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 #[redacted]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 no 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 is 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
MissionViejo, CA92691
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 HEARING
TIME: **Tuesday, May 06, 2014 at 9:00 AM**
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 PUBLIC HEARING
TIME: **Wednesday, June 18, 2014 at 5:30 PM**
PLACE:**City Council Chambers, 3rd FL City Hall-Court House, 15 W Kellogg Blvd**
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

CONTINUED ON REVERSE SIDE

NOTIFICATION DATE 04/15/2014

GC-350

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, state bar 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

CONSERVATEE

FOR RECORDER'S USE ONLY

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

(SEAL)

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

Date: MAR 13 2006

ALAN SLATER
Clerk, by _____, Deputy
DIANE A. DAVIS

This form may be recorded as notice of the establishment of a conservatorship of the estate as provided in Probate Code section 1875.

CONSERVATORSHIP OF *(Name)*: HALEY HAUSE CONSERVATEE	CASE NUMBER: A234698

LETTERS OF CONSERVATORSHIP

AFFIRMATION

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

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

Theresa M. Hause
(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

(SEAL)

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

a HealthCare

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	HEATHPLAN CODE: 040	ID NUMBER: NCF745A67628	
GROUP NAME: Capistrano Unified	GROUP/DIVISION NUMBER: 57AJYA		

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 (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	HEATHPLAN 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.

To Identify the Treating Physician:

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

Physician Name:

Specialty: PSYCHIATRY

License Number: MN 31580

Address:

Telephone Number: 651-999-0263

Fax Number: 651-999-0264

Diagnosis(es) (ICD-9) V15.52, 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: _____

Date: _____

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

6/17/13

Anthem Blue Cross

DISABLED DEPENDENT CERTIFICATION

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) Hause, Theresa M.			1a. Identification Number NCF745A67628
2. Home Address (Number, Street, City, State and Zip Code) 25923 Blascos, Mission Viejo, CA 92691			
3. Group Name Capistrano Unified			3a. Group Number 57AJYA
4. Dependent's Name Haley Christine Hause	4a. Dependent's Birth Date 10-18-1987	4b. Dependent's Marital Status Single	
5. Does the Dependent reside in your Home? X Yes ☐ No	6. Is he more then 50% dependent upon you for support? X Yes ☐ No	7. Is he listed as dependent in your last Federal Income Tax Return? X Yes ☐ No	
8. Is dependent employed? N/A	8a. Date of Hire 9-92	8b. Number of hours employed per week. 40hrs	
8c. Describe nature of duties. F.S. Lead			

I certify that the above information is correct and authorize the release of medical information requested with respect to this certification.

Theresa M. Hause — Signature of Subscriber

6-17-2013 — 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
traumatic brain injury; major depressive d/o; pervasive developmental disorder;

3. To what extent does the disability limit normal activity
Patient unable to work - gets agitated easily; trouble sleeping; poor cognition

4. What is your prognosis including your estimates of length of time this disability may be expected to continue?

Name of Physician Robert Roddy M.D.	Physician's Signature	Date Signed 6/17/13
Address of Physician 280 N. Smith Ave #410 St. Paul, MN 55102		

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. J14088A

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

Please return this GOLD CARD <u>within 5 days</u>
<u>IF</u> you wish to appear before the Hearing Officer.

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