.

(3) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history.

(4) The performance of a physical examination for evidence of child physical abuse or neglect.

(5) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures.

(6) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated.

(7) Procedures for the preservation and disposition of evidence.

(8) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays.

(9) An assessment as to whether there are findings that indicate physical abuse or neglect.

(c) The forms shall become part of the patient's medical record pursuant to guidelines established by the advisory committee of the agency or agencies designated by the Director of Finance pursuant to Section 13820 and subject to the confidentiality laws pertaining to the release of a medical forensic examination records.

(D) The forms shall be made accessible for use on the Internet.

APPENDIX B



CALIFORNIA CLINICAL FORENSIC MEDICAL TRAINING CENTER

Improving the Healthcare Response to Violence

California Clinical Forensic Medical Training Center (CCFMTC)
921 11th Street
Suite 300
Sacramento, CA 95814
Telephone: (916) 930-3080
Website: www.ccfmtc.org

The CCFMTC offers skill-based training for performing quality medical/evidentiary examinations for victims of child physical abuse, child sexual abuse, sexual assault, domestic violence, and elder and dependent adult abuse and neglect. Training modalities include multi-day, skill-based training and one-to-eight hour lectures. Telecourses, case consultation, Internet, and CD-ROM self-instruction courses are under development.

The California Penal Code includes eight specific objectives for the CCFMTC:

- Develop and implement a standardized training program for medical personnel that has been reviewed and approved by a multi-disciplinary peer review committee.
- Develop a telecommunications system network between the Training Center and other areas of the state, including rural and midsize counties. This service shall provide case consultations to medical personnel, law enforcement, and the courts and provide continuing medical education.
- Provide basic, advanced, and specialized training programs.

- Develop guidelines for the reporting and management of child physical abuse and neglect, domestic violence, and elder abuse and neglect.
- Develop guidelines for evaluating the results of training for the medical personnel performing examinations.
- Provide standardized training for law enforcement officers, district attorneys, public defenders, investigative social workers, and judges on medical evidentiary examination procedures and the interpretation of findings.
- Promote an interdisciplinary approach in the assessment and management of child abuse and neglect, sexual assault, elder abuse, domestic violence, and abuse or assault against persons with disabilities.
- Provide training in the dynamics of victimization, including, but not limited to, rape trauma syndrome, battered woman syndrome, the effects of child abuse and neglect, and the various aspects of elder abuse.

APPENDIX C

MANDATORY REPORTERS DEFINED BY PENAL CODE SECTION 11165.7

As used in this article, "mandated reporter" is defined as any of the following:

- A teacher.
- An instructional aide.
- A teacher's aide or teacher's assistant employed by an public or private school.
- A classified employee of any public school.
- An administrative officer or supervisor of child welfare and attendance, or a certificated pupil personnel employee of any public or private school.
- An administrator of a public or private day camp.
- An administrator or employee of a public or private youth center, youth recreation program, or youth organization.
- An administrator or employee of a public or private organization whose duties require direct contact and supervision of children.
- Any employee of a county office of education or the California Department of Education, whose duties bring the employee into contact with children on a regular basis.
- A licensee, an administrator, or an employee of a licensed community care or child day care facility.
- A headstart teacher.
- A licensing worker or licensing evaluator employed by a licensing agency as defined in Section 11165.11.
- A public assistance worker.
- An employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities.
- A social worker, probation officer, or parole officer.
- An employee of a school district police or security department.
- Any person who is an administrator or presenter of, or counselor in, a child abuse prevention program in any public or private school.
- A district attorney investigator, inspector, or local child support agency caseworker unless the investigator, inspector, or caseworker is working with an attorney appointed pursuant to Section 317 of the Welfare and Institutions Code to represent a minor.
- A peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2, who is not otherwise described in this section.
- A fire fighter, except for volunteer fire fighters.
- A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

- Any emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.
- A psychological assistant registered pursuant to Section 2913 of the Business and Professions Code.
- A marriage, family, and child therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code.
- An unlicensed marriage, family, and child therapist intern registered under Section 4980.44 of the Business and Professions Code.
- A state or county public health employee who treats a minor for venereal disease or any other condition.
- A coroner.
- A medical examiner, or any other person who performs autopsies.
- A commercial film and photographic print processor, as specified in subdivision (e) of Section 11166. As used in this article, "commercial film and photographic print processor" means any person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, for compensation. The term includes any employee of such a person; it does not include a person who develops film or makes prints for a public agency.
- A child visitation monitor. As used in this article, "child visitation monitor" means any person who, for financial compensation, acts as monitor of a visit between a child and any other person when the monitoring of that visit has been ordered by a court of law.
- An animal control officer or humane society officer. For the purposes of this article, the following terms have the following meanings:
  - "Animal control officer" means any person employed by a city, county, or city and county for the purposes of enforcing animal control laws or regulations.
  - "Humane society officer" means any person appointed or employed by a public or private entity as a humane officer who is qualified pursuant to Section 14502 or 14503 of the Corporations Code.
- A clergy member, as specified in subdivision (c) of Section 11166. As used in this article, "clergy member" means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.
- Any custodian of records of a clergy member, as specified in this section and subdivision (c) of Section 11166.
- Any employee of any police department, county sheriff's department, county probation department, or county welfare department.
- An employee or volunteer of a Court Appointed Special Advocate program, as defined in Rule 1424 of the Rules of Court.

- Volunteers of public or private organizations whose duties require direct contact and supervision of children are encouraged to obtain training in the identification and reporting of child abuse.
- Training in the duties imposed by this article shall include training in child abuse identification and training in child abuse reporting. As part of that training, school districts shall provide to all employees being trained a written copy of the reporting requirements and a written disclosure of the employees' confidentiality rights.
- School districts that do not train their employees specified in subdivision (a) in the duties of mandated reporters under the child abuse reporting laws shall report to the State Department of Education the reasons why this training is not provided.
- The absence of training shall not excuse a mandated reporter from the duties imposed by this article.

APPENDIX D

SUSPECTED CHILD ABUSE REPORT FORM
Department of Justice (DOJ) SS 8572

Department of Justice (DOJ) Form SS 8572 can be downloaded from this website:

http://caag.state.ca.us/childabuse/forms.htm

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ❒ YES ❒ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

❒ LAW ENFORCEMENT ❒ COUNTY PROBATION ❒ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY	
ADDRESS Street City Zip		DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE		TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip				TELEPHONE ( )
PRESENT LOCATION OF VICTIM	SCHOOL		CLASS	GRADE
PHYSICALLY DISABLED? ❒ YES ❒ NO	DEVELOPMENTALLY DISABLED? ❒ YES ❒ NO	OTHER DISABILITY (SPECIFY)		PRIMARY LANGUAGE SPOKEN IN HOME
IN FOSTER CARE? ❒ YES ❒ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ❒ DAY CARE ❒ CHILD CARE CENTER ❒ FOSTER FAMILY HOME ❒ FAMILY FRIEND ❒ GROUP HOME OR INSTITUTION ❒ RELATIVE'S HOME			TYPE OF ABUSE *(CHECK ONE OR MORE)* ❒ PHYSICAL ❒ MENTAL ❒ SEXUAL ❒ NEGLECT ❒ OTHER (SPECIFY)
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ❒ YES ❒ NO			DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ❒ YES ❒ NO ❒ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )			BUSINESS PHONE ( )
NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )			BUSINESS PHONE ( )

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip				TELEPHONE ( )
OTHER RELEVANT INFORMATION				

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ❒ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

APPENDIX E

CALIFORNIA CHILD PROTECTIVE SERVICES AGENCIES

For current contact information, go to the Department of Social Services website at <*http://www.dss.cahwnet.gov/cfsweb/Res/pds/EmergencyR_315.pdf*>.

ALAMEDA COUNTY
Alameda County Welfare Dept.
8000 Edgewater Drive
Oakland, CA 94621

Main: (510) 259-1800

ALPINE COUNTY
Alpine County Dept. of Social Services
P.O. Box 277
Markleeville, CA 96120

Main: (530) 694-2235
Hotline: (888) 755-809

AMADOR COUNTY
Amador County Dept. of Social Services
1003 Broadway
Jackson, CA 95642

Days: (209)223-6550
Evenings: (209) 223-1075

BUTTE COUNTY
Butte County Dept. of Social Services
#1 County Center Drive
Oroville, CA 95249

Oroville: (530) 538-7617
Others: (800) 400-0902

CALAVERAS COUNTY
Calaveras County Dept. of Social Welfare
Government Center
San Andreas, CA 95249

Days: (209) 754-6452
After Hours: (209) 754-6500

COLUSA COUNTY
Colusa County Dept. of Social Welfare
P.O. Box 370
Colusa, CA 95932

Main: (530) 458-0280

CONTRA COSTA COUNTY
Contra Costa County Employment & Human Services.
2530 Arnold Drive, Suite 300
Martinez, CA 94553-4359

Central: (925) 646-1680
West: (510) 374-3324
East: (925) 427-8811

DEL NORTE COUNTY Main: (707) 464-3191
Del Norte County Welfare Dept.
880 Northcrest Drive
Crescent City, CA 95531

EL DORADO COUNTY
El Dorado County Dept. of Social Services S. Tahoe: (530) 544-7236
3057 Briw Road #A Placerville: (530) 642-7100
Placerville, CA 95667

FRESNO COUNTY
Fresno County Dept. of Adult Protective Services Main: (559) 255-8320
P.O. Box 1912
Fresno, CA 93750-0001

GLENN COUNTY
Glenn County Dept. of Social Services Main: (530) 934-6520
420 East Laurel Street
Willows, CA 95988

HUMBOLDT COUNTY
Humboldt County Dept. of Social Services Main: (707) 445-6180
929 Koster Street
Eureka, CA 95501

IMPERIAL COUNTY
Imperial County CWS Agency Main: (760) 337-7750
2995 South 4th Street, Suite 105
El Centro, CA 92243

INYO COUNTY
Inyo County Welfare Dept. Main: (760) 872-1727
Drawer A, Extension 2338
Independence, CA 93526

KERN COUNTY
Kern County Dept. of Human Services Main: (661) 631-6011
P.O. Box 511
Bakersfield, CA 93302

KINGS COUNTY

Kings County Human Services Agency
1200 South Drive
Hanford, CA 93230

Main: (559) 582-8776

LAKE COUNTY

Lake County Social Services
P.O. Box 2-9000
Lower Lake, CA 95457

Main: (707) 262-0235

LASSEN COUNTY

Lassen County Welfare Dept.
P.O. Box 1359
Susanville, CA 96130

Days: (530) 251-8277
After Hours: (530) 257-6121

LOS ANGELES COUNTY

Los Angeles County Community & Senior Services
3175 West 6th Street 2-90020
Los Angeles, CA 2-90020

In-State: (800) 540-4000
Out-of-State: (213) 639-4500

MADERA COUNTY

Madera County Dept. of Public Welfare
P.O. Box 569
Madera, CA 93639

Main: (559) 675-7829
(800) 801-3999

MARIN COUNTY

Marin County Dept. of Health and Human Services
10 N. San Pedro Road, #1004
San Rafael, CA 94913

Main: (415) 499-7153
TDD: (415) 479-1601

MARIPOSA COUNTY

Mariposa County Dept. of Social Welfare
P.O. Box 7
Mariposa, CA 95338

Main: (209) 966-3030

MENDOCINO COUNTY

Mendocino County Dept. of Social Services
P.O. Box 839
Ukiah, CA 95482

Main: (707) 463-5600

MERCED COUNTY

Merced County Dept. of Human Services Agency
P.O. Box 112
Merced, CA 95341

Days: (209) 385-3104
After Hours: (209) 385-9915

MODOC COUNTY

Modoc County Dept. of Social Services
120 North Main Street
Alturas, CA 96101

Days: (530) 233-6501
After Hours: (530) 233-4416

MONO COUNTY

Mono County Dept. of Social Welfare
P.O. Box 93517
Bridgeport, CA 93517

Main: (760) 932-7755
Statewide: (800) 340-5411

MONTEREY COUNTY

Monterey County Dept. of Social Services
1000 South Main, Suite 202
Salinas, CA 93901

Main: (831) 755-4661

NAPA COUNTY

Napa County Human Services
2261 Elm St.
Napa, CA 94559

Main: (707) 253-4261

NEVADA COUNTY

Nevada County Department of Public Social Services
P.O. Box 1210
Nevada City, CA 95959

Main: (530) 265-9380

ORANGE COUNTY

Orange County Social Services Agency
P.O. Box 22006
Santa Ana, CA 92702-2006

Main: (714) 940-1000
(800) 207-4464

PLACER COUNTY

Placer County Welfare Department
11519 B Avenue
Auburn, CA 95603

Main: (530) 886-5310
(800) 488-4308

PLUMAS COUNTY

Plumas County Dept. of Social Services
P.O. Box 360
Quincy, CA 95971

Main: (530) 283-6350

RIVERSIDE COUNTY

Riverside County Dept. of Public Social Services
1020 Iowa Avenue
Riverside, CA 92507

Main: (800) 442-4918

SACRAMENTO COUNTY

Sacramento County Dept. of Social Services
4875 Broadway
Sacramento, CA 95817

Main: (916) 875-5437

SAN BENITO COUNTY

San Benito County Human Services Agency
1111 San Felipe Rd.
Hollister, CA 95023

Days: (831) 636-4190
After Hours: (831) 636-4330

SAN BERNARDINO COUNTY

San Bernardino Co. Social Services
494 North E Street
San Bernardino, CA 92401

Main: (800) 827-8724
After Hours: (909) 422-3266

SAN DIEGO COUNTY

San Diego County Department of Social Services
1261 Third Avenue
Chula Vista, CA 91911

Main: (858) 560-2191

SAN FRANCISCO COUNTY

San Francisco City and County Dept. of Human Services
P.O. Box 7988
San Francisco, CA 94120-9939

Main: (415) 558-2650
(800) 856-5553

SAN JOAQUIN COUNTY

San Joaquin County Human Services Agency
P.O. Box 201056
Stockton, CA 95201

Main: (209) 468-1333
(209) 468-1330

SAN LUIS OBISPO COUNTY

San Luis Obispo County Dept. of Social Services
P.O. Box 8119
San Luis Obispo, CA 93403-8819

Main: (805) 781-5437
(805) 834-5437

SAN MATEO COUNTY

San Mateo County Department of Health
225 West 37th Avenue
San Mateo, CA 94403

Main: (650) 595-7922
(800) 632-4615
Fax: (650) 595-7518

SANTA BARBARA COUNTY

Santa Barbara County Dept. of Social Services
234 Camino Del Remedio
Santa Barbara, CA 93110-1369

Days: (800) 367-0166
Lompoc: (805) 737-7078
After Hours: (805) 683-2724

SANTA CLARA COUNTY

Santa Clara County Department of Social Services
591 North King Road
Santa Clara, CA 95133

North: (408) 299-2071
South: (408) 683-0601

SANTA CRUZ COUNTY

Santa Cruz County Human Resources Agency
P.O. Box 1320
Santa Cruz, CA 95061

Main: (831) 454-4222
Watsonville: (831) 763-8850

SHASTA COUNTY

Shasta County Department of Social Services
P.O. Box 496005
Redding, CA 96049-6005

Main: (530) 225-5144

SIERRA COUNTY

Sierra County Department of Health and Human Services
P.O. Box 1019
Loyalton, CA 96118

24 Hours: (530) 289-3720
Bus. Hours: (530) 993-6720

SISKIYOU COUNTY

Siskiyou County Human Services	24 Hours:	(530) 842-7009
818 South Main	Bus. Hours:	(530) 841-4200
Yreka, CA 96097		

SOLANO COUNTY

Solano County Social Services	Main:	(800) 544-8696
275 Beck Ave.		
Fairfield, CA 94533		

SONOMA COUNTY

Sonoma County Social Services Department	Main:	(707) 565-4304
P.O. Box 1539		
Santa Rosa, CA 95402		

STANISLAUS COUNTY

Stanislaus County Community Service Agency	Main:	(800) 558-3665
P.O. Box 42		
Modesto, CA 95353		

SUTTER COUNTY

Sutter County Welfare Department	Main:	(530) 822-7155
P.O. Box 1599		
Yuba City, CA 95992		

TEHAMA COUNTY

Tehama County Department of Social Welfare	Main:	(800) 323-7711
		(530) 527-9416
P.O. Box 1515		
Red Bluff, CA 96080		

TRINITY COUNTY

Trinity County Welfare Department	Main:	(530) 623-1314
P.O. Box 1470		
Weaverville, CA 96093		

TULARE COUNTY

Tulare County Department of Public Social Services	Main:	(559) 730-2677
	Co. Only	(800) 331-1585
P.O. Box 671		
Visalia, CA 93279		

TUOLUMNE COUNTY

Tuolumne Department of Social Services	Days:	(209) 533-5717
20075 Cedar Road North	After Hours:	(209) 533-4357
Sonora, CA 95370		

VENTURA COUNTY

Ventura County Department of Social Services	Main:	(805) 654-3200
4651 Telephone Road, Suite 201		
Ventura, CA 93001		

YOLO COUNTY

Yolo County Department Employment &	Main:	(530) 669-2345
Social Services		(530) 669-2346
25 North Cottonwood Avenue	After Hours:	(530) 666-8920
Woodland, CA 95695		(888) 400-0022

YUBA COUNTY

Yuba County Health and Welfare Department	Main:	(530) 749-6288
6000 Lindhurst Avenue		
Marysville, CA 95901		

APPENDIX F

CALIFORNIA VICTIM/WITNESS ASSISTANCE CENTERS

For current contact information go to the Victim Compensation and Government Claims Board web site at <*http://www.boc.ca.gov/vwlist.htm*>.

ALAMEDA COUNTY
Victim/Witness Assistance Center
Alameda County District Attorney's Office
1401 Lakeside Drive, Suite 802
Oakland, CA 94612
Tel: (510) 272-6180
Fax: (510) 208-9565

ALPINE COUNTY
Victim/Witness Assistance Center
Alpine County District Attorney's Office
270 Laramie Street
P.O. Box 248
Markleeville, CA 96120
Tel: (530) 694-2971
Fax: (530) 694-2980

AMADOR COUNTY
Victim/Witness Assistance Center
Amador County District Attorney's Office
45 Summit Street
Jackson, CA 95642
Tel: (209) 223-6474
Fax: (209) 223-1953

BUTTE COUNTY
Victim/Witness Assistance Center
Butte County Probation Department
42 County Center Drive
Oroville, CA 95965
Tel: (530) 538-7340
Fax: (530) 534-8301

CALAVERAS COUNTY
Victim/Witness Assistance Center
Calaveras County District Attorney's Office
891 Mountain Ranch Road
San Andreas, CA 95249
Tel: (209) 754-6565
Fax: (209) 754-6732

COLUSA COUNTY
Victim/Witness Assistance Center
Colusa County Probation Department
532 Oak Street
Colusa, CA 95932
Tel: (530) 458-0659
Fax: (530) 458-3009

CONTRA COSTA COUNTY

Victim/Witness Assistance Center
Contra Costa County Probation Department
100 Glacier Drive, Suite A
Martinez, CA 94553

Toll Free: (800) 648-0600
Tel: (925) 646-2474
Fax: (925) 646-2739

San Pablo Victim/Witness Assistance Center
West County Office
2555 El Portal Drive
San Pablo, CA 94806

Tel: (510) 374-3272, or
(510) 374-3246
Fax: (510) 374-3441

DEL NORTE COUNTY

Victim/Witness Assistance Center
Del Norte County District Attorney's Office
450 H Street, Room 182
Crescent City, CA 95531

Tel: (707) 464-7273
Fax: (707) 464-2975

EL DORADO COUNTY

Victim/Witness Assistance Center
El Dorado County District Attorney's Office
South Lake Tahoe Office
1360 Johnson Boulevard, Suite 105
South Lake Tahoe, CA 96150

Toll Free: (800) 584-4438
Tel: (530) 573-3337
Fax: (530) 544-6413

Placerville Office
520 Main Street
Placerville, CA 95667

Toll Free: (888) 422-6492
Tel: (530) 621-6450
Fax: (530) 295-2602

FRESNO COUNTY

Victim/Witness Assistance Center
Fresno County Probation Department
2220 Tulare Street, Suite 1126
Fresno, CA 93721

Tel: (559) 488-3425
Fax: (559) 488-3826

GLENN COUNTY

Victim/Witness Assistance Center
HRA Community Action Division
420 East Laurel Street
Willows, CA 95988

Toll Free: (800) 287-8711
Tel: (530) 934-6510
Fax: (530) 934-6650

HUMBOLDT COUNTY

Victim/Witness Assistance Center
Humboldt County District Attorney's Office
712 Fourth Street
Eureka, CA 95501

Tel: (707) 445-7417
Fax: (707) 445-7490

IMPERIAL COUNTY

Victim/Witness Assistance Center
Imperial County Probation Department
217 South Tenth, Building A
El Centro, CA 92243

Tel: (760) 336-3930
Fax: (760) 353-3292

INYO COUNTY

Victim/Witness Assistance Center
301 West Line Street, Suite C
Bishop, CA 93514

Tel: (760) 873-6669
Fax: (760) 873-8359

Inyo County District Attorney's Office
P.O. Drawer D
Independence, CA 93526

Tel: (760) 878-0282
Fax: (760) 878-2383

KERN COUNTY

Victim/Witness Assistance Center
Kern County Probation Department
1415 Truxtun Avenue, 6th Floor, Room 603
Bakersfield, CA 93301

Tel: (661) 868-4535
Fax: (661) 868-4586

KINGS COUNTY

Victim/Witness Assistance Center
Kings County Probation Department
Kings County Government Center
1400 West Lacey Boulevard
Hanford, CA 93230

Tel: (559) 582-3211 ext. 2640
Fax: (559) 584-7038

LAKE COUNTY

Victim/Witness Assistance Center
Lake County District Attorney's Office
420 Second Street
Lakeport, CA 95453

Tel: (707) 262-4282
Fax: (707) 262-5851

LASSEN COUNTY

Victim/Witness Assistance Center
Lassen County District Attorney's Office
Courthouse
220 South Lassen Street, Suite 8
Susanville, CA 96130

Tel: (530) 251-8283
Fax: (530) 257-2-9009

LOS ANGELES COUNTY

Victim/Witness Assistance Center
Los Angeles County District Attorney's Office
3204 Rosemead Boulevard, Suite E
El Monte, CA 91731

Tel: (626) 927-2525
Fax: (626) 569-9541

Central Victim/Witness Office
210 West Temple, No. 12-514
Los Angeles, CA 2-90012

Toll free: (800) 773-7540
Tel: (213) 774-7499
Fax: (213) 625-8104

El Monte Victim/Witness Office
3220 North Rosemead Boulevard
El Monte, CA 91731

Toll Free: (800) 492-5944
Tel: (626) 572-6366
Fax:(626) 280-0817

El Monte Victim/Witness
11234 East Valley Boulevard
El Monte, CA 91731

Tel: (626) 350-4583
Fax: (626) 442-6543

Sexual Crimes/Child Abuse Unit
Hall of Records
320 West Temple Street, Room 740
Los Angeles, CA 2-90012

Tel: (213) 974-3801
Fax: (213) 625-2810

Carson Sheriff
21356 South Avalon Boulevard
Carson, CA 90745

Tel: (310) 830-8376
Fax: (310) 847-8368

Compton Courthouse
200 West Compton Boulevard, Room 700
Compton, CA 90220

Tel: (310) 603-7579, or
(310) 603-7574, or
(310) 603-7127
Fax: (310) 603-0493

Statutory Rape Program Hall of Records 320 West Temple Street, No. 740 Los Angeles, CA 2-90012	Tel: (213) 974-3908 Fax: (213) 625-2810
Inglewood Courthouse One Regent Street, Room 405 Inglewood, CA 90301	Tel: (310) 419-6764, or (310) 419-5175 Fax: (310) 674-7839
Long Beach Courthouse 415 West Ocean Boulevard, Room 305 Long Beach, CA 90802	Tel: (562) 491-6347, or (562) 491-6310 Fax: (562) 436-9849
Santa Monica Courthouse 1725 Main Street, Room 228 Santa Monica, CA 90401	Tel: (310) 260-3678 Fax: (310) 458-6518
Torrance Courthouse 825 Maple Avenue Torrance, CA 90503	Tel: (310) 222-3599 Fax: (310) 783-1684
Antelope Valley Courthouse 1110 West Avenue J Lancaster, CA 93534	Tel: (661) 945-6464 Fax: (661) 945-6179
Hollywood LAPD 1358 North Wilcox Avenue Los Angeles, CA 2-90028	Tel: (323) 871-1184 Fax: (213) 485-8891
Industry Sheriff 150 North Hudson Avenue City of Industry, CA 91744	Tel: (626) 934-3004 Fax: (626) 333-1895
Pasadena Courthouse 300 East Walnut Street, Room 107 Pasadena, CA 91101	Tel: (626) 356-5714, or (626) 356-5715 Fax: (626) 796-3176
Pomona Courthouse 400 Civic Center Drive, Room 201 Pomona, CA 91766	Tel: (909) 620-3381, or (909) 620-3382 Fax: (909) 629-6876

San Fernando Area
2-900 – 3rd Street, Room G14
San Fernando, CA 91340
Tel: (818) 898-2406
Fax: (818) 898-2743

Temple City Sheriff
8838 East Las Tunas Drive
Temple City, CA 91780
Tel: (626) 292-3333
Fax: (626) 287-7353

Van Nuys Courthouse
6230 Sylmar Avenue, 5th Floor
Van Nuys, CA 91401
Tel: (818) 374-3075
Fax: (818) 782-5349

Central LAPD
251 East Sixth Street
Los Angeles, CA 2-90014
Tel: (213) 627-1619
Fax: (213) 847-2956

East Los Angeles Courthouse
214 South Fetterly Avenue, Room 201
Los Angeles, CA 2-90022
Tel: (323) 780-2045
Fax: (323) 269-4869

Huntington Park Area Office
2958 East Florence Avenue
Huntington Park, CA 90255
Tel: (323) 586-6337
Fax: (323) 584-9055

Lakewood Sheriff
5130 North Clark Avenue
Lakewood, CA 90712
Tel: (562) 920-5156
Fax: (562) 867-4712

Norwalk Courthouse
12720 Norwalk Boulevard, Room 201
Norwalk, CA 90650
Tel: (562) 807-7230
Fax: (562) 929-7626

Rampart LAPD
303 South Union
Los Angeles, CA 2-90057
Tel: (213) 483-6731
Fax: (213) 207-2108

Southeast LAPD
145 West 108th Street
Los Angeles, CA 2-90061
Tel: (323) 754-8064
Fax: (323) 485-8340

Southwest LAPD
1546 Martin Luther King Boulevard
Los Angeles, CA 2-90062

Tel: (323) 296-8645
Fax: (323) 473-6757

Eastlake Juvenile Office
1601 Eastlake Avenue, Room 132
Los Angeles, CA 2-90033

Tel: (323) 226-8918
Fax: (323) 223 6248

Family Violence Division
Criminal Courts Building
210 W. Temple Street, Room 603
Los Angeles, CA 2-90012

Tel: (213) 974-7410, or
(213) 974-3879
Fax: (213) 217-4992

Stalking & Threat Management Team
Hall of Records
320 W. Temple Street, Room 780-41
Los Angeles, CA 2-90012

Tel: (213) 893-0896
Fax: (213) 626-2758

Whittier Branch Office
7339 S. Painter Ave., Room 200
Whittier, CA 90602

Tel: (562) 907-3189
Fax: (562) 696-9631

Child Abuse Crisis Center
Harbor-UCLA Medical Center
1000 W. Carson St.
Box 460 Trailer N-26
Torrance, CA 90509

Tel: (310) 222-1208
Fax: (310) 320-7849

East L.A. Sheriff
5019 E. Third Street
Los Angeles, CA 2-90022

Tel: (323) 981-5024
Fax: (323) 267-0637

<u>LOS ANGELES CITY</u> (Subgrant to Los Angeles County Victim/Witness)

Victim/Witness Assistant Center
Los Angeles City Attorney's Office
312 South Hill Street, Third Floor
Los Angeles, CA 2-90013
Tel: (213) 485-6976
Fax: (213) 847-8667

Victim Assistance Program
Korean Outreach Project
312 South Hill Street, Second Floor
Los Angeles, CA 2-90013
Tel: (213) 485-9889
Fax: (213) 847-8667

North Hollywood Station LAPD
Victim Assistance Program
11640 Burbank Boulevard
North Hollywood, CA 91601
Tel: (818) 623-4056
Fax: (818) 623-4121

Victim Assistance Program
San Pedro City Hall
638 S. Beacon St., Room 326
San Pedro, CA 90731
Tel: (310) 732-4611
Fax: (310) 732-4618

Victim Assistance Program
Van Nuys City Hall
14410 Sylvan Street, Room 117
Van Nuys, CA 91401
Tel: (818) 756-8488
Fax: (818) 756-9444

Wilshire Area Station LAPD
Victim Assistance Program
4861 Venice Boulevard
Los Angeles, CA 2-90019
Tel: (213) 847-1991
Fax: (213) 847-0668

West Los Angeles Station LAPD
Victim Assistance Program
1663 Butler Avenue
West Los Angeles, CA 2-90025
Tel: (310) 575-8441
Fax: (310) 575-6710

Newton Area Station LAPD
Victim Assistance Program
3400 South Central Avenue
Los Angeles, CA 2-90011

Tel: (323) 846-5374
Fax: (323) 846-6586

77th Street Area Station LAPD
Victim Assistance Program
7600 South Broadway
Los Angeles, CA 2-90003

Tel: (213) 485-8848
Fax: (213) 847-0667

Hollenbeck Area Station LAPD
Victim Assistance Program
2111 East First Street
Los Angeles, CA 2-90033

Tel: (323) 526-3190
Fax: (323) 485-8401

MADERA COUNTY

Victim/Witness Assistance Center
Madera County Community Action Committee, Inc.
1200 West Maple Street, Suite C
Madera, CA 93637

Tel: (559) 661-1000
Fax: (559) 661-8389

MARIN COUNTY

Victim/Witness Assistance Center
Marin County District Attorney's Office
3501 Civic Center Drive, Room 130
San Rafael, CA 94903

Tel: (415) 499-6450
Fax: (415) 499-3719

MARIPOSA COUNTY

Victim/Witness Assistance Center
Mariposa County District Attorney's Office
P.O. Box 730
Mariposa, California 95338

Tel: (209) 742-7441
Fax: (209) 742-5780

MENDOCINO COUNTY

Victim/Witness Assistance Center
Mendocino County District Attorney's Office
Courthouse, Room 10
100 North State Street
P.O. Box 144
Ukiah, CA 95482

Tel: (707) 463-4218
Fax: (707) 468-3371

MERCED COUNTY
Victim/Witness Assistance Center
Merced County District Attorney's Office
658 W. 20th St.
Merced, CA 95340

Tel: (209) 725-3515
Fax: (209) 725-3669

MODOC COUNTY
Victim/Witness Assistance Center
Modoc County District Attorney's Office
204 South Court Street
Alturas, CA 96101

Tel: (530) 233-3311
Fax: (530) 233-5024

MONO COUNTY
Victim/Witness Assistance Center
452 Old Mammoth Road, Third Floor
P.O. Box 2053
Mammoth Lakes, CA 93546

Tel: (760) 924-1710
Fax: (760) 924-1711

Bridgeport Victim/Witness Office
P.O. Box 617
Bridgeport, CA 93517

Tel: (760) 932-5550
Fax: (760) 924-1711

MONTEREY COUNTY
Victim/Witness Assistance Center
Monterey County District Attorney's Office
240 Church Street #101
P.O. Box 1311
Salinas, CA 93901

Tel: (831) 755-5272
Fax: (831) 796-6448

NAPA COUNTY
Victim/Witness Assistance Center
Napa County Volunteer Center, Inc.
1820 Jefferson Street
Napa, CA 94559

Tel: (707) 252-6222
Fax: (707) 226-5179

NEVADA COUNTY
Victim/Witness Assistance Center
Nevada County Probation Department
109 ½ North Pine Street
Nevada City, CA 95959

Tel: (530) 265-1246, or
(530) 265-1331
Fax: (530) 265-6304

ORANGE COUNTY

Victim/Witness Assistance Administrative Center
Community Service Programs, Inc.
1821 East Dyer, Suite 200
Santa Ana, CA 92705-5700
Tel: (949) 975-0244
Fax: (949) 975-0250

Superior Court
Central Justice Center
700 Civic Center Drive West
P.O. Box 1994
Santa Ana, CA 92702
Tel: (714) 834-4350
Fax: (714) 834-2688

North Justice Center
1275 North Berkeley Avenue
Fullerton, CA 92635
Tel: (714) 773-4575
Fax: (714) 441-3575

Harbor Justice Center-Laguna Niguel
30143 Crown Valley Parkway
Laguna Niguel, CA 92677
Tel: (949) 249-5037
Fax: (949) 249-5100

West Justice Center
8141 13th Street
Westminster, CA 92683
Tel: (714) 896-7188
Fax (714) 896-7526

Harbor Justice Center-Newport Beach
4601 Jamboree Boulevard, Suite 103
Newport Beach, CA 92660
Tel: (949) 476-4855
Fax: (949) 476-4623

Lamoreaux Justice Center
301 The City Drive
Orange, CA 92668
Tel: (714) 935-7074
Fax: (714) 935-6341

PLACER COUNTY

Victim/Witness Assistance Program
Placer County District Attorney's Office
11562 B Avenue
Auburn, CA 95603
Tel: (530) 889-7021
Fax: (530) 886-2294

PLUMAS COUNTY

Victim/Witness Assistance Center
Plumas County Sheriff's Department
75 Court Street, Suite A
Quincy, CA 95971

Tel: (530) 283-6285
Fax: (530) 283-6226

RIVERSIDE COUNTY

Victim/Witness Assistance Center
Riverside County District Attorney's Office
4075 Main Street, First Floor
Riverside, CA 92501

Tel: (909) 955-5450
Fax: (909) 955-5640

Banning Victim/Witness Office
Western Riverside County
135 North Alessandro, Room 205
Banning, CA 92220

Tel: (909) 849-6218
Fax: (909) 922-7135

Blythe Victim/Witness Office
Eastern Riverside County
225 North Broadway
Blythe, CA 92225

Tel: (935) 921-7878
Fax: (935) 921-7849

Southwest Justice Center
30755-D Auld Road
Murrieta, CA 92563

Tel: (909) 304-5500
Fax: (909) 304-5503

Indio Victim/Witness Office
Eastern Riverside County
82-675 Highway 111, Fourth Floor
Indio, CA 92201

Tel: (760) 863-8408
Fax: (760) 863-7640, or
(760) 863-8987

Riverside Juvenile Office
Western Riverside County
9991 County Farm Road
Riverside, CA 92503

Tel: (909) 358-4152
Fax: (909) 358-4497

Corona Police Department
515 So. Corona Mall
Corona, CA 92882

Tel: (909) 739-4872
Fax: (909) 279-3599

SACRAMENTO COUNTY
Victim/Witness Assistance Center
Sacramento County District Attorney's Office
901 G Street
P.O. Box 749
Sacramento, CA 95814
Tel: (916) 874-5701
Fax: (916) 874-5271

SAN BENITO COUNTY
Victim/Witness Assistance Center
San Benito County District Attorney's Office
419 Fourth Street
Hollister, CA 95023-3801
Tel: (831) 637-8244
Fax: (831) 636-4126

SAN BERNARDINO COUNTY
Victim/Witness Assistance Center
San Bernardino County District Attorney's Office
316 North Mountain View Avenue, 3rd Floor
San Bernardino, CA 92415
Tel: (909) 387-6540, or
(909) 387-6384
Fax: (909) 387-6313

San Bernardino Juvenile Division
2-900 East Gilbert Street
San Bernardino, CA 92415
Tel: (909) 387-8665
Fax: (909) 387-6980

San Bernardino Police Department
710 North D Street
San Bernardino, CA 92401
Tel: (909) 388-42-900
Fax: (909) 388-4843

Colton Police Department
650 North La Cadena Drive
Colton, CA 92324
Tel: (909) 370-5164
Fax: (909) 370-5158

Fontana Victim/Witness Center
17830 Arrow Boulevard
Fontana, CA 92335
Tel: (909) 356-6406
Fax: (909) 356-6779

Ontario Police Department
200 North Cherry Avenue
Ontario, CA 91764
Tel: (909) 395-2713
Fax: (909) 395-2730

Rancho Cucamonga Victim/WitnessOffice
8303 North Haven Avenue, 4th Floor
Rancho Cucamonga, California 91730
Tel: (909) 945-4241
Fax: (909) 945-4035

Victorville Victim/Witness Office
14455 Civic Drive
Victorville, California 92392
Tel: (760) 243-8619
Fax: (760) 243-8619

Barstow Victim/Witness Office
235 East Mountain View
Barstow, CA 92311
Tel: (760) 256-4802
Fax: (760) 256-4869

Joshua Tree Victim/Witness Center
6527 White Feather Road
Joshua Tree, CA 92252
Tel: (760) 366-5740
Fax: (760) 366-4126

SAN DIEGO COUNTY

Victim/Witness Assistance Center
San Diego County District Attorney's Office
330 West Broadway, Suite 800
P.O. Box 121011
San Diego, CA 92101
Tel: (619) 531-4041
Fax: (619) 685-6521

Chula Vista Victim/Witness Office
500 Third Avenue
Chula Vista, CA 92010
Tel: (619) 691-4539
Fax: (619) 691-4459

El Cajon Victim/Witness Office
250 East Main Street, 5th Floor
El Cajon, CA 92020
Tel: (619) 441-4538
Fax: (619) 441-4095

Vista Victim/Witness Office
325 South Melrose, Suite 5000
Vista, CA 92083
Tel: (760) 806-4079
Fax: (760) 806-4162, or
(760) 806-4163

Juvenile Victim/Witness Office
2851 Meadowlark Drive
San Diego, CA 92123

Tel: (858) 694-4595
Fax: (858) 694-4774

San Diego Police Department
1401 Broadway
San Diego, California 92101

Tel: (619) 531-2772, or
(619) 531-2773
Fax: (619) 525-8433

SAN FRANCISCO COUNTY AND CITY

Victim/Witness Assistance Center
San Francisco County District Attorney's Office
850 Bryant Street, Room 320
San Francisco, CA 94103

Tel: (415) 553-9044
Fax: (415) 553-1034

SAN JOAQUIN COUNTY

Victim/Witness Assistance Center
San Joaquin County District Attorney's Office
222 East Weber Avenue, Room 245
Stockton, CA 95202

Tel: (209) 468-2500
Fax: (209) 468-2521

SAN LUIS OBISPO COUNTY

Victim/Witness Assistance Center
San Luis Obispo County District Attorney's Office
County Government Center, Room 121
San Luis Obispo, CA 93408

Toll Free: (866) 781-5821
Tel: (805) 781-5822
Fax: (805) 781-5828

SAN MATEO COUNTY

Victim/Witness Assistance Center
San Mateo County District Attorney's Office
1024 Mission Road
South San Francisco, CA 94080

Tel: (650) 877-5492
Fax: (650) 877-7001

SANTA BARBARA COUNTY

Victim/Witness Assistance Center
Santa Barbara County District Attorney's Office
118 East Figueroa Street
Santa Barbara, CA 93101
Tel: (805) 568-2408
Fax: (805) 568-2453

Santa Maria Victim/Witness Office
312 East Cook Street
Santa Maria, CA 93454
Tel: (805) 346-7529
Fax: (805) 346-7585

Lompoc Victim/Witness Office
115 Civil Plaza Center
Lompoc, CA
Tel: (805) 737-7910
Fax: (805) 737-7732

SANTA CLARA COUNTY

Santa Clara County Victim/Witness
Assistance Center
National Conference for Community and Justice
777 North First Street, Suite 220
San Jose, CA 95112
Tel: (408) 295-2656
Fax: (408) 295-2045

SANTA CRUZ COUNTY

Victim/Witness Assistance Center
Santa Cruz County District Attorney's Office
701 Ocean Street, Room 200
Santa Cruz, CA 95060
Tel: (831) 454-2010, or
(831) 454-2623
Fax: (831) 454-2612

SHASTA COUNTY

Victim/Witness Assistance Center
Shasta County District Attorney's Office
1525 Court Street
Redding, CA 96001
Tel: (530) 225-5220, or
(530) 225-5195
Fax: (530) 245-6334

SIERRA COUNTY

Victim/Witness Assistance Center
Sierra County Probation Department
604B Main Street
P.O. Box 886
Loyalton, CA 96118
Tel: (530) 993-4617
Fax: (530) 993-4327

SISKIYOU COUNTY

Victim/Witness Assistance Center
Siskiyou County District Attorney's Office
311 4th Street
P.O. Box 986
Yreka, CA 96097

Tel: (530) 842-8229
Fax: (530) 842-8222

Tulelake Office
298 Street
P.O. Box 790
Tulelake, CA 96134

Tel: (530) 667-2147
Fax: (530) 667-2822

SOLANO COUNTY

Victim/Witness Assistance Center
Solano County District Attorney's Office
Hall of Justice
600 Union Avenue
Fairfield, CA 94533

Tel: (707) 421-6844
Fax: (707) 421-7986

Solano Victim/Witness Office
Solano County Justice Building
321 Tuolumne Street
Vallejo, California 94590

Tel: (707) 554-5400
Fax: (707) 554-5654

SONOMA COUNTY

Vacant, Project Coordinator
Victim/Witness Assistance Center
Sonoma County District Attorney's Office
P.O. Box 6023
Santa Rosa, CA 95406

Tel: (707) 565-8250
Fax: (707) 565-8262

STANISLAUS COUNTY

Victim/Witness Assistance Center
Stanislaus County District Attorney's Office
800 11th Street, Room 200
P.O. Box 442
Modesto, CA 95354

Tel: (209) 525-5541
Fax: (209) 525-5551

SUTTER COUNTY
Victim/Witness Assistance Center
Sutter County District Attorney's Office
204 C Street
P.O. Box 1555
Yuba City, CA 95991
Tel: (530) 822-7345
Fax: (530) 822-7464

TEHAMA COUNTY
Victim/Witness Assistance Center
Tehama County District Attorney's Office
444 Oak Street
P.O. Box 519
Red Bluff, CA 96080
Tel: (530) 527-4296
Fax: (530) 527-4735

TRINITY COUNTY
Victim/Witness Assistance Center
Trinity County Probation Department
333 Tom Bell Road
P.O. Box 158
Weaverville, CA 96093
Tel: (530) 623-1204
Fax: (530) 623-1237

TULARE COUNTY
Victim/Witness Assistance Center
Tulare County District Attorney's Office
221 South Mooney Boulevard #264
Visalia, CA 93291
Tel: (559) 733-6754
Fax: (559) 730-2931

TUOLUMNE COUNTY
Victim/Witness Assistance Center
Tuolumne County District Attorney's Office
423 North Washington Street
Sonora, CA 95370
Tel: (209) 588-5440
Fax: (209) 588-5455

VENTURA COUNTY
Victim/Witness Assistance Center
Ventura County District Attorney's Office
800 South Victoria Avenue, Room 311
Ventura, CA 93009
Tel: (805) 654-3622
Fax: (805) 662-6523

YOLO COUNTY

Victim/Witness Assistance Center
Yolo County District Attorney's Office
301 Second Street
Woodland, CA 95695

Tel: (530) 666-8187
Fax: (530) 666-8185

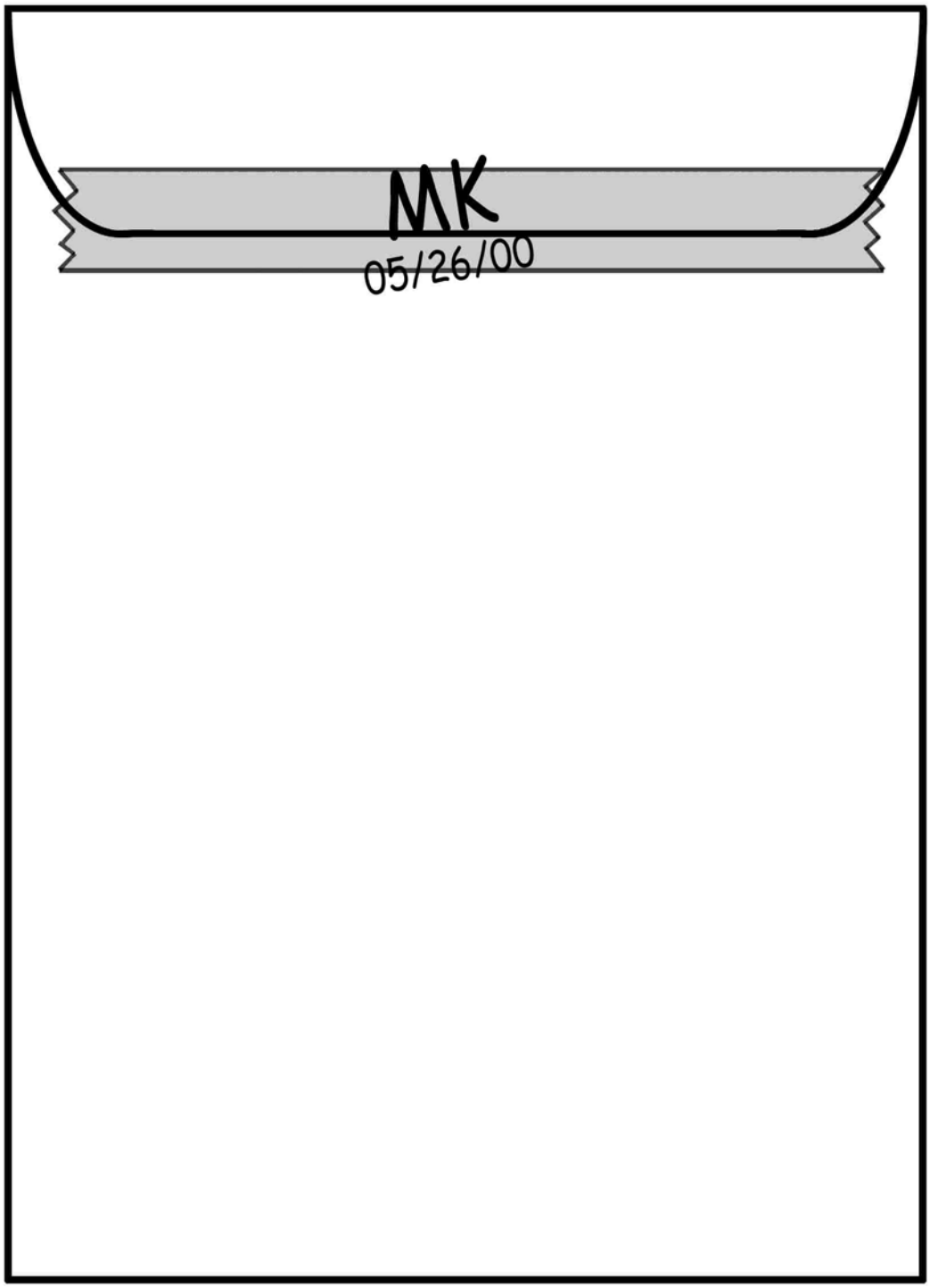
YUBA COUNTY

Victim/Witness Assistance Center
Yuba County Probation Department
4240 Dan Avenue
Marysville, CA 95901

Tel: (530) 741-6275
Fax: (530) 749-7913

APPENDIX G

EXAMPLE OF SEALED EVIDENCE ENVELOPE



Note: Sign and date over the seal.

APPENDIX H

CHAIN OF CUSTODY FORM

CALIFORNIA COUNTY
Laboratory of Forensic Sciences

EVIDENCE COLLECTION KIT

FOR HOSPITAL PERSONNEL
(Please print)

Name of Patient:_____ **Date of Birth:** _____ ☐ **Female** ☐ **Male**

Name of Examiner:_____

Name of Hospital:_____ **Date of Exam:**_____

Law Enforcement Agency: _____

Agency Case No.: _____

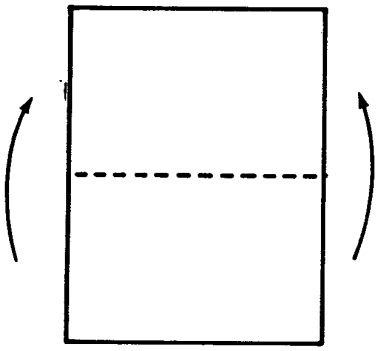
AFFIX BIOHAZARD LABEL HERE AFTER SPECIMEN COLLECTION

CHAIN OF CUSTODY

FROM: (Print Name and Sign)	**TO:** (Print Name and Sign)	**DATE**	**TIME**

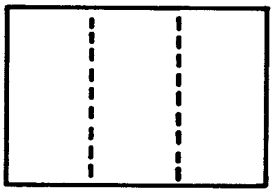
APPENDIX I

HOW TO MAKE A BINDLE



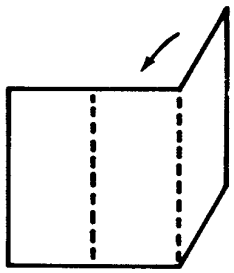
1

Fold the paper in half.



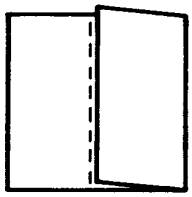
2

Fold the half-sized paper into thirds.

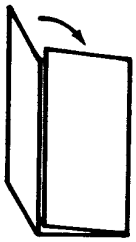


3

Fold over the right flap.

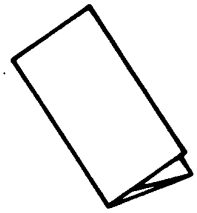


4



5

Fold over the left flap.



6



7

Fold in half. Seal the open end of the bindle, not the folded end. Initial the tape prior to sealing.

APPENDIX J

CalOES 2-900 FORM AND INSTRUCTIONS

The CalOES 2-900 form can be downloaded from these websites:

California Office of Emergency Services -- **www.CalOES.ca.gov**
Look for Criminal Justice Programs Division. Click on the appropriate document in Publications and Brochures to view document list.

California Clinical Forensic Medical Training Center
www.ccfmtc.org.

State of California
California Office of Emergency Services

MEDICAL REPORT:
SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION

CalOES 2-900

For more information or assistance in completing the CalOES 2-900, please contact California Clinical Forensic Medical Training Center at:(916) 930-3080 or www.ccfmtc.org

Forms available at: **www.CalOES.ca.gov and www.ccfmtc.org**

MEDICAL REPORT: SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION
State of California
California Office of Emergency Services CalOES 2-900

Confidential Document: Restricted Release | **Patient Identification:** | **Date:**

A. GENERAL INFORMATION

☐ See Patient Label/Registration Face Sheet

1. Name of Medical Facility Where Exam Performed	Facility Address	2. Date of Exam	Time of Exam

3. Patient's Last Name	First Name	M.I.	Telephone	Cell Phone

4. Street Address	City	County	State	Zip Code

5. Age	Date of Birth	Gender ☐ Female ☐ Male	Ethnicity

6. Interpreter Used: ☐ No ☐ Yes Language Used: _____

Name of Interpreter: _____ Telephone: _____

Affiliation of interpreter: ☐ Facility Interpreting Services

☐ Contracted Agency, specify: _____

☐ Family ☐ Friend ☐ Other, specify: _____

7. Name of Child's Caregiver ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____ **Gender** ☐ Female ☐ Male **Telephone** (w) (h) (c)

Street Address	City	County	State	Zip Code

8. Name of Child's Caregiver ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____ **Gender** ☐ Female ☐ Male **Telephone** (w) (h) (c)

Street Address	City	County	State	Zip Code

9. Name(s) of Siblings	Gender	Age	DOB	Name(s) of Siblings	Gender	Age	DOB
	M F				M F		
	M F				M F		

B. MANDATORY REPORTING FOR SUSPECTED CHILD ABUSE AND NEGLECT

Mandatory Child Abuse/Neglect Report made to both Law Enforcement and CPS Agencies (Pursuant to Penal Code §11166):

☐ Law Enforcement ☐ Telephone Report ☐ Written Report Submitted Name of Person Taking Report:	Name of Agency	Telephone	Date
☐ Child Protective Services ☐ Telephone Report ☐ Written Report Submitted Name of Person Taking Report:	Name of Agency	Telephone	Date

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

Name **ID Number** **Agency** ☐ **Unknown**

Child Protective Services _____

and/or

Law Enforcement Officer _____

D. PATIENT CONSENT AND AUTHORIZATION FOR EXAMINATION (See instructions)

☐ Law Enforcement Authorized ☐ CPS Authorized ☐ Placed in protective custody ☐ Physician authority pursuant to state law ☐ Parent/Guardian consent

E. DISTRIBUTION OF CalOES 2-900 (Check all that apply)

☐ Law Enforcement Agency (original) ☐ Hand Delivered ☐ Mailed ☐ Faxed	☐ Child Protective Services (copy) ☐ Hand Delivered ☐ Mailed ☐ Faxed
☐ Crime Laboratory (copy included with evidence)	☐ Medical Facility Records (copy)

F. PATIENT HISTORY

1. Name of Person(s) Providing History	Relationship to Patient

2. Child Accompanied to Facility By	Relationship to Patient

Patient Identification: **Date:**

3. History of Present Illness ☐ **See dictation for additional information.** ☐ **N/A**

If dictating, provide brief 2-3 sentence handwritten summary. Print or write legibly. Include date, time or timeframe, place of incident, and initial reporting party. Distinguish statements made by child in quotation marks from those statements made by other historians.

G. PAST MEDICAL HISTORY

	Yes	No	Unknown	Describe
Birth History (if applicable)	☐	☐	☐	
Physical Abuse History	☐	☐	☐	
Sexual Abuse History	☐	☐	☐	
Neglect History	☐	☐	☐	
Emotional Abuse History	☐	☐	☐	
Domestic Violence Exposure	☐	☐	☐	
Alcohol/Drug Exposure ☐ Prenatal ☐ Postnatal ☐ Alcohol ☐ Drug	☐	☐	☐	Specify types of drugs if known, and collect urine toxicology up to 96 hours after ingestion:
Hospitalization(s)	☐	☐	☐	
Surgery	☐	☐	☐	
Significant Illness/Injury	☐	☐	☐	
Any pertinent medical condition(s) that may affect the interpretation of findings?	☐	☐	☐	
Allergies	☐	☐	☐	
Medications	☐	☐	☐	
Immunizations Up To Date	☐	☐	☐	
Disabilities	☐	☐	☐	(Specify):
Growth & Development ☐ WNL ☐ ABN ☐ Unknown	☐	☐	☐	

H. REVIEW OF SYSTEMS ☐ Negative except as noted below

☐ See dictation for additional information ☐ N/A

I. NAME OF PERSON TAKING HISTORY (Print Name)	Signature	Telephone	Date

J. GENERAL PHYSICAL EXAMINATION

1. Temperature	Pulse	Respiration	Blood Pressure

2. Height (cm or in)	(%)	Weight (kg or lb)	(%)	Children under 2: (HC)	(%)

3. General physical appearance, demeanor, and level of physical discomfort/pain. Provide brief handwritten summary even if dictating. ☐ See dictation for additional information. ☐ N/A

Patient Identification: **Date:**

4. Record results of physical examination.

	WNL	ABN	Not Examined	See Body Diagram	Describe Abnormal Findings. ☐ N/A ☐ See dictation for additional information
Skin					
Head					
Eyes					
Ears					
Nose					
Mouth/Pharynx					
Teeth					
Neck					
Lungs					
Chest					
Heart					
Abdomen					
Back					
Buttocks					
Extremities					
Neurological					
Genitalia					

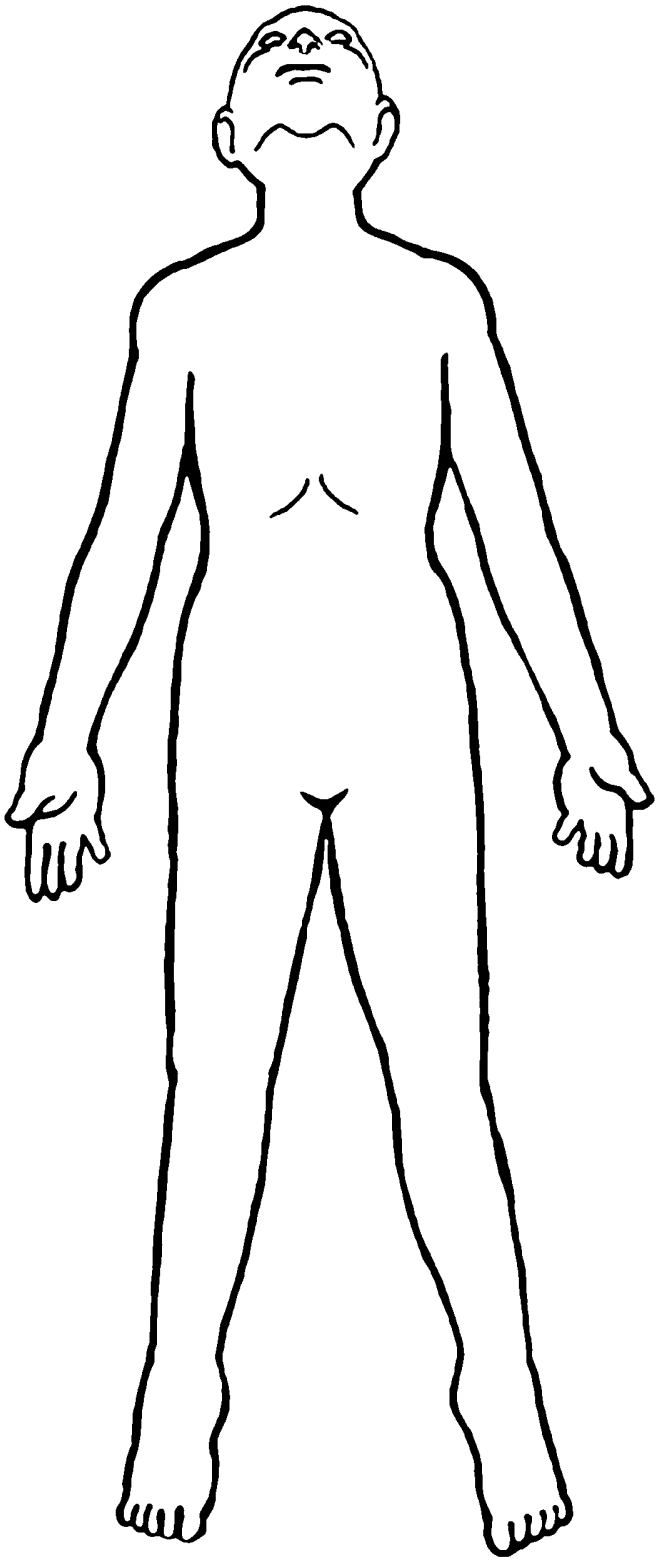
5. If genital injuries are sustained, use copies of page(s) 6 and 7 (if applicable) from CalOES 930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form or CalOES 925 Forensic Medical Report: NonAcute (>72 hours) Child/Adolescent Sexual Abuse Examination to document findings and attach to this form.

J. GENERAL PHYSICAL EXAMINATION (continued)

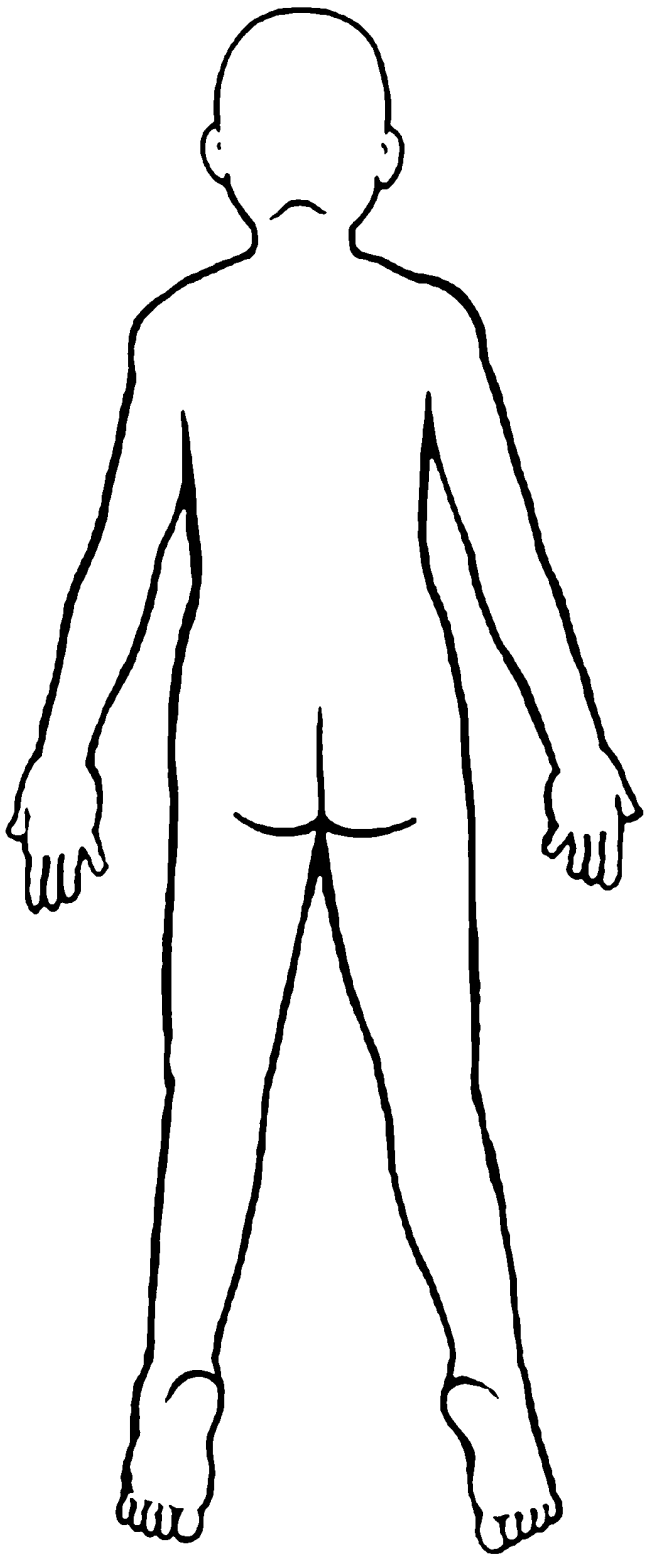
6. Conduct physical examination and record findings using the diagrams.

Patient Identification: **Date:**

A



B

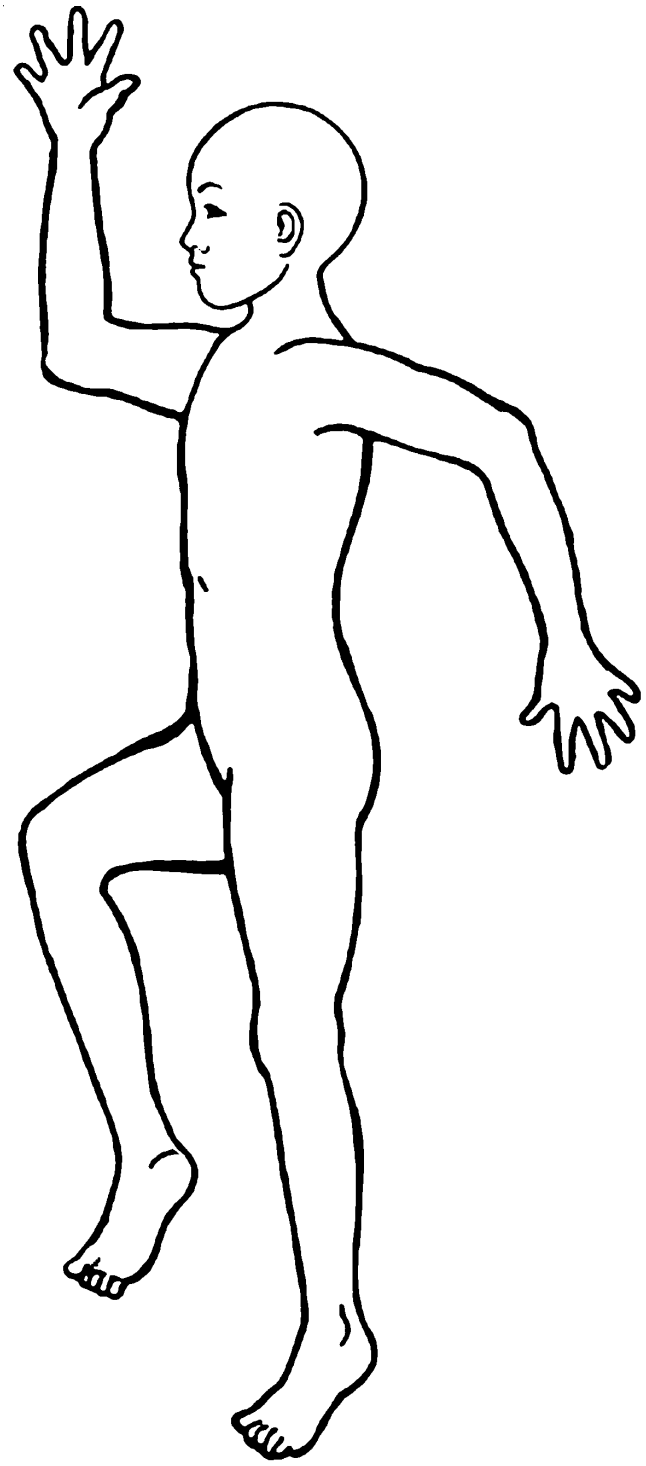


J. GENERAL PHYSICAL EXAMINATION (continued)

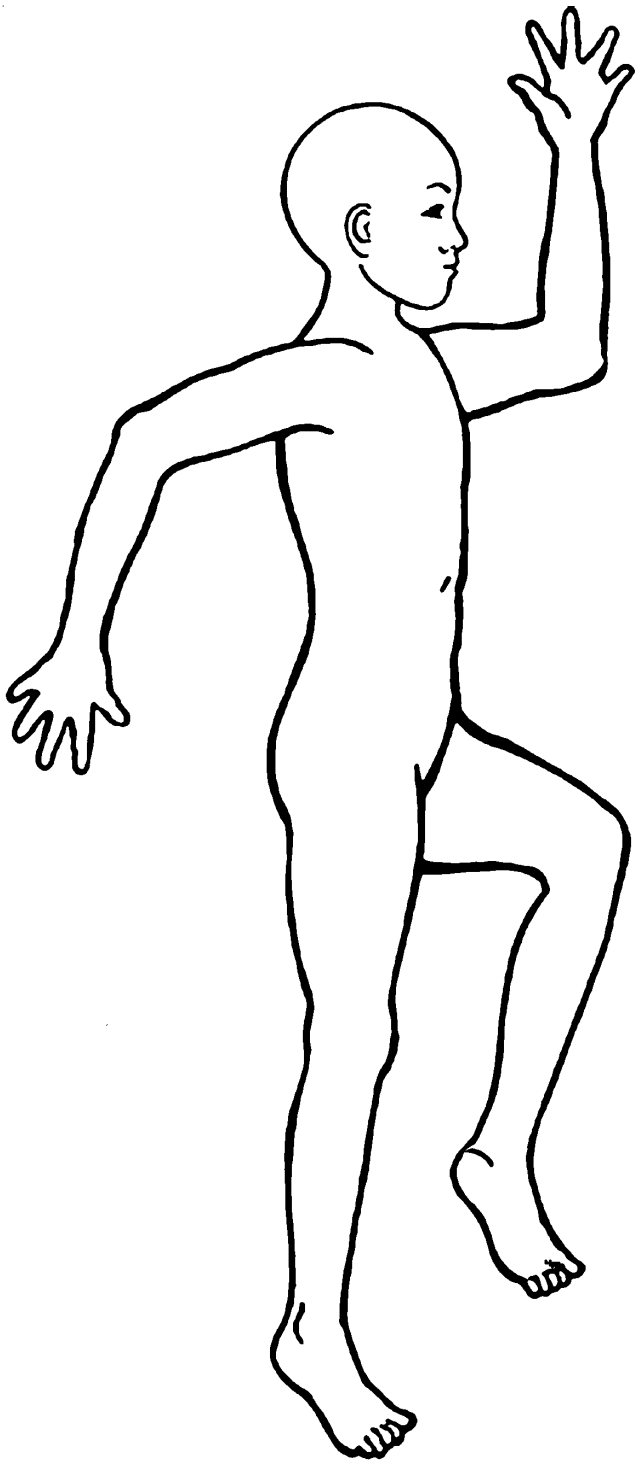
6. Conduct physical examination and record findings using the diagrams.

Patient Identification: **Date:**

C



D

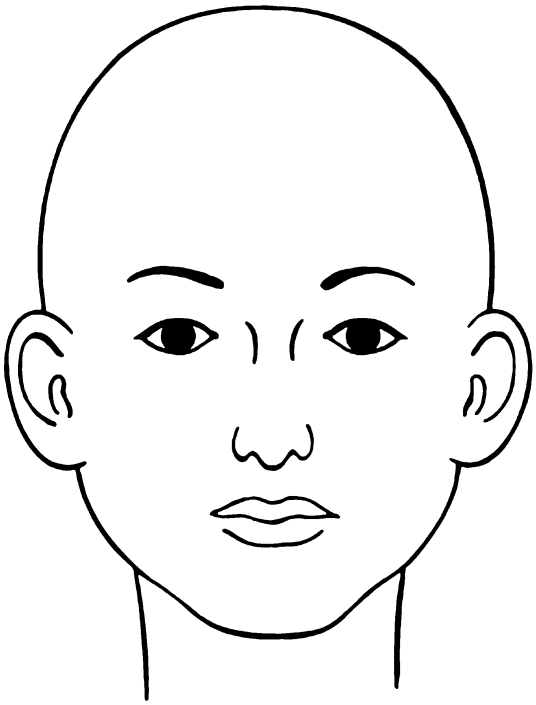


J. GENERAL PHYSICAL EXAMINATION (continued)

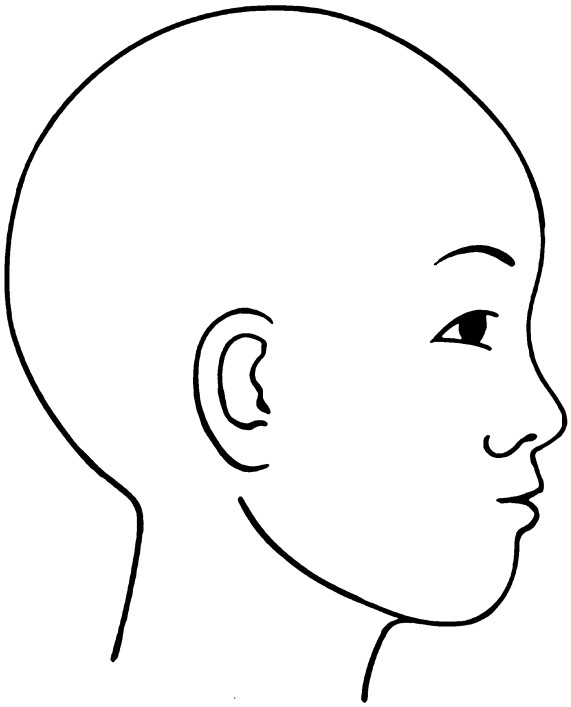
7. Examine the face, head, ears, hair, scalp, neck, and mouth for

Patient Identification: **Date:**

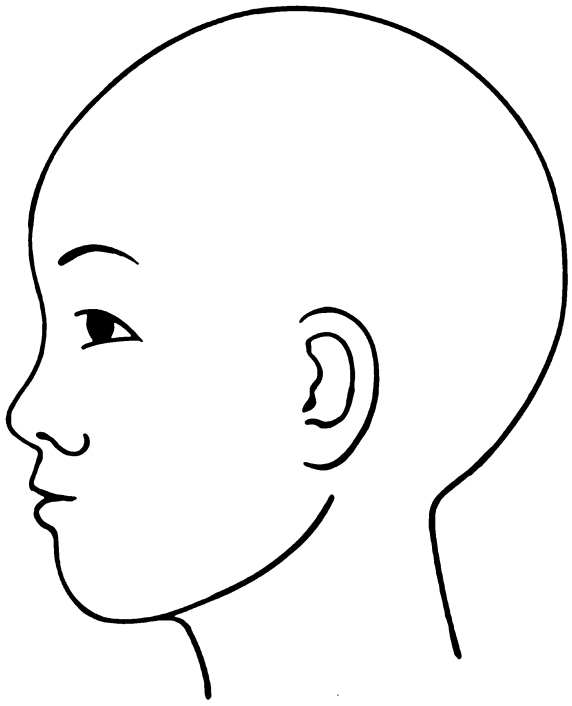
E



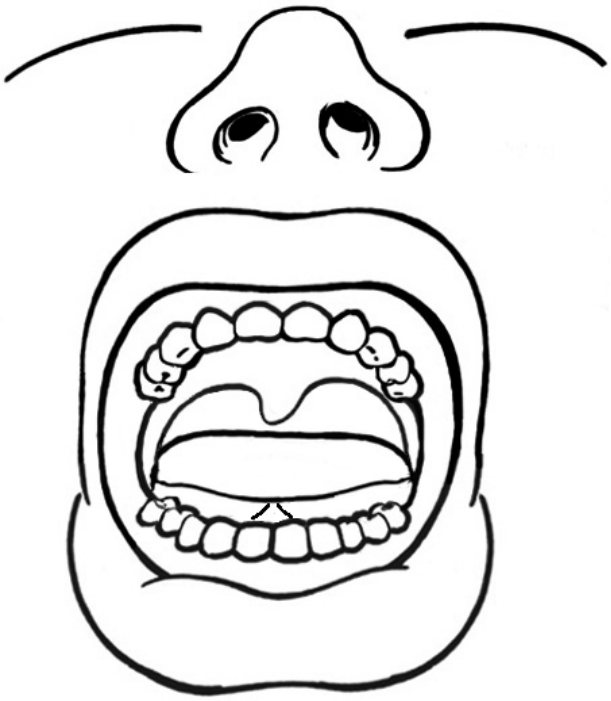
F



G



H



K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing Collected ☐ No ☐ Yes ☐ N/A

Clothing Placed in Evidence Kit	Clothing Placed in Paper Bag

2. Foreign Materials Collected

	N/A	No	Yes	Collected by:
Swabs/suspected blood	☐	☐	☐	
Dried secretions	☐	☐	☐	
Fiber/loose hairs	☐	☐	☐	
Soil/debris/vegetation	☐	☐	☐	
Swabs/suspected saliva	☐	☐	☐	
Foreign body	☐	☐	☐	
Control swabs	☐	☐	☐	
Fingernail scrapings	☐	☐	☐	
Matted hair cuttings	☐	☐	☐	

Other types, describe: _____

L. TOXICOLOGY SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood Alcohol / Toxicology	☐	☐	☐		
Urine Toxicology	☐	☐	☐		

M. REFERENCE SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood (lavender top tube)	☐	☐	☐		
Blood card (optional)	☐	☐	☐		
Buccal swabs (optional)	☐	☐	☐		
Saliva swabs	☐	☐	☐		

N. DIAGNOSTIC STUDIES ☐ Refer to dictation

1. Laboratory:

	WNL	ABN	N/A	Pending	Results
☐ CBC	☐	☐	☐	☐	
☐ Platelets	☐	☐	☐	☐	
☐ INR, PTT, PT	☐	☐	☐	☐	
☐ SGOT, SGPT	☐	☐	☐	☐	
☐ Urinalysis	☐	☐	☐	☐	
☐ Toxicology Screen	☐	☐	☐	☐	
☐ Other	☐	☐	☐	☐	

2. Diagnostic Imaging

	WNL	ABN	N/A	Preliminary Reading	Final Report
☐ Skeletal Survey	☐	☐	☐	☐	☐
☐ CT Scan	☐	☐	☐	☐	☐
☐ M R I	☐	☐	☐	☐	☐
☐ Other	☐	☐	☐	☐	☐

Describe:

3. Exam Performed by Ophthalmologist:

☐ N/A ☐ No ☐ Yes ☐ Pending ☐ See Medical Record for Report

Name of Ophthalmologist: _____

Photographs Taken By: _____

O. PHOTO DOCUMENTATION

☐ No ☐ Yes ☐ N/A ☐ Film Retained

☐ Film Released to: _____

Photographs taken by: _____

35mm ☐ Digital ☐ Instant ☐ Other ☐ _____

Recommend follow-up photographs be taken in 1-2 days

☐ No ☐ Yes ☐ N/A

Patient Identification: **Date:**

P. REQUIRED SUMMARY AND INTERPRETATION OF HISTORY, EXAMINATION, AND DIAGNOSTIC STUDIES

Describe:

☐ Neglect
☐ Physical abuse
☐ Evaluation suspicious for physical abuse. Further information needed.
☐ Indeterminate cause
☐ Evaluation indicates non-abusive cause of medical findings.

☐ See Additional Dictation Dictation Reference Number:

Q. DISTRIBUTION OF EVIDENCE

	Released To
Clothing (items not placed in evidence kit) ☐ N/A	
Evidence Kit ☐ N/A	
Reference samples ☐ N/A	
Toxicology samples ☐ N/A	

R. PERSONNEL INVOLVED

Examination Performed By: (Print)	Signature of Examiner	
License No.	Telephone	Date
Examination Assisted By: (Print)	Signature	
License No.	Telephone	Date
Specimen labeled and sealed by:	Signature	
License No.	Telephone	Date

S. PATIENT DISPOSITION

☐ Admitted ☐ Home ☐ Protective Custody

☐ Follow Up Exam Needed (specify reason): _____

State of California
California Office of Emergency Services

MEDICAL REPORT:
SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION

CalOES 2-900 INSTRUCTIONS

For more information or assistance in completing the CalOES 2-900, please contact California Clinical Forensic Medical Training Center at:(888) 705-4141 or www.ccfmtc.org

Forms available at: **www.CalOES.ca.gov and www.ccfmtc.org**

CalOES 2-900
Medical Report: Suspected Child Physical Abuse and Neglect Examination

REQUIRED USE OF STANDARD STATE FORM:
Penal Code § 11171 established the use of a standard form to record findings from examinations performed for suspected child physical abuse and neglect. This form is intended to facilitate identification of child physical abuse and neglect, and as such, is not a complete medical treatment record.

SUGGESTED USE OF THE STANDARD STATE FORMS: FOLLOW LOCAL POLICY

CalOES 2-900	**Medical Report: Suspected Child Physical Abuse and Neglect Examination** • Suspected child physical abuse and neglect • Examination of children and adolescents under age 18
CalOES 925	**Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination** • History of **nonacute sexual assault** (>72 hours) • Examination of children and adolescents under age 18
CalOES 930	**Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abus Examination** • History of **acute sexual assault or assault** (<72 hours) • Examination of children and adolescents under age 18

INSTRUCTIONS FOR CalOES 2-900
These instructions contain the recommended methods for meeting the minimum legal standards established by Penal Code § 11171 for performing examinations. Consult the California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect published by CalOES for additional information including the knowledge, skills, and abilities necessary for health practitioners to complete the medical examination.

LIABILITY AND RELEASE OF INFORMATION
This medical report is subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Penal Code§ 11164 or privilege), the Medical Information Act (Civil Code § 58 et seq.), the Physician-Patient Privilege (Evidence Code § 990), the Official Information Privilege (Evidence Code § 1040) and Penal Code § 11171.2. It can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services worker, child abuse and neglect team member, county licensing agency, and coroner. Records may be released to the defense counsel only through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

Complete this report in its entirety. Print legibly. Use N/A (not applicable) when appropriate to show that the examiner attended to the question.	Patient identification: This space is provided for hospitals and clinics using plastic plates for stamping identification information; or, for facilities to write in an identification number and date.

A. GENERAL INFORMATION
Note: If the facility patient label or registration face sheet includes the information requested in items #1-5 below, these may be used in lieu of handwritten entries. Mark the box and attach the label or registration face sheet to this form.

1. **Enter the name and address of the facility where the examination was performed.**
2. **Enter the date and time of the exam.**
3. **Enter the patient's name and telephone number.**
4. **Enter the patient's street address, city, county, state, and zip code.**
5. **Enter the patient's age, date of birth (DOB), gender, and ethnicity.**
6. **Enter whether an interpreter was used, the language used, and who provided interpreting services.**
7. **Enter the name of the child's caregiver, gender, street address, city, county, state, zip code, and telephone numbers.**
8. **Enter the name of the child's caregiver, gender, street address, city, county, state, zip code, and telephone numbers.**
9. **Enter the name(s) of siblings, gender, age, and date of birth.**

B. MANDATORY REPORTING FOR SUSPECTED CHILD ABUSE AND NEGLECT: Suspected Child Abuse and Neglect Form Department of Justice (DOJ) SS 8572.

1. **Penal Code § 11166 requires all professional medical personnel to report suspected child abuse and neglect, defined by Penal Code § 11165, immediately by telephone and to submit a written report (DOJ SS 8572) within 36 hours to a local law enforcement agency OR a child protective services agency.**
2. **The CalOES 2-900 should not replace the DOJ SS 8572 Suspected Child Abuse and Neglect Report. The SS 8572 is used by all mandated reporters to report suspected child abuse and neglect. The CalOES 2-900 is used by medical personnel to document physical findings and is part of the medical treatment record (Penal Code § 11171.2(d).**
   - Check the appropriate box to indicate that a telephone report was made to a law enforcement agency and/or Child Protective Services. Identify the person who took the report, his/her telephone number, and the date the report was made.
   - Check the appropriate box to indicate whether the written report was submitted to a law enforcement agency or to Child Protective Services.
3. **See California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect for further discussion.**

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

1. **Record name(s) of responding personnel from a law enforcement or child protective services agency and identifying information.**
2. **If unknown, check box.**

D. PATIENT CONSENT AND AUTHORIZATION FOR EXAMINATION

1. **See page 2 for information on consent and authorization for examinations.**
2. **Authorization by law enforcement or child protective services is not required for healthcare providers to use this form. Authorization, however, may be required if either agency is the designated payor.**
3. **Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy.**
4. **See California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect for further discussion.**

E. DISTRIBUTION OF CalOES 2-900
Check boxes to indicate the distribution of the form.

F. PATIENT HISTORY

1. **Record the name(s) of the person(s) providing the history and their relationship to the patient.**
2. **Record the name(s) of the person(s) accompanying the child to the facility and their relationship to the patient.**
3. **Record the history of present illness.**
   - If dictating, provide brief 2-3 sentence handwritten summary.
   - Include date, time or timeframe of incident, place of incident, and the name, if known, of the initial reporting party.
   - If documenting specific statements made by the patient or historian, use quotation marks.
   - Document if statement(s) made by patient were spontaneous (i.e. not in response to a question or comment).
   - When interviewing verbal children, ask open-ended questions such as "What happened to you? Tell me what happened to you. How did this happen? What did he do or what did she do?" These are the easiest questions for children to answer. Avoid WHY questions or questions that require understanding abstract or complex concepts.
   - If there is an alleged accident, include details of the event. Ask where it happened, who witnessed the event, and how it happened. For example, if there is an alleged fall, ask the height of the fall and onto what surface.
   - Patient statements not heard directly by the recorder may be included, e.g. the child told his teacher that he was hit by a belt.
   - Document chronology of events leading up to medical presentation.

G. PAST MEDICAL HISTORY

1. **Record past medical history, if known.**
2. **Record past abuse history, history of exposure to domestic violence, if known.**
3. **Record history of exposure to prenatal and postnatal alcohol and drug exposure, if known.**
4. **Obtain urine toxicology according to hospital protocol or follow local policy established by criminal justice and child protection agencies under the circumstances described below.**
   - There is a reported history of child's removal from a drug manufacturing home, living in a home with significant drug exposure, or a request by law enforcement or CPS.
   - The child's clinical presentation is concerning and drug ingestion is suspected.
   - Some drugs may be detected in the urine up to 96 hours after ingestion. Collect urine in a clean container. It is important to collect the first available sample.
5. **Record any cognitive, developmental, physical, or mental/emotional disabilities.**
6. **Record whether growth and development is within normal limits. Check WNL, if within normal limits, ABN, if abnormal, or unknown.**
7. **Indicate whether there are any other pertinent medical conditions, particularly if any conditions may affect the interpretation of findings (e.g. bleeding disorders, bone diseases, etc).**

H. REVIEW OF SYSTEMS

Check the box "Negative except as noted below" if there are no identified medical problems. Describe, if signs and symptoms are present. Check the box if there is additional dictation in medical progress notes or another format.

I. NAME OF PERSON TAKING HISTORY

Print the name of the person taking the history, sign, date, and provide telephone number.

PATIENT CONSENT AND AUTHORIZATION FOR EXAM

Suspected child abuse: non-consenting parents

Parental consent is not required to examine, treat or collect evidence for suspected child abuse. In the absence of parental consent or in the case of parental refusal, children must be taken into protective custody by a child protective agency (e.g. law enforcement agency or county child protective services agency) in order to perform the examination. Follow local policy regarding placement of children in protective custody.

Welfare and Institutions Code Section 324.5

Whenever allegations of physical or sexual abuse of a child come to the attention of a local law enforcement agency or the local child welfare department and the child is taken into protective custody, the local law enforcement agency or child welfare department may, as soon as practically possible, consult with a medical practitioner, who has specialized training in detecting and treating child abuse injuries and neglect, to determine whether a physical examination of the child is appropriate. If deemed appropriate, the local law enforcement agency, or the child welfare department, shall cause the child to undergo a physical examination performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, and whenever possible, shall ensure that this examination takes place within 72 hours of the time the child was taken into protective custody. In the event the allegations are made while the child is in custody, the physical examination shall be performed within 72 hours of the time the allegations were made.

PHOTOGRAPHS OF INJURIES

Penal Code Section 11171.2

A physician, surgeon, or dentist or their agents, and by their direction, may take skeletal x-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of the child abuse or neglect.

Penal Code Section 11171.5

If a peace officer, in the course of an investigation of child abuse or neglect, has reasonable cause to believe that the child has been the victim of physical abuse, the officer may apply to a magistrate for an order directing that the victim be x-rayed without parental consent. Any x-ray taken pursuant to this subdivision shall be administered by a physician, surgeon, or dentist or their agents.

With respect to the cost of an x-ray taken by the county coroner or at the request of the county coroner in suspected child abuse or neglect cases, the county may charge the parent or legal guardian of the child victim the costs incurred by the county for the x-ray. No person who administers an x-ray pursuant to this section shall be entitled to reimbursement from the county for an administrative cost that exceeds 5 percent of the cost of the x-ray.

J. GENERAL PHYSICAL EXAMINATION

1. Record vital signs.

2. Record height in either centimeters or inches and weight in either kilograms or pounds. Indicate percentiles, if growth charts are available. For children under age 2, record head circumference and percentile.

3. Describe the patient's general physical appearance.
- Describe the patient's general demeanor including level of discomfort and pain.
- Provide brief handwritten summary, even if dictating. Check box if there is additional dictation in progress notes.
- Documentation helps the examiner recall the patient's behavior and response during the exam for future reference.

4. Record results of physical examination.
- Record all findings and whether the general exam was within normal limits (WNL).
- Describe abnormal findings (ABN).

> **Physical Findings:** A physical finding includes observable or palpable tissue injuries, physiologic changes, or foreign materials.

- Be observant for erythema (redness), abrasions, bruises, swelling, lacerations, bites, and burns.
- Note areas of tenderness, deformity, or induration.
- Record size and appearance of injuries and other findings using the diagrams. Describe shape, size, and color of bruises or other cutaneous injuries.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

5. If genital injuries are sustained, use copies of page(s) 6 and 7 from the CalOES 930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form to document findings; or use that form to document all findings, if the history indicates that the patient has been sexually and physically abused.

J. PHYSICAL EXAMINATION (continued)

6. Conduct general physical examination.

- Record size and appearance of injuries and other findings using Diagrams A and B.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

Bite marks

- Photograph or arrange to have bite marks photographed. Individuals can be identified by the size and shape of their bite marks.
  - > Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from saliva remaining at the bitemark site. Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbitten atraumatic area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
- Casting bite marks:
  - > If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
  - > A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
  - > Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

Bruises

- Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.
- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

J. PHYSICAL EXAMINATION (continued)

6. Conduct general physical examination.

- Record size and appearance of injuries and other findings using Diagrams C and D.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

Bite marks

- Photograph or arrange to have bite marks photographed. Individuals can be identified by the size and shape of their bite marks.
  - > Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from saliva remaining at the bitemark site. Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbitten atraumatic area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
- Casting bite marks:
  - > If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
  - > A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
  - > Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

Bruises

- Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.
- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

J. EXAMINATION OF THE HEAD, NECK, AND MOUTH

7. Examine the face, head, ears, hair, scalp, and neck for injury.

- Record injuries and other findings using the Diagrams E, F, G, and H.
- Examine mouth for injury and for missing or chipped teeth, or neglect of oral health.
  - > Signs and symptoms of dentofacial trauma may include: avulsed teeth, lip lacerations, tongue injuries, frenulum injuries, and jaw and facial fractures.
  - > Signs and symptoms of dental neglect may include: untreated rampant cavities, untreated pain, infection, bleeding, or trauma; and/or lack of continuity of care once informed that the above conditions exist.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.
- For head trauma cases:
  - > Examine head closely for evidence of scalp trauma. Record any bruises, areas of scalp swelling, or hair loss.
  - > In infants, note fullness or bulging of the anterior fontanelle or splitting of the sutures.
  - > Examine earlobes carefully for any bruising or petechiae. Record injuries using the diagrams.

K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LABORATORY

All swabs and slides must be air dried prior to packaging (Penal Code § 13823.11). Air dry in a stream of cool air for 60 minutes. Place samples from one patient at a time in the swab drying box. Wipe or spray the swab drying box with 10 percent bleach before each use.
Labeling requirements: Swabs, bindles, and small containers must be individually labeled with the patient's name and sample source. Containers for these individual items must be labeled with the name of the patient, date of collection, description of the evidence including location from which it was taken, and signature or initials of the person who collected the evidence. All containers must be labeled and sealed. Record all evidence transfers, also known as the chain of custody.

1. **Record whether clothing was collected, the items collected, and whether they were placed in an evidence kit or a paper bag. If not, check N/A.**
   - Collect outer and under clothing, if applicable. Coordinate with the law enforcement officer or child protective services worker regarding clothing to be collected. Clothing with bloodstains, tears, and burn holes can be related to physical abuse. Soiled, unkempt clothing can be related to neglect.
   - Wear gloves while collecting clothing. Have the patient disrobe on two large sheets of paper, placed one on top of the other, on the floor. Remove child's shoes before stepping on to the paper. Package each garment in an individual paper bag, label, and seal. Wet stains or garments require special handling. Consult local policy.
2. **Record all foreign materials collected and the name of the person who collected them. If none were collected, check N/A. Foreign materials (soil, vegetation) should be placed in bindles and/or envelopes. Use a separate bindle or envelope for materials collected from different locations. Label and seal.**
3. **Record whether saliva swabs from bite marks were obtained. Record whether a control swab was obtained from an unbitten atraumatic area. Swabs must be labeled with the patient's name and sample source.**

L. TOXICOLOGY SAMPLES

Record whether a urine toxicology sample was obtained. Up to 96 hours after suspected ingestion of drugs, collect a urine specimen in a clean container. It is important to collect the first available sample.

M. REFERENCE SAMPLES

1. **Record whether a DNA reference sample was collected.**
   - Policies pertaining to the collection of reference samples at the time of exam or later vary by jurisdiction. If collected at the time of the exam, ALWAYS collect after the evidence samples. A buccal (inner cheek) swab is less invasive and may be easier to obtain than a blood sample via venipuncture. Consult your local crime laboratory.
2. **Buccal swabs**
   - Rub two swabs gently but firmly along the inside of the cheek in a rotating motion to ensure even sampling. Air dry, package, label, and seal.
3. **Blood**
   - Collect blood sample in lavender stoppered evacuated vial. A blood card is optional in some jurisdictions. Label the vial, place into an envelope, and seal.

N. DIAGNOSTIC STUDIES

1. **Record the types of laboratory work ordered, results, if known, and whether results are pending.**

CBC	Complete Blood Count
INR	International Normalized Ratio
PTT	Partial Thromboplastin Time
PT	Prothrombin Time
SGOT/SGPT	Liver Enzymes

2. **Record diagnostic imaging studies ordered, results, if known, and whether results are pending.**

Skeletal Survey	Series of radiographic images which encompass the entire skeleton
CT Scan	Computed Tomography Imaging
MRI	Magnetic Resonance Imaging

3. **Record whether patient was referred for evaluation by an ophthalmologist.**

O. PHOTO DOCUMENTATION

Record whether photographs were taken, type of camera used, and whether film was retained or released to a law enforcement agency.

P. REQUIRED SUMMARY AND INTERPRETATION OF HISTORY, EXAMINATION, AND DIAGNOSTIC STUDIES

Provide interpretation and medical impression of history, examination, and diagnostic studies. Findings and interpretations are based on both the patient history available and the medical examination. Check the box if there is additional dictation in medical progress notes or another format and record dictation reference number.

Q. DISTRIBUTION OF EVIDENCE

List to whom the evidence was released. Check N/A if not applicable.

R. PERSONNEL INVOLVED

1. **Document who performed the examination by printing the examiner's name. The examiner must sign, date, and provide license and telephone number.**
2. **Document whether another healthcare provider assisted with the examination or evidence collection and handling. If so, print name, sign, date, and provide license and telephone number.**

S. PATIENT DISPOSITION

Indicate disposition and whether a follow-up exam is needed.

AB 1402 (Megan Dahle) - Medical evidentiary examinations: reimbursement

Version: March 30, 2023
Urgency: No
Hearing Date: August 21, 2023

Policy Vote: PUB. S. 5 - 0
Mandate: No
Consultant: Matthew Fleming

Bill Summary: AB 1402 would require that costs of a medical evidentiary examination of a victim of physical child abuse or neglect be submitted by specified medical examiners for reimbursement by the Office of Emergency Services (OES), rather than charged directly or indirectly to the victim. Reimbursements would be subject to an appropriation by the Legislature.

Fiscal Impact:

- Ongoing, annual cost pressures in the high millions to low tens of millions to reimburse the costs of medical examinations following an incident child abuse or neglect (General Fund). See Staff Comments for additional detail.

- Ongoing, annual costs of approximately $800,000 to the OES for additional staffing to manage reimbursement to victims who receive child abuse or neglect examinations (General Fund).

Background: The Violence against Women Act (VAWA) gives sexual assault victims the right to obtain a medical evidentiary examination after a sexual assault. The victim may not be charged for the exam. The costs are charged to the local law enforcement agency. Law enforcement can seek reimbursement for cases where the victim is undecided whether to report to the assault to law enforcement. The OES uses discretionary funds from various federal grants to offset the costs of the examination. OES makes a determination on how much the reimbursement shall be under these circumstances and can reassess the reimbursement every 5 years. Law enforcement can also seek reimbursement to offset the costs of conducting an examination when the victim has decided to report the assault to law enforcement. OES makes a determination on how much the reimbursement shall be under these circumstances. OES is to provide reimbursement from funds to be made available upon appropriation for this purpose. (Pen. Code, § 13823.95).

In AB 2185 (Weber), Chapter 557, Statutes of 2022, the Legislature provided domestic violence victims access to medical evidentiary exams, free of charge, by SART, SAFE teams, or other qualified medical evidentiary examiners. Each county's board of supervisors is required to authorize a designee to approve the SART, SAFE teams, or other qualified medical evidentiary examiners to receive reimbursement through OES for the performance of medical evidentiary examinations for victims of domestic violence. Costs incurred for the medical evidentiary portion of the examination cannot be charged directly or indirectly to the victim. The costs associated with these medical evidentiary exams are to be funded by the state, subject to appropriation by the

Legislature, and require the OES to establish a 60-day reimbursement process within one year upon initial appropriation.

Proposed Law:

- Provides that the costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect shall be separate from diagnostic treatment and procedure costs associated with medical treatment and prohibits those costs from being charged directly or indirectly to the victim of child physical abuse or neglect.

- Provides that each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Team (SART), Sexual Assault Forensic Exam (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services (OES) for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify OES of this designation.

- Provides that the costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature.

- Requires each county's designated SART, SAFE, or other qualified medical evidentiary examiners to submit invoices to OES, who shall administer the program. Provides that a flat reimbursement rate shall be established.

- Specifies that within one year upon initial appropriation, OES shall establish a 60-day reimbursement process. OES shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years.

- Prohibits reduced reimbursement rates based on patient history or other reasons.

- Authorizes victims of child physical abuse or neglect to receive a medical evidentiary exam outside of the jurisdiction where the crime occurred and requires that county's approved SART, SAFE teams, or qualified medical evidentiary examiners to be reimbursed for the performance of these exams.

Related Legislation:

- AB 2185 (Weber) Ch. 557, Stats. 2022 provided domestic violence victims access to medical evidentiary exams, free of charge.

- AB 145 (Comm. on Budget), Ch. 80, Stats. 2021, authorized OES to provide full reimbursement to counties for the cost of sexual assault evidentiary exams.

Staff Comments: This bill is similar to recent legislation intended to provide no-cost medical examinations to victims of sexual and domestic violence. Rather than directly charging victims of child abuse and neglect for physical examinations, this bill would require counties to set up systems to provide examinations at no cost to the victim and then submit invoices for reimbursement to OES.

Under existing law, the OES reimburses $911 for each sexual assault examination. Assuming the cost of a child abuse evidentiary exam is similar, the OES will require significant GF allocations to reimburse counties. According to a 2022 report by the California State Auditor, there were 52,000 reports of child abuse substantiated by social workers in the 4 years from July 2017, to June 2021. Assuming costs of $911 for each examination, and an average of 13,000 exams per year, this bill would require approximately $11.8 million annually for local reimbursements. Staff notes that no funding has been included in the 2023-24 budget for these purposes.

-- END --

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

I am a resident of the County of Sacramento and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

On March 11, 2025, I served the:

- **Current Mailing List dated March 7, 2025**
- **Notice of Complete Test Claim, Schedule for Comments, and Notice of Tentative Hearing Date issued March 11, 2025**
- **Test Claim filed by the County of Santa Clara on December 31, 2024**

  Child Physical Abuse and Neglect Exams, 24-TC-05
  Statutes 2023, Chapter 841, (AB 1402); Penal Code Section 11171(f)
  County of Santa Clara, Claimant

by making it available on the Commission's website and providing notice of how to locate it to the email addresses provided on the attached mailing list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on March 11, 2025 at Sacramento, California.

Jill Magee

Jill Magee
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814
(916) 323-3562

COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 3/7/25

Claim Number: 24-TC-05

Matter: Child Physical Abuse and Neglect Exams

Claimant: County of Santa Clara

TO ALL PARTIES, INTERESTED PARTIES, AND INTERESTED PERSONS:

Each commission mailing list is continuously updated as requests are received to include or remove any party or person on the mailing list. A current mailing list is provided with commission correspondence, and a copy of the current mailing list is available upon request at any time. Except as provided otherwise by commission rule, when a party or interested party files any written material with the commission concerning a claim, it shall simultaneously serve a copy of the written material on the parties and interested parties to the claim identified on the mailing list provided by the commission. (Cal. Code Regs., tit. 2, § 1181.3.)

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RECEIVED
April 10, 2025
Commission on State Mandates

April 10, 2025

Juliana Gmur
Executive Director
Commission on State Mandates
980 Ninth Street, Suite 300
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Test Claim 24-TC-05, Child Physical Abuse and Neglect Exams

Dear Director Gmur:

The Department of Finance (Finance) has completed its review of test claim 24-TC-05 submitted to the Commission on State Mandates (Commission) by the County of Santa Clara (Claimant), in which the Claimant alleges it incurred reimbursable, state-mandated costs associated with Chapter 841, Statutes of 2023 (Assembly Bill 1402).

Prior to 2024, Penal Code section 11171 required the Office of Emergency Services (Cal OES), in cooperation with various entities, to establish forensic forms, instructions, and examination protocols for victims of child physical abuse or neglect.

Effective January 1, 2024, AB 1402 added Penal Code section 11171, subdivision (f) to require that costs of the medical evidentiary examination of a victim of child physical abuse or neglect not be charged directly or indirectly to the victim. AB 1402 also requires the costs of such exams to be funded by the state, subject to appropriation by the Legislature, and be submitted to Cal OES for reimbursement. However, no appropriation has been provided to Cal OES for this purpose.

The Claimant alleges it incurred $221,046 in state-mandated, reimbursable costs in fiscal year 2023-24 to comply with Penal Code section 11171, subdivision (f) and estimates $717,496 in such costs in 2024-25.

Finance asserts that any costs incurred by the Claimant to carry out the requirements of Penal Code section 11171, subdivision (f) are not state-reimbursable, because there is not an increase in the actual level or quality of governmental service provided to the public. Penal Code section 11171(f) simply requires the county to absorb the costs of medical evidentiary exams that the county was already required to perform under existing law, instead of passing those costs along to a third party. The new requirements constitute neither the provision of a service to the public through a new program, nor the provision of a new service or a higher level of service to the public through an existing program.

When reviewing Test Claim 00-TC-20/02-TC-02, Workers' Compensation Disability Benefits for Government Employees, the Commission found on May 31, 2007, that extending the workers' compensation leave benefits to additional employees does not mandate a new program or higher level of service within an existing program. Specifically, it found that additional costs for increased employee benefits, without an increase in the actual level or quality of governmental service provided to the public, do not constitute a new program or higher level of service. Finance believes this same reasoning is applicable to this test claim.

If you have any questions regarding this letter, please contact Chris Hill, Principal Program Budget Analyst at (916) 445-3274.

Sincerely,

TERESA CALVERT
Program Budget Manager

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

I am a resident of the County of Sacramento and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

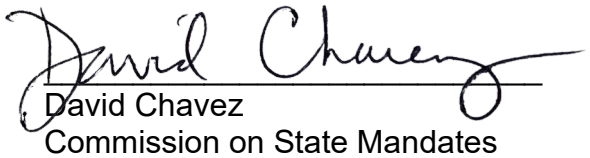
On April 10, 2025, I served the:

- **Current Mailing List dated April 10, 2025**
- **Finance's Comments on the Test Claim filed April 10, 2025**

  Child Physical Abuse and Neglect Exams, 24-TC-05
  Statutes 2023, Chapter 841, (AB 1402); Penal Code Section 11171(f)
  County of Santa Clara, Claimant

by making it available on the Commission's website and providing notice of how to locate it to the email addresses provided on the attached mailing list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on April 10, 2025 at Sacramento, California.



David Chavez
Commission on State Mandates
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COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 4/10/25

Claim Number: 24-TC-05

Matter: Child Physical Abuse and Neglect Exams

Claimant: County of Santa Clara

TO ALL PARTIES, INTERESTED PARTIES, AND INTERESTED PERSONS:

Each commission mailing list is continuously updated as requests are received to include or remove any party or person on the mailing list. A current mailing list is provided with commission correspondence, and a copy of the current mailing list is available upon request at any time. Except as provided otherwise by commission rule, when a party or interested party files any written material with the commission concerning a claim, it shall simultaneously serve a copy of the written material on the parties and interested parties to the claim identified on the mailing list provided by the commission. (Cal. Code Regs., tit. 2, § 1181.3.)

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Commission on State Mandates

May 7, 2025

Exhibit C

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And Parties, Interested Parties, and Interested Persons (See Mailing List)

Re: Rebuttal to the Department of Finance
Child Physical Abuse and Neglect Exams, 24-TC-05
Statutes 2023, Chapter 841, Section 1 (AB 1402); Penal Code Section 11171, subd. (f)
County of Santa Clara, Claimant

Dear Director Gmur:

The County of Santa Clara ("County") files the following rebuttal to the Commission on State Mandates ("Commission") in response to the Department of Finance ("DOF"), which commented on test claim 24-TC-05 ("Test Claim"), concerning child physical abuse and neglect exams. The Test Claim asserts that the AB 1402, which added subdivision (f) to section 11171 of the Penal Code ("Test Claim Statute"), imposes an unfunded mandate on counties and thus requires subvention pursuant to article XIII B, section 6 of the California Constitution ("Section 6").

DISCUSSION

Section 6 "requires the state to provide a subvention of funds to compensate local governments for the cost of a new program or higher level of service mandated by the state." (*Department of Fin. v. Comm'n on State Mandates* (2022) 85 Cal.App.5th 535, 549.) A mandate imposes a new program or higher level of service when "the

requirements are new in comparison with the preexisting scheme in view of the circumstance that they did not exist prior to the enactment" of the mandate and "the requirements were intended to provide an enhanced service to the public." (*San Diego Unified Sch. Dist. v. Comm'n on State Mandates* (2004) 33 Cal.4th 859, 878.)

DOF argues that the Test Claim Statute is not reimbursable because the statute's requirements do not increase the actual level or quality of governmental service provided to the public, and that the Test Claim Statute instead requires the Claimant to "absorb the costs of medical evidentiary exams that the county was already required to perform under existing law, instead of passing those costs along to a third party." (DOF, *supra*, at p. 1.) DOF also argues that the reasoning for a previously denied test claim, 00-TC-20/02-TC-02, should apply here. The County respectfully disagrees with DOF and asks the Commission to approve the Test Claim.

A. By Increasing Access to Child Physical Abuse and Neglect Exams, the Test Claim Statute Enhances a Governmental Service.

Although DOF characterizes the Test Claim Statute as a mere cost-shifting device, it unambiguously increases the quality of governmental service provided to the public. Courts have repeatedly found that state laws aimed at providing beneficial and protective public services create programs or higher levels of service under this prong. (See, e.g., *Department of Fin*., *supra*, 85 Cal. App. 5th at pp. 555-56; *Lucia Mar Unified Sch. Dist. v. Honig* (1988) 44 Cal. 3d 830, 835; *San Diego Unified Sch. Dist.*, *supra*, 33 Cal. 4th at p. 879.) In enacting Section 11171, the Legislature found and declared "that adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations." (Pen. Code, § 11171, subd. (a)(1).) The legislative intent establishes that the Test Claim Statute makes these exams free of charge to make them more accessible to the public. **(**See Sen. Comm. on Approps., Analysis of Assem. Bill No. 1402 (2023-2024 Reg. Sess.), pp. 2-3.) The Test Claim Statute also promotes child welfare, as these exams are often necessary to investigate potential child abuse. (See, e.g., Welf. & Inst. Code, §§ 328, 329; Fam. Code, § 3027; Prob. Code, § 1513; Pen. Code, §§ 11166.3, 11169.)

B. The California Supreme Court Previously Rejected the Very Argument DOF Raises Here in *County of San Diego v. State of California*.

The California Supreme Court's decision in *County of San Diego v. State of California* (1997) 15 Cal.4th 68, explains why the State cannot simply have counties "absorb the costs of medical evidentiary exams that the county was already required to perform under existing law." (DOF, *supra*, at p. 1.) That decision concerned the State's attempt to pass onto San Diego healthcare costs for medically indigent people ("MIP") by excluding MIP from Medi-Cal, offering reimbursement for these costs to San Diego, and then decreasing reimbursement to San Diego. There, the State likewise argued

that the "counties have always borne legal and financial responsibility" for the medical care of MIPs under Welfare and Institutions Code section 17000 ("Section 17000"). (*County of San Diego*, at p. 91.) However, the Court explained that Section 17000 only required the County to support indigent people when other sources—including State institutions—fell short. (*Id*., at p. 92.) And by the time the voters adopted Section 6, the State became "primarily responsible for the costs of the program." (*Id*., at p. 93.)

The Court continued that the MIP care did not operate merely as a State reimbursement program for counties. (*Id*., at pp. 96-98.) Although MIPs could seek medical care at private and county providers alike, the "administration of Medi–Cal over the years has been the responsibility of various state departments and agencies." (*Id*., at p. 96.) That rationale applies with greater force here. Ever since it enacted Penal Code section 11171, the Legislature has played a central role in defining child physical abuse and neglect exams by developing rules and standards, issuing a form for notating the exam, and creating an exam protocol to ensure consistent and comprehensive exams. (See Stats. 2003, ch. 249, § 4 [adding Section 11171].)

Further, the State's own protocol makes clear that counties did not ever assume the financial responsibility for these exams, and instead billed Medi-Cal or private insurance. (See California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims ("Protocol"), Governor's Office of Emergency Services, State of California, 9.) By prohibiting counties from billing any insurance program for the costs of child physical abuse and neglect exams, assuming full financial responsibility for those exams, and then saddling counties with those very costs by declining to appropriate reimbursement funds, the Test Claim Statute did exactly what the Supreme Court admonished in *County of San Diego*: "*knowing* and *intending* that [its actions] would trigger the counties' responsibility to provide medical care . . . the Legislature attempted to do precisely that which the voters enacted section 6 to prevent: 'transfer[ ] to [counties] the fiscal responsibility for providing services which the state believed should be extended to the public.'" (*County of San Diego*, *supra*, 15 Cal.4th at p. 98.) The Commission should apply *County of San Diego* and approve the Test Claim.

C. Test Claim 00-TC-20/02-TC-02 is Not Akin to This Test Claim.

DOF argues that the same reasoning adopted in Test Claim 00-TC-20/02-TC-02, Workers' Compensation Disability Benefits for Government Employees ("Workers' Compensation Test Claim"), is applicable to this test claim. It summarizes the Commission findings that "extending the workers' compensation leave benefits to additional employees does not mandate a new program or higher level of service within an existing program," and "that additional costs for increased employee benefits, without an increase in the actual level or quality of governmental service provided to the public, do not constitute a new program or higher level of service."

The Workers' Compensation Test Claim is not an apt comparison. The Workers' Compensation Test Claim addressed modifications to Labor Code section 4850, which expanded a preexisting leave benefit to additional categories of employees. (Statement of Decision, Workers' Compensation Disability Benefits for Government Employees, 00-TC-20/02-TC-02 (May 31, 2007), at p. 1.) The Test Claim Statute does not extend a benefit to an additional category of beneficiaries within an existing program without increasing the actual level or quality of governmental service. As detailed above, the Test Claim Statute extends a benefit to the public for the first time—free child physical abuse and neglect exams—with the clear intent to make those exams more accessible, thus promoting child welfare and public safety. By shifting full financial responsibility from the State to counties, the Test Claim Statute and legislative action use county resources to finance this enhanced public service.

The Statement of Decision for the Workers' Compensation Test Claim differs in other respects as well. There, the Commission applied *County of Los Angeles v. State of California* (1987) 43 Cal.3d 46, and its progeny for the narrow principle "that statutes that increase the cost of employee benefits do not mandate a new program or higher level of service in an existing program." (Statement of Decision, *supra*, at p. 8.) In *County of Los Angeles*, the California Supreme Court emphasized that "the intent underlying section 6 was to require reimbursement to local agencies for the costs involved in carrying out functions peculiar to government, not for expenses incurred by local agencies as an incidental impact of laws that apply generally to all state residents and entities." (*County of Los Angeles*, *supra*, 43 Cal.3d at pp. 57-58.)

The Test Claim Statute at issue does not impose the same generally applicable burden akin to workers' compensation. Even though private hospitals are likewise prohibited from billing patients for child physical abuse and neglect exams, private hospitals are not practically compelled like counties to provide such exams. And indeed, the County's physician overseeing child physical abuse and neglect exams confirms that pro bono child abuse evaluations do not happen in Santa Clara County or anywhere else to her knowledge. (Test Claim, Child Physical Abuse and Neglect Exams, 24-TC-05, at p. 39.) Thus, private hospitals needn't and likely wouldn't offer child physical abuse and neglect exams when the Legislature declines to appropriate reimbursement for them. In contrast, counties have no practical alternative but to provide these exams, which are necessary to child welfare and public safety.

The Statement of Decision denying the Workers' Compensation Test Claim distinguishes *Carmel Valley Fire Protection District v. State of California* (1987) 190 Cal.App.3d 521, which serves as a more apt comparison to the Test Claim. There, the State issued executive orders requiring counties to purchase protective clothing and equipment. (*Carmel Valley*, at p. 530.) First, it found that "fire protection is a peculiarly governmental function"—one "not weakened by State's assertion that there are private sector fire fighters who are also subject to the executive orders." (*Id*., at p. 537.)

Second, the Court found that even with the existence of private fire brigades, the "requirements imposed on local governments are also unique because fire fighting is overwhelmingly engaged in by local agencies." (*Id*., at p. 538.) Later decisions applying *Carmel Valley* have emphasized that "[b]ecause this increased safety equipment apparently was designed to result in more effective fire protection, the mandate evidently was intended to produce a higher level of service to the public." (*San Diego Unified School Dist*., *supra*, 33 Cal.4th at pp. 876-877.) By enhancing a public safety service through increased local expenditures, the Test Claim Statute here is much closer in comparison to *Carmel Valley* than it is to a scheme to increase workers' compensation, which was not found to enhance a governmental service.

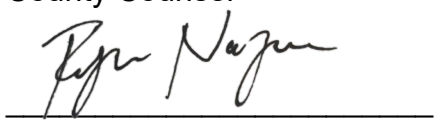
CONCLUSION

With this rebuttal comment, the County respectfully disagrees with DOF and urges the Commission to adopt a decision approving the Test Claim. As the Claimant demonstrates, implementing the Test Claim Statute will require significant local government resources that require subvention pursuant to Section 6. These resources are crucial to realizing the core mission of the Test Claim Statute, which is to make more accessible an indispensable tool to child welfare and public safety.

Certification

I certify by my signature below, under penalty of perjury under the laws of the State of California, that the statements made in this document are true and complete to the best of my own personal knowledge or based on information and belief and that I am authorized and competent to do so.

Very truly yours,
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DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

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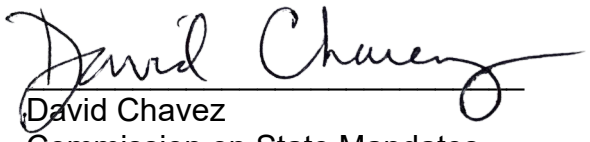
On May 7, 2025, I served the:

- **Current Mailing List dated April 23, 2025**
- **Claimant's Rebuttal Comments filed May 7, 2025**

  Child Physical Abuse and Neglect Exams, 24-TC-05
  Statutes 2023, Chapter 841, (AB 1402); Penal Code Section 11171(f)
  County of Santa Clara, Claimant

by making it available on the Commission's website and providing notice of how to locate it to the email addresses provided on the attached mailing list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on May 7, 2025 at Sacramento, California.



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COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 4/23/25

Claim Number: 24-TC-05

Matter: Child Physical Abuse and Neglect Exams

Claimant: County of Santa Clara

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Each commission mailing list is continuously updated as requests are received to include or remove any party or person on the mailing list. A current mailing list is provided with commission correspondence, and a copy of the current mailing list is available upon request at any time. Except as provided otherwise by commission rule, when a party or interested party files any written material with the commission concerning a claim, it shall simultaneously serve a copy of the written material on the parties and interested parties to the claim identified on the mailing list provided by the commission. (Cal. Code Regs., tit. 2, § 1181.3.)

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KERN COUNTY HUMAN SERVICES

Lito Morillo
Director

Friday, April 4, 2025

Exhibit D

Re: Test Claim 24-TC-05, Child Physical Abuse and Neglect Exams, Statutes 2023, Chapter 841, (AB 1402); Penal Code Section 11171(f)

RECEIVED
April 11, 2025
Commission on State Mandates

LATE FILING

To Whom It May Concern:

We commend the intent of AB 1402 to ensure that victims of child physical abuse and neglect receive free medical evidentiary examinations through a unified local mechanism involving Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, and other qualified providers. However, we are deeply concerned about the bill's misalignment with child welfare's legal mandate and the significant hidden operational and administrative burdens it imposes on counties.

Child welfare agencies operate under the Welfare and Institutions Code (WIC) §300, which governs civil child protection matters such as safety assessments, case planning, and dependency court processes. AB 1402, in contrast, is grounded in Penal Code §11171, which governs forensic investigation and evidence gathering for criminal prosecution. Requiring child welfare agencies to coordinate, oversee, and ensure reimbursement for medical evidentiary exams blurs a critical boundary between the civil and criminal systems. These functions have traditionally resided with law enforcement, district attorneys, and specialized forensic providers.

Given the current budget constraints facing the state, we are cautious about assuming additional responsibilities that may detract from our capacity to implement mission-critical priorities. While AB 1402 outlines a reimbursement pathway through Cal OES, it does not account for the substantial non-reimbursable infrastructure counties must build to comply with this mandate, including designating and managing a pool of approved medical evidentiary examiners, training staff and community partners in evidentiary protocols and documentation and ensuring compliance and audit readiness for Cal OES reimbursement

These responsibilities require substantial investments of staff time, legal oversight, interagency coordination, and risk management—none of which are supported through current statutory funding. While Kern County fully supports timely access to medical exams for child victims, we are concerned that the operational demands of implementing AB 1402 could jeopardize our ability to meet the foundational goals of child safety, well-being, and permanency.

For these reasons, we strongly urge the Commission to recognize the administrative burden and legal misalignment that AB 1402 imposes on counties. We support Santa Clara County's test claim (24-TC-05) and respectfully request that the Commission determine that AB 1402 constitutes an unfunded mandate under the California Constitution.

L. Morillo

Lito Morillo
Director
Kern County Department of Human Services

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

I am a resident of the County of Sacramento and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

On April 11, 2025, I served the:

- **Current Mailing List dated April 10, 2025**
- **Kern County's Late Comments on the Test Claim filed April 11, 2025**

  Child Physical Abuse and Neglect Exams, 24-TC-05
  Statutes 2023, Chapter 841, (AB 1402); Penal Code Section 11171(f)
  County of Santa Clara, Claimant

by making it available on the Commission's website and providing notice of how to locate it to the email addresses provided on the attached mailing list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on April 11, 2025 at Sacramento, California.

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980 Ninth Street, Suite 300
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COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 4/10/25

Claim Number: 24-TC-05

Matter: Child Physical Abuse and Neglect Exams

Claimant: County of Santa Clara

TO ALL PARTIES, INTERESTED PARTIES, AND INTERESTED PERSONS:

Each commission mailing list is continuously updated as requests are received to include or remove any party or person on the mailing list. A current mailing list is provided with commission correspondence, and a copy of the current mailing list is available upon request at any time. Except as provided otherwise by commission rule, when a party or interested party files any written material with the commission concerning a claim, it shall simultaneously serve a copy of the written material on the parties and interested parties to the claim identified on the mailing list provided by the commission. (Cal. Code Regs., tit. 2, § 1181.3.)

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STATE of CALIFORNIA
COMMISSION ON STATE MANDATES

Exhibit E

September 26, 2025

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And Parties, Interested Parties, and Interested Persons (See Mailing List)

Re: Draft Proposed Decision, Schedule for Comments, and Notice of Hearing
Child Physical Abuse and Neglect Exams, 24-TC-05
Statutes 2023, Chapter 841 (AB 1402); Penal Code Section 11171(f), effective January 1, 2024
County of Santa Clara, Claimant

Dear Mr. Hill and Mr. Narayan:

The Draft Proposed Decision for the above-captioned matter is enclosed for your review and comment.

Written Comments: Written comments may be filed on the Draft Proposed Decision no later than **5:00 pm on October 17, 2025**. Please note that all representations of fact submitted to the Commission must be signed under penalty of perjury by persons who are authorized and competent to do so and must be based upon the declarant's personal knowledge, information, or belief. (Cal. Code Regs., tit. 2, § 1187.5.) Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but shall not be sufficient in itself to support a finding unless it would be admissible over an objection in civil actions. (Cal. Code Regs., tit. 2, § 1187.5.) The Commission's ultimate findings of fact must be supported by substantial evidence in the record.[1]

You are advised that comments filed with the Commission are required to be electronically filed (e-filed) in an unlocked legible and searchable PDF file, using the Commission's Dropbox. (Cal. Code Regs., tit. 2, § 1181.3(c)(1).) Refer to https://www.csm.ca.gov/dropbox.shtml on the Commission's website for electronic filing instructions. If e-filing would cause the filer undue hardship or significant prejudice, filing may occur by first class mail, overnight delivery or personal service only upon approval of a written request to the executive director. (Cal. Code Regs., tit. 2, § 1181.3(c)(2).)

If you would like to request an extension of time to file comments, please refer to section 1187.9(a) of the Commission's regulations.

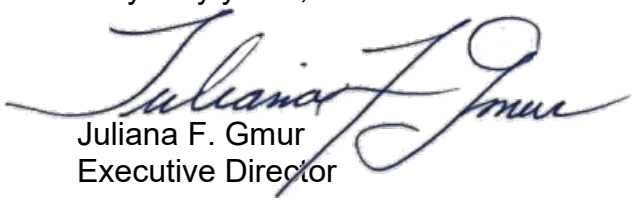
[1] Government Code section 17559(b), which provides that a claimant or the state may commence a proceeding in accordance with the provisions of section 1094.5 of the Code of Civil Procedure to set aside a decision of the Commission on the ground that the Commission's decision is not supported by substantial evidence in the record.

Hearing: This matter is set for hearing on **Friday, February 13, 2026** at 10:00 a.m. The Proposed Decision will be issued on or about January 30, 2026.

If you plan to address the Commission on this item, please notify the Commission Office not later than noon on the Tuesday prior to the hearing, **February 10, 2026**. Please also include the names of the people who will be speaking for inclusion on the witness list and the names and emails addresses of the people who will be speaking both in person and remotely to receive a hearing panelist link in Zoom. When calling or emailing, please identify the item you want to testify on and the entity you represent. The Commission Chairperson reserves the right to impose time limits on presentations as may be necessary to complete the agenda.

If you would like to request postponement of the hearing, please refer to section 1187.9(b) of the Commission's regulations.

Very truly yours,



Juliana F. Gmur
Executive Director

ITEM ___
TEST CLAIM
DRAFT PROPOSED DECISION

Penal Code Section 11171(f), Effective January 1, 2024

Statutes 2023, Chapter 841 (AB 1402)

Child Physical Abuse and Neglect Exams

24-TC-05

County of Santa Clara, Claimant

EXECUTIVE SUMMARY

Overview

This Test Claim alleges new state-mandated activities and costs arising from Penal Code section 11171(f), which prohibits counties from billing the victim or the victim's insurance for child physical abuse and neglect exams, as of January 1, 2024. Instead of counties billing the victim or the victim's insurance for child physical abuse and neglect exams, a system of state funding was created by the test claim statute in Penal Code section 11171(g) ("The costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature"), but no appropriation has yet been made.[1] Formerly, from January 1, 2004, until December 31, 2023, the counties billed the child's private insurance, if available, and Medi-Cal or the State Victim Compensation Board (VCB).

For reasons stated in the analysis, staff recommends the Commission partially approve this Test Claim.

Procedural History

The claimant filed the Test Claim on December 31, 2024.[2] The Department of Finance (Finance) filed comments on the Test Claim on April 10, 2025.[3] Kern County

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[1] Exhibit B, Finance's Comments on the Test Claim, page 1 ("AB 1402 also requires the costs of such exams to be funded by the state, subject to appropriation by the Legislature, and be submitted to Cal OES for reimbursement. However, no appropriation has been provided to Cal OES for this purpose.").

[2] Exhibit A, Test Claim.

[3] Exhibit B, Finance's Comments on the Test Claim.

Department of Human Services filed late comments on the Test Claim on April 11, 2025.[4] The claimant filed rebuttal comments on May 7, 2025.[5]

Commission staff issued the Draft Proposed Decision on September 26, 2025.[6]

Commission Responsibilities

Under article XIII B, section 6 of the California Constitution, local agencies and school districts are entitled to reimbursement for the costs of state-mandated new programs or higher levels of service. In order for local government to be eligible for reimbursement, one or more similarly situated local agencies or school districts must file a test claim with the Commission. "Test claim" means the first claim filed with the Commission alleging that a particular statute or executive order imposes costs mandated by the state. Test claims function similarly to class actions and all members of the class have the opportunity to participate in the test claim process and all are bound by the final decision of the Commission for purposes of that test claim.

The Commission is the quasi-judicial body vested with exclusive authority to adjudicate disputes over the existence of state-mandated programs within the meaning of article XIII B, section 6 of the California Constitution and not apply it as an "equitable remedy to cure the perceived unfairness resulting from political decisions on funding priorities."[7]

Claims

The following chart provides a brief summary of the claims and issues raised and staff's recommendation.

Issue	Description	Staff Recommendation
Was the Test Claim timely filed?	Government Code section 17551(c) requires test claims "be filed not later than 12 months following the effective date of a statute or executive order, or within 12 months of incurring increased costs as a result of a statute or executive order, whichever is later." Section 1183.1(c) of the Commission's regulations	*Yes, the Test Claim was timely filed*. The claimant filed the Test Claim on December 31, 2024 (during FY 2024-2025); thus, the potential period of reimbursement under Government Code section 17557(e) would begin at the start of the prior fiscal year, which is July 1, 2023.

[4] Exhibit D, Kern County Department of Human Services' Late Comments on the Test Claim.

[5] Exhibit C, Claimant's Rebuttal Comments.

[6] Exhibit E, Draft Proposed Decision.

[7] *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1264, 1281 citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

Issue	Description	Staff Recommendation
	defines "12 months" as 365 days. Government Code section 17557(e) requires: "A test claim shall be submitted on or before June 30 following a fiscal year in order to establish eligibility for reimbursement for that year."	However, since the test claim statute has a later effective date, the potential period of reimbursement begins on the statute's effective date, or January 1, 2024.
Does Penal Code 11171(f) as added by the test claim statute impose a reimbursable state-mandated program on counties?	Penal Code section 11171(f) - (h) was added by the test claim statute as follows: "(f) The costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect shall be separate from diagnostic treatment and procedure costs associated with medical treatment. ***Costs for the medical evidentiary portion of the examination shall not be charged directly or indirectly to the victim of child physical abuse or neglect.*** (g) Each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services for the performance of medical evidentiary examinations for victims of child physical	Yes. The test claim statute imposes a partial state-mandated new program or higher level of service on counties, under article XIII B, section 6(c), resulting in increased costs mandated by the state. Under prior law, counties had the authority to bill the victim's private medical insurance, Medi-Cal, or the Victim's Compensation Board (VCB) for the cost of the child physical abuse and neglect evidentiary exam.[i] Penal Code section 11171(f), as amended by the test claim statute, prohibits counties from billing the victim directly or indirectly for the cost of the exam, beginning January 1, 2024. The test claim statute does *not* mandate a new program or higher level of service for the increased costs of child physical abuse and neglect evidentiary exams when the costs could have been recovered directly from the victim or from the victim's

Issue	Description	Staff Recommendation
	abuse or neglect and shall notify the Office of Emergency Services of this designation. ***The costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature.*** Each county's designated SART, SAFE, or other qualified medical evidentiary examiners shall submit invoices to the Office of Emergency Service, who shall administer the program. A flat reimbursement rate shall be established. Within one year upon initial appropriation, the Office of Emergency Service shall establish a 60-day reimbursement process. The Office of Emergency Service shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years. (h) Reimbursement shall not be subject to reduced reimbursement rates based on patient history or other reasons. Victims of child physical abuse or neglect may receive a medical evidentiary exam outside of the jurisdiction where the	private medical insurance. There is no new activity required by the test claim statute, the state has not shifted any costs which were previously the responsibility of the state under these circumstances, and increased costs alone do not constitute a reimbursable mandate under article XIII B, section 6.[9] However, absent an appropriation from the state sufficient to cover the costs of the child physical abuse and neglect evidentiary exams, and where the state, through Medi-Cal or the VCB, previously paid for the child physical abuse and neglect medical evidentiary exams, the test claim statute shifts those costs from the state to the counties under article XIII B, section 6(c), resulting in a mandated new program or higher level of service. Counties are compelled to provide child physical abuse and neglect exams when the facts present themselves and section 11171(g) requires the counties to authorize a designee to approve the counties' Sexual Assault Response Teams (SART),

[9] California Constitution, article XIII B, section 6(a) and (c); *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1816 ("Section 6 was not intended to entitle local entities to reimbursement for *all* increased costs resulting from Legislative enactments, but only those costs mandated by a new program or an increased level of service imposed upon them by the State.").

Issue	Description	Staff Recommendation
	crime occurred and that county's approved SART, SAFE teams, or qualified medical evidentiary examiners shall be reimbursed for the performance of these exams."[8] To date, the Legislature has not appropriated funds to pay for the cost of the evidentiary exams pursuant to section 11171(g). Article XIII B, section 6(c), as added by Proposition 1A in 2004, defines a mandated new program or higher level of service to also include "a transfer by the Legislature from the State to cities, counties, cities and counties, or special districts of complete or partial financial responsibility for a required program for which the State previously had complete or partial financial responsibility."	Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the California Office of Emergency Services (Cal OES) for the performance of medical evidentiary examinations for victims of child physical abuse or neglect. Thus, the cost of the exams, which has been shifted from the state to the counties with respect to previous Medi-Cal and VCB reimbursement for the exams, are a component of a mandated program. Finally, based on substantial evidence in the record, the mandated new program or higher level of service results in increased costs mandated by the state and none of the exceptions to reimbursement in Government Code section 17556 apply.[10]

Staff Analysis

This Test Claim alleges new state-mandated activities and costs arising from Penal Code section 11171(f), which prohibits counties from billing the victim or the victim's insurance for child physical abuse and neglect exams, as of January 1, 2024. Instead of counties billing the victim or the victim's insurance for child physical abuse and neglect exams, a system of state funding was created by the test claim statute in Penal Code section 11171(g) ("The costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature"), but no

[8] Penal Code section 11171, as amended by Statutes 2023, chapter 841, section 1.

[10] Exhibit A, Test Claim, pages 35-36, paragraphs 9, 12-13 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

appropriation has yet been made.[11] Formerly, from January 1, 2004, until December 31, 2023, the counties billed the child's private insurance, if available, and Medi-Cal or the State Victim Compensation Board (VCB).

Staff finds the Test Claim is timely filed with a potential period of reimbursement beginning January 1, 2024.

Staff finds that the test claim statute does not mandate a new program or higher level of service for the increased costs of child physical abuse and neglect evidentiary exams when the costs could have been recovered directly from the victim or from the victim's private medical insurance. There is no new activity required by the test claim statute, the state has not shifted any costs which were previously the responsibility of the state, and increased costs alone do not constitute a reimbursable mandate under article XIII B, section 6.[12]

However, absent an appropriation from the state sufficient to cover the costs of the child physical abuse and neglect evidentiary exams, and where the state, through Medi-Cal or the VCB, previously paid for the child physical abuse and neglect medical evidentiary exams, the test claim statute shifts those costs from the state to the counties under article XIII B, section 6(c), resulting in a mandated new program or higher level of service. The voters added article XIII B, section 6(c) to the California Constitution in 2004 (Proposition 1A), recognizing reimbursable mandates in the transfer "of complete or partial financial responsibility for a required program for which the State previously had complete or partial financial responsibility."

From January 1, 2004, to December 31, 2023, funds from Medi-Cal and the VCB reimbursed counties for the cost of child physical abuse and neglect medical evidentiary exams. Both billing options have been acknowledged on the Cal OES exam instructions since 2001.[13] Under Chapter IV, "Reimbursements for

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[11] Exhibit B, Finance's Comments on the Test Claim, page 1 ("AB 1402 also requires the costs of such exams to be funded by the state, subject to appropriation by the Legislature, and be submitted to Cal OES for reimbursement. However, no appropriation has been provided to Cal OES for this purpose.").

[12] California Constitution, article XIII B, section 6(a) and (c); *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1816 ("Section 6 was not intended to entitle local entities to reimbursement for *all* increased costs resulting from Legislative enactments, but only those costs mandated by a new program or an increased level of service imposed upon them by the State.").

[13] Exhibit A, Test Claim, page 235; Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025) ("**3. Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy.**" Emphasis in original.).

Examinations," the Cal OES Protocol stated before the test claim statute, attached to forms dated January 1, 2004:

> In the majority of counties in California, charges for child physical abuse and neglect examinations ***are billed to Medi-Cal*** or to the patient's private insurance. Standard diagnostic and procedural coding manuals are used to generate charges. For patients without insurance, or who are underinsured, reimbursement of ***charges may be obtained through California Victim Compensation and Government Claims Board***.[14]

Since at least 1982, Medi-Cal assumed financial responsibility for abused and neglected children. The State Department of Healthcare Services advised all county directors in 1982 that individuals receiving "Emergency Assistance," including "Abused, Neglected or Exploited Children (EA-ANEC)" were considered "public assistance recipients" and "will be eligible for Medi-Cal benefits and a Medi-Cal card."[15] Social workers have since been applying on behalf of an abused or neglected child for "Retroactive Medi-Cal," using Form MC 250.[16] Thus, if these children were not already enrolled in Medi-Cal, they would become enrolled by the social worker on an emergency basis.[17] Under

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[14] Exhibit A, Test Claim, page 134; Exhibit X (6), California Medical Protocol For Examination of Child Physical Abuse and Neglect Victims, page 15, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025), emphasis added.

[15] Exhibit X (8), Department of Health Services Letter to All County Welfare Directors, August 17, 1982, Letter 82-44, page 1; Exhibit X (9), Department of Health Services Letter to All County Welfare Directors, December 22, 1982 Letter 82-72, pages 1-7; see also California Code of Regulations, title 22, section 50038.5 (defining "Emergency Assistance" as programs providing assistance for up to 30 days, including for "[t]hose children who are being, or are in immediate danger of being abused, neglected or exploited and to families of such children.").

[16] Exhibit X (15), Retroactive Medi-Cal, page 1, https://stgenssa.sccgov.org/debs/program_handbooks/foster_care/assets/28medi-cal/retromedical.htm?agt=index (accessed on July 24, 2025); Exhibit X (10) Form MC 250, Application and Statement of Facts for Child Not Living with a Parent or Relative for Whom a Public Agency Is Assuming Some Financial Responsibility, pages 1-2, https://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc250.pdf (accessed on July 24, 2025); California Code of Regulations, title 22, section 50251 ("(e) Children specified in (a)(3) shall be eligible and certified for Medi-Cal: (1) On the basis of the information provided by the public agency on form MC 250. (2) Without considering the property or income of the child or the child's parents.").

[17] California Code of Regulations, title 22, section 50143(a)(3); see also Exhibit X (1), Aid Codes Master Chart, updated April 2022, pages 33 and 35, https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/869D30AF-4BC7-4132-AF6A-AF75893E9221/aidcodes.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO (accessed on July 24, 2025) (Aid Code 45 provides: "FC. Covers children supported by

Continuing Eligibility for Children (CEC), coverage would then continue, uninterrupted at least until the next annual redetermination.[18]

Counties could also bill the VCB if a child was somehow uninsured or underinsured by Medi-Cal.[19] If counties pursued this option, they, or their contracted providers, could bill the VCB directly as a service provider, but had to accept the limits of the VCB payment schedule.[20]

The payments to counties or their providers from Medi-Cal and the VCB have been the responsibility of the state. The California Supreme Court has found that Medi-Cal "has been the responsibility of various state departments and agencies."[21] Likewise, the VCB is a state agency.[22] The VCB has been in existence since 2002 under its current name and role.[23]

Accordingly, since the state, through Medi-Cal or the VCB, previously paid for the child physical abuse and neglect medical evidentiary exams, Penal Code section 11171(f), as amended by the test claim statute, which prohibits counties from billing the victim indirectly for the exams, shifts those costs from the state to the counties under article XIII B, section 6(c), resulting in a new program or higher level of service.

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public funds other than AFDC-FC" with no share of costs.); see also Exhibit X (19), Short Doyle Medi-Cal Aid Code Chart, February 23, 2023, page 6, https://www.dhcs.ca.gov/services/MH/Pages/medccc-library.aspx (accessed on July 24, 2025) (Aid Code "5K" provides "Emergency Assistance (EA) Foster Care" with no share of costs).

[18] Exhibit X (7), Continuous Eligibility for Children (CEC), page 1, https://stgenssa.sccgov.org/debs/program_handbooks/foster_care/assets/28medi-cal/contnuselgblty.htm (accessed on July 24, 2025); California Code of Regulations, title 22, section 50189.

[19] Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025) ("**3. Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy.**" Emphasis in original.).

[20] Government Code sections 13957.7(c)(1) and 13957.2; California Code of Regulations, title 2, section 649.23.

[21] *County of San Diego v. State of California* (1997) 15 Cal.4th 68, 96.

[22] Government Code sections 11000 and 13950.

[23] Government Code sections 13950-13951, as added by Statutes 2002, chapter 1141, section 2.

In addition, counties are practically compelled to provide child physical abuse and neglect exams and, thus, the cost of the exams, which has been shifted from the state to the counties with respect to previous Medi-Cal and VCB reimbursement for the exams, are a component of a mandated program. Penal Code section 11171, which originally became effective on January 1, 2004, does not by its plain language require counties to perform child physical abuse and neglect exams.[24] Instead, it required what is now Cal OES to standardize child physical abuse and neglect exams by creating forms, protocols, and instructions to be used statewide.[25] These forms, protocols, and instructions set the "minimum legal standards"[26] for "adequate protection of victims of child physical abuse or neglect."[27] Thus, there is no legal compulsion to perform the exams under the test claim statute.

However, counties have no choice but are compelled as a practical matter to ensure that a physical abuse and neglect exam is provided when the facts present themselves.[28] The Legislature declared in 1996 "that all children are entitled to be safe and free from abuse and neglect."[29] In 2002, the Legislature set a floor of adequacy when it enacted the program of state standardized medical evidentiary exams. It declared that "adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations."[30] In addition, the counties' obligation to provide child physical abuse and neglect exams stems from an existing requirement to investigate all incoming child abuse reports, a duty that has been confirmed by the courts.[31] Existing state law also requires counties to ensure that a child taken into protective custody undergo a physical examination

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[24] Penal Code section 11171(a)-(e), as added by Statutes 2002, chapter 249, section 4 (SB 580).

[25] Penal Code section 11171, as added by Statutes 2002, chapter 249, section 4 (SB 580).

[26] Exhibit X (6), California Medical Protocol For Examination of Child Physical Abuse and Neglect Victims, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025); Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[27] Penal Code section 11171(a)(1).

[28] *Coast Community College District v. Commission on State Mandates* (2022) 13 Cal.5th 800, 815-817.

[29] Welfare and Institutions Code section 16500, as amended by Statutes 1996, chapter 1084, section 10.

[30] Penal Code section 11171(a)(1), as added by Statutes 2002, chapter 249.

[31] Penal Code section 11166.3 (formerly 11166.1); see also *Alejo v. City of Alhambra* (1999) 75 Cal.App.4th 1180, 1185-1186.

performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, when appropriate and following allegations of physical abuse, and "whenever possible, shall ensure that this examination take place within 72 hours of the time the child was taken into protective custody, when there are allegations of physical abuse."[32] Where a child is not immediately taken into protective custody under Welfare and Institutions Code section 324.5, other statutory duties compel the physical abuse and neglect exams. If allegations of abuse or neglect are made in a family court child custody proceeding, for example, "the court may request that the local child welfare services agency conduct an investigation of the allegations pursuant to Section 328 of the Welfare and Institutions Code."[33] Although this statute uses the word "may," it is a court's duty to protect the child, and thus the investigations prompted on this case by case basis are practically compelled.[34] And section 11171(g), as amended by the test claim statute, states that counties "shall" set up the reimbursement system with Cal OES and designate SART, SAFE, or other "qualified medical evidentiary examiners" to obtain reimbursement if the Legislature appropriates funds for this program.[35]

Finally, the claimant submitted evidence that the test claim statute imposes costs mandated by the state and none of the exceptions to costs mandated by the state in Government Code section 17556 apply. The claimant has no fee authority to offset the increased costs. There is no appropriation offsetting the costs, which Finance presently confirms.[36] And there is no change to any crime or penalty for any crime of child abuse or neglect.

Conclusion

Based on the foregoing analysis, staff finds that Penal Code section 11171(f), as amended by the test claim statute, imposes a reimbursable state-mandated program beginning January 1, 2024, on counties within the meaning of article XIII B, section 6(c) of the California Constitution only for the following costs:

- Costs incurred for child physical abuse and neglect exams conducted in accordance with Penal Code section 11171, by the county's designated Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners, when the child is eligible for Medi-Cal or Victim Compensation Board coverage.

[32] Welfare and Institutions Code section 324.5.

[33] Family Code section 3027(b).

[34] *In re Joshuia S.* (1988) 205 Cal.App.3d 119, 125.

[35] Penal Code section 11171(g).

[36] Exhibit A, Test Claim, page 33, paragraph 20 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara); Exhibit B, Finance's Comments on the Test Claim, page 1.

Reimbursement is ***not*** required to the extent the Legislature appropriates funds for child physical abuse and neglect exams under Penal Code section 11171(g).

Staff Recommendation

Staff recommends that the Commission adopt the Proposed Decision to partially approve the Test Claim and authorize staff to make any technical, non-substantive changes to the Proposed Decision following the hearing.

BEFORE THE

COMMISSION ON STATE MANDATES

STATE OF CALIFORNIA

IN RE TEST CLAIM Penal Code Section 11171(f) Statutes 2023, Chapter 841 (AB 1402), Effective January 1, 2024 Filed on December 31, 2024 County of Santa Clara, Claimant	Case No.: 24-TC-05 *Child Physical Abuse and Neglect Exams* DECISION PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; CALIFORNIA CODE OF REGULATIONS, TITLE 2, DIVISION 2, CHAPTER 2.5, ARTICLE 7. (*Adopted December 5, 2025*)

DECISION

The Commission on State Mandates (Commission) heard and decided this Test Claim during a regularly scheduled hearing on February 13, 2026. [Witness list will be included in the adopted Decision.]

The law applicable to the Commission's determination of a reimbursable state-mandated program is article XIII B, section 6 of the California Constitution, Government Code sections 17500 et seq., and related case law.

The Commission [adopted/modified] the Proposed Decision to [approve/partially approve/deny] the Test Claim by a vote of [vote will be included in the adopted Decision], as follows:

Member	**Vote**
Lee Adams, County Supervisor	
Deborah Gallegos, Representative of the State Controller, Vice Chairperson	
Karen Greene Ross, Public Member	
Renee Nash, School District Board Member	
William Pahland, Representative of the State Treasurer	
Michele Perrault, Representative of the Director of the Department of Finance, Chairperson	
Alexander Powell, Representative of the Director of the Governor's Office of Land Use and Climate Innovation	

Summary of the Findings

This Test Claim alleges new state-mandated activities and costs arising from Penal Code section 11171(f), which prohibits counties from billing the victim or the victim's insurance for child physical abuse and neglect exams, as of January 1, 2024. Instead

of counties billing the victim or the victim's insurance for child physical abuse and neglect exams, a system of state funding was created by the test claim statute in Penal Code section 11171(g) ("The costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature"*)*, but no appropriation has yet been made.[37] Formerly, from January 1, 2004, until December 31, 2023, the counties billed the child's private insurance, if available, and Medi-Cal or the State Victim Compensation Board (VCB).

The Commission finds the Test Claim is timely filed with a potential period of reimbursement beginning January 1, 2024.

The Commission finds that the test claim statute does not mandate a new program or higher level of service for the increased costs of child physical abuse and neglect evidentiary exams when the costs could have been recovered directly from the victim or from the victim's private medical insurance. There is no new activity required by the test claim statute, the state has not shifted any costs which were previously the responsibility of the state, and increased costs alone do not constitute a reimbursable mandate under article XIII B, section 6.[38]

However, absent an appropriation from the state sufficient to cover the costs of the child physical abuse and neglect evidentiary exams, and where the state, through Medi-Cal or the VCB, previously paid for the child physical abuse and neglect medical evidentiary exams, the test claim statute shifts those costs from the state to the counties under article XIII B, section 6(c), resulting in a mandated new program or higher level of service. The voters added article XIII B, section 6(c) to the California Constitution in 2004 (Proposition 1A), recognizing reimbursable mandates in the transfer "of complete or partial financial responsibility for a required program for which the State previously had complete or partial financial responsibility."

From January 1, 2004, to December 31, 2023, funds from Medi-Cal and the VCB reimbursed counties for the cost of child physical abuse and neglect medical evidentiary exams. Both billing options have been acknowledged on the California Office of Emergency Services (Cal OES) exam instructions since 2001.[39] Under Chapter IV, "Reimbursements for Examinations," the Cal OES

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[37] Exhibit B, Finance's Comments on the Test Claim, page 1 ("AB 1402 also requires the costs of such exams to be funded by the state, subject to appropriation by the Legislature, and be submitted to Cal OES for reimbursement. However, no appropriation has been provided to Cal OES for this purpose.").

[38] California Constitution, article XIII B, section 6(a) and (c); *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1816 ("Section 6 was not intended to entitle local entities to reimbursement for *all* increased costs resulting from Legislative enactments, but only those costs mandated by a new program or an increased level of service imposed upon them by the State.").

[39] Exhibit A, Test Claim, page 235; Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-

Protocol stated before the test claim statute, attached to forms dated January 1, 2004:

> In the majority of counties in California, charges for child physical abuse and neglect examinations ***are billed to Medi-Cal*** or to the patient's private insurance. Standard diagnostic and procedural coding manuals are used to generate charges. For patients without insurance, or who are underinsured, reimbursement of ***charges may be obtained through California Victim Compensation and Government Claims Board***.[40]

Since at least 1982, Medi-Cal assumed financial responsibility for abused and neglected children. The State Department of Healthcare Services advised all county directors in 1982 that individuals receiving "Emergency Assistance," including "Abused, Neglected or Exploited Children (EA-ANEC)" were considered "public assistance recipients" and "will be eligible for Medi-Cal benefits and a Medi-Cal card."[41] Social workers have since been applying on behalf of an abused or neglected child for "Retroactive Medi-Cal," using Form MC 250.[42] Thus, if these children were not already enrolled in Medi-Cal,

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administration/grants-management/victim-services/forms/ (accessed on June 20, 2025) ("**3. Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy.**" Emphasis in original.).

[40] Exhibit A, Test Claim, page 134; Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 15, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025), emphasis added.

[41] Exhibit X (8), Department of Health Services Letter to All County Welfare Directors, August 17, 1982, Letter 82-44, page 1; Exhibit X (9), Department of Health Services Letter to All County Welfare Directors, December 22, 1982 Letter 82-72, pages 1-7; see also California Code of Regulations, title 22, section 50038.5 (defining "Emergency Assistance" as programs providing assistance for up to 30 days, including for "[t]hose children who are being, or are in immediate danger of being abused, neglected or exploited and to families of such children.").

[42] Exhibit X (15), Retroactive Medi-Cal, page 1, https://stgenssa.sccgov.org/debs/program_handbooks/foster_care/assets/28medi-cal/retromedical.htm?agt=index (accessed on July 24, 2025); Exhibit X (10) Form MC 250, Application and Statement of Facts for Child Not Living with a Parent or Relative for Whom a Public Agency Is Assuming Some Financial Responsibility, https://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc250.pdf (accessed on July 24, 2025); California Code of Regulations, title 22, section 50251 ("(e) Children specified in (a)(3) shall be eligible and certified for Medi-Cal: (1) On the basis of the information provided by the public agency on form MC 250. (2) Without considering the property or income of the child or the child's parents.").

they would become enrolled by the social worker on an emergency basis.[43] Under Continuing Eligibility for Children (CEC), coverage would then continue, uninterrupted at least until the next annual redetermination.[44]

Counties could also bill the VCB if a child was somehow uninsured or underinsured by Medi-Cal.[45] If counties pursued this option, they, or their contracted providers, could bill the VCB directly as a service provider, but had to accept the limits of the VCB payment schedule.[46]

The payments to counties or their providers from Medi-Cal and the VCB have been the responsibility of the state. The California Supreme Court has found that Medi-Cal "has been the responsibility of various state departments and agencies."[47] Likewise, the VCB is a state agency.[48] The VCB has been in existence since 2002 under its current name and role.[49]

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[43] California Code of Regulations, title 22, section 50143(a)(3); see also Exhibit X (1), Aid Codes Master Chart, updated April 2022, pages 33 and 35, https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/869D30AF-4BC7-4132-AF6A-AF75893E9221/aidcodes.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO (accessed on July 24, 2025) (Aid Code 45 provides: "FC. Covers children supported by public funds other than AFDC-FC" with no share of costs.); see also Exhibit X (19), Short Doyle Medi-Cal Aid Code Chart, February 23, 2023, page 6, https://www.dhcs.ca.gov/services/MH/Pages/medccc-library.aspx (accessed on July 24, 2025) (Aid Code "5K" provides "Emergency Assistance (EA) Foster Care" with no share of costs).

[44] Exhibit X (7), Continuous Eligibility for Children (CEC), page 1, https://stgenssa.sccgov.org/debs/program_handbooks/foster_care/assets/28medi-cal/contnuselgblty.htm (accessed on July 24, 2025); California Code of Regulations, title 22, section 50189.

[45] Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2 **,** https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025) ("**3. Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy.**" Emphasis in original.).

[46] Government Code sections 13957.7(c)(1) and 13957.2; California Code of Regulations, title 2, section 649.23.

[47] *County of San Diego v. State of California* (1997) 15 Cal.4th 68, 96.

[48] Government Code sections 11000 and 13950.

[49] Government Code sections 13950-13951, as added by Statutes 2002, chapter 1141, section 2.

Accordingly, since the state, through Medi-Cal or the VCB, previously paid for the child physical abuse and neglect medical evidentiary exams, Penal Code section 11171(f), as amended by the test claim statute, which prohibits counties from billing the victim indirectly for the exams, shifts those costs from the state to the counties under article XIII B, section 6(c), resulting in a new program or higher level of service.

In addition, counties are practically compelled to provide child physical abuse and neglect exams and, thus, the cost of the exams, which has been shifted from the state to the counties with respect to previous Medi-Cal and VCB reimbursement for the exams, are a component of a mandated program. Penal Code section 11171, which originally became effective on January 1, 2004, does not by its plain language require counties to perform child physical abuse and neglect exams.[50] Instead, it required what is now Cal OES to standardize child physical abuse and neglect exams by creating forms, protocols, and instructions to be used statewide.[51] These forms, protocols, and instructions set the "minimum legal standards"[52] for "adequate protection of victims of child physical abuse or neglect."[53] Thus, there is no legal compulsion to perform the exams under the test claim statute.

However, counties have no choice but are compelled as a practical matter to ensure that a physical abuse and neglect exam is provided when the facts present themselves.[54] The Legislature declared in 1996 "that all children are entitled to be safe and free from abuse and neglect."[55] In 2002, the Legislature set a floor of adequacy when it enacted the program of state standardized medical evidentiary exams. It declared that "adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations."[56]

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[50] Penal Code section 11171(a)-(e), as added by Statutes 2002, chapter 249, section 4 (SB 580).

[51] Penal Code section 11171, as added by Statutes 2002, chapter 249, section 4 (SB 580).

[52] Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025);

Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[53] Penal Code section 11171(a)(1).

[54] *Coast Community College District v. Commission on State Mandates* (2022) 13 Cal.5th 800, 815-817.

[55] Welfare and Institutions Code section 16500, as amended by Statutes 1996, chapter 1084, section 10.

[56] Penal Code section 11171(a)(1), as added by Statutes 2002, chapter 249.

In addition, the counties' obligation to provide child physical abuse and neglect exams stems from an existing requirement to investigate all incoming child abuse reports, a duty that has been confirmed by the courts.[57] Existing state law also requires counties to ensure that a child taken into protective custody undergo a physical examination performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, when appropriate and following allegations of physical abuse, and "whenever possible, shall ensure that this examination take place within 72 hours of the time the child was taken into protective custody, when there are allegations of physical abuse."[58] Where a child is not immediately taken into protective custody under Welfare and Institutions Code section 324.5, other statutory duties compel the physical abuse and neglect exams. If allegations of abuse or neglect are made in a family court child custody proceeding, for example, "the court may request that the local child welfare services agency conduct an investigation of the allegations pursuant to Section 328 of the Welfare and Institutions Code."[59] Although this statute uses the word "may," it is a court's duty to protect the child, and thus the investigations prompted on this case by case basis are practically compelled.[60] And section 11171(g), as amended by the test claim statute, states that counties "shall" set up the reimbursement system with Cal OES and designate SART, SAFE, or other "qualified medical evidentiary examiners" to obtain reimbursement if the Legislature appropriates funds for this program.[61]

Finally, the claimant submitted evidence that the test claim statute imposes costs mandated by the state and none of the exceptions to costs mandated by the state in Government Code section 17556 apply. The claimant has no fee authority to offset the increased costs. There is no appropriation offsetting the costs, which the Department of Finance (Finance) presently confirms.[62] And there is no change to any crime or penalty for any crime of child abuse or neglect.

Accordingly, the Commission partially approves this test claim and finds that Penal Code section 11171(f), as amended by the test claim statute, imposes a reimbursable state-mandated program beginning January 1, 2024, on counties within the meaning of article XIII B, section 6(c) of the California Constitution and Government Code section 17514 only for the following costs:

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[57] Penal Code section 11166.3 (formerly 11166.1); see also *Alejo v. City of Alhambra* (1999) 75 Cal.App.4th 1180, 1185-1186.

[58] Welfare and Institutions Code section 324.5.

[59] Family Code section 3027(b).

[60] *In re Joshuia S.* (1988) 205 Cal.App.3d 119, 125.

[61] Penal Code section 11171(g).

[62] Exhibit A, Test Claim, page 33, paragraph 20 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara); Exhibit B, Finance's Comments on the Test Claim, page 1.

- Costs incurred for child physical abuse and neglect exams conducted in accordance with Penal Code section 11171, by the county's designated Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners, when the child is eligible for Medi-Cal or Victim Compensation Board coverage.

  Reimbursement is ***not*** required to the extent the Legislature appropriates funds for child physical abuse and neglect exams under Penal Code section 11171(g).

COMMISSION FINDINGS

I. Chronology

01/01/2024 Penal Code section 11171(f), as added by Statutes 2023, chapter 841 (AB 1402), became effective.

12/31/2024 The claimant filed the Test Claim.[63]

04/10/2025 The Department of Finance (Finance) filed comments on the Test Claim.[64]

04/11/2025 Kern County Department of Human Services filed late comments on the Test Claim.[65]

05/07/2025 The claimant filed rebuttal comments.[66]

09/26/2025 Commission staff issued the Draft Proposed Decision.[67]

II. Background

A. Prior Law

Protecting children is a general county function subject to state law.[68] In 1968, the Legislature provided, under a chapter then entitled "State Protective Services for Children," that the state, through itself and the counties, shall establish a statewide

[63] Exhibit A, Test Claim.

[64] Exhibit B, Finance's Comments on the Test Claim.

[65] Exhibit D, Kern County Department of Human Services' Late Comments on the Test Claim.

[66] Exhibit C, Claimant's Rebuttal Comments.

[67] Exhibit E, Draft Proposition Decision.

[68] Welfare and Institutions Code sections 300, 10800 and 16500; *In re Social Services Payment Cases* (2008) 166 Cal.App.4th 1249, 1256 ("The Legislature has determined that the provision of public social services, including foster care, is a county function and responsibility subject to any applicable state and federal statutes and regulations. (§ 10800.) Counties are responsible for a public system of statewide child welfare services, which includes providing for the investigation of possible abuse or neglect of a child warranting removal from parental custody. (§§ 300 et seq. & 16500 et seq.)").

system of child protective services to be made available by all counties.[69] The counties' responsibility for this statewide child welfare system exists in a principal-agent relationship with the state.[70]

In 1996, the Legislature elaborated on its intent for the 1968 law directing the statewide system of protecting children. It declared "that all children are entitled to be safe and free from abuse and neglect."[71]

In addition to the general duty to protect, specific duties have been imposed on counties when receiving reports of suspected child abuse and neglect. These duties are to accept, to cross-report, and to investigate all such reports made to the counties. In 1980, the Legislature began requiring counties to cross-report "every instance of suspected child abuse."[72] In 1985, the Legislature began requiring "investigation of suspected child abuse cases" through "cooperative arrangements" between "law enforcement agencies and the county welfare or social services department," and it imposed reporting requirements on those agencies.[73] And in 2000, the Legislature required county welfare departments, along with police and other county departments, to accept *all* reports of suspected child abuse and neglect, stating in the legislation that counties "shall accept a report of suspected child abuse or neglect whether offered by a mandated reporter or another person."[74] In sum, counties must accept reports of

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[69] Welfare and Institutions Code section 16500, as added by Statutes 1968, chapter 69, section 1.

[70] Welfare and Institutions Code sections 16501(a)(1)(B), 16501(a)(2), and 16501(c) ("The county shall provide child welfare services as needed pursuant to an approved service plan and in accordance with regulations promulgated, in consultation with the counties, by the [state] department."); *Ross v. Superior Court* (1977) 19 Cal.3d 899, 908; *Hassell v. Bird* (2018) 5 Cal.5th 522, 553, Kruger, J., concurring ("counties act on behalf of the state in administering welfare benefits"); *In re M.C.* (2011) 199 Cal.App.4th 784, 810 (county social service agency is an administrative agency of the executive branch when providing child welfare services, subject to supervision by Department of Social Services) citing Welfare and Institutions Code sections 202.5, 10000, 10051, 10800, 16500, 16500.1, and 16501, *Scott v. County of Los Angeles* (1994) 27 Cal.App.4th 125, 143-144, and *In re Danielle W.* (1989) 207 Cal.App.3d 1227, 1235-1236, n. 6.).

[71] Welfare and Institutions Code section 16500, as amended by Statutes 1996, chapter 1084, section 10.

[72] Penal Code section 11166(f), as added by Statutes 1980, chapter 1071, section 4 (subsequently renumbered as section 11166(j)).

[73] Penal Code section 11166.1(a), as added by Statutes 1985, chapter 1262, section 2 (subsequently renumbered as 11166.3, as amended by Statutes 1987, chapter 531, section 3.)

[74] Penal Code section 11165.9, as added by Statutes 2000, chapter 1214, section 8.

suspected child abuse from any person, must cross-report, and must investigate those reports.

In 1999, the Court of Appeal clarified the difference between the general and specific duties of counties to protect children.[75] The Court of Appeal found that while the police have a general duty of public protection, a duty to investigate *each* incoming report of suspected child abuse would require a specific statute. It found Penal Code section 11166 to be that statute.[76] The court thus found a specific statutory duty of investigation upon each individual report of suspected child abuse.[77]

Overlapping with the growth of law regarding child abuse investigation, various laws were added regarding medical evidentiary exams. Such exams are provided in suspected cases of sexual assault (adult or child), domestic violence, or, as relevant here, child physical abuse and neglect.

In 1985, the Legislature began requiring specific protocols for sexual assault medical evidentiary exams, including child sexual abuse.[78] These laws required counties to designate one acute care hospital to provide such exams.[79] They further required forms and extensive specific protocols for conducting the exams, and they set "minimum standards" for examinations of sexual abuse victims.[80]

In 1995, the Legislature passed Senate Bill 857, expanding the scope of medical evidentiary examinations from just sexual assault (adult or child) to the wider context of

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[75] *Alejo v. City of Alhambra* (1999) 75 Cal.App.4th 1180.

[76] *Alejo v. City of Alhambra* (1999) 75 Cal.App.4th 1180, 1185-1186 ("First, the statute imposes a duty to investigate."), disapproved on another ground in *B.H. v. County of San Bernardino* (2015) 62 Cal.4th 168; see also *Holman v. County of Butte* (2021) 68 Cal.App.5th 189 (county negligence case for failure to investigate and cross-report); see also Welfare and Institutions Code section 328 and Family Code section 3027.

[77] The Commission, in *Interagency Child Abuse and Neglect Investigation Reports,* 00-TC-22, found a mandate to investigate reports of suspected child abuse in Penal code section 11169(a), California Code of Regulations, title 11, section 903, and "Child Abuse Investigation Report" Form SS 8583. The claim therein under Penal Code section 11166 was denied as not unique to local government, but this does not contravene *Alejo*'s holding that the counties have a duty to investigate incoming reports of suspected child abuse or neglect. See Commission on State Mandates, Decision and Parameters and Guidelines on *Interagency Child Abuse and Neglect Investigation Reports,* 00-TC-22, adopted December 6, 2013, https://www.csm.ca.gov/decisions/00-TC-22_adoptedSODandpsgs120613.pdf (accessed on September 23, 2025), pages 38-40.

[78] Statutes 1985, chapter 812.

[79] Penal Code section 13823.9(c) as added by Statutes 1985, chapter 812, section 7.

[80] Penal Code sections 13823.7 and 13823.11, as added by Statutes 1985, chapter 812, sections 7-8.

"domestic violence, child abuse, elder abuse, and sexual assault."[81] It further sought to ensure proper medical training for such exams.

The Legislature declared that "to provide comprehensive, competent evidentiary examinations for use by law enforcement agencies, it is necessary to take immediate steps to ensure there are appropriately trained medical professionals throughout California."[82] To that end, the Legislature then defined the phrase "perform a medical evidentiary examination" as meaning to "evaluate, collect, preserve, and document evidence, interpret findings, and document examination results."[83] SB 857 required creation of two hospital-based training centers, one in northern California and one in southern California, which would teach medical professionals how to conduct the medical evidentiary examinations, and to make "use of advanced medical technology in the evaluation of child victims of sexual or physical abuse or neglect, or of sexual assault, elder abuse, and domestic violence victims, or both."[84]

In 2002, the Legislature changed its requirement of two training centers to one. The single training center is now known as the California Clinical Forensic Medical Training Center (CCFMTC). [85]

In 1999, the Legislature began requiring medical evidentiary exams for children taken into protective custody where abuse is suspected and where it is determined appropriate by a specialized medical practitioner.[86] This law also provides that where additional medical evidentiary exams may be needed, the same practitioner should provide them, and if not available, then another practitioner with the same specialized training should do so.[87]

In 2002, the program regarding child physical abuse and neglect exams began. By adding Penal Code section 11171, the Legislature declared that "adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations."[88] To ensure adequate protection against child physical abuse and neglect, the Legislature created a statewide program requiring

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[81] Statutes 1995, chapter 860, section 1(c).

[82] Statutes 1995, chapter 860, section 1(c).

[83] Penal Code section 13823.93(a)(2), as added by Statutes 1995, chapter 860, section 2.

[84] Penal Code section 13823.93(c)(4), as added by Statutes 1995, chapter 860, section 2.

[85] Penal Code section 13823.93(b) – (d), as amended by Statutes 2002, chapter 256, section 1; Penal Code section 13823.93(b).

[86] Welfare and Institutions Code section 324.5.

[87] Welfare and Institutions Code section 324.5(b).

[88] Penal Code section 11171(a)(1).

creation and use of a standardized form, instructions and protocols for child physical abuse and neglect medical evidentiary exams.[89] The law required the following:

> On or before January 1, 2004, the Office of Criminal Justice Planning[90] shall, in cooperation with the State Department of Social Services, the Department of Justice, the California Association of Crime Lab Directors, the California State District Attorneys Association, the California State Sheriffs Association, the California Peace Officers Association, the California Medical Association, the California Police Chiefs' Association, child advocates, the California Medical Training Center, child protective services, and other appropriate experts, establish medical forensic forms, instructions, and examination protocol for victims of child physical abuse or neglect using as a model the form and guidelines developed pursuant to Section 19823.5.[91]

The state standardized form was required to include:

> (1) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures.
>
> (2) Addressing relevant consent issues, if indicated.
>
> (3) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history.
>
> (4) The performance of a physical examination for evidence of child physical abuse or neglect.
>
> (5) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures.
>
> (6) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated.
>
> (7) Procedures for the preservation and disposition of evidence.

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[89] Penal Code section 11171, as added by Statutes 2002, chapter 249, section 4 (SB 580).

[90] The Office of Criminal Justice Planning was abolished on January 1, 2004. Its duties were largely transferred to Cal OES that same year. See Penal Code section 13820, as added by Statutes 2003, chapter 229, section 26, and as amended by Statutes 2013, chapter 352, section 428; Exhibit X (20), The history of Cal OES, page 2, https://www.caloes.ca.gov/cal-oes/history/ (accessed on September 23, 2024) ("In 2004, the California Legislature merged OES and the Governor's Office of Criminal Justice Planning, which was responsible for providing state and federal grant funds to local communities to prevent crime and help crime victims.").

[91] Penal Code section 11171(b), as added by Statutes 2001, chapter 249, section 4.

(8) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays.

(9) An assessment as to whether there are findings that indicate physical abuse or neglect.[92]

The form created as required by Penal Code section 11171 is called Medical Report: Suspected Child Physical Abuse and Neglect Examination OES 2-900.[93] It is downloadable from the Cal OES website as well as the CCFMTC website.[94]

Instructions and Protocol were also issued as required. The Instructions state:

> Required Use of Standard State Form: Penal Code § 11171 established the use of a standard form to record findings from examinations performed for suspected child physical abuse and neglect. This form is intended to facilitate identification of child physical abuse and neglect, and as such, is not a complete medical treatment record.[95]

The protocol is entitled California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims Medical Protocol for Examination of Child Physical Abuse and Neglect Victims.[96] Its preface by Cal OES represents Penal Code section 11171 as setting the "minimum legal standards" for performing the medical evidentiary examination, and then briefly summarizes the protocols:

> Pioneers in the field of child physical abuse and neglect began in the field of medicine. They were subsequently joined by the disciplines of social work, nursing, law enforcement, psychology, psychiatry, and child development.

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[92] Penal Code section 11171(c).

[93] Exhibit A, Test Claim, pages 226-233; Exhibit X (12), Medical Report: Suspected Child Physical Abuse and Neglect Examination Cal OES 2-900, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[94] Exhibit A, Test Claim, page 225; Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 106, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025); Penal Code section 11171(e).

[95] Exhibit A, Test Claim, pages 234-241; Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[96] Exhibit A, Test Claim, pages 120-233; Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

The history of this intervention movement is characterized by peaks and plateaus as the larger community assimilated new developments lead by the pioneering disciplines. Medicine began the movement with published observations by a pediatric radiologist, Dr. John Caffey, in the 1940's. Dr. Henry Kempe, a pediatrician, galvanized the movement by establishing the concept of the "battered child syndrome" in 1962. He took his concerns to Congress and by 1965, most states had enacted child abuse reporting laws.

Issuance of the CalOES 2-900 Medical Report for Suspected Child Physical Abuse and Neglect Examinations and Protocol takes the field to a new level. In 2002, the California Legislature and Governor declared that adequate protection of victims of child physical abuse and neglect has been hampered by the lack of consistent and comprehensive medical examinations. The Legislature enacted and the Governor signed SB 580, Statutes of 2002 (Figueroa), into law to address this need by establishing a standardized medical report form and protocol.

Many deserve recognition for the vision captured in these documents. The Children's Justice Act Task Force recommended the allocation of funds to accomplish this project; the Child Physical Abuse and Neglect Advisory Committee contributed wisdom, consultation, and guidance; and, the California Clinical Forensic Medical Training Center is commended for strong work, expertise, and dedication to the production of the form, instructions, and protocol. This collective effort moves the field forward on behalf of children.

The California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect Victims provides recommended methods for meeting the minimum legal standards established by Penal Code Section 11171 for performing medical examinations of physically abused and neglected children. This protocol contains the following information:

• Standard medical report form (CalOES 2-900) for documentation of findings from suspected child physical abuse and neglect examinations;

• Step-by-step procedures for conducting examinations opposite each page of the standard forms;

• Examination protocol for child physical abuse and neglect;

• Contextual information for performing examinations and implementing a multidisciplinary team approach; and

• Relevant and expanded information on patient consent, mandatory reporting laws, financial compensation for examinations, crime victim compensation, and evidence collection and preservation.[97]

[97] Exhibit A, Test Claim, page 121; Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 2,

Until the test claim statute, only minor and clarifying amendments were made to Penal Code section 11171. The examination requirements imposed on counties have continued, as has use of the Cal OES documents.

Also, according to the Cal OES Protocol, counties could bill Medi-Cal and, alternatively, the Victims Compensation Board (VCB) for the examination costs. Under Chapter IV, "Reimbursements for Examinations," the Protocol stated:

> In the majority of counties in California, charges for child physical abuse and neglect examinations are billed to Medi-Cal or to the patient's private insurance. Standard diagnostic and procedural coding manuals are used to generate charges. For patients without insurance, or who are underinsured, reimbursement of charges may be obtained through California Victim Compensation and Government Claims Board.[98]

Also until the test claim statute, counties could seek Medi-Cal coverage on a child's behalf.[99] Children in danger of abuse, neglect, or exploitation (ANEC) had been eligible for Medi-Cal since at least 1982 as a matter of emergency assistance (EA).[100] Many had also been eligible under other programs, such as Aid to Families with Dependent Children (AFDC),[101] as "categorically needy persons,"[102] or under the Medically Needy Program.[103]

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https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[98] Exhibit A, Test Claim, page 134; Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 15, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[99] Exhibit A, Test Claim, pages 32-33, paragraphs 12, 15, and 17 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara); Exhibit A, Test Claim, page 134; Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 15, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025); California Code of Regulations, title 22, section 50143(a)(3).

[100] California Code of Regulations, title 22, section 50038.5; Exhibit X (8), Department of Health Services Letter to All County Welfare Directors, August 17, 1982, Letter 82-44, page 1; Exhibit X (9), Department of Health Services Letter to All County Welfare Directors, December 22, 1982, Letter 82-72, pages 1-7.

[101] California Code of Regulations, title 22, section 50201(a).

[102] Welfare and Institutions Code sections 14005.1, 14050.1 and 14005.

[103] California Code of Regulations, title 22, sections 50203 and 50205.

Counties could alternatively recover costs directly from the VCB if the child were somehow uninsured or underinsured. In that case, their compensation would be capped by the VCB provider payment schedule.[104]

To cover medical expenses when a child is removed from the home by a social worker and taken for a medical evidentiary exam, the child is presumptively eligible for Medi-Cal. A Foster Care Eligibility Worker (FC EW) applies for Retroactive Medi-Cal on the child's behalf, resulting in three months retroactive coverage.[105] To do so, the FC EW completes a State of California Department of Health Care Services (DHCS) Form MC 250, which is entitled "Application and Statement of Facts For Child Not Living with a Parent or Relative For Whom A Public Agency is Assuming Some Financial Responsibility," using Medi-Cal Aid Code 45.[106] Aid Codes allow health care providers to confirm eligibility for Medi-Cal recipients through Medi-Cal's "automated eligibility

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[104] Government Code section 13957.7(c)(1) ("The board may authorize direct payment to a provider of services that are reimbursable pursuant to this chapter and may make those payments prior to verification. However, the board may not, without good cause, authorize a direct payment to a provider over the objection of the victim or derivative victim.").

Government Code section 13957.2 ("A provider who accepts payment from the program for a service shall accept the program's rates as payment in full and shall not accept any payment on account of the service from any other source if the total of payments accepted would exceed the maximum rate set by the board for that service. A provider shall not charge a victim or derivative victim for any difference between the cost of a service provided to a victim or derivative victim and the program's payment for that service.").

See also California Code of Regulations, title 2, section 649.23 referring to "all cash payments *or* reimbursement for medical-related services of the victim," emphasis added; See also Exhibit X (11), Medical Providers New! CALVCB Online, pages 1-2, https://victims.ca.gov/uploads/2022/08/Medical-and-Dental-Factsheet-3-17-20.pdf (accessed on July 24, 2025).

[105] Exhibit X (15), Retroactive Medi-Cal, page 1, https://stgenssa.sccgov.org/debs/program_handbooks/foster_care/assets/28medi-cal/retromedical.htm?agt=index (accessed July on 24, 2025).

[106] Exhibit X (15), Retroactive Medi-Cal, page 1, https://stgenssa.sccgov.org/debs/program_handbooks/foster_care/assets/28medi-cal/retromedical.htm?agt=index (accessed on July 24, 2025); Exhibit X (10), Form MC 250, Application and Statement of Facts for Child Not Living with a Parent or Relative for Whom a Public Agency Is Assuming Some Financial Responsibility, pages 1-2, https://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc250.pdf (accessed on July 24, 2025).

verification system."[107] Aid Code 45 as well as Aid Code 5K confirm Medi-Cal eligibility for such children, with no share of cost.[108]

Coverage is designed to continue seamlessly. These children remain continuously eligible for Medi-Cal until at least the next annual redetermination.[109] Their health records become part of what is known as the child's "health and education passport."[110]

To ensure continuing coverage and care, DHCS has been expanding programming and comprehensive Medi-Cal coverage for children in the child welfare system. Per an Executive Summary in November of 2022, DHCS intends that "the child welfare system have streamlined access to reliable, high-quality, integrated, trauma-informed, strength-based, patient-centered, and family-centered care."[111]

Until the test claim statute became effective and impacted the medical evidentiary exam process, Cal OES billing instructions on the Form 2-900 advised counties generally: "Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy."[112]

B. The Test Claim Statute

In 2023, the Legislature passed Statutes 2023, chapter 841 (AB 1402), amending Penal code section 11171. AB 1402 added the following three provisions regarding child physical abuse and neglect medical evidentiary exams, the first of which prohibited billing the child's Medi-Cal or other insurance as of January 1, 2024:

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[107] Welfare and Institutions Code section 14042.

[108] Exhibit X (1), Aid Codes Master Chart, updated April 2022, pages 33 and 35, https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/869D30AF-4BC7-4132-AF6A-AF75893E9221/aidcodes.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO (accessed on July 24, 2025); Exhibit X (19), Short Doyle Medi-Cal Aid Code Chart, page 6, February 23, 2023, https://www.dhcs.ca.gov/services/MH/Pages/medccc-library.aspx (accessed on July 24, 2025).

[109] Exhibit X (7), Continuous Eligibility for Children (CEC), page 1, https://stgenssa.sccgov.org/debs/program_handbooks/foster_care/assets/28medi-cal/contnuselgblty.htm (accessed on July 24, 2025); California Code of Regulations, title 22, section 50189.

[110] Welfare and Institutions Code section 16010.

[111] Exhibit X (14), Medi-Cal's Foster Care Strategies, November 2022, page 1, https://www.dhcs.ca.gov/Documents/DHCS-Medi-Cal-Foster-Care-Strategies-11-22-2022.pdf (accessed on July 24, 2025).

[112] Exhibit A, Test Claim, page 235; Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

(f) The costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect shall be separate from diagnostic treatment and procedure costs associated with medical treatment. ***Costs for the medical evidentiary portion of the examination shall not be charged directly or indirectly to the victim of child physical abuse or neglect.***

(g) Each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify the Office of Emergency Services of this designation. ***The costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature.*** Each county's designated SART, SAFE, or other qualified medical evidentiary examiners shall submit invoices to the Office of Emergency Service, who shall administer the program. A flat reimbursement rate shall be established. Within one year upon initial appropriation, the Office of Emergency Service shall establish a 60-day reimbursement process. The Office of Emergency Service shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years.

(h) Reimbursement shall not be subject to reduced reimbursement rates based on patient history or other reasons. Victims of child physical abuse or neglect may receive a medical evidentiary exam outside of the jurisdiction where the crime occurred and that county's approved SART, SAFE teams, or qualified medical evidentiary examiners shall be reimbursed for the performance of these exams.[113]

The claimant has expressly pled only subsection (f).[114] In short, subsection (f) prohibits counties from billing the victim directly or indirectly (i.e., billing their insurance, including Medi-Cal) for the medical evidentiary portion of a child abuse or neglect exam. By not allowing the victim or the victim's insurance to pay, only an unrelated volunteer or a government entity (but not through an insurance system for the child, such as Medi-Cal) could legally pay for the child physical abuse or neglect medical evidentiary exams.

State funding is intended to replace insurance billing. Subsection (g) states that "[t]he costs associated with these medical evidentiary exams shall be funded by the state,

[113] Penal Code section 11171, as amended by Statutes 2023, chapter 841, section 1, emphasis added.

[114] Exhibit A, Test Claim, page 13. The claimant is therefore not seeking reimbursement under subsection (g) for the costs of designating SART, SAFE, or other qualified medical examiners, or for submitting invoices to Cal OES.

subject to appropriation by the Legislature." To date, however, the Legislature has not made an appropriation as provided for in subsection (g).[115]

C. Related Background Laws

Similar medical evidentiary exam laws exist for victims of sexual assault and domestic violence, each likewise requiring standardized forms, instructions, and protocols for the medical evidentiary exams.[116] These laws have also been recently amended to prohibit billing the victim or their insurance and to replace that system with state funding.

In 2021, AB 145 directed Cal OES to determine reimbursement amounts to counties for the cost of sexual assault exams. These reimbursements were to be made from funds "available upon appropriation for this purpose."[117] They are now reimbursed at $911 per exam.[118]

In 2022, AB 2185 directed Cal OES to determine reimbursement amounts to counties for the cost of domestic violence exams. Like the test claim statute, AB 2185 stated "[t]he costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature."[119] To date, no appropriation or reimbursement appears to have been made for the domestic violence exams. The only form available for reimbursement of a medical evidentiary exam on the Cal OES website is for the sexual assault examinations.[120]

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[115] Exhibit B, Finance's Comments on the Test Claim, page 1 ("However, no appropriation has been provided to Cal OES for this purpose.").

[116] Penal Code sections 13823.95 and 11161.2.

[117] Penal Code section 13823.95(e), as added by Statutes 2021, chapter 80, section 25.

[118] Exhibit X (16), Senate Committee on Appropriations, August 21, 2023, on AB 1402, as amended March 30, 2023, page 3; Exhibit X (2), Assembly Committee on Appropriations, May 10, 2023, on AB 1402, as amended March 30, 2023, page 1; Exhibit X (5), Cal OES Invoice for Reimbursement for Medical Evidentiary Examination, 2021, page 1, https://www.safeta.org/wp-content/uploads/2022/03/invoice_for_reimbursement_fo.pdf (accessed on July 31, 2025); Exhibit X (4), Cal OES Informational Bulletin Sexual Assault Medical Evidentiary Examination Reimbursement, May 2022, pages 1-2, https://www.ccfmtc.org/wp-content/uploads/Informational-Bulletin-Medical-Evidentiary-Examination-Reimbursement-Rev.-5-22.pdf (accessed on July 31, 2025).

[119] Penal Code section 11161.2(g), as added by Statutes 2022, chapter 557, section 1; Penal Code section 11171(g), as added by Statutes 2023, chapter 841.

[120] Exhibit X (4), Cal OES Informational Bulletin Sexual Assault Medical Evidentiary Examination Reimbursement, May 2022, pages 1-2, https://www.ccfmtc.org/wp-content/uploads/Informational-Bulletin-Medical-Evidentiary-Examination-Reimbursement-Rev.-5-22.pdf (accessed on July 31, 2025); Exhibit X (5) Cal OES Invoice for Reimbursement for Medical Evidentiary Examination, 2021, page 1,

Per legislative history, the test claim statute "mirrors the process set forth by AB 2185, to provide free medical evidentiary examinations for a victim of child physical abuse or neglect."[121] That is, the test claim statute "mirrors" the domestic violence medical evidentiary exam law.

III. Positions of the Parties and Interested Parties

A. County of Santa Clara

The claimant asserts the test claim statute imposes a reimbursable state-mandated program. The claimant states in the Test Claim:

> As a result of [Penal Code section 11711] [s]ubdivision (f), county providers can no longer bill Medi-Cal or private insurance for physical abuse and neglect exams administered to children. Rather than charge Medi-Cal or private insurance for physical abuse and neglect exams, counties are now required to authorize a designee to approve providers who can perform these exams and send invoices to CalOES. (*Id*., subd. (g).) CalOES, who administers the reimbursement program under Section 11171, must reimburse counties within 60 days and adjust reimbursement rates every five years. (*Ibid*.)
>
> Notwithstanding the mandatory reimbursement provision of AB 1402, the Legislature has failed to appropriate any funding for child physical abuse and neglect exams. (See Stats. 2024, ch. 22, § 2.00; Stats. 2023, ch. 38; see also Sen. Comm. On Approps., Analysis of Assem. Bill No. 1402 (2023-2024 Reg. Sess.), p. 3 ["Staff notes that no funding has been included in the 2023-2024 budget for these purposes."].) Nor has CalOES issued any guidance or form for AB 1402 reimbursements. (Declaration of Serena Sy, at p. 3 ("Sy Decl.")) As a result, counties are now forced to absorb the costs of physical abuse or neglect exams for children.[122]

The claimant states that paying for the exams is a new reimbursable activity:

> In other words, the new activity mandated by Subdivision (f) – and the corresponding new program or higher level of service – is the new requirement that the County assume the full cost of providing child abuse

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https://www.safeta.org/wp-content/uploads/2022/03/invoice_for_reimbursement_fo.pdf (accessed on July 31, 2025).

[121] Exhibit X (17), Senate Committee on Public Safety, June 27, 2023, on AB 1402, as amended March 30, 2023, page 3; Exhibit X (18), Senate Rules Committee, Office of Senate Floor Analyses, September 2, 2023, on AB 1402, as amended March 30, 2023, page 4; Exhibit X (3), Assembly Committee on Public Safety, April 25, 2023, on AB 1402, as amended March 30, 2023, page 4.

[122] Exhibit A, Test Claim, pages 13-14.

> and neglect exams free of charge whenever the State declines to reimburse these costs.[123]

The claimant states that before the test claim statute, "counties [had] long provided child physical abuse and neglect exams under the State's supervision," but "were never responsible for funding these exams."[124] Following the test claim statute, and without state reimbursement thereunder, "the County must now perform its existing duties – provide these exams consistent with the State's guidance, protocols, and forms – *and* assume financial responsibility for these exams."[125]

The claimant analogizes this claim to *County of San Diego v. State of California*, a California Supreme Court decision where the court found a new reimbursable program after the state had shifted costs for a class of Medi-Cal beneficiaries from itself to the counties.[126] The claimant argues that, as in *County of San Diego*, "[s]ubdivision (f) compels local governments to assume the full financial responsibility for these crucial exams whenever the State declines to provide reimbursement. Section 6 requires the State to reimburse these costs."[127]

The claimant also argues that practical compulsion results in a new state-mandated program or higher level of service.[128] For example, the claimant analogizes child physical abuse and neglect exams to stormwater drainage systems as a matter of public health and safety, in that not providing them is "no alternative at all."[129] Further, the claimant asserts that relying on non-expert exams would be inadequate:

> Standard physical exams, such as well child visits and emergency room encounters, are not a reasonable substitute for child physical abuse and neglect exams. (Sturm Decl., at p. 5.) Child abuse pediatrics is a medical specialty within pediatrics, like pediatric cardiology or pediatric neurology. (*Id*. at p. 3.) Without specific and continuing education in child abuse pediatrics, general practitioners are not qualified to provide expert medical opinions about whether a child has endured and survived maltreatment or determine the best course of treatment. (Ibid.) Medical professionals who are not trained to identify child abuse and neglect miss opportunities for diagnosis and intervention. (*Id*. at p. 5.)[130]

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[123] Exhibit A, Test Claim, page 16.

[124] Exhibit A, Test Claim, page 16.

[125] Exhibit A, Test, Claim, pages 16-17.

[126] Exhibit A, Test Claim, page 17 citing *County of San Diego v. State of California* (1997) 15 Cal.4th 68.

[127] Exhibit A, Test Claim, page 17.

[128] Exhibit A, Test Claim, page 20.

[129] Exhibit A, Test Claim, pages 20-21.

[130] Exhibit A, Test Claim, page 24.

The claimant asserts that child physical abuse and neglect exams, in many cases, are "necessary to uncover abuse and neglect."[131] The claimant states that "counties – and more importantly, the infants and children they serve – face severe and certain consequences were counties to cease using child physical abuse and neglect exams as a tool in their child welfare investigations."[132] The claimant also points to specific statutory law requiring such an exam within 72 hours when a medical specialist determines it necessary for a child in protective custody.[133] It concludes that not consulting the medical specialists upon a report of suspected child abuse is "not an acceptable alternative."[134] The claimant then argues that the duty to investigate child abuse reports also requires these medical exams.[135]

Attached to the Test Claim are four declarations of County of Santa Clara employees:

1. Declarant Serena Sy is the Director of Primary Care Operations for Santa Clara Valley Healthcare ("SCVH").[136] Ms. Sy oversees SCVH operations over primary care clinics and programs throughout the County of Santa Clara, including child physical abuse and neglect exams.[137]

   Explaining the claimant's work in child physical abuse and neglect exams, Ms. Sy declares that the "County conducts the vast majority of physical abuse and neglect exams to comply with child welfare investigations."[138] Ms. Sy adds: "Physical abuse and neglect exams are also conducted pursuant to law enforcement investigations into potential crimes against children."[139] As to the population of children served, Ms. Sy declares that the "County is one of [the] only providers of physical abuse and neglect exams in its region. SCVH and

[131] Exhibit A, Test Claim, page 23 citing page 47, paragraphs 18-19 and 21-22 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County).

[132] Exhibit A, Test Claim, page 21.

[133] Exhibit A, Test Claim, page 21 citing Welfare and Institutions Code section 324.5.

[134] Exhibit A, Test Claim, page 22.

[135] Exhibit A, Test Claim, page 22.

[136] Exhibit A, Test Claim, page 31, paragraph 2 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara).

[137] Exhibit A, Test Claim, page 31, paragraph 3 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara).

[138] Exhibit A, Test Claim, page 31, paragraph 7 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara).

[139] Exhibit A, Test Claim, page 31, paragraph 9 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara).

CAC frequently receive referrals from other agencies and hospitals to perform these exams for children."[140]

Regarding billing, Ms. Sy declares "there is no entity the County can bill for child physical abuse and neglect exams."[141] "To comply with Subdivision (f), the County can no longer bill Medi-Cal or private insurance."[142]

2. Declarant Kiyomi Ross is the Director of Financial Planning and Performance for the County of Santa Clara.[143] Ms. Ross oversees the County's cost accounting system, including for the county's health system, which includes all its hospitals and clinics.[144] Ms. Ross provides cost data for the child physical abuse and neglect exams performed in the County of Santa Clara.[145]

   Ms. Ross attests to "the costs of providing child physical abuse and neglect exams free of charge to patients and without reimbursement from the State."[146] With explanations and exhibits, Ms. Ross declares that "the average cost of each exam is $3,455" and that "the County provides an average of 15 such exams each month," working out to an "expected annual average cost to the County of $621,927."[147] The County first incurred costs for performing a medical exam on

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[140] Exhibit A, Test Claim, page 32, paragraph 11 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara).

[141] Exhibit A, Test Claim, page 33, paragraph 17 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara).

[142] Exhibit A, Test Claim, pages 33-34, paragraph 15 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara).

[143] Exhibit A, Test Claim, page 35, paragraph 2 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[144] Exhibit A, Test Claim, page 35, paragraph 3 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[145] Exhibit A, Test Claim, pages 35-36, paragraphs 5-13 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[146] Exhibit A, Test Claim, page 35, paragraph 5 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[147] Exhibit A, Test Claim, pages 35-36, paragraph 9 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

January 3, 2024, and in fiscal year 2023-2024 performed a total of 83 exams.[148] Costs are expected to reach $717,496 for fiscal year 2024-2025.[149]

3. Declarant Melissa Suarez is a Social Services Program Manager III ("Bureau Manager") for the Department of Family and Children's Services ("DFCS") for the County of Santa Clara.[150] Ms. Suarez oversees emergency social workers from South San Jose to the southernmost boundary of the County's jurisdiction, and supports DFCS division managers in emergency response, court, and non-court services for the county's welfare system.[151]

   Ms. Suarez declares that "laws, rules, and regulations impose upon County social workers a duty to investigate allegations of child physical abuse so that they may determine whether child welfare services should be offered to the family and whether proceedings in the juvenile court should be commenced."[152]

   Ms. Suarez details many circumstances under which a child physical abuse and neglect exam may be prompted (i.e., reports from child, witness, daycare, school, community member, law enforcement, healthcare providers) and what indicia county social workers look for (i.e., disclosures, bruising, burns, fractures, unexplained injury, domestic violence, drug use) when considering requesting an exam.[153] She notes that "time is of the essence" because "[i]njuries may fade and heal, invisible injuries may worsen without treatment (e.g., brain bleeds), and the child may be at grave risk of harm the longer they remain in an unsafe environment."[154]

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[148] Exhibit A, Test Claim, page 36, paragraphs 10 and 12 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[149] Exhibit A, Test Claim, page 36, paragraph 13 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[150] Exhibit A, Test Claim, page 40, paragraphs 2-3 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

[151] Exhibit A, Test Claim, page 40, paragraph 4 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

[152] Exhibit A, Test Claim, page 40, paragraph 6 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

[153] Exhibit A, Test Claim, pages 41-42, paragraphs 15-16 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

[154] Exhibit A, Test Claim, page 42, paragraph 17 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

Ms. Suarez declares that the exams are "indispensable in the child welfare system," stating that they allow assessments to be made "without having to depend on the observations of witnesses or the disclosure of children. Witnesses to child abuse and neglect are rare, the adults who perpetrate abuse and neglect rarely admit to their crimes, and children may be too traumatized to disclose their injuries (or may be retraumatized by having to disclose their injuries)."[155] Ms. Suarez speaks to the use of exams when "the victim or potential victim is an infant, pre-verbal, nonverbal, developmentally delayed, or otherwise unable to communicate their abuse or neglect" and conveys concern that without the exams as presently performed, "cases of actual abuse and neglect would be missed," and "more children would be at risk of additional injury or death."[156] She later adds: "Where social workers are unable to substantiate a report of child physical abuse or neglect, they risk returning the child to an unsafe environment, where the siblings may also be unsafe."[157] Ms. Suarez declares the following severe consequences she is "certain based on [her] own experience and that of the County's child welfare agency" would occur if the County were to cease providing the physical abuse and neglect exams:

a. Law enforcement officials' investigation into child abuse and neglect crimes would be severely limited;

b. Social workers would be unable to substantiate suspected cases of child physical abuse or neglect, particularly for nonverbal, pre-verbal, disabled, and developmentally delayed children;

c. Children and families who would otherwise receive support services following medical findings of abuse or neglect would not be assisted; and

d. Children whose abuse or neglect would be uncovered by a physical abuse and neglect exam would remain in dangerous

[155] Exhibit A, Test Claim, pages 40-41, paragraph 9 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

[156] Exhibit A, Test Claim, page 41, paragraphs 10-12 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

[157] Exhibit A, Test Claim, page 41, paragraph 14 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

situations, and in some cases, would be severely harmed or killed.[158]

Ms. Suarez also declares that "[s]tandard physical exams, such as well child visits, are not a substitute for physical abuse and neglect exams. County social workers seek physical abuse and neglect exams from the County's Child Advocacy Center ("CAC") because the examiners there are trained to identify and assess the presence of child abuse and neglect. Our social workers' experience is that standard physical exams do not reliably capture child abuse and neglect."[159]

4. Declarant Marlene Sturm, MD is the Medical Director of the Children's Advocacy Center ('CAC') at the Santa Clara Valley Medical Center ("SCVMC").[160] Dr. Sturm has "supervised the County's child abuse pediatrics program since 2017."[161] Dr. Sturm directly supervises or herself provides child abuse medical examinations, consults with numerous hospital units, provides exams for adjacent counties, and works with social workers and law enforcement on investigations of child abuse and neglect.[162]

   Dr. Sturm declares that the County receives over 20,000 child abuse reports annually, and that, "in many cases, expert medical evaluation for child physical abuse and neglect exams are *required* to diagnose missed cases of child abuse and neglect."[163] Dr. Sturm explains, "a general pediatric examination may miss subtle fractures, injuries to internal organs, or retinal hemorrhages inside the eye.

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[158] Exhibit A, Test Claim, pages 42-43, paragraph 18 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

[159] Exhibit A, Test Claim, page 41, paragraph 13 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

[160] Exhibit A, Test Claim, page 44, paragraphs 2 and 5 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County).

[161] Exhibit A, Test Claim, page 44, paragraph 2 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County).

[162] Exhibit A, Test Claim, page 44, paragraphs 5-6 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County).

[163] Exhibit A, Test Claim, pages 46-47, paragraphs 14 and 21 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County).

> Of greatest concern, a child can have a relatively normal neurologic exam and 'appear normal,' yet have an evolving brain hemorrhage."[164]
>
> Echoing the Declaration of Melissa Suarez, Dr. Sturm extensively details medical literature and cites statistics of child abuse and neglect being missed through "standard physical exams."[165] Dr. Sturm adds that, "without expert medical evaluations for child physical abuse and neglect, the County risks *underinclusive and overinclusive* child protection actions."[166] In an underinclusive action, "social services may not have enough evidence to place the child in protective custody" when needed, and an overinclusive action could mean that a child is placed "in protective custody because of incomplete or inaccurate information," which may "break apart families and treat innocent adults as perpetrators."[167] In short, in Dr. Sturm's "professional experience, expert medical evaluations for child physical abuse and neglect exams are necessary to ensure the safety of the child, to support effective collaboration with social services, and when appropriate, to file criminal charges."[168]

The claimant declares it first incurred costs under the test claim statute on January 3, 2024.[169] It declares incurring $221,046 for FY 2023-2024[170] and estimates

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[164] Exhibit A, Test Claim, page 47, paragraph 21 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County).

[165] Exhibit A, Test Claim, pages 48-49, paragraph 24 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County).

[166] Exhibit A, Test Claim, page 48, paragraph 23 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County).

[167] Exhibit A, Test Claim, page 48, paragraph 23 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County).

[168] Exhibit A, Test Claim, page 47, paragraph 19 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County).

[169] Exhibit A, Test Claim, pages 11 and 36, paragraph 10 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[170] Exhibit A, Test Claim, page 36, paragraph 12 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

costs of $717,496 for FY 2024-2025.[171] It estimates a statewide cost of $11,800,000 for FY 2024-2025.[172] The claimant declares this estimate is based on the Senate Committee on Appropriations analysis of the test claim statute, multiplying the average number of child abuse cases by the reimbursement amount that Cal OES currently provides for each sexual assault medical evidentiary exam, which is $911 per exam.[173] However, the claimant also declares that each exam costs $3,455.[174] The claimant declares it has received no funds from any state, federal, or other non-local agency for the program, and that its general funds must be used.[175]

The claimant asserts that the test claim statute imposes requirements unique to local government because the services to the public are provided by the counties.[176] It additionally asserts that the test claim statute carries out state policy of "public safety, child welfare, and guardianship" through the "free provision of child abuse and neglect exams" because the exams are the county's responsibility whether performed in-house or through contractors.[177]

The claimant finally asserts that no condition exists creating an exception to reimbursement under Government Code section 17556.[178]

The claimant filed rebuttal comments on May 7, 2025.[179] In response to Finance's comment that there is no increased level of governmental service being provided to the

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[171] Exhibit A, Test Claim, page 36, paragraph 13 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[172] Exhibit A, Test Claim, pages 11 and 33-34, paragraph 24 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara).

[173] Exhibit A, Test Claim, pages 33-34, paragraph 24 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara citing Senate Committee on Appropriations, August 21, 2023, on AB 1402, as amended March 30, 2023, page 3).

[174] Exhibit A, Test Claim, pages 35-36, paragraph 9 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[175] Exhibit A, Test Claim, pages 12, 15 and 33, paragraphs 17 and 20 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara); pages 35-36, paragraphs 5 and 10-11 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[176] Exhibit A, Test Claim, pages 26-27.

[177] Exhibit A, Test Claim, page 27.

[178] Exhibit A, Test Claim, pages 28-29.

[179] Exhibit C, Claimant's Rebuttal Comments.

public, the claimant newly argues that the test claim statute does increase the quality of service to the public.[180] The claimant argues there is an enhanced quality of service because "the Test Claim statute makes these exams free of charge to make them more accessible to the public."[181]

Further, the claimant disagrees with Finance's comment that *Workers' Compensation Disability Benefits for Government Employees*, 00-TC-20/02-TC-02 applies. The claimant summarizes the *Workers' Compensation Disability Benefits* test claim statute as having "expanded a preexisting leave benefit to additional categories of employees."[182] Here instead, the claimant states: "By shifting full financial responsibility from the State to counties, the Test Claim Statute and legislative action use county resources to finance this enhanced public service."[183]

B. Department of Finance

Finance contends that the test claim statute does not impose a reimbursable state-mandated program. Citing *Workers' Compensation Disability Benefits for Government Employees*, 00-TC-20/02-TC-02, Finance asserts:

> [T]here is not an increase in the actual level or quality of governmental service provided to the public. Penal Code section 11171(f) simply requires the county to absorb the cost of medical evidentiary exams that the county was already required to perform under existing law, instead of passing those costs along to a third party.[184]

C. Kern County Department of Human Services

The Kern County Department of Human Services (KCDHS) is an interested person under section 1181.2(j) of the Commission's regulations. KCDHS filed late comments on the Test Claim on April 11, 2025.[185]

KCDHS is "deeply concerned about the bill's misalignment with child welfare's legal mandate and the significant hidden operational and administrative burden it imposes on counties."[186] As to the asserted misalignment with child welfare's legal mandate, it states: "Requiring child welfare agencies to coordinate, oversee, and ensure reimbursement for medical evidentiary exams blurs a critical boundary between the civil

[180] Exhibit C, Claimant's Rebuttal Comments, page 2.

[181] Exhibit C, Claimant's Rebuttal Comments, page 2.

[182] Exhibit C, Claimant's Rebuttal Comments, page 4.

[183] Exhibit C, Claimant's Rebuttal Comments, page 4.

[184] Exhibit B, Finance's Comments on the Test Claim, page 1.

[185] Exhibit D, Kern County Department of Human Services' Late Comments on the Test Claim, page 1.

[186] Exhibit D, Kern County Department of Human Services' Late Comments on the Test Claim, page 1.

and criminal systems."[187] As to the operational and administrative burden, it states: "While AB 1402 outlines a reimbursement pathway through Cal OES, it does not account for the substantial non-reimbursable infrastructure counties must build to comply with this mandate, including designating and managing a pool of approved medical evidentiary examiners, training staff and community partners in evidentiary protocols and documentation and ensuring compliance and audit readiness for Cal OES reimbursement."[188] KCDHS "strongly urge[s] the Commission to recognize the administrative burden and legal misalignment that AB 1402 imposes on counties."[189]

That said, KCDHS "support[s] Santa Clara County's test claim (24-TC-05) and respectfully request[s] that the Commission determine that AB 1402 constitutes an unfunded mandate under the California Constitution."[190]

IV. Discussion

Article XIII B, section 6 of the California Constitution provides in relevant part the following:

> Whenever the Legislature or any state agency mandates a new program or higher level of service on any local government, the state shall provide a subvention of funds to reimburse such local government for the costs of such programs or increased level of service…

The purpose of article XIII B, section 6 is to "preclude the state from shifting financial responsibility for carrying out governmental functions to local agencies, which are 'ill equipped' to assume increased financial responsibilities because of the taxing and spending limitations that articles XIII A and XIII B impose."[191] Thus, the subvention requirement of section 6 is "directed to state-mandated increases in the services provided by [local government] …."[192]

Reimbursement under article XIII B, section 6 is required when the following elements are met:

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[187] Exhibit D, Kern County Department of Human Services' Late Comments on the Test Claim, page 1.

[188] Exhibit D, Kern County Department of Human Services' Late Comments on the Test Claim, page 1.

[189] Exhibit D, Kern County Department of Human Services' Late Comments on the Test Claim, page 1.

[190] Exhibit D, Kern County Department of Human Services' Late Comments on the Test Claim, page 1.

[191] *County of San Diego v. State of California* (1997) 15 Cal.4th 68, 81.

[192] *County of Los Angeles v. State of California* (1987) 43 Cal.3d 46, 56.

1. A state statute or executive order requires or "mandates" local agencies or school districts to perform an activity.[193]

2. The mandated activity constitutes a "program" that either:

   a. Carries out the governmental function of providing a service to the public; or

   b. Imposes unique requirements on local agencies or school districts and does not apply generally to all residents and entities in the state.[194]

3. The mandated activity is new when compared with the legal requirements in effect immediately before the enactment of the test claim statute or executive order and it increases the level of service provided to the public.[195]

4. The mandated activity results in the local agency or school district incurring increased costs, within the meaning of section 17514. Increased costs, however, are not reimbursable if an exception identified in Government Code section 17556 applies to the activity.[196]

In 2004, article XIII B, section 6 was amended by the voter's approval of Proposition 1A, which added subdivision (c) to define a mandated new program or higher level of service to also include:

> a transfer by the Legislature from the State to cities, counties, cities and counties, or special districts of complete or partial financial responsibility for a required program for which the State previously had complete or partial financial responsibility.[197]

The Commission is vested with the exclusive authority to adjudicate disputes over the existence of state-mandated programs within the meaning of article XIII B, section 6 of the California Constitution.[198] The determination whether a statute or executive order

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[193] *San Diego Unified School District v. Commission on State Mandates* (2004) 33 Cal.4th 859, 874.

[194] *San Diego Unified School District v. Commission on State Mandates* (2004) 33 Cal.4th 859, 874-875 (reaffirming the test set out in *County of Los Angeles* (1987) 43 Cal.3d 46, 56).

[195] *San Diego Unified School District* (2004) 33 Cal.4th 859, 874-875, 878; *Lucia Mar Unified School District v. Honig* (1988) 44 Cal.3d 830, 835.

[196] *County of Fresno v. State of California* (1991) 53 Cal.3d 482, 487; *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1265, 1284; Government Code sections 17514 and 17556.

[197] Proposition 1A, November 2004.

[198] *Kinlaw v. State of California* (1991) 54 Cal.3d 326, 335.

imposes a reimbursable state-mandated program is a question of law.[199] In making its decisions, the Commission must strictly construe article XIII B, section 6 of the California Constitution, and not apply it as an "equitable remedy to cure the perceived unfairness resulting from political decisions on funding priorities."[200]

A. The Test Claim Is Timely Filed with a Potential Period of Reimbursement Beginning January 1, 2024.

A test claim must be filed within 12 months of the effective date of a statute or an executive order, or within 12 months of incurring increased costs as a result of the statute or executive order, whichever is later.[201] The Commission's regulations clarify that "within 12 months of incurring costs" means "within 12 months (365 days) of *first* incurring costs as a result of a statute or executive order."[202]

The effective date of the test claim statute is January 1, 2024.[203] The claimant filed the Test Claim on December 31, 2024.[204] As this is within 12 months of the effective date of the statute, the Test Claim is timely filed.

Government Code section 17557(e) provides that a Test Claim "shall be submitted on or before June 30 following a fiscal year in order to establish eligibility for reimbursement for that fiscal year." Because the claimant filed the Test Claim on December 31, 2024 (during FY 2024-2025), the potential period of reimbursement under Government Code section 17557(e) would begin at the start of the prior fiscal year, which is July 1, 2023. However, since the test claim statute has a later effective date, the potential period of reimbursement begins on the statute's effective date, or January 1, 2024.[205]

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[199] *County of San Diego v. State of California* (1997) 15 Cal.4th 68, 109.

[200] *County of Sonoma v. Commission on State Mandates* (2000) 84 Cal.App.4th 1265, 1280 citing *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1817.

[201] Government Code section 17551(c).

[202] California Code of Regulations, title 2, section 1183.1(c), emphasis added.

[203] California Constitution, article IV, section 8(c)(1); Government Code section 9600.

[204] Exhibit A, Test Claim.

[205] *Southern California Gas Co. v. Public Utilities Commission* (1985) 38 Cal.3d 64, 67 ("It is well settled that a statute has no force whatsoever until its effective date.").

B. The Test Claim Statute Mandates a New Program or Higher Level of Service Pursuant to Article XIII B, Section 6(c) of the California Constitution, Only in Fiscal Years the State Does Not Appropriate Funds to Counties Sufficient to Cover the Costs of Child Physical Abuse and Neglect Exams and Instead Shifts those Costs to Counties by Prohibiting Them from Billing State-Funded Medi-Cal or the Victims Compensation Board for the Costs of the Exams.

Reimbursement under article XIII B, section 6, of the California Constitution is required only when:

- The state mandates local agencies to perform new activities, which impose a new program or higher level of service and result in costs mandated by the state;[206]

  or

- The state transfers from itself to local agencies the complete or partial financial responsibility for a required program for which the state previously had complete or partial financial responsibility and results in costs mandated by the state.[207]

As explained below, the test claim statute does not require the counties to perform any new activities. However, the test claim statute prohibits counties from charging the victim of the physical abuse or neglect, either directly or indirectly, for the costs of the medical evidentiary portion of the examination.[208]

The Commission finds that the test claim statute does not mandate a new program or higher level of service for the increased costs of child physical abuse and neglect evidentiary exams when the costs could have been recovered directly from the victim or from the victim's private medical insurance.

However, absent an appropriation from the state sufficient to cover the costs of the child physical abuse and neglect evidentiary exams, and where the state, through Medi-Cal or the VCB, previously paid for the child physical abuse and neglect medical evidentiary exams, the test claim statute shifts those costs from the state to the counties under article XIII B, section 6(c), resulting in a mandated new program or higher level of service.

[206] California Constitution, article XIII B, section 6(a).

[207] California Constitution, article XIII B, section 6(c).

[208] Penal Code section 11171(f), as added by Statutes 2023, chapter 841.

1. Penal Code Section 11171(f), as Amended by the Test Claim Statute, Does Not Require the Counties to Perform Any New Activities And Does Not Shift Costs from the State to the Counties Under Article XIII B, Section 6(c) for the Costs of the Exam Previously Recoverable From the Victim's Private Insurance or from the Victim Directly and, Thus, Does Not Impose a State-Mandated New Program or Higher Level of Service Under These Circumstances.

Penal Code section 11171(f), as amended by the test claim statute, does not require the counties to perform any new activities and does not shift costs from the state to the counties under article XIII B, section 6(c) for the costs of the exam previously recoverable from the victim's private insurance or from the victim directly.

As explained in the Background, counties have long been required to investigate all incoming child abuse reports, a duty that has been confirmed by the courts.[209] Existing state law also requires counties to ensure that a child taken into protective custody undergo a physical examination performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, when appropriate and following allegations of physical abuse, and "whenever possible, shall ensure that this examination take place within 72 hours of the time the child was taken into protective custody, when there are allegations of physical abuse."[210] In 2002, Penal Code section 11171 was added, and it has applied to all children in the state since January 1, 2004.[211] With the exception of amendments to the name of the office directed to lead the creation of the form, instructions, and examination protocols as the California Office of Emergency Services (Cal OES) after the Office of Criminal Justice Planning was dissolved, the requirements for the medical evidentiary exams ensured by the counties have been the same for two decades. At all times, the same standard nine components of the exam have been required:

> (1) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures.
>
> (2) Addressing relevant consent issues, if indicated.
>
> (3) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history.
>
> (4) The performance of a physical examination for evidence of child physical abuse or neglect.

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[209] Penal Code section 11166.3 (formerly 11166.1); see also *Alejo v. City of Alhambra* (1999) 75 Cal.App.4th 1180, 1185-1186.

[210] Welfare and Institutions Code section 324.5.

[211] Penal Code section 11171(a)-(e), as added by Statutes 2002, chapter 249, section 4 (SB 580).

(5) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures.

(6) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated.

(7) Procedures for the preservation and disposition of evidence.

(8) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays.

(9) An assessment as to whether there are findings that indicate physical abuse or neglect.[212]

Cal OES issued the state standardized exam form on January 1, 2004.[213] This form, its protocols, and its instructions remain dated January 1, 2004.[214]

Thus, the counties' duties relating to the medical examination requirements for child physical abuse and neglect are not new.

What is new under the test claim statute is subdivisions (f) – (h) of Penal Code section 11171.[215] Subdivision (f), the only provision pled by the claimant, prohibits the counties from billing the victim directly or indirectly for the medical examination.[216] Before the enactment of the test claim statute, counties or their contracted providers could bill the victim or the victim's private insurance, Medi-Cal, or the VCB for child physical abuse and neglect exams. This was specified directly on the Cal OES Form 2-900 Instructions.[217] The Cal OES Protocol states that the "the majority of counties" billed

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[212] Penal Code section 11171(c); See Penal Code section 11171, as added by Statutes 2002, chapter 249, section 4 (SB 580).

[213] Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 7, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[214] Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, pages 7; 108-114; 116-122, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[215] Penal Code section 11171, as amended by Statutes 2023, chapter 841, section 1.

[216] Penal Code section 11171(f).

[217] Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025) ("**3. Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law**

Medi-Cal or private insurance, and occasionally the VCB.[218] While subdivision (f) prohibits counties from billing the victim directly or indirectly, subdivision (g) now states that the costs associated with the medical evidentiary exams "shall be funded by the state, subject to appropriation by the Legislature" and requires the county's designated SART, SAFE, or other qualified medical examiners to bill Cal OES for reimbursement.[219] And subdivision (h) requires that reimbursement not be reduced based on patient history; and that victims may receive exams outside of the jurisdiction where the crime occurred, and that the county's SART, SAFE, or other qualified examiners will be reimbursed by Cal OES under those circumstances.[220] The Test Claim does not request reimbursement to designate a SART, SAFE, or other medical examiner to bill Cal OES for reimbursement and, thus, no mandate findings are made on that provision.

Accordingly, the test claim statute does not mandate counties to perform new activities and, thus, there is not a new program or higher level of service pursuant to article XIII B, section 6(a).

Moreover, Penal Code section 11171(f), as amended by the test claim statute, does not impose a state-mandated new program or higher level of service under article XIII B, section 6(c) for the costs of the child physical abuse and neglect evidentiary exams that were previously recoverable from the victim's private insurance or from the victim directly because the state did not "previously [have] complete or partial financial responsibility" for those costs. Since 1971, Welfare and Institutions Code section 10025 has provided that the "state shall not reimburse any local government or any facility thereof, under Medi-Cal or under any other health program . . . , for care provided to a person covered under any disability insurance, health insurance, or prepaid health plan."[221] Thus, victims who were not eligible for Medi-Cal were responsible for those costs under prior law. Now that the test claim statute in subdivision (f) prohibits counties from recovering the costs from the victim directly or indirectly through private insurance as of January 1, 2024, the counties do experience increased costs, but are not required to comply with a *new* state-mandated program. The courts have been

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enforcement agencies or Child Protective Services (CPS). Follow local policy." Emphasis in original.).

[218] Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 15 https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[219] Penal Code section 11171(g).

[220] Penal Code section 11171(h). Because the claimant has pled only subsection (f), the Commission need not determine whether this subsection's statement that victims of child physical abuse or neglect "may receive a medical evidentiary exam outside of the jurisdiction where the crime occurred" is new.

[221] Welfare and Institutions Code section 10025 (Stats. 1971, ch. 812).

clear that increased costs alone do not create a reimbursable state-mandated program.[222]

Accordingly, the test claim statute does not impose a state-mandated new program or higher level of service under article XIII B, section 6 of the California Constitution for the costs of the child physical abuse and neglect evidentiary exams that were previously recoverable from the victim's private insurance of from the victim directly.

2. Absent an Appropriation from the State, and Where the State, Through Medi-Cal or the VCB, Previously Paid for the Child Physical Abuse and Neglect Medical Evidentiary Exams, Penal Code Section 11171(f), as Amended by the Test Claim Statute, Shifts Those Costs from the State to the Counties Under Article XIII B, Section 6(c), Resulting in a Mandated New Program or Higher Level of Service.

Absent an appropriation from the state, and where the state's Medi-Cal or the VCB programs previously paid for the child physical abuse and neglect medical evidentiary exams, the test claim statute shifts those costs from the state to the counties under article XIII B, section 6(c), resulting in a "mandated new program or higher level of service."[223] Article XIII B, section 6(c), added to the California Constitution by the voters in 2004 as Proposition 1A, states:

> A mandated new program or higher level of service includes a transfer by the Legislature from the State to cities, counties, cities and counties, or special districts of complete or partial financial responsibility for a required program for which the State previously had complete or partial financial responsibility.

Proposition 1A was a constitutional amendment placed on the ballot by the Legislature (SCA 4) as part of the 2004-2005 budget agreement to protect property tax revenues of local agencies. It was proposed, in part, to address the court's ruling in *County of Sonoma v. Commission on State Mandates*, which denied reimbursement under article XIII B, section 6 for the reduction of county property tax revenue and allocation of that revenue into the Educational Revenue Augmentation Fund (ERAF) to fund K-14 schools, on the ground that the state had not assumed complete financial responsibility for K-14 education before adoption of section 6.[224] The court in *County of Sonoma* held that article XIII B, section 6 only "prohibits the state from shifting to counties the cost of state programs for which the state assumed *complete financial responsibility before*

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[222] *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, 1816 ("Section 6 was not intended to entitle local entities to reimbursement for *all* increased costs resulting from Legislative enactments, but only those costs mandated by a new program or an increased level of service imposed upon them by the State.").

[223] Penal Code section 11171(f)–(h).

[224] Exhibit X (21) Assembly Floor Analysis, July 27, 2004, on SCA 4, as amended July 27, 2004, page 5.

adoption of section 6."[225] Thus, Proposition 1A added section 6(c) to article XIII B, to expand the definition of a new program or higher level of service to include situations when the Legislature transfers from the state to a local agency "complete or partial financial responsibility for a required program for which the State previously had complete or partial financial responsibility."

a. The test claim statute shifts the Medi-Cal and VCB costs, which were previously used to pay for the child physical abuse and neglect evidentiary exams, from the state to the counties and, thus, the test claim statute imposes a new program or higher level of service within the meaning of article XIII B, section 6(c).

From January 1, 2004, to December 31, 2023, funds from Medi-Cal and the VCB reimbursed counties for the cost of child physical abuse and neglect medical evidentiary exams. Both billing options have been acknowledged on the Cal OES exam instructions since 2001.[226] Under Chapter IV, "Reimbursements for Examinations," the Cal OES Protocol stated before the test claim statute, attached to forms dated January 1, 2004:

> In the majority of counties in California, charges for child physical abuse and neglect examinations ***are billed to Medi-Cal*** or to the patient's private insurance. Standard diagnostic and procedural coding manuals are used to generate charges. For patients without insurance, or who are underinsured, reimbursement of ***charges may be obtained through California Victim Compensation and Government Claims Board***.
>
> Some counties have contracts with private hospitals for various medical services (e.g., indigent care) and include a provision for payment of these examinations ***if there is no public or private insurance reimbursement***. Follow local policy.[227]

This information was also specified directly on the Cal OES Form 2-900 Instructions.[228] The Cal OES Protocol states that the "the majority of counties" billed Medi-Cal or private

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[225] *County of Sonoma v. Commission on State Mandates* (2000), 84 Cal.App.4th 1264, 1286 citing *County of San Diego v. State of California* (1997), 15 Cal.4th 68, 99, fn. 20.

[226] Exhibit A, Test Claim, page 235; Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[227] Exhibit A, Test Claim, page 134; Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 15, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025), emphasis added.

[228] Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2, https://www.caloes.ca.gov/office-of-the-

insurance, and occasionally the VCB.[229] The evidence corroborates that Medi-Cal was billed until January 1, 2024.[230]

As set forth in the Background, Medi-Cal had assumed financial responsibility for abused and neglected children since at least 1982. The State Department of Healthcare Services advised all county directors at that time that individuals receiving "Emergency Assistance," including "Abused, Neglected or Exploited Children (EA-ANEC)" were considered "public assistance recipients" and "will be eligible for Medi-Cal benefits and a Medi-Cal card."[231] Social workers have since been applying on behalf of an abused or neglected child for "Retroactive Medi-Cal," using Form MC 250.[232] Thus,

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director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025) ("**3. Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy.**" Emphasis in original.).

[229] Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 15, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[230] Exhibit A, Test Claim, pages 32-33, paragraphs 12, 15, and 17 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara); Exhibit A, Test Claim, page 134; Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 15, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025); California Code of Regulations, title 22, section 50143(a)(3).

[231] Exhibit X (8), Department of Health Services Letter to All County Welfare Directors, August 17, 1982, Letter 82-44, page 1; Exhibit X (9), Department of Health Services Letter to All County Welfare Directors, December 22, 1982 Letter 82-72, pages 1-7; see also California Code of Regulations, title 22, section 50038.5 (defining "Emergency Assistance" as programs providing assistance for up to 30 days, including for "[t]hose children who are being, or are in immediate danger of being abused, neglected or exploited and to families of such children.").

[232] Exhibit X (15), Retroactive Medi-Cal, page 1, https://stgenssa.sccgov.org/debs/program_handbooks/foster_care/assets/28medi-cal/retromedical.htm?agt=index (accessed on July 24, 2025); Exhibit X (10) Form MC 250, Application and Statement of Facts for Child Not Living with a Parent or Relative for Whom a Public Agency Is Assuming Some Financial Responsibility, pages 1-2, https://www.dhcs.ca.gov/formsandpubs/forms/Forms/mc250.pdf (accessed on July 24, 2025); California Code of Regulations, title 22, section 50251 ("(e) Children specified in (a)(3) shall be eligible and certified for Medi-Cal: (1) On the basis of the

if these children were not already enrolled in Medi-Cal, they would become enrolled by the social worker on an emergency basis.[233] Under Continuing Eligibility for Children (CEC), coverage would then continue, uninterrupted at least until the next annual redetermination.[234]

Counties could also bill the VCB if a child was somehow uninsured or underinsured by Medi-Cal.[235] If counties pursued this option, they, or their contracted providers, could bill the VCB directly as a service provider, but had to accept the limits of the VCB payment schedule.[236]

The payments to counties or their providers from Medi-Cal and the VCB have been the responsibility of the state. The California Supreme Court has found that Medi-Cal "has been the responsibility of various state departments and agencies."[237] Likewise, the

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information provided by the public agency on form MC 250. (2) Without considering the property or income of the child or the child's parents.").

[233] California Code of Regulations, title 22, section 50143(a)(3); see also Exhibit X (1), Aid Codes Master Chart, updated April 2022, pages 33 and 35, https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/869D30AF-4BC7-4132-AF6A-AF75893E9221/aidcodes.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO (accessed on July 24, 2025) (Aid Code 45 provides: "FC. Covers children supported by public funds other than AFDC-FC" with no share of costs.); see also Exhibit X (19), Short Doyle Medi-Cal Aid Code Chart, February 23, 2023, page 6, https://www.dhcs.ca.gov/services/MH/Pages/medccc-library.aspx (accessed on July 24, 2025) (Aid Code "5K" provides "Emergency Assistance (EA) Foster Care" with no share of costs).

[234] Exhibit X (7), Continuous Eligibility for Children (CEC), page 1, https://stgenssa.sccgov.org/debs/program_handbooks/foster_care/assets/28medi-cal/contnuselgblty.htm (accessed on July 24, 2025); California Code of Regulations, title 22, section 50189.

[235] Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025) ("**3. Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy.**" Emphasis in original.).

[236] Government Code sections 13957.7(c)(1) and 13957.2; California Code of Regulations, title 2, section 649.23.

[237] *County of San Diego v. State of California* (1997) 15 Cal.4th 68, 96.

VCB is a state agency.[238] The VCB has been in existence since 2002 under its current name and role.[239]

Accordingly, since the state, through Medi-Cal or the VCB, previously paid for the child physical abuse and neglect medical evidentiary exams, Penal Code Section 11171(f), as amended by the test claim statute, shifts those costs from the state to the counties under article XIII B, section 6(c), resulting in a new program or higher level of service.

The Commission has made one previous decision under article XIII B, section 6(c), which is analogous here. In *Sheriff Court-Security Services*, 09-TC-02, the state had accepted responsibility for funding security services to trial courts but later shifted back to the counties the costs of retiree health benefits for those security employees.[240] In that claim, the state had formally assumed responsibility on January 1, 1998, through the 1997 Trial Court Funding Act.[241] Thus, the state had financial responsibility when, in 2009, it legislated part of that responsibility back to the counties by excluding retiree health benefits from the statutorily defined cost of "court operations."[242] As here, the Commission found that the state had financial responsibility for what was "billed to the state" and partially shifted it to the counties under article XIII B, section 6(c), thus causing a "new program" under that section.[243]

Finance's conclusion that the claimant has merely experienced increased costs and should accordingly have its claim denied ignores Proposition 1A and is therefore incorrect. It cites the Commission's Decision in *Workers' Compensation Disability Benefits for Government Employees*, 00-TC-20/02-TC-02 for support.[244] Its reliance on that Test Claim is misplaced because there was no cost-shift at issue. In *Workers Compensation Disability Benefits for Government Employees*, 00-TC-20/02-TC-02, costs were increased for local government when workers' compensation benefits were expanded, resulting in

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[238] Government Code sections 11000 and 13950.

[239] Government Code sections 13950-13951, as added by Statutes 2002, chapter 1141, section 2.

[240] Commission on State Mandates, Test Claim Decision on *Sheriff Court-Security Services,* 09-TC-02, adopted December 5, 2014, https://csm.ca.gov/decisions/121214a.pdf (accessed on September 23, 2025).

[241] Commission on State Mandates, Test Claim Decision on *Sheriff Court-Security Services,* 09-TC-02, adopted December 5, 2014 https://csm.ca.gov/decisions/121214a.pdf (accessed on September 23, 2025), page 6.

[242] Commission on State Mandates, Test Claim Decision on *Sheriff Court-Security Services,* 09-TC-02, adopted December 5, 2014, https://csm.ca.gov/decisions/121214a.pdf (accessed on September 23, 2025), page 17.

[243] Commission on State Mandates, Test Claim Decision on *Sheriff Court-Security Services,* 09-TC-02, adopted December 5, 2014, https://csm.ca.gov/decisions/121214a.pdf (accessed on September 23, 2025), page 38.

[244] Exhibit B, Finance's Comments on the Test Claim, page 2.

some disabled government employees receiving a paid year off.[245] While this did increase local government costs without constituting enhanced service to the public, it was not shifting an expense of a program required by state law to local government that was previously paid for by the state.[246] The voters added article XIII B, section 6(c) by Proposition 1A to address that situation, which has occurred in the Test Claim as it did in *Sheriff Court-Security Services*, 09-TC-02.[247]

The claimant asserts that the Legislature drafted Penal Code section 11171(g) in a manner that it was "knowing and intending" to trigger county responsibility to pay for the child physical abuse and neglect exams.[248] That section provides, in part, "[t]he costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature."[249] The clause "subject to appropriation by the Legislature," the claimant asserts, in combination with the Legislature's lack of appropriation, means that the Legislature was "knowing and intending" to transfer financial responsibility to the counties.[250]

It is not clear and the Commission need not decide whether the state is "attempting to divest itself of responsibility to provide fiscal support for a program" [251] it created in 2002 to standardize child physical abuse and neglect exams. Legislative history only forewarned: "Staff notes that no funding has been included in the 2023-2024 budget for these purposes."[252]

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[245] Commission on State Mandates, Test Claim Decision on *Workers' Compensation Disability Benefits for Government Employees*, 00-TC-20/02-TC-02, adopted May 31, 2007, https://csm.ca.gov/decisions/154.pdf (accessed on September 23, 2025), page 1.

[246] Commission on State Mandates, Test Claim Decision on *Workers' Compensation Disability Benefits for Government Employees*, 00-TC-20/02-TC-02, adopted May 31, 2007, https://csm.ca.gov/decisions/154.pdf (accessed on September 23, 2025), pages 1-2.

[247] Commission on State Mandates, Test Claim Decision on *Sheriff Court-Security Services,* 09-TC-02, adopted December 5, 2014, https://csm.ca.gov/decisions/121214a.pdf (accessed on September 23, 2025), page 22.

[248] Exhibit C, Claimant's Rebuttal Comments, page 3 citing *County of San Diego v. State of California* (1997) 15 Cal.4th 68, 98.

[249] Penal Code section 11171(g).

[250] Exhibit A, Test Claim, page 17.

[251] *County of Los Angeles v. Commission on State Mandates* (2003) 110 Cal.App.4th 1176, 1194; Penal Code section 11171, as added by Statutes 2002, chapter 249.

[252] Exhibit X (16), Senate Committee on Appropriations, August 21, 2023, on AB 1402, as amended March 30, 2023, page 3.

Nonetheless, by having assumed financial responsibility for this program for two decades through Medi-Cal and the VCB and then not appropriating funding as provided for in the test claim statute, the state has shifted costs from itself to the counties under article XIII B, section 6(c). This indefinite cost-shift to the counties is further apparent in the legislative intent that the exams be "free" or "no-cost" to all victims. [253] The bill was said to "require counties to set up systems to provide examinations at no cost to the victim" and then to submit invoices to Cal OES.[254] Without reimbursement from Cal OES, the counties are now required to assume the financial responsibility previously carried by the state.

In addition, the test claim statute resembles that of the 1997 California Supreme Court case on which the claimant relies regarding the Legislature's exclusion of medically-indigent-persons from Medi-Cal. There, the Court found that "the Legislature excluded adult MIP's from Medi-Cal *knowing* and *intending* that the 1982 legislation would trigger the counties' responsibility to provide medical care as providers of last resort under section 17000."[255] Here, while the Commission makes no finding as to the Legislature's intent, the effect is the same. As in the 1997 case, the counties are providers of last resort, here for abused and neglected children, as well as the agents of the state's child welfare system.[256] Inevitably, the state has shifted these costs to the counties to the extent it does not appropriate the funding as declared intended. As Finance partially states, "Penal Code section 11171(f) simply requires the county to absorb the costs of

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[253] Exhibit X (3), Assembly Committee on Public Safety, April 25, 2023, on AB 1402, as amended March 30, 2023, pages 3-4; Exhibit X (16), Senate Committee on Appropriations, August 21, 2023, on AB 1402, as amended March 30, 2023, page 2; Exhibit X (17), Senate Committee on Public Safety, June 27, 2023, on AB 1402, as amended March 30, 2023, page 3; Exhibit X (18), Senate Rules Committee, Office of Senate Floor Analyses, September 2, 2023, on AB 1402, as amended March 30, 2023, pages 4-5.

[254] Exhibit X (16), Senate Committee on Appropriations, August 21, 2023, on AB 1402, as amended March 30, 2023, page 2.

[255] *County of San Diego v. State of California* (1997) 15 Cal.4th 68, 98.

[256] Welfare and Institutions Code sections 300, 10800, 16500, and 17000; *In re Social Services Payment Cases* (2008) 166 Cal.App.4th 1249, 1256; Welfare and Institutions Code sections 16501(a)(1)(B), 16501(a)(2), and 16501(c) ("The county shall provide child welfare services as needed pursuant to an approved service plan and in accordance with regulations promulgated, in consultation with the counties, by the [state] department."); *Ross v. Superior Court* (1977) 19 Cal.3d 899, 908; *Hassell v. Bird* (2018) 5 Cal.5th 522, 553, Kruger, J., concurring ("counties act on behalf of the state in administering welfare benefits"); *In re M.C.* (2011) 199 Cal.App.4th 784, 810 (county social service agency is an administrative agency of the executive branch when providing child welfare services, subject to supervision by Department of Social Services citing Welfare and Institutions Code sections 202.5, 10000, 10051, 10800, 16500, 16500.1, and 16501, *Scott v. County of Los Angeles* (1994) 27 Cal.App.4th 125, 143-144, and *In re Danielle W.* (1989) 207 Cal.App.3d 1227, 1235-1236, n. 6.).

medical evidentiary exams that the county was already required to perform under existing law, instead of passing those costs along to a third party."[257] What follows, however, is that because the state *was* a responsible third party through Medi-Cal and VCB payments for the costs of the exams, the state has shifted those costs to the counties with the passage of the test claim statute to the extent the corresponding appropriation from the Legislature is lacking.

Finally, the test claim statute imposes unique requirements on counties which do not apply generally to all residents and entities in the state and carries out the governmental function of providing services to the public and, thus, imposes a new program or higher level of service.[258] If the Legislature does not appropriate funds, the new requirement to pay for child physical abuse and neglect exams once paid by the state through Medi-Cal and VCB is uniquely imposed on county government. Counties uniquely provide child welfare services, including emergency response to abused and neglected children.[259] The new requirement to pay for child physical abuse and neglect exams also furthers the state policy that all children are entitled to be free from abuse and neglect.[260]

Thus, absent an appropriation from the state pursuant to 11171(g), the Commission finds that Penal Code section 11171(f), as amended by the test claim statute, imposes a new program or higher level of service on counties pursuant to article XIII B, section 6(c), for those costs previously paid through Medi-Cal and the VCB.

b. Providing child physical abuse and neglect exams is mandated by state law and, thus, the cost of the exams, which has been shifted from the state to the counties with respect to previous Medi-Cal and VCB reimbursement *for the exams,* are a component of the mandated program.

To find a mandated new program or higher level of service, the counties' obligation to provide child physical abuse and neglect exams must also be legally or practically compelled. "Legal compulsion occurs when a statute or executive action uses mandatory language that " 'require[s]' or 'command[s]' " a local entity to participate in a

[257] Exhibit B, Finance's Comments on the Test Claim, page 1.

[258] *Carmel Valley Fire Protection District v. State of California* (1987) 190 Cal.App.3d 521, 537 citing *County of Los Angeles v. State of California* (1987) 43 Cal.3d 46, 56, emphasis in original.

[259] Welfare and Institutions Code section 16500 ("All counties shall establish and maintain specialized organizational entities within the county welfare department which shall have sole responsibility for the operation of the child welfare services program."); Welfare and Institutions Code section 16206.

[260] Welfare and Institutions Code section 16500, as amended by Statutes 1996, chapter 1084, section 10.

program or service."[261] Practical compulsion occurs when a local entity has "no true choice but to comply."[262]

The required program that began operating on January 1, 2004, does not have language using the term "shall," to command the provision of the child physical abuse and neglect exams. Using the word "shall," it commanded what is now Cal OES to create the program, including the forms, instructions, content, protocols, and to make the forms electronically accessible as follows:

> (a)(1) The Legislature hereby finds and declares that adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations.
>
> (2) Enhancing examination procedures, documentation, and evidence collection relating to child abuse or neglect will improve the investigation and prosecution of child abuse or neglect as well as other child protection efforts.
>
> (b) The Office of Emergency Services shall, in cooperation with the State Department of Social Services, the Department of Justice, the California Association of Crime Lab Directors, the California District Attorneys Association, the California State Sheriffs' Association, the California Peace Officers Association, the California Medical Association, the California Police Chiefs' Association, child advocates, the California Medical Training Center, child protective services, and other appropriate experts, establish medical forensic forms, instructions, and examination protocols for victims of child physical abuse or neglect using as a model the form and guidelines developed pursuant to Section 13823.5.
>
> (c) The forms shall include, but not be limited to, a place for notation concerning each of the following:
>
> (1) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures.
>
> (2) Addressing relevant consent issues, if indicated.
>
> (3) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history.
>
> (4) The performance of a physical examination for evidence of child physical abuse or neglect.

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[261] *Coast Community College District v. Commission on State Mandates* (2022) 13 Cal.5th 800, 815.

[262] *Coast Community College District v. Commission on State Mandates* (2022) 13 Cal.5th 800, 821.

(5) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures.

(6) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated.

(7) Procedures for the preservation and disposition of evidence.

(8) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays.

(9) An assessment as to whether there are findings that indicate physical abuse or neglect.

(d) The forms shall become part of the patient's medical record pursuant to guidelines established by the advisory committee of the Office of Emergency Services and subject to the confidentiality laws pertaining to the release of medical forensic examination records.

(e) The forms shall be made accessible for use in an electronic format.[263]

Although the legislative finding asserts that the program is necessary for "adequate protection" of child victims of abuse and neglect, nothing in the above statute directly states that these exams "shall" be provided by counties. By comparison, one of two related statutes, the sexual assault exam statute, does have direct language commanding similar exams. Using the word, "shall," the sexual assault exam statute directly provides that a victim "shall be provided with a standardized medical evidentiary examination, using the medical evidentiary examination report forms and protocols for victims of sexual assault developed pursuant to Section 13823.5."[264]

And even so, the words "shall" and "may" are not specifically defined as "mandatory" or "permissive" in the Penal Code nor in the Welfare and Institutions Code. Thus, even if there were statutory language similar to that for sexual assault examinations saying they "shall" be provided to child physical abuse and neglect victims, clarity on the exact nature of that directive would remain lacking.[265]

Given this omission of a direct command in the child physical abuse and neglect statutes similar to the one in the sexual assault examination statute, the Commission finds that the child physical abuse and neglect exams are not legally compelled by state law. However, the Commission finds the exams practically compelled and, thus, mandated by the state.

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[263] Penal Code section 11171 (a)–(e).

[264] Penal Code section 13923.95(b)(1).

[265] See *People v. Lara* (2010) 48 Cal.4th 216, 227 (In determining whether a statute is mandatory where no definition exists in the relevant code, "[n]either the word 'may,' nor the word 'shall,' is dispositive.").

Practical compulsion, appropriate here, may be found as a substitute for legal compulsion in special circumstances. As an example, in cities where "deciding not to provide a stormwater drainage system is no alternative at all," those cities are "compelled as a practical matter to obtain an NPDES [stormwater] permit and fulfill the permit's conditions."[266] Like these cities that must apply for stormwater permits to continue providing regular water service, the claimant must provide child physical abuse and neglect examinations regardless of there being no statute clearly mandating that they "shall" provide them.

The California Supreme Court recently considered a test claim where a statute fell short of satisfying the legal compulsion standard and remanded it for consideration of practical compulsion and held that practical compulsion requires showing that failing to perform the activity will result in certain and severe penalties or other draconian consequences.[267] Any alternative to performing the activity according to standards set by the higher government entity must be "so far beyond the realm of practical reality" as to leave the responsible government entity without any real discretion.[268] Factors courts require considering include the nature and purpose of the program, whether the design of the program suggests an intent to coerce, when the respective governments' participation began, the penalties for refusal to comply, and any other legal and practical consequences of nonparticipation, noncompliance, or withdrawal.[269] An early example of practical compulsion (there, by the federal government upon the state government) was found where California employers would have faced double taxation had the State of California not complied with federal legislation to provide unemployment insurance to public employees.[270]

The Test Claim involves a combination of statutes and practical realities inducing the counties to provide the child physical abuse and neglect exams. These statutes and practical realities compel the counties into being mandated to perform child physical abuse and neglect exams. The counties have "no true alternative."[271]

Fundamentally, the rights of children come first. As set forth in the Background, the Legislature declared in 1996 "that all children are entitled to be safe and free from

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[266] *Department of Finance v. Commission on State Mandates* (2022) 85 Cal.App.5th 535, 558.

[267] *Coast Community College District v. Commission on State Mandates* (2022) 13 Cal.5th 800, 816, 822 citing *Department of Finance v. Commission on State Mandates (Kern)* (2003) 30 Cal.4th 727, 748-752.

[268] *City of Sacramento v. State of California* (1990) 50 Cal. 3d 51, 74.

[269] *City of Sacramento v. State of California* (1990) 50 Cal. 3d 51, 76.

[270] *City of Sacramento v. State of California* (1990) 50 Cal. 3d 51, 74.

[271] *Coast Community College District v. Commission on State Mandates* (2022)13 Cal. 5th 800, 820 citing *Department of Finance v. Commission on State Mandates (Kern)* (2003) 30 Cal.4th 727, 731, 751 and *City of Sacramento v. State of California* (1990) 50 Cal. 3d 51, 74.

abuse and neglect."[272] And in 2002, the Legislature set a floor of adequacy when it enacted the program of state standardized medical evidentiary exams. It declared that "adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations."[273]

In addition, counties "shall" investigate all incoming child abuse reports, a duty that has been confirmed by the courts.[274] Such investigation naturally includes examining the child and doing so adequately. Further, the counties, as "child protective services" were to be consulted as part of the Cal OES team that was required to create the state standardized form, instructions, and protocols, and so presumably are required to be using them.[275] As mentioned, Cal OES proclaims that the form, protocols, and instructions are the "minimum legal standards" created in the same statute.[276] Counties "shall" set up the reimbursement system with Cal OES and designate SART, SAFE, or other "qualified medical evidentiary examiners."[277] Victims "may" have an exam in another county, indicating that counties must be available to provide exams to children whose abuse occurred in a different county.[278] If the counties must acknowledge an out-of-county child's entitlement to a medical evidentiary exam, they must certainly provide them to their own residents as needed.

Welfare and Institutions Code section 324.5 compels the medical exams where a child is taken into protective custody and a physical examination of the child is "appropriate," acknowledging the initial discretionary decision of local government and medical practitioners as follows:

> (a) Whenever allegations of physical or sexual abuse of a child come to the attention of a local law enforcement agency or the local child welfare department and the child is taken into protective custody, the local law enforcement agency, or child welfare department may, as soon as practically possible, consult with a medical practitioner, who has

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[272] Welfare and Institutions Code section 16500, as amended by Statutes 1996, chapter 1084, section 10.

[273] Penal Code section 11171(a)(1).

[274] Penal Code section 11166.3 (formerly 11166.1); see also *Alejo v. City of Alhambra* (1999) 75 Cal.App.4th 1180, 1185-1186.

[275] Penal Code section 11171(b).

[276] Exhibit X (6), California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025); Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 2, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[277] Penal Code section 11171(g).

[278] Penal Code section 11171(h).

specialized training in detecting and treating child abuse injuries and neglect, to determine whether a physical examination of the child is appropriate. If deemed appropriate, the local law enforcement agency, or the child welfare department, shall cause the child to undergo a physical examination performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, and, whenever possible, shall ensure that this examination take place within 72 hours of the time the child was taken into protective custody. In the event the allegations are made while the child is in custody, the physical examination shall be performed within 72 hours of the time the allegations were made.

In the case of a petition filed pursuant to Section 319, the department shall provide the results of the physical examination to the court and to any counsel for the minor, and counsel for the parent or guardian of the minor. Failure to obtain this physical examination shall not be grounds to deny a petition under this section.

(b) The local child welfare agency shall, whenever possible, request that additional medical examinations to determine child abuse injuries or neglect, be performed by the same medical practitioner who performed the examinations described in subdivision (a). If it is not possible to obtain additional medical examinations, the local child welfare agency shall ensure that future medical practitioners to whom the child has been referred for ongoing diagnosis and treatment have specialized training in detecting and treating child abuse injuries and neglect and have access to the child's medical records covering the current and previous incidents of child abuse.[279]

The above statute initially uses the word "may" to say whether county employees will consult a medical practitioner, and then uses "shall" to say that an exam will be performed once the medical practitioner deems it appropriate. But there is a duty to protect the child.[280] While it is thus technically within the law enforcement or county welfare employee's initial discretion to consult a medical practitioner, the county's obligation is nonetheless going to be compelled by any reasonably-formed suspicion indicating that the child should be examined and protected. Accordingly, the Commission finds the child physical abuse and neglect exams for children taken into protective custody practically compelled.

An exam may also be necessary for a child *not* taken into protective custody under Welfare and Institutions Code section 324.5. According to Cal OES instructions, some children receive exams with parental consent and without being taken into protective custody:

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[279] Welfare and Institutions Code section 324.5.

[280] Welfare and Institutions Code sections 328, 16500, 16500.1, and 16501; Family Code section 3027; *In re Joshuia S.* (1988) 205 Cal.App.3d 119, 125.

Suspected child abuse: non-consenting parents

> Parental consent is not required to examine, treat or collect evidence for suspected child abuse. In the absence of parental consent or in the case of parental refusal, children must be taken into protective custody by a child protective agency (e.g. law enforcement agency or county child protective services agency) in order to perform the examination. Follow local policy regarding placement of children in protective custody.[281]

Where a child is not immediately taken into protective custody under Welfare and Institutions Code section 324.5, other statutory duties practically compel the exams. If allegations of abuse or neglect are made in a family court child custody proceeding, for example, "the court may request that the local child welfare services agency conduct an investigation of the allegations pursuant to Section 328 of the Welfare and Institutions Code."[282] Although this statute uses the word "may," it is a court's duty to protect the child, and thus the investigations prompted on this case by case basis are practically compelled.[283]

A social worker receiving a child abuse or neglect referral has a duty to investigate as needed.[284] If not requested through a family court proceeding, this begins with a social worker's belief from any other referral, which triggers the duty to investigate, which proceeds under the social worker's discretion and duty:

> If the social worker has cause to believe that there was or is within the county, or residing in the county, a person described in Section 300, the social worker shall immediately make any investigation the social worker deems necessary to determine whether child welfare services should be offered to the family and whether proceedings in the juvenile court should be commenced.[285]

The social worker is constrained by duty to perform investigations that are the least disruptive, but most thorough as necessary. The Legislature has declared: "It is the intent of the Legislature that this section not disrupt the family unnecessarily or intrude inappropriately into family life."[286]

Because the social worker performs "any investigation the social worker deems necessary," the social worker is bound by duty to seek a child physical abuse or neglect

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[281] Exhibit X (13), Medical Report: Suspected Child Physical Abuse and Neglect Instructions Cal OES 2-900, page 3, https://www.caloes.ca.gov/office-of-the-director/policy-administration/finance-administration/grants-management/victim-services/forms/ (accessed on June 20, 2025).

[282] Family Code section 3027(b).

[283] *In re Joshuia S.* (1988) 205 Cal.App.3d 119, 125.

[284] Welfare and Institutions Code section 328(a).

[285] Welfare and Institutions Code section 328(a).

[286] Welfare and Institutions Code section 300.

exam when called for in his or her professional judgment.[287] Accordingly, the Commission finds the exams are practically compelled when the social worker "deems necessary."[288]

In addition, numerous practical realities have been explained by the claimant to support a finding of practical compulsion. Two of the claimant's four declarations provide significant information on these realities. Per a declaration by Dr. Marlene Sturm, Medical Director of the Medical Clinic at the Children's Advocacy Center of Santa Clara County, child abuse pediatrics is a necessary medical specialty which goes beyond general medicine, general pediatrics and general emergency medicine.[289] Without training in child abuse pediatrics, such as that provided by the statutorily-created training hospital, the CCFMTC,[290] abused and neglected children will be misdiagnosed and there will be overinclusive and underinclusive findings, causing both avoidable danger to children and unnecessary disruption to families.[291]

Per a declaration by Melissa Suarez, Bureau Manager of the Department of Family and Children's Services, "time is of the essence" because "[i]njuries may fade and heal, invisible injuries may worsen without treatment (e.g., brain bleeds), and the child may be at grave risk of harm the longer they remain in an unsafe environment."[292] Also, the following are potential consequences of not providing the child physical abuse and neglect exams as prescribed by the state:

a. Law enforcement officials' investigation into child abuse and neglect crimes would be severely limited;

b. Social workers would be unable to substantiate suspected cases of child physical abuse or neglect, particularly for nonverbal, pre-verbal, disabled, and developmentally delayed children;

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[287] Welfare and Institutions Code section 328(a).

[288] Welfare and Institutions Code section 328(a).

[289] Exhibit A, Test Claim, pages 46-48, paragraphs 17, 19, and 24 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County).

[290] Penal Code section 13823.93(b)-(d), as amended by Statutes 2002, chapter 256, section 1; Penal Code section 13823.93(b).

[291] Exhibit A, Test Claim, pages 47-49, paragraphs 21, 23, and 24 (Declaration of Marlene Sturm, MD, Medical Director, Medical Clinic at the Children's Advocacy Center, Children's Advocacy Center of Santa Clara County); See also Exhibit A, Test Claim, page 30-31, paragraph 13 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

[292] Exhibit A, Test Claim, page 42, paragraph 17 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

c. Children and families who would otherwise receive support services following medical findings of abuse or neglect would not be assisted; and

d. Children whose abuse or neglect would be uncovered by a physical abuse and neglect exam would remain in dangerous situations, and in some cases, would be severely harmed or killed.[293]

The Commission finds that, taken together, the above statutes and practical realities would result in "severe consequences that leave the local entity no reasonable alternative but to comply" with the program of providing the child physical abuse and neglect exams as prescribed by the state.[294]

Accordingly, the Commission finds that the counties' obligation to provide child abuse and neglect exams is practically compelled by the state and, thus, the cost of the exams, which has been shifted from the state to the counties with respect to previous Medi-Cal and VCB reimbursement for the exams, is a component of the state-mandated program.

C. The Test Claim Statute Results in Costs Mandated by the State.

Finally, Government Code section 17514 defines "costs mandated by the state" as any increased costs which a local agency or school district is required to incur as a result of any statute or executive order that mandates a new program or higher level of service. Government Code section 17564(a) specifically requires that no claim or payment shall be made unless the claim exceeds $1,000.

A finding of such costs mandated by the state also means that no exception in Government Code section 17556 applies.

The claimant has filed declarations signed under penalty of perjury identifying the following increased costs exceeding $1,000 to comply with the test claim statute:

	FY 2023-2024	FY 2024-2025	Ongoing Estimates
Serena Sy, Director of Primary Care Operations, Santa			$11,800,000 estimated statewide annually[295]

[293] Exhibit A, Test Claim, pages 42-43, paragraph 18 (Declaration of Melissa Suarez, Bureau Manager, Department of Family and Children's Services, County of Santa Clara).

[294] *Coast Community College District v. Commission on State Mandates* (2022) 13 Cal.5th 800, 816 citing *Department of Finance v. Commission on State Mandates (Kern High School District)* (2003) 30 Cal.4th 727, 748-752.

[295] Exhibit A, Test Claim, pages 33-34, paragraph 24 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara).

Clara Valley Healthcare			
Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare	$221,046[296]	$717,496 estimated[297]	$621,927 estimated annually for the claimant[298]

There is no evidence rebutting these declarations.

Moreover, none of the exceptions to costs mandated by the state in Government Code section 17556 apply to this Test Claim. The claimant has no fee authority per Government Code section 17556(d) to offset the increased costs, which the claimant confirms.[299] There is no appropriation offsetting the costs per Government Code section 17556(e), which Finance confirms.[300] And there is no change to any crime or penalty for any crime of child abuse or neglect per Government Code section 17556(g). The test claim statute only concerns a process of gathering evidence, which may be used for criminal and non-criminal purposes.

Given the substantial evidence in the record, the Commission finds that the test claim statute imposes increased costs mandated by the state under article XIII B, section 6(c) and Government Code section 17514.

V. Conclusion

Based on the foregoing analysis, the Commission partially approves this Test Claim and finds that Penal Code section 11171(f), as amended by test claim statute, imposes a reimbursable state-mandated program beginning January 1, 2024, on counties within the meaning of article XIII B, section 6(c) of the California Constitution for only the following costs:

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[296] Exhibit A, Test Claim, page 36, paragraph 12 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[297] Exhibit A, Test Claim, page 36, paragraph 13 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[298] Exhibit A, Test Claim, pages 35-36, paragraph 9 (Declaration of Kiyomi Ross, Director of Financial Planning and Performance, Santa Clara Valley Healthcare, County of Santa Clara).

[299] Exhibit A, Test Claim, page 33, paragraph 20 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara).

[300] Exhibit A, Test Claim, page 33, paragraph 20 (Declaration of Serena Sy, Director of Primary Care Operations, Santa Clara Valley Healthcare, County of Santa Clara); Exhibit B, Finance's Comments on the Test Claim, page 1.

- Costs incurred for child physical abuse and neglect exams conducted in accordance with Penal Code section 11171, by the county's designated Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners, when the child is eligible for Medi-Cal or Victim Compensation Board coverage.

  Reimbursement is ***not*** required to the extent the Legislature appropriates funds for child physical abuse and neglect exams under Penal Code section 11171(g).

All other claims for reimbursement are denied.

DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

I am a resident of the County of Sacramento and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

On September 26, 2025, I served the:

- **Current Mailing List dated September 26, 2025**
- **Draft Proposed Decision, Schedule for Comments, and Notice of Hearing issued September 26, 2025**

  Child Physical Abuse and Neglect Exams, 24-TC-05
  Statutes 2023, Chapter 841, (AB 1402); Penal Code Section 11171(f), effective January 1, 2024
  County of Santa Clara, Claimant

by making it available on the Commission's website and providing notice of how to locate it to the email addresses provided on the attached mailing list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on September 26, 2025 at Sacramento, California.

Jill Magee

Jill Magee
Commission on State Mandates
980 Ninth Street, Suite 300
Sacramento, CA 95814
(916) 323-3562

COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 9/26/25

Claim Number: 24-TC-05

Matter: Child Physical Abuse and Neglect Exams

Claimant: County of Santa Clara

TO ALL PARTIES, INTERESTED PARTIES, AND INTERESTED PERSONS:

Each commission mailing list is continuously updated as requests are received to include or remove any party or person on the mailing list. A current mailing list is provided with commission correspondence, and a copy of the current mailing list is available upon request at any time. Except as provided otherwise by commission rule, when a party or interested party files any written material with the commission concerning a claim, it shall simultaneously serve a copy of the written material on the parties and interested parties to the claim identified on the mailing list provided by the commission. (Cal. Code Regs., tit. 2, § 1181.3.)

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Commission on State Mandates
Filed Date
10/07/2025

October 7, 2025

Exhibit F

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And Parties, Interested Parties, and Interested Persons (See Mailing List)

Re: Comment on the Draft Proposed Decision
Child Physical Abuse and Neglect Exams, 24-TC-05
Statutes 2023, Chapter 841, Section 1 (AB 1402); Penal Code Section 11171, subd. (f)
County of Santa Clara, Claimant

Dear Director Gmur:

The County of Santa Clara ("County") files the following comment in response to the Draft Proposed Decision on test claim 24-TC-05 ("Test Claim"), concerning child physical abuse and neglect exams. The Test Claim asserted that AB 1402, which added subdivision (f) to section 11171 of the Penal Code ("Test Claim Statute"), imposes an unfunded mandate on counties and thus requires subvention pursuant to article XIII B, section 6 of the California Constitution ("Section 6"). The Draft Proposed Decision recommends that the Commission on State Mandates ("Commission") partially approve the test claim.

The County recognizes the careful and rigorous work of the Commission and largely agrees with the Draft Proposed Decision. This Comment focuses narrowly on a single point of contention. The Draft Proposed Decision finds that the Test Claim Statute does not mandate a new program or higher level of service for the increased costs of child physical abuse or neglect exams (hereinafter, "exams") when those costs

could have been recovered in the past directly from the victim or from the victim's private medical insurance. The Draft Proposed Decision reasons that the Test Claim Statute, as to this subset of exams, does not require any new activity, the Test Claim Statute did not shift any costs from the State to counties, and Section 6 does not require reimbursement for increased costs alone. This finding contrasts with the finding that those exams that were previously reimbursable by the State via Medi-Cal and the Victims' Compensation Board are now reimbursable under Section 6, so long as the Legislature does not appropriate funds to reimburse these exams pursuant to the Test Claim Statute. The County respectfully disagrees with this distinction and requests that the Commission modify the Draft Proposed Decision to recommend reimbursement for all exams (subject to appropriations by the Legislature), whether they were previously reimbursable by the State or by private medical insurance.

DISCUSSION

By transferring full financial responsibility from the State to counties, the Test Claim Statute mandates a new activity as to those exams which were previously chargeable to private medical insurance. In addition, the rationale offered by the Draft Proposed Decision regarding its finding as to private medical insurance would contravene the voters' intent behind Section 6.

A. By Requiring Counties to Provide Exams Free of Charge to Privately Insured Patients, the Test Claim Statute Mandates a New Activity that Transfers Financial Responsibility from the State to Counties.

Among other criteria, Section 6 requires reimbursement when a statute imposes upon counties a new activity and that activity constitutes a "program" that either carries out a governmental function of providing a service to the public or imposes requirements unique to local governments. (*San Diego Unified School Dist. v. Commission on State Mandates* (2004) 33 Cal.4th 859, 874.) In 2004, the voters amended Section 6 to clarify that "[a] mandated new program or higher level of service includes a transfer by the Legislature from the State to cities, counties, cities and counties, or special districts of complete or partial financial responsibility for a required program for which the State previously had complete or partial financial responsibility." (Cal. Const., art. XIII B, § 6, subd. (c).)

Subdivision (f) of Penal Code section 11171 does not distinguish between children who have public medical insurance and those who have private medical insurance—in both cases, the Test Claim Statute prohibits charging the victim for the cost of exams. Likewise, the Draft Proposed Decision does not find that counties implement the Test Claim Statute differently whether the child receiving the exam has public insurance or private medical insurance. Yet, it reasons that counties should not receive reimbursement when the child has private medical insurance because the State

did not shift any costs onto counties where counties previously billed private medical insurance rather than the State.

However, the State did assume full financial responsibility for the mandate before it summarily transferred those costs onto counties. When the Test Claim Statute went into effect on January 1, 2024 and subdivision (g) of Penal Code section 11171 established that "[t]he costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature," the State assumed full responsibility for all exam costs, regardless of the child's underlying insurance status. When the Legislature *subsequently* declined to appropriate funding for the Test Claim Statute (Draft Proposed Decision, p. 1 n. 1), it transferred from the State to counties complete responsibility for a required program for which the State previously had complete financial responsibility. (Cal. Const., art. XIII B, § 6, subd. (c).)

Subdivision (c) of Section 6 does not by its terms require the State to hold complete or partial responsibility over the relevant program for any particular duration before transferring financial responsibility to local governments. Prior to Proposition 1A, which added subdivision (c) to Section 6, the California Supreme Court in *Lucia Mar Unified School District v. Honig* (1988) 44 Cal.3d 830 identified a mandate that transferred partial financial responsibility from the State to school districts two years after the State assumed full financial responsibility for the cost. (44 Cal.3d at pp. 832-833.) In *County of San Diego v. State of California* (1997) 15 Cal.4th 68, the State assumed full financial responsibility for certain Medi-Cal costs for six years before transferring partial financial responsibility to the county. (15 Cal.4th at p. 80.) What matters is that in each case, the State assumed full responsibility for the program before transferring that cost to local governments. Here, the State assumed full financial responsibility for the cost of exams that were previously reimbursed by private medical insurance. When the Legislature failed to appropriate funding to reimburse these costs, it transferred that financial responsibility in full to counties.

The Draft Proposed Decision relies on *City of San Jose v. State of California* (1996) 45 Cal.App.4th 1802, for the proposition that "increased costs alone do not constitute a reimbursable mandate." (45 Cal.App.4th at p. 1817.) *City of San Jose*, however, is not fully applicable to the Test Claim Statute. There, the test claim statute did not impose a mandate because it gave counties the discretionary authority to shift costs from one local government, counties, to another, cities. (*Id*. at pp. 1815-1816.) There, the fact that the test claim statute resulted in increased costs to cities did not provide an independent basis to identify a reimbursable mandate under Section 6. But in decisions like *Lucia Mar* and the *County of San Diego*, the increased costs were reimbursable because they followed the transfer of financial responsibility from the State to the local government. The Test Claim Statute effects a transfer of financial responsibility akin to those in *Lucia Mar* and the *County of San Diego* and does not mirror the facts or reasoning in *City of San Jose*.

B. Section 6 Does Not Permit the State to Evade its Reimbursement Obligation by Repealing a Local Government Fee Authority.

Legal limitations on local governments' ability to charge fees and taxes "is a primary reason article XIII B, section 6 exists and requires subvention." (*Department of Finance v. Commission on State Mandates* (2022) 85 Cal.App.5th 535, 580.) "[T]he purpose of article XIII B, section 6 'is to preclude the state from shifting financial responsibility for carrying out governmental functions to local agencies, which are "ill equipped" to assume increased financial responsibilities because of the taxing and spending limitations that articles XIII A and XIII B impose.' " (*Ibid*., quoting *County of San Diego v. State of California* (1997) 15 Cal.4th 68, 81.) Article XIII A and Article XIII C, which limit local government taxing authority, are complemented by Article XIII B, which limits government spending. (*Id*. at pp. 598-599.) Section 6 requires subvention because "limits on local governments' taxing and spending authority . . . deprive local governments of the authority to enact taxes to pay for new state mandates. . . . They limit local government's authority to proposing a tax only, a level of authority that does not guarantee resources to pay for a new mandate. Article XIII B, section 6 provides them with those resources." (*Id*. at p. 599.)

The Test Claim Statute goes farther than the concern animating *Department of Finance v. Commission on State Mandates* (2022) 85 Cal.App.5th 535, which concerned voter approval requirements for fees. In that case, the court grappled with whether a local government had sufficient fee authority to recoup the cost of a state mandate. If the local government possessed such fee authority, it could not receive reimbursement pursuant to Section 6 and Government Code section 17556, subdivision (d). (85 Cal.App.5th at p. 560.) Here, there is no dispute that counties had fee authority prior to the Test Claim Statute to charge private medical insurance for these exams. Rather, with the Test Claim Statute, the State *eliminated* the county fee authority and transferred full financial responsibility for child physical abuse and neglect exams onto counties. Where the fee authority in *Department of Finance* was insufficient because it was contingent on voter approval, here the counties are unconditionally barred from charging private medical insurance for exams.

If adopted as final, the Draft Proposed Decision would approve an unlawful basis for the State to evade its obligations under Section 6—namely, the State could impose a mandate for which there is fee authority and subsequently eliminate that fee authority without having to provide reimbursement under Section 6. This maneuver, which would have sweeping implications for all fee-based activities, flouts the voters' intent behind Section 6 and is unconstitutional.

CONCLUSION

The County respectfully disagrees with that portion of the Draft Proposed Decision concerning exams formerly chargeable to private medical insurance. The County thus urges the Commission to adopt a decision approving the Test Claim in full.

Certification

I certify by my signature below, under penalty of perjury under the laws of the State of California, that the statements made in this document are true and complete to the best of my own personal knowledge or based on information and belief and that I am authorized and competent to do so.

Very truly yours,
TONY LOPRESTI
County Counsel

RAJIV NARAYAN
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DECLARATION OF SERVICE BY EMAIL

I, the undersigned, declare as follows:

I am a resident of the County of Sacramento and I am over the age of 18 years, and not a party to the within action. My place of employment is 980 Ninth Street, Suite 300, Sacramento, California 95814.

On October 8, 2025, I served the:

- **Current Mailing List dated September 26, 2025**
- **Claimant's Comments on the Draft Proposed Decision filed October 7, 2025**

  Child Physical Abuse and Neglect Exams, 24-TC-05
  Statutes 2023, Chapter 841, (AB 1402); Penal Code Section 11171(f), effective January 1, 2024
  County of Santa Clara, Claimant

by making it available on the Commission's website and providing notice of how to locate it to the email addresses provided on the attached mailing list.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on October 8, 2025 at Sacramento, California.

_____

David Chavez
Commission on State Mandates
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COMMISSION ON STATE MANDATES

Mailing List

Last Updated: 9/26/25

Claim Number: 24-TC-05

Matter: Child Physical Abuse and Neglect Exams

Claimant: County of Santa Clara

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Each commission mailing list is continuously updated as requests are received to include or remove any party or person on the mailing list. A current mailing list is provided with commission correspondence, and a copy of the current mailing list is available upon request at any time. Except as provided otherwise by commission rule, when a party or interested party files any written material with the commission concerning a claim, it shall simultaneously serve a copy of the written material on the parties and interested parties to the claim identified on the mailing list provided by the commission. (Cal. Code Regs., tit. 2, § 1181.3.)

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Aid Codes Master Chart

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The Aid Codes Master Chart was developed for use in conjunction with the Medi-Cal Automated Eligibility Verification System (AEVS). Providers must submit an inquiry to AEVS to verify a recipient's eligibility for services. The eligibility response returns a message indicating whether the recipient is eligible, and for what services. The message includes an aid code if the recipient is eligible. If a recipient has an unmet Share of Cost (SOC), an aid code is not returned, since the recipient is not considered eligible until the SOC is met. A recipient may have more than one aid code, and may be eligible for multiple programs and services.

The aid codes in this chart are meant to assist providers in identifying the types of services for which Medi-Cal and public health program recipients are eligible. The chart includes only aid codes used to bill for services through the Medi-Cal claims processing system and for other non-Medi-Cal programs that need to verify eligibility through AEVS.

Note: Unless stated otherwise, these aid codes cover United States citizens, United States nationals and immigrants in a satisfactory immigration status. ‹‹Satisfactory immigration status includes lawful permanent residents, Permanent Residence Under Color of Law (PRUCOL) non-citizens and certain amnesty non-citizens.››

Aid Codes Master Chart

Code	Benefits	SOC	Program/Description
A1	Hearing aid and audiology	No	Non-Medi-Cal Hearing Aid Coverage for Children Program *
C1	Restricted to pregnancy-related, postpartum and emergency services	No	‹‹Omnibus Budget Reconciliation Act (OBRA) Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens.›› Aid to the Aged – Medically Needy (MN). Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
C2	Restricted to pregnancy-related, postpartum and emergency services	Yes	‹‹OBRA Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens.›› Aid to the Aged – MN, SOC. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
C3	Restricted to pregnancy-related, postpartum and emergency services	No	‹‹OBRA Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens.›› Blind – MN. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
C4	Restricted to pregnancy-related, postpartum and emergency services	Yes	‹‹OBRA Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens.›› Blind – MN, SOC. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
C5	Restricted to pregnancy-related, postpartum and emergency services	No	‹‹OBRA Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens.›› Aid to Families with Dependent Children (AFDC) – MN. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
C6	Restricted to pregnancy-related, postpartum and emergency services	Yes	‹‹OBRA Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens.›› AFDC – MN, SOC. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
C7	Restricted to pregnancy-related, postpartum and emergency services	No	‹‹OBRA Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens.›› Disabled – MN. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
C8	Restricted to pregnancy-related, postpartum and emergency services	Yes	‹‹OBRA Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens.›› Disabled – MN, SOC. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
C9	Restricted to pregnancy-related, postpartum and emergency services	No	‹‹OBRA Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens.›› Medically Indigent (MI) – Child. Covers MI persons age 21 or younger who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
D1	Restricted to pregnancy-related, postpartum and emergency services	Yes	OBRA Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens. MI – Child, SOC. Covers MI persons age 21 or younger who meet the eligibility requirements of MI. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
D2	Restricted to pregnancy-related, postpartum and emergency services	No	OBRA Non-Citizens – Not PRUCOL and Unverified Citizens – Long Term Care (LTC) services. Covers eligible undocumented non-citizens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the *OBRA* and *IRCA* section in this manual. Aid to the Aged – LTC. Covers persons age 65 or older who are MN and in LTC status. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).* Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
D3	Restricted to pregnancy-related, postpartum and emergency services	Yes	OBRA Non-Citizens – Not PRUCOL and Unverified Citizens – LTC services. Covers eligible undocumented non-citizens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the *OBRA* and *IRCA* section in this manual. Aid to the Aged – LTC, SOC. Covers persons age 65 or older who are MN and in LTC status. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).* Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
D4	Restricted to pregnancy-related, postpartum and emergency services	No	OBRA Non-Citizens – Not PRUCOL and Unverified Citizens – LTC services. Covers eligible undocumented non-citizens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the *OBRA* and *IRCA* section in this manual. Blind – LTC. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).* Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
D5	Restricted to pregnancy-related, postpartum and emergency services	Yes	OBRA Non-Citizens – Not PRUCOL and Unverified Citizens – LTC services. Covers eligible undocumented non-citizens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the *OBRA* and *IRCA* section in this manual. Blind – LTC, SOC. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).* Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
D6	Restricted to pregnancy-related, postpartum and emergency services	No	OBRA Non-Citizens – Not PRUCOL and Unverified Citizens – LTC services. Covers eligible undocumented non-citizens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the *OBRA* and *IRCA* section in this manual. Disabled – LTC. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy support services and therapies).* Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
D7	Restricted to pregnancy-related, postpartum and emergency services	Yes	OBRA Non-Citizens – Not PRUCOL and Unverified Citizens – LTC services. Covers eligible undocumented non-citizens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the *OBRA* and *IRCA* section in this manual. Disabled – LTC, SOC. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).* Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
D8	Restricted to pregnancy-related, postpartum and emergency services	No	OBRA Non-Citizens and Unverified Citizens – Pregnant Woman. Covers eligible pregnant non-citizen women who do not have satisfactory immigration status and unverified citizens. MI – Confirmed Pregnancy. Covers persons age 21 or older, with confirmed pregnancy, who meet the eligibility requirements of MI. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
D9	Restricted to pregnancy-related, postpartum and emergency services	Yes	OBRA Non-Citizens and Unverified Citizens – Pregnant Woman. Covers eligible pregnant non-citizen women who do not have satisfactory immigration status and unverified citizens. MI – Confirmed Pregnancy, SOC. Covers persons age 21 or older, with confirmed pregnancy, who meet the eligibility requirements of MI but are not eligible for 185 percent/200 percent or the MN programs. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
E1	Restricted to pregnancy-related, postpartum and emergency services	Yes	OBRA Non-Citizens – Not PRUCOL and Unverified Citizens – LTC services. Covers eligible undocumented non-citizens in LTC who are not PRUCOL and unverified citizens. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the *OBRA* and *IRCA* section in this manual. Disabled – LTC, SOC. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).* Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
E6	Full	No	Medi-Cal Access Program (MCAP)-linked (Title XXI). Infants and children age zero through one year old in the Medi-Cal Optional Targeted Low-Income Children's Program (OTLICP). Provides full-scope, no-cost Medi-Cal coverage to MCAP-linked infants and children age zero through one year old whose family income is above 213 percent up to and including 266 percent of the Federal Poverty Level (FPL).
E7	Full	No	MCAP (Title XXI). Infants and children age zero through two years old. Provides health care services (medical, dental and vision) through Medi-Cal Managed Care Plans with a premium to children whose family income is above 266 percent up to and including 322 percent of the FPL.
‹‹E8	Full	No	Newborn Gateway Linked Infant-MCAIP (Title XXI). Provides full benefits with no SOC to newborns aged zero to one, born to mothers enrolled in MCAP under 0E in the month of the newborn's birth. Eligibility will continue until the newborn is evaluated for MCAIP by MAXIMUS.››
F3	Limited	No	Adult County Inmate Program (ACIP) (Title XIX). Limited to full scope inpatient hospital and inpatient mental health services only, for inmates in county correctional facilities who receive those services off the grounds of the correctional facility.

‹‹**Aid Codes Master Chart (continued)**››

Code	Benefits	SOC	Program/Description
F4	Restricted	No	ACIP Title (XIX/Title XXI). Restricted to covered inpatient hospital emergency, inpatient mental health emergency (Title XIX) and inpatient pregnancy-related (Title XXI) services only, for undocumented inmates in correctional facilities who receive those services off the grounds of the correctional facility.
G3	Limited	Yes	ACIP (Title XIX). Limited to full scope inpatient hospital and inpatient mental health services only, for inmates in county correctional facilities who receive those services off the grounds of the correctional facility.
G4	Restricted	Yes	ACIP (Title XIX/Title XXI). Restricted to covered inpatient hospital emergency, inpatient mental health emergency (Title XIX), and inpatient pregnancy-related (Title XXI) services only, for undocumented inmates in correctional facilities who receive those services off the grounds of the correctional facility.
G5	Limited	No	Juvenile County Ward Program (JCWP) (Title XIX). Limited to all covered inpatient hospital and inpatient mental health services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.
G6	Restricted	No	JCWP (Title XIX/Title XXI). Restricted to covered inpatient hospital emergency, inpatient mental health emergency (Title XIX), and inpatient pregnancy-related (Title XXI) services only, for undocumented juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.
G7	Limited	Yes	JCWP (Title XIX). Limited to all covered inpatient hospital and inpatient mental health services only, for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.

‹‹**Aid Codes Master Chart (continued)**››

Code	Benefits	SOC	Program/Description
G8	Restricted	Yes	JCWP (Title XIX/Title XXI). Restricted to all covered inpatient hospital emergency, inpatient mental health emergency (Title XIX), and inpatient pregnancy-related (Title XXI) services only, for undocumented juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.
H1	Full	No	Medi-Cal OTLICP (Title XXI). Infants. Provides full-scope, no-cost Medi-Cal coverage for infants age 0 through 12 months old, whose family's household income is above 200 percent up to and including 250 percent of the FPL.
H2	Full	No	Medi-Cal OTLICP (Title XXI). Children age 1 through 6 years old. Provides full-scope, no-cost Medi-Cal coverage to children whose family's household income is above 133 percent up to and including 150 percent of FPL.
H3	Full	No	Medi-Cal OTLICP (Title XXI). Children age 1 through 6 years old. Provides full-scope Medi-Cal coverage with a premium payment to children whose family's household income is above 150 percent up to and including 250 percent of the FPL.
H4	Full	No	Medi-Cal OTLICP (Title XXI). Children age 6 through 19 years old. Provides full-scope, no-cost Medi-Cal coverage to children whose family's household income is above 100 percent up to and including 150 percent of the FPL.
H5	Full	No	Medi-Cal OTLICP (Title XXI). Children age 6 through 19 years old. Provides full-scope Medi-Cal coverage with a premium payment to children whose family's household income is above 150 percent up to and including 250 percent of the FPL.
H6	Full	No	Hospital Presumptive Eligibility (HPE) (Title XXI). Provides full-scope, no cost Medi-Cal coverage for infants age 0 through 12 months old whose family income is 209 up to and including 266 percent of the FPL.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
H7	Full	No	HPE (Title XIX). Provides full-scope, no cost Medi-Cal coverage for children age 1 through 6 years old whose family income is 0 up to and including 142 percent of the FPL.
H8	Full	No	HPE (Title XIX). Provides full-scope, no cost Medi-Cal coverage for children age 6 through 19 years old whose family income is 0 up to and including 133 percent of the FPL
H9	Full	No	HPE (Title XXI). Provides full-scope, no cost Medi-Cal coverage for children age 1 through 6 years old whose family income is 143 up to and including 266 percent of the FPL.
H0	Full	No	HPE (Title XXI). Provides full-scope, no cost Medi-Cal coverage for children age 6 through 19 years old whose family income is above 133 up to and including 266 percent of the FPL.
‹‹I2	Restricted	No	90-Day Pre-Release Services Affordable Care Act (ACA). Grants limited Justice-Involved (JI) pre-release services to incarcerated individuals currently eligible on a 90/10 ACA primary Medi-Cal aid code. Federal financial participation (FFP) is 90 percent federal and 10 percent State General Fund for this aid code. The pre-release eligibility period is up to 90 days prior to the release date. The services must be provided onsite of the facility in which the individual is incarcerated.
I3	Restricted	No	90-Day Pre-Release Services Title XIX. Grants limited Justice-Involved pre-release services to incarcerated individuals currently eligible on a 50/50 Title XIX primary Medi-Cal aid code. FFP is 50 percent federal and 50 percent State General Fund for this aid code. The pre-release eligibility period is up to 90 days prior to the release date. The services must be provided onsite of the facility in which the individual is incarcerated.››

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
‹‹I4	Restricted	No	90-Day Pre-Release Services Title XXI. Grants limited Justice-Involved pre-release services to incarcerated individuals currently eligible on a 65/35 Title XXI Medi-Cal primary aid code. FFP is 65 percent federal and 35 percent State General Fund for this aid code. The pre-release eligibility period is up to 90 days prior to the release date. The services must be provided onsite of the facility in which the individual is incarcerated.
I5	Restricted	No	90-Day Pre-Release Services State Only. Grants limited Justice-Involved pre-release services to incarcerated individuals currently eligible on a 0/100 State General Fund Medi-Cal primary aid code. FFP is 100 percent State General Fund for this aid code. The pre-release eligibility period is up to 90 days prior to the release date. The services must be provided onsite of the facility in which the individual is incarcerated.
I6	Restricted	No	90-Day Pre-Release Services Unsatisfactory Immigration Status (UIS). Grants limited Justice-Involved pre-release services to incarcerated UIS individuals currently eligible on a Title XIX Medi-Cal primary aid code. FFP is Title XIX for emergency services, Title XXI for pregnancy services, and 100 percent State General Fund for in-reach services not covered under emergency or pregnancy. The pre-release eligibility period is up to 90 days prior to the release date. The services must be provided onsite of the facility in which the individual is incarcerated.››

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
J1	Full	No	County Compassionate Release/Medical Probation (CCRP/CMPP) (Title XIX). Recipients eligible for all covered Medi-Cal services.
J2	Full	Yes	CCRP/CMPP (Title XIX). Recipients eligible for all covered Medi-Cal services.
J3	Restricted	No	CCRP/CMPP (Title XIX/Title XXI). Restricted to all undocumented recipients covered for emergency, mental health emergency and pregnancy-related (Title XXI) services only.
J4	Restricted	Yes	CCRP/CMPP (Title XIX/Title XXI). Restricted to all covered for emergency, mental health emergency (Title XIX) and pregnancy-related (Title XXI) services only. For undocumented recipients who do not have satisfactory immigration status.
J5	Limited	No	CCRP/CMPP (Title XIX), SOC for the recipients age 65 or older who reside in LTC facilities. Recipients are eligible for all Medi-Cal covered LTC services only.
J6	Restricted	No	CCRP/CMPP (Title XIX/Title XXI). SOC for undocumented recipients age 65 or older who reside in LTC facilities. Restricted to covered emergency, mental health emergency (Title XIX), and pregnancy-related (Title XXI) services only. Covers all Medi-Cal covered LTC services.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
J7	Limited	No	CCRP/CMPP (Title XIX), SOC for disabled not on supplemental security income (SSI) recipients who reside in LTC facilities. Recipients eligible for all Medi-Cal covered LTC services only.
J8	Restricted	No	CCRP/CMPP (Title XIX/Title XXI), SOC for disabled, not on SSI, undocumented recipients who reside in LTC facilities. Restricted to all Medi-Cal covered emergency, mental health emergency (Title XIX), and pregnancy-related (Title XXI) services only. Covers all Medi-Cal covered LTC services.
K1	Full	No	California Work Opportunity and Responsibility to Kids (CalWORKs) – Single-Parent Safety Net and Drug/Fleeing Felon Family
K6	Full	No	County Compassionate Release Program (CCRP) and County Medical Probation Program (CMPP) (Title XIX). Newly-eligible, citizen/satisfactory immigration status recipients age 19 through 64 years old with income less than or equal to 138 percent of the FPL, including disabled/blind recipients, with income above 128 up to and including 138 percent of the FPL. Recipients eligible for all covered Medi-Cal services, including mental health services.
K7	Restricted	No	CCRP and CMPP (Title XIX/Title XXI). Newly eligible, undocumented recipients age 19 through 64 years old with income less than or equal to 138 percent of the FPL, including disabled/blind recipients, with income above 128 up to and including 138 percent of the FPL. Restricted to all covered emergency services, including labor/delivery and mental health (Title XIX), and all pregnancy-related (Title XXI) services only.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
K8	Full	No	CCRP and CMPP (Title XIX). Not newly-eligible, citizen/satisfactory immigration status recipients age 19 through 64 years old, including disabled/blind recipients without Medicare, with income less than or equal to 128 percent of the FPL. Recipients eligible for all covered Medi-Cal services, including mental health services.
K9	Restricted	No	CCRP and CMPP (Title XIX/Title XXI). Not newly-eligible, undocumented recipients age 19 through 64 years old, including disabled/blind recipients without Medicare, with income less than or equal to 128 percent of the FPL. Restricted to all covered emergency, including mental health (Title XIX) and all covered pregnancy-related (Title XXI) services only.
L1	Full	No	Low Income Health Program (LIHP) Medicaid Covered Expansion (MCE) transition to Medi-Cal (Title XIX). Eligible recipients age 19 through 65 years old enrolled in the LIHP MCE program on December 31, 2013, whose family's income is at or below 138 percent of the FPL.
L6	Full	No	Title XIX. Expansion adults who are disabled/blind, Eligible recipients age 19 up to 65 years old, with income at or below 128 percent of the FPL, and are citizens or lawfully present.
L7	Restricted	No	Title XIX. Expansion adults who are disabled/blind, Eligible recipients age 19 up to 65 years old, with income at or below 128 percent of the FPL, and are undocumented.
M1	Full	No	Title XIX. Adults Eligible recipients age 19 through 65 years old. Provides full-scope, no-cost Medi-Cal coverage to adults with income at or below 138 percent of the FPL.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
M2	Pregnancy, 365-day postpartum, emergency and LTC services	No	Title XIX. Adults Eligible recipients age 19 through 65 years old. Provides the full breadth of medically necessary services during pregnancy and for 365 days postpartum, emergency services and LTC services to undocumented adults with income at or below 138 percent of the FPL. With aid code 76, also provides the full breadth of medically necessary services for 365 days postpartum, in addition to during the pregnancy. The full breadth of medically necessary Medi-Cal services includes medical, dental, specialty mental health, vision and substance use disorder. Contact the county to add aid code 76. **Note:** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).*
M3	Full	No	Title XIX. Parents/caretaker relatives. Provides full-scope, no-cost Medi-Cal coverage to citizens/lawfully present parent/caretaker relatives with income at or below 109 percent of the FPL.
M4	Pregnancy, 365-day postpartum, emergency and LTC services	No	Title XIX. Parents/caretaker relatives. Provides the full breadth of medically necessary services during pregnancy and for 365 days postpartum, emergency services and LTC services to undocumented parents/caretaker relatives with income at or below 109 percent of the FPL. With aid code 76, also provides the full breadth of medically necessary services for 365 days postpartum, in addition to during the pregnancy. The full breadth of medically necessary Medi-Cal services includes medical, dental, specialty mental health, vision and substance use disorder. Contact the county to add aid code 76. **Note:** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).*

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
M5	Full	No	Title XXI. Children age six through 19 years old. Provides full-scope, no-cost Medi-Cal coverage to citizens/lawfully present children with family income of 108 up to and including 133 percent of the FPL.
M6	Restricted to pregnancy-related, postpartum, emergency and LTC services	No	Title XXI. Children age six through 19 years old. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, emergency services and LTC services to undocumented children with family income at 108 up to and including 133 percent of the FPL. **Note:** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).*
M7	Full	No	Title XIX. Pregnancy. Provides full-scope, no-cost Medi-Cal coverage to citizens/lawfully present pregnant individuals with income up to and including 138 percent of the FPL.
M8	Pregnancy, 365-day postpartum, emergency and LTC services.	No	Title XIX. Pregnancy. Provides the full breadth of medically necessary services during pregnancy and for 365 days postpartum, and emergency services to pregnant individuals without satisfactory immigration status with income up to and including 138 percent of the FPL. The full breadth of medically necessary Medi-Cal services includes medical, dental, specialty mental health, vision and substance use disorder. Aid code 76 does not need to be included to receive full breadth of medically necessary services.
M9	Full	No	Title XIX. Pregnancy. Provides full-scope, no-cost Medi-Cal coverage to citizens/lawfully present pregnant individuals with income above 138 up to and including 213 percent of the FPL.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
M0	Pregnancy, 365-day postpartum, emergency and LTC services.	No	Title XIX. Pregnancy. Provides the full breadth of medically necessary services during pregnancy and for 365 days postpartum, and emergency services to pregnant individuals without satisfactory immigration status with income above 138 up to and including 213 percent of the FPL. The full breadth of medically necessary Medi-Cal services includes medical, dental, specialty mental health, vision and substance use disorder. Aid code 76 does not need to be included to receive full breadth of medically necessary services.
N7	Limited	No	ACIP (Title XIX). Adult inmates age 19 through 64 years old in county correctional facilities who receive those services off the grounds of the correctional facility, with income 0 percent to 138 percent FPL. Limited to all covered inpatient hospital and inpatient mental health services only.
N8	Restricted	No	ACIP (Title XIX/Title XXI). Adult inmates age 19 through 64 years old in county correctional facilities who receive those services off the grounds of the correctional facility, with income 0 percent to 138 percent FPL. Restricted to covered undocumented inpatient hospital emergency, inpatient mental health emergency (Title XIX), and inpatient pregnancy-related (Title XXI) services only.
N0	Limited	No	ACIP (Title XIX). Adult inmates age 19 through 64 years old enrolled in the Low Income Health Program on December 31, 2013, with income 0 percent to 138 percent FPL. Limited to inpatient hospital services and inpatient mental health services off the grounds of the correctional facility.
P1	Full	No	HPE (Title XIX). Provides full-scope, no cost Medi-Cal coverage for infants age 0 through 12 months old whose family income is at or below 208 percent of the FPL.
P2	Full	No	HPE (Title XIX). Provides full-scope, no cost Medi-Cal coverage for parent-caretakers with income at or below 109 percent of the FPL.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
P3	Full	No	HPE (Title XIX). Provides full-scope, no cost Medi-Cal coverage for adults age 19 through 65 years old with income at or below 138 percent of the FPL.
P4	Limited to specific prenatal ambulatory services	No	HPE (Title XIX). Provides no cost Medi-Cal coverage limited to specific prenatal ambulatory services for pregnant women with income at or below 213 percent of the FPL.
P5	Full	No	Title XIX. Children age 6 through 19 years old. Provides full-scope, no-cost Medi-Cal coverage with income at or below 133 percent of the FPL.
P6	Restricted to pregnancy-related, postpartum, emergency and LTC services	No	Title XIX. Children age 6 through 19 years old. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, emergency services and LTC services to undocumented children with income at or below 133 percent of the FPL. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy support services and therapies).*
P7	Full	No	Title XIX. Children age 1 through 6 years old. Provides full-scope, no-cost Medi-Cal coverage with income at or below 142 percent of the FPL.
P8	Restricted to emergency and LTC services	No	Title XIX. Children age 1 through 6 years old. Provides emergency and LTC services to undocumented children with income at or below 142 percent of the FPL.
P9	Full	No	Title XIX. Infants age 0 through 12 months old. Provides full-scope, no-cost Medi-Cal coverage with income at or below 208 percent of the FPL.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
P0	Restricted to emergency and LTC services	No	Title XIX. Infants age 0 through 12 months old. Provides emergency and LTC services to undocumented children with income at or below 208 percent of the FPL.
R1	Full	No	Full-scope Medi-Cal benefits with no SOC for non-citizens eligible for the Trafficking and Crime Victims Assistance Program (TCVAP). Covers eligible non-citizen individuals who have been the victim of human trafficking, domestic violence or other serious crimes. TCVAP services and benefits also include English language training, employment-related services and cash assistance. Services and benefits under TCVAP are equivalent to federal benefits available to persons who enter this country with the immigration status of refugee.
T1	Full	No	OTLICP (Title XXI). Children age 6 through 19 years old. Provides full-scope, no cost Medi-Cal benefits to children whose family income is above 160 up to and including 266 percent of the FPL. OTLICP premiums apply.
T2	Full	No	OTLICP (Title XXI). Children age 6 through 19 years old. Provides full-scope, no cost Medi-Cal benefits to children whose family income is above 133 up to and including 160 percent of the FPL.
T3	Full	No	OTLICP (Title XXI). Children age 1 through 6 years old. Provides full-scope, no cost Medi-Cal benefits to children whose family income is above 160 up to and including 266 percent of the FPL. OTLICP premiums apply.
T4	Full	No	OTLICP (Title XXI). Children age 1 through 6 years old. Provides full-scope, no cost Medi-Cal benefits to children whose family income is above 142 up to and including 160 percent of the FPL.
T5	Full	No	OTLICP (Title XXI). Infants age 0 through 12 months old. Provides full-scope, no cost Medi-Cal benefits to children whose family income is above 208 up to and including 266 percent of the FPL.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
T6	Restricted to pregnancy-related, postpartum, emergency and LTC services	No	OTLICP (Title XXI). Children age 6 through 19 years old, without satisfactory immigration status. Provides no cost benefits restricted to pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, emergency services and state-funded LTC services to children whose family income is above 160 up to and including 266 percent of the FPL. OTLICP premiums apply. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).*
T7	Restricted to pregnancy-related, postpartum, emergency and LTC services	No	OTLICP (Title XXI). Children age 6 through 19 years old, without satisfactory immigration status. Provides no cost benefits restricted to pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, emergency services and state-funded LTC services to children whose family income is above 133 up to and including 160 percent of the FPL. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy support services and therapies).*
T8	Restricted to emergency and LTC services	No	OTLICP (Title XXI). Children age 1 through 6 years old, without satisfactory immigration status. Provides no cost benefits restricted to emergency and state-funded LTC services to children whose family income is above 160 up to and including 266 percent of the FPL. OTLICP premiums apply.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
T9	Restricted	No	OTLICP (Title XXI). Children age 1 through 6 years old, without satisfactory immigration status. Provides no cost benefits restricted to emergency and state-funded LTC services to children whose family income is above 142 up to and including 160 percent of the FPL.
T0	Restricted	No	OTLICP (Title XXI). Infants age 0 through 12 months old without satisfactory immigration status. Provides no cost benefits restricted to emergency and state-funded LTC services to children whose family income is above 208 up to and including 266 percent of the FPL.
‹‹V2+	Limited	No	Coronavirus (COVID-19) Uninsured Group – Diagnostic Testing, Testing-Related, and Treatment Services Only – Limited Scope. There are no age, income, or resources limits. Satisfactory immigration status is not required. Provides limited scope benefits to California residents seeking diagnostic testing, testing-related services and treatment related services. Including all medically necessary care such as associated office, clinic, inpatient or emergency room visit related to COVID-19.
0A	Full	No	Refugee Cash Assistance. Covers all eligible refugees during their first eight months in the United States, including unaccompanied children who are not subject to the eight-month limitation. This population is the same as aid code 01, except that they are exempt from grant reductions on behalf of the Assistance Payments Demonstration Project/California Work Pays Demonstration Project.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
0C	HF services only (no Medi-Cal)	No	MCAP. Infants enrolled in HF whose family's income is 200 up to and including 300 percent of the FPL, born to a mother enrolled in MCAP. The infant's enrollment in HF is based on the mother's participation in MCAP.
0E	Full	No	MCAP (Title XXI). Provides full-scope, no SOC health care services (medical, dental and vision), through the Medi-Cal managed care delivery system, to pregnant women who are California residents with a modified adjusted gross income (MAGI) above 213 percent and up to and including 322 percent of the FPL. This code is not valid for an infant using the mother's ID.
0G	Full	No	MCAP (Title XXI). Provides full-scope, no SOC health care services (medical, dental, and vision), through fee-for-service Medi-Cal, to pregnant women who are California residents with a MAGI above 213 percent and up to and including 322 percent of the FPL. This code is not valid for an infant using the mother's ID.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
0L	Restricted to pregnancy-related, postpartum, emergency and LTC services	No	Breast and Cervical Cancer Treatment Program (BCCTP) Transitional coverage until the County makes a determination of Medi-Cal eligibility. It covers: • BCCTP recipients formerly in aid code 0U, without satisfactory immigration status, who are no longer in need of treatment, and/or have creditable health coverage and are not eligible for state-funded BCCTP. • BCCTP recipients formerly in aid code 0V, without satisfactory immigration status, who have turned 65 years old, have other health coverage (OHC), and/or are no longer in need of treatment and have exhausted their 18-month (breast cancer) or 24-month (cervical cancer) time limit. • BCCTP recipients formerly in aid code 0X with creditable health coverage who have exhausted their 18 months (breast cancer) or 24 months (cervical cancer) of state eligibility. • BCCTP recipients formerly in aid code 0Y, age 65 or older who have exhausted their 18 months (breast cancer) or 24 months (cervical cancer) of state eligibility. Recipients eligible only for transitional federal pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, emergency services and state-only LTC services. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the recipient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).*
0M	Full	No	BCCTP – Accelerated Enrollment (AE). Provides temporary AE for full-scope, no SOC Medi-Cal for eligible individuals age 65 or younger who have been diagnosed with breast and/or cervical cancer. Limited to two months.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
0N	Full	No	BCCTP – AE. Provides temporary AE for full-scope, no SOC Medi-Cal while an eligibility determination is made for eligible individuals age 65 or younger without creditable health coverage who have been diagnosed with breast and/or cervical cancer.
0P	Full	No	BCCTP. Provides full-scope, no SOC Medi-Cal for eligible individuals age 65 or younger who are diagnosed with breast and/or cervical cancer and are without creditable insurance coverage. They remain eligible while still in need of treatment and meet all other eligibility requirements.
0R	Restricted Services	No	BCCTP – High Cost OHC. State-funded. Provides payment of premiums, co-payments, deductibles and coverage for non-covered cancer-related services for eligible all-age individuals, including undocumented non-citizens, who have been diagnosed with breast and/or cervical cancer, if premiums, co-payments and deductibles are greater than $750. Breast cancer-related services covered for 18 months. Cervical cancer-related services covered for 24 months.
0T	Restricted Services	No	BCCTP – State-funded. Provides 18 months of breast cancer treatments and 24 months of cervical cancer treatments for eligible individuals age 65 or older, regardless of citizenship, who have been diagnosed with breast and/or cervical cancer. Does not cover individuals with expensive, creditable insurance. Breast cancer-related services covered for 18 months. Cervical cancer-related services covered for 24 months.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
0U	Restricted to pregnancy-related, postpartum, emergency and LTC services	No	BCCTP – Undocumented Non-Citizens. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, emergency services and LTC services to individuals age 65 or younger with unsatisfactory immigration status who have been diagnosed with breast and/or cervical cancer. Does not cover individuals with creditable insurance. State-funded cancer treatment services are covered for 18 months (breast) and 24 months (cervical). ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the recipient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).*
0V	Restricted to pregnancy-related, postpartum, emergency and LTC services	No	Post-BCCTP. Provides limited-scope no SOC Medi-Cal pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, emergency services and LTC services for individuals age 65 or younger with unsatisfactory immigration status and without creditable health insurance coverage who have exhausted their 18-month (breast) or 24-month (cervical) period of cancer treatment coverage under aid code 0U. No cancer treatment. Continues as long as the individual is in need of treatment and, other than immigration, meets all other eligibility requirements. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the recipient's day-to-day plan of care in the LTC facility (for example, pharmacy support services and therapies).*

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
0W	Full	No	BCCTP Transitional Coverage. Covers recipients formerly in aid code 0P who no longer meet federal BCCTP requirements due to reaching age 65, are no longer in need of treatment for breast and/or cervical cancer, or have obtained creditable health coverage. Recipients in aid code 0W will continue to receive transitional full-scope Medi-Cal services until the county completes an eligibility determination for other Medi-Cal programs.
0X	Restricted to pregnancy-related, postpartum, emergency and LTC services	No	BCCTP Transitional Coverage. Covers recipients formerly in aid code 0U who do not have satisfactory immigration status, have obtained creditable health coverage, still require treatment for breast and/or cervical cancer and have not exhausted their 18 months (breast cancer) or 24 months (cervical cancer) of coverage under state-funded BCCTP. Recipients eligible only for transitional pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, emergency services, state-only LTC services, and co-pays, deductibles and/or non-covered breast and/or cervical cancer treatment and related services. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).*

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
0Y	Restricted to pregnancy-related, postpartum, emergency and LTC services	No	BCCTP Transitional Coverage. Covers recipients formerly in aid code 0U who do not have satisfactory immigration status, have reached 65 years old, still require treatment for breast and/or cervical cancer and have not exhausted their 18 months (breast cancer) or 24 months (cervical cancer) state-funded BCCTP. Recipients eligible only for transitional pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, emergency services, state-only LTC services, and state-funded cancer treatment and related services. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).*
02	Full	No	Refugee Medical Assistance (RMA)/Entrant Medical Assistance. Covers eligible refugees and entrants who are not eligible for Medi-Cal or HF and do not qualify for or want cash assistance.
03	Full	No	Adoption Assistance Program (AAP). Covers children receiving federal cash grants under Title IV-E to facilitate the adoption of hard-to-place children who would require permanent foster care (FC) placement without such assistance.
04	Full	No	AAP/Aid for Adoption of Children (AAC). Covers children receiving cash grants under the state-only AAP/AAC program.
06	Full	No	AAP Child. Covers children receiving federal AAP cash subsidies from out of state. Provides eligibility for Continuous Eligibility for Children (CEC) if for some reason the child is no longer eligible under AAP prior to his/her 18th birthday.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
07	Full	No	Title IV-E Extended AAP/FFP Medi-Cal. AAP Federal: A cash grant program to facilitate the ongoing adoptive placement of hard-to-place non-minors, whose initial AAP payment occurred on or after age 16 and are over age 18 but under age 21 and participating in one of five conditions who would require permanent FC placement without such assistance.
08	Full	No	Entrant Cash Assistance (ECA). Covers Cuban/Haitian entrants during their first eight months in the United States who are receiving ECA benefits, including unaccompanied children who are not subject to the eight-month provision.
1E	Full	No	Craig v. Bonta Aged Pending SB 87 Redetermination. Covers former Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipients who are aged, until the county redetermines their Medi-Cal eligibility.
1H	Full	No	FPL – Aged. Covers the aged in the Aged and Disabled (A&D) FPL program.
1U	Restricted to pregnancy-related, postpartum and emergency services	No	Restricted FPL – Aged. Covers the aged in the A&D FPL program that do not have satisfactory immigration status. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
1X	Full	No	Aid to the Aged – Multipurpose Senior Services Program (MSSP). Allows special institutional deeming rules (spousal impoverishment) for MSSP transitional and non-transitional services individuals ‹‹age 60 or older.››
1Y	Full	Yes	Aid to the Aged – MSSP. Allows special institutional deeming rules (spousal impoverishment) for MSSP transitional and non-transitional services for individuals ‹‹age 60 or older.››.
10	Full	No	Aid to the Aged – SSI/SSP.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
13	Full	Y/N	Aid to the Aged – LTC. Covers individuals age 65 or older who are MN and in LTC status.
14	Full	No	Aid to the Aged – MN.
16	Full	No	Aid to the Aged – Pickle Eligibles.
17	Full	Yes	Aid to the Aged – MN, SOC.
18	Full	No	Aid to the Aged – In-Home Support Services (IHSS).
2A	Full	No	Abandoned Baby Program. Provides full-scope benefits to children up to three months of age who were voluntarily surrendered within 72 hours of birth pursuant to the Safe Arms for Newborns Act.
2C	Full	No	County Children's Health Initiative Program (CCHIP). Provides county-specific, full-scope medical, dental, mental health and vision benefits to children 18 years of age or younger with a modified adjusted gross income above 266 and up to and including 322 percent of the U.S. Department of Health and Human Services (HHS) poverty guidelines.
2E	Full	No	Craig v. Bonta Blind – Pending SB 87 Redetermination. Covers former SSI/SSP recipients who are blind, until the county redetermines their Medi-Cal eligibility.
2H	Full	No	Blind – Federal Poverty Level – covers blind individuals in the FPL for the Blind Program.
2P	Full	No	Approved Relative Caregiver (ARC) Program. Medi-Cal coverage for foster children and youth age 18 or younger (eligibility ends on the last day of the month of their 18th birthday) participating in the ARC Program who do not qualify for state CalWORKs.
2R	Full	No	ARC Program – Non-Minor Dependent (NMD). Medi-Cal coverage for foster youth age 18 through 21 years old (eligibility ends on the last day of the month of their 21st birthday) participating in the ARC Program as a NMD who does not qualify for state CalWORKs.
2S	Full	No	ARC Program – Federal CalWORKs. Medi-Cal coverage for foster children and youth age 18 or younger (eligibility ends on the last day of the month of their 18th birthday) participating in the ARC Program who qualify for federal CalWORKs.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
2T	Full	NO	ARC Program – State CalWORKs. Medi-Cal coverage for foster children and youth age 18 or younger (eligibility ends on the last day of the month of their 18th birthday) participating in the ARC Program who qualify for state CalWORKs.
2U	Full	No	ARC Program – State CalWORKs NMD. Medi-Cal coverage for foster youth age 18 through 21 years old (eligibility ends on the last day of the month of their 21st birthday) participating in the ARC Program as a NMD who qualifies for state CalWORKs.
2V	Full	No	TCVAP. Refugee Medical Assistance (RMA). Covers non-citizen victims of human trafficking, domestic violence and other serious crimes.
20	Full	No	Blind – SSI/SSP – Cash.
23	Full	Y/N	Blind – LTC.
24	Full	No	Blind – MN.
26	Full	No	Blind – Pickle Eligibles.
27	Full	Yes	Blind – MN, SOC.
28	Full	No	Blind – IHSS.
3A	Full	No	CalWORKs Timed-Out, Safety Net – All Other Families.
3C	Full	No	CalWORKs Timed-Out, Safety Net – Two-Parent Families.
3D	Full	No	CalWORKs – Pending, Medi-Cal Eligible.
3E	Full	No	CalWORKs – Legal Immigrant – Family Group.
3F	Full	No	CalWORKs – Two-Parent Safety Net and Drug/Fleeing Felon Family.
3G	Full	No	CalWORKs – Zero Parent Exempt.
3H	Full	No	CalWORKs – Zero Parent Mixed.
3L	Full	No	CalWORKs – Legal Immigrant – Aid to Families.
3M	Full	No	CalWORKs – Legal Immigrant – Two Parent.
3N	Full	No	AFDC – Section 1931(b). Non-CalWORKs.
3P	Full	No	CalWORKs – All Families – Exempt.
3R	Full	No	CalWORKs – Zero Parent – Exempt.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
3T	Restricted to pregnancy-related, postpartum and emergency services	No	Initial Transitional Medi-Cal (TMC). Provides six months of coverage for eligible non-citizens without satisfactory immigration status who have been discontinued from Section 1931(b) due to increased earnings from employment.
3U	Full	No	CalWORKs – Legal Immigrant – Two Parent Mixed.
3V	Restricted to pregnancy-related, postpartum and emergency services	No	AFDC – Section 1931(b) Non CalWORKs. Covers those eligible for the Section 1931(b) program who do not have satisfactory immigration status. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
3W	Full	No	Temporary Assistance for Needy Families (TANF) Timed-Out, Mixed Case.
30	Full	No	CalWORKs – All Families.
32	Full	No	TANF Timed-Out.
33	Full	No	CalWORKs – Zero Parent.
34	Full	No	AFDC – MN.
35	Full	No	CalWORKs – Two Parent.
36	Full	No	Aid to Disabled Widow(er)s.
37	Full	Yes	AFDC – MN, SOC.
38	Full	No	Edwards v. Kizer.
39	Full	No	Initial TMC (6 months). Provides six months of coverage for those discontinued from CalWORKs or the Section 1931(b) program due to increased earnings or increased hours of employment.
4A	Full	No	Out-of-State AAP. Covers children for whom there is a state-only AAP agreement between any state other than California and adoptive parents.
4E	Full	No	HPE (Title XIX). Covers former foster care children age 26 or younger with no income screening.
4F	Full	No	Kinship Guardianship Assistance Payment (Kin-GAP) Cash Assistance. Covers children in the federal program for children in relative placement receiving cash assistance.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
4G	Full	No	Kin-GAP Cash Assistance. Covers children in the state program for children in relative placement receiving cash assistance.
4K	Full	No	Emergency Assistance (EA) FC. Covers juvenile probation cases placed in FC.
4L	Full	No	FC children in Section 1931(b).
4M	Full	No	Former Foster Youth (FFY).
4N	Full	No	CalWORKs for NMD/FFP Medi-Cal.
4S	Full	No	Title IV-E Extended for NMD Kin-GAP/FFP Medi-Cal.
4T	Full	No	A federal Title IV-E Kin-GAP that serves former and current foster youth by moving them from FC placements to more permanent placement options through the establishment of a relative guardianship.
4V	Full	Yes	TCVAP – RMA. Covers non-citizen victims of human trafficking, domestic violence and other serious crimes.
4W	Full	No	State Extended for NMC Kin-GAP/FFP Medi-Cal.
40	Full	No	AFDC-FC. Covers children on whose behalf financial assistance is provided for state only FC placement.
42	Full	No	AFDC-FC. Covers children on whose behalf financial assistance is provided for federal FC placement.
43	Full	No	State Extended FC/FFP Medi-Cal. AFDC-FC State: Covers non-minor dependents (NMDs), age 18 through 21 years old, under AB 12 on whose behalf financial assistance is provided for state-only FC placement.
44	Restricted to pregnancy-related and postpartum services	No	213 Percent FPL Pregnant (Income Disregard Program – Pregnant). Provides eligible pregnant women of any age with family planning, pregnancy-related services, including services for conditions that may complicate the pregnancy, and postpartum services if family income is at or below 213 percent of the FPL.
45	Full	No	FC. Covers children supported by public funds other than AFDC-FC.
46	Full	No	Interstate Compact on the Placement of Children – Child. Covers foster children placed in California from another state. Provides eligibility for CEC if for some reason the child is no longer eligible under FC prior to his/her 18th birthday. Also provides eligibility for the FFY program (aid code 4M) at age 18.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
47	Full	No	200 Percent FPL Infant (Income Disregard Program – Infant). Provides full Medi-Cal benefits to eligible infants age 0 through 12 months old or continues beyond 1 year when inpatient status, which began before first birthday, continues and family income is at or below 200 percent of the FPL.
48	Restricted to family planning, pregnancy-related, and postpartum services	No	213 Percent FPL Pregnant OBRA (Income Disregard Program – Pregnant OBRA). Provides eligible pregnant non-citizens of any age without satisfactory immigration status with family planning, pregnancy-related services, including services for conditions that may complicate the pregnancy, and postpartum services if family income is at or below 213 percent of the FPL.
49	Full	No	Title IV-E Extended FC/FFP Medi-Cal. AFDC-FC Federal: Covers NMDs age 18 through 21 years old, under AB 12 on whose behalf financial assistance is provided for federal FC placement.
5C	Full	No	Medi-Cal Presumptive Eligibility (PE) (Title XXI), Healthy Families Program (HFP) Transitional Children. Provides no cost, full-scope Medi-Cal coverage with no premium payment for children whose family's income is at or below 150 percent of the FPL during the transition period by the state until the annual eligibility review by the county.
5D	Full	No	Medi-Cal PE (Title XXI), HFP Transitional Children. Provides full-scope Medi-Cal coverage with a premium payment for children whose family's income is above 150 percent up to and including 250 percent of the FPL during the transition period by the state until the annual eligibility review by the county.
5E	Full	No	HFP to the Medi-Cal PE program. Provides immediate, temporary, fee-for-service (FFS), full-scope Medi-Cal benefits to certain children age 19 or younger.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
5F	Restricted to pregnancy-related, postpartum and emergency services	Y/N	‹‹OBRA Non-Citizen – Pregnant Woman. Covers eligible pregnant non-citizen women who do not have satisfactory immigration status. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
5J	Restricted to family planning, pregnancy-related, and postpartum services	No	SB 87 Pending Disability Program. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
5K	Full	No	EA FC. Covers child welfare cases placed in EA foster care.
5L	Full	No	Emergency assistance foster care. For children, youth and non-minor dependents (NMDs) up to age 21 if they do not meet eligibility requirements for the federal Emergency Assistance Foster Care (EA-TANF) program, aid code 5K.
5T	Restricted to pregnancy-related, postpartum and emergency services	No	Continuing TMC. Provides an additional six months of emergency services coverage for those beneficiaries who received six months of initial TMC coverage under aid code 3T. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
5V	Full	No	TCVAP. Covers non-citizen victims of human trafficking, domestic violence and other serious crimes.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
5W	Restricted to pregnancy-related, postpartum and emergency services	No	Four-Month Continuing (FMC) Pregnancy and Emergency Services Only. Provides four months of pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, and emergency services for non-citizens without satisfactory immigration status who are no longer eligible for Section 1931(b) due to the collection or increased collection of child/spousal support.
50	Full	‹‹Y/N››	County Medical Services Program (CMSP).
53	Restricted to LTC and related services	Yes	MI – LTC services. Covers eligible persons age 21 through 65 years old who are residing in a Nursing Facility Level A or B with or without SOC. For more information about LTC services, refer to the County Medical Services Program (CMSP) section in this manual. **Note:** LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).
54	Full	No	FMC Eligibility. Covers persons discontinued from CalWORKs or Section 1931(b) due to the increased collection of child/spousal support.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
55	Restricted to pregnancy-related, postpartum and emergency services	No	OBRA Not PRUCOL – LTC services. Covers eligible undocumented non-citizens in LTC who are not PRUCOL. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the *OBRA* and *IRCA* section in this manual. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services. ***Note:*** *LTC services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support services and therapies).*
58	Restricted to pregnancy-related, postpartum and emergency services	Y/N	OBRA Non-Citizens. Covers eligible non-citizens who do not have satisfactory immigration status. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
59	Full	No	Continuing TMC (6 months). Provides an additional six months of TMC for beneficiaries who had six months of initial TMC coverage under aid code 39.
6A	Full	No	Disabled Adult Child(ren) (DAC) Blind.
6C	Full	No	DAC Disabled.
6E	Full	No	Craig v. Bonta Disabled – Pending SB 87 redetermination. Covers former SSI/SSP recipients who are disabled, until the county redetermines their Medi-Cal eligibility.
6G	Full	No	250 Percent Working Disabled Program.
6H	Full	No	Disabled – FPL. Covers the disabled in the A&D FPL program.

‹‹Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
6J	Full	No	SB 87 Pending Disability. Covers with no SOC beneficiaries age 21 through 65 years old who have lost their non-disability linkage to Medi-Cal and are claiming disability.
6N	Full	No	Former SSI No Longer Disabled in SSI Appeals Status.
6P	Full	No	Personal Responsibility and Work Opportunity Reconciliation Act/
6R	Full	Yes	SB 87 Pending Disability (SOC). Covers with an SOC those age 21 through 65 years old who have lost their non-disability linkage to Medi-Cal and are claiming disability.
6U	Restricted to pregnancy-related, postpartum and emergency services	No	Restricted FPL – Disabled. Covers the disabled in the A&D FPL program who do not have satisfactory immigration status. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
6V	Full	No	Department of Developmental Services (DDS) Waivers (No SOC).
6W	Full	Yes	DDS Waivers (SOC).
6X	Full	No	Medi-Cal In-Home Operations (IHO) Waiver (No SOC).
6Y	Full	Yes	Medi-Cal IHO Waiver (SOC).
60	Full	No	Disabled – SSI/SSP – Cash.
63	Full	Y/N	Disabled – LTC.
64	Full	No	Disabled – MN.
65	Full	Y/N	Katrina-Covers eligible evacuees of Hurricane Katrina.
66	Full	No	Disabled – Pickle Eligibles.
67	Full	Yes	Disabled – MN, SOC.
68	Full	No	Disabled – IHSS.
69	Restricted to emergency services	No	200 Percent Infant OBRA. Provides emergency services only for eligible infants without satisfactory immigration status who are age 0 through 12 months old or beyond 1 year when inpatient status, which began before 1st birthday, continues and family income is at or below 200 percent of the FPL.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
7A	Full	No	100 Percent Child. Provides full benefits to otherwise eligible children, age 6 through 18 years old or beyond 19 when inpatient status began before the 19th birthday and family income is at or below 100 percent of the FPL.
7C	Restricted to pregnancy-related, postpartum and emergency services	No	100 Percent OBRA Child. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services to otherwise eligible children, without satisfactory immigration status who are age 6 through 18 years old or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the FPL.
7D	Full	No	Hospital Presumptive Eligibility (HPE). Provides eligibility for those age 65 or older who are at or below 138 percent of the federal poverty level. 7D is not eligible for LEA.
7F	Valid for pregnancy verification office visit	No	PE – Pregnancy Verification. This option allows the Qualified Provider (QP) to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7F is valid for pregnancy test, initial visit, and services associated with the initial visit. Persons placed in 7F have pregnancy test results that are negative.
7G	Valid only for specific ambulatory prenatal care services	No	PE – Ambulatory Prenatal Care. This option allows the QP to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7G is valid for specific Ambulatory Prenatal Care Services. Persons placed in 7G have self-attested to the pregnancy or have a pregnancy test result that is positive. QP issues a paper Immediate Needs Card.
7H	Valid only for TB-related outpatient services	No	Tuberculosis (TB) Program. Covers eligible individuals who are TB-infected for TB-related outpatient services only.
7J	Full	No	CEC. Provides full-scope benefits to children age 19 or younger who would otherwise lose their no SOC Medi-Cal.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
7K	Restricted to pregnancy-related, postpartum and emergency services	No	CEC. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services with no SOC to children without satisfactory immigration status who are age 19 old who would otherwise lose their no SOC Medi-Cal.
7M	Valid for Minor Consent services	Y/N	‹‹Medi-Cal Minor Consent Services.›› Covers eligible minors age 12 through 21 years old. Limited to services related to Sexually Transmitted Diseases (STDs), sexual assault, drug and alcohol abuse, and family planning. Paper Immediate Needs Card issued.
7N	Valid for Minor Consent services, limited to pregnancy-related and postpartum services	No	‹‹Medi-Cal Minor Consent Services.›› Covers eligible pregnant minors age 21 or younger. Limited to pregnancy-related services, including services for conditions that may complicate the pregnancy and postpartum services. Paper Immediate Needs Card issued.
7P	Valid for Minor Consent services	Y/N	‹‹Medi-Cal Minor Consent Services.›› Covers eligible minors age 12 through 21 years old. Limited to services related to STDs, sexual assault, drug and alcohol abuse, family planning, and outpatient mental health treatment. Paper Immediate Needs Card issued.
7R	Valid for Minor Consent services	Y/N	‹‹Medi-Cal Minor Consent Services.›› Covers eligible minors age 12 or younger. Limited to services related to family planning and sexual assault. Paper Immediate Needs Card issued.
7S	Full	No	Express Lane Enrollment (ELE) (Title XIX). CalFresh (CF) parents from age 19 through 65 years old who are neither blind nor disabled. Full-scope, no cost Medi-Cal coverage.
7T	Full	No	ELE – National School Lunch Program (NSLP).

‹‹**Aid Codes Master Chart (continued)**

Code	Benefits	SOC	Program/Description
7U	Full	No	ELE (Title XIX). CF adults from age 19 through 65 years old who are citizens or lawfully present, and neither blind nor disabled.
7V	Full	Yes	TCVAP. Covers non-citizen victims of human trafficking, domestic violence and other serious crimes.
7W	Full	No	ELE (Title XIX). CF children ages 19 or younger who are neither blind nor disabled. Full-scope, no cost Medi-Cal coverage.
71	Restricted to dialysis and supplemental dialysis-related services	Y/N	Medi-Cal Dialysis Only Program/Medi-Cal Dialysis Supplement Program. Covers eligible persons of any age who are eligible only for dialysis and related services.
72	Full	No	133 Percent Program. Provides full Medi-Cal benefits to eligible children ages one through five years old or beyond 6 when inpatient status, which began before sixth birthday, continues and family income is at or below 133 percent of the FPL.››

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
73	Restricted to parenteral hyper-alimentation and related expenses	Y/N	Total Parenteral Nutrition. Covers eligible persons of any age who are eligible for parenteral hyperalimentation and related services and persons of any age who are eligible under the MN or MI programs.
74	Restricted to emergency services	No	133 Percent Program (OBRA). Provides emergency services only for eligible children without satisfactory immigration status who are age 1 through 5 years old or beyond 6 when inpatient status, which began before 6th birthday, continues and family income is at or below 133 percent of the FPL.
76	The full breadth of medically necessary services	No	365-Day Postpartum Program. Provides Medi-Cal at no SOC to individuals who, while pregnant, received active eligibility under Medi-Cal. They continue to be eligible for the full breadth of medically necessary services throughout the pregnancy and 365 days postpartum. This coverage ends the last day of the month in which the 365th day occurs. The full breadth of medically necessary Medi-Cal services includes medical, dental, specialty mental health, vision and substance use disorder.
77	Limited to organ transplant anti-rejection medication only	No	Organ transplants: Anti-rejection medications program.
8E	Full	No	Accelerated Enrollment. Provides immediate, temporary, fee-for-service, full-scope Medi-Cal benefits

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
8F	CMSP acute inpatient services only	Y/N	CMSP Companion Aid Code. Used in conjunction with Medi-Cal aid code 53. Aid Code 8F will appear as a special aid code and will entitle the eligible client to acute inpatient services only while residing in a Nursing Facility Level A or B. For more information about LTC services, refer to the *County Medical Services Program (CMSP)* section in this manual.
8G	Full	No	Severely Impaired Working Individual.
8H	Family Planning	N/A	Family Planning, Access, Care and Treatment (Family PACT). Comprehensive family planning services for low income residents of California with no other source of health care coverage. Health Access Plan card issued.
8L	Full	No	Accelerated Enrollment. Provides immediate, temporary, fee-for-service, full-scope Medi-Cal benefits for adults 19 years of age or older.
‹‹8M	CMSP services only (no Medi-Cal)	No	CMSP mCase No SOC is a CMSP aid code. There are no Medi-Cal benefits, and this aid code is not a companion aid code to Medi-Cal. The recipients eligible for this aid code reside in a CMSP-participating county, are ages 21 to 64, 138 percent Federal Poverty Level (FPL) or below, documented or undocumented with no share of cost and have full scope CMSP benefits.››
8N	Restricted to emergency services	No	133 Percent Excess Property Child – Emergency Services Only. Provides emergency services only for eligible children without satisfactory immigration status who are age one through five years old or beyond six when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the FPL.
8P	Full	No	133 Percent Excess Property Child. Provides full-scope Medi-Cal benefits to eligible children ages one through five years old or beyond six when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the FPL.
8R	Full	No	100 Percent Excess Property Child. Provides full-scope benefits to otherwise eligible children, age six through 18 years old or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the FPL.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
‹‹8S	CMSP services only (no Medi-Cal)	Yes	CMSP mCase - SOC is a CMSP aid code. There are no Medi-Cal benefits, and this aid code is not a companion aid code to Medi-Cal. The recipients eligible for this aid code reside in a CMSP-participating county, are ages 21 to 64, above 138 percent and not more than 300 percent FPL, documented or undocumented with share of cost and have full scope CMSP benefits.››
8T	Restricted to pregnancy-related, postpartum and emergency services	No	100 Percent Excess Property Child – Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services to otherwise eligible children without satisfactory immigration status who are age six through 18 years old or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the FPL.
8U	Full	No	Children's Presumptive Eligibility (CPE) or Newborn Gateway Deemed Infant. Provides full-scope, no SOC Medi-Cal benefits for infants born to mothers who were enrolled in Medi-Cal with no SOC in the month of the infant's birth.
8W	Full	No	CPE zero to 19. Provides for the pre-enrollment of children who are screened as probable for Medi-Cal eligibility, including children with unsatisfactory immigration status. Provides temporary full-scope Medi-Cal benefits with no SOC.
8X	Full	No	CPE Title XXI Medi-Cal PE, Targeted Low-Income FPL for Children (Medicaid-Children's Health Insurance Program Title XXI). Provides for the pre-enrollment of children who are screened as probable for Medi-Cal eligibility, including children with unsatisfactory immigration status. Provides temporary full-scope Medi-Cal benefits with no SOC.
80	Restricted to Medicare expenses	No	Qualified Medicare Beneficiary. Provides payment of Medicare Part A premium and Part A and B coinsurance and deductibles for eligible low income aged, blind or disabled individuals.
81	Full	Y/N	MI – Adults Aid Paid Pending.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
82	Full	No	MI – Child. Covers MI individuals age 21 or younger who meet the eligibility requirements of medical indigence. Covers persons until the age of 22 who were in an institution for mental disease before age 21. Persons may continue to be eligible under aid code 82 until age 22 if they have filed for a State hearing.
83	Full	Yes	MI – Child SOC. Covers MI individuals age 21 or younger who meet the eligibility requirements of MI.
84	CMSP services only (no Medi-Cal)	No	MI – Adult. Covers MI adults age 21 through 64 years old who meet the eligibility requirements of MI.
85	CMSP services only (no Medi-Cal)	Yes	MI – Adult. Covers MI adults age 21 through 65 years old who meet the eligibility requirements of MI.
86	Full	No	MI – Confirmed Pregnancy. Covers individuals age 21 or older, with confirmed pregnancy, who meet the eligibility requirements of MI.
87	Full	Yes	MI – Confirmed Pregnancy SOC. Covers individuals age 21 or older, with confirmed pregnancy, who meet the eligibility requirements of MI but are not eligible for 185 percent/200 percent or the MN programs.
88	CMSP services only (no Medi-Cal)	No	MI – Adult – Disability Pending. Covers MI adults age 21 through 65 years old who meet the eligibility requirements of MI and have a pending Medi-Cal disability application.
89	CMSP services only (no Medi-Cal)	Yes	MI – Adult – Disability Pending SOC. Covers MI adults age 21 through 65 years old who meet the eligibility requirements of MI and have a pending Medi-Cal disability application.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
9A	EWC only (no Medi-Cal)	No	Every Woman Counts (EWC) recipient identifier. EWC offers benefits to uninsured and underinsured women whose household income is at or below 200 percent of the FPL. EWC offers reimbursement for screening, diagnostic and case management services. ***Note:*** *EWC and Medi-Cal are separate programs; however, EWC relies on the Medi-Cal billing process (with few exceptions).*
9D	CCS-only (no Medi-Cal)	No	California Children's Services (CCS)-only. Children who meet CCS eligibility requirements, but are not Medi-Cal recipients. Assigned only to CCS enrollees of specified CCS 1115 Waiver Demonstration Projects.
9J	GHPP	No	Genetically Handicapped Persons Program (GHPP)-eligible. Eligible for GHPP benefits and case management.
9K	CCS	No	CCS-eligible. Eligible for all CCS benefits (such as diagnosis, treatment, therapy and case management).
9M	CCS MTP only	No	Eligible for CCS Medical Therapy Program (MTP) services only.
9N	CCS Case Management	No	Eligible for CCS only if concurrently eligible for full-scope, no SOC Medi-Cal. CCS authorization required.
9R	CCS	No	CCS-eligible HF child. A child in this program is enrolled in a HF plan and is eligible for all CCS benefits (such as diagnosis, treatment, therapy and case management). The child's county of residence has no cost sharing for the child's CCS services.

Aid Codes Master Chart (continued)

Code	Benefits	SOC	Program/Description
9U	CCS	No	CCS-eligible HF child. A child in this program is enrolled in a HF plan and is eligible for all CCS benefits (such as diagnosis, treatment, therapy and case management). The child's county of residence has county cost sharing for the child's CCS services.
9V	PFC/PPCW	No	CCS-eligible Partners for Children/Pediatric Palliative Care Waiver (PFC/PPCW) program participant. A child assigned this aid code has met the requirements for, and is enrolled in the PFC/PPCW program. Loss of Medi-Cal eligibility will result in the discontinuance of state-funded services and waiver benefits. **Note**: The PPCW program was terminated in 2019. Providers may refer to the Palliative Care section of the Medi-Cal Provider Manual for current policy on palliative care.
9W	PFC/PPCW	No	CCS-eligible PFC/PPCW program participant. A child assigned this aid code has met the requirements for, and is enrolled in both CCS and the PFC/PPCW program. Loss of Medi-Cal eligibility will result in the discontinuance of waiver benefits and reassignment to an appropriate non-waiver based CCS aid code for the child by the responsible CCS county program. **Note:** The PPCW program was terminated in 2019. Providers may refer to the Palliative Care section of the Medi-Cal Provider Manual for current policy on palliative care.

Special Share of Cost (SOC) Case Indicators:

These indicators, which appear on a recipient's SOC Case Summary Form, are used to identify the following:

- **IE – Ineligible:** A person who is IE for Medi-Cal benefits in the case. An IE person may only use medical expenses to meet the SOC for other family members associated within the same case. Upon certification of the SOC, the IE individual is not eligible for Medi-Cal benefits in this case. An IE person may be eligible for Medi-Cal benefits in another case where the person is not identified as IE.
- **RR – Responsible Relative:** An RR is allowed to use medical expenses to meet the SOC for other family members for whom he/she is responsible. Upon certification of the SOC, an RR individual is not eligible for Medi-Cal benefits in this Medi-Cal Budget Unit (MBU). The individual may be eligible for Medi-Cal benefits in another MBU where the person is not identified as RR.

For more information, refer to the *Share of Cost (SOC)* section of the Part 1 manual.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Providers may access the Hearing Aid Coverage for Children Program page for more information.
+	Effective on June 1, 2023, aid code V2 is end-dated.

Date of Hearing: May 10, 2023

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Chris Holden, Chair
AB 1402 (Megan Dahle) – As Amended March 30, 2023

Policy Committee: Public Safety Vote: 8 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill requires that costs of the medical evidentiary examination of a victim of physical child abuse or neglect be submitted by specified medical examiners for reimbursement by the Office of Emergency Services (OES), rather than charged directly or indirectly to the victim.

Specifically, this bill:

1) Prohibits costs for the medical evidentiary portion of the examination from being charged directly or indirectly to the victim of child physical abuse or neglect.

2) Provides that each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Team (SART), Sexual Assault Forensic Exam (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the OES for the performance of specified medical evidentiary examinations.

3) States that the costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature.

4) Requires each county's designated SART, SAFE, or other qualified medical evidentiary examiners to submit invoices to OES, who shall administer the program. A flat reimbursement rate shall be established, and OES must provide reimbursement within 60 days.

5) Allows victims of child physical abuse or neglect to receive a medical evidentiary exam outside of the jurisdiction where the crime occurred and requires that county's approved SART, SAFE teams, or qualified medical evidentiary examiners to be reimbursed for the performance of these exams.

FISCAL EFFECT:

Costs (General Fund) to OES of $790,000 annually for additional staff to manage reimbursement to victims who receive child abuse or neglect examinations. Additional cost pressures (General Fund) to OES in the millions to tens of millions of dollars to provide reimbursement to counties for the cost of child abuse and neglect examinations. When prior similar legislation was considered, OES reimbursed $911 for each exam. Assuming the cost of a child abuse and neglect examination is similar, cost pressures could be around $9 million annually if 10,000 examinations are reimbursed by OES.

COMMENTS:

1) **Author's Statement.** According to the author's office:

> Despite providing reimbursement for the medical forensic examination of domestic violence, adult and pediatric sexual assault, existing law does not provide reimbursement for the medical forensic examination of suspected child physical abuse or neglect. This makes it difficult for clinics and providers to offer this service, especially in rural districts where access is scarce. For example, there is one primary provider of these exams located in Shasta County who covers the territory of seven large counties in the First Assembly District. Victims seeking these exams are forced to travel up to three hours for an exam.

2) **Background.** This bill follows other recent legislation that sought to provide no-cost medical examinations to victims of sexual and domestic violence. Rather than directly charging victims of child abuse and neglect for physical examinations, this bill would require counties to set up systems to provide examinations and submit invoices for reimbursement to OES.

3) **Prior Legislation.** AB 2185 (Weber), Chapter 557, Statutes of 2022, authorized reimbursements from OES for costs of medical evidentiary examinations of domestic violence victims.

   AB 145 (Committee on Budget), Chapter 80, Statutes of 2021, authorized reimbursements from OES for the costs of conducting medical evidentiary examinations of sexual assault survivors regardless of whether they have decided to report the assault to law enforcement.

Analysis Prepared by: Annika Carlson / APPR. / (916) 319-2081

Date of Hearing: April 25, 2023
Counsel: Cheryl Anderson

ASSEMBLY COMMITTEE ON PUBLIC SAFETY
Reginald Byron Jones-Sawyer, Sr., Chair

AB 1402 (Megan Dahle) – As Amended March 30, 2023

SUMMARY: Prohibits costs for the medical evidentiary portion of a child abuse or neglect examination from being charged directly or indirectly to the victim. Specifically, **this bill**:

1) Requires the costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect to be separate from diagnostic treatment and procedure costs associated with medical treatment.

2) Prohibits costs for the medical evidentiary portion of the examination from being charged directly or indirectly to the victim of child physical abuse or neglect.

3) Provides that each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Team (SART), Sexual Assault Forensic Exam (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services (OES) for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify OES of this designation.

4) States that the costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature.

5) Requires each county's designated SART, SAFE, or other qualified medical evidentiary examiners to submit invoices to OES, who shall administer the program. A flat reimbursement rate shall be established.

6) Specifies that within one year upon initial appropriation, OES shall establish a 60-day reimbursement process. OES shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years.

7) Prohibits reduced reimbursement rates based on patient history or other reasons.

8) Allows victims of child physical abuse or neglect to receive a medical evidentiary exam outside of the jurisdiction where the crime occurred and requires that county's approved SART, SAFE teams, or qualified medical evidentiary examiners to be reimbursed for the performance of these exams.

EXISTING LAW:

1) Requires OES to, in cooperation with the State Department of Social Services, the Department of Justice, the California Association of Crime Lab Directors, the California

District Attorneys Association, the California State Sheriffs' Association, the California Peace Officers Association, the California Medical Association, the California Police Chiefs' Association, child advocates, the California Medical Training Center, child protective services, and other appropriate experts, to establish medical forensic forms, instructions, and examination protocols for victims of child physical abuse or neglect using as a model the form and guidelines developed for sexual assault medical evidentiary examinations. (Pen. Code, § 11171, subd. (b).)

2) Specifies that the forms shall include, but not be limited to, a place for notation concerning each of the following:

   a) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures;

   b) Addressing relevant consent issues, if indicated;

   c) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history;

   d) The performance of a physical examination for evidence of child physical abuse or neglect;

   e) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures;

   f) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated;

   g) Procedures for the preservation and disposition of evidence;

   h) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays; and,

   i) An assessment as to whether there are findings that indicate physical abuse or neglect. (Pen. Code, § 11171, subd. (c).)

3) Provides that the forms shall become part of the patient's medical record pursuant to guidelines established by the advisory committee of OES and subject to the confidentiality laws pertaining to the release of medical forensic examination records. (Pen. Code, § 11171, subd. (d).)

4) Requires that the forms be made accessible for use on the Internet. (Pen. Code, § 11171, subd. (e).)

5) Makes sexual assault forensic medical examinations reimbursable. (Pen. Code, § 13823.95.)

6) Makes domestic violence forensic medical examinations reimbursable. (Pen. Code, § 11161.2.)

FISCAL EFFECT: Unknown

COMMENTS:

1) **Author's Statement**: According to the author, "AB 1402 continues the important work accomplished in AB 925 (M. Dahle) which authorized the appropriate local law enforcement agency to seek reimbursement from the Office of Emergency Services (OES), using the specified federal funds for the cost of conducting the medical evidentiary examination of a sexual assault victim. AB 1402 would simply allow child abuse exams to also be eligible for reimbursement."

2) **Need for this Bill:** According to information provided by the author's office, "Despite providing reimbursement for the medical forensic examination of domestic violence, adult and pediatric sexual assault, existing law does not provide reimbursement for the medical forensic examination of suspected child physical abuse or neglect. This makes it difficult for clinics and providers to offer this service, especially in rural districts where access is scarce. For example, there is one primary provider of these exams located in Shasta County who covers the territory of seven large counties in the First Assembly District. Victims seeking these exams are forced to travel up to three hours for an exam."

3) **Reimbursement for the Cost of Sexual Assault and Domestic Violence Medical Evidentiary Exams:** The Violence against Women Act (VAWA) affords sexual assault victims the right to obtain a medical evidentiary examination after a sexual assault. The victim may not be charged for the exam. The costs are charged to the local law enforcement agency. Law enforcement can seek reimbursement for cases where the victim is undecided whether to report to the assault to law enforcement. The OES uses discretionary funds from various federal grants to offset the costs of the examination. OES makes a determination on how much the reimbursement shall be under these circumstances and can reassess the reimbursement every 5 years. Law enforcement can also seek reimbursement to offset the costs of conducting an examination when the victim has decided to report the assault to law enforcement. OES makes a determination on how much the reimbursement shall be under these circumstances. OES is to provide reimbursement from funds to be made available upon appropriation for this purpose. (Pen. Code, § 13823.95).

   In AB 2185 (Weber), Chapter 557, Statutes of 2022, the Legislature provided domestic violence victims access to medical evidentiary exams, free of charge, by SART, SAFE teams, or other qualified medical evidentiary examiners. Each county's board of supervisors is required to authorize a designee to approve the SART, SAFE teams, or other qualified medical evidentiary examiners to receive reimbursement through OES for the performance of medical evidentiary examinations for victims of domestic violence. Costs incurred for the medical evidentiary portion of the examination cannot be charged directly or indirectly to the victim. The costs associated with these medical evidentiary exams are to be funded by the state, subject to appropriation by the Legislature, and require the OES to establish a 60-day reimbursement process within one year upon initial appropriation. (Pen. Code, § 11161.2.)

This bill mirrors the process set forth by AB 2185, to provide free medical evidentiary examinations for a victim of child physical abuse or neglect.

4) **Argument in Support**: None on file.

5) **Argument in Opposition**: None on file.

6) **Prior Legislation**:

a) AB 2185 (Weber), Chapter 557, Statutes of 2022, provided domestic violence victims access to medical evidentiary exams, free of charge, by SART, SAFE teams, or other qualified medical evidentiary examiners.

b) AB 145 (Committee on Budget), Chapter 80, Statutes of 2021, authorized reimbursements from OES for the costs of conducting medical evidentiary examinations of sexual assault survivors regardless of whether they have decided to report the assault to law enforcement.

c) AB 925 (Dahle), of the 2021-2022 Legislative Session, would have authorized a law enforcement agency to seek reimbursement from OES, to offset the costs of a medical evidentiary exam of a sexual assault victim who at the time of the examination has decided not to report to law enforcement, and reimburses the law enforcement agency at the same established rate for victims who have decided to report an assault at the time of the examination. AB 925 was not heard in the Senate Appropriations Committee.

d) AB 334 (Cooper), of the 2017-2018 Legislative Session, would have made a number of changes to existing law regarding sexual assault forensic medical examinations, including the reimbursement rate for exams of survivors who do not aid or otherwise participate with law enforcement. AB 334 was not heard in the Senate Public Safety Committee at the request of the author.

e) SB 580 (Figueroa), Chapter 249, Statutes of 2003, required the Office of Criminal Justice Planning (OCJP) to develop a standard form for health practitioners to report any physical injury resulting from suspected abusive conduct, and another standard form for the forensic examination of victims of child abuse or neglect.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file

Opposition

None on file

Analysis Prepared by: Cheryl Anderson / PUB. S. / (916) 319-3744

Informational Bulletin: Sexual Assault Medical Evidentiary Examination Reimbursement

General Information

California Penal Code §13823.95 directs Cal OES to reimburse law enforcement to offset the cost of conducting medical evidentiary examinations, for victims of sexual assault, from one of two sources of funds (i.e., federal grant fund and State General Fund). The source of funds depends on whether the victim, at the time of the examination, has determined to report the assault to law enforcement (State General Fund) or is undecided whether to report the assault to law enforcement (federal grant fund).

Cal OES will reimburse law enforcement to offset the cost of medical evidentiary examinations as follows:

- The actual cost of the examination up to **$911** for **victims that are undecided**, at the time of an examination, whether to report the assault to law enforcement.

  Examinations must have occurred on, or after, October 1, 2020.

  Law enforcement may request reimbursement at this rate for the use of:
  - *The Forensic Medical Report: Abbreviated Adult/Adolescent Sexual Assault Examination (Cal OES 2-924), or*
  - *The Forensic Medical Report: Acute Adult/Adolescent Sexual Assault Examination (Cal OES 2-923).*

- The actual cost of the examination up to **$1,127** for **victims that have determined**, at the time of the examination, to report the assault to law enforcement, to the extent that funds are available.

  Examinations must have occurred on, or after, July 1, 2021.

  Law enforcement may request reimbursement at this rate for the use of:
  - *The Forensic Medical Report: Acute Adult/Adolescent Sexual Assault Examination (Cal OES 2-923),*
  - *The Forensic Medical Report: Nonacute Child-Adolescent Sexual Abuse Examination (Cal OES 2-925), or*
  - *The Forensic Medical Report: Acute Child-Adolescent Sexual Abuse Examination (Cal OES 2-930).*

How to Request Reimbursement

To request reimbursement:

- Copy the **Medical Evidentiary Examination Reimbursement Invoice,**
- Complete all relevant sections,
- Paste the template onto your **agency's letterhead**, and
- Submit to Cal OES at vsb@caloes.ca.gov within **one year** of the examination.

Additional rows may be added to the tables as needed. The **Medical Evidentiary Examination Reimbursement Invoice** can be found on the Cal OES website at https://www.caloes.ca.gov/governments-tribal/grants-management/forms. **Questions may be sent to vsb@caloes.ca.gov.**

Penal Code § 13823.95

- Costs incurred by a qualified health care professional, hospital, clinic, sexual assault forensic examination team, or other emergency medical facility for a medical evidentiary examination of a victim of a sexual assault, shall not be charged directly or indirectly to the victim of the assault.

- The cost of a medical evidentiary examination performed by a qualified health care professional, hospital, or other emergency medical facility for a victim of a sexual assault shall be treated as a local cost and charged to and reimbursed within 60 days by the local law enforcement agency in whose jurisdiction the alleged offense was committed.

- The local law enforcement agency may seek reimbursement to offset the cost of conducting the medical evidentiary examination of a sexual assault victim who is undecided at the time of an examination whether to report to law enforcement or who has decided not to report to law enforcement. The Office of Emergency Services shall use the discretionary funds from the STOP (Services, Training, Officers, and Prosecutors) Violence Against Women Formula Grant Program, to offset the cost of the medical evidentiary examination.

- The local law enforcement agency may seek reimbursement to offset the cost of conducting the medical evidentiary examination of a sexual assault victim who has determined, at the time of the examination, to report the assault to law enforcement. This subparagraph does not permit a law enforcement agency to reduce the existing locally negotiated rate or rates for medical evidentiary examinations. Reimbursements shall be provided from funds to be made available upon appropriation for this purpose.

Revised 5/2022

Cal OES
GOVERNOR'S OFFICE
OF EMERGENCY SERVICES

Invoice for Reimbursement for Medical Evidentiary Examination

Per Penal Code § 13823.95 local law enforcement agency may seek reimbursement to offset the cost of conducting the medical evidentiary examination of a sexual assault victim who is undecided at the time of an examination whether to report to law enforcement.

Law enforcement agencies may request up to $911 per examination. If the examination cost is less, the law enforcement agency may only request the amount paid.

Invoices must be submitted within 6 months of the medical evidentiary examination. Email completed form to: VSB@caloes.ca.gov

---

Law Enforcement Agency: _____

Physical Address: _____

Payment Mailing Address: _____

Case #:	Date of Examination:	Officer in Charge of Investigation:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

■ Victim(s) was/were undecided, at time of examination, whether to report to law enforcement.

Amount Requested:

Number of Examinations		Amount per Examination		Total Request
_____	X	_____	=	$ 0.00

Contact Person: _____

Telephone: _____ Email: _____

Cal OES (2021)

CALIFORNIA MEDICAL PROTOCOL FOR EXAMINATION OF CHILD PHYSICAL ABUSE AND NEGLECT VICTIMS



State of California
Governor's Office of
Emergency Services
www.caloes.ca.gov

PREFACE

Pioneers in the field of child physical abuse and neglect began in the field of medicine. They were subsequently joined by the disciplines of social work, nursing, law enforcement, psychology, psychiatry, and child development.

The history of this intervention movement is characterized by peaks and plateaus as the larger community assimilated new developments lead by the pioneering disciplines. Medicine began the movement with published observations by a pediatric radiologist, Dr. John Caffey, in the 1940's. Dr. Henry Kempe, a pediatrician, galvanized the movement by establishing the concept of the "battered child syndrome" in 1962. He took his concerns to Congress and by 1965, most states had enacted child abuse reporting laws.

Issuance of the CalOES 2-900 Medical Report for Suspected Child Physical Abuse and Neglect Examinations and Protocol takes the field to a new level. In 2002, the California Legislature and Governor declared that adequate protection of victims of child physical abuse and neglect has been hampered by the lack of consistent and comprehensive medical examinations. The Legislature enacted and the Governor signed SB 580, Statutes of 2002 (Figueroa), into law to address this need by establishing a standardized medical report form and protocol.

Many deserve recognition for the vision captured in these documents. The Children's Justice Act Task Force recommended the allocation of funds to accomplish this project; the Child Physical Abuse and Neglect Advisory Committee contributed wisdom, consultation, and guidance; and, the California Clinical Forensic Medical Training Center is commended for strong work, expertise, and dedication to the production of the form, instructions, and protocol. This collective effort moves the field forward on behalf of children.

The California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect Victims provides recommended methods for meeting the minimum legal standards established by Penal Code Section 11171 for performing medical examinations of physically abused and neglected children. This protocol contains the following information:

- Standard medical report form (CalOES 2-900) for documentation of findings from suspected child physical abuse and neglect examinations;
- Step-by-step procedures for conducting examinations opposite each page of the standard forms;
- Examination protocol for child physical abuse and neglect;
- Contextual information for performing examinations and implementing a multi-disciplinary team approach; and
- Relevant and expanded information on patient consent, mandatory reporting laws, financial compensation for examinations, crime victim compensation, and evidence collection and preservation.

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CHAPTER I

USE OF STANDARDIZED FORMS AND TRAINING

In 2002, the California Legislature enacted and the Governor signed SB 580 Statutes of 2002 (Figueroa) into law to amend the penal code pertaining to the performance of medical examinations for physically abused and neglected children. See **Appendix A** for a copy of this penal code section. The Legislature declared that:

- Adequate protection of victims of child physical abuse and neglect has been hampered by the lack of consistent and comprehensive medical examinations; and

- Enhancing examination procedures, documentation, and evidence collection relating to child abuse and neglect will improve the investigation of child abuse and neglect as well as other child protection efforts.

A. CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATIONS

As a result, the Governor's Office of Emergency Services issued effective January 1, 2004 the CalOES 2-900 Medical Report: Suspected Child Physical Abuse and Neglect Examination for recording the results of medical examinations.

CalOES 2-900	**Medical Report: Suspected Child Physical Abuse and Neglect Examination** • Suspected child physical abuse and neglect • Examination of children and adolescents under age 18

B. CHILD SEXUAL ABUSE EXAMINATIONS

In 1984, the California Legislature enacted legislation to establish standardized procedures for the performance of child sexual abuse and sexual assault medical evidentiary examinations. California Penal Code Section 13823.5 requires the use of these standard forms for examinations of victims of child sexual abuse and adult and adolescent sexual assault.

Required Standard State Forms for Child Sexual Abuse and Sexual Assault Exams

CalOES 923	**Forensic Medical Report: Acute (<72 hours) Adult/Adolescent Sexual Assault Examination**
CalOES 925	**Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination**
CalOES 930	**Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination**

Recommended Standard State Form

CalOES 950	**Forensic Medical Report: Sexual Assault Suspect Examination**

Key terms for Sexual Assault and Child Sexual Abuse Examinations
These terms are used to describe time frames. They are not intended to suggest that, after 72 hours, a complete examination should not be done. It is not uncommon to detect physical findings after 72 hours.

Acute	**Less than 72 hours have passed since the incident (<72 hours)**
Nonacute	**More than 72 hours have passed since the incident (>72 hours)**

C. SUGGESTED USE OF THE STANDARD STATE FORMS: FOLLOW LOCAL POLICY

CalOES 923	**Forensic Medical Report: Acute (<72 hours) Adult/Adolescent Sexual Assault Examination** • History of **acute sexual assault** (<72 hours) • Examination of adults (age 18 and over) and adolescents (ages 12-17)
CalOES 925	**Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination** • History of **nonacute sexual abuse** (>72 hours) • Examination of children and adolescents under age 18
CalOES 930	**Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination** • History of **chronic sexual abuse (incest) and recent incident** (<72 hours) • Examination of children and adolescents under age 18
CalOES 950	**Forensic Medical Report: Sexual Assault Suspect Examination** • Examination of person(s) suspected of sexual assault or child sexual abuse

D. TRAINING

The California Clinical Forensic Medical Training Center (CCFMTC) was established by Penal Code Section 13823.93 and is grant funded to provide training for physicians and nurses on how to perform medical evidentiary examinations for victims of:

- Child physical abuse and neglect;
- Child sexual abuse;
- Sexual assault;
- Domestic violence; and
- Elder and dependent adult abuse and neglect.

Training is also provided to criminal justice and investigative social services personnel on the interpretation of medical findings for use in case investigations, prosecution, and for others involved in the evaluation of medical evidence. See **Appendix B** for information on how to contact the California Clinical Forensic Medical Training Center.

The California Clinical Forensic Medical Training Center developed the CalOES 2-900 form, instructions and examination protocol under an additional grant from the Governor's Office of Criminal Justice Planning (now the California Office of Emergency Services).

CHAPTER II

MANDATORY REPORTING AND CONFIDENTIALITY OF REPORTS

A. MANDATORY REPORTING

The Child Abuse and Neglect Reporting Act is contained in Penal Code Section 11164-11174.4. The intent and purpose of the mandatory reporting law is to protect children from abuse and neglect. As used in this section, a child means a person under the age of 18.

1. Health practitioners are mandated reporters

There are 35 categories of professionals, paraprofessionals and employees of institutions, organizations, and commercial film and photographic print processing companies required to report suspected child abuse and neglect pursuant to Penal Code Section 11165.7. See **Appendix C** for a list of these categories.

Health practitioners are required to report known or suspected child abuse and neglect **immediately by telephone and to submit a written report within 36 hours** to a child protective agency.

- A health practitioner means a physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code (Penal Code Section 11165.7).

- Related categories include emergency medical technicians I or II, paramedics, or other persons certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a coroner, and a medical examiner.

- A child protective agency means a law enforcement agency, the county department of social services, or the county probation department.

- The obligation of mandated reporters to make a report to a child protective agency arises when they, in their professional capacity or within the scope of their employment, have knowledge of or observe a child who they know or reasonably suspect has been the victim of child abuse (Penal Code Section 11166).

- The term “reasonable suspicion” means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate, on his or her training and

experience, to suspect child abuse and neglect. For the purpose of this article, the pregnancy of a minor does not, in and of itself, constitute a reason for a reasonable suspicion of child sexual abuse (Penal Code Section 11166).

- For purposes of this article, a positive toxicology screen at the time of the delivery of an infant is not in and of itself, a sufficient basis for reporting child abuse and neglect. However, any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child pursuant to Section 123605 of the Health and Safety Code. If other factors are present that indicate risk to a child, then a report shall be made. However, a report based on risk to a child which relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse shall be made only to a county welfare or probation department, and not to a law enforcement agency (Penal Code Section 11165.3).

- No supervisor or administrator may impede or inhibit these reporting duties and no person making such a report shall be subject to any sanction for making the report (Penal Code Section 11166).

2. Criminal penalties for failure to report child abuse or neglect

The failure of a mandated reporter to report known or suspected child abuse or neglect is punishable by a fine not to exceed $1,000, by imprisonment in the county jail for a period not to exceed six months, or both (Penal Code Section 11166).

3. Telephone and written report requirements (Penal Code Sections 11165-11168)

- Make an immediate telephone report to a child protective agency and include the following information:
  - Name of the person making the report;
  - Name of the child;
  - Present location of the child;
  - Nature and extent of the injury; and
  - Other information requested by the child protective agency.

- Submit a written report to a child protective agency within 36 hours, using the Suspected Child Abuse Report Form (DOJ SS 8572). See **Appendix D** for a copy of this form. See **Appendix E** for a list of Child Protective Services (CPS) agencies for every county in California to obtain information and training on the use of the form.

- When two or more persons, who are required to report, jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the telephone report may be made by a member of the

team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report (Penal Code Section 11166).

4. **Immunity from civil or criminal liability for complying with the child abuse reporting law**
   - Health practitioners and others required to report known or suspected child abuse cannot be held civilly or criminally liable for any report required or authorized by the child abuse reporting law (Penal Code Section 11172).

   - Physicians and hospitals may be held liable for injuries sustained by a child for failure to diagnose and report child abuse to authorities resulting in the child being returned to the parents and receiving further injuries by them (Landeros v. Flood, (1926) 131 CAL. RPTER 69, 551 P.2d 389, 17 C.3d 399, 97 A.L.R. 3d 324).

5. **Definitions of unfounded, substantiated, and inconclusive reports used by child protective agencies (Penal Code Section 11165.12)**

   Unfounded Report
   Unfounded report means a report that is determined by the investigator who conducted the investigation to be false, to be inherently improbable, to involve an accidental injury, or not to constitute child abuse or neglect, as defined in Penal Code Section 11165.6.

   Substantiated Report
   Substantiated report means a report that is determined by the investigator who conducted the investigation, based upon some credible evidence, to constitute child abuse or neglect, as defined in Penal Code Section 11165.6.

   Inconclusive Report
   Inconclusive report means a report that is determined by the investigator who conducted the investigation not to be unfounded, but one in which the findings are inconclusive and there is insufficient evidence to determine whether child abuse or neglect, as defined in Section 11165.6, has occurred.

B. CONFIDENTIALITY OF REPORTS

1. **Confidentiality of suspected child abuse and neglect report forms**
   Written reports required by the child abuse reporting law are confidential and can only be released to agencies receiving or investigating mandated reports (law enforcement or child protective services); to the district attorney involved in a

criminal prosecution; counsel appointed pursuant to subdivision (c) of Section 317 of the Welfare and Institutions Code; county counsel; a county or state licensing agency when abuse or neglect in out-of-home care is reasonably suspected; coroners; medical examiners; and multi-disciplinary personnel teams as defined in Section 18951 of the Welfare and Institutions Code; Hospital SCAN Teams; and other specified institutional entities (Penal Code Section 11167.5). Any violation of confidentiality is punishable by up to six months in jail, by a fine of $500, or both (Penal Code Section 11167.5).

- **Multi-disciplinary Team**
  Multi-disciplinary personnel, defined in Welfare and Institutions Code Section 18951, means any team of three or more persons who are trained in the prevention, identification, and treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child abuse.

  The team may include, but not be limited to:
  - Psychiatrists, psychologists, or other trained counseling personnel;
  - Police officers or other law enforcement agents;
  - Medical personnel with sufficient training to provide health services;
  - Social workers with experience or training in child abuse prevention; and
  - Any public or private school teacher, administrative officer, supervisor of child welfare attendance, or certified pupil personnel employee.

- **Hospital SCAN Team**
  A hospital SCAN (Suspected Child Abuse and Neglect) team means a team of three or more persons established by a hospital, or two or more hospitals in the same county, consisting of health care professionals and representatives of law enforcement and child protective services, the members of which are engaged in the identification of child abuse or neglect. The disclosure authorized by this section includes disclosure among all hospital SCAN teams (Penal Code Section 11167.5).

2. **Release of medical reports of suspected child abuse and neglect**
   Medical report(s) are subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Penal Code 11164-11174.4 or privilege), the Medical Information Act (Civil Code Section 58 et seq.), the Physician-Patient Privilege (Evidence Code Section 990), and the Official Information Privilege (Evidence Code Section 1040). They can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services social worker, a child abuse and neglect multi-disciplinary team member, county licensing agency, and coroner. Medical reports can only be released to the defense counsel through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

CHAPTER III

CONSENT ISSUES

A. CHILDREN/MINORS

1. Suspected child abuse: non-consenting parents

Parental consent is not required to examine, treat, or collect evidence for suspected child abuse. In the absence of parental consent or in the case of parental refusal, children must be taken into protective custody by a child protective agency (e.g., law enforcement agency or child protection services) to perform the examination. Follow local policy regarding placement of children in protective custody.

2. Photographs of injuries

Penal Code Section 11171.2

A physician, surgeon, or dentist or their agents and by their direction may take skeletal x-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of the child abuse or neglect.

Penal Code Section 11171.5

If a peace officer, in the course of an investigation of child abuse or neglect, has reasonable cause to believe that the child has been the victim of physical abuse, the officer may apply to a magistrate for an order directing that the victim be x-rayed without parental consent. Any x-ray taken pursuant to this subdivision shall be administered by a physician, surgeon, or dentist or their agents.

With respect to the cost of an x-ray taken by the county coroner or at the request of the county coroner in suspected child abuse or neglect cases, the county may charge the parent or legal guardian of the child-victim the costs incurred by the county for the x-ray.

No person who administers an x-ray pursuant to this section shall be entitled to reimbursement from the county for an administrative cost that exceeds 5 percent of the cost of the x-ray.

B. MINORS DEFINED BY STATUTE AS 12 YEARS OF AGE OR OLDER

1. Consent to medical treatment

- Minors may give consent to the provision of medical care related to the diagnosis or treatment of a sexual assault and the collection of evidence (Family Code Sections 6927 and 6928).
- Minors may give consent to the provision of medical care related to the prevention or treatment of pregnancy (Family Code Section 6925).
- Minors may give consent to the provision of medical care related to the diagnosis or treatment of sexually transmitted diseases (Family Code Section 6926).
- Consent given by a minor is not subject to disaffirmance because of minority (Family Code Section 6921).

2. Consent to mental health treatment, residential shelter services, or drug and alcohol counseling services

- Minors may consent to mental health treatment, counseling on an out-patient basis or residential shelter services if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services; the minor would present danger of serious physical or mental health harm to self or to others without the mental health treatment or counseling or residential treatment services; or, is the alleged victim of incest or child abuse (Family Code Section 6924).
- Minors may consent to medical care and counseling related to the diagnosis and treatment of a drug or alcohol related problem (Family Code Section 6929).

CHAPTER IV

REIMBURSEMENT FOR EXAMINATIONS

A. CHILD PHYSICAL ABUSE AND NEGLECT MEDICAL EXAMINATION REIMBURSEMENTS

In the majority of counties in California, charges for child physical abuse and neglect examinations are billed to Medi-Cal or to the patient's private insurance. Standard diagnostic and procedural coding manuals are used to generate charges. For patients without insurance, or who are underinsured, reimbursement of charges may be obtained through California Victim Compensation and Government Claims Board. See Chapter V Crime Victim Compensation and Victim Assistance Programs.

Some counties have contracts with private hospitals for various medical services (e.g., indigent care) and include a provision for payment of these examinations if there is no public or private insurance reimbursement. Follow local policy.

A direction for the future to support the development of local medical experts in the evaluation of child physical abuse and neglect examinations is to develop a fee structure for rendering an expert opinion.

B. CHILD SEXUAL ABUSE AND SEXUAL ASSAULT MEDICAL EVIDENTIARY EXAMINATION REIMBURSEMENTS (PENAL CODE SECTION 13823.95)

No costs incurred by a qualified health care professional, hospital, or other emergency medical facility for the examination of a victim of a sexual assault or child sexual abuse, as described in the protocol developed pursuant to Penal Code Section 13823.5, when the examination is performed, pursuant to Sections 13823.5 and 13823.7, for the purposes of gathering evidence for possible prosecution, shall be charged directly or indirectly to the victim of the assault. These costs shall be treated as local costs and charged to the local governmental agency in whose jurisdiction the alleged offense was committed.

Charges for the forensic medical examination, not medical treatment, shall be submitted to the law enforcement agency requesting the examination. See California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims published by the Governor's Office of Emergency Services (www.CalOES.ca.gov).

CHAPTER V

CRIME VICTIM COMPENSATION AND VICTIM ASSISTANCE PROGRAMS

A. VICTIM COMPENSATION PROGRAM (VCP)

The Victim Compensation Program (VCP) can help victims of violent crime and their families deal with the emotional, physical, and financial aftermath of crime. Victims can apply for compensation by filing an application with the California Victim Compensation and Government Claims Board, which administers VCP.

1. Eligibility

- A California resident or out-of-state resident injured in California who suffers physical injury and/or threat of physical injury, or death. Victims of sexual assault and child sexual abuse are presumed to have suffered physical injury;
- A person who is physically injured or threatened with physical injury as a result of a crime or act of terrorism that occurred in the State of California;
- A California resident or member of the military stationed in California who is a victim of a qualifying crime, wherever it occurs;
- An eligible family member or other specified persons who were legally dependent on the victim;
- A parent, sibling, spouse, or child of the victim;
- The fiancé(e) of the victim at the time of the crime or another family member of the victim who witnessed the crime;
- A grandparent or grandchild of the victim at the time of the crime, or a person living with the victim at the time of the crime, or who had previously lived with the victim for at least two years in a relationship similar to a parent, grandparent, spouse, sibling, child, or grandchild of the victim;
- A minor who witnesses a crime of domestic violence or who resides in a home where domestic violence occurs;
- Anyone who pays or assumes legal liability for a deceased victim's medical, funeral, or burial expenses, or anyone who pays for the costs of crime scene clean-up for a homicide that occurred in a residence; and
- A person who is the primary caretaker of a minor victim when treatment is rendered.

2. Expenses that are eligible for reimbursement

- Medical and medical-related expenses for the victim, including dental expenses;
- Outpatient mental health treatment or counseling;
- Inpatient psychiatric hospitalization costs under dire or exceptional circumstances;
- Funeral and burial expenses;

- Wage or income loss;
- Loss of financial support for legal dependents of a deceased or injured victim;
- Job retraining expenses;
- Relocation expenses up to $1000 per household;
- Home security installation or improvements up to $1000, if the crime occurred in the victim's home;
- Crime scene clean-up to $1000, if the victim dies as a result of a crime in the residence; and
- Medically necessary renovation or retrofitting of a home or vehicle for a person permanently disabled as a result of the crime.

3. Reimbursable expenses

For crimes that occurred prior to January 1, 2001, the maximum amount that can be reimbursed is $46,000. For crimes that occurred after January 1, 2001, the maximum amount that can be reimbursed is $70,000. Expenses for psychological counseling are also reimbursable, but are generally limited to 40 sessions. Additional sessions may be authorized upon request.

4. Examples of eligible victims

- Child physical abuse victims
- Child sexual abuse victims
- Child endangerment or abandonment
- Domestic violence victims (e.g. spouses, cohabitants) including children in domestic violence households
- Stalking
- Elder and dependent adult abuse victims
- Sexual assault victims
- Survivors of homicide victims
- Assault and battery victims
- Robbery victims
- Hit and run victims
- Victims of acts of terrorism
- Victims of drivers under the influence of drugs and/or alcohol

5. Definition of a victim, injury, and derivative victims

- A victim is defined as a person who suffers injury or death as a direct result of a crime.

- An injury means either a physical injury or an emotional injury if the victim also suffered physical injury or threat of physical injury. Specified victims, including child victims of neglect and of most sex crimes, are presumed to have sustained physical injury.

- A derivative victim is defined as a person who has any of the following characteristics:

- At the time of the crime was the parent, grandparent, sibling, spouse, or child/grandchild of the victim;
- At the time of the crime was living in the household of the victim;
- A person who has previously lived in the household of the victim for a period of not less than two years in a relationship substantially similar to that of a parent, sibling, spouse, or child of the victim; or,
- A family member of the victim, including the victim's fiancé, and who witnessed the crime.

6. Requirements

- The crime must be reported to a law enforcement agency or to Child or Adult Protective Services. In some domestic violence cases, a restraining order may suffice.

- The victim must cooperate with law enforcement in the investigation and prosecution of any known suspect(s). If the victim is a child who has been confirmed as abused, the child may qualify with or without the child's legal guardian's cooperation with the authorities, or the identification or prosecution of any known suspects.

- The victim must not have knowingly and willingly participated in the commission of the crime or engaged in conduct that causes or leads to the crime. This provision does not apply to children.

- Victims (18 years or older at the time of the crime) must file an application with the State Victim Compensation Program within one year from the date of the crime. Victims (under 18 years of age at the time of the crime) must file the application before their 19th birthday. Late claims may be accepted if "good cause" is provided.

- Eligibility for program benefits will be limited if the victim/claimant was convicted of a felony committed on or after January 1, 1989, and has not been discharged from probation, parole, or released form a correctional institution at the time of the incident (Government Code Section 13956 (d)).

7. Responsibilities of hospitals

- **Display posters in the emergency room**
  Licensed hospitals in the state of California must prominently display posters in the Emergency Department notifying crime victims of the availability of victim compensation and the existence and location of the local county victim/witness assistance center (Government Code Section 13962).
- **Provision of crime victim compensation claim forms**
  County hospitals must provide Application for Crime Victim Compensation forms to sexual assault victims (Health and Safety Code Section 1492).

8. Application for compensation

Information on crime victim compensation can be obtained by contacting local county victim/witness assistance centers or the State Victim Compensation Program administered by the Victim Compensation and Government Claims Board (www.boc.ca.gov/victims.htm). Local county victim/witness assistance centers provide assistance to victims in the preparation and submission of these applications for compensation.

Claims can also be submitted directly to the State by completing an application form and mailing it to:

Victim Compensation Program
P.O. Box 3036
Sacramento, CA 95812

The application can be completed online at www.boc.ca.gov/victims.htm. Directions are provided on the website.

Victims may also be assisted by a private attorney in filing claims. California Government Code Section 13957.7(g) provides that the Board shall pay private attorney fees of 10 percent of the approved award up to a maximum of $500, and these fees are not deducted from the applicant's award.

9. Limitations

The Victim Compensation Program (VCP) is the "payer of last resort." Other sources of reimbursement such as health or disability insurance must be used first.

B. VICTIM ASSISTANCE PROGRAMS

County victim/witness assistance centers, child abuse treatment programs, domestic violence shelters, and special crime victim counseling centers exist in California to provide counseling and other forms of assistance to crime victims. Contact the county victim/witness assistance center for information on local resources. See **Appendix F** for a list of victim/witness assistance centers. Or, call the State Victim Compensation Program at 1-800-777-9229 or 1-800-735-2929 for the hearing impaired.

CHAPTER VI

KNOWLEDGE AND SKILLS NEEDED BY MEDICAL PERSONNEL IN THE PERFORMANCE OF EXAMINATIONS

A. KNOWLEDGE

Medical personnel performing medical examinations of physically abused and neglected children should be knowledgeable about:

- Health professionals' responsibilities as "mandated reporters";
- Roles of law enforcement, child protective services, county counsel, deputy district attorneys, crime laboratories, attorneys appointed for court dependent children, and CASA (Court Appointed Special Advocates);
- Importance of scene investigation by law enforcement, particularly in the forensic evaluation of burn injuries;
- Epidemiology and clinical presentations of common accidental injuries in children;
- Pathophysiology of traumatic injury to the cutaneous, skeletal, visceral, central nervous system, and ocular areas of children;
- Injuries to children that are highly specific for physical abuse;
- Medical conditions and accidental injuries that can mimic physical abuse injuries;
- Types of child neglect, clinical presentation, and differential diagnosis;
- Differential diagnosis of failure to thrive;
- Role of radiology in the evaluation of physically abused children;
- Role of laboratory tests in the evaluation of injuries that may represent abuse;
- Role of pediatric subspecialists in the evaluation of children alleged to have been abused; and
- Role of the juvenile or family, and superior court system.

B. SKILLS

Medical personnel must be able to:

- Take a complete history from a parent or guardian about the circumstances of the child's injury, past medical conditions, and birth history;
- Perform a detailed and careful physical examination of an infant, child, or adolescent;
- Document cutaneous injuries clearly in writing and by proper use of photographic equipment;
- Make an assessment of the injury as to the likelihood of abuse based upon the history, physical examination, and laboratory and radiologic evaluation;
- Make an assessment of child neglect;
- Communicate clearly and in lay terms with non-medical personnel about the medical findings;
- Communicate in a non-adversarial manner with parents and/or guardian about the responsibilities of medical professionals to report suspected child abuse; and
- Testify in court as to one's objective findings and assessment of injuries.

CHAPTER VII

EXAMINATION PROTOCOL: CHILD PHYSICAL ABUSE

A. STEP ONE: RECOGNIZE A PATIENT HISTORY THAT DOES NOT MATCH FINDINGS

1. Patient history patterns suggestive of possible child maltreatment

- No explanatory history for significant trauma or trauma in a highly supervised age.
- Inconsistent history given:
  - History fails to explain the nature, severity, or pattern of the injury;
  - History of the logistics or mechanics of the injury do not match the injury;
  - History of minor or common trauma to explain severe or unusual injuries;
  - History describes child actions that are inconsistent with developmental abilities;
  - History blames or suggests a third party; and
  - Injuries are indicative of an object (e.g. belt buckle not included in history).
- History changes with retelling or provider probing.
- History blames the child for injuring himself or herself.
- History blames another child for causing the injury.
- History suggests neglect and/or lack of supervision.

2. Patient history with discrepancies

Care providers falsify histories to protect themselves and others from culpability associated with the true events. When health practitioners point out the inconsistency of the given or absent history, care providers may alter their story in an attempt to satisfy the practitioner. When detailed histories are taken from two historians, or at different times, discrepancies may appear as on-the-spot falsification of events occurs. Discrepancies that cannot be resolved are a strong indication of falsification and the culpability it implies.

B. STEP TWO: RECOGNIZE MEDICAL EVIDENCE OF POSSIBLE PHYSICAL ABUSE

Physical abuse is characterized by inflicting physical injury by slapping, hitting, punching, beating, kicking, throwing, biting, burning, or otherwise physically harming a child. The injury may be the result of a single episode or of repeated episodes. The physical trauma can range in severity from minor bruising, abrasions, lacerations, burns, eye injuries, and fractures to damage to the brain and internal organs (liver, spleen, abdomen, pancreas, and kidneys). Head and internal injuries are the leading causes of child

abuse-related deaths. This form of abuse also includes extreme forms of punishment such as torture or confinement of children in dark closets, boxes, or rooms for days, months, or even years at a time.

1. **Cutaneous patterns suggestive of possible child maltreatment**
   - Bruises or burns shaped like recognizable objects;
   - Repeated but unrecognizable patterned bruises or burns;
   - Bruises in children who are not pulling themselves up, and walking along furniture;
   - Buttock bruises in children wearing diapers;
   - Two or more facial bruises without clear explanation;
   - "High tide mark" burn distribution;
   - Symmetrical lesions;
   - Burns with no evidence of motion effect;
   - Evidence of untreated healing fractures; and
   - New fractures on old.

2. **Skeletal injuries suggestive of possible child maltreatment**
   - Rib fractures in young children, particularly when posterior;
   - Metaphyseal corner fractures;
   - Fractures in infants other than simple skull and clavicle fractures;
   - High energy fractures without serious accidents (e.g., long distance fall, MVA); and
   - Multiple fracture sites without serious accidents (e.g., long distance fall, MVA).

3. **Signs and symptoms of dentofacial trauma**
   - Avulsed teeth;
   - Lip lacerations;
   - Tongue injuries;
   - Frenulum injuries; and
   - Jaw and facial fractures.

4. **Syndromes of possible child maltreatment**
   - **Battered Child Syndrome**
     - Multiple distinct injuries, separated by time or cause; and
     - Inadequate explanation by disease, accident, or typical childhood injury.
   - **Shaken Baby Syndrome also called Abusive Head Trauma**
     - Intra-cranial injury;
     - Absence of verified severe trauma (e.g., MVA, long distance fall);
     - Additional findings of rib fracture, metaphyseal fractures, other injuries; and
     - Retinal hemorrhages.

Syndromes are patterns of associated findings, which suggest an etiology. Two syndromes have become well established in the abuse literature. The **Battered Child**

Syndrome can be defined as the presence of multiple separate injuries with inadequate explanation. The injuries must be distinct enough in age, location and mechanism, so that they were separately caused. Explanation by disease state, adequate history of accidental injury, and typical events of childhood, must be excluded. Once these conditions are met, inflicted injury is the most likely cause. The concept of multiple injuries in time and space is included in discussions of many of the specific abuse entities, and is a basic principle with high predictive value in child abuse. Once the whole story is known, this theme is seen again in the abuser's tendency to use violence on multiple family members, and even family pets. For many abusers, violence or losing control is a habit identified in child abuse cases.

The other major syndrome of child abuse is the **Shaken Baby Syndrome also called Abusive Head Trauma**. Originally described as the co-occurrence of long bone fractures and sub-dural hematoma, it is now known that fractures of the ribs or metaphyses are present about half of the time, and retinal hemorrhages are present about eighty percent of the time. The finding of retinal hemorrhages has been particularly well studied, and almost always signifies child abuse. Due to controversies in understanding the basic mechanism of injury, many authors now simply refer to Abusive Head Trauma. Identifying abusive head trauma rests on another basic principle of child abuse. The presence of intra-cranial traumatic injury, without a history of severe trauma identifies probable abuse. This principle of severe injury with trivial history has been noted in fractures, and is also found in abdominal and other internal injuries.

5. **Disclosure and findings associated with child sexual abuse**
    - Child discloses sexual abuse;
    - Sexually obsessive, aggressive or coercive behavior;
    - Sexually transmitted diseases;
    - Acute anogenital injuries without clear accidental cause; and
    - Absence or interruption of the posterior hymen.

    For further discussion, consult the California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims available at www.CalOES.ca.gov.
6. **Other findings suggestive of possible child maltreatment**
    - Child does not gain weight as expected;
    - Child's development and behavior is disturbed;
    - Child has too many accidents;
    - Illnesses are more severe or prolonged than expected;
    - Illnesses defy diagnosis;
    - Medical treatments are not effective;
    - Illnesses are found to be due to poisoning or occult trauma; and
    - Accidental or non-accidental illicit drug ingestion.

C. STEP THREE: EVALUATE THE CHILD FOR POSSIBLE ABUSE

1. **Obtain history from the patient (separately if possible) and caregivers**
   - **Extensively probe the history of explanatory events**
     - Do not accept absent history;
     - Challenge inadequate histories;
     - Note changes in history and when they occur; and
     - Push for details consistent with the apparent mechanism of injury.
   - **Conduct review of systems**
     - Evaluate medical history suggesting alternate diagnoses;
     - Evaluate medical history of significant concurrent illness; and
     - Obtain information on immunization and developmental status.

2. **Perform comprehensive physical examination**
   - **Record height and weight, and plot against age-based norms. For children under age two, record head circumference and percentile.**
   - **Assess developmental abilities, particularly speech**
   - **Perform multisystem total body exam**
   - **Give special scrutiny to important abuse areas**
     - Scalp;
     - Behind ears, in folds of pinna, and along top edge of pinna;
     - Mouth, labial and lingual frenula, tonsillar pillars, posterior pharynx; and
     - Palms of hands and soles of feet.
   - **Perform genital exam**
     - Traction of labia majora; and
     - Knee chest exam.

3. **Request ancillary studies, if indicated**
   - **Radiology**
     - Skeletal survey on children less than two; and
     - CT scan of the head for abused children with any neurologic signs.
   - **Laboratory**
     - CBC, PT, PTT, bleeding time for abusive bruises; and
     - Urinalysis, amylase and transaminases for occult abdominal injury.
   - **Consultative examinations**
     - Indirect ophthalmoscopy for any suspicion of Shaken Baby Syndrome also known as Abusive Head Trauma.

4. **Obtain a history from the child and caregiver**

   - **Obtain history from the child, if verbal; and separate from the caregiver, if possible.**
     If the child is verbal, the medical practitioner should take the history separate from the caregiver, if possible. The child may be able to tell the practitioner the true history, or may produce significant inconsistencies to protect the caregiver, which should be noted. Other reasons exist to speak with the child. Many children from abusive and neglectful homes are developmentally delayed. Careful listening to the child's speech, and general questioning about their life may lead to diagnoses of developmental delay, depression, or anxiety.

   - **Obtain history from caregiver.**
     When an injured child presents with a responsible care provider, the practitioner must take the opportunity to request an explanation of the injuries. Bruises on young infants, and patterned bruises on older children should not be bypassed without comment or question. In most cases of abuse, diagnosis rests with the lack of adequate explanatory history. Careful, persistent questioning, pursuing areas of apparent inconsistency, may produce a true abuse disclosure, or serve to further demonstrate the inconsistency. On the other hand, failure to accept the initial, inconsistent history, may force the caretaker to reveal details of an unusual accident, which they were too embarrassed, upset, or confused to disclose when questioned. When the practitioner has a strong sense of how the injuries occurred, he or she may choose to reveal this in questioning. Before doing so, it is important to carefully note the caretaker's first response, as abusers may incorporate your suggestions into their defensive falsehoods. Documenting this changing history may become important in identifying child abuse. Similarly, the medical practitioner must take a history that probes for possible exonerating differential diagnoses. It is best that these questions be asked neutrally, and answers examined critically, so as to avoid providing an excuse for the guilty, or missing innocent explanations. The format of a traditional review of systems and family history is excellent in that it is familiar to practitioners, seeks all information pertinent to the care of the child, and reviews a wide range of information, the significance of which may only be grasped later.

5. **Perform a comprehensive medical examination**
   Perform a comprehensive "head-to-toe" medical examination. Certain elements of the examination take on particular importance in the setting of possible child abuse. As the most common target for abusive injury, all surfaces of the skin deserve special scrutiny. The scalp is often difficult to see due to long or dense hair. Contusions, lacerations, scars or even tattoos may be hidden by hair. The external ears are often overlooked. Looking behind the ears may reveal fingernail marks

or other injuries. Small subtle bruises may be found within the folds or along the top of the pinna, which are strong evidence of abusively striking or pulling the ears. Other less commonly seen surfaces of the skin, including the perineum and bottoms of the feet should be viewed, searching for injuries.

- **Areas of injury**
  Special attention should be paid to areas of injury. Providers should carefully look at injuries for pattern or shape, evidence of healing or delayed care seeking, and possible alternate explanation. Red marks should be pressed or stretched to see if they blanche, in order to distinguish vascular markings from bruises. Follow up examination may be required to completely evaluate skin findings. Fresh bruises often become more prominent. Injuries such as bruises and lacerations are expected to heal over a predictable period of time. Following them through healing may help to distinguish trauma from other findings such as nevi, vascular lesions, and “mongolian” spots. All injuries should be measured, described, drawn, and, where possible, photographed with a size standard in the photo. Use a 35mm or a digital camera. Follow local policy. See Chapter X Photography.

- **Head, eyes, and mouth**
  Other structures of the head should be examined more closely than in typical well child checks. Petechiae of the conjunctiva are seen both with direct trauma, and with strangulation or suffocation. Retinal hemorrhages are sometimes seen during direct ophthalmoscopy, and are significant both as signs of abuse, and probable neurologic injury. The mouth requires careful attention. Bruises, lacerations or impressions inside the lips may occur when a child is struck in the face. Tearing of the labial or lingual frenula may occur during blows to the mouth, or forced feeding. Lacerations of the posterior pharynx have also occurred during forced feeding, and may result in serious medical complication. The abdomen and head are the most common sites for severe and fatal injuries to children. The examiner must be certain that the belly is benign, and the child’s neurological status is clear.

- **Musculoskeletal system**
  The musculoskeletal system, as another commonly injured system, also receives greater scrutiny than in typical general physical exams. Observe the child for deformity. See if a limb is favored, or seems painful. The chest and extremities should be palpated, feeling for tenderness, mass, or crepitance. Any signs of possible trauma require examination in greater detail, and radiological assessment.

A skeletal survey is recommended when evaluating possibly abused children below age two. Unfortunately, as suggested previously, child abuse is an event that is likely to be repeated, with children held back from medical attention. Skeletal injuries may be clinically inapparent because they have begun to heal. Many fractures found in child abuse settings are clinically unexpected. Inexperienced facilities may obtain whole body views or “baby grams” when a skeletal survey is requested. This is inadequate. Properly posed and exposed views of the ribs, spine, head, upper extremities, lower extremities, hands and feet are required. Two views of the ankles, knees, shoulders and elbow, will help to detect metaphyseal fractures. When rib fractures are suspected, oblique views may help to detect them.

- **Genitals and anus**
  Putting the child on his or her knees, with the buttocks in the air, chest on the table, and back in a lordotic posture makes this examination much easier. Evaluation of the anus and genitals may require special techniques, which are easily learned by general medical examiners. Separation of the buttocks in this posture gives a clear view of the anus. Lifting and separating the buttocks exposes the female genitalia giving the best view for evaluating the hymen. Female genitalia may also be evaluated with the child on her back with the legs abducted and externally rotated. Grasping and drawing outward on the labia majora will open the vestibule and vaginal orifice for better inspection.

- **Laboratory testing**
  Laboratory testing is ordered based on the practitioner’s assessment of the child. A complete blood count will screen for anemia, which is commonly found in neglected children. The platelet count will also help to rule out causes of easy bleeding. A prothrombin and partial thromboplastin time, and possibly a Von Willebrand’s Panel will complete this screen in children with bruises. If there is suspicion of abdominal trauma, but the patient does not appear to require imaging or surgery, urinalysis, amylase and liver transaminases will increase the likelihood of detecting milder internal injuries. Children who have neurologic injury, and those with rib or metaphyseal fractures, should have a dilated indirect ophthalmoscopy exam. Direct ophthalmoscopy, even with dilation, is inadequate to completely rule out retinal hemorrhages. Any child with signs of abuse, such as facial bruises, and even mild neurologic signs, such as vomiting without diarrhea, irritability or somnolence deserves a CT scan of the head. Milder forms of abusive head injury have been overlooked, and children returned with complications from the delay, in similar situations.

- **Screen for developmental, behavioral, and emotional problems**
  The physical examination of an abused or neglected child must evaluate all body systems. A high percentage of abused and neglected children have been found to have medical problems. A good well child examination serves as the basis for a sound child maltreatment evaluation. Such an examination begins with a developmental assessment. The behavioral, mental, and physical development should be compared against age based norms. A Denver Developmental Screening Test (DDST) or similar developmental inventory will begin to screen for delays in language and motor development. An experienced practitioner will have an experience with similar aged children, and should comment on important departures in the child's behavior. Accurate height, weight, and head circumference must be obtained and plotted on appropriate growth charts. Small children may be further evaluated by having a body mass index, or weight for height checked. Single points in developmentally or growth delayed children are of limited value. When the initial assessment is concerning, follow up evaluation and more in depth assessment will be necessary.

6. **Report suspected child abuse and neglect and refer for consultation**
   Once the medical practitioner has completed the evaluation, the decision must be made if there is reasonable suspicion of child maltreatment. Many practitioners feel that they must prove abuse prior to reporting. This is not true. The legal statute for mandated reporters in the state of California requires a report for a reasonable suspicion of abuse or neglect. If the practitioner has a genuine concern for child maltreatment, and has not eliminated it through their own evaluation, an immediate telephone report must be made to the county children's protective services, or local law enforcement agency, and a written report filed within 36 hours. If a practitioner recognizes one of the medical findings detailed above, and fails to find a reasonable explanation, suspicion is reasonable regardless of the social circumstances and reporting should occur.

   A report is not treated as proof of abuse. The appropriate agencies will investigate the family situation, often finding important information of which the practitioner is not aware. The investigation may request more medical information from the practitioner, or consult a medical child abuse expert. Sometimes cases are unsubstantiated, because the investigation finds other explanatory evidence, or cannot adequately establish that abuse has occurred.

   Practitioners sometimes fail to report cases of child maltreatment. Usually, this is because they have failed to acknowledge the possibility, missed medical signs, or consciously chosen to set aside concerns of abuse. Child abuse experts at tertiary medical centers are usually willing to discuss cases by phone, or take direct referrals to help resolve these difficult cases. It is helpful to consider the legally required telephone and written report as a mandatory consultation.

Whether the practitioner makes a report of a suspicious situation, or refers the patient to a medical expert, addressing the reporting issue is central to providing adequate medical care for these children. Approximately 70% of children dying from abusive injuries have evidence of earlier abuse that could have been detected, possibly saving the child's life. By acknowledging the possibility of abuse, recognizing medical evidence, thoroughly evaluating, and then reporting suspicions, medical practitioners can fulfill their obligation to the state and the children they serve.

This chapter is a condensed version of the article entitled "Abuse, Detection, and Screening" by Stephen Boos, M.D. from the book Child Abuse and Neglect: Guidelines for Identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment and case management of various forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor's Office of Criminal Justice Planning (now the Governor's Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

CHAPTER VIII

EXAMINATION PROTOCOL: CHILD NEGLECT

A. EVALUATION OF CHILD NEGLECT

1. **Obtain a complete medical history in children presenting with any condition suspected of being the result of neglect**
   - Obtain the birth history and weight at birth.
   - Ask whether the mother received prenatal care.
   - What immunizations has the child had?
   - Has the child received the appropriate health care over his/her lifetime?
   - Does the child have a primary care provider?
   - What is the baby's diet? Does the family have sufficient resources to meet everyone's nutritional needs? Do they receive food stamps? How often does the family skip a meal because of inadequate resources?
   - Obtain a history of developmental milestones.
   - Obtain information about schooling and school attendance. How often have children missed school during the previous six months? What school do they attend and what is their school performance?
   - Where does the family live? Who else lives in the household?
   - Obtain a social history, including economic resources, educational level of parents, substance abuse and incarceration. Who cares for the child when the parents are not available? Is extended family available?

2. **Perform a complete physical examination**
   - Weigh and measure the child, and plot measurements for gender and age on appropriate growth curves. When possible, review all prior growth parameters to determine whether growth impairment, if present, has been chronic or is of recent onset.
   - Assess nutrition and hygiene. Evidence of substandard nutrition can be noted on physical examination in the form of diminished subcutaneous tissue.
   - Assess bruises, scars, untreated injuries. Neglected children are at increased risk of physical abuse and for accidental injuries because of a general lack of supervision.
   - Screen for sexual abuse. Neglected and homeless children are at risk for sexual victimization.
   - Assess hygiene and absence of appropriate clothing (e.g. , cleanliness, smelling of urine or stool, or lack of shoes and clothing).

- Assess healthcare history.
  - Has there been lack of care for accidental injuries?
  - If there is a chronic medical condition, has there been treatment?
  - What are physical findings relevant to the condition?
- Review immunizations to ascertain whether the child is up to date. Depending upon the circumstances of the case, records may need to be obtained from schools, other hospitals and clinics, the local CHDP (Child Health, Disability, and Prevention Program), or the CWS/CMS system (a computerized database for managing information about children in the California child welfare system).
- Note clingy, aggressive, or overly-compliant behavior when experiencing painful procedures.

3. **Screen for dental problems**
   Unattended dental cavities are frequently present in neglected children. Signs and symptoms of dental neglect include untreated, rampant cavities; untreated pain, infection, bleeding, or trauma; and/or lack of continuity of care once informed that the above conditions exist.

4. **Screen for developmental problems (e.g., motor skills, speech and language delay)**
   This screening should include the following areas: developmental milestones and history, sensorymotor abilities, speech and language acquisition, fine and gross motor skills, socio-emotional functioning, and adapative skills (e.g., eating patterns, sleeping, etc.).

5. **Order laboratory testing, if indicated**
   Laboratory tests should be ordered to diagnose and evaluate untreated and/or chronic medical conditions and to ascertain whether there are conditions which may be mistaken for neglect. In general, a hemoglobin is an appropriate study to obtain to determine if the child is anemic. Obtaining lead levels for children under six years of age is recommended.

6. **Order imaging studies, if indicated**
   Skeletal trauma series are indicated in children under the age of two years who have signs of severe neglect. The purpose of these studies is to detect the presence of occult fractures.

   Additional imaging studies are rarely needed in the assessment of the child who has been physically neglected unless there is some underlying medical condition that warrants such an evaluation. For instance, the child with recurrent urinary tract infections who has not been given the prophylactic antibiotics might need a renal scan to determine the extent of renal scarring that has developed.

7. **Assess whether the mother or caretaker will follow through to ensure that the medical problems will be addressed**
   - Has the mother been reliable in the past on medical follow-up?
   - Has anything new developed to prevent the mother from following up on recommended treatment (e.g. alcohol or drug problems, domestic violence, abusive, controlling boyfriend, or mental health problems)?
   - What resources does the family need to ensure compliance (e.g., transportation)?
   - Is the neglect representative of an isolated incident that occurred because of an unusual set of circumstances that has since been remedied? Or, are there risk factors which suggest that the child is at continued risk in their environment? Is the family in need of community resources that require the mobilization of social service agencies?
   - Evaluate whether Children's Protective Services should be involved. Most cases of neglect require an evaluation not only by medical personnel, but also by social services because there are many factors which contribute to a child being neglected. An extensive medical and psychosocial evaluation is key to assuring a good outcome.

B. LEGAL DEFINITIONS: SEVERE AND GENERAL NEGLECT

Neglect means the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person. Severe and general neglect are defined below by Penal Code Section 11165.2.

1. **Severe neglect**
   Severe neglect means the negligent failure of a person having the care or custody of a child to protect the child from severe malnutritionor medically diagnosed non-organic failure to thrive. Severe neglect also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as proscribed by Penal Code Section 11165.3, including the intentional failure to provide adequate food, clothing, shelter, or medical care.

2. **General neglect**
   General neglect means the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred.

   For the purposes of this chapter, a child receiving treatment by spiritual means as provided in Section 16509.1 of the Welfare and Institutions Code, or not receiving specified medical treatment for religious reasons, shall not for that reason alone be

considered a neglected child. An informed and appropriate medical decision made by the parent or guardian after consultation with a physician or physicians who have examined the minor does not constitute neglect.

C. CLINICAL PRESENTATION OF NEGLECT

1. General Neglect

Children who are neglected may come to medical attention for a variety of reasons. Sometimes they are brought to the physician for an unrelated infectious illness, and evidence of neglect is apparent on physical examination. For instance, the child may appear dirty, smell of urine or stool, and be underweight. Other times, neglect may result in children sustaining a serious injury, such as being burned or drowned because of inadequate supervision. Children who receive inadequate food may present with growth impairment. Children with emotional neglect may experience behavioral or conduct problems in school. Some children die as a result of neglect, and these cases are usually evaluated by the medical examiner's office.

2.

Physical Neglect Refusal of Health Care	Failure to provide or allow needed care in accordance with recommendations of a competent health care professional for a physical injury, illness, medical condition, or impairment.
Delay in Health Care	Failure to seek timely and appropriate medical care for a serious health problem which any reasonable person would have recognized as needing professional medical attention.
Abandonment	Desertion of a child without arranging for reasonable care and supervision. This category includes cases in which children are not claimed within two days, and when children are left by parents/substitutes who give no (or false) information about their whereabouts.
Drug Endangered Children (DEC)	Children removed from drug manufacturing homes or homes with extensive drug use are often subject to severe neglect and accidental drug ingestion through common food and drink products in the home and exposure to trays of drug powder or crystals and residue.

Expulsion	Other blatant refusals of custody, such as permanent or indefinite expulsion of a child from the home without adequate arrangement for care by others, or refusal to accept custody of a returned runaway.
Other Custody Issues	Custody-related forms of inattention to the child's needs other than those covered by abandonment or expulsion. For example, repeated shuttling of a child from one household to another due to unwillingness to maintain custody, or chronically and repeatedly leaving a child with others for days/weeks at a time.
Other Physical Neglect	Conspicuous inattention to avoidable hazards in the home; inadequate nutrition, clothing, or hygiene; and, other forms of reckless disregard for the child's safety and welfare, such as driving with the child while under the influence of drugs or alcohol, or leaving a young child unattended in a motor vehicle.
3. Inadequate Supervision	Child left unsupervised or inadequately supervised for extended periods of time or allowed to remain away from home overnight without the parent/substitute knowing (or attempting to determine) the child's whereabouts.
4. Emotional Neglect	
Inadequate Nurturance/ Affection	Marked inattention to the child's needs for affection, emotional support, attention, or competence.
Chronic/Extreme Abuse or Domestic Violence	Chronic or extreme spouse abuse or other domestic violence.
Permitted Drug/ Alcohol Abuse	Encouraging or permitting drug or alcohol use by the child, or cases where parent/guardian was informed of the problem and did not attempt to intervene.
Refusal of Psychological Care	Refusal to allow needed and available treatment for a child's emotional or behavioral impairment or problem in accord with competent professional recommendation.

Delay in Psychological Care	Failure to seek or provide needed treatment for a child's emotional or behavioral impairment or problem which any reasonable person would have recognized as needing professional psychological attention (e.g., severe depression, suicide attempt).
Other Emotional Neglect	Other inattention to the child's developmental/emotional needs not classifiable under any of the above forms of emotional neglect (e.g., markedly overprotective restrictions which foster immaturity or emotional overdependence, chronically applying expectations clearly inappropriate in relation to the child's age or level of development, etc.).

5. Educational Neglect

Permitted Chronic Truancy	Habitual truancy averaging at least five days a month is classifiable under this form of maltreatment, if the parent/guardian has been informed of the problem, and has not attempted to intervene.
Failure to Enroll/ Other Truancy	Failure to register or enroll a child of mandatory school age, causing the school-aged child to remain at home for nonlegitimate reasons (e.g., to work, to care for siblings) an average of at least three days a month.
Inattention to Special Education Needs	Refusal to allow or failure to obtain recommended remedial educational services, or neglect in obtaining or following through with treatment for a child's diagnosed learning disorder, or other special educational needs without reasonable cause.

6. Additional commentary on definitions

Medical neglect

Medical neglect may occur for acute problems, such as burns or injuries that are sustained accidentally; acute illnesses, such as gastroenteritis; or, for routine health maintenance. Some parents do access health care when their children have chronic problems, but then fail to follow the recommendations of the physician. For instance, a child with asthma may be prescribed several medications none of which are administered. As a result, the child may require repeated hospitalizations including admission to an intensive care unit.

Parents may utilize nontraditional medicine to treat their child's ailment. Examples of such practices include cao gio, or coining and moxibustion. Residual bruises from these practices may be mistaken for inflicted trauma. The use of non-traditional medicine is not condemned so long as it does not interfere with the child receiving appropriate medical care, and does not harm the child.

Child abandonment

Abandonment may involve frank abandonment, such as when a child is left in a trash dumpster, or, left alone, unprotected in a house or apartment without any adult supervision. Abandonment also occurs when a parent leaves the child in the care of others and then fails to return at an appointed time. Inadequate supervision is another form of abandonment as well as cases where both parents renege on their responsibilities as parents. Adolescents who are expelled from the home because of "misbehavior" are abandoned. These adolescents are frequently referred to as "throwaways."

Delay in accessing medical care

- Parents may not have the financial means to pay for healthcare, and they delay seeking treatment in the hope that the illness will resolve on its own;
- Parents are unsophisticated and do not appreciate the seriousness of the illness;
- Parents are overtly negligent, and simply do not provide for their child's health care needs;
- Parents are developmentally disabled or mentally ill and cannot properly care for their child; or,
- Parents whose child has been physically and/or sexually abused and they are trying to prevent this matter from coming to the attention of authorities.

Lack of supervision

Children who are left unsupervised may die as a result of such neglect. Common examples include children who die in house fires, from drowning, starvation, or inadequate medical care.

Religious beliefs

Some parents refuse medical care because of religious beliefs. Consult with Child Protective Services (CPS) and follow local protocol.

E. PATHOPHYSIOLOGY

There are many factors that contribute to neglect. Parental factors include maternal depression, parental substance abuse, maternal developmental delay or retardation, and lack of education. There are also features in the child that place additional stress on the parent-child relationship. Children with chronic disabilities may strain the resources of a family. Similarly, infants who have been born prematurely are at increased risk of being neglected or abused. Bonding between a mother and her premature infant may be interrupted because of the separation between the two during the early period after birth. Sometimes the “goodness of fit” between the infant and mother is lacking, and the pair do not act as a reciprocal dyad.

Certain family features are also associated with neglect. These include absent or negative interactions between family members. Poor parenting skills may also be noted. There is frequently social isolation and a single parent struggling with stressors such as unemployment, illness (including mental illness), prison, and eviction. On a more global scale, community and societal factors also contribute to the risk of neglect. The lack of child care in a community means that single parents may leave young children inadequately supervised in order to go to work. The lack of convenient public transportation may impact access to medical care. Poverty, violence, and substandard educational resources all contribute to neglect within certain populations. For instance, in neighborhoods perceived to be unsafe, children are frequently prohibited from playing outdoors and forming normal friendships because of safety concerns.

F. DIFFERENTIAL DIAGNOSIS

In any child who presents with a medical condition that may be related to neglect, healthcare providers must explore other explanations that could account for the findings. Children who appear to be malnourished may suffer from a number of medical problems that affect their ability to grow and gain weight. Children who present with injuries need to be evaluated for the circumstances surrounding the injury. Did the parent’s action contribute to the child being injured? Were these actions substandard, or would other parents have acted in a similar manner? For instance, if a child accidentally drowns in a bathtub, what reasons were given for leaving the child unattended?

The differential diagnosis of physical neglect depends on the presenting complaint. Children who are inadequately clothed may present with hypothermia. The differential diagnosis would include overwhelming sepsis, drug-exposure (COOLS - carbon monoxide, opiates, oral hypoglycemics [insulin], liquor, sedative-hypotics), or

environmental exposure. Children with refractory medical conditions such as intractable asthma or unstable diabetes may be viewed as medically fragile, if the issue of non-compliance is not raised. Failure to obtain medical care in a timely manner may result in disease progression to a point where diagnosis and medical intervention are more difficult.

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CHAPTER IX

IMPORTANT CONSIDERATIONS IN THE COLLECTION AND PRESERVATION OF EVIDENCE

A. CRIME LABORATORIES

Crime laboratories analyze and interpret evidence collected during the medical evidentiary examination. There are 31 public crime laboratories in California: 19 city and county laboratories and 12 California Department of Justice laboratories. There are also a number of privately operated crime laboratories. Crime laboratories have slightly different requirements for the collection and disposition of some types of evidence.

B. ENSURING EVIDENCE INTEGRITY

1. Key components of proper evidence handling are:

- Placing items in appropriate evidence containers;
- Labeling the evidence containers;
- Sealing the evidence containers;
- Storing evidence in a secure area; and
- Maintaining the chain of custody.

2. Use appropriate evidence containers to ensure that evidence cannot leak through the container, be lost, or deteriorate.

• Slide mailers	To protect slides.
• Bindles and other small containers	To protect items that can be easily lost such as crusted materials, soil, and small fibers. Bindles and other small protective containers are then placed into the evidence collection envelopes or boxes described below.
• Envelopes or boxes	To protect evidence such as swabs, reference hair samples, and foreign materials, and to hold the small containers listed above.
• Evidence kit container	A larger envelope or box to hold the individual evidence collection envelopes, small boxes, and slide mailers. The outside of the evidence kit container must have a chain of custody form printed on it or securely attached.
• Paper bags	To hold clothing.

The following chart, not meant to be all-inclusive, is a list of suggested containers for different types of evidence:

Items	Suggested Containers
• Swabs (dried)	• Envelopes • Boxes
• Slides (dried)	• Slide mailers
• Large foreign materials (e.g., hairs, grass)	• Envelopes
• Small or loose foreign materials (e.g., soil, paint, splinters, glass, fibers)	• Bindles placed into envelopes • Tapelifts in clear plastic containers
• Matted hair bearing crusted material	• Bindles placed into envelopes
• Fingernail scrapings or cuttings	• Paper bindles placed into envelopes • Sealable boxes
• Reference blood samples, liquid	• Lavender and/or yellow stoppered evacuated blood collection vials (according to local policy) placed in envelopes
• Saliva reference sample (dried)	• Envelopes
• Clothing	• Paper bags (not plastic)
• Toxicology samples Blood alcohol/toxicology Urine toxicology	• Gray stoppered evacuated blood collection vials • Tightly sealed clean plastic or glass container for urine samples

3. **Label evidence containers**
   Clearly label evidence to enable the person collecting it to later identify it in court and to ensure that the chain of custody is maintained. Many emergency departments use addressograph machines or computerized label generators to expedite labeling of evidence. Label envelopes or boxes with the following information:

   - Full name of patient;
   - Date of collection;
   - Description of the evidence including the location from which it was collected; and
   - Signature or initials of the person who collected the evidence and placed it in the container.

4. **Seal evidence containers**
   Properly seal evidence containers to ensure that contents cannot escape and that nothing can be added or altered by:

   - Securely taping the container (do not lick the adhesive seal); and
   - Initialing and dating the seal by writing over the tape onto the evidence container. Stapling is not considered a secure seal.
   - See **Appendix G**: Sealed Evidence Envelope for an example of proper sealing.

5. **Store evidence in a secure area**
   Evidence must be kept in a secure area when not directly in the possession of a person listed in the chain of custody.

6. **Maintain the chain of custody**
   The chain of custody documents the handling, transfer, and storage of evidence beginning with the collection of the evidence at the medical facility. It continues with each transfer of the evidence to law enforcement, the crime laboratory, and others. Complete documentation of the chain of custody information ensures there has been no loss or alteration of evidence prior to trial.

   - **Document all transfers of evidence with the following information:**
     - Name of person transferring custody;
     - Name of person receiving custody;
     - Date of transfer; and
     - Some jurisdictions also require documentation of time of evidence transfer. Consult your local crime laboratory for their requirements.

- **Chain of custody information can be:**
  - Printed by hand on an evidence envelope or box;
  - Securely attached to an evidence envelope or box; or
  - Preprinted on special envelopes, boxes and/or forms.
  - See **Appendix H** for a sample of the Chain of Custody Form.

C. COLLECTION OF CLOTHING

1. Collect clothing worn by the patient upon arrival at the hospital, if indicated.

2. Types of evidence on clothing

Clothing worn at the time of the assault may contain useful evidence:

- Rips, tears or other damage sustained as a result of the assault;
- Blood and other body fluids from the patient; and
- Foreign materials such as fibers, grass, soil, and other debris.

3. Collection procedures

- **Have patients remove their shoes first, then disrobe on two sheets of paper placed on top of one another on the floor.**
  The purpose of the bottom sheet is to protect the top sheet from dirt and debris on the floor. The purpose of the top sheet is to collect loose trace evidence which may fall from the clothing during disrobing. Using the disposable paper from examination tables is acceptable for this purpose.

- **Shoes**
  The shoes may be collected and packaged separately, if requested by the investigating agency or if indicated by the assault history.

- **Hairs, fibers, and debris**
  Collect loose hairs, fibers, and debris that fall from the clothing on the top sheet of paper placed on the floor for this purpose. After the clothing has been collected, fold the top sheet of paper (from the two sheets on the floor) into a large bindle to ensure that all foreign materials are contained inside. Label and seal to ensure that the contents cannot escape. Place into a large paper bag. The bottom sheet should be discarded.

- **Folding garments**
  Fold each garment as it is removed to prevent body fluid stains or foreign materials from being lost or transferred from one garment to another. Avoid folding the clothing across possible body fluid stains.

- **Wet clothing**
  It is preferable to dry clothing before packaging. If drying is not possible, wet clothing can be folded sandwiched between sheets of paper. After placing the item in a paper bag, clearly label the bag as containing a wet item and notify the law enforcement officer. Consult your local crime laboratory for additional recommendations.

- **Containers for clothing**
  Package each item of clothing in an individual paper bag. **Do not use plastic bags**. Plastic retains moisture which can result in mold and deterioration of biological evidence.

4. **Securely seal and label each clothing bag with the following information:**
   - Full name of patient;
   - Date of collection;
   - Brief description of item; and
   - Signature or initials of the person who collected the evidence and placed it in the container.

5. **Place small bags of clothing and the large paper bindle (from the floor) into large bag(s)**
   Place all bags (except those containing wet evidence) and the bindle made from the top sheet of paper into a large paper bag which has a chain of custody form printed on it or firmly attached. Multiple large bags may be used, if necessary.

D. PROCEDURES FOR BITE MARKS

1. **Photographing bite marks**
   Individuals can be identified by the size and shape of their bite marks. Properly taken photographs of bite marks and bruises can assist in the identification of the person who inflicted the injury. See Chapter X on Photography.

2. **Collecting saliva from bite marks after photo documentation**
   This sample can be examined by the crime laboratory for the presence of saliva and can be genetically typed and compared to potential suspects. Follow these procedures:

   - Swab the general area of trauma with a swab moistened with distilled, deionized or sterile water.

   - **Note:** If the patient history indicates a bite and there are no visible findings, swab the indicated area.

- Collect a control swab from an unbitten atraumatic area adjacent to the suspected saliva stain.

- Label, air dry, and package the evidence and control swabs separately.

3. Casting bite marks

- If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
- A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
- Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

E. BRUISING AND AGING OF INJURIES

Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.

- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in one to two days after the bruising develops more fully.

F. TOXICOLOGY

In addition to clinical implications, the presence of drugs in the patient's blood or urine may have legal significance.

1. Collect toxicology samples if the patient:

- Is unconscious;
- Exhibits abnormal vital signs;
- Reports ingestion of drugs or alcohol;
- Exhibits signs of memory loss, dizziness, confusion, drowsiness, impaired judgment;
- Shows signs of impaired motor skills;
- Describes loss of consciousness, memory impairment or memory loss;
- Reports nausea; and/or
- Exhibits other unexplained neurologic findings such as seizures.

2. Use these containers for toxicology samples:

Blood samples	Gray stoppered evacuated blood collection vials
Urine Samples	Tightly sealed clean plastic or glass container
Note: Refrigeration of toxicology samples is recommended.	

3. Collect toxicology samples as soon as possible

Alcohol metabolizes rapidly. Many drugs are also quickly eliminated from the body.

For alcohol analysis, collect a blood sample (5cc).
• Some drugs may also be detected in this sample if it is collected within 24 hours of ingestion. If this is a consideration, collect additional blood for drug analysis. • Be sure to cleanse the arm with a non-alcoholic solution.

If ingestion of drugs is suspected within 96 hours of the examination, collect the first available urine specimen.
• If the patient must urinate prior to the medical examination, the urine specimen for toxicology should be collected at that time. • “Clean catch” or “mid-stream” sampling methods are unsuitable for urine toxicology specimens. • Consult your local crime laboratory for recommended collection methods.

CHAPTER X

PHOTOGRAPHY

A. POLICIES AND CONSIDERATIONS

Photographs are recommended to supplement documentation of history and physical findings. They may be the only way to adequately document findings such as bite marks, bruises, or massive injuries.

- Photograph every potentially significant injury or finding.
- Photographs may be taken by trained medical forensic examination team members or be arranged with the local law enforcement agency.
- Patients may be concerned about privacy and modesty during photography. Sensitivity to these concerns should be exercised when deciding whether hospital personnel, a male or female law enforcement officer, or crime scene investigator takes the photographs.

B. PHOTOGRAPHIC PROCEDURES

Any good quality camera may be used as long as it can be focused for undistorted, close-up photographs and provides an accurate color rendition.

- Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
- Digital imaging is gaining acceptance in some jurisdictions as long as certain safeguards are in place. Consult with the local District Attorney's Office.
- Use adequate lighting whether the source is natural, flood, or flash.
- Take close-up photographs of bite marks and other wounds with the film plane as parallel to the subject area as possible. Minimize tilting of the camera to avoid distortion of the pictures.
- Include an accurate ruler or scale for size reference in the photograph. The scale should be in close proximity to and in the same plane as the injury or item being photographed. (A right-angle ruler, available commercially from police supply companies, is recommended. Consult your crime laboratory for vendors).
- Include a color bar in the photograph in the first image of the roll or series to ensure accurate color reproduction.

- Link the patient's identity and the examination date to the photographs of injuries and/or findings. This can be accomplished by:

  - Including a picture of the patient's identification card on the roll; or

  - Using a camera databack that can be programmed with the patient's medical record number or another non-duplicative numbering system.

- Avoid obscuring the injury with the ruler, identification label, or color bar. At least one or two photographs should be taken without the scale and/or color bar to orient the injury and to demonstrate that important evidence was not covered up.

- Additional photographs taken with a tangential light source (flash) may be used to enhance textured or irregular surface findings (e.g., bite marks, focal swelling, etc.).

C. GENERAL FORENSIC PHOTOGRAPHIC TECHNIQUES

At least three photographs of findings are required. These principles may be modified or adapted if multiple findings are in the same area.

- First, a "regional" or "orientation" photograph(s) showing the body part and the finding. (This shows the finding in the total context of the body region involved, as well as the anatomical orientation of the finding);

- Second, a close-up shot showing the whole finding; and

- Third, a second close-up using the scale to document size and camera position relative to the finding.

D. FORENSIC PHOTOGRAPHY COURSES

The California Clinical Forensic Medical Training Center (CCFMTC) offers courses on forensic photography. See **Appendix B** for information on how to access CCFMTC courses.

CHAPTER XI

CONSULTATION THROUGH TELEMEDICINE AND TECHNOLOGY

Telemedicine and telecourses are evolving rapidly through technology. Various types and resources are listed below:

A. POTS (PLAIN OLD TELEPHONE SYSTEM) AND POMS (PLAIN OLD MAIL SYSTEM)

Telemedicine began with POTS and POMS. Case consultation began through telephone consultation and using the mail system to send photographs of injuries to experts at other locations for assistance in interpretation and case management. This is the current most common method for obtaining consultation.

B. TWO TYPES OF VIDEO CONSULTATION: REAL TIME AND STORE AND FORWARD

1. Real time consultation

The term "real time" refers to live, clinician to clinician consultation most often between a tertiary hospital and an outlying clinic in a rural area. The rural clinician may need back up in a particular specialty, for example, obstetrics or dermatology. A clinic is scheduled for certain times and days of the week and the tertiary hospital physician is scheduled to consult with the rural clinician at that time. Video cameras are permanently set up and the tertiary center clinician monitors the examination and observes the findings at the same time as the rural clinician.

2. Store and forward consultation

The term "store and forward" means to photograph or videotape the examination, to save or "store" the videotape or photograph, and to forward it to a specialist or expert at a tertiary center for consultation. Software exists to transmit photographic and videotaped images over telephone lines. Hardware requirements include a computer, monitor, and VCR at both sites. Confidentiality and the transmission of medical records have been addressed in the development of this software.

Store and Forward has been found to be most practical in the field of forensic medicine to evaluate child physical and sexual abuse cases. First, the timing of forensic exams is unpredictable and given the low volume in rural areas the "scheduled clinic" approach is more difficult to implement. Second, the time demands are high upon the few forensic medical experts in child abuse and sexual assault. A Store and Forward system makes it easier to view transmitted photographs and videotapes on a time schedule that works for the forensic expert. See **Appendix B** on how to contact the California Clinical Forensic Medical Training Center for further information.

3. **Interactive video consultation**
   Video consultation is generally focused on one or more case studies and is handled through point-to-point computer transmissions. This type of consultation is held around a computer monitor and four to six professionals (or more depending on the size of the monitor or screen) can be accommodated at each site. Point-to-point refers to a connection between a tertiary hospital and one or more outlying areas. A simultaneous telephone connection on a speaker phone is set up and visual images are transmitted on the computer monitor.

4. **Telecourses or distance learning through satellite transmissions**
   These terms are used to refer to courses transmitted simultaneously to different sites to a live audience. A tertiary center broadcasts the course to predetermined sites.

C. CD ROM COURSES

Reference materials and courses are now being developed on CD ROM. See **Appendix B** on how to contact the California Clinical Forensic Medical Training Center for further information.

CHAPTER XII

HOSPITAL SCAN TEAM MODELS

SCAN (Suspected Child Abuse and Neglect) Teams are multi-disciplinary teams involved in the identification and treatment of child victimization. The mission of these teams is to enhance the identification, reporting, and case management of child abuse and neglect cases through a multi-disciplinary approach.

A. HISTORY OF SCAN TEAMS

The first hospital-based child protection teams were established in the late 1950's at Pittsburgh Children's Hospital, the University of Colorado Medical Center, and Children's Hospital in Los Angeles.

Tasks of SCAN Teams include, but are not limited to:

- Performing case review of all child abuse and neglect reports;
- Reviewing medical reports for evaluation, follow-up and referrals;
- Coordination of treatment planning;
- Maintaining a central log of cases and/or a data system;
- Preparing an annual summary report;
- Providing training and education to the various disciplines and professionals involved in cases;
- Providing expert testimony in court; and,
- Providing a focus for research.

B. PRIMARY CARE FACILITY TEAMS

1. Team membership

A physician and medical social worker and/or nurse are designated as resource specialists in the area of child maltreatment.

2. Roles and responsibilities

- Case consultation to other health care providers in their setting regarding the assessment of child maltreatment and the development of an adequate information base for diagnosis;
- Guidance on making the required telephone and written reports;
- Consultation on developing a treatment plan for follow-up with the family;
- Serve as liaison with area hospitals, law enforcement agencies, child protective services, and other public agencies in all cases of child abuse and neglect seen at the facility;
- Provision of training and education for the staff at the facility;
- Developing reporting protocols and procedures; and,
- Case follow-up.

C. SECONDARY LEVEL FACILITY TEAMS

1. Team membership

These teams have a core group of professionals such as physicians, mid-level practitioners, nurses, social workers, child development and mental health specialists, and psychiatrists. Team members have specialized training and expertise in the recognition of child maltreatment, assessment and evaluation, the mechanics of reporting and public agency response, and community resources for treatment and follow-up. Other specialists may be called upon as needed for consultation, such as radiologists, ophthalmologists, and dentists. At this level, a representative from the local child protective services and/or law enforcement agency is usually a member.

2. Roles and responsibilities

- Availability of 24-hour consultation to hospital staff in order to provide immediate assistance on cases. The consultation service approach does not require the SCAN Team to take over the case from the treatment team, but rather, consultation is provided by telephone or in person. Referrals typically come from the Emergency Department, newborn nurseries, inpatient pediatric ward, burn unit, and primary care clinics, such as pediatrics, family medicine, and prenatal care.
- Consultation may also be provided to the psychiatric unit and dental clinics. In many hospitals, consultation with a member of the SCAN Team is required. Any faculty or staff, regardless of discipline, is required to seek consultation with the Team whenever there is concern about maltreatment.
- Guidance for interviewing the child and parents.
- Case management with law enforcement and Child Protective Services (CPS).
- Consultation on clinical studies needed to assist in making the diagnosis.
- Forensic medical evidence collection, related consent issues, dealing with the family, and making the reports.
- Case reviews at regularly scheduled multi-disciplinary meetings.
- Provision of expert testimony in Juvenile and Superior Court.

Some teams meet weekly and review every case referred, regardless of whether a report was made. Other teams review only complex cases in which the diagnosis is more difficult. These case reviews are usually more effective when the treating physician, nurse, social worker, and other relevant staff attend and present their cases, rather than having a “paper review” of the case. Cases where reporting was recommended and completed are reviewed for follow-up. Cases that do not result in reporting are also reviewed to determine other case management alternatives. Multi-disciplinary case reviews are particularly helpful in very complex

and difficult to sort out cases such as those involving medically fragile/chronically ill children with issues of medical noncompliance, failure-to-thrive, abusive head trauma, sexual abuse, medically fragile/chronically ill children where there is noncompliance, and Munchausen by Proxy.

The need to consider complex medical, developmental, social, and psychological data may require a separate meeting on a given case. Recommendations made by the SCAN Team are documented.

3. **Case follow-up**
   Follow-up reporting on case disposition is important to inform the SCAN Team about the response of the child protection system to the case, to know whether the Team's recommendations were acted upon by the public agencies and whether the recommended intervention, services, and treatment plan were put into place. Follow-up also involves the SCAN Team to ensure that all procedures are followed and reports are completed. Without follow-up, the Team is ineffective and risks being perceived as unrealistic and impractical by child protection and other community agencies.

4. **Centralized log of all referred cases**
   A patient identification code, the child's age, gender, referral source, and type of suspected maltreatment are basic elements of the database. The database allows for identification of major trends such as an increase/decrease in the number of reports of specific types of abuse and an increase in the overall referrals from the Emergency Department, law enforcement, and CPS. Depending upon the scope of data collected and recorded, other trends may be identified and lead to further clinical investigation (e.g., an increase in the number of babies delivered exposed to methamphetamines or cocaine, more cases from a particular part of the institution's geographic service area, etc). Documenting trends can assist in garnering support for additional community resources or changes in service-delivery.

   An annual summary report is useful to document the volume of cases referred, trends, and other activities required of, or undertaken by the SCAN Team. Teaching, research, and quality assurance activities are included in this report. Progress on grants obtained and updates on hospital programs addressing child abuse prevention and treatment issues are also included.

5. **Training and education for mandated reporters**
   A master calendar of annual training programs for medical and hospital staff to provide regular updates on child abuse topics is particularly helpful in teaching hospital institutions where there is continual influx of new faculty and staff or for use

in Grand Rounds educational presentations. SCAN Teams provide valuable training to child protection social workers, law enforcement, and criminal and dependency court personnel on medical evidentiary exam findings, and updates from the scientific literature. These training programs are opportunities for communication to increase understanding and appreciation of each discipline's role and methodology for assessment/investigation.

6. Consultation to community agencies

Child Protective Services (CPS), law enforcement, prosecutors, and the courts seek consultation and expert opinion. CPS may seek consultation from the Team on a case of a child who has never been seen at the hospital. SCAN Teams afford access to physicians and other health care providers with expertise in diagnosing child abuse and neglect.

7. Prevention activities

Child abuse prevention activities include: sponsoring awareness-raising campaigns in the hospital and community during Child Abuse Prevention Month; sponsoring annual conferences; developing and distributing materials at patient visits and in public areas of the hospital and community on various topics; providing parenting classes and support groups; providing educational materials to parents of newborns; and conducting child safety campaigns.

Many hospital administrations recognize the role SCAN Teams play in reducing and managing risk. Another value-added element is economy of labor – expert consultation results in improved documentation of cases, which in turn, reduces the volume and time spent on communications with investigating agencies and court appearances. If the situation does not warrant a mandated report, the team may contribute other strategies to use to address the family's problems, or suggest treatment resources.

D. TERTIARY FACILITY TEAMS

1. Coordinated approach to patient care

Some communities are developing highly trained specialized examiner programs using physicians, mid-level practitioners (nurse practitioners and physician assistants), and nurses within their scope of practice. Each model has a physician medical director. Referrals are received from throughout the region or county. There are various acronyms for these teams: SCAN (Suspected Child Abuse and Neglect), CARE (Child Abuse Response Examiners) and CAST (Child Abuse Services Team).

2. Key features of tertiary teams

- Medical leadership in the community, region, and statewide;
- Regional resource center;
- Coordinated team approach;
- Prompt forensic medical examinations for acute cases and consultation;
- Highly trained medical personnel;
- Defined areas of expertise in either child physical or sexual abuse, or both;
- Pre-authorization for reimbursement based upon negotiated contracts;
- Dedicated exam space and equipment;
- Immediate patient support and advocacy;
- Coordinated medical and law enforcement interviews;
- Specialized training for all team members;
- Peer review;
- Continuous quality improvement;
- Collaboration and cooperation with community resources;
- Utilization of best practice standards;
- Inclusion of public agencies in team membership (e.g., law enforcement, child protective services, Multi-Disciplinary Interview Center, and public health nurses);
- Provision of expert testimony throughout the region, state, and nationally;
- Participation in public policy committees and initiatives at the state and national levels;
- Telemedicine consultation and resource center;
- Mental health diagnostic and treatment services;
- Coordination for regional CQI, photo and case review meetings for other examiners to expand expertise;
- Research and publication in peer reviewed journals; and,
- Major conferences, symposia, and training programs.

3. Continuing quality improvement (CQI) and photo review

Formal CQI review is an essential standard of practice for medical evidentiary examination teams. Some community hospitals have developed CQI for the medical team operations and participate in regular CQI with the local law enforcement agencies and Children's Protective Services. CQI sometimes includes brief evaluation forms from the crime laboratory regarding the quality of evidence collection, preservation, and handling for the examination team on a per case basis. See **Appendix B** on how to contact the California Clinical Forensic Medical Training Center for further information.

E. HOSPITAL SCAN TEAMS: HISTORY OF SPAWNING NEW PROGRAMS

1. Development of Child Protection Centers

The early SCAN Teams opened up lines of communication between medical facilities and investigative agencies; increased awareness about child abuse and neglect; provided community education; developed cooperative agency partnerships; provided professional training for law enforcement officers, prosecutors, and investigative social workers on how to interpret medical evidentiary exam findings; and, in many instances, established foundational leadership in the community to address the problem of child abuse and neglect.

Beginning in the 1980's, Child Protection Centers emerged out of SCAN Teams, and built upon the foundation established by the SCAN Team model. The hospital-based centers began to operate on a much larger multi-disciplinary scale. These programs first developed in response to the need for specialized child sexual abuse medical evidentiary examinations and the higher level of collaboration required with investigative agencies. From this foundation, other services began to be developed and offered such as foster care health programs providing clearance and comprehensive medical exams with screening for medical, developmental, dental, and mental health problems; comprehensive mental health programs including individual, group, and family therapy; research; and more formalized regional and statewide conferences and training programs.

These programs are often extensively involved in addressing larger child protection system policy issues; initiating system change to improve intervention services; developing interagency protocols for case management; and engaging in legislative and public policy advocacy at the State and Federal level.

2. Multi-Disciplinary Interview Centers (MDICs) or Multi-Disciplinary Interview Teams (MDIT)

MDICs and MDITs arose from local multi-disciplinary teams and coordinating councils and, in many instances, the original SCAN Team. These programs ensure coordinated case investigations and involve commitments from agencies to participate in a multi-disciplinary, multi-agency approach to interview children utilizing child interview specialists.

These programs are often called Multi-Disciplinary Interview Centers (MDICs) or Multi-Disciplinary Interview Teams (MDITs). In some cases, the MDIC/MDIT is located at the hospital. In most instances, the MDIC/MDIT is located at a public agency such as the District Attorney's Office or Child Protective Services, and makes referrals to the hospital's child abuse specialists for forensic medical exams.

Information from this chapter is based on the article entitled “Hospital SCAN (Suspected Child Abuse and Neglect) Team Models” by Nancy C. Hayes, L.C.S.W. from the book Child Abuse and Neglect: Guidelines for identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment, and case management of carious forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor’s Office of Criminal Justice Planning (now the Governor’s Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

CHAPTER XIII

CHILD DEATH REVIEW TEAMS

A. PURPOSES OF CHILD DEATH REVIEW TEAMS

Child Death Review Teams (CDRTs) are multi-agency, multi-disciplinary state and/or local teams that systematically review child deaths within a specific geographic area. They play a critical role in helping to identify child abuse and neglect fatalities and other preventable child deaths. Local CDRTs are often involved in the case management of child death investigations. State teams primarily serve the local teams or gather data for systems management and policy interventions. Many benefits have accrued from the work of CDRTs, including more accurate identification of child deaths due to child maltreatment, more effective determination of the underlying cause of suspicious deaths, identification of gaps and breakdowns in agencies and systems designed to protect children, and implementation of various prevention interventions.

1. Penal Code Section 11166.7 establishes County Child Death Review Teams

Each county may establish an interagency child death team to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases. Interagency child death teams have been used successfully to ensure that incidents of child abuse or neglect are recognized and other siblings and nonoffending family members receive the appropriate services in cases where a child has expired.

Each county may develop a protocol that may be used as a guideline by persons performing autopsies on children to assist coroners and other persons who perform autopsies in the identification of child abuse or neglect, in the determination of whether child abuse or neglect contributed to death, or whether child abuse or neglect had occurred prior to but was not the actual cause of death, and in the proper written reporting procedures for child abuse or neglect, including the designation of the cause and mode of death.

In developing an interagency child death team and an autopsy protocol, each county, working in consultation with local members of the California State Coroner's Association and county child abuse prevention coordinating councils, may solicit suggestions and final comments from persons, including but not limited to, the following:

- Experts in the field of forensic pathology;
- Pediatricians with expertise in child abuse;
- Coroners and medical examiners;

- Criminologists;
- District Attorneys;
- Child Protective Services staff;
- Law enforcement personnel;
- Representatives of local agencies involved with child abuse or neglect reporting;
- County health department staff who deal with children's health issues; and
- Local associations of professionals listed above.

2. Roles and responsibilities of Child Death Review Teams

Child Death Review Teams may perform any or all of the following tasks:

- Review and assess whether child deaths are homicides associated with abuse or neglect;
- Review and assess the causes of all child deaths with the intent of identifying circumstances surrounding preventable deaths;
- Improve the criminal investigation and prosecution of child abuse homicides;
- Improve dependency investigations and the protection of surviving siblings;
- Serve as a quality assurance team for death investigations;
- Design and implement cooperative protocols for investigation of child deaths;
- Improve linkages, communication and coordination among law enforcement, social services, local health agencies, the District Attorney's Office, the coroner and others;
- Provide a forum for agencies to resolve conflicts;
- Collect uniform and accurate statistics on child deaths; and,
- Identify public health issues and make recommendations to county and state policymakers and legislators.

3. Team Membership

Core members:

- County Medical Examiner or Coroner;
- Law Enforcement Agencies;
- Child Protective Services;
- District Attorney's Office; and
- Pediatrician (preferably with experience in child abuse evaluations).

Additional members:

- Child advocate;
- School representative;
- Fire Department or Emergency Medical Services;
- Mental Health representative;

- Liaison with the California Highway Patrol (CHP) (if available);
- Epidemiologist or data analyst (e.g., Office of Vital Statistics;
- Probation Officer; and
- Injury Control Specialist.

4. Selection criteria

CDRTs systematically select child deaths for review using predetermined criteria. Usually cases are drawn either from the deaths reported to the coroner or from vital statistics death certificates. Many counties (e.g., small and mid-sized counties) review all child deaths, whereas larger counties may have more selective review criteria (e.g., only coroner cases). Age criteria usually range from selecting only children under 7 to selecting all children under 20. The most common age criterion is children under 18 years of age.

Examples of review criteria used by various teams:

- All children under age 18;
- Coroner's cases of all children's deaths;
- "Unexpected", "unexplained", or "suspicious" deaths;
- Deaths under a certain age;
- Deaths of children known to Child Protective Services; and
- Deaths from certain causes.

Recommended minimum criteria:

- All coroner child death cases; and
- All children under 18 years of age.

5. Recommended "best practice" procedures

- Systematic intake and review of cases drawn by protocol from the coroner and/or vital statistics records;
- Teams function as a peer review, respecting confidentiality and sharing information across agency lines;
- Authentic peer review with no agency controlling or censuring the information, discussion, or activity of another;
- Multi-disciplinary team membership of investigative agencies with administrative support to collect, analyze, publish, and distribute the data locally for the Board of Supervisors, directors of public agencies, and in newspaper(s) for the public; and
- Capability for promoting and implementing basic or advanced procedures, policies, and prevention programs through team member agencies (e.g. , County Health Department or Child Abuse Prevention Council) or other community resources.

B. ROLE OF THE STATE CHILD DEATH REVIEW COUNCIL

The California State Child Death Review Council (CSCDRC), established under the auspices of the Department of Justice (DOJ), was organized to establish leadership at the state level with representatives from key state agencies and associations. This statewide council was established pursuant to Penal Code Section 11166.9. According to the legislative mandate, it shall be the duty of the CSCDRC to oversee the statewide coordination and integration of state and local efforts to address fatal child abuse and neglect, and to create a body of information to prevent child death. Goals of the State Council include:

- Create and maintain an integrated, automated statewide data system for all counties and relevant state agencies;
- Promote the use of standardized forms and data collection protocols;
- Foster communication between state and local teams, other states, federal agencies and national associations, including dissemination of data and a statewide directory;
- Address local, state, and federal policy legislation issues and guidelines;
- Seek additional resources and funding for county team efforts;
- Support the development of domestic violence death review teams;
- Promote increased awareness of the relationship between domestic violence and child abuse;
- Promote development of a model for small counties (e.g., multi-county teams or cluster groups for counties with populations under 20,000);
- Raise visibility of child deaths and child death review teams through public education programs and the annual state report;
- Promote education and training for child death review team members;
- Develop an evaluation process to assess team effectiveness;
- Encourage continued research efforts at the state and federal level regarding child deaths and related issues; and
- Provide training and technical assistance to local teams.

This chapter is a condensed version of the articles entitled “Child Death Review Teams” by Michael Durfee, M.D. and Stephen J. Wirtz, Ph.D. from the book Child Abuse and Neglect: Guidelines for Identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment and case management of various forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor’s Office of Criminal Justice Planning (now the Governor’s Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

CHAPTER XIV

MENTAL HEALTH AND DEVELOPMENT ISSUES AND REFERRALS

A. PSYCHOLOGICAL AND BEHAVIORAL OUTCOMES ASSOCIATED WITH CHILD PHYSICAL ABUSE

1. Psychological and Social Problems Associated with Physically Abused Children

- Post-traumatic Stress Disorder (PTSD);
- Generalized anxiety;
- Depression;
- Withdrawal;
- Feeling different from others and socially isolated;
- Poor interpersonal social skills; and
- Poor school performance and/or underachieving

2. Behavioral problems associated with physically abused children

- Difficult or aggressive behavior;
- Oppositional and/or defiant behavior;
- School problems; and
- Bullying and fighting behavior

3. Recommended mental health treatment modalities

- Individual therapy;
- Group therapy;
- Parent-Child Interaction Therapy (PCIT); and
- Home visiting programs

B. PSYCHOLOGICAL AND BEHAVIORAL OUTCOMES ASSOCIATED WITH CHILD NEGLECT

1. Psychological, developmental, and behavioral outcomes associated with child neglect

- Poor impulse control and creativity;
- Poor academic performance;
- Poor interpersonal social skills;
- Poor language comprehension;
- Speech delays;
- Lower IQ scores;
- Not “ready to learn” in school;
- Withdrawn and reticent to participate in activities;
- Depression;

- Anxiety; and
- Vulnerability for developing alcohol and drug abuse problems and for developing significant mental health problems

2. Recommended treatment modalities

- Home visiting programs;
- Individual therapy; and
- Group therapy

C. MENTAL HEALTH TREATMENT

1. Indicators for mental health treatment for abused and neglected children

- History of neglect, physical and sexual abuse;
- Death of a sibling or a parent;
- Child or parent history of alcohol and/or drug abuse;
- Depression, sadness, withdrawal and avoidance of others, fearful;
- Angry, agitated;
- Signs of stress (e.g., unable to go to sleep, wakes during the night, eating problems, quick temper, easily frustrated);
- Acting out behavior (e.g., aggressive with peers, caregivers, teachers);
- History of torture;
- Mistreatment of animals;
- Firesetting;
- School problems (e.g., poor grades, poor concentration, little participation in activities);
- Change or deterioration of behavior;
- Suicidal ideation;
- Risk of placement disruption due to behavioral difficulties;
- Difficulties with self-care not due to developmental disability;
- Hallucinations or delusions; and
- History of receiving psychotropic medication.

2. **Purpose and types of mental health treatment**
   The purpose of mental health treatment is to alleviate psychological and behavior symptoms and to facilitate the development and maintenance of healthy functioning across an individual's life domains (e.g. home, work, or school). The primary treatment modalities are:

   - Individual therapy (e.g., various psychodynamic therapeutic models, sand tray, cognitive-behavioral therapy, and play therapy);
   - Dyadic therapy (e.g., Parent-Child Interaction Therapy);
   - Group therapy; and
   - Family therapy.

   Home-based and family-centered service approaches may also be helpful in supporting children and families. Home visiting programs, family resource centers, family conferencing, and wraparound social service support models are being developed in many communities to enhance existing systems of care.

3. **Indicators for a psychological evaluation**
   Sometimes the clinical or psychosocial assessment indicates a need for a psychological evaluation to obtain more detailed information regarding the child's psychological functioning or when the diagnosis is unclear. For a treatment plan to be successful, it is important to know, for example, whether the child is suffering from Post Traumatic Stress Disorder (PTSD) or has Attention Deficit Hyperactivity Disorder (ADHD) because the symptoms can be similar but the treatment plans are different.

   Psychologists are the only mental health professionals accredited to perform psychological testing and evaluation, and they employ a battery of tests that evaluate:

   - **Cognitive functioning**
     Processing information, learning strengths and weaknesses, memory, verbal and nonverbal abilities, and academic abilities.

   - **Affective functioning**
     Emotions, fantasies, and feelings.

   - **Adaptive functioning**
     How an individual functions in the world in areas such as communication, daily living skills and socialization.

- **Pathological functioning**
  Ways in which the individual's internal conflicts and drives distort or overwhelm the ability to deal effectively with the demands of external reality.

- **Personality**
  Clinical symptoms, personality traits and patterns, and interpersonal functioning.

- **Developmental functioning**
  Cognitive, communication, social, adaptive, and/or motor development.

4. Psychological testing

Psychological testing can address these questions about an individual:

- What are the client's intellectual strengths and limitations?
- Is there evidence of neurological immaturity or impairment?
- What is the nature of past knowledge and achievements, interests, and aptitudes?
- How adequate is reality testing?
- What is the quality of interpersonal relationships?
- What are the adaptive strengths (application of assets and liabilities to new problems, flexibility of approach, persistence, frustration tolerance, and reaction to novelty)?
- To what degree are impulses maintained under control (under-controlled or over-controlled)?
- How does the person defend psychologically (protect the self from feelings, ideas, and experiences that create anxiety through avoidance, repression, fighting or aggression, etc.) against unacceptable internal needs and demands or external experiences? How rigid are the client's defenses?
- What are the areas of conflict?
- Does the child have a psychiatric disorder?
- What is the child's developmental functioning?
- What treatment strategies and services would be most effective in improving functioning?
- What support services would be helpful to the parents or caregivers?

5. Indicators for a psychiatric evaluation

Psychiatric evaluations are sometimes needed to evaluate complex issues that may need to be resolved with hospitalization or medication support for relief of symptoms. Psychiatric evaluations are helpful with parents and children in cases involving:

- Previous psychiatric history;
- Psychotic symptoms such as hallucinations (e.g. , hearing voices), delusional thinking (odd or magical beliefs) or bizarre ideation;
- Suicidal ideation or attempts or self-destructive behaviors;
- Significant anxiety (fears/worrying) and depression (sadness/withdrawal/anger/passivity);
- Episodes of dissociation, (i.e. “spacing out”);
- Inattention, forgetfulness, distractibility, or difficulty concentrating;
- Aggressive outbursts (whether toward others or animals) or firesetting;
- Hyperactivity or excessive energy;
- Changes in sleeping or eating patterns;
- Pain or any medical symptom that does not have medical basis;
- Regressed behaviors (e.g., bedwetting in a previously “dry” child);
- Inappropriate sexualized behaviors; and/or,
- Obsessive thoughts or compulsive behaviors.

D. CHILD DEVELOPMENT EVALUATIONS

1. Indicators for making a referral for a developmental evaluation

Early diagnosis gives the child with developmental disorders an important head start in school or identifies reasons behind school problems. It is especially critical that a treatment plan be determined and implemented before or during the child’s early school years. Guidelines for referral for a developmental evaluation include:

- Delays in reaching early developmental milestones (such as sitting, crawling, babbling or using words, and learning new social or play skills);
- Language delay, cognitive delay, fine and gross motor skill delay;
- Hyperactivity or behavior problems;
- Regression (loss) of skills;

- School or learning problems;
- Atypical behaviors (e.g., inability to interact or play with other children, inattention, daily living skill and self-care deficits);
- History of prenatal drug exposure, low birth weight or prematurity;
- Inability to understand or follow directions, or inability to explain ideas or speak clearly; and/or
- Children with histories of child abuse and neglect.

2. Formal Developmental Evaluation

A formal child developmental evaluation requires a multi-disciplinary team which includes a clinical psychologist with specialized training in child development and developmental disorders, a Developmental-Behavioral Pediatrician, and a social worker with training in child development. Assessment requires knowledge of typical and atypical development, cultural and social aspects of behavior, psychometric concepts, multiple diagnostic measures and techniques, ethnical/legal issues and an understanding of the child welfare and other intervention service systems.

This chapter is a condensed version of the article entitled "Developmental Issues in Abused and Neglected Children" by Theresa Witt, Ph.D. and Robin Lee Hansan, M.D. from the book Child Abuse and Neglect: Guidelines for Identification, Assessment, and Case Management, published by Volcano Press, 2003 (www.volcanopress.com).

This publication contains extensive chapters on the identification, assessment and case management of various forms of child abuse and neglect written by over 95 experts in the field. This project was partially funded by the Governor's Office of Criminal Justice Planning (now the Governor's Office of Emergency Services), State Maternal and Child Health, and Volcano Press, Inc. as a public/private partnership.

APPENDICES

APPENDIX A
California Penal Code Section 11171

This legislation was introduced by Senator Figueroa and signed into state statute August 2002.

11171. (a) (1) The Legislature hereby finds and declares that adequate protection of victims of child physical abuse or neglect has been hampered by the lack of consistent and comprehensive medical examinations.

(2) Enhancing examination procedures, documentation, and evidence collection relating to child abuse or neglect will improve the investigation and prosecution of child abuse or neglect as well as other child protection efforts.

(b) The agency or agencies designated by the Director of Finance pursuant to Section 13820 shall, in cooperation with the State Department of Social Services, the Department of Justice, the California Association of Crime Lab Directors, the California State District Attorneys Association, the California State Sheriffs
Association, the California Peace Officers Association, the California Medical Association, the California Police Chiefs' Association, child advocates, the California Clinical Forensic Medical Training Center, child protective services, and other appropriate experts, establish medical forensic forms, instructions, and examination protocol for victims of child physical abuse or neglect using as a model the form and guidelines developed pursuant to Section 19823.5.

(c) The form shall include, but not be limited to, a place for notation concerning each of the following:

(1) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures.

(2) Addressing relevant consent issues, if indicated.

(3) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history.

(4) The performance of a physical examination for evidence of child physical abuse or neglect.

(5) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures.

(6) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated.

(7) Procedures for the preservation and disposition of evidence.

(8) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays.

(9) An assessment as to whether there are findings that indicate physical abuse or neglect.

(c) The forms shall become part of the patient's medical record pursuant to guidelines established by the advisory committee of the agency or agencies designated by the Director of Finance pursuant to Section 13820 and subject to the confidentiality laws pertaining to the release of a medical forensic examination records.

(D) The forms shall be made accessible for use on the Internet.

APPENDIX B



CALIFORNIA CLINICAL FORENSIC MEDICAL TRAINING CENTER

Improving the Healthcare Response to Violence

California Clinical Forensic Medical Training Center (CCFMTC)
921 11th Street
Suite 300
Sacramento, CA 95814
Telephone: (916) 930-3080
Website: www.ccfmtc.org

The CCFMTC offers skill-based training for performing quality medical/evidentiary examinations for victims of child physical abuse, child sexual abuse, sexual assault, domestic violence, and elder and dependent adult abuse and neglect. Training modalities include multi-day, skill-based training and one-to-eight hour lectures. Telecourses, case consultation, Internet, and CD-ROM self-instruction courses are under development.

The California Penal Code includes eight specific objectives for the CCFMTC:

- Develop and implement a standardized training program for medical personnel that has been reviewed and approved by a multi-disciplinary peer review committee.
- Develop a telecommunications system network between the Training Center and other areas of the state, including rural and midsize counties. This service shall provide case consultations to medical personnel, law enforcement, and the courts and provide continuing medical education.
- Provide basic, advanced, and specialized training programs.

- Develop guidelines for the reporting and management of child physical abuse and neglect, domestic violence, and elder abuse and neglect.
- Develop guidelines for evaluating the results of training for the medical personnel performing examinations.
- Provide standardized training for law enforcement officers, district attorneys, public defenders, investigative social workers, and judges on medical evidentiary examination procedures and the interpretation of findings.
- Promote an interdisciplinary approach in the assessment and management of child abuse and neglect, sexual assault, elder abuse, domestic violence, and abuse or assault against persons with disabilities.
- Provide training in the dynamics of victimization, including, but not limited to, rape trauma syndrome, battered woman syndrome, the effects of child abuse and neglect, and the various aspects of elder abuse.

APPENDIX C

MANDATORY REPORTERS DEFINED BY PENAL CODE SECTION 11165.7

As used in this article, “mandated reporter” is defined as any of the following:

- A teacher.
- An instructional aide.
- A teacher’s aide or teacher’s assistant employed by an public or private school.
- A classified employee of any public school.
- An administrative officer or supervisor of child welfare and attendance, or a certificated pupil personnel employee of any public or private school.
- An administrator of a public or private day camp.
- An administrator or employee of a public or private youth center, youth recreation program, or youth organization.
- An administrator or employee of a public or private organization whose duties require direct contact and supervision of children.
- Any employee of a county office of education or the California Department of Education, whose duties bring the employee into contact with children on a regular basis.
- A licensee, an administrator, or an employee of a licensed community care or child day care facility.
- A headstart teacher.
- A licensing worker or licensing evaluator employed by a licensing agency as defined in Section 11165.11.
- A public assistance worker.
- An employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities.
- A social worker, probation officer, or parole officer.
- An employee of a school district police or security department.
- Any person who is an administrator or presenter of, or counselor in, a child abuse prevention program in any public or private school.
- A district attorney investigator, inspector, or local child support agency caseworker unless the investigator, inspector, or caseworker is working with an attorney appointed pursuant to Section 317 of the Welfare and Institutions Code to represent a minor.
- A peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2, who is not otherwise described in this section.
- A fire fighter, except for volunteer fire fighters.
- A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

- Any emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.
- A psychological assistant registered pursuant to Section 2913 of the Business and Professions Code.
- A marriage, family, and child therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code.
- An unlicensed marriage, family, and child therapist intern registered under Section 4980.44 of the Business and Professions Code.
- A state or county public health employee who treats a minor for venereal disease or any other condition.
- A coroner.
- A medical examiner, or any other person who performs autopsies.
- A commercial film and photographic print processor, as specified in subdivision (e) of Section 11166. As used in this article, "commercial film and photographic print processor" means any person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, for compensation. The term includes any employee of such a person; it does not include a person who develops film or makes prints for a public agency.
- A child visitation monitor. As used in this article, "child visitation monitor" means any person who, for financial compensation, acts as monitor of a visit between a child and any other person when the monitoring of that visit has been ordered by a court of law.
- An animal control officer or humane society officer. For the purposes of this article, the following terms have the following meanings:
  - "Animal control officer" means any person employed by a city, county, or city and county for the purposes of enforcing animal control laws or regulations.
  - "Humane society officer" means any person appointed or employed by a public or private entity as a humane officer who is qualified pursuant to Section 14502 or 14503 of the Corporations Code.
- A clergy member, as specified in subdivision (c) of Section 11166. As used in this article, "clergy member" means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.
- Any custodian of records of a clergy member, as specified in this section and subdivision (c) of Section 11166.
- Any employee of any police department, county sheriff's department, county probation department, or county welfare department.
- An employee or volunteer of a Court Appointed Special Advocate program, as defined in Rule 1424 of the Rules of Court.

- Volunteers of public or private organizations whose duties require direct contact and supervision of children are encouraged to obtain training in the identification and reporting of child abuse.
- Training in the duties imposed by this article shall include training in child abuse identification and training in child abuse reporting. As part of that training, school districts shall provide to all employees being trained a written copy of the reporting requirements and a written disclosure of the employees' confidentiality rights.
- School districts that do not train their employees specified in subdivision (a) in the duties of mandated reporters under the child abuse reporting laws shall report to the State Department of Education the reasons why this training is not provided.
- The absence of training shall not excuse a mandated reporter from the duties imposed by this article.

APPENDIX D

SUSPECTED CHILD ABUSE REPORT FORM
Department of Justice (DOJ) SS 8572

Department of Justice (DOJ) Form SS 8572 can be downloaded from this website:

http://caag.state.ca.us/childabuse/forms.htm

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ❒ YES ❒ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

❒ LAW ENFORCEMENT ❒ COUNTY PROBATION ❒ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY	
ADDRESS Street City Zip		DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE		TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip				TELEPHONE ( )
PRESENT LOCATION OF VICTIM	SCHOOL	CLASS		GRADE
PHYSICALLY DISABLED? ❒ YES ❒ NO	DEVELOPMENTALLY DISABLED? ❒ YES ❒ NO	OTHER DISABILITY (SPECIFY)		PRIMARY LANGUAGE SPOKEN IN HOME
IN FOSTER CARE? ❒ YES ❒ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ❒ DAY CARE ❒ CHILD CARE CENTER ❒ FOSTER FAMILY HOME ❒ FAMILY FRIEND ❒ GROUP HOME OR INSTITUTION ❒ RELATIVE'S HOME			TYPE OF ABUSE *(CHECK ONE OR MORE)* ❒ PHYSICAL ❒ MENTAL ❒ SEXUAL ❒ NEGLECT ❒ OTHER (SPECIFY)
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ❒ YES ❒ NO			DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ❒ YES ❒ NO ❒ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )			BUSINESS PHONE ( )
NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )			BUSINESS PHONE ( )

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip				TELEPHONE ( )
OTHER RELEVANT INFORMATION				

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ❒ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

APPENDIX E

CALIFORNIA CHILD PROTECTIVE SERVICES AGENCIES

For current contact information, go to the Department of Social Services website at <*http://www.dss.cahwnet.gov/cfsweb/Res/pds/EmergencyR_315.pdf*>.

ALAMEDA COUNTY
Alameda County Welfare Dept.
8000 Edgewater Drive
Oakland, CA 94621

Main: (510) 259-1800

ALPINE COUNTY
Alpine County Dept. of Social Services
P.O. Box 277
Markleeville, CA 96120

Main: (530) 694-2235
Hotline: (888) 755-809

AMADOR COUNTY
Amador County Dept. of Social Services
1003 Broadway
Jackson, CA 95642

Days: (209)223-6550
Evenings: (209) 223-1075

BUTTE COUNTY
Butte County Dept. of Social Services
#1 County Center Drive
Oroville, CA 95249

Oroville: (530) 538-7617
Others: (800) 400-0902

CALAVERAS COUNTY
Calaveras County Dept. of Social Welfare
Government Center
San Andreas, CA 95249

Days: (209) 754-6452
After Hours: (209) 754-6500

COLUSA COUNTY
Colusa County Dept. of Social Welfare
P.O. Box 370
Colusa, CA 95932

Main: (530) 458-0280

CONTRA COSTA COUNTY
Contra Costa County Employment & Human Services.
2530 Arnold Drive, Suite 300
Martinez, CA 94553-4359

Central: (925) 646-1680
West: (510) 374-3324
East: (925) 427-8811

DEL NORTE COUNTY — Main: (707) 464-3191
Del Norte County Welfare Dept.
880 Northcrest Drive
Crescent City, CA 95531

EL DORADO COUNTY
El Dorado County Dept. of Social Services — S. Tahoe: (530) 544-7236
3057 Briw Road #A — Placerville: (530) 642-7100
Placerville, CA 95667

FRESNO COUNTY
Fresno County Dept. of Adult Protective Services — Main: (559) 255-8320
P.O. Box 1912
Fresno, CA 93750-0001

GLENN COUNTY
Glenn County Dept. of Social Services — Main: (530) 934-6520
420 East Laurel Street
Willows, CA 95988

HUMBOLDT COUNTY
Humboldt County Dept. of Social Services — Main: (707) 445-6180
929 Koster Street
Eureka, CA 95501

IMPERIAL COUNTY
Imperial County CWS Agency — Main: (760) 337-7750
2995 South 4th Street, Suite 105
El Centro, CA 92243

INYO COUNTY
Inyo County Welfare Dept. — Main: (760) 872-1727
Drawer A, Extension 2338
Independence, CA 93526

KERN COUNTY
Kern County Dept. of Human Services — Main: (661) 631-6011
P.O. Box 511
Bakersfield, CA 93302

KINGS COUNTY

Kings County Human Services Agency
1200 South Drive
Hanford, CA 93230

Main: (559) 582-8776

LAKE COUNTY

Lake County Social Services
P.O. Box 2-9000
Lower Lake, CA 95457

Main: (707) 262-0235

LASSEN COUNTY

Lassen County Welfare Dept.
P.O. Box 1359
Susanville, CA 96130

Days: (530) 251-8277
After Hours: (530) 257-6121

LOS ANGELES COUNTY

Los Angeles County Community & Senior Services
3175 West 6th Street 2-90020
Los Angeles, CA 2-90020

In-State: (800) 540-4000
Out-of-State: (213) 639-4500

MADERA COUNTY

Madera County Dept. of Public Welfare
P.O. Box 569
Madera, CA 93639

Main: (559) 675-7829
(800) 801-3999

MARIN COUNTY

Marin County Dept. of Health and Human Services
10 N. San Pedro Road, #1004
San Rafael, CA 94913

Main: (415) 499-7153
TDD: (415) 479-1601

MARIPOSA COUNTY

Mariposa County Dept. of Social Welfare
P.O. Box 7
Mariposa, CA 95338

Main: (209) 966-3030

MENDOCINO COUNTY

Mendocino County Dept. of Social Services
P.O. Box 839
Ukiah, CA 95482

Main: (707) 463-5600

MERCED COUNTY

Merced County Dept. of Human Services Agency
P.O. Box 112
Merced, CA 95341

Days: (209) 385-3104
After Hours: (209) 385-9915

MODOC COUNTY

Modoc County Dept. of Social Services
120 North Main Street
Alturas, CA 96101

Days: (530) 233-6501
After Hours: (530) 233-4416

MONO COUNTY

Mono County Dept. of Social Welfare
P.O. Box 93517
Bridgeport, CA 93517

Main: (760) 932-7755
Statewide: (800) 340-5411

MONTEREY COUNTY

Monterey County Dept. of Social Services
1000 South Main, Suite 202
Salinas, CA 93901

Main: (831) 755-4661

NAPA COUNTY

Napa County Human Services
2261 Elm St.
Napa, CA 94559

Main: (707) 253-4261

NEVADA COUNTY

Nevada County Department of Public Social Services
P.O. Box 1210
Nevada City, CA 95959

Main: (530) 265-9380

ORANGE COUNTY

Orange County Social Services Agency
P.O. Box 22006
Santa Ana, CA 92702-2006

Main: (714) 940-1000
(800) 207-4464

PLACER COUNTY

Placer County Welfare Department
11519 B Avenue
Auburn, CA 95603

Main: (530) 886-5310
(800) 488-4308

PLUMAS COUNTY

Plumas County Dept. of Social Services
P.O. Box 360
Quincy, CA 95971

Main: (530) 283-6350

RIVERSIDE COUNTY

Riverside County Dept. of Public Social Services
1020 Iowa Avenue
Riverside, CA 92507

Main: (800) 442-4918

SACRAMENTO COUNTY

Sacramento County Dept. of Social Services
4875 Broadway
Sacramento, CA 95817

Main: (916) 875-5437

SAN BENITO COUNTY

San Benito County Human Services Agency
1111 San Felipe Rd.
Hollister, CA 95023

Days: (831) 636-4190
After Hours: (831) 636-4330

SAN BERNARDINO COUNTY

San Bernardino Co. Social Services
494 North E Street
San Bernardino, CA 92401

Main: (800) 827-8724
After Hours: (909) 422-3266

SAN DIEGO COUNTY

San Diego County Department of Social Services
1261 Third Avenue
Chula Vista, CA 91911

Main: (858) 560-2191

SAN FRANCISCO COUNTY

San Francisco City and County Dept. of Human Services
P.O. Box 7988
San Francisco, CA 94120-9939

Main: (415) 558-2650
(800) 856-5553

SAN JOAQUIN COUNTY

San Joaquin County Human Services Agency
P.O. Box 201056
Stockton, CA 95201

Main: (209) 468-1333
(209) 468-1330

SAN LUIS OBISPO COUNTY

San Luis Obispo County Dept. of Social Services
P.O. Box 8119
San Luis Obispo, CA 93403-8819

Main: (805) 781-5437
(805) 834-5437

SAN MATEO COUNTY

San Mateo County Department of Health
225 West 37th Avenue
San Mateo, CA 94403

Main: (650) 595-7922
(800) 632-4615
Fax: (650) 595-7518

SANTA BARBARA COUNTY

Santa Barbara County Dept. of Social Services
234 Camino Del Remedio
Santa Barbara, CA 93110-1369

Days: (800) 367-0166
Lompoc: (805) 737-7078
After Hours: (805) 683-2724

SANTA CLARA COUNTY

Santa Clara County Department of Social Services
591 North King Road
Santa Clara, CA 95133

North: (408) 299-2071
South: (408) 683-0601

SANTA CRUZ COUNTY

Santa Cruz County Human Resources Agency
P.O. Box 1320
Santa Cruz, CA 95061

Main: (831) 454-4222
Watsonville: (831) 763-8850

SHASTA COUNTY

Shasta County Department of Social Services
P.O. Box 496005
Redding, CA 96049-6005

Main: (530) 225-5144

SIERRA COUNTY

Sierra County Department of Health and Human Services
P.O. Box 1019
Loyalton, CA 96118

24 Hours: (530) 289-3720
Bus. Hours: (530) 993-6720

SISKIYOU COUNTY

Siskiyou County Human Services	24 Hours:	(530) 842-7009
818 South Main	Bus. Hours:	(530) 841-4200
Yreka, CA 96097		

SOLANO COUNTY

Solano County Social Services	Main:	(800) 544-8696
275 Beck Ave.		
Fairfield, CA 94533		

SONOMA COUNTY

Sonoma County Social Services Department	Main:	(707) 565-4304
P.O. Box 1539		
Santa Rosa, CA 95402		

STANISLAUS COUNTY

Stanislaus County Community Service Agency	Main:	(800) 558-3665
P.O. Box 42		
Modesto, CA 95353		

SUTTER COUNTY

Sutter County Welfare Department	Main:	(530) 822-7155
P.O. Box 1599		
Yuba City, CA 95992		

TEHAMA COUNTY

Tehama County Department of Social Welfare	Main:	(800) 323-7711
		(530) 527-9416
P.O. Box 1515		
Red Bluff, CA 96080		

TRINITY COUNTY

Trinity County Welfare Department	Main:	(530) 623-1314
P.O. Box 1470		
Weaverville, CA 96093		

TULARE COUNTY

Tulare County Department of Public Social Services	Main:	(559) 730-2677
	Co. Only	(800) 331-1585
P.O. Box 671		
Visalia, CA 93279		

TUOLUMNE COUNTY

Tuolumne Department of Social Services	Days:	(209) 533-5717
20075 Cedar Road North	After Hours:	(209) 533-4357
Sonora, CA 95370		

VENTURA COUNTY

Ventura County Department of Social Services	Main:	(805) 654-3200
4651 Telephone Road, Suite 201		
Ventura, CA 93001		

YOLO COUNTY

Yolo County Department Employment &	Main:	(530) 669-2345
Social Services		(530) 669-2346
25 North Cottonwood Avenue	After Hours:	(530) 666-8920
Woodland, CA 95695		(888) 400-0022

YUBA COUNTY

Yuba County Health and Welfare Department	Main:	(530) 749-6288
6000 Lindhurst Avenue		
Marysville, CA 95901		

APPENDIX F

CALIFORNIA VICTIM/WITNESS ASSISTANCE CENTERS

For current contact information go to the Victim Compensation and Government Claims Board web site at <*http://www.boc.ca.gov/vwlist.htm*>.

ALAMEDA COUNTY
Victim/Witness Assistance Center
Alameda County District Attorney's Office
1401 Lakeside Drive, Suite 802
Oakland, CA 94612
Tel: (510) 272-6180
Fax: (510) 208-9565

ALPINE COUNTY
Victim/Witness Assistance Center
Alpine County District Attorney's Office
270 Laramie Street
P.O. Box 248
Markleeville, CA 96120
Tel: (530) 694-2971
Fax: (530) 694-2980

AMADOR COUNTY
Victim/Witness Assistance Center
Amador County District Attorney's Office
45 Summit Street
Jackson, CA 95642
Tel: (209) 223-6474
Fax: (209) 223-1953

BUTTE COUNTY
Victim/Witness Assistance Center
Butte County Probation Department
42 County Center Drive
Oroville, CA 95965
Tel: (530) 538-7340
Fax: (530) 534-8301

CALAVERAS COUNTY
Victim/Witness Assistance Center
Calaveras County District Attorney's Office
891 Mountain Ranch Road
San Andreas, CA 95249
Tel: (209) 754-6565
Fax: (209) 754-6732

COLUSA COUNTY
Victim/Witness Assistance Center
Colusa County Probation Department
532 Oak Street
Colusa, CA 95932
Tel: (530) 458-0659
Fax: (530) 458-3009

CONTRA COSTA COUNTY

Victim/Witness Assistance Center
Contra Costa County Probation Department
100 Glacier Drive, Suite A
Martinez, CA 94553

Toll Free: (800) 648-0600
Tel: (925) 646-2474
Fax: (925) 646-2739

San Pablo Victim/Witness Assistance Center
West County Office
2555 El Portal Drive
San Pablo, CA 94806

Tel: (510) 374-3272, or
(510) 374-3246
Fax: (510) 374-3441

DEL NORTE COUNTY

Victim/Witness Assistance Center
Del Norte County District Attorney's Office
450 H Street, Room 182
Crescent City, CA 95531

Tel: (707) 464-7273
Fax: (707) 464-2975

EL DORADO COUNTY

Victim/Witness Assistance Center
El Dorado County District Attorney's Office
South Lake Tahoe Office
1360 Johnson Boulevard, Suite 105
South Lake Tahoe, CA 96150

Toll Free: (800) 584-4438
Tel: (530) 573-3337
Fax: (530) 544-6413

Placerville Office
520 Main Street
Placerville, CA 95667

Toll Free: (888) 422-6492
Tel: (530) 621-6450
Fax: (530) 295-2602

FRESNO COUNTY

Victim/Witness Assistance Center
Fresno County Probation Department
2220 Tulare Street, Suite 1126
Fresno, CA 93721

Tel: (559) 488-3425
Fax: (559) 488-3826

GLENN COUNTY

Victim/Witness Assistance Center
HRA Community Action Division
420 East Laurel Street
Willows, CA 95988

Toll Free: (800) 287-8711
Tel: (530) 934-6510
Fax: (530) 934-6650

HUMBOLDT COUNTY

Victim/Witness Assistance Center
Humboldt County District Attorney's Office
712 Fourth Street
Eureka, CA 95501

Tel: (707) 445-7417
Fax: (707) 445-7490

IMPERIAL COUNTY

Victim/Witness Assistance Center
Imperial County Probation Department
217 South Tenth, Building A
El Centro, CA 92243

Tel: (760) 336-3930
Fax: (760) 353-3292

INYO COUNTY

Victim/Witness Assistance Center
301 West Line Street, Suite C
Bishop, CA 93514

Tel: (760) 873-6669
Fax: (760) 873-8359

Inyo County District Attorney's Office
P.O. Drawer D
Independence, CA 93526

Tel: (760) 878-0282
Fax: (760) 878-2383

KERN COUNTY

Victim/Witness Assistance Center
Kern County Probation Department
1415 Truxtun Avenue, 6th Floor, Room 603
Bakersfield, CA 93301

Tel: (661) 868-4535
Fax: (661) 868-4586

KINGS COUNTY

Victim/Witness Assistance Center
Kings County Probation Department
Kings County Government Center
1400 West Lacey Boulevard
Hanford, CA 93230

Tel: (559) 582-3211 ext. 2640
Fax: (559) 584-7038

LAKE COUNTY

Victim/Witness Assistance Center
Lake County District Attorney's Office
420 Second Street
Lakeport, CA 95453

Tel: (707) 262-4282
Fax: (707) 262-5851

LASSEN COUNTY

Victim/Witness Assistance Center
Lassen County District Attorney's Office
Courthouse
220 South Lassen Street, Suite 8
Susanville, CA 96130

Tel: (530) 251-8283
Fax: (530) 257-2-9009

LOS ANGELES COUNTY

Victim/Witness Assistance Center
Los Angeles County District Attorney's Office
3204 Rosemead Boulevard, Suite E
El Monte, CA 91731

Tel: (626) 927-2525
Fax: (626) 569-9541

Central Victim/Witness Office
210 West Temple, No. 12-514
Los Angeles, CA 2-90012

Toll free: (800) 773-7540
Tel: (213) 774-7499
Fax: (213) 625-8104

El Monte Victim/Witness Office
3220 North Rosemead Boulevard
El Monte, CA 91731

Toll Free: (800) 492-5944
Tel: (626) 572-6366
Fax:(626) 280-0817

El Monte Victim/Witness
11234 East Valley Boulevard
El Monte, CA 91731

Tel: (626) 350-4583
Fax: (626) 442-6543

Sexual Crimes/Child Abuse Unit
Hall of Records
320 West Temple Street, Room 740
Los Angeles, CA 2-90012

Tel: (213) 974-3801
Fax: (213) 625-2810

Carson Sheriff
21356 South Avalon Boulevard
Carson, CA 90745

Tel: (310) 830-8376
Fax: (310) 847-8368

Compton Courthouse
200 West Compton Boulevard, Room 700
Compton, CA 90220

Tel: (310) 603-7579, or
(310) 603-7574, or
(310) 603-7127
Fax: (310) 603-0493

Statutory Rape Program Hall of Records 320 West Temple Street, No. 740 Los Angeles, CA 2-90012	Tel: (213) 974-3908 Fax: (213) 625-2810
Inglewood Courthouse One Regent Street, Room 405 Inglewood, CA 90301	Tel: (310) 419-6764, or (310) 419-5175 Fax: (310) 674-7839
Long Beach Courthouse 415 West Ocean Boulevard, Room 305 Long Beach, CA 90802	Tel: (562) 491-6347, or (562) 491-6310 Fax: (562) 436-9849
Santa Monica Courthouse 1725 Main Street, Room 228 Santa Monica, CA 90401	Tel: (310) 260-3678 Fax: (310) 458-6518
Torrance Courthouse 825 Maple Avenue Torrance, CA 90503	Tel: (310) 222-3599 Fax: (310) 783-1684
Antelope Valley Courthouse 1110 West Avenue J Lancaster, CA 93534	Tel: (661) 945-6464 Fax: (661) 945-6179
Hollywood LAPD 1358 North Wilcox Avenue Los Angeles, CA 2-90028	Tel: (323) 871-1184 Fax: (213) 485-8891
Industry Sheriff 150 North Hudson Avenue City of Industry, CA 91744	Tel: (626) 934-3004 Fax: (626) 333-1895
Pasadena Courthouse 300 East Walnut Street, Room 107 Pasadena, CA 91101	Tel: (626) 356-5714, or (626) 356-5715 Fax: (626) 796-3176
Pomona Courthouse 400 Civic Center Drive, Room 201 Pomona, CA 91766	Tel: (909) 620-3381, or (909) 620-3382 Fax: (909) 629-6876

San Fernando Area
2-900 – 3rd Street, Room G14
San Fernando, CA 91340
Tel: (818) 898-2406
Fax: (818) 898-2743

Temple City Sheriff
8838 East Las Tunas Drive
Temple City, CA 91780
Tel: (626) 292-3333
Fax: (626) 287-7353

Van Nuys Courthouse
6230 Sylmar Avenue, 5th Floor
Van Nuys, CA 91401
Tel: (818) 374-3075
Fax: (818) 782-5349

Central LAPD
251 East Sixth Street
Los Angeles, CA 2-90014
Tel: (213) 627-1619
Fax: (213) 847-2956

East Los Angeles Courthouse
214 South Fetterly Avenue, Room 201
Los Angeles, CA 2-90022
Tel: (323) 780-2045
Fax: (323) 269-4869

Huntington Park Area Office
2958 East Florence Avenue
Huntington Park, CA 90255
Tel: (323) 586-6337
Fax: (323) 584-9055

Lakewood Sheriff
5130 North Clark Avenue
Lakewood, CA 90712
Tel: (562) 920-5156
Fax: (562) 867-4712

Norwalk Courthouse
12720 Norwalk Boulevard, Room 201
Norwalk, CA 90650
Tel: (562) 807-7230
Fax: (562) 929-7626

Rampart LAPD
303 South Union
Los Angeles, CA 2-90057
Tel: (213) 483-6731
Fax: (213) 207-2108

Southeast LAPD
145 West 108th Street
Los Angeles, CA 2-90061
Tel: (323) 754-8064
Fax: (323) 485-8340

Southwest LAPD
1546 Martin Luther King Boulevard
Los Angeles, CA 2-90062

Tel: (323) 296-8645
Fax: (323) 473-6757

Eastlake Juvenile Office
1601 Eastlake Avenue, Room 132
Los Angeles, CA 2-90033

Tel: (323) 226-8918
Fax: (323) 223 6248

Family Violence Division
Criminal Courts Building
210 W. Temple Street, Room 603
Los Angeles, CA 2-90012

Tel: (213) 974-7410, or
(213) 974-3879
Fax: (213) 217-4992

Stalking & Threat Management Team
Hall of Records
320 W. Temple Street, Room 780-41
Los Angeles, CA 2-90012

Tel: (213) 893-0896
Fax: (213) 626-2758

Whittier Branch Office
7339 S. Painter Ave., Room 200
Whittier, CA 90602

Tel: (562) 907-3189
Fax: (562) 696-9631

Child Abuse Crisis Center
Harbor-UCLA Medical Center
1000 W. Carson St.
Box 460 Trailer N-26
Torrance, CA 90509

Tel: (310) 222-1208
Fax: (310) 320-7849

East L.A. Sheriff
5019 E. Third Street
Los Angeles, CA 2-90022

Tel: (323) 981-5024
Fax: (323) 267-0637

<u>LOS ANGELES CITY</u> (Subgrant to Los Angeles County Victim/Witness)

Victim/Witness Assistant Center
Los Angeles City Attorney's Office
312 South Hill Street, Third Floor
Los Angeles, CA 2-90013
Tel: (213) 485-6976
Fax: (213) 847-8667

Victim Assistance Program
Korean Outreach Project
312 South Hill Street, Second Floor
Los Angeles, CA 2-90013
Tel: (213) 485-9889
Fax: (213) 847-8667

North Hollywood Station LAPD
Victim Assistance Program
11640 Burbank Boulevard
North Hollywood, CA 91601
Tel: (818) 623-4056
Fax: (818) 623-4121

Victim Assistance Program
San Pedro City Hall
638 S. Beacon St., Room 326
San Pedro, CA 90731
Tel: (310) 732-4611
Fax: (310) 732-4618

Victim Assistance Program
Van Nuys City Hall
14410 Sylvan Street, Room 117
Van Nuys, CA 91401
Tel: (818) 756-8488
Fax: (818) 756-9444

Wilshire Area Station LAPD
Victim Assistance Program
4861 Venice Boulevard
Los Angeles, CA 2-90019
Tel: (213) 847-1991
Fax: (213) 847-0668

West Los Angeles Station LAPD
Victim Assistance Program
1663 Butler Avenue
West Los Angeles, CA 2-90025
Tel: (310) 575-8441
Fax: (310) 575-6710

Newton Area Station LAPD
Victim Assistance Program
3400 South Central Avenue
Los Angeles, CA 2-90011

Tel: (323) 846-5374
Fax: (323) 846-6586

77th Street Area Station LAPD
Victim Assistance Program
7600 South Broadway
Los Angeles, CA 2-90003

Tel: (213) 485-8848
Fax: (213) 847-0667

Hollenbeck Area Station LAPD
Victim Assistance Program
2111 East First Street
Los Angeles, CA 2-90033

Tel: (323) 526-3190
Fax: (323) 485-8401

MADERA COUNTY

Victim/Witness Assistance Center
Madera County Community Action Committee, Inc.
1200 West Maple Street, Suite C
Madera, CA 93637

Tel: (559) 661-1000
Fax: (559) 661-8389

MARIN COUNTY

Victim/Witness Assistance Center
Marin County District Attorney's Office
3501 Civic Center Drive, Room 130
San Rafael, CA 94903

Tel: (415) 499-6450
Fax: (415) 499-3719

MARIPOSA COUNTY

Victim/Witness Assistance Center
Mariposa County District Attorney's Office
P.O. Box 730
Mariposa, California 95338

Tel: (209) 742-7441
Fax: (209) 742-5780

MENDOCINO COUNTY

Victim/Witness Assistance Center
Mendocino County District Attorney's Office
Courthouse, Room 10
100 North State Street
P.O. Box 144
Ukiah, CA 95482

Tel: (707) 463-4218
Fax: (707) 468-3371

MERCED COUNTY
Victim/Witness Assistance Center
Merced County District Attorney's Office
658 W. 20th St.
Merced, CA 95340

Tel: (209) 725-3515
Fax: (209) 725-3669

MODOC COUNTY
Victim/Witness Assistance Center
Modoc County District Attorney's Office
204 South Court Street
Alturas, CA 96101

Tel: (530) 233-3311
Fax: (530) 233-5024

MONO COUNTY
Victim/Witness Assistance Center
452 Old Mammoth Road, Third Floor
P.O. Box 2053
Mammoth Lakes, CA 93546

Tel: (760) 924-1710
Fax: (760) 924-1711

Bridgeport Victim/Witness Office
P.O. Box 617
Bridgeport, CA 93517

Tel: (760) 932-5550
Fax: (760) 924-1711

MONTEREY COUNTY
Victim/Witness Assistance Center
Monterey County District Attorney's Office
240 Church Street #101
P.O. Box 1311
Salinas, CA 93901

Tel: (831) 755-5272
Fax: (831) 796-6448

NAPA COUNTY
Victim/Witness Assistance Center
Napa County Volunteer Center, Inc.
1820 Jefferson Street
Napa, CA 94559

Tel: (707) 252-6222
Fax: (707) 226-5179

NEVADA COUNTY
Victim/Witness Assistance Center
Nevada County Probation Department
109 ½ North Pine Street
Nevada City, CA 95959

Tel: (530) 265-1246, or
(530) 265-1331
Fax: (530) 265-6304

ORANGE COUNTY

Victim/Witness Assistance Administrative Center
Community Service Programs, Inc.
1821 East Dyer, Suite 200
Santa Ana, CA 92705-5700
Tel: (949) 975-0244
Fax: (949) 975-0250

Superior Court
Central Justice Center
700 Civic Center Drive West
P.O. Box 1994
Santa Ana, CA 92702
Tel: (714) 834-4350
Fax: (714) 834-2688

North Justice Center
1275 North Berkeley Avenue
Fullerton, CA 92635
Tel: (714) 773-4575
Fax: (714) 441-3575

Harbor Justice Center-Laguna Niguel
30143 Crown Valley Parkway
Laguna Niguel, CA 92677
Tel: (949) 249-5037
Fax: (949) 249-5100

West Justice Center
8141 13th Street
Westminster, CA 92683
Tel: (714) 896-7188
Fax (714) 896-7526

Harbor Justice Center-Newport Beach
4601 Jamboree Boulevard, Suite 103
Newport Beach, CA 92660
Tel: (949) 476-4855
Fax: (949) 476-4623

Lamoreaux Justice Center
301 The City Drive
Orange, CA 92668
Tel: (714) 935-7074
Fax: (714) 935-6341

PLACER COUNTY

Victim/Witness Assistance Program
Placer County District Attorney's Office
11562 B Avenue
Auburn, CA 95603
Tel: (530) 889-7021
Fax: (530) 886-2294

PLUMAS COUNTY

Victim/Witness Assistance Center
Plumas County Sheriff's Department
75 Court Street, Suite A
Quincy, CA 95971

Tel: (530) 283-6285
Fax: (530) 283-6226

RIVERSIDE COUNTY

Victim/Witness Assistance Center
Riverside County District Attorney's Office
4075 Main Street, First Floor
Riverside, CA 92501

Tel: (909) 955-5450
Fax: (909) 955-5640

Banning Victim/Witness Office
Western Riverside County
135 North Alessandro, Room 205
Banning, CA 92220

Tel: (909) 849-6218
Fax: (909) 922-7135

Blythe Victim/Witness Office
Eastern Riverside County
225 North Broadway
Blythe, CA 92225

Tel: (935) 921-7878
Fax: (935) 921-7849

Southwest Justice Center
30755-D Auld Road
Murrieta, CA 92563

Tel: (909) 304-5500
Fax: (909) 304-5503

Indio Victim/Witness Office
Eastern Riverside County
82-675 Highway 111, Fourth Floor
Indio, CA 92201

Tel: (760) 863-8408
Fax: (760) 863-7640, or
(760) 863-8987

Riverside Juvenile Office
Western Riverside County
9991 County Farm Road
Riverside, CA 92503

Tel: (909) 358-4152
Fax: (909) 358-4497

Corona Police Department
515 So. Corona Mall
Corona, CA 92882

Tel: (909) 739-4872
Fax: (909) 279-3599

SACRAMENTO COUNTY
Victim/Witness Assistance Center
Sacramento County District Attorney's Office
901 G Street
P.O. Box 749
Sacramento, CA 95814
Tel: (916) 874-5701
Fax: (916) 874-5271

SAN BENITO COUNTY
Victim/Witness Assistance Center
San Benito County District Attorney's Office
419 Fourth Street
Hollister, CA 95023-3801
Tel: (831) 637-8244
Fax: (831) 636-4126

SAN BERNARDINO COUNTY
Victim/Witness Assistance Center
San Bernardino County District Attorney's Office
316 North Mountain View Avenue, 3rd Floor
San Bernardino, CA 92415
Tel: (909) 387-6540, or
(909) 387-6384
Fax: (909) 387-6313

San Bernardino Juvenile Division
2-900 East Gilbert Street
San Bernardino, CA 92415
Tel: (909) 387-8665
Fax: (909) 387-6980

San Bernardino Police Department
710 North D Street
San Bernardino, CA 92401
Tel: (909) 388-42-900
Fax: (909) 388-4843

Colton Police Department
650 North La Cadena Drive
Colton, CA 92324
Tel: (909) 370-5164
Fax: (909) 370-5158

Fontana Victim/Witness Center
17830 Arrow Boulevard
Fontana, CA 92335
Tel: (909) 356-6406
Fax: (909) 356-6779

Ontario Police Department
200 North Cherry Avenue
Ontario, CA 91764
Tel: (909) 395-2713
Fax: (909) 395-2730

Rancho Cucamonga Victim/WitnessOffice
8303 North Haven Avenue, 4th Floor
Rancho Cucamonga, California 91730
Tel: (909) 945-4241
Fax: (909) 945-4035

Victorville Victim/Witness Office
14455 Civic Drive
Victorville, California 92392
Tel: (760) 243-8619
Fax: (760) 243-8619

Barstow Victim/Witness Office
235 East Mountain View
Barstow, CA 92311
Tel: (760) 256-4802
Fax: (760) 256-4869

Joshua Tree Victim/Witness Center
6527 White Feather Road
Joshua Tree, CA 92252
Tel: (760) 366-5740
Fax: (760) 366-4126

SAN DIEGO COUNTY

Victim/Witness Assistance Center
San Diego County District Attorney's Office
330 West Broadway, Suite 800
P.O. Box 121011
San Diego, CA 92101
Tel: (619) 531-4041
Fax: (619) 685-6521

Chula Vista Victim/Witness Office
500 Third Avenue
Chula Vista, CA 92010
Tel: (619) 691-4539
Fax: (619) 691-4459

El Cajon Victim/Witness Office
250 East Main Street, 5th Floor
El Cajon, CA 92020
Tel: (619) 441-4538
Fax: (619) 441-4095

Vista Victim/Witness Office
325 South Melrose, Suite 5000
Vista, CA 92083
Tel: (760) 806-4079
Fax: (760) 806-4162, or
(760) 806-4163

Juvenile Victim/Witness Office
2851 Meadowlark Drive
San Diego, CA 92123

Tel: (858) 694-4595
Fax: (858) 694-4774

San Diego Police Department
1401 Broadway
San Diego, California 92101

Tel: (619) 531-2772, or
(619) 531-2773
Fax: (619) 525-8433

SAN FRANCISCO COUNTY AND CITY

Victim/Witness Assistance Center
San Francisco County District Attorney's Office
850 Bryant Street, Room 320
San Francisco, CA 94103

Tel: (415) 553-9044
Fax: (415) 553-1034

SAN JOAQUIN COUNTY

Victim/Witness Assistance Center
San Joaquin County District Attorney's Office
222 East Weber Avenue, Room 245
Stockton, CA 95202

Tel: (209) 468-2500
Fax: (209) 468-2521

SAN LUIS OBISPO COUNTY

Victim/Witness Assistance Center
San Luis Obispo County District Attorney's Office
County Government Center, Room 121
San Luis Obispo, CA 93408

Toll Free: (866) 781-5821
Tel: (805) 781-5822
Fax: (805) 781-5828

SAN MATEO COUNTY

Victim/Witness Assistance Center
San Mateo County District Attorney's Office
1024 Mission Road
South San Francisco, CA 94080

Tel: (650) 877-5492
Fax: (650) 877-7001

SANTA BARBARA COUNTY

Victim/Witness Assistance Center
Santa Barbara County District Attorney's Office
118 East Figueroa Street
Santa Barbara, CA 93101
Tel: (805) 568-2408
Fax: (805) 568-2453

Santa Maria Victim/Witness Office
312 East Cook Street
Santa Maria, CA 93454
Tel: (805) 346-7529
Fax: (805) 346-7585

Lompoc Victim/Witness Office
115 Civil Plaza Center
Lompoc, CA
Tel: (805) 737-7910
Fax: (805) 737-7732

SANTA CLARA COUNTY

Santa Clara County Victim/Witness
Assistance Center
National Conference for Community and Justice
777 North First Street, Suite 220
San Jose, CA 95112
Tel: (408) 295-2656
Fax: (408) 295-2045

SANTA CRUZ COUNTY

Victim/Witness Assistance Center
Santa Cruz County District Attorney's Office
701 Ocean Street, Room 200
Santa Cruz, CA 95060
Tel: (831) 454-2010, or
(831) 454-2623
Fax: (831) 454-2612

SHASTA COUNTY

Victim/Witness Assistance Center
Shasta County District Attorney's Office
1525 Court Street
Redding, CA 96001
Tel: (530) 225-5220, or
(530) 225-5195
Fax: (530) 245-6334

SIERRA COUNTY

Victim/Witness Assistance Center
Sierra County Probation Department
604B Main Street
P.O. Box 886
Loyalton, CA 96118
Tel: (530) 993-4617
Fax: (530) 993-4327

SISKIYOU COUNTY

Victim/Witness Assistance Center
Siskiyou County District Attorney's Office
311 4th Street
P.O. Box 986
Yreka, CA 96097

Tel: (530) 842-8229
Fax: (530) 842-8222

Tulelake Office
298 Street
P.O. Box 790
Tulelake, CA 96134

Tel: (530) 667-2147
Fax: (530) 667-2822

SOLANO COUNTY

Victim/Witness Assistance Center
Solano County District Attorney's Office
Hall of Justice
600 Union Avenue
Fairfield, CA 94533

Tel: (707) 421-6844
Fax: (707) 421-7986

Solano Victim/Witness Office
Solano County Justice Building
321 Tuolumne Street
Vallejo, California 94590

Tel: (707) 554-5400
Fax: (707) 554-5654

SONOMA COUNTY

Vacant, Project Coordinator
Victim/Witness Assistance Center
Sonoma County District Attorney's Office
P.O. Box 6023
Santa Rosa, CA 95406

Tel: (707) 565-8250
Fax: (707) 565-8262

STANISLAUS COUNTY

Victim/Witness Assistance Center
Stanislaus County District Attorney's Office
800 11th Street, Room 200
P.O. Box 442
Modesto, CA 95354

Tel: (209) 525-5541
Fax: (209) 525-5551

SUTTER COUNTY
Victim/Witness Assistance Center
Sutter County District Attorney's Office
204 C Street
P.O. Box 1555
Yuba City, CA 95991
Tel: (530) 822-7345
Fax: (530) 822-7464

TEHAMA COUNTY
Victim/Witness Assistance Center
Tehama County District Attorney's Office
444 Oak Street
P.O. Box 519
Red Bluff, CA 96080
Tel: (530) 527-4296
Fax: (530) 527-4735

TRINITY COUNTY
Victim/Witness Assistance Center
Trinity County Probation Department
333 Tom Bell Road
P.O. Box 158
Weaverville, CA 96093
Tel: (530) 623-1204
Fax: (530) 623-1237

TULARE COUNTY
Victim/Witness Assistance Center
Tulare County District Attorney's Office
221 South Mooney Boulevard #264
Visalia, CA 93291
Tel: (559) 733-6754
Fax: (559) 730-2931

TUOLUMNE COUNTY
Victim/Witness Assistance Center
Tuolumne County District Attorney's Office
423 North Washington Street
Sonora, CA 95370
Tel: (209) 588-5440
Fax: (209) 588-5455

VENTURA COUNTY
Victim/Witness Assistance Center
Ventura County District Attorney's Office
800 South Victoria Avenue, Room 311
Ventura, CA 93009
Tel: (805) 654-3622
Fax: (805) 662-6523

YOLO COUNTY

Victim/Witness Assistance Center
Yolo County District Attorney's Office
301 Second Street
Woodland, CA 95695

Tel: (530) 666-8187
Fax: (530) 666-8185

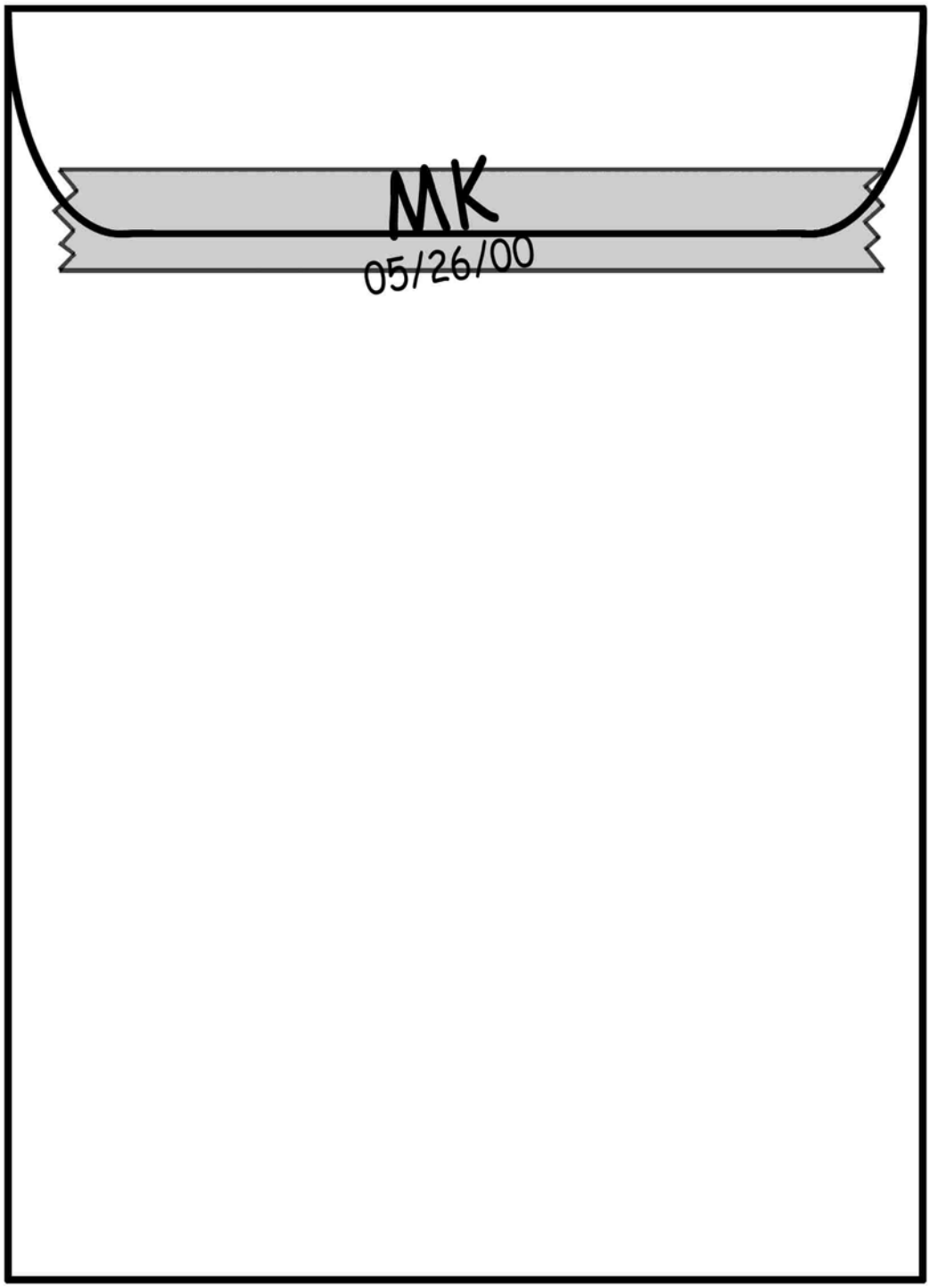
YUBA COUNTY

Victim/Witness Assistance Center
Yuba County Probation Department
4240 Dan Avenue
Marysville, CA 95901

Tel: (530) 741-6275
Fax: (530) 749-7913

APPENDIX G

EXAMPLE OF SEALED EVIDENCE ENVELOPE



Note: Sign and date over the seal.

APPENDIX H

CHAIN OF CUSTODY FORM

CALIFORNIA COUNTY
Laboratory of Forensic Sciences

EVIDENCE COLLECTION KIT

FOR HOSPITAL PERSONNEL
(Please print)

Name of Patient:_____ **Date of Birth:** _____ ☐ **Female** ☐ **Male**

Name of Examiner:_____

Name of Hospital:_____ **Date of Exam:**_____

Law Enforcement Agency: _____

Agency Case No.: _____

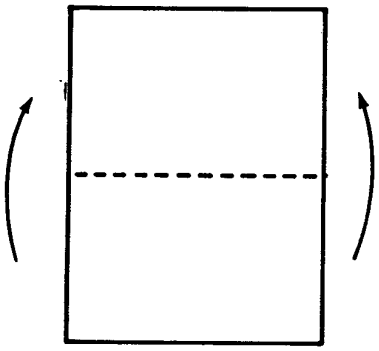
AFFIX BIOHAZARD LABEL HERE AFTER SPECIMEN COLLECTION

CHAIN OF CUSTODY

FROM: (Print Name and Sign)	**TO:** (Print Name and Sign)	**DATE**	**TIME**

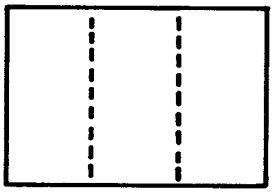
APPENDIX I

HOW TO MAKE A BINDLE



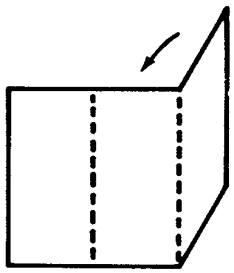
1

Fold the paper in half.



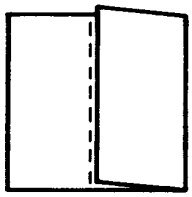
2

Fold the half-sized paper into thirds.

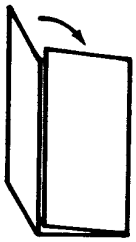


3

Fold over the right flap.

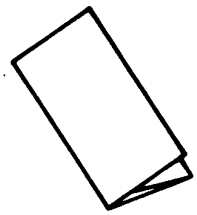


4



5

Fold over the left flap.



6



7

Fold in half. Seal the open end of the bindle, not the folded end. Initial the tape prior to sealing.

APPENDIX J

CalOES 2-900 FORM AND INSTRUCTIONS

The CalOES 2-900 form can be downloaded from these websites:

California Office of Emergency Services -- **www.CalOES.ca.gov**
Look for Criminal Justice Programs Division. Click on the appropriate document in Publications and Brochures to view document list.

California Clinical Forensic Medical Training Center
www.ccfmtc.org.

State of California
California Office of Emergency Services

MEDICAL REPORT:
SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION

CalOES 2-900

For more information or assistance in completing the CalOES 2-900, please contact California Clinical Forensic Medical Training Center at:(916) 930-3080 or www.ccfmtc.org

Forms available at: **www.CalOES.ca.gov and www.ccfmtc.org**

MEDICAL REPORT: SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION
State of California
California Office of Emergency Services CalOES 2-900

Confidential Document: Restricted Release | **Patient Identification:** | **Date:**

A. GENERAL INFORMATION

☐ See Patient Label/Registration Face Sheet

1. Name of Medical Facility Where Exam Performed	Facility Address	2. Date of Exam	Time of Exam

3. Patient's Last Name	First Name	M.I.	Telephone	Cell Phone

4. Street Address	City	County	State	Zip Code

5. Age	Date of Birth	Gender ☐ Female ☐ Male	Ethnicity

6. Interpreter Used: ☐ No ☐ Yes Language Used: _____

Name of Interpreter: _____ Telephone: _____

Affiliation of interpreter: ☐ Facility Interpreting Services

☐ Contracted Agency, specify: _____

☐ Family ☐ Friend ☐ Other, specify: _____

7. Name of Child's Caregiver ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____ **Gender** ☐ Female ☐ Male **Telephone** (w) (h) (c)

Street Address	City	County	State	Zip Code

8. Name of Child's Caregiver ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____ **Gender** ☐ Female ☐ Male **Telephone** (w) (h) (c)

Street Address	City	County	State	Zip Code

9. Name(s) of Siblings	Gender	Age	DOB	Name(s) of Siblings	Gender	Age	DOB
	M F				M F		
	M F				M F		

B. MANDATORY REPORTING FOR SUSPECTED CHILD ABUSE AND NEGLECT

Mandatory Child Abuse/Neglect Report made to both Law Enforcement and CPS Agencies (Pursuant to Penal Code §11166):

☐ Law Enforcement ☐ Telephone Report ☐ Written Report Submitted Name of Person Taking Report:	Name of Agency	Telephone	Date
☐ Child Protective Services ☐ Telephone Report ☐ Written Report Submitted Name of Person Taking Report:	Name of Agency	Telephone	Date

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

Name **ID Number** **Agency** ☐ **Unknown**

Child Protective Services _____

and/or

Law Enforcement Officer _____

D. PATIENT CONSENT AND AUTHORIZATION FOR EXAMINATION (See instructions)

☐ Law Enforcement Authorized ☐ CPS Authorized ☐ Placed in protective custody ☐ Physician authority pursuant to state law ☐ Parent/Guardian consent

E. DISTRIBUTION OF CalOES 2-900 (Check all that apply)

☐ Law Enforcement Agency (original) ☐ Hand Delivered ☐ Mailed ☐ Faxed	☐ Child Protective Services (copy) ☐ Hand Delivered ☐ Mailed ☐ Faxed
☐ Crime Laboratory (copy included with evidence)	☐ Medical Facility Records (copy)

F. PATIENT HISTORY

1. Name of Person(s) Providing History	Relationship to Patient

2. Child Accompanied to Facility By	Relationship to Patient

Patient Identification: **Date:**

3. History of Present Illness ☐ **See dictation for additional information.** ☐ **N/A**

If dictating, provide brief 2-3 sentence handwritten summary. Print or write legibly. Include date, time or timeframe, place of incident, and initial reporting party. Distinguish statements made by child in quotation marks from those statements made by other historians.

G. PAST MEDICAL HISTORY

	Yes	No	Unknown	Describe
Birth History (if applicable)	☐	☐	☐	
Physical Abuse History	☐	☐	☐	
Sexual Abuse History	☐	☐	☐	
Neglect History	☐	☐	☐	
Emotional Abuse History	☐	☐	☐	
Domestic Violence Exposure	☐	☐	☐	
Alcohol/Drug Exposure ☐ Prenatal ☐ Postnatal ☐ Alcohol ☐ Drug	☐	☐	☐	Specify types of drugs if known, and collect urine toxicology up to 96 hours after ingestion:
Hospitalization(s)	☐	☐	☐	
Surgery	☐	☐	☐	
Significant Illness/Injury	☐	☐	☐	
Any pertinent medical condition(s) that may affect the interpretation of findings?	☐	☐	☐	
Allergies	☐	☐	☐	
Medications	☐	☐	☐	
Immunizations Up To Date	☐	☐	☐	
Disabilities	☐	☐	☐	(Specify):
Growth & Development ☐ WNL ☐ ABN ☐ Unknown	☐	☐	☐	

H. REVIEW OF SYSTEMS ☐ Negative except as noted below

☐ See dictation for additional information ☐ N/A

I. NAME OF PERSON TAKING HISTORY (Print Name)	Signature	Telephone	Date

J. GENERAL PHYSICAL EXAMINATION

1. Temperature	Pulse	Respiration	Blood Pressure

2. Height (cm or in)	(%)	Weight (kg or lb)	(%)	Children under 2: (HC)	(%)

3. General physical appearance, demeanor, and level of physical discomfort/pain. Provide brief handwritten summary even if dictating. ☐ See dictation for additional information. ☐ N/A

Patient Identification: **Date:**

4. Record results of physical examination.

	WNL	ABN	Not Examined	See Body Diagram	Describe Abnormal Findings. ☐ N/A ☐ See dictation for additional information
Skin					
Head					
Eyes					
Ears					
Nose					
Mouth/Pharynx					
Teeth					
Neck					
Lungs					
Chest					
Heart					
Abdomen					
Back					
Buttocks					
Extremities					
Neurological					
Genitalia					

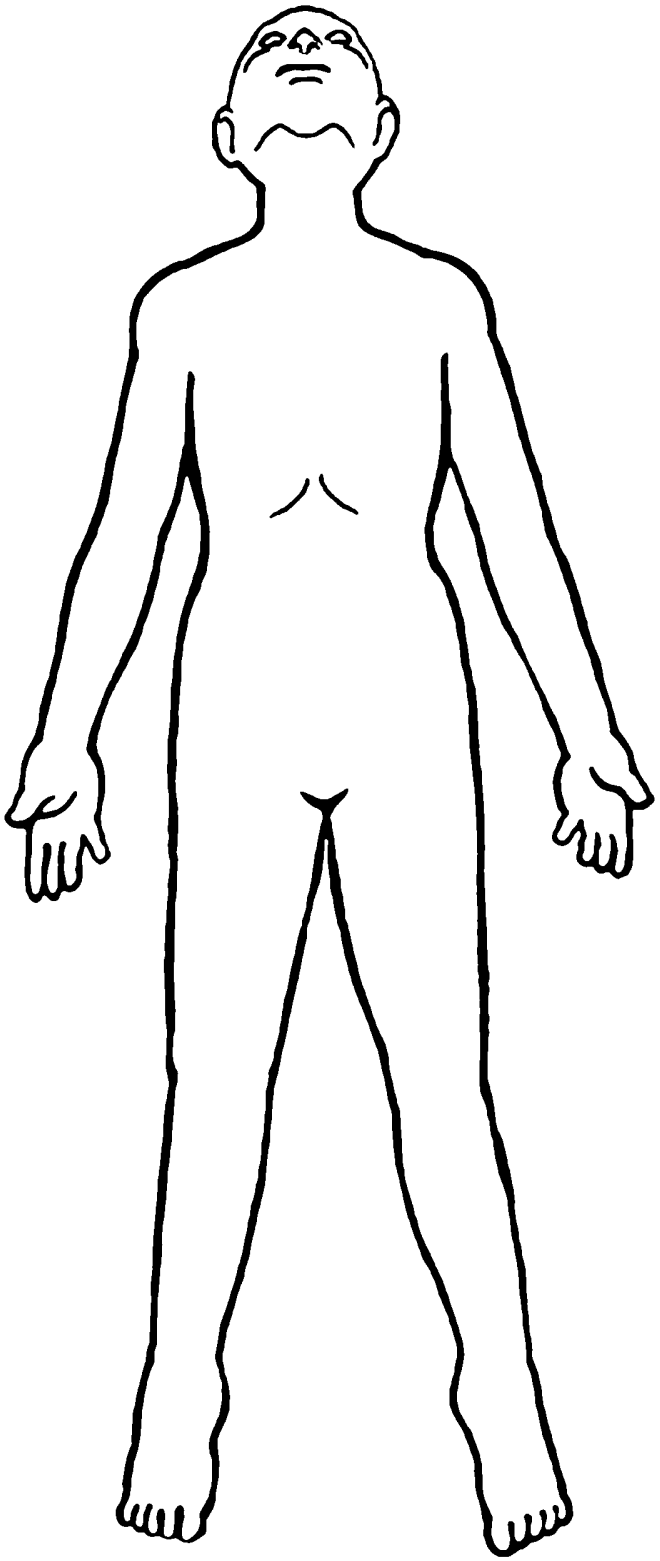
5. If genital injuries are sustained, use copies of page(s) 6 and 7 (if applicable) from CalOES 930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form or CalOES 925 Forensic Medical Report: NonAcute (>72 hours) Child/Adolescent Sexual Abuse Examination to document findings and attach to this form.

J. GENERAL PHYSICAL EXAMINATION (continued)

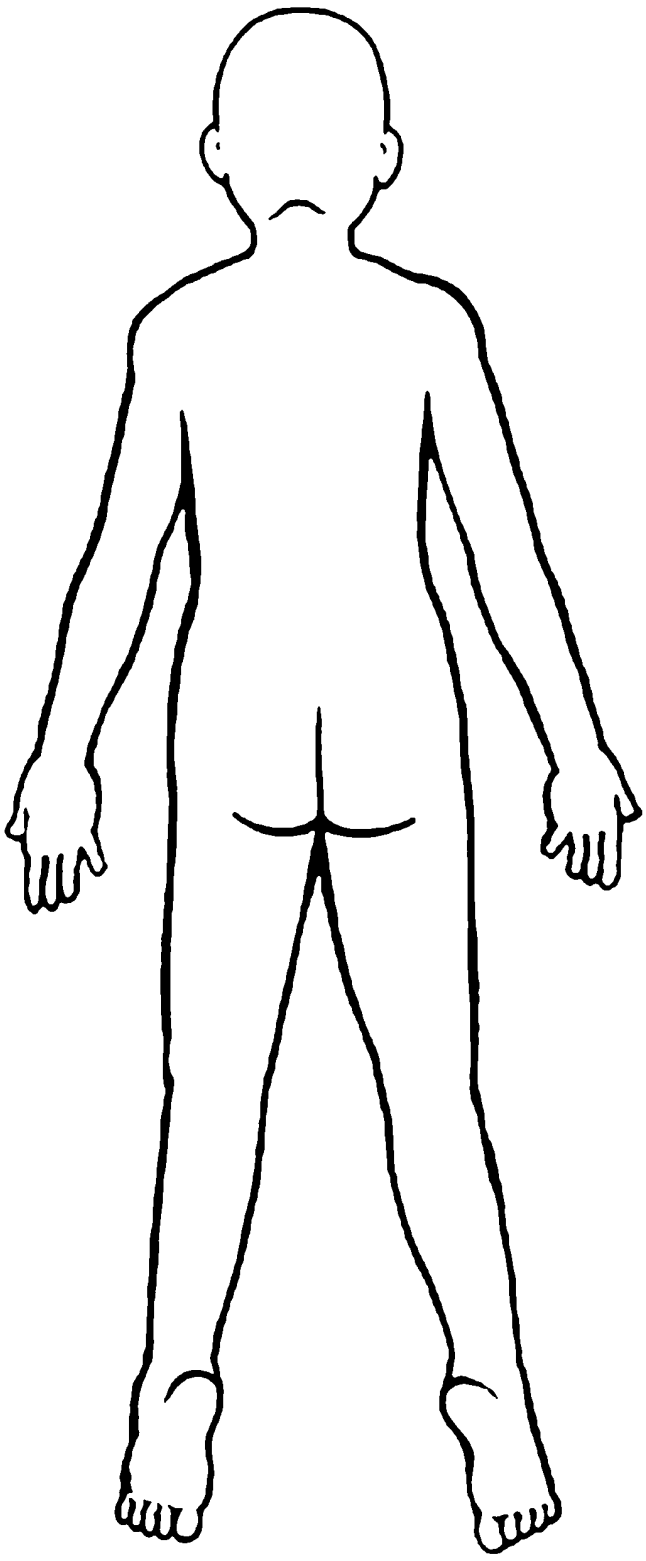
6. Conduct physical examination and record findings using the diagrams.

Patient Identification: **Date:**

A



B

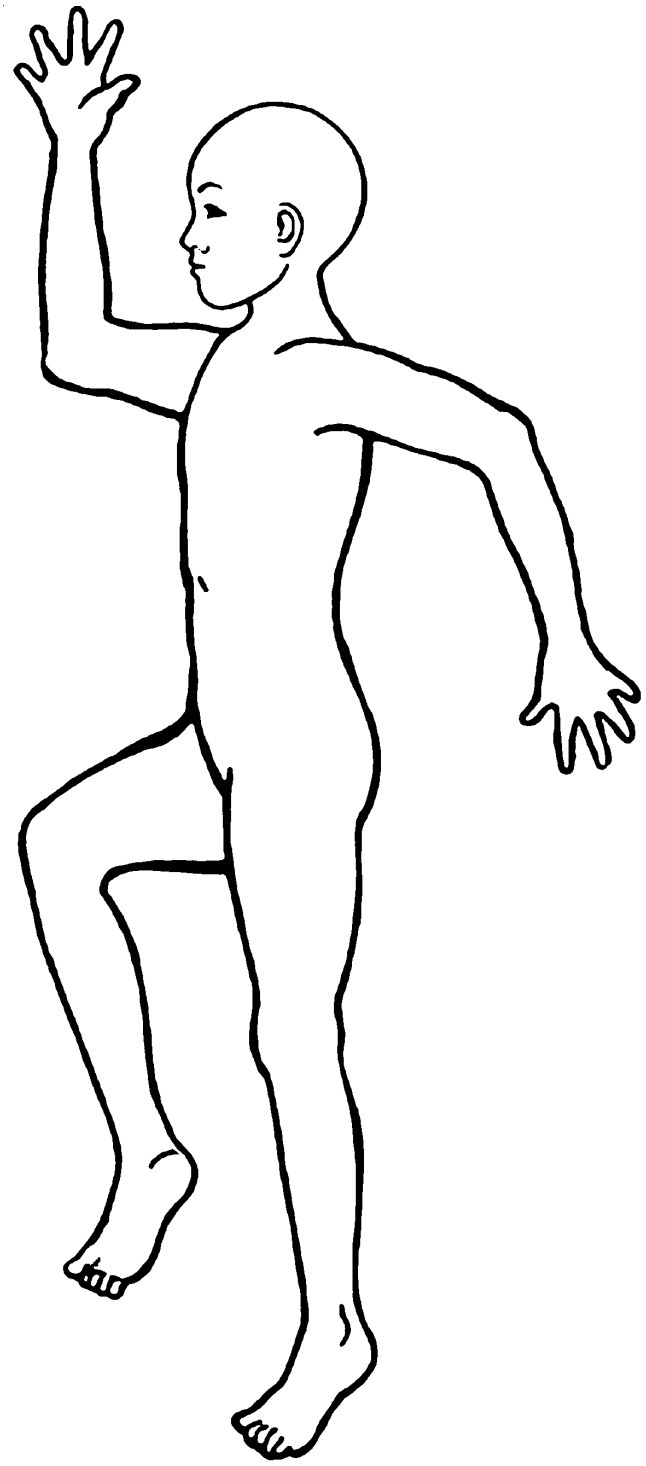


J. GENERAL PHYSICAL EXAMINATION (continued)

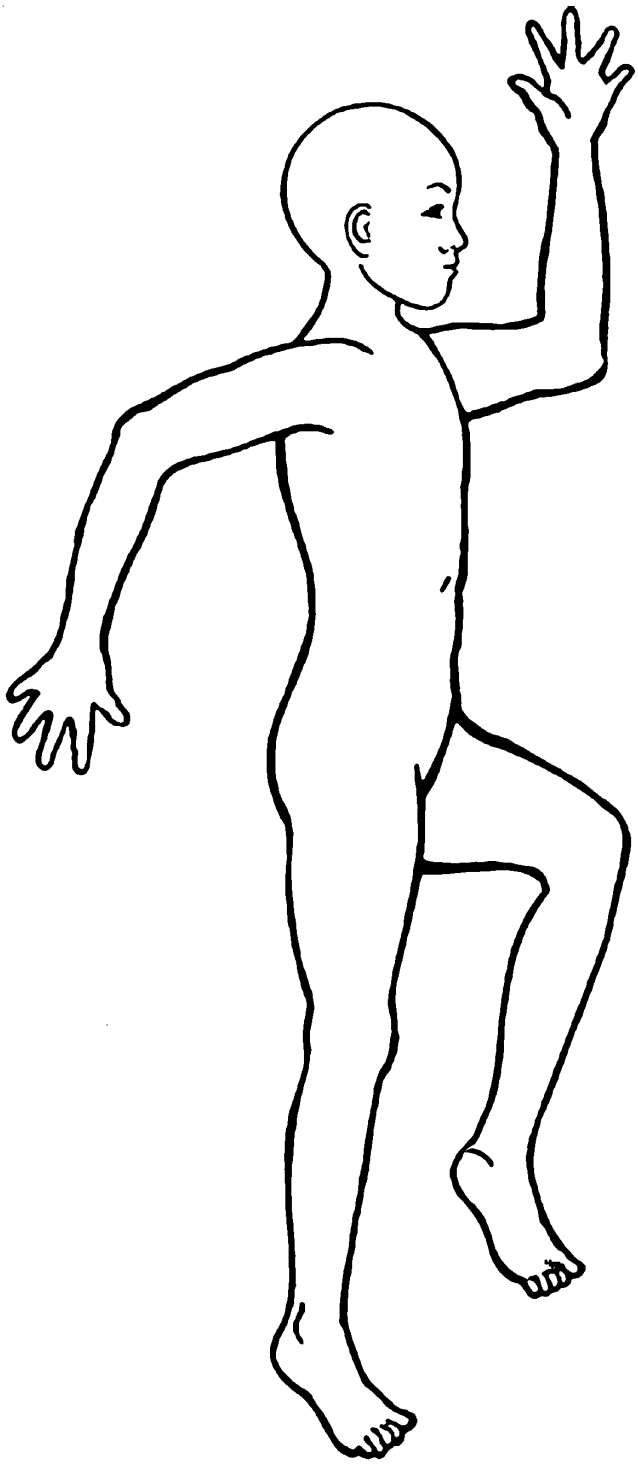
6. Conduct physical examination and record findings using the diagrams.

Patient Identification: **Date:**

C



D

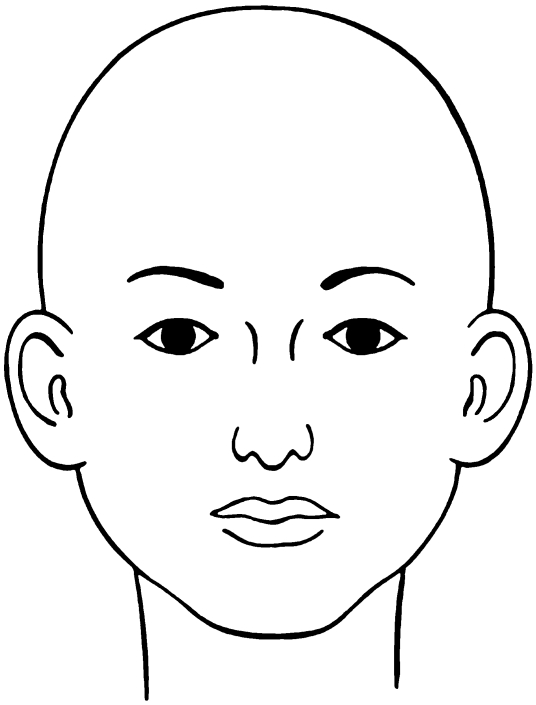


J. GENERAL PHYSICAL EXAMINATION (continued)

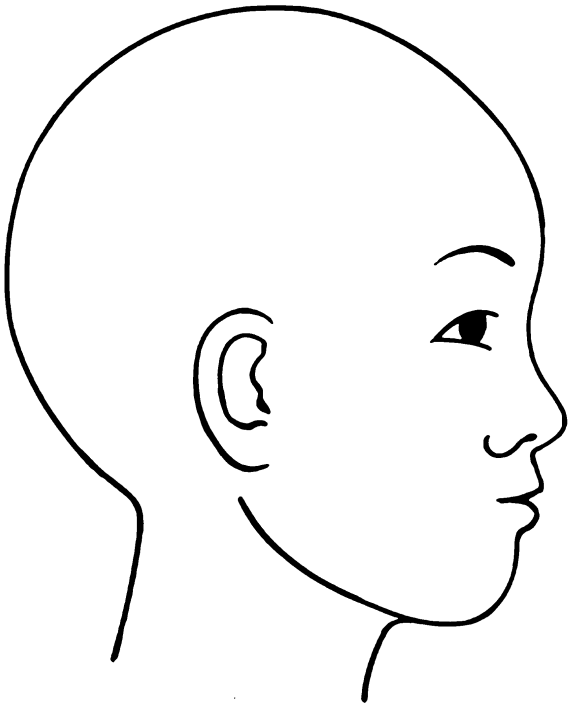
7. Examine the face, head, ears, hair, scalp, neck, and mouth for

Patient Identification: **Date:**

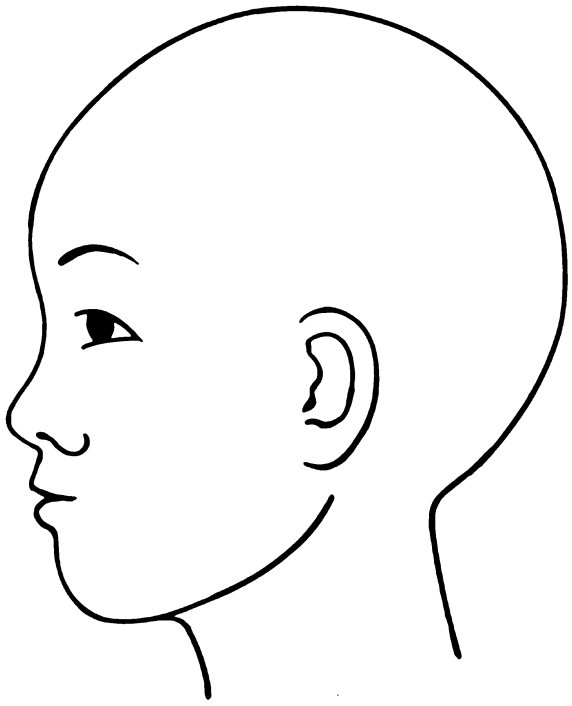
E



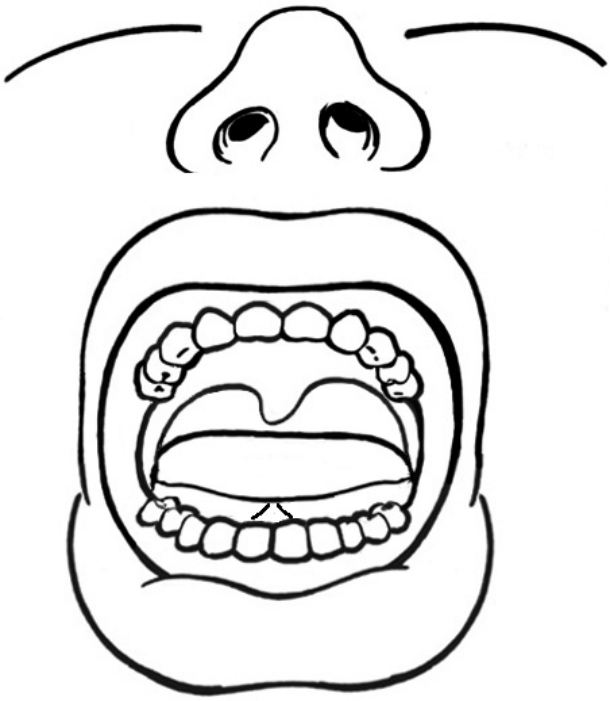
F



G



H



K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing Collected ☐ No ☐ Yes ☐ N/A

Clothing Placed in Evidence Kit	Clothing Placed in Paper Bag

2. Foreign Materials Collected

	N/A	No	Yes	Collected by:
Swabs/suspected blood	☐	☐	☐	
Dried secretions	☐	☐	☐	
Fiber/loose hairs	☐	☐	☐	
Soil/debris/vegetation	☐	☐	☐	
Swabs/suspected saliva	☐	☐	☐	
Foreign body	☐	☐	☐	
Control swabs	☐	☐	☐	
Fingernail scrapings	☐	☐	☐	
Matted hair cuttings	☐	☐	☐	

Other types, describe: _____

L. TOXICOLOGY SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood Alcohol / Toxicology	☐	☐	☐		
Urine Toxicology	☐	☐	☐		

M. REFERENCE SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood (lavender top tube)	☐	☐	☐		
Blood card (optional)	☐	☐	☐		
Buccal swabs (optional)	☐	☐	☐		
Saliva swabs	☐	☐	☐		

N. DIAGNOSTIC STUDIES ☐ Refer to dictation

1. Laboratory:

	WNL	ABN	N/A	Pending	Results
☐ CBC	☐	☐	☐	☐	
☐ Platelets	☐	☐	☐	☐	
☐ INR, PTT, PT	☐	☐	☐	☐	
☐ SGOT, SGPT	☐	☐	☐	☐	
☐ Urinalysis	☐	☐	☐	☐	
☐ Toxicology Screen	☐	☐	☐	☐	
☐ Other	☐	☐	☐	☐	

2. Diagnostic Imaging

	WNL	ABN	N/A	Preliminary Reading	Final Report
☐ Skeletal Survey	☐	☐	☐	☐	☐
☐ CT Scan	☐	☐	☐	☐	☐
☐ M R I	☐	☐	☐	☐	☐
☐ Other	☐	☐	☐	☐	☐

Describe:

3. Exam Performed by Ophthalmologist:

☐ N/A ☐ No ☐ Yes ☐ Pending ☐ See Medical Record for Report

Name of Ophthalmologist: _____

Photographs Taken By: _____

O. PHOTO DOCUMENTATION

☐ No ☐ Yes ☐ N/A ☐ Film Retained

☐ Film Released to: _____

Photographs taken by: _____

35mm ☐ Digital ☐ Instant ☐ Other ☐ _____

Recommend follow-up photographs be taken in 1-2 days

☐ No ☐ Yes ☐ N/A

Patient Identification: **Date:**

P. REQUIRED SUMMARY AND INTERPRETATION OF HISTORY, EXAMINATION, AND DIAGNOSTIC STUDIES

Describe:

☐ Neglect
☐ Physical abuse
☐ Evaluation suspicious for physical abuse. Further information needed.
☐ Indeterminate cause
☐ Evaluation indicates non-abusive cause of medical findings.

☐ See Additional Dictation Dictation Reference Number:

Q. DISTRIBUTION OF EVIDENCE

	Released To
Clothing (items not placed in evidence kit) ☐ N/A	
Evidence Kit ☐ N/A	
Reference samples ☐ N/A	
Toxicology samples ☐ N/A	

R. PERSONNEL INVOLVED

Examination Performed By: (Print)	Signature of Examiner	
License No.	Telephone	Date
Examination Assisted By: (Print)	Signature	
License No.	Telephone	Date
Specimen labeled and sealed by:	Signature	
License No.	Telephone	Date

S. PATIENT DISPOSITION

☐ Admitted ☐ Home ☐ Protective Custody

☐ Follow Up Exam Needed (specify reason): _____

State of California
California Office of Emergency Services

MEDICAL REPORT:
SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION

CalOES 2-900 INSTRUCTIONS

For more information or assistance in completing the CalOES 2-900, please contact California Clinical Forensic Medical Training Center at:(888) 705-4141 or www.ccfmtc.org

Forms available at: **www.CalOES.ca.gov and www.ccfmtc.org**

CalOES 2-900
Medical Report: Suspected Child Physical Abuse and Neglect Examination

REQUIRED USE OF STANDARD STATE FORM:
Penal Code § 11171 established the use of a standard form to record findings from examinations performed for suspected child physical abuse and neglect. This form is intended to facilitate identification of child physical abuse and neglect, and as such, is not a complete medical treatment record.

SUGGESTED USE OF THE STANDARD STATE FORMS: FOLLOW LOCAL POLICY

CalOES 2-900	**Medical Report: Suspected Child Physical Abuse and Neglect Examination** • Suspected child physical abuse and neglect • Examination of children and adolescents under age 18
CalOES 925	**Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination** • History of **nonacute sexual assault** (>72 hours) • Examination of children and adolescents under age 18
CalOES 930	**Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abus Examination** • History of **acute sexual assault or assault** (<72 hours) • Examination of children and adolescents under age 18

INSTRUCTIONS FOR CalOES 2-900
These instructions contain the recommended methods for meeting the minimum legal standards established by Penal Code § 11171 for performing examinations. Consult the California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect published by CalOES for additional information including the knowledge, skills, and abilities necessary for health practitioners to complete the medical examination.

LIABILITY AND RELEASE OF INFORMATION
This medical report is subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Penal Code§ 11164 or privilege), the Medical Information Act (Civil Code § 58 et seq.), the Physician-Patient Privilege (Evidence Code § 990), the Official Information Privilege (Evidence Code § 1040) and Penal Code § 11171.2. It can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services worker, child abuse and neglect team member, county licensing agency, and coroner. Records may be released to the defense counsel only through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

Complete this report in its entirety. Print legibly. Use N/A (not applicable) when appropriate to show that the examiner attended to the question.	Patient identification: This space is provided for hospitals and clinics using plastic plates for stamping identification information; or, for facilities to write in an identification number and date.

A. GENERAL INFORMATION
Note: If the facility patient label or registration face sheet includes the information requested in items #1-5 below, these may be used in lieu of handwritten entries. Mark the box and attach the label or registration face sheet to this form.

1. **Enter the name and address of the facility where the examination was performed.**
2. **Enter the date and time of the exam.**
3. **Enter the patient's name and telephone number.**
4. **Enter the patient's street address, city, county, state, and zip code.**
5. **Enter the patient's age, date of birth (DOB), gender, and ethnicity.**
6. **Enter whether an interpreter was used, the language used, and who provided interpreting services.**
7. **Enter the name of the child's caregiver, gender, street address, city, county, state, zip code, and telephone numbers.**
8. **Enter the name of the child's caregiver, gender, street address, city, county, state, zip code, and telephone numbers.**
9. **Enter the name(s) of siblings, gender, age, and date of birth.**

B. MANDATORY REPORTING FOR SUSPECTED CHILD ABUSE AND NEGLECT: Suspected Child Abuse and Neglect Form Department of Justice (DOJ) SS 8572.

1. **Penal Code § 11166 requires all professional medical personnel to report suspected child abuse and neglect, defined by Penal Code § 11165, immediately by telephone and to submit a written report (DOJ SS 8572) within 36 hours to a local law enforcement agency OR a child protective services agency.**
2. **The CalOES 2-900 should not replace the DOJ SS 8572 Suspected Child Abuse and Neglect Report. The SS 8572 is used by all mandated reporters to report suspected child abuse and neglect. The CalOES 2-900 is used by medical personnel to document physical findings and is part of the medical treatment record (Penal Code § 11171.2(d).**
   - Check the appropriate box to indicate that a telephone report was made to a law enforcement agency and/or Child Protective Services. Identify the person who took the report, his/her telephone number, and the date the report was made.
   - Check the appropriate box to indicate whether the written report was submitted to a law enforcement agency or to Child Protective Services.
3. **See California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect for further discussion.**

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

1. **Record name(s) of responding personnel from a law enforcement or child protective services agency and identifying information.**
2. **If unknown, check box.**

D. PATIENT CONSENT AND AUTHORIZATION FOR EXAMINATION

1. **See page 2 for information on consent and authorization for examinations.**
2. **Authorization by law enforcement or child protective services is not required for healthcare providers to use this form. Authorization, however, may be required if either agency is the designated payor.**
3. **Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy.**
4. **See California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect for further discussion.**

E. DISTRIBUTION OF CalOES 2-900
Check boxes to indicate the distribution of the form.

F. PATIENT HISTORY

1. **Record the name(s) of the person(s) providing the history and their relationship to the patient.**
2. **Record the name(s) of the person(s) accompanying the child to the facility and their relationship to the patient.**
3. **Record the history of present illness.**
   - If dictating, provide brief 2-3 sentence handwritten summary.
   - Include date, time or timeframe of incident, place of incident, and the name, if known, of the initial reporting party.
   - If documenting specific statements made by the patient or historian, use quotation marks.
   - Document if statement(s) made by patient were spontaneous (i.e. not in response to a question or comment).
   - When interviewing verbal children, ask open-ended questions such as "What happened to you? Tell me what happened to you. How did this happen? What did he do or what did she do?" These are the easiest questions for children to answer. Avoid WHY questions or questions that require understanding abstract or complex concepts.
   - If there is an alleged accident, include details of the event. Ask where it happened, who witnessed the event, and how it happened. For example, if there is an alleged fall, ask the height of the fall and onto what surface.
   - Patient statements not heard directly by the recorder may be included, e.g. the child told his teacher that he was hit by a belt.
   - Document chronology of events leading up to medical presentation.

G. PAST MEDICAL HISTORY

1. **Record past medical history, if known.**
2. **Record past abuse history, history of exposure to domestic violence, if known.**
3. **Record history of exposure to prenatal and postnatal alcohol and drug exposure, if known.**
4. **Obtain urine toxicology according to hospital protocol or follow local policy established by criminal justice and child protection agencies under the circumstances described below.**
   - There is a reported history of child's removal from a drug manufacturing home, living in a home with significant drug exposure, or a request by law enforcement or CPS.
   - The child's clinical presentation is concerning and drug ingestion is suspected.
   - Some drugs may be detected in the urine up to 96 hours after ingestion. Collect urine in a clean container. It is important to collect the first available sample.
5. **Record any cognitive, developmental, physical, or mental/emotional disabilities.**
6. **Record whether growth and development is within normal limits. Check WNL, if within normal limits, ABN, if abnormal, or unknown.**
7. **Indicate whether there are any other pertinent medical conditions, particularly if any conditions may affect the interpretation of findings (e.g. bleeding disorders, bone diseases, etc).**

H. REVIEW OF SYSTEMS

Check the box "Negative except as noted below" if there are no identified medical problems. Describe, if signs and symptoms are present. Check the box if there is additional dictation in medical progress notes or another format.

I. NAME OF PERSON TAKING HISTORY

Print the name of the person taking the history, sign, date, and provide telephone number.

PATIENT CONSENT AND AUTHORIZATION FOR EXAM

Suspected child abuse: non-consenting parents

Parental consent is not required to examine, treat or collect evidence for suspected child abuse. In the absence of parental consent or in the case of parental refusal, children must be taken into protective custody by a child protective agency (e.g. law enforcement agency or county child protective services agency) in order to perform the examination. Follow local policy regarding placement of children in protective custody.

Welfare and Institutions Code Section 324.5

Whenever allegations of physical or sexual abuse of a child come to the attention of a local law enforcement agency or the local child welfare department and the child is taken into protective custody, the local law enforcement agency or child welfare department may, as soon as practically possible, consult with a medical practitioner, who has specialized training in detecting and treating child abuse injuries and neglect, to determine whether a physical examination of the child is appropriate. If deemed appropriate, the local law enforcement agency, or the child welfare department, shall cause the child to undergo a physical examination performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, and whenever possible, shall ensure that this examination takes place within 72 hours of the time the child was taken into protective custody. In the event the allegations are made while the child is in custody, the physical examination shall be performed within 72 hours of the time the allegations were made.

PHOTOGRAPHS OF INJURIES

Penal Code Section 11171.2

A physician, surgeon, or dentist or their agents, and by their direction, may take skeletal x-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of the child abuse or neglect.

Penal Code Section 11171.5

If a peace officer, in the course of an investigation of child abuse or neglect, has reasonable cause to believe that the child has been the victim of physical abuse, the officer may apply to a magistrate for an order directing that the victim be x-rayed without parental consent. Any x-ray taken pursuant to this subdivision shall be administered by a physician, surgeon, or dentist or their agents.

With respect to the cost of an x-ray taken by the county coroner or at the request of the county coroner in suspected child abuse or neglect cases, the county may charge the parent or legal guardian of the child victim the costs incurred by the county for the x-ray. No person who administers an x-ray pursuant to this section shall be entitled to reimbursement from the county for an administrative cost that exceeds 5 percent of the cost of the x-ray.

J. GENERAL PHYSICAL EXAMINATION

1. Record vital signs.

2. Record height in either centimeters or inches and weight in either kilograms or pounds. Indicate percentiles, if growth charts are available. For children under age 2, record head circumference and percentile.

3. Describe the patient's general physical appearance.
- Describe the patient's general demeanor including level of discomfort and pain.
- Provide brief handwritten summary, even if dictating. Check box if there is additional dictation in progress notes.
- Documentation helps the examiner recall the patient's behavior and response during the exam for future reference.

4. Record results of physical examination.
- Record all findings and whether the general exam was within normal limits (WNL).
- Describe abnormal findings (ABN).

> **Physical Findings:** A physical finding includes observable or palpable tissue injuries, physiologic changes, or foreign materials.

- Be observant for erythema (redness), abrasions, bruises, swelling, lacerations, bites, and burns.
- Note areas of tenderness, deformity, or induration.
- Record size and appearance of injuries and other findings using the diagrams. Describe shape, size, and color of bruises or other cutaneous injuries.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

5. If genital injuries are sustained, use copies of page(s) 6 and 7 from the CalOES 930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form to document findings; or use that form to document all findings, if the history indicates that the patient has been sexually and physically abused.

J. PHYSICAL EXAMINATION (continued)

6. Conduct general physical examination.

- Record size and appearance of injuries and other findings using Diagrams A and B.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

Bite marks

- Photograph or arrange to have bite marks photographed. Individuals can be identified by the size and shape of their bite marks.
  - > Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from saliva remaining at the bitemark site. Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbitten atraumatic area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
- Casting bite marks:
  - > If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
  - > A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
  - > Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

Bruises

- Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.
- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

J. PHYSICAL EXAMINATION (continued)

6. Conduct general physical examination.

- Record size and appearance of injuries and other findings using Diagrams C and D.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

Bite marks

- Photograph or arrange to have bite marks photographed. Individuals can be identified by the size and shape of their bite marks.
  - > Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from saliva remaining at the bitemark site. Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbitten atraumatic area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
- Casting bite marks:
  - > If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
  - > A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
  - > Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

Bruises

- Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.
- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

J. EXAMINATION OF THE HEAD, NECK, AND MOUTH

7. Examine the face, head, ears, hair, scalp, and neck for injury.

- Record injuries and other findings using the Diagrams E, F, G, and H.
- Examine mouth for injury and for missing or chipped teeth, or neglect of oral health.
  - > Signs and symptoms of dentofacial trauma may include: avulsed teeth, lip lacerations, tongue injuries, frenulum injuries, and jaw and facial fractures.
  - > Signs and symptoms of dental neglect may include: untreated rampant cavities, untreated pain, infection, bleeding, or trauma; and/or lack of continuity of care once informed that the above conditions exist.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.
- For head trauma cases:
  - > Examine head closely for evidence of scalp trauma. Record any bruises, areas of scalp swelling, or hair loss.
  - > In infants, note fullness or bulging of the anterior fontanelle or splitting of the sutures.
  - > Examine earlobes carefully for any bruising or petechiae. Record injuries using the diagrams.

K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LABORATORY

All swabs and slides must be air dried prior to packaging (Penal Code § 13823.11). Air dry in a stream of cool air for 60 minutes. Place samples from one patient at a time in the swab drying box. Wipe or spray the swab drying box with 10 percent bleach before each use.
Labeling requirements: Swabs, bindles, and small containers must be individually labeled with the patient's name and sample source. Containers for these individual items must be labeled with the name of the patient, date of collection, description of the evidence including location from which it was taken, and signature or initials of the person who collected the evidence. All containers must be labeled and sealed. Record all evidence transfers, also known as the chain of custody.

1. **Record whether clothing was collected, the items collected, and whether they were placed in an evidence kit or a paper bag. If not, check N/A.**
   - Collect outer and under clothing, if applicable. Coordinate with the law enforcement officer or child protective services worker regarding clothing to be collected. Clothing with bloodstains, tears, and burn holes can be related to physical abuse. Soiled, unkempt clothing can be related to neglect.
   - Wear gloves while collecting clothing. Have the patient disrobe on two large sheets of paper, placed one on top of the other, on the floor. Remove child's shoes before stepping on to the paper. Package each garment in an individual paper bag, label, and seal. Wet stains or garments require special handling. Consult local policy.
2. **Record all foreign materials collected and the name of the person who collected them. If none were collected, check N/A. Foreign materials (soil, vegetation) should be placed in bindles and/or envelopes. Use a separate bindle or envelope for materials collected from different locations. Label and seal.**
3. **Record whether saliva swabs from bite marks were obtained. Record whether a control swab was obtained from an unbitten atraumatic area. Swabs must be labeled with the patient's name and sample source.**

L. TOXICOLOGY SAMPLES

Record whether a urine toxicology sample was obtained. Up to 96 hours after suspected ingestion of drugs, collect a urine specimen in a clean container. It is important to collect the first available sample.

M. REFERENCE SAMPLES

1. **Record whether a DNA reference sample was collected.**
   - Policies pertaining to the collection of reference samples at the time of exam or later vary by jurisdiction. If collected at the time of the exam, ALWAYS collect after the evidence samples. A buccal (inner cheek) swab is less invasive and may be easier to obtain than a blood sample via venipuncture. Consult your local crime laboratory.
2. **Buccal swabs**
   - Rub two swabs gently but firmly along the inside of the cheek in a rotating motion to ensure even sampling. Air dry, package, label, and seal.
3. **Blood**
   - Collect blood sample in lavender stoppered evacuated vial. A blood card is optional in some jurisdictions. Label the vial, place into an envelope, and seal.

N. DIAGNOSTIC STUDIES

1. **Record the types of laboratory work ordered, results, if known, and whether results are pending.**

CBC	Complete Blood Count
INR	International Normalized Ratio
PTT	Partial Thromboplastin Time
PT	Prothrombin Time
SGOT/SGPT	Liver Enzymes

2. **Record diagnostic imaging studies ordered, results, if known, and whether results are pending.**

Skeletal Survey	Series of radiographic images which encompass the entire skeleton
CT Scan	Computed Tomography Imaging
MRI	Magnetic Resonance Imaging

3. **Record whether patient was referred for evaluation by an ophthalmologist.**

O. PHOTO DOCUMENTATION

Record whether photographs were taken, type of camera used, and whether film was retained or released to a law enforcement agency.

P. REQUIRED SUMMARY AND INTERPRETATION OF HISTORY, EXAMINATION, AND DIAGNOSTIC STUDIES

Provide interpretation and medical impression of history, examination, and diagnostic studies. Findings and interpretations are based on both the patient history available and the medical examination. Check the box if there is additional dictation in medical progress notes or another format and record dictation reference number.

Q. DISTRIBUTION OF EVIDENCE

List to whom the evidence was released. Check N/A if not applicable.

R. PERSONNEL INVOLVED

1. **Document who performed the examination by printing the examiner's name. The examiner must sign, date, and provide license and telephone number.**
2. **Document whether another healthcare provider assisted with the examination or evidence collection and handling. If so, print name, sign, date, and provide license and telephone number.**

S. PATIENT DISPOSITION

Indicate disposition and whether a follow-up exam is needed.

Continuous Eligibility for Children (CEC)

CEC ensures that all children under age 19 who are determined eligible for zero SOC MC maintain eligibility until the next annual redetermination or the child turns 19, whichever occurs first. All adverse changes in financial eligibility income, property, including a change in maintenance need levels, are disregarded until the CEC period ends.

CEC Program Eligibility Rules

The following eligibility rules apply to the CEC program:

- The CEC period begins at the first month of MC eligibility for all categories of zero SOC MC, including cash-based categories.
- Any changes in family income, assets or other circumstances reported by the family during the CEC period, which would otherwise move a child under age 19 from:
    - Zero SOC category (including MAGI aid codes) to a SOC category
    - Zero SOC category (including MAGI aid codes) to a Premium aid code,
    - Zero SOC eligibility (including MAGI aid codes) to ineligibility.
- The CEC period continues for up to 12-months, and ends the last day of the month in which the annual redetermination (RD) is due, or when the child turns age 19, whichever occurs first.
- Independent minors living on their own, away from parents (under age 19) are entitled to CEC.

CEC Exceptions

CEC does not apply in the following circumstances:

- A child receiving Minor Consent services
- A child becomes incarcerated
- In the event of death
- The family/child moves out of state.
- A break in aid of more than one month.

The 12 Month CEC Period

The CEC period is always twelve months. The CEC period begins with the first month of an initial zero SOC (or MAGI) eligibility determination or the first month impacted by an annual redetermination, and ends with the last month covered by that determination, or the child's 19th birthday, whichever occurs first. The month impacted by the annual redetermination is the month following the month in which the annual redetermination is completed. CEC can begin at any time during the CEC period after the first zero SOC month.

Example

Guaranteed CEC Period

The CEC guaranteed period is within the CEC period, but must begin with a zero SOC month. CEC can only be triggered following a change from zero SOC MC to either a SOC or ineligibility. The months from the time of the zero SOC determination until the next annual redetermination are referred to as the CEC guaranteed period.

If the initial eligibility determination or the annual redetermination results in coverage for zero SOC Medi-Cal, the CEC period and the CEC guaranteed period start at the same time. The CEC period and the CEC guaranteed period always

end at the time of the next annual redetermination.

During the CEC guaranteed period, any change in family income, assets, or other circumstances resulting in a SOC or ineligibility is disregarded for the child but not for the adult family members. The child is place into CEC and continues to receive zero SOC MC for the remainder of the 12 month CEC eligibility period.

The zero SOC determination is not limited to determinations at initial eligibility or at annual redetermination, however, it can begin no earlier than the first month impacted by an initial eligibility determination or an annual redetermination.

Note: If initial TMC is established at the time of MC RE processing (HH reports increased earnings at the MC RE which is over the MAGI MC limit), then the CEC period is not available to children when TMC ends because there is no loss of zero SOC MC.

CEC Aid Codes

Most children on Non-MAGI aid codes will remain on the same aid code throughout the CEC period, however, there are some instances where a child can no longer stay on that aid code and the CEC aid codes must be utilized (ex: TMC). The Non-MAGI CEC zero SOC Aid Code is as follows:

CEC Aid Codes

Aid Code	Description
7J	Full Scope coverage to qualified children under age 19 (Regardless of CZ/Immigration status)

MAGI and Non-MAGI children eligible for CEC should be granted the Non-MAGI CEC zero SOC aid code during the CEC eligibility period.

CEC Individuals on Soft Pause who Age Out of their Aid Code

When a MAGI child is on Soft Pause and reaches the age limit for their current aid code, system functionality does not allow the aid code to be changed and remain on Soft Pause. A Burman Hold will be placed on these individuals in MEDS, however, this should not cause an issue with access to care. If the client indicates that they were denied services, check the MOPI screen in MEDS for the specific service month. If no eligibility appears in MOPI but there is eligibility on the INQM (Q1, Q2, etc.) screen, review the case and create a GadWIN ticket if necessary. The Burman Hold must not be lifted.

Changes Reported During The CEC Period

MC recipients are still required to report information which may affect the determination of eligibility (i.e., change in family/tax household composition, income or property) within ten calendar days following the date the change occurred. This requirement has not changed. However, any changes reported must not be used to adversely affect a child's eligibility during the CEC period.

Note: If the change in family circumstances causes the child to be moved to a different zero SOC MC category, the EW must authorize the change. The child would continue to be protected by CEC under the new category until redetermination.

Decrease in Income Reported in SOC Month Prior to Annual RD

If the family reports a decrease in income for any month prior to the annual RD that results in the child's eligibility for a zero SOC program, then the guaranteed CEC period based on that report is triggered and continues through the next annual RD.

Annual Redetermination Following a Period of CEC

EWs must take appropriate action based on the information gathered during the redetermination process.

If the redetermination results in...	Then...
The family income level permits the child to continue to be eligible for a zero SOC (or MAGI) MC program,	The child is placed into that program, and a new CEC period begins.
The family income level gives the child a SOC,	A new CEC period does not begin until the child is determined eligible for a zero SOC program.
Total ineligibility for all MC programs,	The child must be discontinued.

CEC Retroactive Eligibility

Applicants and recipients have up to one year to apply for retroactive MC coverage, and must be evaluated for any or all months within the 3-month retroactive period when requested. If a child is determined eligible for a zero SOC MC (or MAGI MC) program in one of the three retroactive months, then CEC applies beginning the first day of the month in which the child is determined eligible.

SOC in Month of Application and Zero SOC in Retroactive Month

When it is determined there is a SOC in the month of application, but there is eligibility for zero SOC (or MAGI) in a retroactive month, the guaranteed CEC period is based on the retroactive zero SOC month, and runs for a period of 12-months.

Example

Eligibility Established Prior to Retroactive Request

A late retroactive request and subsequent CEC eligibility changes the eligibility previously determined in the months already established.

CEC Begins in a Retro Month/CEC Guaranteed Period Ends Prior to RD

When CEC is based on a zero SOC month in the 3-month retroactive period prior to the month of application, the CEC guaranteed period will end before the annual RD 12 months from the date of the application. In this situation, the CEC guaranteed period extends to the annual RD. When the retroactive CEC guaranteed period ends, the guaranteed CEC period based on the month of application is still in effect. The child will have been covered by CEC from the applicable retroactive month to the annual RD.

Example

Note: When the guaranteed CEC period is based on a retroactive zero SOC month, and the family reports a decrease in income for any month prior to the annual RD that results in a child's eligibility for a zero SOC program, then the child's guaranteed CEC period based on that report is triggered and lasts until the annual redetermination. The child has CEC until the annual RD, even though the retroactive CEC period has ended.

CEC for Infants Under Age One

Currently, infants under age one who are born to MC eligible mothers are deemed eligible for full-scope, zero SOC MC without an application, and remain MC eligible under the DE program for one year, regardless of any family income or resource changes during that period. DE takes precedence over the CEC program.

Infants whose DE ends because they are no longer living with the MC eligible mother are eligible for CEC.

Children Discontinued from CalWORKs

When a child is terminated from CalWORKs and there is no longer eligibility for cash-based MC, EWs must first determine if the child qualifies under any other zero SOC MC program, including TMC, and place the child in that appropriate Aid Code.

- If the child is not eligible for any other zero share-of-cost Medi-Cal program, he/she must be placed in a CEC Aid Code.
- CEC begins with the first month of initial eligibility or the first month impacted by an annual redetermination of eligibility, whichever is later.
- CEC ends 12-months from the initial CalWORKs application or annual RD.

Children Losing Foster Care Eligibility

A child receiving Foster Care (FC) and/or Kin-GAP is eligible to receive MC benefits under CEC if he/she is not eligible for any other zero SOC MC Program.

Note: The FFY Program takes priority over CEC. Children who were in FC on their 18th birthday are eligible to receive zero SOC MC until their 26th birthday. These children must be transferred into the FFY Program.

CEC applies whenever a child under 19 loses Foster Care eligibility and does not qualify for the Extended MC Eligibility for Former Foster Youth (FFY) program. The child is entitled to CEC until the next annual redetermination, which is 12 months from the last Foster Care RV. The Foster Care EW will transition the child to the CEC program after being discontinued from Foster Care without requiring a new application. An MC-only case must be established for each CEC child until the end of the CEC period, unless the child moves out of state or requests discontinuance.

Children Losing SSI Cash-Based Medi-Cal

Children losing SSI cash-based benefits continue to receive zero SOC MC (or MAGI) benefits under the Craig vs. Bontá lawsuit until an eligibility determination for ongoing MC is completed.

CEC Procedures

When CEC is triggered, children must either remain on a current zero SOC (or MAGI) program, if applicable, or transferred to the appropriate CEC Aid Code.

EW staff must take the following action for all children under age 19:

CEC Procedures

If...	And...	Then...

A child is on an FPL program,	A change in family income results in a SOC,	Transfer the child to the CEC Program, using the appropriate Aid Code, through either the end of the redetermination period, or the child(ren) turns 19, whichever occurs first.
The child(ren) are receiving TMC,	Changes result in financial ineligibility, or TMC eligibility stops for any other reason,	The child(ren) must be evaluated to determine if he/she is still within the CEC period. If so, transfer the child(ren) into the appropriate CEC Aid Code until the CEC period ends, or the child(ren) turns 19, whichever occurs first. **NOTE: If the child(ren) is not within the CEC period, follow the normal procedures for TMC ineligibility and review for eligibility under another MC program.**
There are child(ren) eligible for CEC,	They are in an MFBU with other family members,	The EW must ensure that any reported changes are acted upon appropriately for the other family members.

Redeterminations Not Completed Timely

When a MC redetermination is not processed timely, and a child is determined to have a SOC, the EW is responsible for reviewing the information for the month the RD was due, and for each month until the RD was actually completed to determine if CEC is applicable.

ICTs

CEC cases are treated the same way current procedures are followed for ICTs. The CEC child continues to receive zero SOC (or MAGI) MC in the receiving county for the remainder of the CEC period. EWs must:

- Review information contained in the case record prior to transfer,
- Ensure that the child(ren)'s zero SOC MC continues during the ICT period, and
- not discontinue the child(ren)'s zero SOC MC benefits until the receiving county has placed the child in CEC or another zero SOC MC Aid Code.

CEC When a Child Leaves the Home

CEC applies when a child under 19 leaves the home as CEC follows the child. The child must be continued in his/her new home (as long as it is in California), regardless of family income and/or living arrangements, as long as the child is still in the CEC period.

In addition, CEC also applies when the CEC guaranteed period is established on a parent's case and the minor moves out, establishing his/her own case.

Confidentiality rules do not apply to the parents or caretaker relatives of the child as long as the child is a minor and under the care of the person they are living with. The custodian of the child may be contacted.

Note: Changes in custody should be reported to the Department of Child Support Services (DCSS).

Whereabouts Unknown

Children on CEC may not be discontinued for Whereabouts Unknown.

Note: Other members in the household must be discontinued as appropriate.

Request for CEC Discontinuance

The parent(s) of an eligible CEC child may request discontinuance of his/her child's MC benefits. If a request is made for discontinuance, the EW must discontinue benefits as requested.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1912

August 17, 1982

To: ALL COUNTY WELFARE DIRECTORS Letter No. 82-44

EMERGENCY ASSISTANCE (EA) PROGRAMS

This is in reference to the Department of Social Services' (DSS) All County Letter No. 82-67 (dated July 9, 1982) instructing counties on the processing of Emergency Assistance - Unemployed Parent (EA-UP) Emergency Assistance - Abused, Neglected or Exploited Children (EA-ANEC).

Based upon current state law (Welfare and Institutions Code Section 14050.1 and 14005.1) individuals receiving an aid payment under the Emergency Assistance program are considered public assistance recipients and are entitled to Medi-Cal benefits. Therefore, effective July 1, 1982, individuals receiving these special EA payments will be eligible for Medi-Cal benefits and a Medi-Cal card. In order to identify these individual programs, two new aid codes have been established: aid code 06 (EA-UP) and aid code 43 (EA-ANEC). Individuals eligible as aid code 43 must not be more than 21 years 0 months of age. Persons eligible in these two categories will receive an EA payment for 30 days; therefore, they could receive a Medi-Cal card for two months before being discontinued from those programs.

The Department of Health Services will add aid codes 06 and 43 to Article 5C of the Medi-Cal Eligibility Manual in the near future. In addition to this letter, a CID Bulletin establishing the aid codes will be sent to each county welfare department data processing liaison.

If you have any questions regarding the Emergency Assistance Program, please contact the Department of Social Services as indicated in All County Letter No. 82-67.

If you have any questions regarding the new aid codes, contact your Medi-Cal Program Consultant.

Sincerely,

Original signed by

Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

December 22, 1982

To: All County Welfare Directors Letter No. 82-72

AFDC-U STATE ONLY AND EA-UP DISCONTINUANCE PROCESS -- NOTICE OF ACTION WORDING

This letter is to provide you with the draft regulations and the following suggested wording for the Notice of Action to be used for discontinuing Medi-Cal eligibility for adults receiving automatic Medi-Cal through the state-only AFDC-U and EA-UP programs:

> You have been receiving Medi-Cal benefits under the state-only AFDC-U or EA-UP program. The state law has changed and you will no longer be eligible to receive Medi-Cal beginning January 1, 1983. In accordance with Welfare and Institutions Code, Section 14005.1 amended by Chapter 1594, Statutes of 1982, persons 21 years of age or over who are eligible for cash assistance under the state-only AFDC-U program and the EA-UP program are no longer eligible to receive a Medi-Cal card.

Counties should include an explanation that this group may be eligible for benefits under CMSP.

If you have any questions, please contact your Medi-Cal Program Consultant.

Sincerely,

Original signed by

Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Informative Digest

Until January 1, 1983 Medi-Cal regulations and state law (Welfare and Institutions Code, Section 14005.1) provide automatic Medi-Cal eligibility for adults receiving Emergency Assistance (EA) or state-only AFDC-U aid payments. These adults are eligible as public assistance recipients; however, there is no federal financial participation under Title XIX for their medical services.

SB 2012 (Chapter 1594, Statutes of 1982) eliminated Medi-Cal eligibility, as of January 1, 1983 for these groups. As a result, the regulations are revised to exclude those persons who are over 21 years of age and receiving EA or state-only AFDC-U since federal financial participation under Title XIX of the Social Security Act is not obtainable.

Statement of Reasons

The purpose of these regulations is to implement the provisions of Section 18, Chapter 1594, Statutes of 1982 (SB 2012) which amended Section 14005.1 of the W&IC. This change eliminates Medi-Cal coverage for adults who receive Emergency Assistance (EA) or state-only AFDC-U coverage.

Regulation changes are necessary to interpret the legislation and to ensure uniform eligibility determinations by county welfare departments throughout the State. Current Medi-Cal regulations provide Medi-Cal coverage for all family members in a situation where the unemployed parent either has no connection to the labor force or has been unemployed less than 30 days. There is no provision in federal law or regulation to allow federal financial participation under Title XIX for medical services for EA or the state-only AFDC-U program.

The anticipated total General Fund savings are $567,320 for Fiscal Year 1982-83 and $1,727,000 for 1983-84.

SB 2012 changed the existing law to eliminate Medi-Cal coverage for the adults receiving EA or state-only AFDC-U. To accomplish this the following regulation changes are made.

- Section 50227 is amended to exclude from Medi-Cal eligibility those persons who are over 21 years of age and receiving EA or state-only AFDC for which federal financial participation under Title XIX is not obtainable for medical services.

- Adoption of Section 50038.5 which provides a definition of EA.

There is no impact on public agencies or private persons or entities for reasonably complying with these regulations.

Composite Authority

Authority: Sections 10725 and 14124.5, Welfare and Institutions Code; Section 87, Chapter 1594, Statutes of 1982.

Reference: Section 14005.1, Welfare and Institutions Code.

50227. Public Assistance Cash Grant Programs. (a) Public assistance cash grant programs include the following programs:

(1) AFDC.

(2) SSI/SSP.

(3) Cuban Refugee Cash Grant.

(4) Indochinese Refugee Cash Grant.

(5) Emergency Assistance (EA).

(b) Except as provided in (d) below persons receiving a cash grant under any one of the programs specified in (a) shall automatically receive a Medi-Cal card for each month in which they receive the cash grant.

(c) Persons not currently in receipt of a cash grant under one of the programs specified in (a), shall automatically receive a Medi-Cal card for each month in which they are ineligible for the cash grant because of either of the following reasons:

(1) Their cash grant has been suspended for an administrative reason such as to:

(A) Determine the amount of the cash grant.

(B) Adjust an overpayment.

(C) Change the recipient's representative payee.

(2) They are in the Zero Basic Grant category because the net income of the family exceeds the AFDC payment standard but does not exceed the Minimum Basic Standard of Adequate Care (MBSAC).

(d) Persons shall not be considered Public Assistance recipients for purposes of Medi-Cal eligibility when the following conditions exist. The person is both:

(1) Age 21 years or older.

(2) Receiving AFDC for which federal financial participation is not obtainable or EA as part of an unemployed parent family.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code; Section 87, Chapter 1594, Statutes of 1982, SB 2012.

Reference: Section 14005.1, Welfare and Institutions Code.

50038.5. Emergency Assistance (EA). (a) Emergency Assistance (EA) means the public assistance programs that provide:

(1) Assistance for 30 days to certain families not meeting the qualifications for the federal AFDC-U program.

(2) Those children in danger of abuse, neglect or exploitation and to families of such children.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code; Section 87, Chapter 1594, Statutes of 1982, SB 2012.

Reference: Sections 11406.5 and 14005.1, Welfare and Institutions Code.

APPLICATION AND STATEMENT OF FACTS FOR CHILD NOT LIVING WITH A PARENT OR RELATIVE AND FOR WHOM A PUBLIC AGENCY IS ASSUMING SOME FINANCIAL RESPONSIBILITY

COUNTY USE ONLY
Case name:
Case number:
Effective date:

❒ New application ❒ Redetermination ❒ Request retroactive coverage for _____ months

Name of child	Sex ❒ Male ❒ Female	Birth date (mm/dd/yy)	Birth place

Social Security number	Social Security claim number	U.S. citizen ❒ Yes ❒ No	❒ MC 13 attached (required) ❒ Alien registration number _____

Mother's name	Mother's Social Security number (if known)	Father's name	Father's Social Security number (if known)

Name of person or institution with whom placed

Address (number, street)	City	State	ZIP code

Mailing address (number, street, P.O. Box) (if different)	City	State	ZIP code

Child is detained under Welfare and Institutions Code, Section 602 ❒ Yes ❒ No

Title IV-E eligible? ❒ Yes ❒ No
Date adoption agreement terminates or renews_____

Monthly amount paid from public funds for child's care which is not reimbursed by the child's parents. $_____

Date of present placement or move to California (children placed by another state) _____

Medical insurance ❒ Yes ❒ No
If yes, insurance company _____

SSI/SSP application made? ❒ Yes ❒ No

Child's Ethnic Group (check one box only)

❒ White (not of Hispanic origin) ❒ Hispanic
❒ American Indian or Alaskan Native ❒ Filipino
❒ Black (not of Hispanic origin)
❒ Asian or Pacific Islander

Child's Language (check one box only) (If he/she can speak and understand English, check English)

❒ English ❒ Korean
❒ Spanish ❒ Vietnamese
❒ Chinese ❒ Filipino (Tagalog)
❒ Japanese ❒ Other (specify) _____

Signature of public agency representative (or attach Cert Letter) ➤	Date	Telephone number ( )

Name of responsible public agency	Contact person	Telephone number ( )

Street address (number, street)	City	State	ZIP code

SEE REVERSE SIDE FOR INSTRUCTIONS

INSTRUCTIONS FOR USE OF FORM MC 250 AS AN APPLICATION

Public Agency Representative

Form MC 250 is to be completed by you when requesting Medi-Cal coverage for a child who is not living with a parent or relative and for whom you are accepting financial responsibility in whole or in part. You are accepting financial responsibility if you have responsibility for the child's placement and you pay for part or all of the child's care with your agency's funds. If you represent a Title IV–E adoptions assistance or foster care child placed by your state, who is now living in California, you must also provide a letter (Cert Letter) certifying the child's federal eligibility and entitlement to Medicaid benefits.

A Social Security number must be provided for the child if the child is a U.S. citizen or if he/she has satisfactory immigration status (SIS). If the child does not have a number and is required to have one, you must apply for one for him/her in order for the child to remain eligible for Medi-Cal. If you have made an application for a Social Security number, write "app. on (the appropriate month, day, and year)" under Social Security number. Notify the county welfare department as soon as you receive the number.

If SIS is claimed for the child, he/she is presumptively eligible for full scope Medi-Cal in accordance with instructions in ACWDL 92-48. SIS includes aliens who are lawful permanent residents, Permanently Residing in the United States Under Color of Law (PRUCOL), or amnesty aliens with a valid and current I-688.

The completed MC 250 is to be mailed to the county welfare department (CWD) which is located in the same county as your agency. Each section of the form must be complete and the information provided must be true and correct to the best of your knowledge. You are also responsible for reporting immediately to the CWD any change in the circumstances of the child which may affect the child's eligibility.

Adoptive/Foster Parents of Title IV–E Children Placed by Another State

You may complete form MC 250 if the placing state provides a Cert Letter certifying your child's Medicaid eligibility under Title IV–E. Please follow the instructions in paragraphs two through four above.

County Welfare Department Worker

The effective date of this application for Medi-Cal is the date this form is received in your department. This date must be entered in the box designated for "County Use Only." Upon receipt, check the form for completeness. If incomplete, contact the public agency responsible for the named child or the adoptive/foster parents of the Title IV–E child placed by another state for the necessary information. Only that information requested on form MC 250 is necessary to establish eligibility for a child not living with a parent or relative and supported by public funds, except for the Title IV–E child placed by another state, now living in California. These children must have a Cert Letter from the placing state certifying Title IV–E eligibility. A Notice of Action is to be sent to the public agency or the adoptive/foster parents of the Title IV–E child when eligibility is established. Medi-Cal cards are to be issued in the child's name and sent to the person or child care facility with whom the child has been placed.

INSTRUCTIONS FOR USE OF FORM MC 250 FOR A DETERMINATION

Public Agency Representative or Adoptive/Foster Parents

Form MC 250 is to be completed by the Public Agency Representative at the time of the annual redetermination of Medi-Cal eligibility for the child named on the reverse side of this form. Please complete the form in accordance with the application instructions above and return it to us within 10 days so that we can certify continuous Medi-Cal eligibility. Adoptive/foster parents need not complete the form annually. See instructions for county welfare department worker.

County Welfare Department Worker

Please complete the redetermination in accordance with the application instructions above for California placed children. For Title IV–E children placed by another state, annually contact the placing state to verify child's eligibility. Note changes on the original MC 250 and take action accordingly.

MEDICAL PROVIDERS

NEW! CALVCB ONLINE

The California Victim Compensation Board (CalVCB) has made submitting and tracking bills easier than ever! With CalVCB Online you can now:

- View application and bill status
- Upload bills and documents
- Update contact information
- Upload W-9, and license documentation
- Access copies of 1099s
- Set up accounts for your administrative staff

CalVCB Online is a secure and private portal that can be easily accessed from a smart phone, tablet or desktop computer.

To create a CalVCB Online Provider account, go to: **online.victims.ca.gov/Home/ProviderInfo**

To create a new account, you will need your CalVCB Provider ID and a CalVCB Provider Start Date. If you do not have this information, please contact Customer Service at **(800) 777-9229**.

MEDICAL EXPENSES

CalVCB can help pay for medical expenses that are the direct result of a crime, including but not limited to: hospitalization, physician's services, surgery, ambulance transportation, telehealth and prescriptions. CalVCB uses the Medicare rate for medical services.

CalVCB is the payor of last resort and can only pay for treatment that is not covered by any other reimbursement source.

Insurance providers must be billed prior to submitting expenses to CalVCB for payment. If the expense is not covered, or is only partially covered, submit your billing with a copy of the explanation of benefits.





SUBMITTING MEDICAL BILLS

Submit bills on a Centers for Medicare & Medicaid Services (CMS) 1500 or 1450 form and include the patient's CalVCB application number. Instructions and forms can be found at: **victims.ca.gov/providers/1500faq.aspx**

COMPLEMENTARY & ALTERNATIVE MEDICINES (CAM)

CalVCB can help pay for chiropractic treatment, acupuncture, holistic medicine, massage therapy and more.

- CalVCB may pay up to 20 sessions
- For more information visit: **victims.ca.gov/victims/camtreatments.aspx**

COSMETIC SURGERY

- CalVCB will reimburse the surgeons' fee at 80% of the billed amount
- Facility and anesthesia fees are reimbursed at the Medicare rate
- Providers may seek pre-authorization from CalVCB before performing cosmetic services

MEDICAL EQUIPMENT

CalVCB can cover medical equipment that became necessary due to the crime or that was lost, stolen or broken during a crime such as wheelchairs, walkers, eyeglasses, hearing aids and prosthetic devices. Providers may request pre-authorization from CalVCB prior to providing services to determine coverage.

LEARN MORE ABOUT VICTIM COMPENSATION

Visit CalVCB's online tutorial "A Victim Compensation Course for Medical Providers" to learn more. Medical professionals and billing agents can familiarize themselves with covered expenses, benefit limits and more.

To take the course visit: **victims.ca.gov/training/**

rev. 3.17.2020

CALIFORNIA CalVCB VICTIM COMPENSATION BOARD

DENTAL PROVIDERS

NEW! CALVCB ONLINE

The California Victim Compensation Board (CalVCB) has made submitting and tracking bills easier than ever! With CalVCB Online you can now:

- View application and bill status
- Upload bills and documents
- Update contact information
- Upload W-9, and license documentation
- Access copies of 1099s
- Set up accounts for your administrative staff

CalVCB Online is a secure and private portal that can be easily accessed from a smart phone, tablet or desktop computer.

To create a CalVCB Online Provider account, go to: **online.victims.ca.gov/Home/ProviderInfo**

To create a new account, you will need your CalVCB Provider ID and a CalVCB Provider Start Date. If you do not have this information, please contact Customer Service at **(800) 777-9229**.

DENTAL EXPENSES

CalVCB can help pay for dental expenses that are the direct result of a crime, including but not limited to hospitalization, physician's services, surgery, and prescriptions.

CalVCB generally pays 75% of the amount billed.

CalVCB is the payor of last resort and can only pay for treatment that is not covered by any other reimbursement source.

Insurance providers must be billed prior to submitting expenses to CalVCB for payment. If the expense is not covered, or is only partially covered, submit your billing with a copy of the explanation of benefits.





SUBMITTING DENTAL BILLS

Submit bills on an American Dental Association (ADA) claim form and include the patient's CalVCB application number.

PRE-AUTHORIZATION FOR TREATMENT

If pre-authorization is required, submit a pre-treatment estimate and obtain pre-authorization for treatment. The estimate is required to be on an approved ADA claim form which can be found at: **victims.ca.gov/providers/dental.aspx**

A written description of the injury and the planned treatment should accompany the claim form. CalVCB will review these documents and confirm whether or not the dental estimate will be covered.

After treatment has occurred, bill CalVCB. If a bill is submitted that is different from the pre-authorized treatment amount, the pre-authorized amount will be honored.

HELP VICTIMS FIND MORE RESOURCES

Visit our Local Help page at: **victims.ca.gov/victims/localhelp.aspx**

Contact CalVCB

- **DentalContact@victims.ca.gov**
- **1-800-777-9229**

For more information, visit: **victims.ca.gov/providers/dental.aspx**

rev. 3.17.2020

CALIFORNIA CalVCB VICTIM COMPENSATION BOARD

State of California
Governor's Office of Emergency Services
(www.caloes.ca.gov)

MEDICAL REPORT: SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION

CAL OES 2-900

For copies of this form or assistance in completing the Cal OES 2-900, please contact
California Clinical Forensic Medical Training Center
www.ccfmtc.org

MEDICAL REPORT: SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION
State of California
Office of Emergency Services
Cal OES 2-900

Confidential Document

Patient Identification

A. GENERAL INFORMATION

☐ See Patient Label/Registration Face Sheet

1. Name of Medical Facility Where Exam Performed	Facility Address	2. Date of Exam	Time of Exam

3. Patient's Last Name	First Name	M.I.	Telephone	Cell Phone

4. Street Address	City	County	State	Zip Code

5. Age	Date of Birth	Gender ☐ Female ☐ Male	Ethnicity

6. Interpreter Used: ☐ No ☐ Yes Language Used: _____

Name of Interpreter: _____ Telephone: _____

Affiliation of interpreter: ☐ Facility Interpreting Services

☐ Contracted Agency, specify: _____

☐ Family ☐ Friend ☐ Other, specify: _____

7. Name of Child's Caregiver ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____	Gender ☐ Female ☐ Male	Telephone (w) (h) (c)

Street Address	City	County	State	Zip Code

8. Name of Child's Caregiver ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____	Gender ☐ Female ☐ Male	Telephone (w) (h) (c)

Street Address	City	County	State	Zip Code

9. Name(s) of Siblings	Gender	Age	DOB	Name(s) of Siblings	Gender	Age	DOB
	M F				M F		
	M F				M F		

B. MANDATORY REPORTING FOR SUSPECTED CHILD ABUSE AND NEGLECT

Mandatory Child Abuse/Neglect Report made to both Law Enforcement and CPS Agencies (Pursuant to Penal Code §11166):

	Name of Agency	Telephone	Date
☐ Law Enforcement ☐ Telephone Report ☐ Written Report Submitted Name of Person Taking Report:			
☐ Child Protective Services ☐ Telephone Report ☐ Written Report Submitted Name of Person Taking Report:			

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

Name	ID Number	Agency	☐ Unknown

Child Protective Services _____

and/or

Law Enforcement Officer _____

D. PATIENT CONSENT AND AUTHORIZATION FOR EXAMINATION (See instructions)

☐ Law Enforcement Authorized ☐ CPS Authorized ☐ Placed in protective custody ☐ Physician authority pursuant to state law ☐ Parent/Guardian consent

E. DISTRIBUTION OF Cal OES 2-900 (Check all that apply)

☐ Law Enforcement Agency (original) ☐ Hand Delivered ☐ Mailed ☐ Faxed	☐ Child Protective Services (copy) ☐ Hand Delivered ☐ Mailed ☐ Faxed
☐ Crime Laboratory (copy included with evidence)	☐ Medical Facility Records (copy)

F. PATIENT HISTORY

1. Name of Person(s) Providing History	Relationship to Patient

2. Child Accompanied to Facility By	Relationship to Patient

Patient Identification

3. History of Present Illness ☐ **See dictation for additional information.** ☐ **N/A**

If dictating, provide brief 2-3 sentence handwritten summary. Print or write legibly. Include date, time or timeframe, place of incident, and initial reporting party. Distinguish statements made by child in quotation marks from those statements made by other historians.

G. PAST MEDICAL HISTORY

	Yes	No	Unknown	Describe
Birth History (if applicable)	☐	☐	☐	
Physical Abuse History	☐	☐	☐	
Sexual Abuse History	☐	☐	☐	
Neglect History	☐	☐	☐	
Emotional Abuse History	☐	☐	☐	
Domestic Violence Exposure	☐	☐	☐	
Alcohol/Drug Exposure ☐ Prenatal ☐ Postnatal ☐ Alcohol ☐ Drug	☐	☐	☐	Specify types of drugs if known, and collect urine toxicology up to 96 hours after ingestion:
Hospitalization(s)	☐	☐	☐	
Surgery	☐	☐	☐	
Significant Illness/Injury	☐	☐	☐	
Any pertinent medical condition(s) that may affect the interpretation of findings?	☐	☐	☐	
Allergies	☐	☐	☐	
Medications	☐	☐	☐	
Immunizations Up To Date	☐	☐	☐	
Disabilities	☐	☐	☐	(Specify):
Growth & Development ☐ WNL ☐ ABN ☐ Unknown	☐	☐	☐	

H. REVIEW OF SYSTEMS ☐ Negative except as noted below

☐ See dictation for additional information ☐ N/A

I. NAME OF PERSON TAKING HISTORY (Print Name)	Signature	Telephone	Date

J. GENERAL PHYSICAL EXAMINATION

1. Temperature	Pulse	Respiration	Blood Pressure

2. Height (cm or in)	(%)	Weight (kg or lb)	(%)	Children under 2: (HC)	(%)

3. General physical appearance, demeanor, and level of physical discomfort/pain. Provide brief handwritten summary even if dictating. ☐ See dictation for additional information. ☐ N/A

Patient Identification

4. Record results of physical examination.

	WNL	ABN	Not Examined	See Body Diagram	Describe Abnormal Findings. ☐ N/A ☐ See dictation for additional information
Skin					
Head					
Eyes					
Ears					
Nose					
Mouth/Pharynx					
Teeth					
Neck					
Lungs					
Chest					
Heart					
Abdomen					
Back					
Buttocks					
Extremities					
Neurological					
Genitalia					

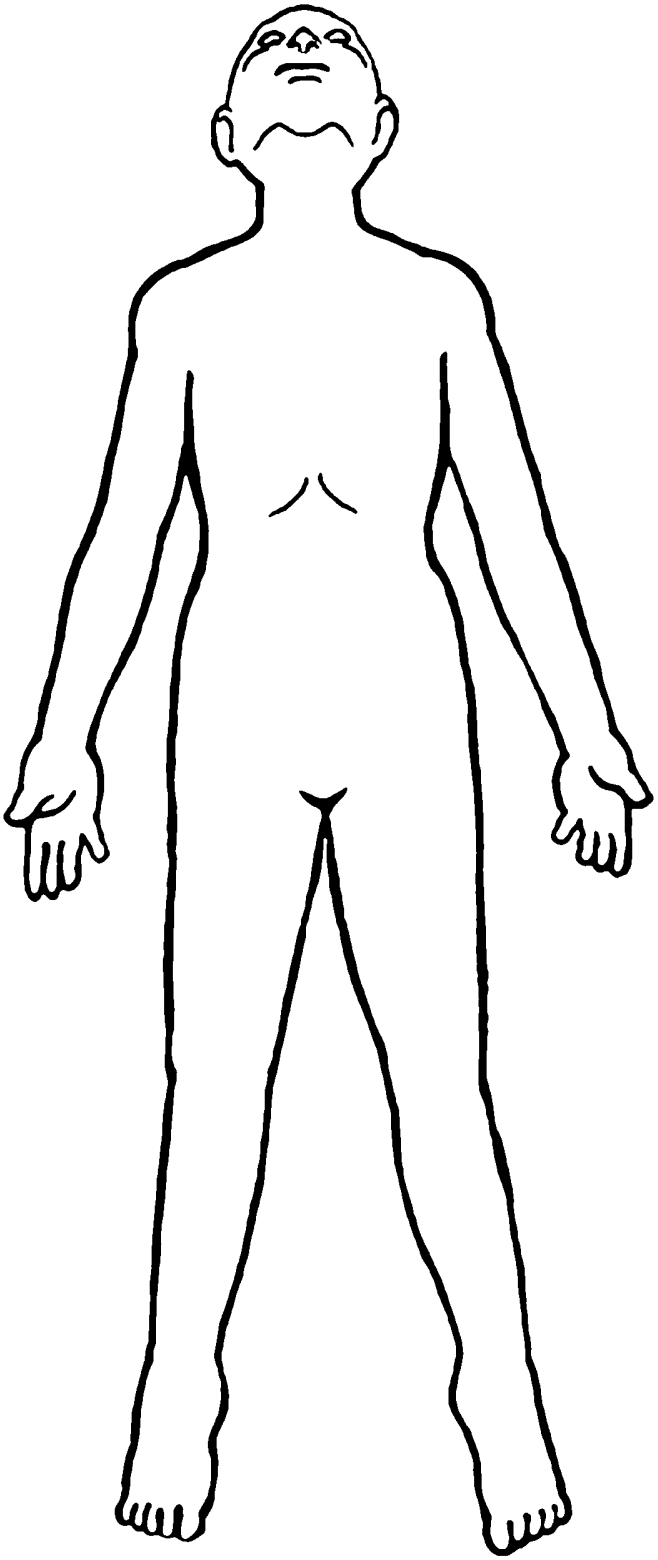
5. If genital injuries are sustained, use copies of page(s) 6 and 7 (if applicable) from Cal OES 2-930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form or Cal OES 2-925 Forensic Medical Report: NonAcute (>72 hours) Child/Adolescent Sexual Abuse Examination to document findings and attach to this form.

J. GENERAL PHYSICAL EXAMINATION (continued)

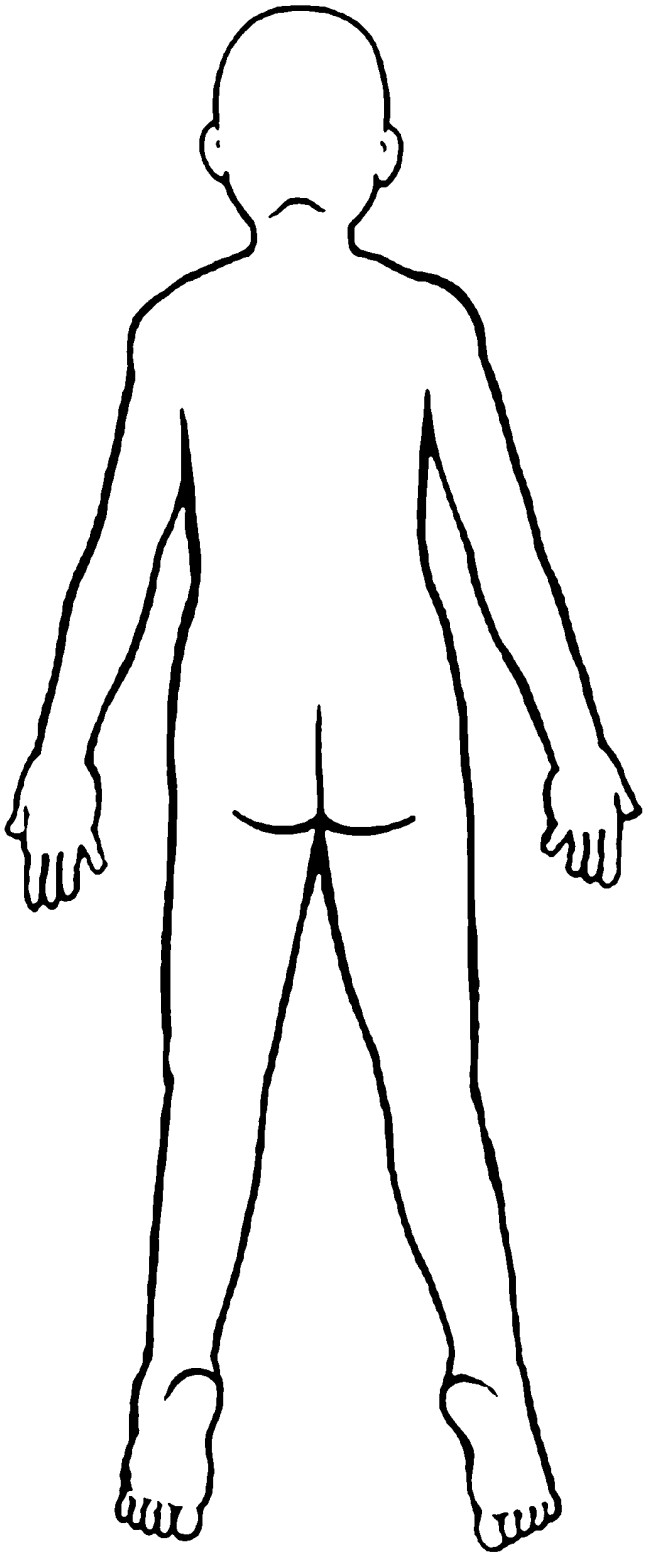
6. Conduct physical examination and record findings using the diagrams.

Patient Identification

A



B

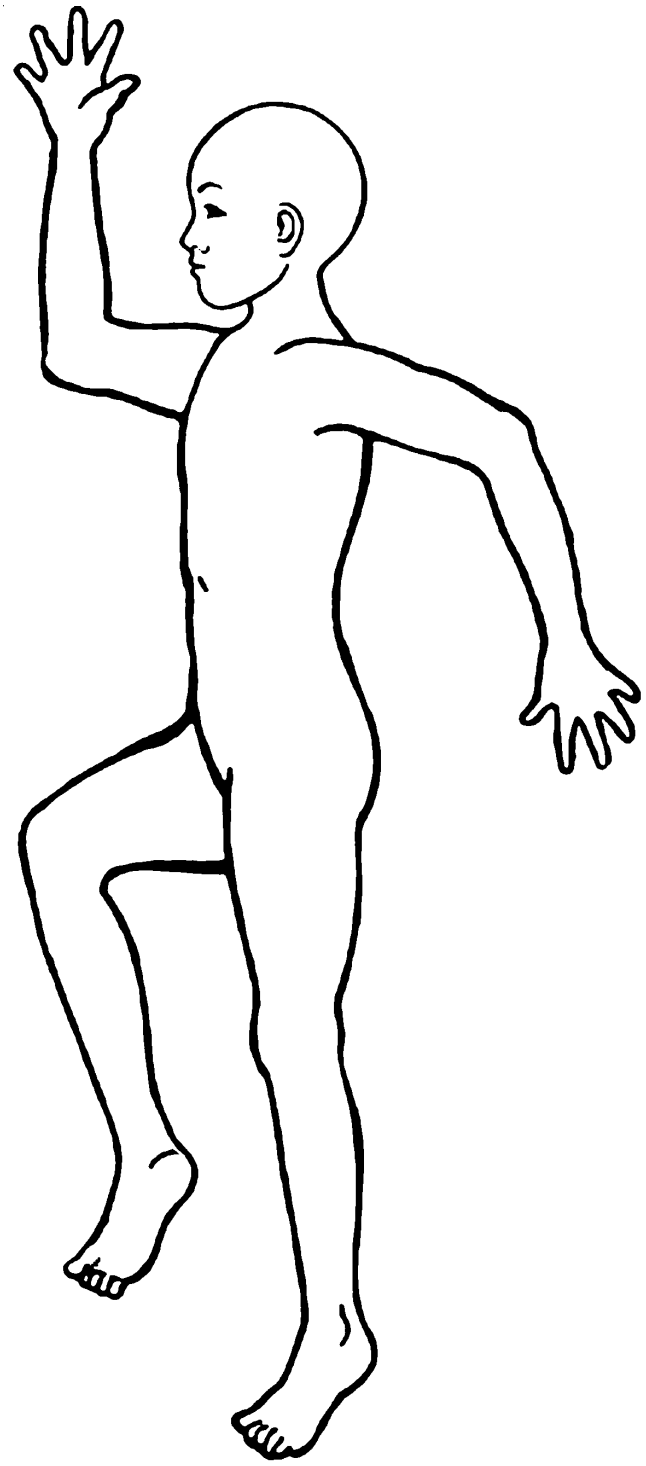


J. GENERAL PHYSICAL EXAMINATION (continued)

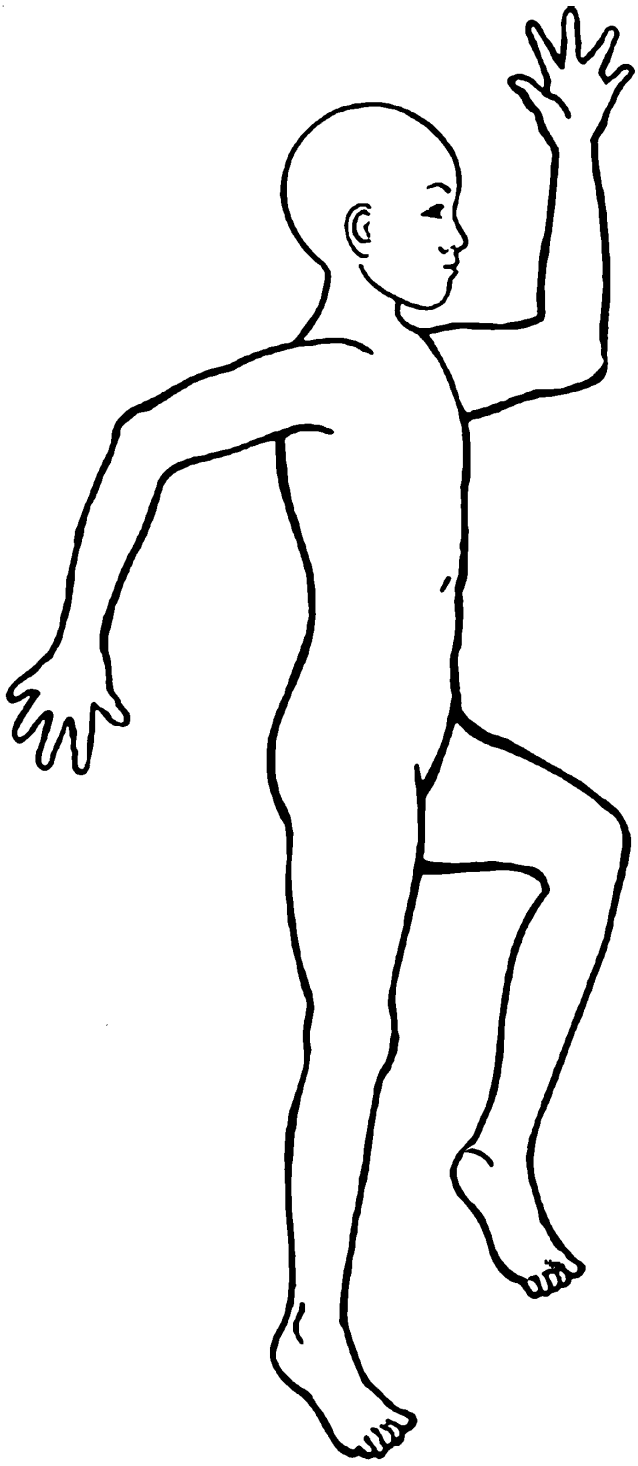
6. Conduct physical examination and record findings using the diagrams.

Patient Identification

C



D

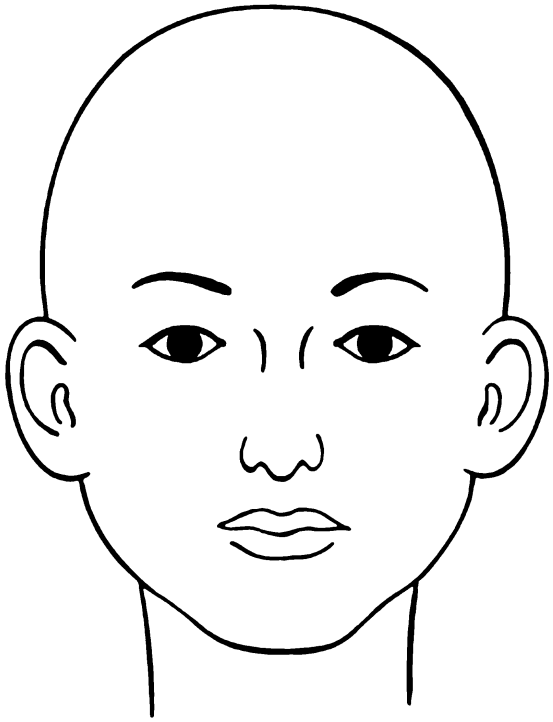


J. GENERAL PHYSICAL EXAMINATION (continued)

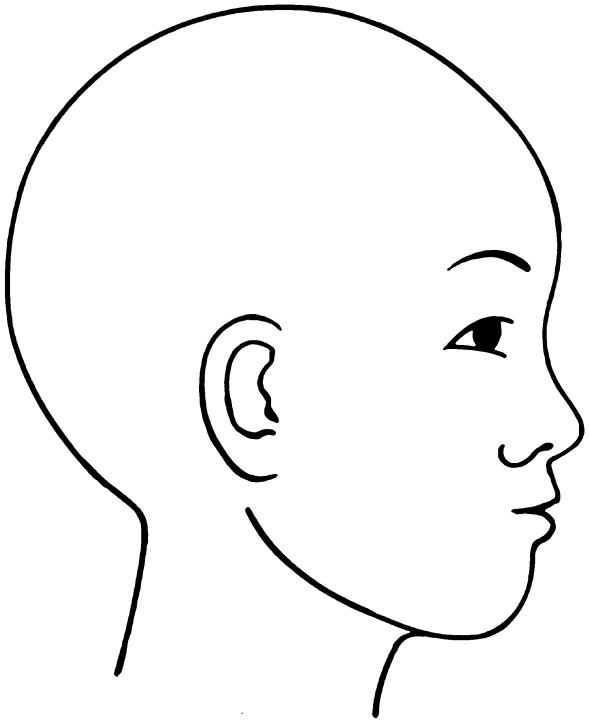
7. Examine the face, head, ears, hair, scalp, neck, and mouth for injury. Record findings using the diagrams.

Patient Identification

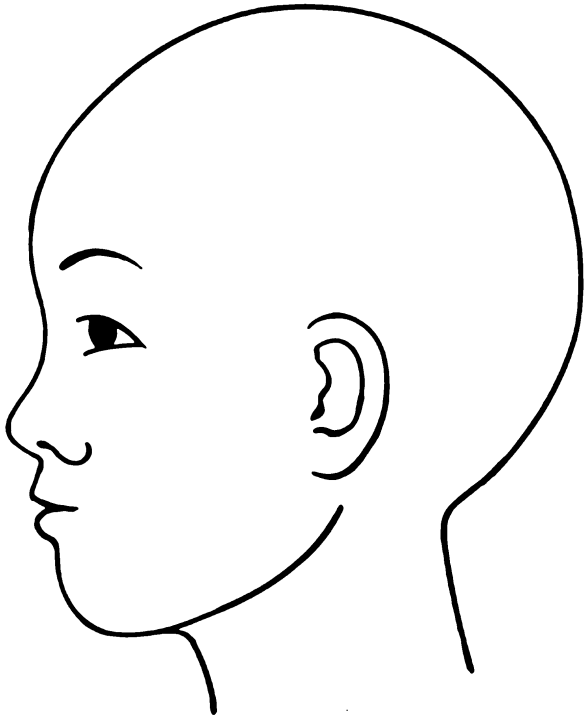
E



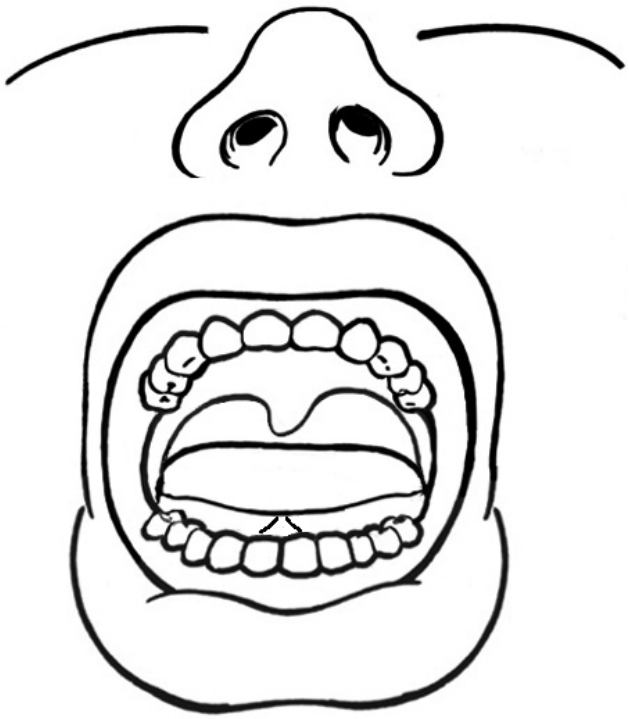
F



G



H



K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing Collected ☐ No ☐ Yes ☐ N/A

Clothing Placed in Evidence Kit	Clothing Placed in Paper Bag

2. Foreign Materials Collected

	N/A	No	Yes	Collected by:
Swabs/suspected blood	☐	☐	☐	
Dried secretions	☐	☐	☐	
Fiber/loose hairs	☐	☐	☐	
Soil/debris/vegetation	☐	☐	☐	
Swabs/suspected saliva	☐	☐	☐	
Foreign body	☐	☐	☐	
Control swabs	☐	☐	☐	
Fingernail scrapings	☐	☐	☐	
Matted hair cuttings	☐	☐	☐	

Other types, describe:

L. TOXICOLOGY SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood Alcohol / Toxicology	☐	☐	☐		
Urine Toxicology	☐	☐	☐		

M. REFERENCE SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood (lavender top tube)	☐	☐	☐		
Blood card (optional)	☐	☐	☐		
Buccal swabs (optional)	☐	☐	☐		
Saliva swabs	☐	☐	☐		

N. DIAGNOSTIC STUDIES ☐ Refer to dictation

1. Laboratory:

	WNL	ABN	N/A	Pending	Results
☐ CBC	☐	☐	☐	☐	
☐ Platelets	☐	☐	☐	☐	
☐ INR, PTT, PT	☐	☐	☐	☐	
☐ SGOT, SGPT	☐	☐	☐	☐	
☐ Urinalysis	☐	☐	☐	☐	
☐ Toxicology Screen	☐	☐	☐	☐	
☐ Other	☐	☐	☐	☐	

2. Diagnostic Imaging

	WNL	ABN	N/A	Preliminary Reading	Final Report
☐ Skeletal Survey	☐	☐	☐	☐	☐
☐ CT Scan	☐	☐	☐	☐	☐
☐ MRI	☐	☐	☐	☐	☐
☐ Other	☐	☐	☐	☐	☐

Describe:

3. Exam Performed by Ophthalmologist:

☐ N/A ☐ No ☐ Yes ☐ Pending ☐ See Medical Record for Report

Name of Ophthalmologist:

Photographs Taken By:

O. PHOTO DOCUMENTATION

☐ No ☐ Yes ☐ N/A ☐ Film Retained

☐ Film Released to:

Photographs taken by:

35mm ☐ Digital ☐ Instant ☐ Other ☐

Recommend follow-up photographs be taken in 1-2 days

☐ No ☐ Yes ☐ N/A

Patient Identification

P. REQUIRED SUMMARY AND INTERPRETATION OF HISTORY, EXAMINATION, AND DIAGNOSTIC STUDIES

Describe:

☐ Neglect
☐ Physical abuse
☐ Evaluation suspicious for physical abuse. Further information needed.
☐ Indeterminate cause
☐ Evaluation indicates non-abusive cause of medical findings.

☐ See Additional Dictation Dictation Reference Number:

Q. DISTRIBUTION OF EVIDENCE	Released To
Clothing (items not placed in evidence kit) ☐ N/A	
Evidence Kit ☐ N/A	
Reference samples ☐ N/A	
Toxicology samples ☐ N/A	

R. PERSONNEL INVOLVED

Examination Performed By: (Print)		Signature of Examiner
License No.	Telephone	Date
Examination Assisted By: (Print)		Signature
License No.	Telephone	Date
Specimen labeled and sealed by:		Signature
License No.	Telephone	Date

S. PATIENT DISPOSITION

☐ Admitted ☐ Home ☐ Protective Custody

☐ Follow Up Exam Needed (specify reason):

State of California
Governor's Office of Emergency Services
(www.caloes.ca.gov)

MEDICAL REPORT: SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT INSTRUCTIONS

CAL OES 2-900

For copies of this form or assistance in completing the Cal OES 2-900, please contact
California Clinical Forensic Medical Training Center
www.ccfmtc.org

Cal OES 2-900
Medical Report: Suspected Child Physical Abuse and Neglect Examination

REQUIRED USE OF STANDARD STATE FORM:
Penal Code § 11171 established the use of a standard form to record findings from examinations performed for suspected child physical abuse and neglect. This form is intended to facilitate identification of child physical abuse and neglect, and as such, is not a complete medical treatment record.

SUGGESTED USE OF THE STANDARD STATE FORMS: FOLLOW LOCAL POLICY

Cal OES 2-900	**Medical Report: Suspected Child Physical Abuse and Neglect Examination** • Suspected child physical abuse and neglect • Examination of children and adolescents under age 18
Cal OES 925	**Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination** • History of **nonacute sexual assault** (>72 hours) • Examination of children and adolescents under age 18
Cal OES 2-930	**Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination** • History of **acute sexual assault or assault** (<72 hours) • Examination of children and adolescents under age 18

INSTRUCTIONS FOR Cal OES 2-900
These instructions contain the recommended methods for meeting the minimum legal standards established by Penal Code § 11171 for performing examinations. Consult the California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect published by Cal OES for additional information including the knowledge, skills, and abilities necessary for health practitioners to complete the medical examination.

LIABILITY AND RELEASE OF INFORMATION
This medical report is subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Penal Code§ 11164 or privilege), the Medical Information Act (Civil Code § 58 et seq.), the Physician-Patient Privilege (Evidence Code § 990), the Official Information Privilege (Evidence Code § 1040) and Penal Code § 11171.2. It can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services worker, child abuse and neglect team member, county licensing agency, and coroner. Records may be released to the defense counsel only through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

Complete this report in its entirety. Print legibly. Use N/A (not applicable) when appropriate to show that the examiner attended to the question.	**Patient identification: This space is provided for hospitals and clinics using plastic plates for stamping identification information; or, for facilities to write in an identification number and date.**

A. GENERAL INFORMATION
Note: If the facility patient label or registration face sheet includes the information requested in items #1-5 below, these may be used in lieu of handwritten entries. Mark the box and attach the label or registration face sheet to this form.

1. **Enter the name and address of the facility where the examination was performed.**
2. **Enter the date and time of the exam.**
3. **Enter the patient's name and telephone number.**
4. **Enter the patient's street address, city, county, state, and zip code.**
5. **Enter the patient's age, date of birth (DOB), gender, and ethnicity.**
6. **Enter whether an interpreter was used, the language used, and who provided interpreting services.**
7. **Enter the name of the child's caregiver, gender, street address, city, county, state, zip code, and telephone numbers.**
8. **Enter the name of the child's caregiver, gender, street address, city, county, state, zip code, and telephone numbers.**
9. **Enter the name(s) of siblings, gender, age, and date of birth.**

B. MANDATORY REPORTING FOR SUSPECTED CHILD ABUSE AND NEGLECT: Suspected Child Abuse and Neglect Form Department of Justice (DOJ) SS 8572.

1. **Penal Code § 11166 requires all professional medical personnel to report suspected child abuse and neglect, defined by Penal Code § 11165, immediately by telephone and to submit a written report (DOJ SS 8572) within 36 hours to a local law enforcement agency OR a child protective services agency.**
2. **The Cal OES 2-900 should not replace the DOJ SS 8572 Suspected Child Abuse and Neglect Report. The SS 8572 is used by all mandated reporters to report suspected child abuse and neglect. The Cal OES 2-900 is used by medical personnel to document physical findings and is part of the medical treatment record (Penal Code § 11171.2(d).**
   - Check the appropriate box to indicate that a telephone report was made to a law enforcement agency and/or Child Protective Services. Identify the person who took the report, his/her telephone number, and the date the report was made.
   - Check the appropriate box to indicate whether the written report was submitted to a law enforcement agency or to Child Protective Services.
3. **See California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect for further discussion.**

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

1. **Record name(s) of responding personnel from a law enforcement or child protective services agency and identifying information.**
2. **If unknown, check box.**

D. PATIENT CONSENT AND AUTHORIZATION FOR EXAMINATION

1. **See page 2 for information on consent and authorization for examinations.**
2. **Authorization by law enforcement or child protective services is not required for healthcare providers to use this form. Authorization, however, may be required if either agency is the designated payor.**
3. **Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy.**
4. **See California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect for further discussion.**

E. DISTRIBUTION OF Cal OES 2-900
Check boxes to indicate the distribution of the form.

F. PATIENT HISTORY

1. **Record the name(s) of the person(s) providing the history and their relationship to the patient.**
2. **Record the name(s) of the person(s) accompanying the child to the facility and their relationship to the patient.**
3. **Record the history of present illness.**
   - If dictating, provide brief 2-3 sentence handwritten summary.
   - Include date, time or timeframe of incident, place of incident, and the name, if known, of the initial reporting party.
   - If documenting specific statements made by the patient or historian, use quotation marks.
   - Document if statement(s) made by patient were spontaneous (i.e. not in response to a question or comment).
   - When interviewing verbal children, ask open-ended questions such as "What happened to you? Tell me what happened to you. How did this happen? What did he do or what did she do?" These are the easiest questions for children to answer. Avoid WHY questions or questions that require understanding abstract or complex concepts.
   - If there is an alleged accident, include details of the event. Ask where it happened, who witnessed the event, and how it happened. For example, if there is an alleged fall, ask the height of the fall and onto what surface.
   - Patient statements not heard directly by the recorder may be included, e.g. the child told his teacher that he was hit by a belt.
   - Document chronology of events leading up to medical presentation.

G. PAST MEDICAL HISTORY

1. **Record past medical history, if known.**
2. **Record past abuse history, history of exposure to domestic violence, if known.**
3. **Record history of exposure to prenatal and postnatal alcohol and drug exposure, if known.**
4. **Obtain urine toxicology according to hospital protocol or follow local policy established by criminal justice and child protection agencies under the circumstances described below.**
   - There is a reported history of child's removal from a drug manufacturing home, living in a home with significant drug exposure, or a request by law enforcement or CPS.
   - The child's clinical presentation is concerning and drug ingestion is suspected.
   - Some drugs may be detected in the urine up to 96 hours after ingestion. Collect urine in a clean container. It is important to collect the first available sample.
5. **Record any cognitive, developmental, physical, or mental/emotional disabilities.**
6. **Record whether growth and development is within normal limits. Check WNL, if within normal limits, ABN, if abnormal, or unknown.**
7. **Indicate whether there are any other pertinent medical conditions, particularly if any conditions may affect the interpretation of findings (e.g. bleeding disorders, bone diseases, etc).**

H. REVIEW OF SYSTEMS

Check the box "Negative except as noted below" if there are no identified medical problems. Describe, if signs and symptoms are present. Check the box if there is additional dictation in medical progress notes or another format.

I. NAME OF PERSON TAKING HISTORY

Print the name of the person taking the history, sign, date, and provide telephone number.

PATIENT CONSENT AND AUTHORIZATION FOR EXAM

Suspected child abuse: non-consenting parents

Parental consent is not required to examine, treat or collect evidence for suspected child abuse. In the absence of parental consent or in the case of parental refusal, children must be taken into protective custody by a child protective agency (e.g. law enforcement agency or county child protective services agency) in order to perform the examination. Follow local policy regarding placement of children in protective custody.

Welfare and Institutions Code Section 324.5

Whenever allegations of physical or sexual abuse of a child come to the attention of a local law enforcement agency or the local child welfare department and the child is taken into protective custody, the local law enforcement agency or child welfare department may, as soon as practically possible, consult with a medical practitioner, who has specialized training in detecting and treating child abuse injuries and neglect, to determine whether a physical examination of the child is appropriate. If deemed appropriate, the local law enforcement agency, or the child welfare department, shall cause the child to undergo a physical examination performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, and whenever possible, shall ensure that this examination takes place within 72 hours of the time the child was taken into protective custody. In the event the allegations are made while the child is in custody, the physical examination shall be performed within 72 hours of the time the allegations were made.

PHOTOGRAPHS OF INJURIES

Penal Code Section 11171.2

A physician, surgeon, or dentist or their agents, and by their direction, may take skeletal x-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of the child abuse or neglect.

Penal Code Section 11171.5

If a peace officer, in the course of an investigation of child abuse or neglect, has reasonable cause to believe that the child has been the victim of physical abuse, the officer may apply to a magistrate for an order directing that the victim be x-rayed without parental consent. Any x-ray taken pursuant to this subdivision shall be administered by a physician, surgeon, or dentist or their agents.

With respect to the cost of an x-ray taken by the county coroner or at the request of the county coroner in suspected child abuse or neglect cases, the county may charge the parent or legal guardian of the child victim the costs incurred by the county for the x-ray. No person who administers an x-ray pursuant to this section shall be entitled to reimbursement from the county for an administrative cost that exceeds 5 percent of the cost of the x-ray.

J. GENERAL PHYSICAL EXAMINATION

1. Record vital signs.

2. Record height in either centimeters or inches and weight in either kilograms or pounds. Indicate percentiles, if growth charts are available. For children under age 2, record head circumference and percentile.

3. Describe the patient's general physical appearance.
- Describe the patient's general demeanor including level of discomfort and pain.
- Provide brief handwritten summary, even if dictating. Check box if there is additional dictation in progress notes.
- Documentation helps the examiner recall the patient's behavior and response during the exam for future reference.

4. Record results of physical examination.
- Record all findings and whether the general exam was within normal limits (WNL).
- Describe abnormal findings (ABN).

> **Physical Findings:** A physical finding includes observable or palpable tissue injuries, physiologic changes, or foreign materials.

- Be observant for erythema (redness), abrasions, bruises, swelling, lacerations, bites, and burns.
- Note areas of tenderness, deformity, or induration.
- Record size and appearance of injuries and other findings using the diagrams. Describe shape, size, and color of bruises or other cutaneous injuries.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

5. If genital injuries are sustained, use copies of page(s) 6 and 7 from the Cal OES 2-930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form to document findings; or use that form to document all findings, if the history indicates that the patient has been sexually and physically abused.

J. PHYSICAL EXAMINATION (continued)

6. Conduct general physical examination.

- Record size and appearance of injuries and other findings using Diagrams A and B.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

Bite marks

- Photograph or arrange to have bite marks photographed. Individuals can be identified by the size and shape of their bite marks.
  - > Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from saliva remaining at the bitemark site. Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbitten atraumatic area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
- Casting bite marks:
  - > If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
  - > A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
  - > Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

Bruises

- Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.
- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

J. PHYSICAL EXAMINATION (continued)

6. Conduct general physical examination.

- Record size and appearance of injuries and other findings using Diagrams C and D.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

Bite marks

- Photograph or arrange to have bite marks photographed. Individuals can be identified by the size and shape of their bite marks.
  - > Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from saliva remaining at the bitemark site. Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbitten atraumatic area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
- Casting bite marks:
  - > If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
  - > A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
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- Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.
- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

J. EXAMINATION OF THE HEAD, NECK, AND MOUTH

7. Examine the face, head, ears, hair, scalp, and neck for injury.

- Record injuries and other findings using the Diagrams E, F, G, and H.
- Examine mouth for injury and for missing or chipped teeth, or neglect of oral health.
  - > Signs and symptoms of dentofacial trauma may include: avulsed teeth, lip lacerations, tongue injuries, frenulum injuries, and jaw and facial fractures.
  - > Signs and symptoms of dental neglect may include: untreated rampant cavities, untreated pain, infection, bleeding, or trauma; and/or lack of continuity of care once informed that the above conditions exist.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
  - > Use an appropriate light source.
  - > Use an accurate ruler or scale for size reference in the photograph.
  - > The plane of the film must be parallel to the plane of the finding.
  - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
  - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.
- For head trauma cases:
  - > Examine head closely for evidence of scalp trauma. Record any bruises, areas of scalp swelling, or hair loss.
  - > In infants, note fullness or bulging of the anterior fontanelle or splitting of the sutures.
  - > Examine earlobes carefully for any bruising or petechiae. Record injuries using the diagrams.

K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LABORATORY

All swabs and slides must be air dried prior to packaging (Penal Code § 13823.11). Air dry in a stream of cool air for 60 minutes. Place samples from one patient at a time in the swab drying box. Wipe or spray the swab drying box with 10 percent bleach before each use.
Labeling requirements: Swabs, bindles, and small containers must be individually labeled with the patient's name and sample source. Containers for these individual items must be labeled with the name of the patient, date of collection, description of the evidence including location from which it was taken, and signature or initials of the person who collected the evidence. All containers must be labeled and sealed. Record all evidence transfers, also known as the chain of custody.

1. **Record whether clothing was collected, the items collected, and whether they were placed in an evidence kit or a paper bag. If not, check N/A.**
   - Collect outer and under clothing, if applicable. Coordinate with the law enforcement officer or child protective services worker regarding clothing to be collected. Clothing with bloodstains, tears, and burn holes can be related to physical abuse. Soiled, unkempt clothing can be related to neglect.
   - Wear gloves while collecting clothing. Have the patient disrobe on two large sheets of paper, placed one on top of the other, on the floor. Remove child's shoes before stepping on to the paper. Package each garment in an individual paper bag, label, and seal. Wet stains or garments require special handling. Consult local policy.
2. **Record all foreign materials collected and the name of the person who collected them. If none were collected, check N/A. Foreign materials (soil, vegetation) should be placed in bindles and/or envelopes. Use a separate bindle or envelope for materials collected from different locations. Label and seal.**
3. **Record whether saliva swabs from bite marks were obtained. Record whether a control swab was obtained from an unbitten atraumatic area. Swabs must be labeled with the patient's name and sample source.**

L. TOXICOLOGY SAMPLES

Record whether a urine toxicology sample was obtained. Up to 96 hours after suspected ingestion of drugs, collect a urine specimen in a clean container. It is important to collect the first available sample.

M. REFERENCE SAMPLES

1. **Record whether a DNA reference sample was collected.**
   - Policies pertaining to the collection of reference samples at the time of exam or later vary by jurisdiction. If collected at the time of the exam, ALWAYS collect after the evidence samples. A buccal (inner cheek) swab is less invasive and may be easier to obtain than a blood sample via venipuncture. Consult your local crime laboratory.
2. **Buccal swabs**
   - Rub two swabs gently but firmly along the inside of the cheek in a rotating motion to ensure even sampling. Air dry, package, label, and seal.
3. **Blood**
   - Collect blood sample in lavender stoppered evacuated vial. A blood card is optional in some jurisdictions. Label the vial, place into an envelope, and seal.

N. DIAGNOSTIC STUDIES

1. **Record the types of laboratory work ordered, results, if known, and whether results are pending.**

CBC	Complete Blood Count
INR	International Normalized Ratio
PTT	Partial Thromboplastin Time
PT	Prothrombin Time
SGOT/SGPT	Liver Enzymes

2. **Record diagnostic imaging studies ordered, results, if known, and whether results are pending.**

Skeletal Survey	Series of radiographic images which encompass the entire skeleton
CT Scan	Computed Tomography Imaging
MRI	Magnetic Resonance Imaging

3. **Record whether patient was referred for evaluation by an ophthalmologist.**

O. PHOTO DOCUMENTATION

Record whether photographs were taken, type of camera used, and whether film was retained or released to a law enforcement agency.

P. REQUIRED SUMMARY AND INTERPRETATION OF HISTORY, EXAMINATION, AND DIAGNOSTIC STUDIES

Provide interpretation and medical impression of history, examination, and diagnostic studies. Findings and interpretations are based on both the patient history available and the medical examination. Check the box if there is additional dictation in medical progress notes or another format and record dictation reference number.

Q. DISTRIBUTION OF EVIDENCE

List to whom the evidence was released. Check N/A if not applicable.

R. PERSONNEL INVOLVED

1. **Document who performed the examination by printing the examiner's name. The examiner must sign, date, and provide license and telephone number.**
2. **Document whether another healthcare provider assisted with the examination or evidence collection and handling. If so, print name, sign, date, and provide license and telephone number.**

S. PATIENT DISPOSITION

Indicate disposition and whether a follow-up exam is needed.

Medi-Cal's Foster Care Strategies

Date: November 2022

Executive Summary

The Department of Health Care Services (DHCS) is building upon years of foster care reform efforts to ensure that children and youth involved with the child welfare system have streamlined access to reliable, high-quality, integrated, trauma-informed, strength-based, patient-centered, and family-centered care. This document reviews activities being undertaken by DHCS, including activities in partnership with the California Department of Social Services, to help meet this goal. These efforts reflect policy changes and benefit expansions underway through the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, and additional ongoing efforts to ensure that this care happens seamlessly, and includes medical, behavioral, dental, social services, and educational systems.

Medi-Cal can promote this care through:

- **Special Features for Children and Youth Receiving Foster Care in Medi-Cal Managed Care Plans (MCPs)**:
  - Managed care enrollment in new Single Plan counties
  - Enhanced Care Management (ECM) and Community Supports
  - Dedicated Foster Care Liaison on MCP staff
  - Enhanced DHCS and CDSS Oversight
- **Enhanced Benefits Structure for All Children and Youth Receiving Foster Care**:
  - Initial behavioral health assessment
  - Evidence-based in-home and family therapies for all children involved with child welfare
  - New Activity Stipends
  - Strengthened statewide standards for medical necessity determinations (utilization review) and clinical guidance for service levels for intensive home-based services (IHBS) and therapeutic behavioral services (TBS)
  - Aligned use of the Child and Adolescent Needs and Strengths (CANS) tool across child welfare and specialty mental health
  - Coordination between the Family Urgent Response System (FURS) and the new statewide mandatory Medi-Cal Mobile Crisis benefit

- **Addressing Equity**
    - Equity-focused implementation plans
    - Culturally responsive care
    - Equity-focused data reporting
- **Increased Accountability, Oversight and Compliance:**
    - New performance expectations for MCPs
    - New performance expectations for Mental Health Plans
    - New performance expectations for Child Welfare Systems
    - New local performance expectations and incentive pool

Medi-Cal's Foster Care Strategies

Purpose

DHCS, through Medi-Cal, has made strengthening California's behavioral health system a key priority, particularly for individuals with the greatest needs. For children receiving foster care, these initiatives are being pursued through multiple vehicles:

- **The California Advancing and Innovating Medi-Cal (CalAIM) initiative**, which takes concrete steps to bring meaning to "whole person care," including by establishing Enhanced Care Management (ECM) and Community Supports (discussed in greater detail below) for the most vulnerable beneficiaries. Children and youth involved in child welfare are a key population of focus for these efforts.

- **The California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration**, a new Medicaid Section 1115 demonstration that DHCS is pursuing to expand access to and strengthen the continuum of mental health services for individuals enrolled in Medi-Cal living with severe mental illness (SMI) or serious emotional disturbance (SED) that includes several core initiatives directed at children and youth.

- **Additional initiatives** to strengthen services and supports for children and youth involved in child welfare, such as ongoing efforts to align the CANS across systems, and direct contracts with Kaiser across 32 counties.

The purpose of this document is to review DHCS' various Medi-Cal strategies to strengthen the child welfare system, some of which are being implemented through CalAIM, some through the CalBH-CBC Demonstration, and additional elements through other initiatives.

Background

Children and families involved in child welfare must navigate several complex and fragmented systems – medical care, behavioral health, social services, intellectual and developmental services, education, and the justice system – and this is most challenging for children in out-of-county placements. There are multiple entities accountable for components of care and supervision, often resulting

in a fragmented experience. Children receiving foster care deserve seamless access to needed care, with a single entity accountable to sharing data and improving outcomes. Separation from parents – even in cases of abuse or neglect – is extremely traumatizing, and the experience of trauma increases the risk of mental illness onset, substance use disorders, and poor health outcomes. Yet half of children and youth receiving foster care do not receive any specialty mental health services (SMHS) which could help address the trauma and prevent the development of later health conditions.

The Foster Care Model of Care Workgroup met between June 2020 and April 2021 and was charged with providing recommendations on how to better deliver coordinated services for children and youth involved with child welfare. The workgroup, co-led by DHCS and CDSS, adopted a charter and guiding principles (see the Appendix), reviewed models from other states, and gave input on a variety of proposals put forward by associations and the State. Examples from Washington and Arizona highlighted the advantage of a single entity accountable for providing or coordinating all care, integrating behavioral health and medical care, and having clear accountability to quality metrics. Workgroup members also highlighted unique structures to California, such as realignment, that influence the ability to adopt models that have been successful in other states.

DHCS, recognizing Medicaid's importance in transforming the experience of children receiving foster care, has launched several initiatives to transform the Medi-Cal program. These initiatives are based on a whole person/whole family approach, designed to improve the experience and outcomes for children and families navigating complex systems, and to build on the numerous efforts to improve the foster care system that were already in motion.

CalAIM seeks to: (1) Identify and manage comprehensive needs through whole person care approaches and social drivers of health; (2) Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform; and (3) Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.

A core principle of the foster care strategies -- and in CalAIM more broadly – is to standardize, simplify and streamline systems to ensure individuals and families receive the care they need without barriers. One of the key behavioral health policy changes in CalAIM is to simplify access to SMHS for children experiencing trauma due to involvement in child welfare. In the new CalAIM access criteria for SMHS, effective January 1, 2022, all children in child welfare (in out-of-home placement and/or with an open case) will meet criteria for an assessment in the SMHS program based on the trauma, grief, and loss associated with child welfare involvement. They do not have to demonstrate impairment or diagnosis in order to qualify for an assessment and medically necessary SMHS. Under CalAIM, DHCS also implemented a "no wrong door" policy that facilitates access to appropriate mental health services, no matter where the beneficiary starts accessing care. In addition, under CalAIM, DHCS is implementing a

statewide Youth Screening Tool for Medi-Cal Mental Health Services, which will ensure that children and youth with child welfare involvement are directly referred for a SMHS assessment if they or an individual acting on their behalf contacts the access line for their Medi-Cal Managed Care Plan or county Mental Health Plan seeking help. And, as mentioned at the beginning of this strategy document and discussed in detail below, ECM is a core component of CalAIM.

The CalBH-CBC Demonstration supports statewide practice transformations and improvements in the county-administered behavioral health system to better enable counties and providers to strengthen the continuum of community-based services and evidence-based practices, to improve the quality of care delivered in residential and inpatient settings, and to strengthen transitions from these settings to the community. Several components of this that will improve the quality of care for children receiving foster care include the development of Centers of Excellence (COEs) and offering incentives to counties for meeting key performance thresholds. COEs can provide orientation, training, coaching, mentoring, fidelity monitoring and other supports needed to build and sustain capacity in delivering evidence-based practices through a culturally sensitive lens. For example, DHCS anticipates that COEs may provide support to counties and providers in delivering evidence-based practices for children and youth, including services for which coverage is already clarified (e.g., Intensive Care Coordination, Intensive Home-Based Services) and services for which coverage will be clarified (e.g., Functional Family Therapy, Parent-Child Interaction Therapy, and Multisystemic Therapy). In addition, DHCS intends to incentivize county MHPs and Drug Medi-Cal Organized Delivery System counties to build a robust quality improvement program, to improve performance on quality measures, and to reduce disparities in access and outcomes. Performance improvement measurements will also include rates specific to populations experiencing disparities in behavioral health care access and outcomes, to include children and youth. Under the CalBH-CBC demonstration, DHCS also proposes to cover Activity Stipends for youth in child welfare to support activities that support emotional and social wellbeing.

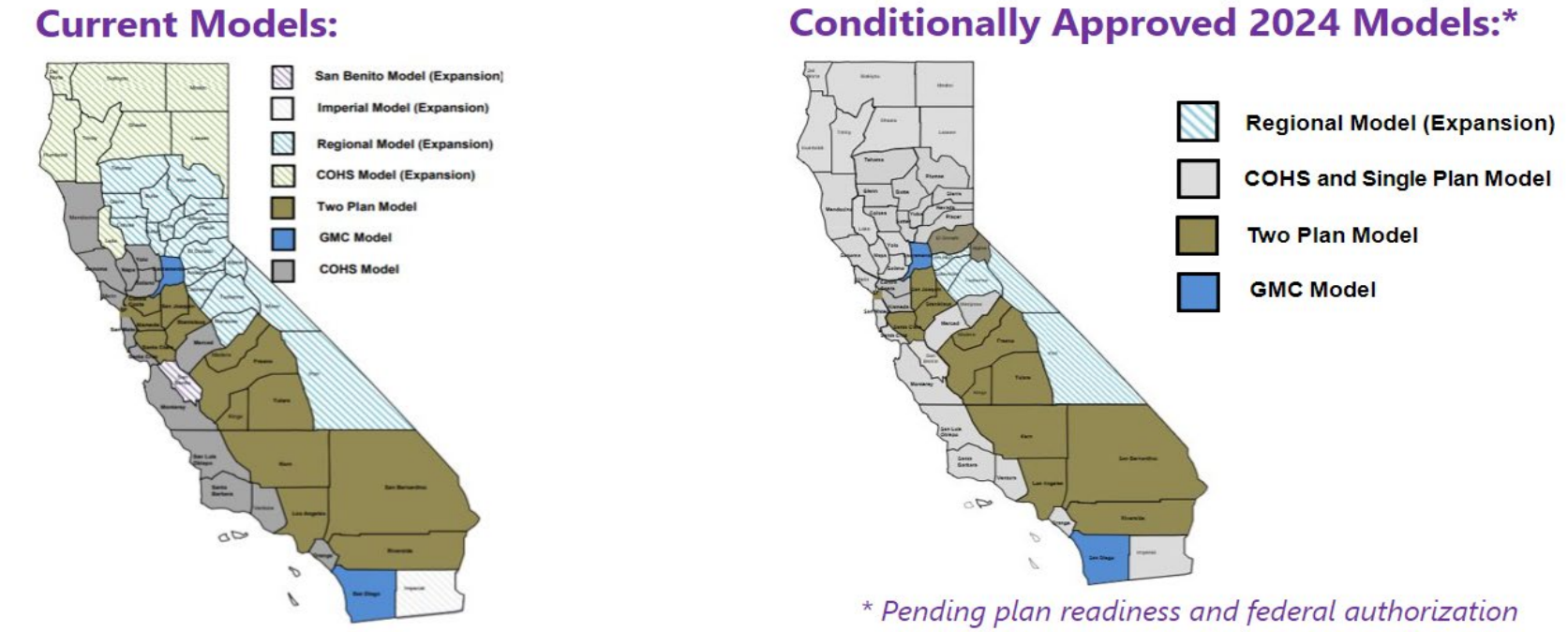
Additionally, Assembly Bill (AB) 2724 (2022) authorized DHCS to establish a direct contract with Kaiser as a Medi-Cal managed care plan in 32 counties. Children and youth in foster care will be able to enroll in Kaiser in these counties and their coverage, health information, and access to the provider network will more seamlessly transition if their placements change among those 32 counties. This provides a step toward a more seamless system in which children and youth in foster care will experience the least amount of disruption when they face changes in placement across some counties.

The sections that follow describe DHCS's foster care strategies in greater detail.

New Special Features for Children and Youth Receiving Foster Care in Medi-Cal Managed Care Plans (MCPs)

1. ***Managed Care Enrollment in New Single Plan Counties.*** It is important that children and youth receiving foster care have access to well-coordinated and managed health care. To that end, DHCS is moving toward greater use of managed care for foster children. Enrollment in managed care is currently voluntary for children in foster care except in eight counties where Medi-Cal managed care is provided by a single County Operated Health Systems (COHS) (See Figure 1 below, left side). The number of counties with COHS and single plans is growing. With the planned MCP model change in 2024, approximately 13,276 children and youth in foster care in counties transitioning to COHS and Single Plan models will be moved to mandatory managed care. DHCS has conditionally approved Medi-Cal managed care model changes in 17 counties, including 12 transitioning to a COHS model and 3 implementing a new county-led Single Plan model (see Figure 1, right side). Participation will be optional for family members of participating children.

Figure 1. Map of current models of managed care as well as conditionally approved 2024 models



2. ***ECM and Community Supports***.[1] At the center of CalAIM is ECM and Community Supports. Together, these two Medi-Cal managed care plan benefits are designed to provide high-risk members and their families with whole person care that extends into health-related social needs. The child welfare-involved population, including children and youth currently receiving foster care as well as children and youth previously receiving foster care in California or another state within the last twelve months, are eligible for ECM as long as they are enrolled in managed care. MCPs are required to contract with community-based providers to deliver ECM services.

   Effective July 1, 2023, when ECM goes live for children and youth receiving foster care, the enhanced care manager ("ECM Provider") will be the single point of contact for children, youth and their families, and will be accountable to coordinate all services: medical, dental, behavioral, developmental and intellectual disability services, sexual and reproductive health and social services, working with county behavioral health, child welfare services, educational systems, and Regional Centers. The ECM Lead Care Manager will serve as an "air traffic controller," knowing every component of the child or youth's needs and services and ensuring they are coordinated.

   Many children and youth receiving foster care who will be eligible for ECM may already be receiving some level of care management through other programs or benefits such as Intensive Care Coordination (ICC) or Intensive Home Based Services (IHBS). In many of these instances, ECM will be additive, improving management of care across delivery systems, and comprehensively addressing unmet medical and/or social needs. MCPs are also expected to contract with existing programs that provide care management services to ECM Populations of Focus and could serve as ECM Providers.[2] For example, If a child or youth is enrolled in both ECM and Intensive Care Coordination, California Wraparound or Health Care Program for Children in Foster Care (HCPCFC) and their existing wraparound coordinator is a contracted ECM Provider, then the managed care plan may assign that care manager as that child's ECM Provider, at the child or caregiver's preference.[3] County welfare departments or county behavioral health departments will be able to contract with managed care plans to serve as an ECM Provider, as long as they demonstrate the capacity to meet the requirements to be an ECM Provider.[4]

[1] ECM is a Medi-Cal Managed Care benefit and only available to Members enrolled in Managed Care. As of July 2022, about 69 percent of children involved in child welfare are enrolled in Managed Care.

[2] For more information on ECM policies, see the ECM Policy Guide.
[3] Additional operational guidance can be found in the ECM Policy Guide.
[4] For more information ECM provider requirements, see the ECM & Community Supports Provider Standard Terms & Conditions.

ECM Providers are responsible for the coordination of and referral to community and social support services, including but not limited to services offered by the MCP such as Community Supports, to meet the needs of the Member.[5] CalAIM ECM Children and Youth in Child Welfare population of focus eligibility criteria includes children and youth who are under age 21 and are currently receiving foster care in California; are under age 21 and previously received foster care in California or another state within the past 12 months; have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state; are under age 18 and are eligible for and/or in California's Adoption Assistance Program; or are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months.

A child or youth involved in child welfare and enrolled in the Medi-Cal managed care plan can also qualify for Community Supports. DHCS offers 14 pre-approved Community Supports services. Examples of Community Supports services[6] that may specifically be beneficial to foster children and youth include:

- Day Habilitation Programs.
- Respite Services
- Medically Tailored Meals/Medically-Supportive Food.
- Environmental Accessibility Adaptions (Home Modifications).
- Asthma Remediation

3. ***Dedicated Foster Care Liaison on MCP Staff.*** Through work undertaken in tandem with the CalBH-CBC demonstration, DHCS will require each managed care plan to assign a foster care liaison to enable effective oversight and delivery of ECM. The foster care liaison will have expertise in child welfare services, county behavioral health services, and other sectors, ensure appropriate ECM staff attend Child and Family Team meetings, and ensure managed care services are closely coordinated with other services. The Foster Care Liaison will be a management level position at the MCP with responsibility to oversee the ECM providers providing services to child welfare involved children and youth in their case load, provide technical assistance to MCP staff as needed, and serve as point of escalation for care managers if they face operational obstacles when working with county and community partners. DHCS will develop standards and expectations for this role to ensure consistency for all MCPs.

[5] For more information on Community Supports, see the Community Supports Policy Guide.
[6] For more information on pre-approved Community Supports services, see the Community Supports Policy Guide.

4. ***Enhanced DHCS and CDSS Oversight.*** As part of both CalAIM and the upcoming CalBH-CBC initiative, DHCS and CDSS are enhancing oversight and monitoring of managed care plans, county behavioral health and child welfare departments.

Enhanced Benefits Structure for All Children and Youth Receiving Foster Care

Building on existing initiatives and requirements, including Early and Periodic Screening Diagnostic and Treatment (EPSDT), the foster care strategies are designed to simplify and improve care for children and youth receiving foster care across the full scope of Medi-Cal benefits. These include the full array of inpatient and outpatient services, including medical visits, surgeries, diagnostic tests, drugs, hospitalization and therapy, and services provided under EPSDT. As noted above, children and youth receiving foster care will be eligible for the ECM benefit, Community Support services as defined in CalAIM, and activity stipends, as defined above.

In addition, the foster care strategies include clarification of key forms of evidence-based practices that must be provided to children and their families. The services will be trauma-informed and evidence-based, designed to support both biological families/families of origin and resource families.

Telehealth offers a unique opportunity to deliver personalized, low-barrier access to services for children and youth across geographic divides. Telehealth allows the continuation of trusted relationships with clinicians, counselors, enhanced care managers, or other supports, regardless of whether a child is placed out of county. Telehealth allows more frequent touchpoints as it eliminates transportation and other logistical barriers. It allows flexibility to support family therapy for children where in-person visits may not be feasible or advisable (potentially including parents who are incarcerated or out of state.) Telehealth can also allow connections linking children, youth, and families to culturally responsive services that may not be available locally. Services through a virtual service platform will be available once this platform is launched through the Children and Youth Behavioral Health Initiative.

The clarified benefits and services include:

1. ***Initial Behavioral Health Assessment.*** As part of the Foster Care Model of Care Workgroup, the County Behavioral Health Directors Association of California and the County Welfare Directors Association proposed a joint home visit with the child welfare worker and a specialty mental health provider for every child or youth entering the child welfare system. DHCS proposes to clarify that a specialty mental health provider should accompany the child welfare worker during the home visit, within 30 days of substantiating an allegation of abuse or neglect and upon the child's entry into the child welfare system. The specialty mental health provider would do a comprehensive behavioral health assessment to identify mental health and/or substance use conditions related to the child and/or the family, identify necessary social supports, and then connect the child

and family (both the biological family/family of origin and the resource family, as appropriate) to any needed clinical or community services. As part of the CalBH-CBC Demonstration, DHCS proposes to develop standards and requirements for the behavioral health assessment and cross-agency collaboration.

The goal is to ***start SMHS and SUD treatment services at the time of entry into the child welfare system,*** instead of depending on child welfare worker referrals. Currently, only half of children receive at least one specialty mental health service, and the data shows many drop-off from referral to actual service). This proposal is synergistic with (but not duplicative of) the Family First Preventive Services Act (FFPSA), since the joint visit will allow the child welfare social worker and the SMHS provider to collaborate on offering any federally approved "well supported" FFPSA services as enumerated in the Title IV-E Prevention Services Clearinghouse that the family could be eligible to receive in support of family health and permanence.

2. ***Evidence-Based Family Therapy for All Children Involved with Child Welfare*.** The CalBH-CBC Demonstration is designed to expand and strengthen the continuum of community-based care, especially for children, youth, and their families. While a comprehensive set of community-based services for children and youth are currently coverable under Medi-Cal pursuant to the EPDST mandate, DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement of specific evidence-based practices statewide. DHCS proposes clarifying statewide coverage requirements and ensuring access to at least three specific evidence-based services that can be delivered at home or in the community under current Medi-Cal coverage authority: Multisystemic Therapy, Functional Family Therapy, and Parent-Child Interaction Therapy. These services are known to help reduce the institutionalization of high-risk children and youth, including those who are involved in the juvenile justice system and those who have been removed from their homes, experienced homelessness, or confronted other major disruptions. DHCS' guidance will include specific service definitions, provider qualifications, implementation requirements and dedicated billing codes to incentivize provider delivery and monitor utilization and performance. With the COEs, resources will be available to support county and provider implementation of these and other services with fidelity to service models and reflecting the cultural factors and diversity of California children and youth.
    - Multisystemic Therapy (MST). MST is an evidence-based intensive family and community-based intervention for children and young people aged 11-17 who are at risk of out-of-home placement in either care or custody due to a history of arrest or behavioral health issues. DHCS intends to issue guidance to counties that clarifies and streamlines Medi-Cal coverage and reimbursement of MST as a bundled service for qualifying children and youth.
    - Functional Family Therapy (FFT). FFT is a family-based prevention and intervention program for high-risk youth between the ages of 11 and 18 that addresses complex and multidimensional problems with a flexibly structured and

culturally responsive practice. DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement for FFT.

- Parent-Child Interaction Therapy (PCIT). PCIT is an evidence-based, short-term treatment designed to teach parents strategies that will promote positive behaviors in children and youth who exhibit disruptive or externalizing behavioral problems. DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement for PCIT.

DHCS will continue engaging stakeholders and exploring opportunities to issue guidance on Medi-Cal coverage of other therapeutic supports. In addition, DHCS will engage stakeholders on opportunities to incorporate community-defined practices and cultural adaptations of evidence-based practices to ensure culturally and linguistically centered services given the rich diversity in California's communities.

3. ***New Activity Stipends.*** Many children and youth in child welfare do not have access to the activities that support physical health, mental wellness, healthy attachment and social connections – all protective factors that promote resilience and prevent mental illness and substance use disorders. In response, DHCS intends to develop a new benefit for children aged 3 and older in the child welfare system to be used for activities to promote social and emotional well-being and resilience, manage stress, build self-confidence, and counteract the harmful effects of trauma.[7] These payments would support activities not otherwise reimbursable in Medi-Cal, such as mindfulness-based stress reduction, movement activities, sports, leadership, nature activities, music and art programs, and other activities to support healthy relationships with peers and supportive adults. DHCS intends to request federal expenditure authority to support the activity stipends in the CalBH-CBC Demonstration application, which will be administered by CDSS and county child welfare agencies.

4. ***Strengthened Statewide Standards for Medical Necessity Determinations (Utilization Review) and Clinical Guidance for Services Levels for Intensive Home-Based Services (IHBS) and Therapeutic Behavioral Services (TBS).*** Currently, there is substantial county-by-county variation regarding who is eligible for IHBS and TBS services, and what service level is indicated based on the need of the child or youth. DHCS is currently updating the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) Services and will use this opportunity to strengthen expectations and requirements for these critical services.

[7] To align with CalAIM ECM Children and Youth in Child Welfare population of focus eligibility criteria, DHCS proposes to include children and youth who are under age 21 and are currently receiving foster care in California; are under age 21 and previously received foster care in California or another state within the last 12 months; have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state; are under age 18 and are eligible for and/or in California's Adoption Assistance Program; are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months.

5. ***Aligned Use of the Child and Adolescent Needs and Strengths (CANS) Tool*** across child welfare and specialty mental health by (1) ensuring that both child welfare and behavioral health providers are using the same CANS tool with the same modules; and (2) inclusion of CANS benchmarks in the cross-sector incentive pool. These actions will ensure that the CANS tool is administered in the same way, whether done by a specialty mental health provider or by a child welfare worker, so that outcomes can be tracked over time. Robust outcome measurements will allow the State to incentivize outcomes. In addition, under the CalBH-CBC, DHCS proposes to build on the current SMHS requirement for using the CANS tools for children and youth aged 6-20 for performance data reporting purposes to help guide level-of-care determination and inform treatment planning for select intensive SMHS. This process will include a stakeholder input process.

6. ***Coordination Between the Family Urgent Response System (FURS) and the New Statewide Mandatory Medi-Cal Mobile Crisis Benefit*****,** which will launch in January 2023. FURS is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth. As outlined in emerging policy guidance on the new mobile crisis benefit that will go live as early as January 2023, as part of the implementation of the new mobile crisis benefit, Medi-Cal behavioral health delivery systems will need to describe how mobile crisis teams will coordinate with FURS.

Addressing Equity:

Racial inequities exist throughout the child welfare system, with Black, Indigenous, and People of Color children disproportionately referred into the system and placed out of the home. A commitment to addressing inequity is an essential part of the new foster care strategy:

1. ***Equity-Focused Implementation Plans***. Before implementing CalBH-CBC Demonstration activities, opt-in counties may be required to submit and secure DHCS approval of an implementation plan. DHCS is proposing that county implementation plans include equity-centered strategies for expanding services and supports for populations disproportionately affected by SMI/SED or for whom gaps in care are particularly notable, including children and youth, especially those involved in the child welfare system, among other populations.

2. ***Culturally Responsive Care***. DHCS will continue to seek stakeholder feedback related to Medi-Cal coverage of culturally responsive evidence-based practices. In addition, under the CalBH-CBC demonstration, COE can provide orientation,

training, coaching, mentoring, fidelity monitoring and other supports needed to build and sustain capacity in delivering evidence-based practices through a culturally sensitive lens. DHCS will engage stakeholders on opportunities to incorporate community-defined practices and cultural adaptations of evidence-based practices to ensure culturally and linguistically centered services given the rich diversity in California's communities.

3. ***Equity-Focused Data Reporting***. All data dashboards, currently under development, will be required to show data broken down by race, ethnicity, and gender. When reliable data is available, data will also be displayed by sexual orientation and gender identity (not feasible now due to inconsistent data collection).

Increased Accountability, Oversight and Compliance:

Consistent with CalAIM and as part of CalBH-CBC, DHCS and CDSS are establishing a cross-sector incentive pool with an accountability framework grounded in continuous quality improvement principles which includes a robust compliance program, quality monitoring and improvement standards, and reporting in a new public dashboard, based on integrated data sources across the three systems – managed care, county behavioral health, and county child welfare systems.

As part of the cross-sector incentive pool, the State will set benchmarks and hold all systems – MCPs, MHPs and child welfare systems (CWS) – accountable to meet the benchmarks. The new cross-sector incentive pool would be designed to align systems and reward improvement in outcomes, based on process utilization and quality outcomes. An accountability framework would include a robust quality monitoring and compliance program to ensure that MCPs, MHPs, and CWS will have the following elements: standards and procedures; oversight; training and communication; monitoring and auditing, and authority necessary to enforce standards and apply corrective action plans or sanctions when necessary.

Following issuance of guidance and to facilitate shared implementation and accountability at the local level (between MCPs, MHPs, CWS), DHCS and CDSS will require a memorandum of understanding (MOU) between the systems, to ensure the systems share data, and work together to improve outcomes that require collaboration across systems, including process measures (such as appropriate cross-sector attendance at CFT Meetings), utilization measures (such as the population receiving all appropriate medical, dental, and behavioral health screenings and interventions) and outcome measures (such as shorter intervals until placement stability, shorter time to reunification). These agreements will be informed by stakeholder engagement.

Appendix A

The following guiding principles were adopted by the Foster Care Model of Care Workgroup and are included here for reference.

Recommendations for a New Model of Care: Guiding Principles

1. Builds upon existing foster care reform efforts, such as the Integrated Core Practice Model and AB 2083 model of care, and the Continuum of Care Reform.
2. Provides timely and appropriate access to care for children and youth in out-of-home placements and former foster youth, up to age 26 years. Coordination across child-serving systems should be increased and appropriate services should be available to meet the needs of this vulnerable population.
3. Ensures that children and youth have continuity of care through maintaining trusted relationships and preserving connection to family, community, and culture.
4. Meets the needs of diverse children, families, caregivers, and youth through a trauma-informed health delivery system that focuses on recovery and resiliency.
5. Identifies and reduces disparities and ensures that identified needs are addressed and supportive services are provided in a culturally responsive manner, including race, ethnicity, language, sexual orientation, and gender identity perspectives.
6. Values youth/family voice and choice in preserving and furthering California's investment in a child- and family-centered approach to care planning and decision-making
7. Identifies needs as early as possible. The needs of children, youth, and families in the foster system and of those entering or at risk of re-entering the child welfare services system must be addressed and met comprehensively and expeditiously.
8. Assesses and treats the health needs of children and families entering or at risk of re-entering the foster system.
9. Children and youth receive services in the least restrictive environment. The participants of Child and Family Teams (CFTs), including the placing agency, county behavioral health representatives, as well as other health providers, must base placement and services recommendations on the specific needs of children/youth and families with a goal of supporting children and families in the least restrictive and most family like setting possible.
10. Ensures children and families receive services provided by knowledgeable providers who are apprised of the proper resources available to address their needs. Providers should be trained in collaboration across child-serving systems, including county and contracted provider networks, and should recognize the specific needs a child in the foster system and their family may have. Additionally, the child-serving systems should receive training to understand the role each sector plays

in addressing attachment, permanency, and trauma-related needs of children and their families/caregivers, which aligns with the intent of the AB 2083 model of care.

11. Establishes streamlined and standardized processes to unify (or at least closely coordinate) systems, to prevent duplication and eliminate complexity of reporting.
12. Ensures accountability, and that processes and tools are in place to monitor and be adapted as needed, based on outcomes and child, family, and community engagement.
13. Ensure the development of an intensive ongoing training framework dedicated to establishing clinical models to address the specific needs of foster youth and their families/caregivers.

Appendix B

Whole Person/Whole Approach:
The State is launching several new efforts to support the whole person/whole family approach to care. The following interventions are designed to support healthy families through providing access to coverage, integrated services, and treatment. Some initiatives listed below are focused on the child welfare population; others are designed to ensure all children are offered help before a problem grows to the point of threatening family integrity and safety. Implementation dates are listed in bold.

1. **Implementation of Family First Prevention Services Act** offering evidence-based prevention services to support families at risk of out-of-home placement. ***October 2021.***

2. **Family Urgent Response System**: promoting stable family placements and intervening quickly if risk of disruption. ***July 2021***

3. **Programs Addressing Access to Services for All Populations,** with potential to decrease family stress and avoid child welfare involvement:
    a. **Children and Youth Behavioral Health Initiative:**
        i. **Virtual Services Platform**: this statewide virtual platform will provide screening, tools and supports for ALL young people through age 24 and their caregivers. It creates a universal point of entry, with a tiered mode: the most effective, least resource-intensive treatment is delivered first, with referrals to managed care plans and county behavioral health for higher level of service, with navigation tools to help connect people to support and services. An e-consult/e-referral system will also be built in, to allow primary care providers to receive support and consultation, to better manage behavioral health conditions. ***2024***.
        ii. **Expanding Evidence-Based Practices (EBPS) Statewide**: an expert workgroup will identify evidence-based practices, which could include evidence-based family therapies to support healthy parenting and resilience. ***Fiscal year 2022-23.***
        iii. **Dyadic Services,** a new benefit providing behavioral health screening and treatment to parents/caregivers during well infant and child exams, to identify issues that could affect the child's well-being and address them. Dyadic services ensure that well infant, child and adolescent visits to primary care providers are paired with behavioral health assessments and interventions, with the goal of identifying stressors to families before they affect the children's wellbeing and allowing trained professionals to provide real-time supports and interventions. ***July 2022.***
        iv. **Workforce:** The Department of Health Care Access and Information will be launching multiple programs to build out the workforce needed to meet the growing behavioral health needs of children and youth: expanding training of

youth peer providers, building out behavioral health training programs, awarding grants to expand the supply of behavioral health provider, and creating a new category of provider, behavioral health coaches) to significantly expand the workforce, especially in schools.

b. **Population Health Management Program:** Implements a series of robust requirements for health plans designed to ensure that all children enrolled in Medi-Cal managed care receive whole-person care across the continuum of care, from wellness and prevention through to addressing complex needs. ***January 2023 and ongoing***
c. **Postpartum Coverage:** DHCS will allow a full year of post-partum Medi-Cal coverage for all women, supporting the well-being of both the woman and child. The goal is to ensure women have access to needed medical and behavioral health services during the critical first year of an infant's life. This extension of post-partum coverage for a full year will be available for all women and will not require any particular diagnosis. ***April 2022.***
d. **Implementing ACES Aware**: supporting universal trauma screening in primary care settings, identification of unmet needs, and referral to services. This program trains and incentivizes primary care providers to ask important questions to identify trauma, and to intervene before the trauma leads to problems that could threaten family stability. ***Current and ongoing.***
e. **988 Hotline and Mobile Crisis Response Teams:** Offering robust crisis response through implementation of the federal 988 hotline and coordinating with mobile crisis response services, allowing de-escalation of crises before they lead to child welfare referrals. ***Current and ongoing****.*
f. **Behavioral Health Continuum Infrastructure Project:** expanding access to mental health and substance use disorder treatment. This project will provide grants to support building new or expanding existing treatment facilities, to ensure access to prompt treatment is available across the state at all levels of care. The goal is to ensure children, youth and families can receive services locally, especially in regions with inadequate treatment infrastructure. ***Current and ongoing****.*
g. **Behavioral Health Quality Improvement Program:** supporting counties through training, technical assistance, and incentives, building a stronger behavioral health delivery system. This program allows DHCS to provide financial incentives to counties as they make progress towards implementing new statewide initiatives. ***Current and ongoing.***
h. **Medi-Cal's Strategy to Support Health and Opportunity for Children and Families:** exploring strategies to work across agencies to coordinate existing and emerging initiatives for children health. This includes initiatives to increase preventive and primary care, eligibility and enrollment enhancements, and behavioral health services and MCP accountability and engagement to identify and reduce health disparities. The strategies will align with these efforts. ***Current and ongoing.***
i. **Children's Preventive Services Report:** assesses the provision of preventive services and used to identify and monitor appropriate utilization of preventive services, including blood lead testing, for children in Medi-Cal managed care. This report builds accountability to ensure children receive key preventive services. ***Current and ongoing.***

j. **Behavioral Health Workforce Investments**: investing in expanding the behavioral health workforce through training, stipends, and workforce development (through the Department of Healthcare Access and Information, formerly known as OSHPD). This project aims to address workforce shortages, including for services focused on children and youth. ***Fiscal year 2021-22.***

k. Implementation of Peer Support Services Benefit: New Medi-Cal benefit covering new provider type and new services. **July 2022.**

Appendix C: Child Welfare Populations: Eligibility for Services

Note: the new enhanced behavioral health benefits (expanding eligibility for intensive home-based services and therapeutic behavioral health services, and the new family therapy benefit) would be available to all children in Medi-Cal.

BH services for all children and youth are based on their needs, after the completion of the assessment

Populations		**Numbers (CDSS data)**	**Joint home visits**
Substantiated Allegations	After disposition hearing substantiates allegations, pending placement decisions	72,373 hotline cases; assume 2/3 already on Medi-Cal (5-year pre-COVID average)	X
	Family Maintenance (open case, not removed from home)	22,712 (5-year pre-COVID average)	X
	Out of home placement	21,292 new entries, (5-year pre-COVID average) 54,373 total out of home (FY 2021-22)	X
	Family members of children in family maintenance and out of home placements[8]	TBD	
	Non-minor dependents (18-20)	7,503	NA
	Child Welfare involved, post-adoption	85,939 (FY 2021-22)	NA

[8] For the purpose of eligibility for the special population MCP, DHCS proposes to allow biologic family members (family of origin) to opt into the plan if they share a household with the involved child or youth and are either a parent/guardian (the role primarily responsible for the child) or a sibling (regardless of genetic relationship). This benefit would not be available for resource families.

Retroactive Medi-Cal

Retroactive Medi-Cal may be requested for a child placed in FC three months immediately preceding the month of application. The requestor has 12 months from the month of application to apply for the retroactive Medi-Cal. Eligibility to retroactive Medi-Cal must initiate at intake. Although each specific request should be evaluated separately, general guidelines are to be followed.

Note: For more information regarding the Retroactive Medi-Cal refer to Medi-Cal Handbook Chapter.

Effective Date/Retroactive Medi-Cal

When the FC child/youth is removed from the home they are placed in aid code 45 until an eligibility determination for FC is approved or denied. The effective date for Medi-Cal is the first of the month of application. Three-month retroactive coverage can also be established.

Whenever the FC EW is approving Medi-Cal prior to FC approval, the following requirements apply:

- An “Application and Statement of Facts For Children Not Living with a Parent or Relative For Whom A Public Agency is Assuming Some Financial Responsibility” form (MC 250) must be completed by the FC EW for Medi-Cal aid code 45 before FC benefits are approved. When retroactive Medi-Cal is needed, a “Supplement to the Statement Of Facts for Retroactive Coverage/Restoration” (MC 210A) must be completed by the FC EW for the retro month(s).
- In the rare instance that retroactive Medi-Cal is only requested, an MC 250 must be completed for the first retro month and an MC 210A must be completed for the 2nd and 3rd month(s).

When the information on MEDS is incorrect and CalSAWS has correct information, the FC EW must complete an SCD 1296 and request the MTO complete a manual online transaction to correct the MEDS record.

Retro Medi-Cal Process

When children are placed in FC the FC EW is responsible requesting retroactive Medi-Cal. The FC EW must refer to the following procedures to determine retro Medi-Cal:

- Medi-Cal Handbook Chapter 5.18.

Related Topics

Medi-Cal

SENATE COMMITTEE ON APPROPRIATIONS
Senator Anthony Portantino, Chair
2023 - 2024 Regular Session

AB 1402 (Megan Dahle) - Medical evidentiary examinations: reimbursement

Version: March 30, 2023
Urgency: No
Hearing Date: August 21, 2023

Policy Vote: PUB. S. 5 - 0
Mandate: No
Consultant: Matthew Fleming

Bill Summary: AB 1402 would require that costs of a medical evidentiary examination of a victim of physical child abuse or neglect be submitted by specified medical examiners for reimbursement by the Office of Emergency Services (OES), rather than charged directly or indirectly to the victim. Reimbursements would be subject to an appropriation by the Legislature.

Fiscal Impact:

- Ongoing, annual cost pressures in the high millions to low tens of millions to reimburse the costs of medical examinations following an incident child abuse or neglect (General Fund). See Staff Comments for additional detail.

- Ongoing, annual costs of approximately $800,000 to the OES for additional staffing to manage reimbursement to victims who receive child abuse or neglect examinations (General Fund).

Background: The Violence against Women Act (VAWA) gives sexual assault victims the right to obtain a medical evidentiary examination after a sexual assault. The victim may not be charged for the exam. The costs are charged to the local law enforcement agency. Law enforcement can seek reimbursement for cases where the victim is undecided whether to report to the assault to law enforcement. The OES uses discretionary funds from various federal grants to offset the costs of the examination. OES makes a determination on how much the reimbursement shall be under these circumstances and can reassess the reimbursement every 5 years. Law enforcement can also seek reimbursement to offset the costs of conducting an examination when the victim has decided to report the assault to law enforcement. OES makes a determination on how much the reimbursement shall be under these circumstances. OES is to provide reimbursement from funds to be made available upon appropriation for this purpose. (Pen. Code, § 13823.95).

In AB 2185 (Weber), Chapter 557, Statutes of 2022, the Legislature provided domestic violence victims access to medical evidentiary exams, free of charge, by SART, SAFE teams, or other qualified medical evidentiary examiners. Each county's board of supervisors is required to authorize a designee to approve the SART, SAFE teams, or other qualified medical evidentiary examiners to receive reimbursement through OES for the performance of medical evidentiary examinations for victims of domestic violence. Costs incurred for the medical evidentiary portion of the examination cannot be charged directly or indirectly to the victim. The costs associated with these medical evidentiary exams are to be funded by the state, subject to appropriation by the

Legislature, and require the OES to establish a 60-day reimbursement process within one year upon initial appropriation.

Proposed Law:

- Provides that the costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect shall be separate from diagnostic treatment and procedure costs associated with medical treatment and prohibits those costs from being charged directly or indirectly to the victim of child physical abuse or neglect.

- Provides that each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Team (SART), Sexual Assault Forensic Exam (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services (OES) for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify OES of this designation.

- Provides that the costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature.

- Requires each county's designated SART, SAFE, or other qualified medical evidentiary examiners to submit invoices to OES, who shall administer the program. Provides that a flat reimbursement rate shall be established.

- Specifies that within one year upon initial appropriation, OES shall establish a 60-day reimbursement process. OES shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years.

- Prohibits reduced reimbursement rates based on patient history or other reasons.

- Authorizes victims of child physical abuse or neglect to receive a medical evidentiary exam outside of the jurisdiction where the crime occurred and requires that county's approved SART, SAFE teams, or qualified medical evidentiary examiners to be reimbursed for the performance of these exams.

Related Legislation:

- AB 2185 (Weber) Ch. 557, Stats. 2022 provided domestic violence victims access to medical evidentiary exams, free of charge.

- AB 145 (Comm. on Budget), Ch. 80, Stats. 2021, authorized OES to provide full reimbursement to counties for the cost of sexual assault evidentiary exams.

Staff Comments: This bill is similar to recent legislation intended to provide no-cost medical examinations to victims of sexual and domestic violence. Rather than directly charging victims of child abuse and neglect for physical examinations, this bill would require counties to set up systems to provide examinations at no cost to the victim and then submit invoices for reimbursement to OES.

Under existing law, the OES reimburses $911 for each sexual assault examination. Assuming the cost of a child abuse evidentiary exam is similar, the OES will require significant GF allocations to reimburse counties. According to a 2022 report by the California State Auditor, there were 52,000 reports of child abuse substantiated by social workers in the 4 years from July 2017, to June 2021. Assuming costs of $911 for each examination, and an average of 13,000 exams per year, this bill would require approximately $11.8 million annually for local reimbursements. Staff notes that no funding has been included in the 2023-24 budget for these purposes.

-- END --

SENATE COMMITTEE ON PUBLIC SAFETY

Senator Aisha Wahab, Chair
2023 - 2024 Regular

Bill No:	AB 1402	**Hearing Date:**	June 27, 2023
Author:	Megan Dahle		
Version:	March 30, 2023		
Urgency:	No	**Fiscal:**	Yes
Consultant:	MK		

Subject: ***Medical evidentiary examinations: reimbursement***

HISTORY

Source: Dr. Sean Dugan, Shasta Health

Prior Legislation: AB 2185 (Weber), Chapter 557, Statutes of 2022
AB 145 (Committee on Budget), Chapter 80, Statutes of 2021
AB 925 (Dahle) was not set Sen Appropriations 2021
SB 580 (Figueroa), Chapter 249, Statutes of 2003

Support: Unknown

Opposition: None known

Assembly Floor Vote: 77 - 0

PURPOSE

The purpose of this bill is to prohibit costs for the medical evidentiary portion of a child abuse or neglect examination from being charged directly or indirectly to the victim

Existing law requires OES to, in cooperation with the State Department of Social Services, the Department of Justice, the California Association of Crime Lab Directors, the California District Attorneys Association, the California State Sheriffs' Association, the California Peace Officers Association, the California Medical Association, the California Police Chiefs' Association, child advocates, the California Medical Training Center, child protective services, and other appropriate experts, to establish medical forensic forms, instructions, and examination protocols for victims of child physical abuse or neglect using as a model the form and guidelines developed for sexual assault medical evidentiary examinations. (Penal Code § 11171 (b).)

Existing law specifies that the forms shall include, but not be limited to, a place for notation concerning each of the following:

a) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures;
b) Addressing relevant consent issues, if indicated;
c) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history;

d) The performance of a physical examination for evidence of child physical abuse or neglect;
e) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures;
f) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated;
g) Procedures for the preservation and disposition of evidence;
h) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays; and,
i) An assessment as to whether there are findings that indicate physical abuse or neglect. (Penal Code § 11171 (c).)

Existing law provides that the forms shall become part of the patient's medical record pursuant to guidelines established by the advisory committee of OES and subject to the confidentiality laws pertaining to the release of medical forensic examination records. (Penal Code § 11171 (d).)

Existing law requires that the forms be made accessible for use on the Internet. (Penal Code, § 11171 (e).)

Existing law makes sexual assault forensic medical examinations reimbursable. (Penal Code § 13823.95.)

Existing law makes domestic violence forensic medical examinations reimbursable. (Penal Code § 11161.2.)

This bill requires the costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect to be separate from diagnostic treatment and procedure costs associated with medical treatment.

This bill prohibits costs for the medical evidentiary portion of the examination from being charged directly or indirectly to the victim of child physical abuse or neglect.

This bill provides that each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Team (SART), Sexual Assault Forensic Exam (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services (OES) for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify OES of this designation.

This bill states that the costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature.
This bill requires each county's designated SART, SAFE, or other qualified medical evidentiary examiners to submit invoices to OES, who shall administer the program. A flat reimbursement rate shall be established.

This bill specifies that within one year upon initial appropriation, OES shall establish a 60-day reimbursement process. OES shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years.

This bill prohibits reduced reimbursement rates based on patient history or other reasons.

This bill allows victims of child physical abuse or neglect to receive a medical evidentiary exam outside of the jurisdiction where the crime occurred and requires that county's approved SART, SAFE teams, or qualified medical evidentiary examiners to be reimbursed for the performance of these exams.

COMMENTS

1. Need for This Bill

According to the author:

> AB 1402 continues the important work accomplished in AB 925 (M. Dahle) which authorized the appropriate local law enforcement agency to seek reimbursement from the Office of Emergency Services (OES), using the specified federal funds for the cost of conducting the medical evidentiary examination of a sexual assault victim. AB 1402 would simply allow child abuse exams to also be eligible for reimbursement.

2. Reimbursement for the Cost of Sexual Assault and Domestic Violence Medical Evidentiary Exams

The Violence against Women Act (VAWA) gives sexual assault victims the right to obtain a medical evidentiary examination after a sexual assault. The victim may not be charged for the exam. The costs are charged to the local law enforcement agency. Law enforcement can seek reimbursement for cases where the victim is undecided whether to report to the assault to law enforcement. The OES uses discretionary funds from various federal grants to offset the costs of the examination. OES makes a determination on how much the reimbursement shall be under these circumstances and can reassess the reimbursement every 5 years. Law enforcement can also seek reimbursement to offset the costs of conducting an examination when the victim has decided to report the assault to law enforcement. OES makes a determination on how much the reimbursement shall be under these circumstances. OES is to provide reimbursement from funds to be made available upon appropriation for this purpose. (Pen. Code, § 13823.95).

In AB 2185 (Weber), Chapter 557, Statutes of 2022, the Legislature provided domestic violence victims access to medical evidentiary exams, free of charge, by SART, SAFE teams, or other qualified medical evidentiary examiners. Each county's board of supervisors is required to authorize a designee to approve the SART, SAFE teams, or other qualified medical evidentiary examiners to receive reimbursement through OES for the performance of medical evidentiary examinations for victims of domestic violence. Costs incurred for the medical evidentiary portion of the examination cannot be charged directly or indirectly to the victim. The costs associated with these medical evidentiary exams are to be funded by the state, subject to appropriation by the Legislature, and require the OES to establish a 60-day reimbursement process within one year upon initial appropriation. (Pen. Code, § 11161.2.)

This bill mirrors the process set forth by AB 2185, to provide free medical evidentiary examinations for a victim of child physical abuse or neglect.

-- END –

Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: AB 1402
Author: Megan Dahle (R)
Amended: 3/30/23 in Assembly
Vote: 21

SENATE PUBLIC SAFETY COMMITTEE: 5-0, 6/27/23
AYES: Wahab, Ochoa Bogh, Bradford, Skinner, Wiener

SENATE APPROPRIATIONS COMMITTEE: 7-0, 9/1/23
AYES: Portantino, Jones, Ashby, Bradford, Seyarto, Wahab, Wiener

ASSEMBLY FLOOR: 77-0, 5/25/23 - See last page for vote

SUBJECT: Medical evidentiary examinations: reimbursement

SOURCE: Dr. Sean Dugan, Shasta Health

DIGEST: This bill prohibits costs for the medical evidentiary portion of a child abuse or neglect examination from being charged directly or indirectly to the victim

ANALYSIS:

Existing law:

1) Requires OES to, in cooperation with the State Department of Social Services, the Department of Justice, the California Association of Crime Lab Directors, the California District Attorneys Association, the California State Sheriffs' Association, the California Peace Officers Association, the California Medical Association, the California Police Chiefs' Association, child advocates, the California Medical Training Center, child protective services, and other appropriate experts, to establish medical forensic forms, instructions, and examination protocols for victims of child physical abuse or neglect using as a model the form and guidelines developed for sexual assault medical evidentiary examinations. (Penal Code § 11171 (b).)

2) Specifies that the forms shall include, but not be limited to, a place for notation concerning each of the following:

   a) Any notification of injuries or any report of suspected child physical abuse or neglect to law enforcement authorities or children's protective services, in accordance with existing reporting procedures;
   b) Addressing relevant consent issues, if indicated;
   c) The taking of a patient history of child physical abuse or neglect that includes other relevant medical history;
   d) The performance of a physical examination for evidence of child physical abuse or neglect;
   e) The collection or documentation of any physical evidence of child physical abuse or neglect, including any recommended photographic procedures;
   f) The collection of other medical or forensic specimens, including drug ingestion or toxication, as indicated;
   g) Procedures for the preservation and disposition of evidence;
   h) Complete documentation of medical forensic exam findings with recommendations for diagnostic studies, including blood tests and X-rays; and,
   i) An assessment as to whether there are findings that indicate physical abuse or neglect. (Penal Code § 11171 (c).)

3) Provides that the forms shall become part of the patient's medical record pursuant to guidelines established by the advisory committee of OES and subject to the confidentiality laws pertaining to the release of medical forensic examination records. (Penal Code § 11171 (d).)

4) Requires that the forms be made accessible for use on the Internet. (Penal Code, § 11171 (e).)

5) Makes sexual assault forensic medical examinations reimbursable. (Penal Code § 13823.95.)

6) Makes domestic violence forensic medical examinations reimbursable. (Penal Code § 11161.2.)

This bill:

1) Requires the costs associated with the medical evidentiary examination of a victim of child physical abuse or neglect to be separate from diagnostic treatment and procedure costs associated with medical treatment.

2) Prohibits costs for the medical evidentiary portion of the examination from being charged directly or indirectly to the victim of child physical abuse or neglect.

3) Provides that each county's board of supervisors shall authorize a designee to approve the Sexual Assault Response Team (SART), Sexual Assault Forensic Exam (SAFE) teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services (OES) for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and shall notify OES of this designation.

4) States that the costs associated with these medical evidentiary exams shall be funded by the state, subject to appropriation by the Legislature.

5) Requires each county's designated SART, SAFE, or other qualified medical evidentiary examiners to submit invoices to OES, who shall administer the program. A flat reimbursement rate shall be established.

6) Specifies that within one year upon initial appropriation, OES shall establish a 60-day reimbursement process. OES shall assess and determine a fair and reasonable reimbursement rate to be reviewed every five years.

7) Prohibits reduced reimbursement rates based on patient history or other reasons.

8) Allows victims of child physical abuse or neglect to receive a medical evidentiary exam outside of the jurisdiction where the crime occurred and requires that county's approved SART, SAFE teams, or qualified medical evidentiary examiners to be reimbursed for the performance of these exams.

Background

The Violence against Women Act (VAWA) gives sexual assault victims the right to obtain a medical evidentiary examination after a sexual assault. The victim may not be charged for the exam. The costs are charged to the local law enforcement agency. Law enforcement can seek reimbursement for cases where the victim is

undecided whether to report to the assault to law enforcement. The OES uses discretionary funds from various federal grants to offset the costs of the examination. OES makes a determination on how much the reimbursement shall be under these circumstances and can reassess the reimbursement every 5 years. Law enforcement can also seek reimbursement to offset the costs of conducting an examination when the victim has decided to report the assault to law enforcement. OES makes a determination on how much the reimbursement shall be under these circumstances. OES is to provide reimbursement from funds to be made available upon appropriation for this purpose. (Pen. Code, § 13823.95).

In AB 2185 (Weber), Chapter 557, Statutes of 2022, the Legislature provided domestic violence victims access to medical evidentiary exams, free of charge, by SART, SAFE teams, or other qualified medical evidentiary examiners. Each county's board of supervisors is required to authorize a designee to approve the SART, SAFE teams, or other qualified medical evidentiary examiners to receive reimbursement through OES for the performance of medical evidentiary examinations for victims of domestic violence. Costs incurred for the medical evidentiary portion of the examination cannot be charged directly or indirectly to the victim. The costs associated with these medical evidentiary exams are to be funded by the state, subject to appropriation by the Legislature, and require the OES to establish a 60-day reimbursement process within one year upon initial appropriation. (Pen. Code, § 11161.2.)

This bill mirrors the process set forth by AB 2185, to provide free medical evidentiary examinations for a victim of child physical abuse or neglect.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: No

According to the Senate Appropriations Committee:

1) Ongoing, annual cost pressures in the high millions to low tens of millions to reimburse the costs of medical examinations following an incident child abuse or neglect (General Fund). See Staff Comments for additional detail.

2) Ongoing, annual costs of approximately $800,000 to the OES for additional staffing to manage reimbursement to victims who receive child abuse or neglect examinations (General Fund).

SUPPORT: (Verified 9/1/23)

Dr. Sean Dugan, Shasta Health (source)

Los Angeles County District Attorney's Office

OPPOSITION: (Verified 9/1/23)

None received

ARGUMENTS IN SUPPORT: According to the Los Angeles County District Attorney's Office"

> Existing law provides reimbursement costs for the medical forensic examination of domestic violence, adult and pediatric sexual assault victims. Unfortunately, existing law does not provide reimbursement for the cost of medical forensic examinations in cases of suspected child physical abuse or neglect. This makes it difficult for clinics and providers to offer this service.
>
> Evidentiary medical exams are an important tool for law enforcement and for victims. It makes little sense to offer free evidentiary medical exams to victims of sexual assault and domestic violence but not to victims of child abuse or neglect.

ASSEMBLY FLOOR: 77-0, 5/25/23
AYES: Addis, Alanis, Alvarez, Arambula, Bains, Bauer-Kahan, Bennett, Berman, Boerner, Bonta, Bryan, Calderon, Juan Carrillo, Wendy Carrillo, Cervantes, Chen, Connolly, Megan Dahle, Davies, Dixon, Essayli, Flora, Mike Fong, Vince Fong, Friedman, Gabriel, Gallagher, Garcia, Gipson, Grayson, Haney, Hart, Holden, Hoover, Irwin, Jackson, Jones-Sawyer, Kalra, Lackey, Lee, Low, Lowenthal, Maienschein, McCarty, McKinnor, Muratsuchi, Stephanie Nguyen, Ortega, Pacheco, Jim Patterson, Joe Patterson, Pellerin, Petrie-Norris, Quirk-Silva, Ramos, Reyes, Luz Rivas, Robert Rivas, Rodriguez, Blanca Rubio, Sanchez, Santiago, Schiavo, Soria, Ta, Ting, Valencia, Villapudua, Waldron, Wallis, Ward, Weber, Wicks, Wilson, Wood, Zbur, Rendon
NO VOTE RECORDED: Aguiar-Curry, Mathis, Papan

Prepared by: Mary Kennedy / PUB. S. /
9/2/23 9:57:21**** **END** ****

Short Doyle Medi-Cal Aid Code Chart
Updated 2/23/2023
MedCCC@dhcs.ca.gov

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Introduction: Not all Medi-Cal aid codes are Drug Medi-Cal (DMC) and/or Specialty Mental Health Services (SMHS) eligible. The table below includes covered aid codes as well as a description, scope of coverage, and a "yes" or "no" indicating the aid code covers SMHS, DMC or EPSDT. If the SDMC effective or end date is available it will be noted in columns G and H. If there is no value in Column "I" the aid code is still active. For a complete list of all Medi-Cal aid codes please see the link below.

California Medicaid Eligibility Groups by Medi-Cal Aid Code - California Medicaid Eligibility Groups by Medi-Cal Aid Code - California Health and Human Services Open Data Portal

Aid Code	Aid Code Description	Regular SDMC Aid Code Type	Scope of Coverage	SMHS	DMC	EPSDT	SDMC Effective Date	SDMC End Date
01	Refugee Cash Assistance (FFP). Includes unaccompanied children. Covers all eligible refugees during their first eight months in the United States. Unaccompanied children are not subject to the eighth-month limitation provision.	Refugee	Full scope, no SOC	Yes	Yes	Yes		
02	Refugee Medical Assistance/Entrant Medical Assistance (FFP). Covers refugees and entrants who need Medi-Cal and who do not qualify for or want cash assistance.	Refugee	Full scope, with or without SOC	Yes	Yes	Yes		
03	Adoption Assistance Program (AAP). Covers children receiving federal cash grants under Title IV-E to facilitate the adoption of hard-to-place children who would require permanent foster care (FC) placement without such assistance.	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
04	AAP/Aid for Adoption of Children (AAC). Covers children receiving cash grants under the state-only AAP/AAC program.	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
06	AAP Child. Covers children receiving federal AAP cash subsidies from out of state. Provides eligibility for Continuous Eligibility for Children (CEC) if for some reason the child is no longer eligible under AAP prior to his/her 18th birthday.	Regular FFP	Full scope, no SOC	Yes	No	Yes		
07	Title IV-E Extended AAP/FFP Medi-Cal. AAP Federal: A cash grant program to facilitate the ongoing adoptive placement of hard-to-place non-minors, whose initial AAP payment occurred on or after age 16 and are over age 18 but under age 21, and participating in one of five conditions who would require permanent FC placement without such assistance.	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
08	Entrant Cash Assistance (ECA). Covers Cuban/Haitian entrants during their first eight months in the United States who are receiving ECA benefits, including unaccompanied children who are not subject to the eight-month provision.	Refugee	Full scope, no SOC	Yes	Yes	Yes		
10	Aid to the Aged – SSI/SSP	Regular FFP	Full scope, no SOC	Yes	Yes	No		
13	Aid to the Aged – LTC. Covers persons 65 years of age or older who are MN and in LTC status.	Regular FFP	Full scope, with or without SOC	Yes	Yes	No		
14	Aid to the Aged – MN	Regular FFP	Full scope, no SOC	Yes	Yes	No		
16	Aid to the Aged – Pickle Eligible	Regular FFP	Full scope, no SOC	Yes	Yes	No		
17	Aid to the Aged – MN, SOC.	Regular FFP	Full scope, with SOC	Yes	Yes	No		
20	Blind – SSI/SSP – Cash	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
23	Blind - Long Term Care (LTC) Medically Needy (MN)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
24	Blind - Medically Needy (MN)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
26	Blind - Pickle Eligible	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
27	Blind - Medically Needy (MN)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
30	CalWORKs - All Families	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
32	Temporary Assistance to Needy Families (TANF) - Timed Out	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
33	CalWORKs – Zero Parent	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
34	Aid to Families with Dependent Children (AFDC) - Medically Needy (MN)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
35	CalWORKs – Two Parent	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
36	Aid to Disabled Widow(ers)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
37	Aid to Families with Dependent Children (AFDC) - Medically Needy (MN)	Regular FFP	Full scope, with SOC	Yes	Yes	Yes		
38	Edwards v. Kizer Discontinued Aid to Families with Dependent Children (AFDC) - Pending Eligibility Determination	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
39	Initial TMC (6 months). Provides six months of coverage for those discontinued from CalWORKs or the Section 1931(b) program due to increased earnings or increased hours of employment.	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
40	Aid to Families with Dependent Children (AFDC) - State Foster Care - Non Federal	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
42	Aid to Families with Dependent Children (AFDC) - Federal Foster Care	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
43	Aid to Families with Dependent Children (AFDC) - State Extended Foster Care	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
44	Pregnant - 0% to 200% Federal Poverty Level (FPL) Property Disregard	County Funds Only	Restricted to pregnancy-related and postpartum services, no SOC	Yes	Yes	Yes		
45	Non Aid to Families with Dependent Children (AFDC) Foster Care	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
46	Foster Care California Placement - Interstate Compact on the Placement of Children (ICPC)	Regular FFP	Full scope, no SOC	Yes	No	Yes		
47	Infants - Ages 0 to 1 - 0% to 200% Federal Poverty Level (FPL)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
48	Pregnant - 0% to 200% Federal Poverty Level (FPL) Property Disregard	County Funds Only	Restricted to family planning, pregnancy-related, and postpartum services, no SOC	Yes	Yes	No		
49	Title IV-E Extended Foster Care - Aid to Families with Dependent Children (AFDC) Non Minor Dependent (NMD)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
54	Four-Month Continuing Medi-Cal. Covers persons discontinued from CalWORKs or Section 1931(b) due to the increased collection of child/spousal support.	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
55	Long Term Care (LTC)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		5/1/2020
58	Omnibus Budget Reconciliation Act (OBRA) Individuals	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, with or without SOC	Yes	Yes	No		
59	Transitional Medi-Cal (TMC) - Additional 6 Months	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
60	Disabled - Supplemental Security Income/State Supplementary Payment (SSI/SSP)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
63	Disabled - Long Term Care (LTC)	Regular FFP	Full scope, with or without SOC	Yes	Yes	Yes		
64	Disabled - Medically Needy (MN)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
66	Disabled - Pickle Eligible	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
67	Disabled - Medically Needy (MN)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
69	Infants - Ages 0 to 1 - 0% to 200% Federal Poverty Level (FPL)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		5/1/2020
72	Children - Ages 1 to 6 - 0% to 133% Federal Poverty Level (FPL)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		5/1/2020
74	Children - Ages 1 to 6 - 0% to 133% Federal Poverty Level (FPL)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		5/1/2020
76	365 - Day Postpartum Regular FFP regardless of immigrantion status	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
80	Qualified Medicare Beneficiary (QMB); Provides payment of Medicare Part A premium and Part A and B coinsurance and deductibles for eligible low-income aged, blind, or disabled individuals.	County Funds Only	Restricted to Medicare expenses, no SOC	Yes	No	No		
82	Age Under 21 - Medically Indigent (MI)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
83	Age Under 21 - Medically Indigent (MI)	Regular FFP	Full scope, with SOC	Yes	Yes	Yes		
86	Pregnancy Confirmed - Age Over 21 - Medically Indigent (MI)	Regular FFP	Full scope, no SOC	Yes	Yes	No		
87	Pregnancy Confirmed - Age Over 21 - Medically Indigent (MI)	Regular FFP	Full scope, with SOC	Yes	Yes	No		
0A	Refugee Cash Assistance (RCA)	Refugee	Full scope, no SOC	Yes	Yes	Yes		

0E	Pregnant - Modified Adjusted Gross Income (MAGI) 213% to 322% Federal Poverty Level (FPL) - Medi-Cal Access Program (MCAP) - Medi-Cal Managed Care	MCAP	Full scope, no SOC	Yes	Yes	Yes		
0G	Pregnant - Modified Adjusted Gross Income (MAGI) 0% to 213% Federal Poverty Level (FPL) - Medi-Cal Access Program (MCAP)	MCAP	Full scope, no SOC	Yes	Yes	Yes		
0M	Breast and Cervical Cancer Treatment Program (BCCTP) -Accelerated Enrollment (AE) - 2 months	Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
0N	Breast and Cervical Cancer Treatment Program (BCCTP) -Accelerated Enrollment (AE)	Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
0P	Breast and Cervical Cancer Treatment Program (BCCTP)	Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
0U	Breast and Cervical Cancer Treatment Program (BCCTP)	County Funds Only	Restricted to pregnancy-related, postpartum, emergency and LTC services, no SOC	Yes	No	No		
0V	Post Breast and Cervical Cancer Treatment Program (BCCTP)	County Funds Only	Restricted to pregnancy-related, postpartum, emergency and LTC services, no SOC	Yes	No	No		
0W	Breast and Cervical Cancer Treatment Program (BCCTP) - Transitional	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
1E	Craig v. Bonta Continued Elig.-Aged	Regular FFP	Full scope, no SOC	Yes	Yes	No	1/1/2024	
1H	Aged Federal Poverty Level - Full Scope	Regular FFP	Full scope, no SOC	Yes	Yes	No	1/1/2024	
1U	Aged - Federal Poverty Level (FPL) Program	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
1X	Aged - Multipurpose Senior Services Program (MSSP) Institutional Deeming/Spousal Impoverishment	Regular FFP	Full scope, no SOC	Yes	Yes	No		
1Y	Aged - Multipurpose Senior Services Program (MSSP) Institutional Deeming/Spousal Impoverishment	Regular FFP	Full scope, no SOC	Yes	Yes	No		
2A	Abandoned Baby Program. Provides full-scope benefits to children up to three months of age who were voluntarily surrendered within 72 hours of birth pursuant to the Safe Arms for Newborns Act.	Regular FFP	Full scope, no SOC	Yes	No	Yes		
2C	County Children's Health Initiative Program (C-CHIP)	Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
2E	Blind - Pending SB 87 Redetermination	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
2H	Blind - Federal Poverty Level (FPL) Program	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
2P	Foster Children/Youth - Approved Relative Caregiver (ARC) - Medi-Cal for Non State CalWORKs	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
2R	Non-Minor Dependent (NMD). Medi-Cal coverage for foster youth 18 to 21 years of age (eligibility ends on the last day of the month of their 21st birthday) participating in the ARC Program as a NMD who does not qualify for state CalWORKs.	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
2S	Medi-Cal coverage for foster children and youth up to 18 years of age (eligibility ends on the last day of the month of their 18th birthday) participating in the ARC Program who qualify for federal CalWORKs.	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
2T	Foster Children/Youth - Approved Relative Caregiver (ARC) - Medi-Cal for State CalWORKS	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
2U	Foster Care Non Minor Dependents (NMD) - Approved Relative Caregiver (ARC) - Medi-Cal for State CalWORKS	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3A	CalWORKS - Timed-Out, Safety Net - All Other Families	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3C	CalWORKS - Timed-Out, Safety Net -Two-Parent Families	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3D	CalWORKS - Pending	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3E	CalWORKS - Legal Immigrant Family Group	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3F	CalWORKS - Children of Two-Parent Safety Net and Drug/Fleeing Felon Family	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3G	CalWORKS - (State) - Zero Parent Exempt	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3H	CalWORKS - Zero Parent Mixed	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3L	CalWORKS - Legal Immigrant - Aid to Families	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3M	CalWORKS - Legal Immigrant - Two Parent	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3N	Aid to Families with Dependent Children (AFDC) - 1931(b) Non CalWORKS	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3P	CalWORKS - All Families - Exempt	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3R	CalWORKS - Zero Parent - Exempt	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3T	Transitional Medi-Cal (TMC) - Initial 6 months	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
3U	CalWORKS - Legal Immigrant - Two Parent Mixed	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
3V	Aid to Families with Dependent Children (AFDC) - Non CalWORKS	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
3W	Temporary Assistance to Needy Families (TANF) - Timed Out - Mixed Case	Regular FFP	Full scope, no SOC	Yes	No	Yes		
4A	Adoption Assistance Program (AAP) - Adoption Out-of-State	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
4E	Hospital Presumptive Eligibility (HPE) - Former Foster Youth - **Beneficiary eligibility effective date is HPE application date.**	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
4F	Foster Children/Youth - Kinship Guardianship Assistance Payment (Kin-GAP)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
4G	Foster Children/Youth - Kinship Guardianship Assistance Payment (Kin-GAP) State Program	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
4H	Foster Children/Youth - in CalWORKS	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
4K	Foster Children/Youth - Emergency Assistance (EA)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
4L	Foster Children/Youth - in 1931(b)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
4M	Former Foster Youth (FFY)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
4N	Foster Care Non Minor Dependent (NMD) - CalWORKS	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
4S	Foster Care Non Minor Dependent (NMD) - Title IV-E Extended - Kinship Guardianship Assistance Payment (Kin-GAP)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
4T	Foster Children/Youth - Title IV-E Kinship Guardianship Assistance Program (Kin-GAP)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
4W	Foster Care Non Minor Dependent (NMD) - Kinship Guardianship Assistance Program (Kin-GAP) - State Cash	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
5C	Medi-Cal Presumptive Eligibility Transitional Children - Healthy Families Program (HFP) (Obsolete)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
5D	Medi-Cal Presumptive Eligibility Transitional Children - Healthy Families Program (HFP) (Obsolete) Premium	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
5E	Medi-Cal Presumptive Eligibility Transitional Children - Healthy Families Program (HFP) (Obsolete)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
5F	Pregnant - Omnibus Budget Reconciliation Act (OBRA) Alien (Deactivated Aid Code)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, with or without SOC	Yes	Yes	No		
5J	Pending SB 87 Disability Determination	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
5K	Emergency Assistance (EA) Foster Care	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
5L	Emergency Assistance (EA) Foster Care	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
5R	Pending SB 87 Disability Determination	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, with SOC	Yes	No	No		
5T	Transitional Medi-Cal (TMC) - Additional 6 Month	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
5V	Trafficking and Crime Victims Assistance Program (TCVAP)	SGF Only	Full scope, no SOC	Yes	Yes	No		
5W	Four-Month Continuing	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
6A	Disabled Adult Child(ren) (DAC) - Blind	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		

6C	Disabled Adult Child(ren) (DAC) - Disabled	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
6E	Disabled - Pending SB 87 Redetermination	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
6G	Working Disabled Program - 250% Federal Poverty Level (FPL) - Premium	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
6H	Disabled - Federal Poverty Level (FPL) Program	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
6J	SB 87 Pending Disability	Regular FFP	Full scope, no SOC	Yes	Yes	No		
6N	Former Supplemental Security Income (SSI) Recipients - No Longer Disabled In Appeals Status	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
6P	Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) - No Longer Disabled Children	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
6R	SB 87 Pending Disability	Regular FFP	Full scope, with SOC	Yes	Yes	No		
6U	Disabled - Federal Poverty Level (FPL) Program	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
6V	Disabled - Department of Developmental Services (DDS) Waiver	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
6W	Disabled - Department of Developmental Services (DDS) Waivers	Regular FFP	Full scope, with SOC	Yes	Yes	Yes		
6X	Medi-Cal In-Home Operations (IHO) Waiver	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
6Y	Medi-Cal In-Home Operations (IHO) Waiver	Regular FFP	Full scope, with SOC	Yes	Yes	Yes		
7A	Children - Ages 6 to 19 - 0% to 100% Federal Poverty Level (FPL)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
7C	Children - Ages 6 to 19 - 0% to 100% Federal Poverty Level (FPL)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
7J	Children - Up To Age 19 - Continuous Eligibility for Children (CEC)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
7K	Children - Up To Age 19 - Continuous Eligibility for Children (CEC)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
7M	Minor Consent Program - Ages 12 to 21 - Minor Consent Program. Covers eligible minors at least 12 years of age and under the age of 21. Limited to services related to Sexually Transmitted Diseases (STDs), sexual assault, drug and alcohol abuse, and family planning.	County Funds Only	Valid for Minor Consent services, with or without SOC	No	Yes	No		
7N	Minor Consent Program. Covers eligible pregnant minors under the age of 21. Limited to pregnancy-related services, including services for conditions that may complicate the pregnancy and postpartum services.	County Funds Only	Valid for Minor Consent services, limited to pregnancy-related and postpartum services, no SOC	No	Yes	No		
7P	Minor Consent Program. Covers eligible minors at least 12 years of age and under the age of 21. Limited to services related to STDs, sexual assault, drug and alcohol abuse, family planning, and outpatient mental health treatment.	County Funds Only	Valid for Minor Consent services, with or without SOC	No	Yes	No		
7S	Parent and Caretaker Relative Express Lane Enrollment (ELE)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
7U	Adults - Ages 19 to 64 - Express Lane Enrollment (ELE) (Obsolete)	ACA New Eligible**	Full scope, no SOC	Yes	Yes	Yes		
7V	Trafficking and Crime Victims Assistance Program (TCVAP)	County Funds Only	Full scope, with SOC	Yes	Yes	No		
7W	Children - Age Under 19 - Express Lane Enrollment (ELE)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
7X	One Month Medi-Cal to Healthy Families Bridge (Obsolete)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
8E	Children - Accelerated Enrollment (AE)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
8G	Qualified Working Disabled Under 1619(b)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
8L	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
8N	Children - Ages 1 to 6 - 0% to 133% Federal Poverty Level (FPL) - Excess Property	County Funds Only	Restricted to emergency services, no SOC	Yes	No	No		
8P	Children - Ages 1 to 6 - 0% to 133% Federal Poverty Level (FPL) - Excess Property	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
8R	Children - Ages 6 to 19 - 100% Federal Poverty Level (FPL) - Excess Property	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
8T	Children - Ages 6 to 19 - 100% Federal Poverty Level (FPL) - Excess Property	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
8U	Deemed Infant - Child Health Disability and Prevention (CHDP) - Gateway	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
8V	Deemed Infant - Child Health Disability and Prevention (CHDP) - Gateway	Regular FFP	Full scope, with SOC	Yes	Yes	Yes		
8W	Child Health Disability and Prevention (CHDP) - Gateway Pre Enrollment	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
8X	Child Health Disability and Prevention (CHDP) - Presumptive Eligibility Targeted Low-Income	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
9H	Children - 200% Federal Poverty Level (FPL) Healthy Families (HF) (Obsolete)	Enhanced FFP	Full scope, no SOC	Yes	No	No		
C1	Omnibus Budget Reconciliation Act (OBRA) Aliens and Unverified Citizens. Aged - Medically Needy (MN)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
C2	Omnibus Budget Reconciliation Act (OBRA) Aliens and Unverified Citizens. Aged - Medically Needy (MN)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, with SOC	Yes	Yes	No		
C3	Omnibus Budget Reconciliation Act (OBRA) Aliens and Unverified Citizens. Aged - Blind, Medically Needy (MN)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
C4	Omnibus Budget Reconciliation Act (OBRA) Aliens and Unverified Citizens. Aged - Blind, Medically Needy (MN)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, with SOC	Yes	Yes	No		
C5	Omnibus Budget Reconciliation Act (OBRA) Aliens and Unverified Citizens. Aged - Aid to Families with Dependent Children (AFDC) – Medically Needy (MN)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
C6	Omnibus Budget Reconciliation Act (OBRA) Aliens and Unverified Citizens. Aged - Aid to Families with Dependent Children (AFDC) – Medically Needy (MN)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, with SOC	Yes	Yes	No		
C7	Omnibus Budget Reconciliation Act (OBRA) Aliens and Unverified Citizens. Aged - Disabled - Medically Needy (MN)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
C8	Omnibus Budget Reconciliation Act (OBRA) Aliens and Unverified Citizens. Aged - Disabled - Medically Needy (MN)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, with SOC	Yes	Yes	No		
C9	Child Under Age 21 - Medically Indigent (MI)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
D1	Child Under Age 21 - Medically Indigent (MI)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, with SOC	Yes	Yes	No		
D2	Aged - Long Term Care (LTC)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
D3	Aged - Long Term Care (LTC)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, with SOC	Yes	Yes	No		

D4	Blind - Long Term Care (LTC)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
D5	Blind - Long Term Care (LTC)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services with SOC	Yes	Yes	No		
D6	Disabled - Long Term Care (LTC)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
D7	Disabled - Long Term Care (LTC)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, with SOC	Yes	Yes	No		
D8	Pregnant Age Over 21 - Medically Indigent (MI)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
D9	Pregnant Age Over 21 - Medically Indigent (MI)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, with SOC	Yes	Yes	No		
E6	Infants - Ages 0 to 1 - 213% to 266% Federal Poverty Level (FPL) - Medi-Cal Access Program (MCAP) Optional Targeted Low Income Children's Program (OTLIC)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	No	Yes		
E7	Infants - Age Under 2 - 266% to 322% Federal Poverty Level (FPL) - Medi-Cal Access Program (MCAP) Targeted Low Income Children's Program (TLIC)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	No	Yes		
F3	Medi-Cal Adult County Inmates Hospital Inpatient Services	County Funds Only	Limited to inpatient services only, no SOC	Yes	No	No		
F4	Medi-Cal Adult County Inmates Hospital Inpatient Services for undocumented inmates in correctional facilities who receive those services off the grounds of the correctional facility.	County Funds Only	Restricted to covered inpatient hospital emergency, inpatient mental health emergency and inpatient pregnancy-related services only, no SOC	Yes	No	No		
G0	Medi-Cal Adult State Medical Parole Program	Regular FFP	Full scope, no SOC	Yes	No	Yes		
G1	Medi-Cal State Juvenile Inmates Hospital Inpatient Services	County Funds Only	Limited to inpatient services only, no SOC	Yes	No	Yes		
G2	Medi-Cal Juvenile State Inmates Hospital Inpatient Services	County Funds Only	Limited to inpatient services only, no SOC	Yes	No	Yes		
G3	Medi-Cal Adult County Inmates Hospital Inpatient Services	County Funds Only	Limited to inpatient services only, with SOC	Yes	No	No		
G4	Medi-Cal Adult County Inmates Hospital Inpatient Services	County Funds Only	Limited to inpatient services only, with SOC	Yes	No	No		
G5	Juvenile County Ward Program (JCWP) (Title XIX). for juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility	County Funds Only	Limited to inpatient services only, no SOC	Yes	No	Yes		
G6	Medi-Cal Juvenile County Inmates Hospital Inpatient Services. For undocumented juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.	County Funds Only	Limited to covered inpatient hospital emergency, inpatient mental health emergency, and inpatient pregnancy-related services only, no SOC	Yes	No	Yes		
G7	Medi-Cal Juvenile County Inmates Hospital Inpatient Services. For juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.	County Funds Only	Limited to all covered inpatient hospital and inpatient mental health services only, with SOC	Yes	No	Yes		
G8	Medi-Cal Juvenile County Inmates Hospital Inpatient Services. For undocumented juvenile inmates in county correctional facilities who receive those services off the grounds of the correctional facility.	County Funds Only	Restricted to all covered inpatient hospital emergency, inpatient mental health emergency, and inpatient pregnancy-related services only, with SOC	Yes	No	Yes		
G9	Medi-Cal Adult State Medical Parole Program	County Funds Only	Restricted or Limited, no SOC	Yes	No	No		
H0	Children - Ages 6 to 19 - 133% to 266% Federal Poverty Level (FPL) Hospital Presumptive Eligibility (HPE) **- Beneficiary eligibility effective date is HPE application date.**	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
H1	Infants - Ages 0 to 1 - 200% to 250% Federal Poverty Level (FPL) Optional Targeted Low-Income Children's Program (OTLIC)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
H2	Children - Ages 1 to 6 - 133% to 150% Federal Poverty Level (FPL) Optional Targeted Low-Income Children's Program (OTLIC)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
H3	Children - Ages 1 to 6 - 150% to 250% Federal Poverty Level (FPL) Optional Targeted Low-Income Children's Program (OTLIC)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
H4	Children - Ages 6 to 19 - 150% to 250% Federal Poverty Level (FPL) Optional Targeted Low-Income Children's Program (OTLIC)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
H5	Children - Ages 6 to 19 - 100% to 150% Federal Poverty Level (FPL) Optional Targeted Low-Income Children's (OTLIC)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
H6	Infants - Ages 0 to 1 - 209% to 266% Federal Poverty Level (FPL) Hospital Presumptive Eligibility (HPE) **- Beneficiary eligibility effective date is HPE application date.**	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
H7	Children - Ages 1 to 6 - 0% to 142% Federal Poverty Level (FPL) Hospital Presumptive Eligibility (HPE) **- Beneficiary eligibility effective date is HPE application date.**	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
H8	Children - Ages 6 to 19 - 0% to 133% Federal Poverty Level (FPL) Hospital Presumptive Eligibility (HPE) **- Beneficiary eligibility effective date is HPE application date.**	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
H9	Children - Ages 1 to 6 - 143% to 266 Federal Poverty Level (FPL) Hospital Presumptive Eligibility (HPE) **- Beneficiary eligibility effective date is HPE application date.**	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
J1	County Compassionate Release	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
J2	County Compassionate Release	Regular FFP	Full scope, with SOC	Yes	Yes	Yes		
J3	County Compassionate Release	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
J4	County Compassionate Release	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
J5	County Compassionate Release - Long Term Care (LTC) - Aged	Regular FFP	Full scope, no SOC	Yes	No	No		
J6	County Compassionate Release - Long Term Care (LTC) - Aged	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
J7	County Compassionate Release - Long Term Care (LTC) - Disabled	Regular FFP	Full scope, no SOC	Yes	No	Yes		
J8	County Compassionate Release - Long Term Care (LTC) - Disabled	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
K1	CalWORKS - Single-Parent Safety Net and Drug/Fleeing Felon Family	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
K6	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL) - County Compassionate Release	ACA New Eligible**	Full scope, no SOC	Yes	Yes	Yes		

K7	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL) - County Compassionate Release	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
K8	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 128% Federal Poverty Level (FPL) - Blind/Disabled - County Compassionate Release	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
K9	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 128% Federal Poverty Level (FPL) - Blind/Disabled - County Compassionate Release	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
L1	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL)- Low Income Health Program (LIHP)	ACA New Eligible**	Full scope, no SOC	Yes	Yes	Yes		
L6	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 128% Federal Poverty Level (FPL) - Blind/Disabled (Not Newly Eligible)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
L7	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 128% Federal Poverty Level (FPL) - Blind/Disabled (Not Newly Eligible)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
M0	Pregnant - Modified Adjusted Gross Income (MAGI) 138% to 213% Federal Poverty Level (FPL)	Regular FFP	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
M1	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL) - ACA	ACA New Eligible**	Full scope, no SOC	Yes	Yes	Yes	1/1/2014	
M2	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
M3	Parent and Caretaker Relative - Modified Adjusted Gross Income (MAGI) 0% to 109% Federal Poverty Level (FPL)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
M4	Parent and Caretaker Relative - Modified Adjusted Gross Income (MAGI) 0% to 109% Federal Poverty Level (FPL)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
M5	Children - Ages 6 to 19 - Modified Adjusted Gross Income (MAGI) 108% to 133% Federal Poverty Level (FPL)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
M6	Children - Ages 6 to 19 - Modified Adjusted Gross Income (MAGI) 108% to 133% Federal Poverty Level (FPL)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
M7	Pregnant - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
M8	Pregnant - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
M9	Pregnant - Modified Adjusted Gross Income (MAGI) 138% to 213% Federal Poverty Level (FPL)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	Yes		
N0	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL) - Low Income Health Program (LIHP) - County Inmate	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
N5	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL) - State Inmate	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
N6	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL) - State Inmate	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
N7	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL) - County Inmate	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
N8	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL) - County Inmate	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
N9	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL) - Low Income Health Program (LIHP) - State Inmate	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
P0	Infants - Ages 0 to 1 - Modified Adjusted Gross Income (MAGI) 0% to 208% Federal Poverty Level (FPL)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
P1	Infants - Ages 0 to 1 - Modified Adjusted Gross Income (MAGI) 0% to 208% Federal Poverty Level (FPL) Hospital Presumptive Eligibility (HPE) - **Beneficiary eligibility effective date is HPE application date.**	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
P2	Parent and Caretaker Relatives - Modified Adjusted Gross Income (MAGI) 0% to 109% Federal Poverty Level (FPL) Hospital Presumptive Eligibility (HPE) **- Beneficiary eligibility effective date is HPE application date.**	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
P3	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL) Hospital Presumptive Eligibility (HPE) - **Beneficiary eligibility effective date is HPE application date.**	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
P4	Pregnant - Modified Adjusted Gross Income (MAGI) 0% to 213% Federal Poverty Level (FPL) Hospital Presumptive Eligibility (HPE) - **Beneficiary eligibility effective date is HPE application date.**	County Funds Only	Limited to specific prenatal ambulatory services, no SOC	Yes	Yes	No		
P5	Children Ages - 6 to 19 - Modified Adjusted Gross Income (MAGI) 0% to 133% Federal Poverty Level (FPL)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
P6	Children - Ages 6 to 19 - Modified Adjusted Gross Income (MAGI) 0% to 133% Federal Poverty Level (FPL)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	Yes	No		
P7	Children - Ages 1 to 6 - Modified Adjusted Gross Income (MAGI) 0% to 142% Federal Poverty Level (FPL)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
P8	Children - Ages 1 to 6 - Modified Adjusted Gross Income (MAGI) 0% to 142% Federal Poverty Level (FPL)	County Funds Only	Restricted to pregnancy-related, postpartum and emergency services, no SOC	Yes	No	No		
P9	Infants - Ages 0 to 1 - Modified Adjusted Gross Income (MAGI) 0% to 208% Federal Poverty Level (FPL)	Regular FFP	Full scope, no SOC	Yes	Yes	Yes		
R1	CalWORKS - Trafficking and Crime Victims Assistance Program (TCVAP)	SGF Only	Full scope, no SOC	Yes	Yes	Yes		
T0	Infants - Ages 0 to 1 - Modified Adjusted Gross Income (MAGI) 208% to 266% Federal Poverty Level (FPL) - Optional Targeted Low Income Children (OTLIC)	County Funds Only	Restricted to emergency services, no SOC	Yes	No	No		
T1	Children - Ages 6 to 19 - Modified Adjusted Gross Income (MAGI) 160% to 266% Federal Poverty Level (FPL) - Optional Targeted Low Income Children (OTLIC) - Premium	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
T2	Children - Ages 6 to 19 - Modified Adjusted Gross Income (MAGI) 133% to 160% Federal Poverty Level (FPL) - Optional Targeted Low Income Children (OTLIC)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		

T3	Children - Ages 1 to 6 - Modified Adjusted Gross Income (MAGI) 160% to 266% Federal Poverty Level (FPL) - Optional Targeted Low Income Children (OTLIC) - Premium	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
T4	Children - Ages 1 to 6 - Modified Adjusted Gross Income (MAGI) 142% to 160% Federal Poverty Level (FPL) - Optional Targeted Low Income Children (OTLIC)	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
T5	Infants - Ages 0 to 1 - Modified Adjusted Gross Income (MAGI) 208% to 266% Federal Poverty Level (FPL) - Optional Targeted Low Income Children (OTLIC) Program	MCHIP - Enhanced FFP	Full scope, no SOC	Yes	Yes	Yes		
T6	Children - Ages 6 to 19 - Modified Adjusted Gross Income (MAGI) 160% to 266% Federal Poverty Level (FPL) - Optional Targeted Low Income Children (OTLIC) - Premium	County Funds Only	Restricted to pregnancy-related, postpartum, emergency services, no SOC	Yes	Yes	No		
T7	Children - Ages 6 to 19 - Modified Adjusted Gross Income (MAGI) 133% to 160% Federal Poverty Level (FPL) - Optional Targeted Low Income Children (OTLIC)	County Funds Only	Restricted to pregnancy-related, postpartum, emergency services, no SOC	Yes	Yes	No		
T8	Children - Ages 1 to 6 - Modified Adjusted Gross Income (MAGI) 160% to 266% Federal Poverty Level (FPL) - Optional Targeted Low Income Children (OTLIC) - Premium	County Funds Only	Restricted to emergency services, no SOC	Yes	No	No		
T9	Children - Ages 1 to 6 - Modified Adjusted Gross Income (MAGI) 142% to 160% Federal Poverty Level (FPL) - Optional Targeted Low Income Children (OTLIC)	County Funds Only	Restricted to emergency services, no SOC	Yes	No	No		

The history of Cal OES

EN

With over 38 million residents (12% of the population), the State of California is th s state in the nation and has the third largest land area among the states (163,695 square miles). California is culturally, ethnically, economically, ecologically, and politically diverse, and maintains the eighth largest economy in the world with 13 percent of the U.S. gross domestic product. California also faces numerous risks and threats to our people, property, economy, environment and is prone to earthquakes, floods, significant wildfires, prolonged drought impacts, public health emergencies, cybersecurity attacks, agricultural and animal disasters, as well threats to homeland security. Cal OES takes a proactive approach to addressing these risks, threats, and vulnerabilities that form the basis of our mission and has been tested through real events, as well as comprehensive exercises that help us maintain our state of readiness and plan for and mitigate impacts.

Cal OES History. The California Governor's Office of Emergency Services (Cal OES) began as the State War Council in 1943. With an increasing emphasis on emergency management, it officially became OES in 1970. In 2004, the California Legislature merged OES and the Governor's Office of Criminal Justice Planning, which was responsible for providing state and federal grant funds to local communities to prevent crime and help crime victims.

In 2003, with the State increasing its focus on terrorism prevention after the attacks of 9/11, the Governor's Office of Homeland Security (OHS) was established through an Executive Order by Governor Gray Davis.

In 2009, the California Legislature merged the powers, purposes, and responsibilities of the former OES with those of OHS into the newly-created California Emergency Management Agency (Cal EMA).

On July 1, 2013, Governor Edmund G. Brown Jr.'s Reorganization Plan #2 eliminated Cal EMA and restored it to the Governor's Office, renaming it the California Governor's Office of Emergency Services (Cal OES), and merging it with the Office of Public Safety Communications.

Today, Cal OES performs its broader mission by administering numerous programs that support our stakeholders, protect our communities, and help create a resilient California.

(Without Reference to File)

SENATE THIRD READING
SCA 4 (Torlakson)
As Amended July 27, 2004
2/3 vote

SENATE VOTE :Vote not relevant

SUMMARY : Places a Constitutional Amendment to protect local government revenues before the voters at the November 2, 2004 General Election. Specifically, this measure :

1)Protects the property tax revenues of local governments (i.e., cities, counties and special districts). Prohibits the Legislature from enacting any law on or after November 3, 2004, that would reduce local governments' percentage share of the 1% property tax revenue in any county below what that share would be under existing state law as of November 3. The effect of this protection would be that the Legislature could not, by enacting a law, shift a larger share of the 1% property tax away from local governments to schools or community colleges (where the revenue would offset the state's funding obligation under Proposition 98). This new protection would have the following features:

a) Includes protection for property tax revenue shifted from K-14 education to cities and counties to replace Vehicle License Fee (VLF) revenue, as proposed in the 2004-05 Budget;

b) Prohibits the Legislature from passing any law that would reduce the countywide share of the property tax allocated to local governments below the share that otherwise would occur in any fiscal year (FY) based on the state law in effect on November 3. This allows for local growth and decision making by protecting local government revenues on a countywide basis but not locking in specific percentage amounts. Thus, it would preclude the Legislature from enacting new "ERAF shifts" to take property tax money away from local governments (absent suspensions, as discussed below). However, this measure does not prohibit changes in local governments' share of property tax revenues that result from circumstances or decisions that would be allowed under existing law. For example, changes

in local governments' share could occur because of different rates of growth in assessed value within a county that happen to result in an increase in the school share of countywide revenue. Likewise, local decisions over the formation of local agencies and regarding redevelopment would not be restricted.

c) Requires that any bill that reallocates property tax revenues among local agencies (except for voluntary local agreements) must be passed by a two-thirds vote; and,

d) Restores and protects the temporary $1.3 billion revenue reduction to local agencies proposed in the 2004-05 budget, after 2005-06. The 2004-05 budget proposal shifts $1.3 billion in property tax revenue to K-14 education in 2004-05 and 2005-06. If the budget proposal is adopted, then existing state law on November 3 will allow this temporary shift but only for the two years. The Legislature could not (absent suspension) extend this property tax shift because doing so would reduce local governments' percentage share of property tax revenues below what they otherwise would be under existing state law in 2006-07 or subsequent years.

2)Allows suspension of the property tax protection provision for any individual FY, starting with 2008-09, subject to the following requirements:

a) A proclamation of severe fiscal hardship by the Governor;

b) Enactment of an urgency statute by a two-thirds vote of the Legislature;

c) Enactment of a statute providing for full repayment of any revenue loss, including interest, to local governments by the end of the third FY following the year of suspension.

d) Suspension may not result in a loss of more than 8% of the property tax revenues of local governments; and,

e) No suspension may occur before a previously suspended amount has been repaid. Suspensions may not occur more than twice in any 10-year period. Furthermore, no suspension

may occur until after the VLF "gap" amount has been paid ($1.3 billion of VLF backfill payments deferred from 2003-04 to be paid in August of 2006).

3)Constitutionally protects the sales tax replacement revenue that cities and counties receive while the quarter-cent suspension of the Bradley-Burns local sales and use tax is in effect. Existing law suspends a quarter-cent of the local sales tax rate and increases the state sales tax rate by the same amount until the Economic Recovery Bonds authorized by Proposition 57 have been paid off. During this "revenue exchange" period, the "Triple-Flip" mechanism provides replacement property tax revenue to cities and counties. The Constitutional Amendment prohibits the state from reducing, suspending, or delaying the replacement revenue during the revenue exchange period. This measure also prohibits the Legislature from extending the revenue exchange period or failing to restore the quarter-cent local tax rate after the revenue exchange period.

4)Constitutionally protects local sales tax revenues. Specifically, this measure prohibits the Legislature from restricting the authority of a city or county to impose the Bradley-Burns Uniform Local Sales and Use Tax and any local Transactions and Use Taxes. This measure also prohibits the Legislature from changing the method of distribution of these local sales taxes. This would retain in place the current "situs" basis of sales tax, under which the jurisdiction in which the sale occurs receives the sales tax revenue from that sale. The Legislature, however, could revise the allocation of the use tax portion of the Bradley-Burns tax if necessary to comply with federal law or an interstate compact.

5)Enables the Legislature to authorize two or more specifically identified local agencies within any county to exchange property tax and Bradley-Burns sales tax revenues with approval by a majority vote of the governing bodies of each entity.

6)Revises the dedication of VLF revenues in the Constitution. Currently, the California Constitution requires that all VLF revenues above the costs of collection and refunds must be allocated to cities and counties according to statute. This Constitutional Amendment provides for the following uses of VLF revenues:

a) First, to the Local Revenue Fund to pay for health and social services programs that are carried out by counties and several cities as part of the state-local program realignment that was enacted in the early 1990s. These costs currently are paid out of a share of VLF revenues and General Fund backfill payments;

b) Second, any remaining amounts within a VLF rate of 0.65% (the current effective rate after offsets are applied) are dedicated to cities and counties as provided by law. This remaining amount currently is about $200 million; and,

c) Third, the state would be required to provide for replacement revenue to local governments if the VLF rate is reduced below 0.65% in the future. There is no restriction, however, on the use of any additional VLF revenue, should any be available in the future.

6)Provides additional requirements for payment of state-mandated local costs. Currently, the California Constitution requires the state to reimburse local agencies for the costs of implementing a new state mandated program or higher level of service. It does not specify when or how often the costs must be reimbursed. Mandate requirements continue in force even if payment has been deferred. This measure would restrict the state's ability to defer payment as follows:

a) Prohibits the Legislature, beginning in 2005-06, from deferring mandate payments by requiring that the Legislature either appropriate the full amount payable in the annual Budget Act or suspend the operation of the mandate for the FY to which the Budget Act applies. The state would remain liable, however, for any past mandated costs, even in the event of suspension, as under current law.

b) This requirement would not apply to:

i) Education mandates;

ii) Mandates that provide substantive or procedural protections, rights or benefits to local government employees or retirees; and,

iii) Mandate costs incurred prior to 2004-05, for which payable claims have been determined prior to 2005-06 and payment has been deferred. This measure allows these deferred claims to be repaid over a period of years as provided by law (the local government trailer bill provides for payment over five years starting in 2006-07).

d) Specifies that reimbursable mandate costs include any shift of financial responsibility for a required program from the state to local government, including an increase in the local funding ratio for a required program that is jointly funded by the state and local government. The California Constitution requires the state to reimburse local agencies for the costs of implementing a state mandated new program or higher level of service. It does not specify the precise meaning of "new program or higher level of service." However, language in the decision on the Sonoma County case indicated that simply increasing a local funding percentage in a jointly-funded program would not be result in a reimbursable mandate.

e) Includes an explicit statement that the state may not use allocations of property tax revenue to pay for mandated costs.

7) Declares that this measure is a comprehensive alternative to the Local Government Property Tax Protection Act, Proposition 65 on the November 2 ballot, and that accordingly, none of the provisions of Proposition 65 would take effect if both measures pass and SCA 4 receives a larger number of affirmative votes.

FISCAL EFFECT : This measure is consistent with the fiscal assumptions in the Governor's May Revision Budget proposal and with the overall agreement on the 2004-05 Budget.

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