

RECEIVED

MAY 01 2014

CITY CLERK

March 28, 2014

DSI- Code Enforcement
375 Jackson Street, Suite 220
Saint Paul, MN 55101

Legislative Hearing/Public Hearing
Room 330/Third Floor
City Hall-Court House
15W. Kellogg Blvd
Saint Paul, MN 55102

RE:

File #1408A

Assessment #148524

Property Address: 867 Randolph Ave

Parcel ID: 11-28-23-24-0180

To whom it may concern,

My daughter Haley C. Hause came to Saint Paul in August 2010 due to medical issues which your state handles much better than California. In March 2011 the decision was for my adult disabled daughter to reside in Saint Paul and we purchased the above house. At the age of 15 (2003) my daughter was hit by a 18 wheeled Mach truck going 55 mph, killing the driver (her boyfriend) and leaving her with multiple disabilities. On February 11, 2014 to March 18, 2014 Haley C Hause (homeowner and occupant) was hospitalized and again April 2, 2014 to April 8, 2014 for severe seasonal depression, depression, suicidal issues and traumatic brain injury.

I NOW know the snow removal issue for your city and do not argue the merit. I received notification for snow removal (the California address) after the removal service was complete. I called the office immediately, hired AJ Services (name given to me by the office for the disabled) and had all issues handled upon receipt of the notice. Unfortunately, I agree that it was after the city had gone out. I would like to state that although you came out and removed snow at the 867 address, there were multiple addresses on the same street not given notice, with just as much snow on the walkway. When AJ Services came out he noted that the other houses had not been shoveled, singling out an Adult disabled person not even home and hospitalized.

The reason for my letter is to ask that you look at the cost of this assessment for it is outrageously high for shoveling a house front. I apologize for not keeping up with the city ordinance but my main concern at the time was my daughter, her safety and her wellbeing. I ask that you please adjust the cost to a more affordable charge.

I thank you in advance for your consideration. I will be sure in the future that with every snowfall that the property is maintained.

Theresa M Hause
For Haley C Hause
25923 Blascos

Mission Viejo, CA 92691

949-295-9942

Theresa M. Hause



Saint Paul City Council

Public Hearing Notice

Ratification of Assessment

OWNER OR TAXPAYER

Haley C Hause
 25923 Blascos
 Mission Viejo CA 92691-5812

COUNCIL DISTRICT #
 PLANNING DISTRICT #
 FILE #J1408A
 ASSESSMENT #148524
 PROPERTY ADDRESS
 867 RANDOLPH AVE
 PARCEL ID
 11-28-23-24-0180

PROPERTY TAX DESCRIPTION

MICHEL AND ROBERTSON'S ADDITION LOT 28 BLK 11

Please return the GOLD card within 5 days if you wish to be heard by the Hearing Officer

LEGISLATIVE TIME: Tuesday, May 06, 2014 at 9:00 AM

HEARING PLACE: Room 330, Third Floor, City Hall-Court House, 15 W Kellogg Blvd
An inspector will be present at this hearing to report on what occurred at your property.

THE TIME: Wednesday, June 18, 2014 at 5:30 PM

PUBLIC PLACE: City Council Chambers, 3rd FL City Hall-Court House, 15 W Kellogg Blvd
HEARING Oral or written statements from an owner will be considered by the Council as a further appeal after first attending the Legislative Hearing.

PURPOSE To consider approval of the assessment for:
 Property Clean Up on Private Property during the time period of February 3 to February 28, 2014.

ASSESSMENT INFORMATION If the City Council approves the file, the proposed assessment will be assessed against the property. The ESTIMATED assessment for the above property is **\$320.00**.

NOTE: THIS IS NOT A BILL!

Please see **PAYMENT INFORMATION** on the reverse side of this notice.

| | | | | | | |
|-----------------------------------|-----------------------|--------|---|-------|---|----------|
| ASSESSMENT CALCULATION | Summary Abatement | 160.00 | X | 1.00 | = | \$160.00 |
| | DSI Admin Fee | 120.00 | X | 1.00 | = | \$120.00 |
| | Real Estate Admin Fee | 1.00 | X | 35.00 | = | \$35.00 |
| | Attorney Fee | 1.00 | X | 5.00 | = | \$5.00 |

Invoice will be sent to the taxpayer

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, state, number, and address):

After recording return to:
LYNNE HAYES; SBN 150717
Law Offices of Lynne Hayes
765 The City Drive South, Suite 280

TELEPHONE NO.: (714) 750-3500
FAX NO. (Optional): (714) 740-9484

E-MAIL ADDRESS (Optional):
ATTORNEY FOR (Name): Petitioner Theresa Hause

SUPERIOR COURT OF CALIFORNIA, COUNTY OF ORANGE

STREET ADDRESS: 341 The City Drive
MAILING ADDRESS: P. O. Box 14171
CITY AND ZIP CODE: Orange, CA 92863
BRANCH NAME: Lamoreaux Justice Center

CONSERVATORSHIP OF (Name): HALEY HAUSE

FOR RECORDER'S USE ONLY

CONSERVATEE

CASE NUMBER:
A234698

LETTERS OF CONSERVATORSHIP

Person Estate Limited Conservatorship

FOR COURT USE ONLY

FILED

SUPERIOR COURT OF CALIFORNIA
COUNTY OF ORANGE
LAMOREAUX JUSTICE CENTER

MAR 13 2006

ALAN SLATER, Clerk of the Court

D. Davis
BY D. DAVIS

1. (Name): Theresa Hause is the appointed conservator limited conservator of the person estate of (name): HALEY HAUSE

2. (For conservatorship that was on December 31, 1980, a guardianship of an adult or of the person of a married minor) (Name):
was appointed the guardian of the person estate by order dated (specify): and is now the conservator of the person estate of (name):

3. Other powers have been granted or conditions imposed as follows:

a. Exclusive authority to give consent for and to require the conservatee to receive medical treatment that the conservator in good faith based on medical advice determines to be necessary even if the conservatee objects, subject to the limitations stated in Probate Code section 2356.

(1) This treatment shall be performed by an accredited practitioner of the religion whose tenets and practices call for reliance on prayer alone for healing of which the conservatee was an adherent prior to the establishment of the conservatorship.

(2) (If court order limits duration) This medical authority terminates on (date):

- b. Authority to place conservatee in a care or nursing facility described in Probate Code section 2356.5(b).
- c. Authority to authorize the administration of medications appropriate for the care and treatment of dementia described in Probate Code section 2356.5(c).
- d. Powers to be exercised independently under Probate Code section 2590 as specified in Attachment 3d (specify powers, restriction, conditions, and limitations).
- e. Conditions relating to the care and custody of the property under Probate Code section 2402 as specified in Attachment 3e.
- f. Conditions relating to the care, treatment, education, and welfare of the conservatee under Probate Code section 2358 as specified in Attachment 3f.
- g. (For limited conservatorship only) Powers of the limited conservator of the person under Probate Code section 2351.5 as specified in Attachment 3g.
- h. (For limited conservatorship only) Powers of the limited conservator of the estate under Probate Code section 1830(b) as specified in Attachment 3h.
- i. other (specify): See Attachment 3i

- 4. The conservator is not authorized to take possession of money or any other property without a specific court order.
- 5. Number of pages attached: 1

WITNESS, clerk of the court, with seal of the court affixed.

Date: MAR 13 2006

ALAN SLATER

Clerk, by

Diane A. Davis

DIANE A. DAVIS

, Deputy

Page 1 of 2



LETTERS OF CONSERVATORSHIP

AFFIRMATION

I solemnly affirm that I will perform according to law the duties of conservator limited conservator.

Executed on (date): **Feb 27, 2006**, at (place): **Orange, CA**


(SIGNATURE OF APPOINTEE)

Theresa Hause

CERTIFICATION

I certify that this document and any attachments is a correct copy of the original on file in my office, and that the letters issued to the person appointed above have not been revoked, annulled, or set aside, and are still in full force and effect.

Date: **MAR 13 2006**

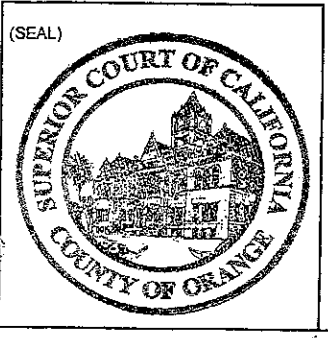
ALAN SLATER

Clerk, by

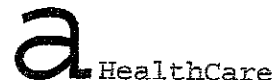


, Deputy

DIANE A. DAVIS



**Questionnaire for Verification of Full-Time Student
or Handicapped Adult Dependent Eligibility**



| | | |
|----------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------|
| DATE: 6-17-13 | SUBSCRIBER'S NAME (EMPLOYEE) Theresa M. Hause | DEPENDENT'S NAME Haley C. Hause |
| SUBSCRIBER'S ADDRESS: Street: 25923 Blascos City: Mission Viejo State: CA Zip Code: 92691 | | |
| NAME OF HEALTH PLAN: Anthem Blue Cross | | HEALTHPLAN CODE: 040 |
| GROUP NAME Capistrano Unified | ID NUMBER: NCF745A67628 | |
| | | GROUP/DIVISION NUMBER 57A JVA |

Please complete Section A or B, and sign/date this Questionnaire on the reverse side. Please return the Questionnaire with the appropriate documentation in the enclosed envelope. Please make sure the return address appears in the

CIGNA HealthCare
PO BOX 22170
Tempe, AZ 85285-2170

A. Full-Time Student Verification.

_____ Named dependent qualifies for continued coverage under the plan terms (e.g. unmarried, primarily supported by the employee, and enrolled in a secondary school, college or university as a full-time student); please check your booklet/certificate for the plan terms that apply to you. Note that not all plans contain provisions for student coverage. Please return this Questionnaire with one of the following forms of verification:

- A copy of the **current** semester official class schedule clearly indicating **full-time** student status and/or **total credit hours** (12 credit hours required for undergraduate; 9 credit hours required for graduate), as well as **school name**; OR
- A signed statement from the Registrar or Dean of Students verifying **full-time** student status; OR
- A copy of the current semester tuition bill showing **full-time** student status and/or **total credit hours**

Please note that the above documentation must include the school's name, the student's name and the semester. In addition, when submitting the documents please provide the account number and ID number located on the front of your CIGNA ID Card. If any of this information is missing it could result in termination of coverage until it is received.

_____ Named dependent does not qualify for continued coverage as a full-time student under the plan terms.

_____ My plan does not contain a provision for full-time student coverage.

B. Handicap/Disabled Dependent Verification

Is this Dependent:

- Your natural child, step-child, or adopted child or a child that a court has ordered you to support? Yes No

- Your grandchild? Yes No

- Married? Yes No

No Primarily dependent on you for support or legally dependent on you for support? Yes No

- Continuously incapable of self-sustaining employment as a result of a mental or physical handicap? Yes No

Please describe the mental or physical handicap:

When did this handicap become severe enough to prohibit self-sustaining employment:

- Before your child reached the limiting age for a dependent under your plan?

Yes No

- While your child was covered as a full-time student?

Yes No

PHYSICIAN FORM FOR HANDICAPPED DEPENDENT

MR Type-for internal use only

| | | |
|------------------------------------------------|------------------------------------------------|----------------------------------|
| DATE: 6-17 | SUBSCRIBER'S NAME (EMPLOYED): Theresa M. Hause | DEPENDENT'S NAME: Haley C. Hause |
| SUBSCRIBER'S ADDRESS: Street: 25923 Blascos | City: Mission Viejo | State: CA Zip Code: 92691 |
| NAME OF HEALTH PLAN: Anthem Blue Cross | HEALTH PLAN CODE: 640 | ID NUMBER: NCF745A67628 |
| GROUP NAME: Capistrano Unified | GROUP/DIVISION NUMBER: 57AJVA | |

Please respond to the questions below in as complete a manner as possible. This information will assist CIGNA HealthCare in determining this patient's eligibility for continued health care coverage as a handicapped dependent.

Robert Roddy M.D.
280 N. Smith Ave #410
St. Paul, MN 55102

To Identify the Treating Physician:

Physician Name:

Specialty: PSYCHIATRY

License Number: MN 31580

Address:

Telephone Number: 651-999-0263

Fax Number: 651-999-0264

Diagnosis(es) (ICD-9) 115.52, 296.32, 314.01,

1. How long have you treated this patient and when did you last see him/her? Since 3/11/11. I saw her last 6/17/13.

2. What is the degree of physical/mental impairment?

Moderate

3. In your professional opinion, is this patient continuously incapable of self-sustaining

Yes

Please return this entire Questionnaire with the enclosed Physician Form completed by the attending physician.

_____ Named dependent does not qualify for continued coverage as a handicapped dependent under the plan terms.

Verification of dependent eligibility may be requested periodically.

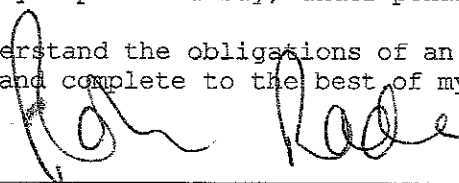
Please complete this form on the reverse side

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

I, _____, hereby depose and say, under penalty of perjury, that:

1. I am over eighteen years of age and understand the obligations of an oath.
2. The information provided above is true and complete to the best of my knowledge.

Signature: _____



Printed Name: _____

Robert Roddy M.D.
280 N. Smith Ave #410
St. Paul, MN 55102

6/17/13

TO BE COMPLETED BY THE SUBSCRIBER

After completing the following section, please forward this form along with the enclosed envelope to your physician for his completion.

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| 1. Subscriber's Name (Last, First, Middle Initial) <u>Hause, Theresa M.</u> | | 1a. Identification Number <u>NCF745A67628</u> | |
| 2. Home Address (Number, Street, City, State and Zip Code) <u>25923 Blascos, Mission Viejo, CA 92691</u> | | | |
| 3. Group Name <u>Capistrano Unified</u> | | 3a. Group Number <u>57AJVA</u> | |
| 4. Dependent's Name <u>Haley Christine Hause</u> | | 4a. Dependent's Birth Date <u>10-18-1987</u> | 4b. Dependent's Marital Status <u>Single</u> |
| 5. Does the Dependent reside in your Home? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 6. Is he more than 50% dependent upon you for support? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 7. Is he listed as dependent in your last Federal Income Tax Return? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| 8. Is dependent employed? <u>N/A</u> | 8a. Date of Hire <u>9-92</u> | 8b. Number of hours employed per week. <u>40hrs</u> | |
| 8c. Describe nature of duties. <u>F.S. Lead</u> | | | |
| I certify that the above information is correct and authorize the release of medical information requested with respect to this certification. | | | |
| <u>Theresa M. Hause</u> Signature of Subscriber | | <u>6-17-2013</u> Date Signed | |

TO BE COMPLETED BY ATTENDING PHYSICIAN

An unmarried dependent child who is incapable of self support due to a continuously disabling illness or injury may be continued as a family member on the parent's Anthem Blue Cross Contract. Your medical statement will help us to determine the eligibility of this dependent.

Please return the completed form to ANTHEM BLUE CROSS in the enclosed envelope.

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------|
| 1. List the ICD9 codes relevant to the disabling condition | | |
| 2. Describe the disabling condition <u>traumatic brain injury; major depressive d/o; pervasive developmental disorder;</u> | | |
| 3. To what extent does the disability limit normal activity <u>patient unable to work - gets agitated easily; trouble sleeping; poor cognition</u> | | |
| 4. What is your prognosis including your estimates of length of time this disability may be expected to continue? | | |
| | | |
| | | |
| | | |
| Name of Physician <u>Robert Roddy M.D.</u> | | Physician's Signature <u>[Signature]</u> |
| Address of Physician <u>280 N. Smith Ave #410 St. Paul, MN 55102</u> | | |
| | | Date Signed <u>6/17/13</u> |

Disputes or Questions on Summary Abatement Assessments

We are providing you with this card to give you an opportunity to resolve any questions you may have on this assessment.

Please fill out the information and return this postage-paid card so that we can have your file at the hearing before the legislative hearing officer. Please provide a day phone number. Discussion with staff does not waive your right to appear before the City Council.

NAME: Haley Hause (print legibly) (day) Phone No: 949-295-9942 (include area code)

Property Address: 867 Randolph Ave File No. J1408A

COMMENT/QUESTION: Adult disabled - Hospitalized (print legibly)

***Please return this GOLD CARD within 5 days
IF you wish to appear before the Hearing Officer.***

Necesite un interprete en espanol. Xav tau ib tus hmoob txhais lus.