4H – PROCESSING OF QUARTERLY STATUS REPORTS

Prior to January 1, 2001, Medi-Cal beneficiaries were required to submit quarterly status reports (QSRs). With the passage of Assembly Bill 2877, Chapter 93, Statutes of 2000, this requirement was eliminated for all Medi-Cal beneficiaries except for the first year (federal portion) of Transitional Medi-Cal (TMC). Counties were instructed to process status reports received by December 31, 2000. Beginning January 1, 2001, counties may not take any adverse action based on incomplete or non-receipt of QSRs.

Beneficiaries still have the responsibility to report changes that may affect their Medi-Cal eligibility, such as changes in income, property, family composition, other health coverage, etc. within ten days of such change. Counties must act on any changes that they are aware of, whether the change has been reported directly by the beneficiary, received from the December 2000 QSR, or in conjunction with other public assistance programs (such as when a county has generic eligibility workers for the multiple public assistance programs and thereby becomes aware of such changes).

For status reports required under the TMC program, see Section 5B.

4I — DILIGENT SEARCH PROCEDURES

The following are guidelines to be used in determining eligibility for persons who are comatose, otherwise incompetent, or are amnesiac and there is no friend, guardian, or relative available to supply the information necessary for a Medi-Cal eligibility determination.

I. REFERRAL TO PUBLIC GUARDIAN OR CONSERVATOR

Upon notification from the hospital, the county welfare department shall make a referral to the public guardian's or conservator's office. If the public guardian's office accepts responsibility, the county welfare department shall make an eligibility determination from the information provided by that office. If that office refuses to accept responsibility for an individual, the county welfare department shall complete the search for eligibility information. Documentation of the public guardian's refusal must be in the case record.

II. DISABILITY DETERMINATION REFERRAL

The county welfare department shall make a referral to Disability Evaluation Division (DED) for all persons whose eligibility is determined through these procedures unless the individual is obviously under age 21 or over age 65. The person making the referral shall sign the MC 220, Authorization for Release of Information, and write "patient is comatose" on the face of the form. Forms MC 221, Disability Determination and Transmittal, and MC 223, Statement of Facts for Medi-Cal Regarding Disability, shall be completed with all available information.

III. DILIGENT SEARCH

A. Persons Without Identification

If a member of the hospital staff has attempted to establish the identity of a person who is admitted in a comatose, amnesiac, or senile condition, and the person's identity remains unknown, the county welfare department shall document in the case record that a search by hospital staff was conducted to establish the identity of this person.

B. Persons With Identification

The county welfare department shall conduct the following routine search for a person with identification and document the results in the case file.

1. Property search in the county of physical presence. (If there is information which indicates an address in another county, a property search shall also be requested from the county.)

2. Verification of Social Security benefits via form SSA 1610/ CA 810.

3. Verification of Veterans' Administration benefits via form CA 5.

4. Employment Development Department clearance via form DE 8720.

5. Verification of vehicle registration through written request to the Department of Motor Vehicles.

6. If the personal effects of the individual indicate an account at a specific banking institution, request information from that bank. Request the bank to search for all accounts belonging to the individual.

When requesting any of the above information, include a cover letter indicating the circumstances, i.e., the individual is comatose and therefore cannot sign a release of information form; there is no friend or relative to act on behalf of the individual, and the county is trying to establish Medi-Cal eligibility.

IV. CASE PROCESSING

Action on the application shall not be taken until a determination of ineligibility has been established or the diligent search and the disability determination (for persons 21-64) have been completed. However, if a comatose person is placed in a skilled nursing facility/ intermediate care facility (SNF/ICF), Category 53 may be appropriate. If at any time during the application process the person's condition changes or a friend or relative is found so that information can be obtained in the usual manner, the diligent search efforts shall cease.

Once the diligent search and disability determination have been completed, an eligibility decision shall be made. Following are the instructions for establishing an identity to use in opening up a Medi-Cal case and issuing Medi-Cal cards.

A. Name

If the person's name is unknown, use either John C. Doe or Jane C. Doe for the case name.

B. Aid Code

1. If the person's age is unknown and the person appears to be under 21 years of age, use Aid Code 82.

2. If the person's age is unknown and appears between 21 and 64 and the disability determination has been denied, continue to use Aid Code 53 for those persons who are in an ICF or SNF. If the person is not in an ICF or SNF, deny the application. If the disability determination has been approved, use either Aid Code 64, 67, or if the person is in long-term care status, use Aid Code 63.

3. If the person's age is unknown and the person appears to be over 65 years of age, use Aid Code 14, 17, or if the person is in long-term care status, use Aid Code 13.

C. Birth Date

If unknown, use "01" for the month and "01" for the day; use the following for the year of birth:

1. If the estimated age is under 21, use the current year minus 10 years.

2. If the estimated age is between 21 through 64, use the current year minus 40 years.

3. If the estimated age is 65 or over, use the current year minus 70 years.

D. Social Security Number

If unknown, leave blank. A pseudo number will be assigned by Medi-Cal Eligibility Data System (MEDS).

E. Health Insurance Claim Number

If unknown, leave blank.

F. Address

Since MEDS will produce a reject message if the address field is blank, use either the address of the county welfare department or the address of the facility where the individual is receiving care.

NOTE: If a comatose person regains consciousness or is otherwise identified after eligibility is established, revise the case record to reflect the person's true identity and eligibility status. If the person remains eligible for Medi-Cal and a Medi-Cal identification number has been assigned, retain the serial number and change the aid code if there is a change in eligibility status or category. If the person is found to be ineligible, discontinue the case with timely and adequate notice.

4J--PROMPTNESS REQUIREMENT

A new applicant for Medi-Cal has the right to have his/her eligibility for benefits determined as quickly as possible to ensure his/her access to adequate medical care. Such timely eligibility determination includes the issuance of a Notice of Action (NOA) which addresses the applicant's approval or denial of Medi-Cal benefits, what the share of cost is, if any, and hearing rights if the applicant is dissatisfied with the action specified in the NOA. (Refer to Procedures Section 4U for NOA completion.)

Federal requirements (Title 42, Code of Federal Regulations, Section 435.911) for timely determination of eligibility are:

- Processing time standards may not exceed:
  1. 90 days for applicants who apply for Medi-Cal on the basis of disability; and
  2. 45 days for all other applicants.
- The 45- and 90-day time frames are inclusive from the date the SAWS 1 or other application was filed, to the issuance of the NOA.

The 45- and 90-day requirements may be extended for those items listed in Title 22, California Code of Regulations, Section 50177 (1)(2) as follows:

- The applicant has, with good cause, been unable to return the completed Statement of Facts, the Supplement to Statement of Facts for Retroactive Coverage/Restoration, or other necessary verifications in time for the county to meet the promptness requirement, or
- There has been a delay in the receipt of reports or other information necessary to determine eligibility and the delay is beyond the control of either the applicant or the county department.

The county welfare department shall not use these time standards as a waiting period before granting the application if all documents and information have been provided.

REQUIREMENTS TO EXPEDITE CASE PROCESSING

The county shall expedite processing the eligibility determination within available resources for the following situations:

- Minor consent applicants should have eligibility determined the same day of the intake interview and should be issued a paper Medi-Cal identification card.
- Individuals who require medical treatment which will not be provided without a Medi-Cal card should have eligibility determined as soon as all information has been received by the county. A paper Medi-Cal identification card should be issued until the applicant/beneficiary receives the plastic Benefits Identification Card.
- Pregnant women are considered to have an immediate medical need.

The county shall refer to Procedures Section, Article 22 (Disability Determination Referrals) for the proper completion of disability cases and the related promptness guidelines for referral processing.

Any delay in the determination of eligibility must be documented in the case record.

4K — PROCESSING OF MEDICALLY INDIGENT ADULTS (MIAs) APPLICANTS

County departments may identify persons not eligible under the provisions of Title 22, California Administrative Code, Section 50203 or 50251, prior to completion of a Medi-Cal application. These persons shall be informed:

a. That they have no apparent basis of eligibility for Medi-Cal.

b. Of their right to make a formal Medi-Cal application even though they have no apparent Medi-Cal eligibility.

c. Of the county MIA program.

4L -- RSDI/UI/DI REPORTS

I. BACKGROUND

The RSDI/UI/DI report consists of individual listings concerning RSDI, UI, or DI benefits. It is provided so that counties can verify benefit amounts reported by the beneficiary. If the amount listed on the report differs from the amount reported by the beneficiary, the county may need to contact the beneficiary who must provide verification of the correct current benefit amount.

A. If it is determined that the amount listed in the case record is incorrect, then the corrected benefit amount must be utilized to determine if a share of cost should be established or changed in accordance with Title 22, California Administrative Code (CAC), Sections 50653.3 and 50653.5.

B. If a discrepancy exists, the county is to determine whether a potential overpayment has occurred in accordance with Title 22, CAC, Section 50781. If a potential overpayment has occurred, then the appropriate referral should be completed as required by Title 22, CAC, Section 50783.

C. It is important to know the payment status and communication codes to properly utilize the RSDI/UI/DI information. The following two instructions provide this information:

1. Instructions for interpreting the report of RSDI.

2. Instructions for interpreting the UI/DI formats on the report of RSDI/UI/DI.

II. INSTRUCTIONS FOR INTERPRETING THE REPORT OF RSDI (PVS040-A)

Numbers in parentheses are keyed to items on the Report of RSDI.

GENERAL CASE INFORMATION

(1) ROUTE: The county uses this information to route the report to the district and worker.

(2) RUN DATE: Date the report was printed.

(3) PAGE: RSDI income of all persons in a case will be listed on the report. Each person's income will be shown on a separate page. Persons in a case having more than one type of benefit payment will appear under the case number but on a separate page.

(4) CASE NO.: Includes aid code and case number.

(5) CASE NAME: Surname used by the county to identify the case.

(6) SSN: This is the SSN provided by the recipient.

(7) CASE STATUS: Whether the case is new or continuing.

(8) TYPE OF INCOME: The Report of RSDI will show RSDI and either UI or DI income for one or more persons in the case. A person should not receive UI and DI at the same time.

RSDI BENEFITS

(9) NAME AND SEX (as reported by SSA): This refers to the person in the case who is receiving RSDI.

(10) RECEIVED mm/yy: This is the month and year that the NEW MONTH's check is dated, e.g., 01/83 means that the RSDI check was dated 1/3/83 and should also be received about January 3. The new month could be different for RSDI, UI, and DI.

(11) OLD BENEFIT: What the benefit amount was before it changed.

(12) NEW BENEFIT: The amount of the RSDI benefit for the most current month reported. If there were no changes from the previous month, a report will not be generated.

(13) INITIAL DATE OF ENTITLEMENT: The date the person was first entitled to receive RSDI. This does not necessarily indicate when the first benefit amount was paid.

(14) PAYMENT STATUS CODE: This identifies the RSDI status of the person in the month of the payment. The report will indicate the meaning of the payment status code on the "Pay-message" lines (17). Major pay codes and messages are listed below.

4M - Verification

The following are guidelines to be used in verifying eligibility when determining Medi-Cal. It is not intended to repeat or replace regulatory material in Title 22, California Code of Regulations (CCR). This procedure is all inclusive and attempts to summarize instructions provided under other articles within the Medi-Cal Eligibility Procedures Manual (MEPM). To the extent possible, this procedure cross-references other documentation where a full description of the item is provided. Counties shall refer to the documentation cross-referenced in this article if a more comprehensive explanation of a specific issue is needed.

Verification means the process of obtaining acceptable evidence of items necessary to determine Medi-Cal eligibility which substantiates statements made by an applicant or beneficiary on the Statement of Facts form MC 210 or Medi-Cal Annual Redetermination form MC 210 RV. Verification is to be provided at:

- initial application, reapplication and restoration;
- annual redetermination for items necessary to determine continued Medi-Cal eligibility, subject to change, and not previously verified;
- anytime a change in amount/source/provider of resources, income, or expenses is reported by the applicant/beneficiary or discovered by the County Welfare Department (CWD); and
- requests for retroactive Medi-Cal coverage.

Documentary evidence (written confirmation) is to be used as primary source for all items.

When documentary evidence is required but is unavailable and all other verification attempts have been attempted and are unsuccessful, then a sworn affidavit signed under penalty of perjury by the applicant/beneficiary is acceptable as verification except for the Social Security Number (SSN).

I. VERIFICATION PRIOR TO APPROVAL OF ELIGIBILITY

Reference: Title 22 CCR Section 50167

A. Verification of Income

Reference: Title 22 CCR Section 50167 (a), (7); 50507; 50518; 50503; 50186; MEPM Article 10 and 15

(1) Earned Income

- one pay stub (pay stub not required to have been issued within the last 30 days but must accurately reflect the amount reported on the application; see ACWDL 00-31 and Errata 00-31E)
- a copy of last year's federal income tax return that accurately reflects the current income
- a signed letter from the employer that shows the gross amount and date of paycheck
- if verification cannot be obtained by one of the above methods, the

applicant/beneficiary can sign a statement, under penalty of perjury, indicating his/her gross monthly earned income

(2) Unearned income

- award letter or most recent cost-of-living increase notice
- IEVS/PVS printout
- current bank statement if the applicant has direct deposit (NOTE: the deposit may not reflect gross income if Medicare premiums are being deducted or an overpayment is being collected from the client's check)
- copy of the applicant's current benefit check (NOTE: the check may not reflect gross income if Medi-Cal premiums are being deducted or an overpayment is being collected from the client's check)
- signed statement from the person or organization providing the income

(3) Self Employment

- receipts showing gross earnings and expenses
- business records (profit and loss statements)
- copy of most recent federal individual tax return (IRS 1040) and appropriate Schedule D - Capital Gain or Loss.

(4) Use of Tax Return to Verify Income

A copy of the most recent federal individual income tax return (IRS 1040, 1040EZ, etc.) is acceptable verification of any type of income if it accurately reflects the income reported on the application.

(5) Verification of Unconditionally Available Income

Unconditionally available income is income the applicant/beneficiary only has to claim or accept. *A applicant/beneficiary must apply for unconditionally available income as a condition of eligibility*. Only the individual who refuses to apply for or accept unconditionally available income will be ineligible. Examples of unconditionally available income are Disability Insurance Benefits (DIB), Retirement, Survivors, Disability Insurance (RSDI) benefits, Veterans Administration (VA) benefits and Unemployment Insurance Benefits (UIB).

All applicants/beneficiaries should be considered potentially eligible for UIB and should be referred to the Employment Development Department (EDD) to apply for UIB; however, counties should not refer applicants/beneficiaries in the following circumstances:

- individuals who have not worked in employment covered by UIB
- individuals who have a UIB claim pending
- individuals who are receiving or have exhausted their UIB
- individuals who are receiving DIB
- individuals who are full-time employed

- individuals who are covered under Title 22, CCR, Section 50211
- individuals denied or discontinued from the UIB program
- children under 16 years of age with no employment history
- applicants who are applying for restricted Medi-Cal benefits (see ACWDL 93-59)

(6) Inkind Income

Verification is only required if it is earned or the applicant/beneficiary claims the amount is a lower value than the presumed maximum established in accordance with Title 22 CCR, Section 50511. Written statement from the provider is acceptable as verification.

(7) Fluctuating Income

Check stubs or a signed statement from the person or organization making the payments including the amount and frequency of the payments.

(8) Tip Income

- amount reported on pay stub
- the amount actually reported by the applicant/beneficiary
- if there is a discrepancy between the amount reported on the pay stub and the amount reported by the applicant/beneficiary, the applicant/beneficiary can sign a statement, under penalty of perjury, as to the reason for the discrepancy

(9) Temporary Worker's Compensation (TWC)

An award letter from the insurance company or other entity which identifies the payment as temporary, the amount of the payment and the schedule of payments.

(10) Veteran's Benefits or Aid and Attendance Payments

- completed Veterans' Benefits Verification and Referral form (CA 5)
- viewing the Veterans' Administration check and documenting in the case narrative (unable to copy check)

(11) Interest and Dividend Income

- IRS Interest Income Statement Form 1099
- bank statement (yearly, quarterly, monthly)
- account statement
- payment records (notes/mortgages)

(12) Child Support/Spousal Support

- court papers
- District Attorney/Family Support (DAFS) records
- sworn affidavit from the absent parent
- copy of check

(13) Dependent Care Costs

Acceptable verifications for those who incur child care costs or costs of care for an incapacitated person while someone is employed include:

- receipts
- cancelled checks
- signed statement from the person or organization receiving the payments

(14) Educational Grants and Loans

Financial aid papers provided by the college.

(15) Net Income from Property

- lease or sales agreement
- bookkeeping records (including expense receipts, tax returns, sales records)

(16) Health Care Benefits

An applicant/beneficiary who has Other Health Coverage (OHC) must provide information about the coverage as a condition of eligibility. The Health Insurance Questionnaire (DHS 6155) form must be completed.

B. Real and Personal Property

See Title 22 CCR, Article 9; MEPM Article 9 and All County Welfare Directors Letters for specific information on various property items by Medi-Cal program.

C. Evidence of Residence

Reference: Title 22 CCR Section 50167 (a), (10) and 50320.1

California residency is a requirement for Medi-Cal eligibility.

In determining whether a Medi-Cal applicant/beneficiary meets residency requirements, the CWD must consider all available evidence, including evidence that supports a claim of California residency, as well as, evidence that contradicts a claim of residency.

Documents provided as evidence of California residency must include a California address for the applicant/beneficiary. However, the address on the document need not be the current address. Document provided by a homeless person must be considered even if it does not include an address for the applicant/beneficiary. Evidence includes but is not limited to:

- a current California driver's license or identification card
- a current California vehicle registration form
- any evidence the applicant is employed in California
- any evidence the applicant has registered with a public or private employment agency in California
- any evidence that the applicant has enrolled his or her children in a California school
- any evidence that the applicant is receiving public assistance in California
- a voter registration form or receipt, a voter notification card, or an abstract of voter of registration

Applicants must compete and sign the Medi-Cal Residence Declaration (MC 212) stating both of the following apply:

- they do not own or lease a principal residence outside the state of California (unless exempt under Title 22 CCR Section 50425), and
- they are not receiving public assistance outside of this state

D. Identity

Reference: Title 22 CCR Section 50167 (a), (6)

A California Driver's License (CDL) or identification card issued by the Department of Motor Vehicles is the first choice for identification. The following, or any other document that the CWD deems acceptable, can be used to verify identity.

- United States citizenship or Alien Status document (e.g., passport)
- Birth Certificate
- School Identification Card
- Marriage Record
- Work Badge
- Church Membership or Baptism/Confirmation Record
- Social Security Card

Identity is not required for persons who are:

- institutionalized and verified by the facility
- receiving Medi-Cal through the Aid for Adoption of Children program
- children and identity of one parent is verified; however, if only children are applying, the county shall not require the parent's SSN
- children requesting Medi-Cal for Minor Consent services in accordance with Title 22 CCR Section 50147.1

- children who are not living with a parent or relative and for whom a public agency is assuming financial responsibility in whole or in part
- not acting on their own behalf and a government representative, such as a public guardian, is acting for them
- the spouse of a person whose identity has been verified

E. Verification of Alien Status

Reference: Title 22 CCR Section 50167, (a), (3); 50301.1; 50301.2; 50301.6; MEPM Article 7

Alien status shall be verified following the guidelines outlined in MEPM Article 7 (also see ACWDLs 89-59 and 90-15).

Verification of U.S. citizenship is **not** required **unless:**

- the individual claims U.S. citizenship but was born outside of the U.S. (including children who were born in another country to U.S. citizen parents)
- there is conflicting information about the individual's citizenship status
- citizenship is doubtful
- documentation provided does not appear valid
- the individual claims to be naturalized citizen

Systematic Verification of Entitlements (SAVE)
The SAVE system is used to verify immigration status of Medi-Cal applicants and beneficiaries who claim Satisfactory Immigration Status (SIS). A SAVE request is to be completed and forwarded to the Immigration and Naturalization Service (INS) on every applicant or beneficiary who claims SIS. When the primary SAVE request is returned by INS and indicates "institute secondary verification", then the G-845 form must be completed and forwarded to INS.

Statement of Citizenship (MC 13)
Medi-Cal applicants must complete and sign the MC 13 (see MEPM Article 7G). A new MC 13 is required anytime the beneficiary's immigration status has changed.

F. Pregnancy

Reference: Title 22 CCR Section 50167 (a), (8)

Acceptable pregnancy verification is a written statement from a:

- physician
- physician's assistant
- certified nurse midwife
- certified nurse practitioner
- licensed midwife, or
- designated medical or clinic personnel with access to patient's medical record.

A signed stamped photo copy or carbon copy is acceptable, as long as, it is initialed or counter-signed by the designated medical or clinic personnel providing the verification. The

carbon copy signature that appears on the Pregnancy Verification of the Presumptive Eligibility, "Application for Medi-Cal Program Only" (PREMED2), does not need to be initialed.

Pregnancy verification should include the Estimated Date of Confinement (EDC). If pregnancy verification does not include the EDC, the eligibility worker may ask the applicant/beneficiary for the expected date of birth. A verbal statement made by the applicant/beneficiary regarding the EDC is acceptable and must be documented in the case narrative file.

Pregnancy verification is not required for women applying for minor consent services.

Self-Declaration of Pregnancy

An applicant/beneficiary may self-declare pregnancy on the application, the Statement of Facts form, or by any other signed document. When the self-declaration is made verbally, the eligibility worker must document this fact in the case narrative. The unborn is only counted as one child for maintenance need calculation purposes unless written medical pregnancy verification indicates multiple unborn children.

- For the purpose of self-declaring a pregnancy, *medically verified* is defined as information received by the applicant/beneficiary from a medical provider indicating that a positive pregnancy result has been confirmed or through a home pregnancy test with a positive result.

- Women seeking pregnancy-related only services, whose income is at or below the 200 percent Federal Poverty Level (FPL) program, are allowed to self-declare that their pregnancy has been *medically verified.* Individuals must be income eligible to receive pregnancy-related only services and placed under the appropriate FPL percent program category.

- Women seeking full-scope coverage, whose only linkage to eligibility is the pregnancy, can self-declare that their pregnancy has been *medically verified* and allowed sixty (60) days to provide proof of pregnancy.

- When pregnancy verification is not provided within sixty (60) days, counties must discontinue full-scope benefits with timely and adequate notice and must review income eligibility for placement under the appropriate FPL percent program category for pregnancy-related only services.

G. Verification of Blindness/Disability

Reference: Title 22 CCR Section 50167 (a), (1); MEPM Article 22

Acceptable verification includes:

- proof of Social Security (Title II) benefits based on disability or blindness
- proof of Supplemental Security Income/State Supplemental Payment (SSI/SSP) benefits based on disability or blindness

- proof of Railroad Retirement benefits based on permanent and total disability

Receipt of one of the above types of disability benefits can be adopted for Medi-Cal disability determination and a referral to State Programs-Disability Adult Program Division (SP-DAPD) is not needed. However, if the applicant is not in receipt of one of the above disability benefits, then a disability packet must be completed and sent to SP-DAPD (see MEPM Article 22) for a disability determination.

Receipt of disability benefits under other programs (e.g., State Disability Insurance (SDI), Veteran's Administration, Worker's Compensation) does not establish disability for Medi-Cal.

H. Verification of Incapacity

Reference: Title 22 CCR Section 50167, (a), (2) and 50211

Acceptable verification includes:

- proof of Social Security (Title II) benefits based on disability or blindness
- proof of SSI/SSP benefits based on disability or blindness
- proof of SDI or Worker's Compensation

Verification of one of the above types of disability benefits verifies incapacity; however, if the applicant does not receive one of the above types of benefits, then one of the verifications listed below is required:

- a current Medical Report or certificate of disability form
- a written statement signed by a physician, licensed or certified psychologist, or authorized member of their staff which documents that incapacity exists and gives the expected duration of the condition

When a current Medical Report or a written statement cannot be obtained without delay, then a verbal statement from a licensed physician or an authorized member of their staff shall be accepted as verification for up to sixty (60) days pending receipt of written verification.

Verification from a Chiropractor is not acceptable evidence of incapacity.

I. Legal Responsibility for a Child

Reference: Title 22 CCR Section 50167 (a), (4)

Whenever a child is applying alone on the basis that neither the parents nor any agency will accept legal responsibility for the child, then the CWD must verify that fact. Verification can be any verbal or written communication with the parent(s) and/or agency.

J. Substantial Gainful Activity (SGA)
Reference: MEPM Article 22

SGA disability, as determined in accordance with Section 50223 (a)(2), shall be verified by following procedures established by SP-DAPD.

K. Former Home Listed for Sale
Reference: Title 22 CCR Section 50167 (a), (9); MEPM Article 9

Any documentation from a licensed real estate broker that substantiates the property is listed for sale.

II. VERIFICATION REQUIRED WITHIN SIXTY (60) DAYS OF APPROVAL
Reference: Title 22 CCR Section 50168

A. Social Security Number (SSN)

The SSN for all applicants or beneficiaries must be verified within sixty (60) days of the date of initial application unless:

- the individual is applying for Restricted Medi-Cal or Minor Consent Services
- the individual is a newborn (SSN will be required for the newborn by the age of one year)

Application for an SSN or evidence of an SSN shall be confirmed by viewing:

- SSA district office notification that application for an SSN has been made
- a completed SS-5 (application for an SSN form) or completed MC 194 (referral notice)
- completed SSA 2853 (application for SSN for newborn)

If a social security card is not available, acceptable evidence is:

- a social security award letter
- Medicare Card or check from SSA showing the applicant name and SSN with the letters A, HA, J, T, or M following the SSN
- other documentation from SSA upon approval by the CWD
- MEDS printout indicating a "J" code in the SSN-VER field

SSN's cannot be required for persons not applying for Medi-Cal (e.g. parents applying for children only). Counties may request the parent's SSN but must note that providing the non-applicant parent's SSN is voluntary.

The signature on the Statement of Facts shall not be accepted as verification of a person's

SSN or application for a SSN. Counties are reminded that only individuals applying for full-scope Medi-Cal are required to provide proof of a SSN.

B. Medicare

Medicare Eligibility is verified by viewing:

- the Health Insurance Card (HIC) and number
- a social security award letter displaying the individual's HIC number
- a bill for Premium Part A or Part B (SSA 1545)
- MEDS printout (QB screen)

III. VERIFICATION REQUIREMENTS FOR RETROACTIVE MEDI-CAL

Reference: Title 22 CCR Section 50148 and 50197

The CWD shall not require additional verification beyond that used to determine initial and ongoing eligibility when the applicant or beneficiary completes the MC 210 A and indicates there is no change for the requested retroactive month(s).

When the applicant or beneficiary completes the MC 210 A and indicates a change in either income, property, health insurance, number of people living in the home or California residence between the retroactive month(s) requested and the current signed Statement of Facts, then verification of the change is required.

IV. EX PARTE REVIEWS

Reference: Senate Bill (SB) 87 and ACWDL 01-36

To avoid unnecessary and repetitive requests for verification that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage, counties shall conduct ex parte reviews ***to the extent possible***.

Relevant information and verification from all public assistance case files (e.g., Medi-Cal, CalWORKs, Food Stamps, IHSS, Foster Care, etc.) shall be obtained when appropriate. Additionally, information and verification from other resources including but not limited to MEDS, IEVS, SDX, BENDEX, DAFS Child Support must be used in the ex parte review.

V. ADDITIONAL VERIFICATION REQUIREMENTS

The CWD shall not require additional verifications when the applicant or beneficiary has been previously aided in another public assistance program (CalWORKs, Food Stamps, Medi-Cal, IHSS, etc.) and verifications in those case files are less than twelve (12) months old and consistent with reported information on the application for Medi-Cal. However, when verifications in those case files are inconsistent with what is reported by the applicant or beneficiary, then current verification must be requested.

4N—TIMELY REPORTING BY PUBLIC GUARDIANS/CONSERVATORS OR BENEFICIARY REPRESENTATIVES

A major cause of eligibility errors reflected in Medi-Cal cases for individuals in Long-Term Care, or others having a conservator, is the failure of the beneficiary or their representative to report changes to the county welfare department (CWD) that may affect Medi-Cal eligibility. The following definitions should be noted to avoid possible confusion in regard to the application processes surrounding persons who have a government representative, conservator, or other representative handling their affairs:

Authorized Representative: A person specifically designated in writing by the applicant/beneficiary to accompany, assist, and represent the applicant/beneficiary in the Medi-Cal application/redetermination or fair hearing process. An **Authorized Representative** cannot act on behalf of an incompetent individual.

Conservator: A person appointed by the court to act as the guardian, custodian, or protector of another.

Public Guardian: A county agency acting as a public entity appointed to act on behalf of persons who have lost their ability, either mentally or physically, to handle their own affairs. The **public guardian** acts as the individual's advocate. No private person is allowed to be a "public guardian." The authority vested to the public guardian is derived from the probate code and, for mental health issues, through the Lanterman-Petric-Short (LPS) Conservatorship Act.

Representative: A person acting on the behalf of another who is incapable of handling his/her own personal or business affairs. The **representative** must have specific and personal knowledge of the incompetent individual's circumstance. The representative may be a friend, relative or someone else that has known the applicant/beneficiary and will act responsibly on his/her behalf.

The public guardian frequently represents aged, blind, and disabled persons for Medi-Cal purposes. The public guardian, or other representatives, often have conservatorship responsibilities but, in many instances, fail to understand the importance of keeping the CWD informed timely when changes occur to the recipients circumstances. Many of these changes are a result of changes to income, property, health coverage, and even death.

Regulations specifically exempt the public guardian from the required face to face interview for application [Title 22, California Code of Regulations (CCR) , Section 50157(b),(d)(2)] and all aged, blind, disabled persons are exempt from the face to face interview at redetermination [Title 22, CCR, Section 50189(d)]. Due to this exemption, it is very important that the public guardian, authorized representative, or conservator be aware of her/his on-going responsibilities.

The **DHS 7068, Responsibilities of Public Guardian/Conservators or Applicant/Beneficiary Representatives**, has been developed and revised to assist the counties to inform the public guardians, conservators, and representatives of their reporting responsibilities. The DHS 7068 is to be given or mailed to the public guardian, conservator, or to the representative at the time of the initial application and at each redetermination. The DHS 7068 is printed on NCR paper. The white copy (top sheet) is to be used at application and redetermination time, and should be filed in the

case file. The yellow copy (second sheet) is to be kept by the public guardian, conservator, or representative. (Note: Signature, address and telephone number of the public guardian, conservator, or representative is required on this form.)

A copy of the **MC 219, Important information for Persons Requesting Medi-Cal**, must accompany the DHS 7068. The MC 219 must be signed and dated by the public guardian, conservator, or representative and kept in the case file.

If the CWD mails the DHS 7068 to the representative, the following suggested cover letter may be used.

SAMPLE **SAMPLE**

O O

O {address block} O

O O DATE: _____

O O

As the Public Guardian/Public Conservator of your county, or as the applicant's or beneficiary's representative, you have the responsibility to act on behalf of the individual you represent.

Title 22, CCR, Section 50185 (a)(4), requires Medi-C. eneficiaries or persons acting on their behalf to report to the county welfare department any changes in circumstances affecting eligibility or share of cost within ten calendar days following the date the change occurred.

Additionally, in the event of the beneficiary's death, Probate Code, Section 700.1, and Welfare and Institutions Code, Section 14009.5, require you to report the death of the beneficiary within 90 days of the date of death to the following address:

DHS – Third Party Liability Branch
Recovery Section/Estate Recovery Unit
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425

The attached **DHS 7068 (Responsibilities of Public Guardians/Conservator or applicant/ Beneficiary Representatives)** serves as your acknowledgement of your responsibilities as the representative of the applicant/beneficiary. Please complete the form and return the white copy to the eligibility worker. You should retain the yellow copy for your files.

If you have any questions regarding this form, you may contact

_____ at _____.

SAMPLE **SAMPLE** **SAMPLE**

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

RE: _____
Case name

_____
Case number

_____
Worker number

RESPONSIBILITIES OF PUBLIC GUARDIANS/CONSERVATORS OR APPLICANT/BENEFICIARY REPRESENTATIVES

You have accepted the responsibility to act on behalf of _____.
State law and regulation require you to report to the county welfare department any changes in the circumstances of the applicant/beneficiary within ten calendar days following the date the change occurred. You must also cooperate fully on behalf of the beneficiary in any review that may be required for quality control purposes.

Changes which must be reported within ten days include, but are not limited to.

1. A change in the beneficiary's property, including community property.
2. A change in the beneficiary's income.
3. Entitlement to Veteran's Benefits or an increase in Veteran's Benefits.
4. Changes in health insurance coverage including enrollment in available health insurance or the discontinuance of health insurance.
5. A change in the beneficiary's living arrangement, household members, or residence.
6. The death of the applicant/beneficiary.
7. A change in guardianship/conservator or representative status.
8. Any other change in circumstances which may affect eligibility or share of cost.

You are also required (pursuant to Probate Code, Section 700.1, and Welfare and Institutions Code, Section 14009.5) to report the death of the beneficiary within 90 days of the date of death to:

DHS—Third Party Liability Branch
Recovery Section/Estate Recovery Unit
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425

Refer to "***IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL***" (MC 219) for a more complete list of your reporting responsibilities.

I hereby state, under penalty of perjury, that the information on this form has been reviewed by me and that I fully understand my responsibilities as the guardian, conservator or representative of

_____
Name of Beneficiary

Signature of Guardian/Conservator or Representative	Date
Address of Guardian/Conservator or Representative	**Telephone number of Guardian/Conservator or Representative**

Original—Case File *Copy—Guardian/Conservator or Representative*

RE: _____
Case Name

_____
Case Number

_____
Worker Number

RESPONSIBILITIES OF PUBLIC GUARDIANS/CONSERVATORS OR APPLICANT/BENEFICIARY REPRESENTATIVES

You have accepted the responsibility to act on behalf of _____. State law and regulation require you to report to the county welfare department any changes in the circumstances of the applicant/beneficiary within ten calendar days following the date the change occurred. You must also cooperate fully on behalf of the beneficiary in any review that may be required for quality control purposes.

Changes which must be reported within ten days include, but are not limited to:

1. A change in the beneficiary's property, including community property.
2. A change in the beneficiary's income.
3. Entitlement to Veteran's Benefits or an increase in Veteran's Benefits.
4. Changes in health insurance coverage including enrollment in available health insurance or the discontinuance of health insurance.
5. A change in the beneficiary's living arrangement, household members, or residence.
6. The death of the applicant/beneficiary.
7. A change in guardianship/conservator or representative status.
8. Any other change in circumstances which may affect eligibility or share of cost.

You are also required (pursuant to Probate Code, Section 700.1, and Welfare and Institutions Code Section 14009.5) to report the death of the beneficiary within 90 days of the date of death to:

Department of Health Services
Recovery Section
P.O. Box 2471
Sacramento, CA 95812-2471

Refer to "*IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL*" (MC 219) for a more complete li of your reporting responsibilities.

I hereby state, under penalty of perjury, that the information on this form has been reviewed by me and that I fu understand my responsibilities as the guardian, conservator or representative of

_____
Name of Beneficiary

Signature of Guardian/Conservator or Representative	Date
Address of Guardian/Conservator or Representative	**Telephone Number of Guardian/Conservator or Represent**

White—Case Copy Yellow—Guardian/Conservator or Representative Copy

40 -- ONE MONTH EXTENDED ELIGIBILITY (EDWARDS v. MYERS)

The following procedural instructions are for the purpose of further defining extended eligibility under the Edwards v. Myers court order.

BACKGROUND

The court order in the Edwards v. Myers case provides for uninterrupted Medi-Cal coverage with no share of cost for families/persons discontinued from Aid to Families with Dependent Children (AFDC) until a reevaluation of the family's/person's eligibility or ineligibility for Medi-Cal only is completed and adequate and timely notice is issued. In making the redetermination, the county may not need to seek additional information beyond that already in file. If the available information would permit continued Medi-Cal eligibility on some other basis, then a notice reflecting the interprogram transfer of Medi-Cal eligibility should be sent. Where the county has insufficient information to determine whether a recipient is still eligible for Medi-Cal, the AFDC termination notice should specify the information needed to reinstate Medi-Cal only. Such a termination notice would be sent only if the recipient has not complied with the procedures which the county is required to have for reporting, as set forth in Sections 50185 (a) (3) and (4) and 50191. This provision applies to all persons discontinued from AFDC effective April 30, 1982 and forward for any reason other than the $30 and one-third disregard. Additionally, families eligible for Four Month Continuing must also be granted extended no share-of-cost coverage following the discontinuance of Four Month Continuing if a reevaluation is not completed prior to the end of the fourth month and in sufficient time to allow for a ten-day notice if the Medi-Cal-only eligibility determination adversely affects the family.

ELIGIBILITY

If the reason for AFDC discontinuance is also a condition of Medi-Cal eligibility, or the Medi-Cal-only eligibility determination can be completed at the same time the AFDC determination of ineligibility is made, extended Medi-Cal benefits under this category are not required. Referrals to Continuing Medi-Cal are not to be made for persons being discontinued from AFDC due to one of the following reasons (the appropriate Title 22 section must be cited on the AFDC Notice of Action):

- Loss of contact. (Section 50175 (a) (5))
- Death of recipient. (Section 50176)
- Loss of California residence. (Section 50320)

- Failure to complete the redetermination (renewal) process. (Section 50189)

- Recipient's request and recipient indicates the request to be discontinued from assistance includes Medi-Cal. (Section 50015)

- Admission to an institution which renders the person ineligible. (Section 50273)

The Notice of Action used to discontinue AFDC must also state that Medi-Cal benefits (not just cash-based Medi-Cal) are also being terminated, and the applicable Title 22 section authorizing the Medi-Cal discontinuance must be cited on the notice.

If it is not possible to immediately make a determination of ineligibility for Medi-Cal only and send adequate and timely notice at the time of AFDC discontinuance, no share-of-cost Medi-Cal must be continued until an evaluation of Medi-Cal-only eligibility can be made. A Notice of Action must be sent which contains the following wording:

"Due to an injunction issued in the Edwards v. Myers lawsuit, you are entitled to continue to receive no share-of-cost Medi-Cal coverage following your discontinuance from AFDC until your eligibility for Medi-Cal only can be determined.

"If you are interested in having your eligibility for Medi-Cal only determined, you must complete the enclosed Application/Statement of Facts and return these forms to the county department within 20 days of the date of this notice. If you need assistance in completing the forms, please call _____."

If the beneficiary does not return the Application/Statement of Facts by the 20th day, a 10-day Notice of Action is to be sent discontinuing the extended no share-of-cost Medi-Cal.

If the forms are returned by the 20th day, the beneficiary's eligibility for Medi-Cal only should be immediately determined. A face to face is optional. If the beneficiary is found ineligible for Medi-Cal only or eligible with a share of cost, the extended no share-of-cost Medi-Cal coverage cannot be discontinued until a ten-day Notice of Action can be sent. If the Medi-Cal-only determination does not adversely impact the family's/person's entitlement to Medi-Cal (determined eligible with no share of cost), a Notice of Action discontinuing the extended Medi-Cal coverage must be sent in sufficient time to reach the beneficiary by the effective day of the discontinuance.

IMPACT ON EMERGENCY ASSISTANCE AND THE NONFEDERAL AFDC PROGRAMS

Emergency Assistance Program (EAP)

Persons who receive aid under EAP only, without subsequent receipt of state-only AFDC-U, are not eligible for continuing Medi-Cal under with the Edwards v. Myers court order (Aid Code 38) or Four Month Continuing (Aid Code 39) because EAP is not an AFDC program.

Nonfederal AFDC Program

Adults who are in state-only AFDC-U cases because they do not meet connection to the labor force requirements are not eligible for cash-based Medi-Cal, nor are they entitled to Medi-Cal under Edwards v. Myers. Adults in other nonfederal AFDC cases who were also entitled to Medi-Cal (see Article 5D) are entitled to extended eligibility under Edwards v. Myers. Children in nonfederal AFDC cases, including state-only AFDC-U, are entitled to extended eligibility under Edwards v. Myers.

Discontinuance From AFDC Because Deprivation No Longer Exists

When deprivation ends (e.g., an absent parent returns to the home) and the medically indigent adult persons are not eligible for Medi-Cal as medically needy (MN), adequate and timely notice of Medi-Cal discontinuance must be sent. These persons are not entitled to extended no share-of-cost Medi-Cal eligibility.

Alleged Disability

When the county has determined that there is no basis for continuing Medi-Cal eligibility and the beneficiary alleges disability, he/she should be advised of his/her right to apply as a disabled person. (Refer to 4A through 4F.) These persons are not entitled to extended no share-of-cost Medi-Cal pending the disability determination.

PROCESSING

Completion of Forms

The CA 1 may, at the county's discretion, be mailed with the Statement of Facts (MC 210). The CA 1 is not mandatory. If, at the time AFDC is being discontinued, the county has sufficient information to discontinue Medi-Cal eligibility also but fails to do so, there is no need to send the MC 210/CA 1. However, the family is entitled to extended no share-of-cost Medi-Cal coverage until a ten-day notice can be issued advising the family of their Medi-Cal ineligibility.

Verification

As Edwards v. Myers continuing eligibles (Aid Code 38) are treated as continuing cases rather than new applications, a reasonable amount of time should be given in which to submit verification and other necessary information. The 60-day requirement does not apply. Medi-Cal eligibility under the MN or medically indigent (MI) program can be granted prior to receipt of all necessary verification if the county department has sufficient information to make the MN/MI determination. A face-to-face interview is not mandatory for Edwards v. Myers cases.

County of Responsibility

Should a beneficiary move to a new county during the month of Edwards v. Myers eligibility, the county in which the beneficiary was receiving Aid Code 38 eligibility is responsible for evaluating ongoing Medi-Cal eligibility and transferring the case to the new county in accordance with Title 22, California Administrative Code (CAC), Section 50136.

Medi-Cal Family Budget Unit

When a family is on Edwards v. Myers extended Medi-Cal coverage (Aid Code 38) and other family members apply for Medi-Cal only (i.e., an absent parent returns to the home), the income and needs of the Aid Code 38 eligibles must be included in determining the eligibility of other family members. If the other family members are determined to have a share of cost, only those family members may apply their medical expenses toward meeting the share of cost. The Aid Code 38 family members are not to be listed on the Record of Health Care Costs form, as they have received full complement Medi-Cal cards with no share of cost.

NOTE: While the provisions of the Edwards v. Myers court order specifically apply only to AFDC discontinuances and the expiration of Four Month Continuing, Title 22, CAC, Section 50183, specifies that a person or family whose Medi-Cal eligibility has been discontinued under any program other than Supplemental Security Income/State Supplementary Payment shall be evaluated by the county department to determine if Medi-Cal eligibility exists under any other program. This evaluation, which is not to be considered extended eligibility under Edwards v. Myers (Aid Code 38), includes persons in Nine Month Continuing, individuals who are no longer linked, etc.

4P — CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM

The Medi-Cal eligibility worker (EW) has three major CHDP responsibilities:

1. INFORMING
2. DOCUMENTATION OF INFORMING
3. REFERRALS

The following procedures assist all clients in learning about the CHDP Program and ensure that the program meets all its case management responsibilities to the client:

I. INFORMING

A. In all cases, CHDP informing by the Medi-Cal EW:

1. Is done at intake and annual redeterminations.

2. Is done face to face.

3. Is done in a language understood by the applicant.

4. Is done with persons under 21 years of age, or with those persons who have responsibility for those who are under 21 years of age.

B. The EW must:

1. Give an approved brochure to the applicant. The brochure given must be in a language understandable to the applicant. Approved Cambodian, Chinese, English, Laotian, Portuguese, Samoan, Spanish, Tagalog, and Vietnamese versions of the CHDP brochure are available.

2. Give a verbal explanation of the CHDP Program. All of the following information points are contained in the brochure, and must be included in the verbal explanation:

a. The benefits of regular health checkups.

b. How CHDP services can be obtained.

c. How specific information can be obtained on the location of the nearest providers participating in the program. (CHDP provider lists are available from the local CHDP program.)

d. What is included in a complete health checkup.

e. How often a checkup can be obtained through the CHDP Program.

f. That persons on Medi-Cal under age 21 can receive regular checkups.

g. That if needed, diagnosis and treatment services covered by Medi-Cal will be paid for by Medi-Cal after the share of cost, if any, is met.

h. That assistance with arranging for transportation, scheduling appointments, or referral to other needed services will be provided if a family requests this assistance.

i. That if the eligible person or family does not want the CHDP services right away, the person may request them at a later date as long as the person remains on Medi-Cal.

j. That the beneficiary may choose to receive the CHDP services from the provider of his/her choice.

k. That if a provider does not offer the full range of CHDP services, the beneficiary can receive those services not provided if the person requests them of the agency.

l. That the CHDP services are available at no cost after the share of cost, if any, is met to the eligible person's family. The services are paid for with a proof of eligibility (POE) label from a Medi-Cal card.

C. Special informing circumstances:

1. Informing the Blind and Illiterate — When a person is blind or illiterate, B.1 and 2 above still must be done. However, special care needs to be taken with the CHDP explanation to ensure that the person not only understands the program but also knows how to use the brochure as a reference.

2. Informing the Deaf — The program must be explained to a deaf person, preferably in sign language, and a copy of the brochure given to the person.

11. DOCUMENTATION AND REFERRAL RESPONSIBILITIES

A. In all cases the Medi-Cal EW must check the box in the County Use section of the MC 210, directly opposite the CHDP question, to indicate that the CHDP brochure and the CHDP explanation were given.

35. Services (these questions do not affect your eligibility for Medi-Cal)

A. Are you interested in physical examinations for any family member under 21 through the Child Health Disability Prevention Program? Yes ☐ No ☐

B. Are you interested in information on the Family Planning Program? Yes ☐ No ☐

C. Are you interested in talking to a social services worker about other services which may be available to you? Yes ☐ No ☐ If yes, explain:

B. If the client requests CHDP services or additional CHDP information, the "Yes" box of question 35.A must be checked, and then Part A of the CHDP Referral Form (PM 357) must be completed by the Medi-Cal EW. If the client does not wish to participate in CHDP, or does not want additional CHDP information, then the "No" box of question 35.A must be checked. No further CHDP documentation for the person with a "No" response is needed at this time.

Each county welfare department has developed their own CHDP referral procedures with their local CHDP program. Usually, if more CHDP program information, but no services, has been requested by the applicant, the family is referred to a CHDP/Early and Periodic Screening, Diagnosis, and Treatment (CHDP/EPSDT) program specialist to receive the additional information. If CHDP medical and/or dental services have been requested by the applicant, then arrangements must be made according to local procedures. Transportation assistance and scheduling assistance must be offered and documented as directed if a client asks for CHDP medical and/or dental services. Arrangements will be made according to local county procedures.

If the Medi-Cal EW is responsible for arranging for scheduling and/or transportation, those arrangements must be written down for use by the client. If no other means is available, the brochure which is given to the client is a good place to write down these arrangements. When the agreed upon documentation and referral responsibilities have been completed by the Medi-Cal EW, and eligibility for Medi-Cal has been determined, Copy 1 and Copy 2 of the CHDP Referral Form are sent to the local EPSDT Unit/CHDP program, and Copy 3 is placed in the Beneficiary's Case Record File.

CHDP REFERRAL FORM

All Medi-Cal Eligible Persons Under 21 Years of Age Can Receive a Health and Dental Check-Up
Client. Fill In Unshaded Area Only
PART A: COMPLETE FOR ALL CASES REQUESTING SERVICES OR ADDITIONAL INFORMATION

1. Client Name (Last, First, Middle)	2. Co. Code	3. Aid Code	4. Case Number

5. ☐ Requested Additional Information, But No Services

REQUESTED MEDICAL SERVICES (Health Assessment)

6. Screen	7. Transportation	8. Scheduling
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ No		

REQUESTED DENTAL SERVICES

9. Services	10. Transportation	11. Scheduling
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ No		

12. ☐ New Application 13. ☐ Redetermination 14. ☐ Self-Referral
15. ☐ AFDC 16. ☐ AFDC Foster Care 17. ☐ Medi-Cal Only 18. ☐ Share of Cost

19. Primary Language, If Other Than English _____ 20. Other Circumstances _____

	Person No.	Client Name (Last, First, Middle)	Birthdate Month	Day	Year	Age	
21		Parent or Caretaker Name					If YES, Give Name of Plan
22		Other Parent in Home					If YES, Give Name of Plan
23		Child's Name					If YES, Give Name of Plan
24		Child's Name					If YES, Give Name of Plan
25		Child's Name					If YES, Give Name of Plan
26		Child's Name					If YES, Give Name of Plan
27		Child's Name					If YES, Give Name of Plan
28		Other Person in Home					If YES, Give Name of Plan
29	Residence Address			Zip Code			30. Home Phone
		CA					
31	Mailing Address			Zip Code			32. Message Phone
		CA					
33	Parent or Caretaker's Employer (Optional)		34. Parent or Caretaker's Business (Optional)				

This information is required to meet Federal reporting requirements (Federal Register CFR 42, Part 441) and to inform you of services available. The county is required by law to keep this information confidential except as provided in state or federal law or regulations. Further information is available at your local welfare or CHDP office.

COMMENTS:

Worker Signature	36. Worker Number	37. Worker Phone	38. Date Eligibility Determined

Copy 1 - County CHDP, Copy 2 - County CHDP, Copy 3 - Client Case Record (Welfare Department)

CHDP REFERRAL AND CASE MANAGEMENT FORM

Discontinued Forms
PM 287 (10/81)

Case Name

PART B: Follow-Up re Health Assessment and/or Dental Services

Contact Attempt With Responsible Person.

Type of Contact	Date	Details	Who Contacted	Date	Details	Who Contacted
☐ Face-to-Face						
☐ Telephone						
☐ Mail						

FINAL RESULT
Contact Made
No Contact Made

COMMENTS:

Clinic Name		Type T	Type S	Assistance Given	Date	Provider Name and Phone Number	Appt. Date	Appt. Kept Yes	Appt. Kept No	Payment Do Not Reimburse Yes	Payment Do Not Reimburse No	Source of Info.	Does PM 160 Required
	a												
	b												
	a												
	b												
	a												
	b												
	a												
	b												

(If More Space is Needed, Attach Additional Sheets)

COMMENTS:

WORKER SIGNATURE: Date:

PART C: Follow-up re Diagnosis and Treatment

Contact Attempt With Responsible Person

Type of Contact	Date	Details	Who Contacted	Date	Details	Who Contacted
☐ Face-to-Face						
☐ Telephone						
☐ Mail						

Final Results
☐ Contact Made
☐ No Contact Made

Clinic Name	Type of Condition	Response to Offer Yes	Response to Offer Refusal	Assistance Given	Date	Provider Name and Phone Number	Appt. Date	Appt. Kept Yes	Appt. Kept No	Source Of Info.

COMMENTS:

HEALTH PROFESSIONAL'S SIGNATURE

4Q — PROCEDURES FOR LONG-TERM CARE (LTC) ADMISSIONS AND DISCHARGES FOR SSI/SSP AND MEDI-CAL RECIPIENTS

I. BACKGROUND INFORMATION

The Medi-Cal Long-Term Care Facility Admission and Discharge Notification Form, MC 171 (revised in May 1980), was developed as a means to notify the Social Security Administration (SSA) and the counties on a more timely basis of Supplemental Security Income/State Supplementary Payment (SSI/SSP) and Medi-Cal recipients who enter or leave an LTC facility. The objective is to reduce the number and dollar amount of overpayments that may occur because of delays in reporting the recipient's change in status.

The MC 171 is intended for statewide use, and is to be used when SSI/SSP or medically needy/medically indigent (MN/MI) recipients enter or leave LTC. The form is to be completed by the recipient, representative payee, or other person acting on behalf of the recipient, with the assistance of the facility staff as needed. The LTC facilities are to send the MC 171 to the appropriate SSA district office and to the appropriate county welfare departments.

A second form, the Long-Term Care Facility Information for Public Assistance or Medi-Cal Recipients (MC 171A), was developed for use by the LTC facilities to advise SSI/SSP and Medi-Cal-only recipients of the need to complete the MC 171 and to inform SSA and county departments of their change in status. Since the MC 171A is for information only, no action is required by the counties as a result of this form.

These forms may be ordered from Computer Sciences Corporation by the facilities. Copies of both forms are included in the forms section of the Eligibility Manual.

II. ADMISSIONS PROCEDURES

A. General Instructions

As soon as an SSI/SSP or MN/MI recipient is admitted to an LTC facility, the MC 171 and MC 171A is given to the recipient by the facility. The MC 171 form will be completed by the recipient or a representative payee and the facility; it should be signed by the recipient if possible. The original of the MC 171 is sent to the local Social Security office, a copy is sent to the local county welfare department, and the facility should retain a copy for their records.

Signing of the form by the recipient is not mandatory, but will expedite the processing of the case by the Social Security office. The recipient's signature on the form verifies that there is a change of circumstance (and possibly status), and allows the local Social Security office to take immediate action. If a signature cannot be obtained, the reason will be documented by the facility representative in the designated space (i.e., comatose beneficiary). Documentation is important. If no reason is given, an SSA representative must schedule an appointment with the recipient to document the circumstances prior to taking redetermination action.

B. SSA Responsibilities

SSI/SSP Recipients

Upon receipt of the MC 171, the SSA grant reduction and termination process is initiated since a properly completed MC 171 (signed by the recipient) will serve as a first-party report.

A Notice of Proposed Action (SSA 8155A) is prepared and sent to the recipient immediately upon receipt of a properly completed MC 171. After the Notice of Proposed Action is issued, the district office may ask the recipient to waive his or her right to a timely notice so that action can be taken immediately. If the waiver is not obtained, the district office will take the appropriate action effective no later than 35 days (30 days plus 5 days mailing time) after issuance of the Notice of Proposed Action, unless the recipient asks for a reconsideration (i.e., fair hearing).

SSA will determine whether or not SSI/SSP payments will be terminated and the effective date of the termination. If terminated, an SSA "Notice of Change" is sent to the recipient. Until such notice is received, the recipient will continue to receive a monthly SSI/SSP gold check and a monthly SSI/SSP based Medi-Cal card, which is to be used by the facility for billing Medi-Cal. All questions concerning a person's SSI/SSP eligibility should be referred to the local SSA offices.

C. Department of Health Services Responsibility (Register of SSI/LTC Beneficiaries)

1. Initiate and send to the SSI/SSP beneficiary a "Discontinuance of SSI/SSP Medi-Cal Persons in LTC" Notice of Action.

2. Initiate and send to the counties a monthly register of persons discontinued from SSI/SSP Medi-Cal due to LTC status.

D. County Welfare Department Responsibilities

1. Use the Department of Health Services register of persons discontinued from SSI/SSP Medi-Cal due to LTC status to identify persons needing LTC Medi-Cal.

2. Contact persons in the LTC facility within 30 days of admittance notification and assist them with completion of a Medi-Cal-only application, in accordance with Title 22, California Administrative Code, Section 50147.

NOTE: In some cases a recipient may continue to receive an SSI/SSP based Medi-Cal card after the effective date of SSI/SSP discontinuance.

3. MN/MI Recipients

Upon receipt of an MC 171 from the LTC facility for an MN or MI recipient, the county shall take appropriate action.

4. Important Information for Medi-Cal Nursing Home Patients

The Medi-Cal form (MC Information Notice 004 (7/86)) contains information for Medi-Cal nursing home patients regarding the Medi-Cal coverage of various types of medical equipment, supplies, and services that they may need.

This form is to be provided to Medi-Cal LTC beneficiaries at the time of initial application for Medi-Cal, at the time of initial entrance to an LTC facility, and at least once a year thereafter and may be provided at any county welfare department contact with such beneficiaries (e.g., redetermination, change in share of cost, new application).

III. DISCHARGE PROCEDURES

When an SSI/SSP or MN/MI recipient leaves the facility, Part III of the MC 171 is completed by the facility, and the original and one copy are sent to the Medi-Cal field office by the facility. The Medi-Cal field office will retain the original and send the copy to the appropriate county welfare department. The county shall initiate a redetermination of the case upon the receipt of an MC 171 for a current MN or MI recipient.

When a Medi-Cal beneficiary who is a possible SSI/SSP beneficiary leaves the LTC facility, an application for SSI/SSP may be filed by the beneficiary at the local Social Security district office.

4S – Instructions for the MC 210 and Supplements to the MC 210

A. BACKGROUND

Welfare and Institutions Code Section 14011.15 mandates a simplified Medi-Cal application package and mail-in process for adults and families. The intent of this law is to provide easy access for this population to apply for and receive Medi-Cal benefits as quickly as possible.

The purpose of the Procedures section is to provide counties with policies and instructions, which are effective no later than December 1, 2001. These policies and procedures apply to all Medi-Cal applications.

As of July 1, 2000, state law prohibits counties from making a mandatory face-to-face interview a routine application requirement. The law also requires the development and implementation of a simplified application form and procedure, and simplifies the verification requirements for earned income and pregnancy.

B. APPLICATION FORM

1. The MC 210 (Rev. 9/01) (Medi-Cal Mail-In Application) will replace the current MC 210 Statement of Facts (SOF). Counties are instructed to begin using the new MC 210 as soon as administratively possible but no later than December 1st. At that time, counties must discard their existing stock of old MC 210 SOF. However, if an old MC 210 SOF is received, the county must process the application and shall not require the applicant to fill out a new MC 210.

2. Counties shall accept either the MC 210 or the MC 321 HFP application as an application for Medi-Cal. An MC 321 received directly by the County shall be processed the same as and MC 210 application.

3. A signed MC 210 or MC 321 Healthy Families Program (HFP) is an acceptable replacement for the current Statewide Automated Welfare Systems (SAWS) 1 and now constitutes an official request for Medi-Cal benefits. The SAWS 1 can still be used but is not a mandatory form, unless otherwise specified.

4. The HFP will accept the MC 210 application as an application for Healthy Families benefits, when the counties determine a family has a share of cost (SOC) or is otherwise qualified and requests Healthy Families coverage.

5. The SAWS 2A may be used as a Medi-Cal SOF when the applicant has previously completed the form as a request for cash aid. It can be used in lieu of the MC 210 when the applicant has been found ineligible to receive cash aid (i.e. California Work Opportunity and Responsibility to Kids [CalWORKs] denial). If a SAWS 2A is used as a SOF, a signed, dated SAWS 1 must also be filed in the Medi-Cal case

C. APPLICATION AVAILABILITY

1. Anyone may request an application to be mailed to them by calling their local county welfare department (CWD) office.

2. Applications may be picked up from the local CWD office.

3. In the near future the MC 210 application may be downloaded from the Department website (www.dhs.ca.gov) and either mailed or delivered to the local CWD office.

4. Applications may also be picked up from other sources (i.e. outstations, outreach projects, etc.

REMINDER: Should the applicant request CalWORKs or Food Stamps assistance, they must be told to apply in person. The SAWS 1 for the mail-in process only serves to protect the date of application for Medi-Cal only benefits and retroactive Medi-Cal months.

NOTE: The MC 210 (Rev. 8/01) will be available in eleven threshold languages. Currently, the languages are English, Spanish, Vietnamese, Cambodian, Hmong, American, Cantonese, Korean Russian, Lao, and Farsi. Counties need to ensure that they have the capability to process an application in any of the aforementioned languages.

D. WHAT MUST BE SENT WITH THE APPLICATION

If the application is requested directly from the county, the following information must be provided to the applicant.

1. The "New Mail-In Application and Instructions" (MC 210 [Rev. 8/01]).
2. Postage paid pre-addressed return envelope.
3. Child Health Disability Prevention (CHDP) Informational Publication.
4. MC 007 "Medi-Cal General Property Limitations."
5. Medi-Cal Brochure (Pub. 68).
6. MC 219 "Important Information For Persons Requesting Medi-Cal."
7. MC 13 (Statement of Citizenship) for each family member applying Medi-Cal benefits.
8. MC 003 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Brochure.
9. DHS 7077 "NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY."
10. DHS 7077-A "Notice Regarding Transfer Of A Home For Both A Married And An Unmarried Applicant/Beneficiary."

E. SUBMITTING THE APPLICATION FORM

1. Counties must not require a face-to-face interview. If counties come in contact with an applicant or Authorized Representative (AR), the county must explain his or her option to apply by mail or to go to the CWD.

2. The application can be mailed to the CWD. The CWD will stamp the date the application is received and forward the application for an eligibility determination. In the event that a county, which is not the county of residence receives an application, the county receiving the application must forward it to the correct county as soon as administratively possible (See Article 3 Medi-Cal Eligibility Procedural Manual . The receiving county shall honor the date stamp from the sending county.

3. The applicant or AR may walk the application into the local CWD or outstation site and request to leave it. The applicant may request an appointment to see an eligibility staff member in person, by phone, or through the mail. Counties must accommodate all requests by applicants for a face-to-face interview.

Exception to face-to-face elimination:

a. All applications for minor consent services must be made in person at the county Medi-Cal office or outstation sites,

b. Good cause,

c. Suspicion of fraud, or

d. To complete the application process when:

1. Questionable information appears on the application form or verifications;

2. Individual/family has no visible means of support such as in-kind income or means support not reported for the individual/family;

3. There are obvious discrepancies between information reported on an application and Income Eligibility and Verification System (IEVS) on property or income; or

4. Self-employed individual whose income and expenses do not match reported income and questionable information could not be resolved with follow-up telephone contact and/or mail.

Reminder: When the county requests a face-to-face interview for any reason, eligibility staff must document the reason(s) in the case record for post-eligibility review and audit.

F. DATE OF APPLICATION

1. If an application is mailed directly to the county, the Date of Application is the date the county receives the form.

2. If the application is picked up from the county office and the applicant has contact with a county employee, the county employee must offer the individual the SAWS 1 to complete at that time to protect the Date of Application and retroactive months.

3. If anyone calls the county office and requests that an application be mailed to them, the county employee taking the call is responsible for completing the SAWS 1 on behalf of the applicant to protect the Date of Application and retroactive months. A copy of the SAWS 1 shall be forwarded with the application at the time of mailing. It is not required that the applicant sign and return the SAWS 1.

4. The Date of Application will always be the earlier of the two dates if both an application and SAWS 1 are received separately.

G. COUNTY ACTION UPON RECEIPT OF MEDI-CAL APPLICATION

1. The county will mail the applicant a letter within five working days of the county receipt of the application, advising the applicant or AR that their application has been received and whom they can contact for information and questions. This letter will include a contact name, telephone number, and the address of the appropriate CWD office.

2. The eligibility worker shall review the application for completeness. If additional information is needed for an accurate eligibility determination, the eligibility worker shall use information/verification contained in open public assistance (PA) case records of the individual and their immediate family members and/or case records that have been closed within the last 45 days. If the necessary information cannot be obtained through available PA case records, the eligibility worker shall request this information following current policy. Current guidelines for application processing, property and income verifications have not changed.

REMINDER: An initial Medi-Cal-Only eligibility determination must not be delayed beyond 45 days, pending information/verification from a current or prior PA case record. Counties are reminded that property limits must be met sometime during the month of application and will be valid for 12 months or until there is a reported or discovered change in resources that requires an eligibility review.

NOTE: If the application received was not requested directly from the county, the county must ensure that the information listed in Section D is provided to the applicant.

H. RETROACTIVE MEDI-CAL

Anyone requesting retroactive Medi-Cal using the MC 210 or MC 321 HFP must also complete the MC 210 A (Supplement to Statement of Facts for Retroactive Coverage/Restoration). Counties must send the MC 210 A when retroactive Medi-Cal is requested.

I. COUNTY ACTION FOR INFORMATION ON THE HFP

1. If the applicant or AR indicates on the application that the CWD can send the MC 210 (if they potentially qualify) to the HFP, the CWD must forward the MC 210 to the HFP. Counties must not require a separate application.

2. The MC 210 application must be accompanied by the Med-Cal/Healthy Families Mail-In Application transmittal (MC 334) and a SOC or Federal Poverty Level program denial Notice of Action (NOA). The NOA shall:

   - Not be older than 60 days,
   - Identify those family members determined to have a SOC, or denied due to income above the federal poverty level,
   - Indicate the total number of persons in the Medi-Cal family budget unit,
   - Clearly and separately identify all income sources and deductions, and
   - Include other relevant documentation (e.g. birth certificates, Immigration and Naturalization Service documents) if available.

If the CWD system is unable to create a detailed NOA, the CWD may send a copy of the budget (MC 176 or an automated budget) with the SOC or denial NOA Do not send Sneede allocation budgets.

The Single Point of Entry is currently unable to process Medi-Cal applications initiated by other public assistance program's statement of facts forms, such as the DFA 285 (Food Stamps) and the SAWS 2A (CalWORKs). In these situations, counties shall inform applicants or ARs of the availability of the HFP, including a telephone number to call for information, when the applicant(s) do not qualify for no-cost Medi-Cal

J. COUNTY FOLLOW-UP FOR FURTHER CASE ACTION

1. If an applicant or AR requests information and explanation of any program (e.g. CHDP, Screening, EPSDT, In-Home Support Services/Personal Care Services, etc.) or referral to any services, eligibility staff must ensure the request is met and action taken is annotated in the case record.

2. Eligibility requirements for the Medi-Cal program have not changed. Each case record must contain adequate information with supportive documentation to verify an individual's eligibility. Verification of identity, residence, alien status, income and/or property remains a part of the eligibility determination process. Applicants must provide their Social Security number(s) (SSN) as appropriate, but are not required to submit copies of their Social Security cards, unless the county is unable to verify the number provided.

K. MC 219

1. The MC 219 (11/93) form discusses the Rights and Responsibilities of an applicant/beneficiary as well as the "Citizenship/Immigration Status Information." This set of forms is now separate from the MC 210.

2. The MC 219 must be sent to the applicant. The MC 219 does not have to be returned by the applicant. The county worker shall document in the case record that the information was provided.

L. MC 210 SUPPLEMENTAL FORMS

The following are instructions to be used in determining whether a supplemental form should be given to an applicant or AR. County personnel will notice that the supplemental forms to the MC 210 are numbered MC 210 S-C, S-E, S-I, S-P, and S-W. The 'S' represents Supplement: The -C. -E. -I. etc., refers to the title of the form as detailed below. Not all of the supplemental forms listed below are mandated for use by the Department. The descriptions below will explain whether a form is mandatory. If the form is not mandatory, counties may substitute one of their own, once it has been approved by the Department.

MC 210 S-C ADDITIONAL CHILDREN

The MC 210 S-C is given to a client if he/she has indicated on the MC 210 that the family has more than three children. The information for each child should be filled in completely. If the client is requesting restricted benefits, the shaded portion for SSN should NOT be completed. This form is mandatory.

MC 210 S.E STUDENT EDUCATIONAL EXPENSES

This form is given to the client if the MC 210 indicates any family member is attending college or a similar educational institution. Information is requested on whether the client is receiving a grant, scholarship, or loan, and any student expenses or transportation costs. This form is not mandatory.

MC 210 S.I INCOME IN-KIND AND HOUSING VERIFICATION

The Income In-Kind and Housing Verification form has a two-fold purpose: First, the form should be used if the client has in-kind income, and does not agree with the chart value given by the eligibility worker. If the client does not agree, he or she may use this form as signed verification from the individual providing/sharing housing, utilities, food, or clothing that a different amount is correct. Second, the client is residing with a relative, is paying that relative rent, and has no other verification of residency. If a client is using this form solely for the purpose of verifying in-kind income, it is not a mandatory form. However, if the client wishes to use this form as verification of residency, it is mandatory. Counties

may not use any other form as verification of residency. The form may also be used as a rent receipt from a relative.

MC 210 S-P PROPERTY

This form will be used by a client if certain property questions on the MC 210 require additional information. For example, if a client has answered yes to owning, or having title to, property in another State on the MC 210, this supplemental form must be completed. The MC 210 S-P, will ask for the expenses on that property, the address of the property, value, etc. This form is mandatory when the client has answered yes to the related questions on the application.

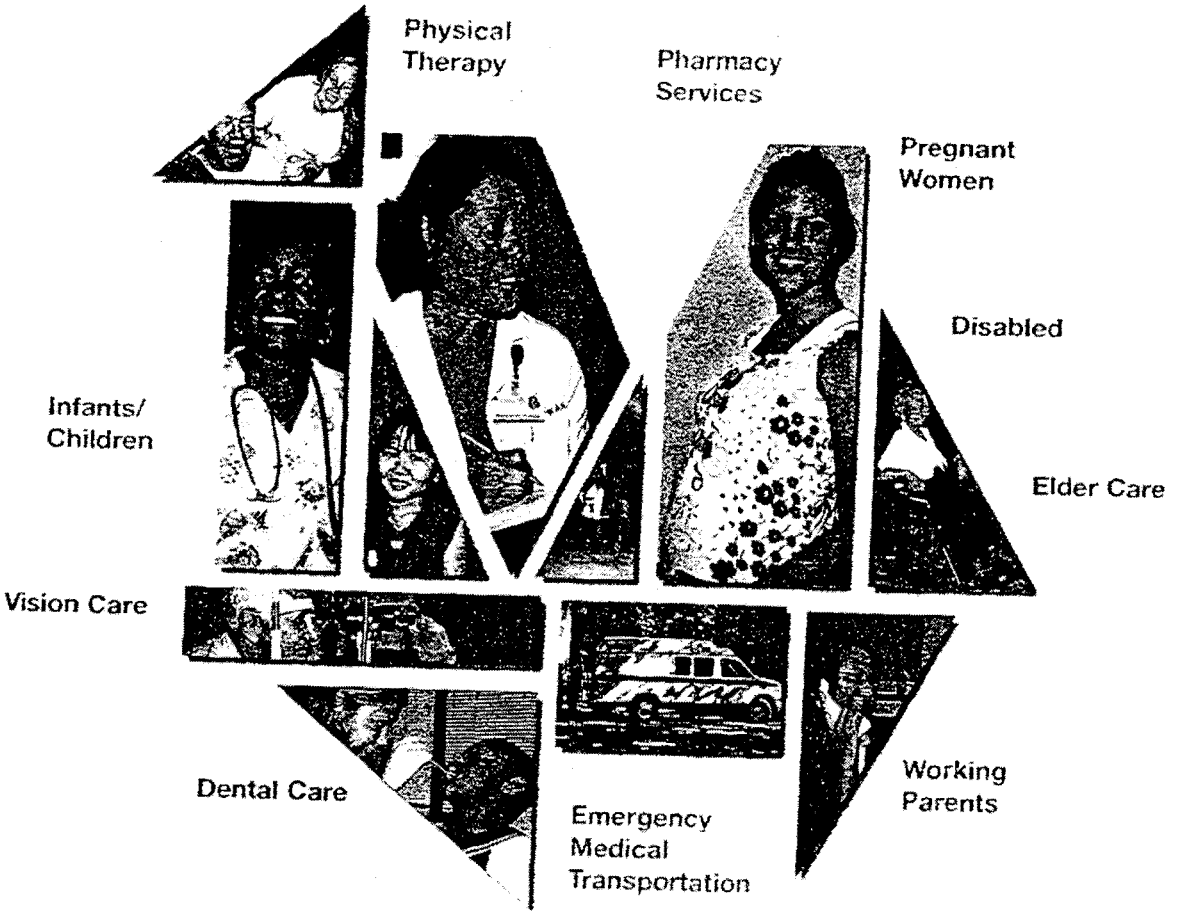
MC 210 S-W WORK HISTORY (EARNING AND EXPENSES)

This form is used if the client is applying as an unemployed parent or if certain income questions on the MC 210 require additional information, such as expenses against income. This form is not considered mandatory.

HEALTH CARE COVERAGE
FOR PEOPLE WITH LIMITED INCOME OR RESOURCES

MEDI-CAL

NEW MAIL-IN APPLICATION AND INSTRUCTIONS



For ***FREE*** help to apply for Medi-Cal,
contact your local welfare office.

What is Medi-Cal?

- Health care coverage for qualifying persons who live in California, who have income and resources below established limits

Who can get Medi-Cal?

- Persons 65 or older
- Persons who are under 21 years of age
- Certain adults between 21 and 65 years of age, if they have minor children living with them
- Persons who are blind or disabled
- Pregnant women
- Persons receiving nursing home care
- Certain Refugees, Asylees, Cuban/Haitian Entrants

Do I have to be a U.S. citizen to get Medi-Cal?

- No, documented and undocumented aliens may be eligible for Medi-Cal. Some persons may receive pregnancy related and emergency services only; others are eligible for full Medi-Cal benefits depending on their alien status

When Medi-Cal says "a minor child," what does it mean?

- A child married or unmarried under 21 years of age living in your home or away at school

What do I do to get Medi-Cal coverage?

- Complete and send in the enclosed application
- Send copies of any required documentation (See instructions)

How can my family and I qualify for Medi-Cal coverage?

If you are in one of the groups listed in "Who can get Medi-Cal?" above:

- We look at your income and subtract some expenses you pay to decide your family's countable income for Medi-Cal
- We look at things you and your family own (bank accounts, vehicles, etc.) to see if you meet the resource limit. **Please Note:** Not all the things you or your family own are counted; your local welfare office can give you more information

If I do not fall into one of the covered groups, how can I get coverage?

- Contact your local welfare office for information about medical services in your county

MC 210 08/01
INSTRUCTIONS

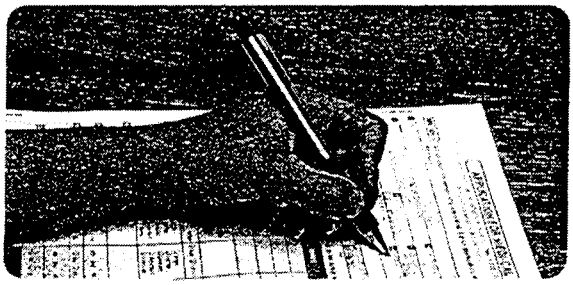
When Applying For Medi-Cal Health Coverage What Should I Do If...

I have an immediate need for health care services, such as severe illness or pregnancy.

- Take this application directly to the nearest welfare office to start the application process.

I have the application, but need help.

- Read Instructions carefully.
- Contact your local welfare office for help.
- Ask a friend or relative to help you.



My spouse or I are entering a nursing home and applying for Medi-Cal.

- Immediately contact your local welfare office for a copy of the notice regarding standards for Medi-Cal eligibility form (DHS 7077). This form will explain certain exempt resources, certain protections against spousal impoverishment, and certain circumstances under which an interest in a home may be transferred without affecting Medi-Cal eligibility.

I filled out the application and want to mail it.

- Complete the application and mail it, using the postage-paid envelope provided with the application. Include requested documentation. (See instructions)

I'm homeless or do not have a mailing address.

DO NOT MAIL THIS APPLICATION.

- Go to the nearest local welfare office to turn in this application.

I'm a minor/teenager and want confidential Minor Consent Services, for family planning, pregnancy related care, mental health, drug and alcohol abuse treatment/ counseling, sexually transmitted diseases (STD) or sexual assault.

- To maintain confidentiality, you must take this application to the local welfare office or eligibility worker site.

DO NOT MAIL IT.

I want to ask for Medi-Cal in person. I do not want to mail the application.

- Contact your local welfare office and ask for an interview to apply in person.

Remember, whether you take your application to the local welfare office or you mail it, you should *not pay* anyone to help you with this application.

www.dhs.ca.gov

For *FREE* help to apply for Medi-Cal, contact your local welfare office.

MC 210 08/01
INSTRUCTIONS

INSTRUCTIONS ➡

How to fill out the application

- Tear out the application
- Read the instructions completely
- Fill out as much of the application as you can
- Include requested documentation (See instructions)
- If help is needed contact the local welfare office
- Do not delay in sending in your application

Whose information should you put on this application?

- If you are an adult not living with a spouse, and you have no children, enter your own information.
- If you are legally married and living together, enter your and your spouse's information.
- If you are legally married but one or both of you are living in a nursing home or board and care facility, enter your and your spouse's information.
- If your children are under 21 years of age and living with you and their other parent, enter your own information, your children's and the other parent's.
- If you are under 21 years of age and not living with your parents, enter your own information.
- If you are an unmarried minor under 21 years of age living with your parent(s) and asking for Minor Consent confidential services, enter your own information.

What will happen after I send in my application?

- The local welfare office will notify you within 10 working days that they received your application. They will give you the name of someone you can contact for more information about your application.
- You will receive a packet from the county with additional program information.
- You may receive a request for additional information that the county will need in order to determine your eligibility.
- In most instances the local welfare office will determine your eligibility within 45 days and notify you in writing of that decision. An eligibility determination based on disability may take up to 90 days.
- If you are determined eligible, depending on what county you live in, you may be able to choose a health plan by completing a separate enrollment form.
- If you do not qualify for no-cost Medi-Cal and you wish to apply for the Healthy Families program, the local welfare office will forward this application to that program.

MC 210 08/01
INSTRUCTIONS

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

APPLICATION FOR MEDI-CAL

To complete this form, use the instructions. Print clearly. Use black or blue ink only.

SECTION 1 **Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.**

1 LAST NAME	FIRST NAME		MIDDLE INITIAL
2 HOME ADDRESS (NUMBER AND STREET) DO NOT LIST A P.O. BOX UNLESS HOMELESS		3 APARTMENT NUMBER	4 HOME PHONE # ( )
5 CITY/STATE	6 COUNTY	7 ZIP CODE	8 WORK PHONE # ( )
9 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX		10 APARTMENT NUMBER	11 MESSAGE PHONE # ( )
12 CITY			13 ZIP CODE
14A WHAT LANGUAGE/DIALECT DO YOU SPEAK BEST?		14B WHAT LANGUAGE DO YOU READ BEST?	

SECTION 2 **Tell us about the person listed in Section 1, his or her family and the children they care for, even if they don't want coverage.**

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
15 Name: Last					
First					
Middle					
16 Relationship to person in Section 1.					
17 If address where living is not the same as listed in Section 1, put address where living:					
18 Gender:	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
19 Marital Status:	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
20 Name of spouse(s) of married minors in the home.					
21 Date of Birth:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
22 Pregnant:	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Due Date:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
23 Has a physical, mental or emotional disability?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Disability expected to last:	❑ 30 Days or More ❑ 12 Months or More	❑ 30 Days or More ❑ 12 Months or More	❑ 30 Days or More ❑ 12 Months or More	❑ 30 Days or More ❑ 12 Months or More	❑ 30 Days or More ❑ 12 Months or More

MC 210 05/01
APPLICATION

A1

CONTINUED ➡

SECTION 2 Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
24 Has any one ever received **cash aid, SSI, Food Stamps** or **Medi-Cal**?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If "Yes," under what name?					
25 Medi-Cal benefits BIC card number, if you have it:					
26 Wants medical benefits?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
27 Do you own or are you buying a home outside California?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 3 **Answer for *all* children in Section 2.**

Child 1	Child 2	Child 3	Unborn
28 Mother's Name:	Mother's Name:	Mother's Name:	Mother's Name:
Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Mother: ☐ Employed ☐ Disabled ☐ Unemployed
29 Father's Name:	Father's Name:	Father's Name:	Father's Name:
Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent	Is Father: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Deceased ☐ Absent

SECTION 4 **List *all* income/money received by persons listed in Section 2.**

30 NAME OF PERSON RECEIVING INCOME/MONEY	31 SOURCE OF INCOME/ MONEY RECEIVED (Employment, social security)	32 HOW MUCH INCOME/MONEY IS RECEIVED	33 HOW OFTEN INCOME/ MONEY RECEIVED (Monthly, bimonthly, weekly, biweekly, daily)

SECTION 5 **Give information about the listed expenses/cost paid by *all* persons listed in Section 2.**

TYPE OF PAYMENT YOUR FAMILY MAKES	34 NAME OF PERSON WHO PAYS	35 MONTHLY AMOUNT PAID
Child Support		
Alimony		
Other Health Insurance Premium		
Medicare Premium		

36 CHILD CARE OR DEPENDENT CARE (List child's or dependent's name)	37 AGE	38 NAME OF PERSON WHO PAYS	39 MONTHLY AMOUNT PAID
1.			
2.			
3.			
4.			

MC 219 08/01
APPLICATION

(A2)

SECTION 6 *Skip this Section if you are **only** applying for children under 19 and/or pregnant women (pregnancy related services only).*

Otherwise answer for *all* persons listed in Section 2.

40	Does anyone have cash or uncashed checks? If "Yes," list amount here _____ (See instructions)	☐ Yes ☐ No
41	Does anyone have a checking, savings account, or life insurance? (See instructions)	☐ Yes ☐ No
42	Is there one car or more in the household? (See instructions)	☐ Yes ☐ No
43	Does anyone have a court ordered settlement or judgement? (See instructions)	☐ Yes ☐ No
44	Does anyone have Long-Term Care insurance? (See instructions)	☐ Yes ☐ No
45	Does anyone own any items such as stocks, bonds, retirement funds, trusts, real estate, motor vehicles for a business, business accounts, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), oil or mineral rights? (See instructions)	☐ Yes ☐ No
46	Has anyone listed on this form transferred, sold, traded or given away any items such as those listed above in the last 30 months? (See instructions)	☐ Yes ☐ No
47	Have any items listed in this section been spent or used as security for medical costs? (See instructions)	☐ Yes ☐ No

SECTION 7 **Answer *only* for persons who want Medi-Cal.**

		Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
48	Social Security #:					
		You may be able to receive Medi-Cal even if you do not have a Social Security Number.				
49	Place of Birth: *State or Country*					
50	U.S. Citizen or National? If "No," write in date of entry into U.S.	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR	☐ Yes ☐ No / / MO DAY YR
51	Living in a Long-Term Care or Board and Care Facility?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If "Yes," name of facility:					
	Do you intend to return home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Do you intend to return home within six months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
52	Has health/dental or vision coverage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
53	Had medical expenses within the 3 months before the month you applied and want Medi-Cal for those expenses.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
54	Lawsuit pending due to accident or injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MC 210 (8/97) APPLICATION

A3

CONTINUED ➥

SECTION 7 Continued	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
55 Current or past U.S. Military Service for adults, spouse or child's parents?	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent	☐ Yes ☐ No ☐ Self ☐ Spouse ☐ Parent
56 Ethnicity (race): (optional)					
57 In school full time?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
58 Living away from home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 8 Information Release (Optional).

59 If family member cannot get no-cost Medi-Cal but may be able to get low-cost health care coverage, can the local welfare office send this form to the Healthy Families Program? ☐ Yes ☐ No

60 I got help from (give name of person) _____ when I filled out this application. I agree that the local welfare office may give them information about the status of this application. ***Applicant please initial*** _____

SECTION 9 Signature and Certification.

61 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, and the documents given are correct and true to the best of my knowledge and belief.

I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

_____
Signature — Date

_____
Witness Signature *(If person signed with a mark)* — Date

_____
Signature of person helping Applicant fill out the form — Telephone Number — Relationship to Applicant — Date

_____
Signature of person acting for Applicant/Beneficiary — Telephone Number — Relationship to Applicant — Date

For information about any of the following programs, check the box(es) below and information will be sent to you. See the Medi-Cal brochure, "Health Care for Families with Children" or visit our website, www.dhs.ca.gov

☐ Personal Care Service Program (PCSP). A program for in-home care.

☐ Access for Infants, and Mothers (AIM). A program to help pregnant women with moderate income obtain health care.

☐ Woman, Infants and Children Nutrition Program (WIC). A nutrition program for pregnant and postpartum women and children under 5.

☐ Family Planning

☐ Child Health and Disability Program (CHDP). Preventive healthcare for children and youth. Do you want your children or youth referred to the CHDP program? ☐ Yes ☐ No

MC 210 08/01
APPLICATION

A4

INSTRUCTIONS

Please read before beginning application.

SECTION 1

Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.

Questions 1-8:
Enter the name, home address and telephone numbers of the person who wants Medi-Cal or the parent/caretaker of the children who want Medi-Cal.

Questions 9-13:
Enter the phone number and mailing address (if different than home address provided in #2) of the person who wants Medi-Cal. This is the address where all information regarding the application and health benefits will be mailed.

Question 14A-B:
Enter the language you speak and/or read best.

Send proof of identity. Only one person (a parent or caretaker) in a family needs to provide an identity document. Send a **photocopy** of one of the following identity items:

- California driver license
- Identification card issued by the Department of Motor Vehicles
- U.S. citizenship or alien status documents (passport).
- School identification card
- Birth certificate
- Marriage record
- Social Security card or document containing a Social Security number.
- Divorce decree
- Work badge, building pass
- Adoption record
- Court order for name change
- Church membership or baptismal confirmation certificate

Identity proof is not needed for

- Persons in an institution
- Children in a family, if identity of one parent has been established
- Children requesting Medi-Cal for Minor Consent services
- The spouse of a person whose identity has been verified

SECTION 2

Tell us about the person listed in Section 1, his or her family and the children they care for, even if they don't want coverage.

If you are applying for more than 5 people, use a separate piece of paper or a photocopy of pages A1, A2, A3 and A4 of the application, to give us information about the additional persons.

Who counts as an adult?

- Persons 21 years of age or older
- Persons under 21 years of age who are not living in the home of their parent or caretaker relative and are not claimed as tax dependents

Who counts as children?

- All natural and adoptive children under 21 living in the home
- All natural and adoptive children between 18 and 21 years of age, away from home and claimed as tax dependents
- All stepchildren under age 21 living in the home

Question 15:
Write the last, first and middle name of each person in the house.

GO TO PAGE 2

SECTION 2 Continued

Question 16:
How is each person related to the person in Section 1. *Example: self, wife, husband, grandparents, friend, daughter, stepchild, nephew, etc.*

Question 17:
Write the complete address, if different from the address in Section 1. *Example: child is in college and living at school.*

Question 18:
Indicate gender of each person.

Question 19:
Indicate the marital status of each person listed.

Question 20:
Write the name of the spouse of any married minors living in the home. Any income of the spouse must be listed in Section 4.

Question 21:
Write month, day and year of birth for each person.

Question 22:
Tell us if this person is pregnant. If "Yes," tell us the due date.

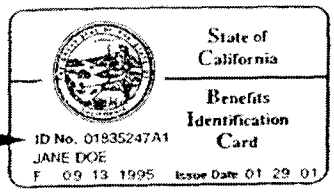
Send proof of pregnancy from a doctor's office or a clinic within 60 days of applying to continue receiving full Medi-Cal benefits. You do not need to send verification if you only want pregnancy related services.

Question 23:
Check "Yes," if person is blind or has a physical or mental illness that is expected to last at least 30 days. If person is unable to work, check "Yes," and check the box that best describes how long the person will be unable to work if declared disabled. This will help us decide if you are eligible for Medi-Cal based on disability.

Question 24:
Tell us if anyone has ever had cash aid, SSI, Food Stamps or Medi-Cal. This will help the local welfare office check for needed information before asking you to give it. If you checked "Yes," tell us the name you received benefits under.

Question 25:
If you have ever received Medi-Cal, tell us your Medi-Cal Benefits Identification Card (BIC) number if you have it.

Your Medi-Cal Benefits Identification Card (BIC) number can be found here.



Question 26:
Check "Yes," if you are asking for medical benefits for this person.

Question 27:
Tell us if you own or are buying a home outside California. Your answer helps us determine your residency.

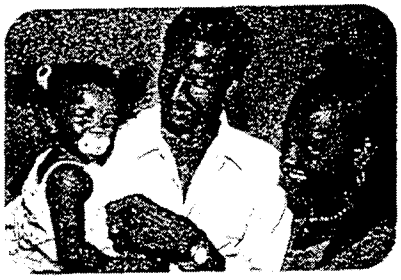
Send proof of California residency. You can use your proof of income as proof of residency. If your income is not from California, send other proof of residence. For example: rent receipts, utility bill or a child's school records.

SECTION 3

Answer for *all* children in Section 2.

Question 28:
Write the name of the natural or adoptive mother of each child. Check the box to tell us if the mother is employed, disabled, unemployed, deceased or absent from the home.

Question 29:
Write the name of the natural or adoptive father of each child. Check the box to tell us if the father is employed, disabled, unemployed, deceased or absent from the home.



GO TO PAGE 3

SECTION 4

List *all* income/money received by persons listed in Section 2.

Questions 30 and 31:

Use a separate line for each person who receives money. If a person receives money from two different places, use two lines.

Example: if the applicant has two jobs, use one line for each job to report her/his earnings.

Question 32:

Write the amount of money you receive each time.

Example: if you get money once a week, write the weekly amounts in the box.

If the money amount changes from time to time, put the average amount you get on a regular basis. We use pay stubs or other documents you give us to figure out the correct monthly income.

If you know your family's income will go up or down in the next few months due to overtime, promotion, raises in pay, expected increases in child support/ alimony, layoffs, furloughs, etc., explain on a separate sheet of paper.

Example: Maria's gross income from her job on this check is $1000 but her regular monthly pay is only $800. Explain on the paper that Maria's paycheck included $200 overtime pay, or a cash bonus and how long the overtime will last or how often she gets bonuses.

Question 33:

How often do you receive this money?

Example: Monthly (once a month); weekly (once-a-week); biweekly (every other week); bimonthly (twice a month); or daily (every day).

Documentation of Income

- **Send proof of income.** Send a copy of the most recent pay stub you have. If a pay stub is not available, get a signed statement from your employer. Gross monthly income and the dates received should be on the statement.

OR

- **A copy of last year's federal income tax return.**

OR

Other proof of income you may need to send:

- If a person is self-employed, send last year's federal income tax return, include Schedule C or F, or the last 3 months' profit and loss statements.
- If a person has income such as disability or retirement, send copies of award letters or bank statements showing the direct deposits.
- If anyone gets child support and/or alimony or spousal support, send copies of the checks received or statements from the District Attorney's Family Support Division for the last month.
- If anyone gets student loans or grants, send in copies of award letters or loan papers.

MC 210 08/01
INSTRUCTIONS

GO TO PAGE 4

SECTION 5

Give information about the listed expenses/costs paid by *all* persons listed in Section 2.

Tell us if you pay court-ordered **child support,** or **alimony,** or have other **health insurance or Medicare** premium costs.

Medi-Cal will pay your medicare premiums and deduct the cost of any other insurance premium from your countable income.

Question 34:
Write the name of the person who pays the cost.

Question 35:
Write in the total amount paid each month.

Question 36:
Write in the costs paid for child care and/or disabled dependent care.

Question 37:
List the age of the child or disabled dependent.

Question 38:
Write the name of the person who pays the cost.

Question 39:
List the total amount paid monthly for each child or disabled dependent.

Send proof of expenses (costs) listed in Section 5. Send in proof of child support or alimony costs. For childcare and dependent care, send receipts or cancelled checks.

SECTION 6

Skip this section if you are only applying for Children under 19 and/or pregnant women applying for pregnancy related services only. Otherwise answer for *all* persons listed in Section 2.

If you have questions or concerns about completing Section 6, leave it blank and contact the local welfare office for help.

The value of the home you are living in is not counted for Medi-Cal.

Question 40:
Tell us the amount of all cash you have on hand and the amount of any checks you have received but not cashed.

Question 41:
If anyone listed has a checking and/or savings account or life insurance policy, please send copies of the following documents:

- Account statements showing current balances in accounts.
- Copies of all life insurance policies.

Question 42:
If you checked "Yes," send us a copy of the vehicle registration(s) or pink slip(s) or estimate(s) of value from a qualified source, such as a dealer or mechanic.

Question 43:
If you check "Yes," send us copies of all court orders, documents and agreements.

Question 44:
If you check "Yes," send us copies of your policies, contracts and purchase agreements. If your policy is certified by the California Partnership for Long-Term Care, give us a copy of your most recent benefit statement.

GO TO PAGE 5

MC 216 08/01
INSTRUCTIONS

Questions 45-47:
If you check "Yes," you may be asked to provide additional information. You may also have to fill out a property supplement form.

SECTION 7

Answer *only* for persons who want Medi-Cal.

Question 48:
A Social Security number for each person applying for full Medi-Cal benefits is required. If you do not have a Social Security number, do not delay sending in this application. You can apply now and give us the number within the next 60 days.

Pregnancy and emergency care services may be available to persons who are unable to get a Social Security number.

For information on how to apply for a Social Security number, call Social Security Administration toll-free, 1-800-772-1213.

Question 49:
Write the place of birth for each person. If born in the United States, write the name of the state. If born outside the U.S., write the name of the country.

Question 50:
Check "Yes" or "No," telling us if the person is a Citizen or U.S. National.

Give immigration information only for people applying for health coverage. Do not give information for people not applying. The State will use this information only for eligibility determination. Information about immigration is private and confidential.

Immigrants who meet all immigration requirements may get **full Medi-Cal benefits.** Undocumented immigrants can get pregnancy related and emergency services.

Send proof of immigration status or an INS receipt showing that you applied to replace a lost document. Many immigrants may get full Medi-Cal even if they do not have a green card or immigration document. Copy both sides and send proof now or within 30 days of application. If you do not send this proof, you may still be eligible for emergency or pregnancy related services.

Do not give immigration information about people who are not asking for Medi-Cal. Information about immigration is private and confidential.

Question 51:
Tell us if the person is in a nursing facility, residential, or board and care facility. If you check "Yes," tell us the name of the facility.

Question 52:
Check box to show if each person has other health insurance coverage.

You can get Medi-Cal and still have other health coverage. Medi-Cal may cover what your other health coverage does not.

GO TO PAGE 6

SECTION 7 Continued

Question 53:
If you check "Yes," Medi-Cal may be able to help pay some or all of the paid or unpaid medical costs you have had in the 3 months before you applied.

Question 54:
Check "Yes," if any person has filed a lawsuit because of an accident or injury, workers compensation, or car accident.

Question 55:
Check box(es) to show if individual, spouse or parent of individual is or was in the U.S. Military. We are asking for this information to see if you can get other services or benefits.

Question 56 (Optional):
You can choose to enter the Ethnicity (race) for each person. This information is used for statistics only and has no effect on your eligibility for Medi-Cal.

Question 57:
Check box to show if person is in school. The earnings of a person under 21 years may not be counted if the person is attending school.

Question 58:
Tell us if the person is living away from home, is away at school, or out of town working.

SECTION 8

Information Release (Optional).

Question 59:
Check "Yes," and the local welfare office will send this application to the Healthy Families program if one or more of the family members applying do not qualify for the Medi-Cal program.

The Healthy Families Program provides comprehensive health, dental, and vision coverage. For further information call **1-800-880-5305** or visit their website at www.healthyfamilies.ca.gov

Question 60:
If you fill out this item you are telling the local welfare office it is okay to give information about your application to the person you have named.

SECTION 9

Signature and Certification.

Who can sign this application?

- The person who wants Medi-Cal, or the spouse of the person who wants Medi-Cal
- The conservator, guardian executor, or caretaker of a child who wants Medi-Cal
- Someone acting for the person who wants Medi-Cal when the person is incompetent, in a comatose condition, or suffering from amnesia and there is no spouse, conservator, guardian or executor
- Persons 14 to 21 years old if they are not living with a parent, caretaker relative, or foster parent
- Persons 14 to 21 requesting Minor Consent Services

Question 61:
State and federal laws require your signature on this application form. Your signature in this section indicates that your declarations and answers are truthful and the documents you submit are true and correct.

GO TO PAGE 7

Medi-Cal Confidentiality Notice

The information given in this application is private and confidential under Welfare and Institutions Code 14100.2.

The information will be disclosed only in accordance with those laws.

Medi-Cal Rights, Responsibilities and Declarations

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- Ask for an interpreter.
- Ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after I get a "Notice of Action". To find out about Medi-Cal fair hearings, call toll-free, 1-800-952-5253.
- A face-to-face interview.
- Review Medi-Cal program rules and manuals.

I have the responsibility to:

- Report any changes within 10 days in the information I give on this application.
- Let local welfare office know if a family member applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- Cooperate if my case is reviewed.
- Apply for available income.
- Cooperate with appropriate paternity determinations and medical support enforcement efforts.
- Assignment of rights to medical support to the State of California.
- Assign rights to third party medical support to the State of California.

I understand that:

- As a condition of Medi-Cal eligibility, all rights to medical support are automatically assigned to the State of California.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.
- Persons I am applying for are not in jail, prison, or any other correctional facility.
- After my death, the State has the right to seek repayment from my estate for all Medi-Cal benefits I receive after age 55 unless I have a surviving spouse, minor child(ren), blind or permanently and totally disabled child(ren).
- If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.

MC 210 08/01
INSTRUCTIONS

Medi-Cal Privacy Notice

The Information Practices Act of 1977 and the Federal Privacy Act require the Department of Health Services to provide the following information: Welfare and Institutions Code Section 14011 and regulations in Title 22, CCR, require applicants for the Medi-Cal program to provide the eligibility information requested in this application.

This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.) The information will be used to process claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application.

Information required by this form is mandatory, with the exception of ethnicity information, and any other item marked voluntary or optional. Social Security Numbers are required by Section 1137(a)(1) of the Social Security Act and by Welfare and Institutions Code Section 14011.2, unless applying for emergency or pregnancy related benefits only.

An individual has a right of access to records containing his/her personal information that are maintained by the Department of Health Services.

Contact your local welfare office to request your records.

Gray Davis
Governor, State of California

Grantland Johnson
Secretary, California Health
and Human Services Agency

Diana M. Bontá, R.N., Dr.P.H.
Director, California
Department of Health Services

9

Provided by the State of California

Flex your POWER

State of California—Health and Human Services Agency

Department of Health Services

ADDITIONAL CHILDREN
(SUPPLEMENT TO THE MEDI-CAL STATEMENT OF FACTS—MC 210)

IF YOU HAVE MORE THAN THREE CHILDREN, *LIST HERE* AND GIVE THIS FORM TO YOUR WORKER.

COUNTY USE ONLY
Case name:
Case number:
Worker number:
Date:

A Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
B Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
C Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
D Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
E Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					
F Child's name (first, middle, last) or "unborn"	Relationship to applicant		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Social Security number	In school ☐ Yes ☐ No	Sex ☐ Male ☐ Female					
Birthdate or date unborn is due	Is the person blind or disabled ☐ Yes ☐ No	Pregnant ☐ Yes ☐ No					
Father's name	Is either parent (✓) ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Mother's name	Child living in home ☐ Yes ☐ No	Medi-Cal requested ☐ Yes ☐ No					

MC 210 S-C (ENG/SP) (1/00)

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

NIÑOS ADICIONALES
(SUPLEMENTO A LA DECLARACION DE DATOS DE MEDI-CAL—MC 210)

SI TIENE MAS DE TRES NIÑOS, *ANOTELOS AQUI* Y DELE ESTA FORMA A SU TRABAJADOR(A)

PARA USO DEL CONDADO
Case name:
Case number:
Worker number:

A Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante		Linkage*	Citizen/ Immig. MC 13	SSN	Preg	ID
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacera el bebe	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Esta cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicito Medi-Cal? ☐ Si ☐ No					
B Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacera el bebé	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Esta cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicito Medi-Cal? ☐ Si ☐ No					
C Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacera el bebe	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Esta cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicito Medi-Cal? ☐ Si ☐ No					
D Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacera el bebe	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Esta cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicito Medi-Cal? ☐ Si ☐ No					
E Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacera el bebe	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Esta cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicito Medi-Cal? ☐ Si ☐ No					
F Nombre del niño (nombre, inicial, apellido) o "por nacer"	Parentesco con el solicitante		Linkage	Citizen/ Immig. MC 13	SSN	Preg	ID
Numero del Seguro Social	¿Asiste a la escuela? ☐ Si ☐ No	Sexo ☐ Masc. ☐ Fem.					
Fecha de nacimiento o fecha en que se espera nacera el bebe	¿Está la persona ciega o incapacitada? ☐ Si ☐ No	¿Embarazada? ☐ Si ☐ No					
Nombre del padre	¿Esta cualquiera de los padres (✓) ☐ Muerto ☐ Incapacitado ☐ Ausente ☐ Desempleado		Medical Support ☐ YES ☐ NO ☐ CA 2.1 ☐ Not in home, 18–21 and tax dep.?				
Nombre de la madre	¿Vive el niño en el hogar? ☐ Si ☐ No	¿Solicito Medi-Cal? ☐ Si ☐ No					

MC 210 S-C (ENG/SP) (5/00)

ate of California - Health and Human Services Agency

Department of Health Services
Medi-Cal Program

Property/Resources
(Supplement to the Medi-Cal Statement of Facts - MC 210)

Please fill in the following, if you answered "YES" to certain Property/Resource questions from the Statement of Facts MC 210.

(1) LIQUID RESOURCES

Fill in the following if more room was needed to list liquid resources (Checking/Savings/IRA'S, Stocks, etc.)

Type of Resource	Owner of Resource	Account Number	Name and Address	Current Value
				$
				$
				$

(2) REAL ESTATE

A. If you or any family member answered "YES" to owning or buying any of the items listed under the Real Estate part of the MC 210, fill in the following. List any property in any state or country and all land you own, have title to, or share title in. ITEMS: Houses, lots, land, apartments, mobile homes taxed as real property, or other.

Address or Legal Description of Property: _____

_____

Name of Owner: _____

Does anyone live there now? ☐ Yes ☐ No How long have they lived there? _____

Name of person living there: _____ Relationship to you: _____

Do you plan to return to that property to live? ☐ Yes ☐ No
(You must notify the county within ten (10) days of any change in plans for living at the property.)

Is the property currently listed for sale? ☐ Yes ☐ No

Full value of property (from tax statement): $ _____ Amount owed: $ _____

Rent collected each month from property: $ _____

Expenses on property:

- Interest $_____ Yearly/Monthly
- Insurance $_____ Yearly/Monthly
- Taxes and Assessments $_____ Yearly/Monthly
- Upkeep and Repairs $_____ Yearly/Monthly
- Utilities $_____ Yearly/Monthly

B. If you or any family member answered "YES" to the life estate property question, please fill in the address of the property below.
Address: _____

_____

_____

Do you or any family member have an income interest in a life estate? ☐ Yes ☐ No

Is the life estate (producing/earning/providing/giving) income? ☐ Yes ☐ No

COUNTY USE ONLY

Case Name:
Case No.:
Worker No.:
Date:

Verification of Good Cause for Nonfurnishing of Property

Verification of Income and Expenses (E-I)

If you or any family member answered "YES" to owning one or more of the items in the VEHICLE section of the Statement of Facts, MC 210, fill in the following information about each vehicle.

VEHICLES ③

A. List all cars, trucks, motorcycles, airplanes or off-road vehicles **(even if not running)** owned by you or your family. If none, write "none."

Make and Model	Year	Class (Registration)	Owner	Amount Owed	Listed for Sale?		Used for Transportation	
					Yes	No	Yes	No
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				

B. **List any** boats, campers (do not include trucks), motor homes, or trailers which are **not** used as a home and are not taxed as real property by the county.

Description	Year	Class (Registration)	Owner	Purchase Price	Listed for Sale?		Used for Transportation	
					Yes	No	Yes	No
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				
				$				

Note: If you think the value the Department of Motor Vehicles will give the items listed in A and B will be too high, you may get three appraisals of the actual value and the average will be used.

COUNTY USE ONLY

List exempt vehicle:

- ☐ Verification of nonexempt vehicles
- ☐ Verification of encumbrance
- ☐ Verification of personal property

If you or any family member answered "YES" to owning items in the **OTHER** or **BUSINESS** section of the Statement of Facts, MC 210, please give more detailed information about those items here.

OTHER

(4) A. If you or any family member own items of jewelry valued at more than $100 each, or are applying under Pickle and your items are over $500, you must fill in the following:
(Do not include wedding, engagement rings, or heirlooms.)

Description	Listed for Sale? Yes	Listed for Sale? No	Amount Owed
			$
			$

B. If you or any family member answered "YES" to owning life insurance, you must fill in the following:

	Insurance Company	Person Insured / Policy Owned By	Face Value	Policy Number	Date Policy Issued	Current Cash Value
1.			$			$
2.			$			$
3.			$			$

C. If you or any family member answered "YES" to owning one or more of the following:
1. burial plot, vault, or crypt, is it for use of immediate family? ☐ Yes ☐ No
or 2. mineral rights or mining claims, is either listed for sale? ☐ Yes ☐ No
Please give more detailed information:
Description: _____
Owned by: _____
Current Value: $ _____ Amount Owed: $ _____
Location: _____

D. If you or any family member answered "YES" to owning a burial reserve or trust, please fill in the following:

Purchase Price	Amount Owed	Purchased For Whom	Purchased From Whom
$	$		
$	$		
$	$		

BUSINESS

(5) If you or any family member answered "YES" to owning one or more of the following types of business items: equipment, vehicles, tools, inventory or materials (including livestock or poultry not for personal use), you must give more detailed information by filling in the following.

Description of Item	Estimated Value	Amount Owed
	$	$
	$	$
	$	$

COUNTY USE ONLY

Heirloom? _____
Total Nonexempt
Appraised Value $ _____
☐ Exempt

Yes No CSV
Exempt ☐ ☐ $_____
Exempt ☐ ☐ $_____
Exempt ☐ ☐ $_____
Total CSV $_____

Exempt ☐ ☐ $_____

☐ Revocable
☐ Irrevocable
☐ Designated Funds
Current Value $ _____

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

VOCATIONAL AND WORK HISTORY
(To Be Completed By Applicant/Beneficiary)

Parent Number 1 Name: _____

List your employment and training history for the last two years. Begin with your current or latest job or training.

Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly	Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly
1.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	4.	☐ Work ☐ Training	From __/__/__ To __/__/__	$
2.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	5.	☐ Work ☐ Training	From __/__/__ To __/__/__	$
3.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	6.	☐ Work ☐ Training	From __/__/__ To __/__/__	$

Parent Number 2 Name: _____

List your employment and training history for the last two years. Begin with your current or latest job or training.

Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly	Name of Employer or Training Program	Work or Training	When Employed	Gross Amount Monthly
1.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	4.	☐ Work ☐ Training	From __/__/__ To __/__/__	$
2.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	5.	☐ Work ☐ Training	From __/__/__ To __/__/__	$
3.	☐ Work ☐ Training	From __/__/__ To __/__/__	$	6.	☐ Work ☐ Training	From __/__/__ To __/__/__	$

MEDI-CAL U-PARENT DETERMINATION WORKSHEET
(To Be Completed By CWD Staff)

Case name: _____ Worker number: _____

Case number: _____ Date: _____

1. Determination of Principal Wage Earner (PWE)

   a. Application date OR date U-Parent deprivation began: _____
   b. To establish 24-month earnings period, check month on chart for each parent:

   Month number 1: subtract two years from line (a): _____

   Month number 24: Month/Year immediately preceding line (a): _____

Parent 1's Earnings	Current year _____		Year _____		Year _____	
	$	Dec.	$	Dec.	$	Dec.
	$	Nov.	$	Nov.	$	Nov.
	$	Oct.	$	Oct.	$	Oct.
Name	$	Sep.	$	Sep.	$	Sep.
	$	Aug.	$	Aug.	$	Aug.
	$	Jul.	$	Jul.	$	Jul.
	$	Jun.	$	Jun.	$	Jun.
	$	May	$	May	$	May
	$	Apr.	$	Apr.	$	Apr.
	$	Mar.	$	Mar.	$	Mar.
Total: $_____	$	Feb.	$	Feb.	$	Feb.
	$	Jan.	$	Jan.	$	Jan.

Parent 2's Earnings	Current year _____		Year _____		Year _____	
	$	Dec.	$	Dec.	$	Dec.
	$	Nov.	$	Nov.	$	Nov.
	$	Oct.	$	Oct.	$	Oct.
Name	$	Sep.	$	Sep.	$	Sep.
	$	Aug.	$	Aug.	$	Aug.
	$	Jul.	$	Jul.	$	Jul.
	$	Jun.	$	Jun.	$	Jun.
	$	May	$	May	$	May
	$	Apr.	$	Apr.	$	Apr.
	$	Mar.	$	Mar.	$	Mar.
Total: $_____	$	Feb.	$	Feb.	$	Feb.
	$	Jan.	$	Jan.	$	Jan.

The parent earning the greater amount is the PWE: _____
(Name of PWE)

2. Is the PWE working 100 hours or more a month? ☐ Yes ☐ No
   If "yes," complete the Unemployed Parent Worksheet (MC 337).

Note: If the PWE is a recipient of Section 1931(b), he/she may exceed 100 hours with no earned income test.

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

INCOME IN-KIND/HOUSING VERIFICATION

(SUPPLEMENT TO THE MC 210 STATEMENT OF FACTS)

WE NEED THE FOLLOWING INFORMATION TO DETERMINE THE VALUE OF THE HOUSING/RENT, UTILITIES, FOOD OR CLOTHING THAT YOU ARE RECEIVING FREE OR IN EXCHANGE FOR WORK.

County Use Box

Case Name: _____

Case No.: _____

Worker No.: _____ Date: _____

Part I. IN-KIND INCOME VERIFICATION

A. Applicant Authorization Section: (Sign this section if you want the county to verify IN-KIND INCOME)

Name(s): _____

Address: _____

I hereby authorize _____ *county to contact* _____ *concerning any of the information requested below.*

Applicant Signature: _____ Date: _____

B. Provider Statement Section: (Statement of person giving/sharing housing, utilities, food, clothing, etc.)

1. The person(s) named above receives from me/my family:
   ☐ Housing/Rent ☐ Utilities ☐ Food ☐ Clothing ☐ Cash
   - This is ☐ Free ☐ In exchange for _____
   - I/We have been providing these items since _____
   - I/We expect to continue to provide these items until _____

2. I/We share household expenses with the person(s) named above. ☐ Yes ☐ No
   (If no, go to number 3.)

   Our shared arrangement is: _____

3. The TOTAL cost of household items at the above address is:

   Housing_____ Rent_____ Utilities_____ Food_____ Clothing_____ Cash_____

   - The number of people in the household at the above address is: _____

4. My relationship to the person(s) named above is: _____

I CERTIFY THAT THE INFORMATION IN THIS SECTION IS TRUE AND CORRECT:

Provider Signature _____ Date: _____

Address: _____ Phone: (____) _____

Part II. HOUSING VERIFICATION

SIGN BELOW ONLY IF YOU, THE APPLICANT, WANT TO PROVIDE INFORMATION ABOUT FREE HOUSING OR RENT PAID TO A RELATIVE AS EVIDENCE OF RESIDENCY. BEFORE YOU SIGN, YOU MUST FILL IN THE HOUSING INFORMATION REQUESTED ABOVE.

I understand that the information I provide as evidence of residency may be verified by county or state employees processing my application. I agree to cooperate with any such employee in the verification of this information. I hereby authorize any county or state employee responsible for administering the Medi-Cal program to contact _____ concerning any of the information provided above.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS STATEMENT IS TRUE, CORRECT, AND COMPLETE.

Applicant Signature: _____ Date: _____

MC 219 (5-1-1999)

State of California—Health and Human Services Agency

Department of Health Services
Medi-Cal Program

INGRESOS – NO EN EFECTIVO/VERIFICACION DE VIVIENDA

(SUPLEMENTO A LA DECLARACION DE DATOS MC 210)

NECESITAMOS LA SIGUIENTE INFORMACION PARA DETERMINAR EL VALOR DE LA VIVIENDA/ALQUILER, SERVICIOS PUBLICOS Y MUNICIPALES, ALIMENTOS O ROPA QUE USTED RECIBE GRATIS O A CAMBIO DE TRABAJO.

Para Uso del Condado

Case Name: _____

Case No.: _____

Worker No.: _____ Date: _____

Parte I. VERIFICACION DE LOS INGRESOS NO EN EFECTIVO

A. Sección de Autorización del Cliente: (Firme esta sección si usted desea que el condado verifique los INGRESOS NO EN EFECTIVO)

Nombre(s): _____

Dirección: _____

Por medio de la presente autorizo al condado de _____ *a que se comunique con* _____ *con relación a cualquier información que se solicita enseguida.*

Firma del Solicitante: _____ Fecha: _____

B. Sección para la Declaración del Proveedor: (Declaración de la persona que da/comparte la vivienda, servicios públicos y municipales, alimentos, ropa, etc.)

1. La(s) persona(s) mencionada(s) arriba recibe(n) de mí/de mi familia:
   ☐ Vivienda/Alquiler ☐ Servicios Públicos y Municipales ☐ Alimentos ☐ Ropa ☐ Dinero en efectivo
   - Esto es ☐ Gratuito ☐ A cambio de _____
   - He/hemos proporcionado estos artículos desde _____
   - Espero/esperamos continuar proporcionando estos artículos hasta _____

2. Comparto/compartimos los gastos del hogar con la(s) persona(s) mencionada(s) arriba. ☐ Sí ☐ No
   (*Si no es así, pase al número 3.*)
   Nuestro arreglo de compartir es: _____

3. El costo TOTAL de los gastos del hogar en la dirección anterior es:
   Vivienda_____ Alquiler_____ Servicios Públicos y Municipales_____ Alimentos_____
   Ropa_____ Dinero en efectivo_____
   - El número de personas en el hogar en la dirección anterior es: _____

4. Mi relación/parentesco con la(s) persona(s) mencionada(s) arriba es: _____

CERTIFICO QUE LA INFORMACION QUE CONTIENE ESTA SECCION ES VERDADERA Y CORRECTA:

Firma del Proveedor: _____ Fecha: _____

Dirección: _____ Tel.: (____) _____

Parte II. VERIFICACION DE VIVIENDA

FIRME ABAJO SOLAMENTE SI USTED, EL SOLICITANTE, DESEA PROPORCIONAR INFORMACION ACERCA DE VIVIENDA GRATUITA O ALQUILER (RENTA) QUE SE LE PAGA A ALGUN PARIENTE COMO PRUEBA DE RESIDENCIA. ANTES DE FIRMAR, USTED TIENE QUE COMPLETAR LA INFORMACION SOBRE VIVIENDA QUE SE LE PIDE ARRIBA.

Entiendo que la información que yo proporcione como prueba de residencia, pudiera ser verificada por empleados del condado o del estado para tramitar mi solicitud. Estoy de acuerdo en cooperar con tal empleado en la verificación de esta información. Por medio de la presente, autorizo a los empleados del condado o del estado, que sean responsables de administrar el programa de Medi-Cal, a ponerse en contacto con _____ con relación a cualquier información que he proporcionado arriba.

DECLARO BAJO PENA DE PERJURIO, EN CONFORMIDAD CON LAS LEYES DEL ESTADO DE CALIFORNIA, QUE LA INFORMACION QUE CONTIENE ESTA DECLARACION ES VERDADERA, CORRECTA, Y COMPLETA.

Firma del Solicitante: _____ Fecha: _____

MC 210 S-I (SP) (11/99)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

Student Educational Expenses
(Supplement to the Medi-Cal Statement of Facts - MC 210)

COUNTY USE ONLY

Case Name: _____

Case No.: _____

Worker No.: _____

Date: _____

If you or any family member are in college or attending a similar educational institution, please fill in the following:

A.	Student's name(s):		
	Name of institution(s):		
	Status of student(s):	☐ Full time ☐ Part time ☐ Grad ☐ Undergrad	☐ Full time ☐ Part time ☐ Grad ☐ Undergrad
B.	Grants, Loans, Scholarships, Fellowships:		
	Amount received:	$	$
	Source(s) of grants, loans, etc:		
	How often received?		
C.	Expenses Per Term:		
	Is term a semester, quarter, year?		
	Tuition/fees:	$	$
	Books, equipment, and supplies:	$	$
	Child care necessary for school:	$	$
D.	Transportation to School/Child Care:		
	Round trip miles per day:		
	School attended how many days per week:		
	Type of transportation used (own car, borrowed car, car pool, bus, etc.)		
	Costs (per month):		
	• Amount paid by student (not own car)	$	$
	• Amount paid by riders:	$	$
	• Parking, tolls, etc:	$	$
	Is public transportation (bus, train, etc.) available?	☐ Yes ☐ No	☐ Yes ☐ No
	• If yes, indicate cost:	$	$

See MEM 50447 for allowable education expenses.

EXEMPT:

☐ Entire amount
☐ Only expenses

VERIFICATION (Incl):

Transportation costs allowed (show computations):

MC 210 S.T. (3/90) (9/94)

ATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM

Gastos Educativos de Estudiantes

(Suplemento a la Declaración de Datos de Medi-Cal - MC 210)

PARA USO DEL CONDADO

Case Name: ____________

Case No.: ____________

Worker No.: ____________

Date: ____________

Si usted o cualquier miembro de la familia asiste a la universidad o una institución donde otorgan medio bachillerato (college) o una institución educativa similar, por favor complete lo siguiente:

A	Nombre del estudiante(s)	____________	____________	See MEM 50447 for allowable education expenses.
	Nombre de la institución(es)	____________	____________	EXEMPT:
	Situación como estudiante(s)	☐ Tiempo compl. ☐ Medio tiempo ☐ Postgraduado ☐ Sin graduarse	☐ Tiempo compl. ☐ Medio tiempo ☐ Postgraduado ☐ Sin graduarse	☐ Entire amount ☐ Only expenses
B	Subvenciones, Préstamos, Becas	____________	____________	VERIFICATION (List)
	Cantidad recibida	$ ____________	$ ____________	
	Fuente(s) de las subvenciones, préstamos, etc.	____________	____________	
	¿Con qué frecuencia se recibe?	____________	____________	
C	Gastos por Curso			
	¿Es el curso un semestre, un trimestre, un año?	____________	____________	
	Colegiatura/cuotas	$ ____________	$ ____________	
	Libros, equipo, y útiles	$ ____________	$ ____________	Transportation costs allowed (show calculations)
	Cuidado de niños necesario para asistir a la escuela	$ ____________	$ ____________	
D.	Transporte a la Escuela/Guardería Infantil			
	Millas por viaje redondo al por día	____________	____________	
	Días por semana que asiste a la escuela	____________	____________	
	Clase de transporte que se usa (auto propio, auto prestado, viaje en grupo, autobús, etc.)	____________	____________	
	Gastos (por mes)	____________	____________	
	• Cantidad que paga el estudiante (no en auto propio)	$ ____________	$ ____________	
	• Cantidad que pagan las personas que viajan con usted	$ ____________	$ ____________	
	• Estacionamiento, peaje, etc.	$ ____________	$ ____________	
	¿Hay a la disposición transporte público (autobús, tren, etc.)?	☐ Sí ☐ No	☐ Sí ☐ No	
	• Si es así, indique el costo.	$ ____________	$ ____________	

MC 210 S F (SP) (9/99)

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

ENGLISH

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits. The information will be used:

1. By the county welfare department to establish first time and ongoing Medi-Cal eligibility.
2. By Electronic Data Systems (EDS) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy-In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Immigration and Naturalization Service (INS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S. Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the INS receives can only be used to determine Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

MEDI-CAL APPLICANT/BENEFICIARY RIGHTS, RESPONSIBILITIES, AND UNDERSTANDINGS

I HAVE THE RIGHT TO:

1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
2. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
3. Apply as a disabled person if I think I am disabled.
4. Be told about the rules for retroactive Medi-Cal eligibility.
5. Apply for Medi-Cal and to be told **in writing** whether I qualify for any Medi-Cal program, even if the county representative tells me during the interview that it appears I am not eligible.
6. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
7. Have all facts that I give to the county welfare department kept in the strictest confidence and to look at those facts during regularly scheduled office hours.
8. Receive an immediate need card, **when possible and eligible**, if I have a medical emergency or I am pregnant.
9. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. **Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens with a valid and current I-688 card are in a satisfactory immigration status.**
10. Be told about the Child Health and Disability Prevention Program and the Special Supplemental Food Program for Women, Infants, and Children, and to ask for help in receiving those services.
11. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.
12. Speak to a social worker about other public or private services or resources that I can get.
13. Be told about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

14. Lower my share of cost by providing past unpaid medical bills (that I still owe).
15. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal, including the month I apply and to be told how I may spend my excess property.
16. Divide countable (nonexempt) community (MY SPOUSE's AND MY) property by written agreement into equal shares of separate property if ether of us entered a long-term care (LTC) facility before September 30, 1989.
17. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.
18. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within **90 days** of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within **90 days** from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest county welfare department.

I HAVE THE RESPONSIBILITY TO TELL MY COUNTY REPRESENTATIVE WITHIN TEN (10) DAYS WHENEVER:

1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money) or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. I have any expenses that are paid for by someone other than myself.
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired so that I/he/she cannot get or keep a job (this would include a child in the family who may not be able to get a job in the future due to the impairment)
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change in the citizenship/immigration status of any family member applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

I HAVE THE RESPONSIBILITY TO:

1. Complete and return a status report by the date required when requested by the county.
2. Give proof that I am a resident of California.
3. Make a declaration about my citizenship/immigration status.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

4. Provide an SSN for myself and/or for any member of my family who has an SSN and wants Medi-Cal benefits. If I am a U.S. citizen, a U.S. national, or an alien in a satisfactory immigration status, I must apply for an SSN and provide it to the county if I do not already have one. If I need to apply for an SSN, I can get help from my eligibility worker, but I must work with the SSA to clear up any questions or my Medi-Cal will be denied or stopped. (Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.)
5. Apply for any income that may be available to me or any member of my family.
6. Apply for Medicare benefits if I am blind, disabled, have End Stage Renal Disease, or am 64 years and 9 months of age or older and eligible. I am responsible for telling my providers that I have both Medi-Cal and Medicare coverage.
7. Apply for and enroll in any health insurance if that is available to me and my family at no cost. I have the responsibility to remain enrolled in the health plan when Medi-Cal approves payment of plan premiums by the State of California.
8. Report to the county department, and to the health care-provider, any health care coverage/insurance I carry or am entitled to use, including Medicare. If I willfully fail to give this fact, I may be guilty of a criminal offense, or may be billed by my provider.
9. Go to my health care plan (such as Kaiser, CHAMPUS, or a Medicare HMO) for medical care. (Medi-Cal will not pay for any services covered by the plan.)
10. Give any insurance payments I receive to the State if Medi-Cal has already paid for my care.
11. Go to a presentation, if presentations are given, and make a written choice, or answer if received by mail, about how I want to get my Medi-Cal benefits. If I do not go and make a choice, or choose by mail, my eligible family members and I may be signed up in a Medi-Cal Health Care Plan near my home.
12. Sign and date my BIC when I get it and ensure it is used only to get necessary health care for myself or eligible family members.
13. Take my BIC to my medical provider when I am sick or have an appointment. In emergencies when the BIC is not in hand, I must get the BIC to the medical provider when possible.
14. Report to the county department when I receive health care services because of an accident or injury caused by another person's action or failure to act, for which Medi-Cal has been, or may be billed.
15. Cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to through an absent parent.
16. Cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be stopped.

I UNDERSTAND THAT:

1. Failure to give necessary facts or deliberately giving false facts can result in Medi-Cal benefits being denied or stopped. My case may also be investigated for suspected fraud.
2. The facts I give will be checked by computer with facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong.
3. Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.
4. Immigration status data given as part of the Medi-Cal application is confidential.
5. Based on my income, I will have to pay or be billed for part of my medical expenses before I can get Medi-Cal.
6. If I do not report changes promptly, and because of this, receive Medi-Cal benefits that I am not eligible for, I may have to repay the State Department of Health Services.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

7. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the SSA, and the SSA denies my disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA allows my claim, then my Medi-Cal benefits will continue. If the SSA does not allow my claim, then my Medi-Cal benefits will stop.
8. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.
9. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.
10. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.
11. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.
12. If I ask a Medi-Cal provider for any services not covered by my **non-Medi-Cal** health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal-covered services.
13. Medi-Cal providers cannot collect insurance copayment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share of cost and/or copayment.
14. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.
15. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse (during his or her lifetime), minor children, blind or permanently and totally disabled children, or it would create a hardship for my heirs.
16. After the death of my surviving spouse, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

_____, am applying for Medi-Cal benefits from _____ County Welfare Department (on behalf of _____).

I hereby state that I have reviewed the information on this form with the county representative and that I fully understand my **RIGHTS AND RESPONSIBILITIES** to have my eligibility determined for Medi-Cal and to maintain that eligibility.

Applicant/Representative Signature	Telephone Number	Date
Interpreter's Signature	Telephone Number	Date

I have explained to the applicant the rights, responsibilities, and other information listed on this form.

Eligibility Worker's Signature	Telephone Number	Date

MC 219 (3/99) OSP 00 36309

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

Case Name _____ Case Number _____

SUPPLEMENT TO STATEMENT OF FACTS FOR RETROACTIVE COVERAGE/RESTORATION

My present circumstances, as listed on the Statement of Facts which I signed on _____ (Date), are true and correct statements, to the best of my knowledge, for the month(s) of _____ (for restorations, this should be the month in which the request is made) except as specified below.

Circumstances that are/were different: (If no change, write in "No change.") Documentation is needed to verify all sources of income and to support any difference in property, residence, etc.

Circumstances	Month:	Month:	Month:
Number of persons living in your home			
Income— Specify any differences in: Amount of income Kind of income Work expenses Education expenses Child care			
All Personal Property including motor vehicles, boats, bank accounts, etc. (Lowest bank account balances should be listed for each month unless they were exactly the same as the balance listed on the Statement of Facts. List differences or state "No change."	Checking: Savings:	Checking: Savings:	Checking Savings
Real Property (list differences only or state " No change.")			
California Resident	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Insurance Coverage Change	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other (List differences only or state "No change.")			

I understand that I may not retroactively spend my property down in order to reduce its amount and thereby qualify for Medi-Cal

I understand that I may be asked to prove my statements but that the county is required by law to keep them confidential, and that if dissatisfied, I have a right to a fair hearing. I understand that if I deliberately make false statements or withhold information, I can be prosecuted for fraud.

Signature	Date
Signature of person acting for applicant and relationship (guardian, conservator, etc.)	Date
Signature of witness (required if applicant signed by mark)	Date

The following person helped me to fill out this form:

Name and relationship to applicant	Address	Date

MC 210 A (3/99) (Formerly MC 213)

4U--NOTICES OF ACTION

Federal regulations (Title 42, Code of Federal Regulations, Section 435.912) require that the welfare department:

> "must send each applicant a written notice of the agency's decision on his application, and, if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of his right to request a hearing."

In addition, Section 431.210 states that the notice must provide an explanation of the circumstances in which aid paid pending applies.

I. Completion of Notices of Action

Approval Notices of Action (NOA) must be sent to the applicant within the time standards specified in Title 22, Code of California Regulations, Section 50177. Approval NOAs must contain the names of the individuals affected, the application date and effective date, if different, and any other information specific to the case, such as share of cost, restricted benefit information, etc.

For persons in a nursing facility, the original NOA should be mailed to the applicant at the nursing facility, and, if requested by the family, a copy to the administrator of the facility. Speed letters and other "conditional notices" are not required to be sent to the administrator. In addition, the county shall send a copy to the individual's representative if another person is acting on his/her behalf.

For any adverse NOA (such as a denial, increase in share of cost or other change in benefits), the appropriate section numbers of Title 22 must be included which would refer the individual to the corresponding regulation. The citation of section numbers for non-adverse NOAs is optional.

NOAs sent to deny or discontinue Medi-Cal benefits must also have the specific reasons stated that necessitated the action. A NOA issued to deny an applicant who has not provided information requested and needed for the eligibility determination, for example, should specifically list the items that had been previously requested but not provided.

EXAMPLE:

Bob and Delores Doe apply on June 1, 1995. During the intake face-to-face interview on June 9, 1995, the applicants are advised that they need to provide their last three pay stubs, a copy of the current bank statement for a savings account at Wells Fargo Bank, and the current statement for a checking account at their credit union. At this time, they are given a written request for these items which are due on June 19. On June 20, the eligibility worker (EW) receives two pay stubs for Mr. Doe and three for Mrs. Doe, and a bank statement for the credit union account, but the Wells Fargo account statement and the May 19 pay stub for Mr. Doe are still needed. The EW send a speed letter to the Doe's stating that the Wells Fargo statement and the May 19 pay stub for Mr. Doe must be received by June 30 or the application will be denied.

On July 3 a denial NOA is sent with the following message:

"Your application dated June 1, 1995 for Medi-Cal is denied. The reason for this denial is:

You did not provide the following information requested on June 9 and June 20, 1995:

pay stub dated 5/19/95 for Bob
Wells Fargo bank statement #42315424 for May 1995."

The NOA must be specific so that the applicant knows exactly what must be provided to the county to determine Medi-Cal eligibility. Some applicants have numerous bank accounts, life insurance policies, etc., and a generic statement that they have not provided a "bank statement" or "life insurance policy" is not adequate without additional identifying information.

In addition, this denial NOA will cite sections 50167 (Verification Prior to Approval) and 50175 (Denial or Discontinuance Due to Lack of Information, Noncooperation or Loss of Contact). Every action that an application may be denied on must be stated on the NOA with the corresponding regulation sections cited.

II. ADEQUATE AND TIMELY NOTICE

"Adequate notice" must be mailed by the county to the applicant/beneficiary no later than the date of the action for the following situations:

- Factual information has been received that the beneficiary is deceased.
- A written statement that the applicant/recipient wishes to withdraw an application or discontinue Medi-Cal benefits.
- The beneficiary signs a waiver of ten-day notice. This will normally occur when a change to the individuals' income, property or family makeup would result in termination, or increase in share of cost and the beneficiary knows that the adverse action must take place due to that change.
- The beneficiary's whereabouts are unknown and mail has been returned indicating no forwarding address. If a new forwarding address is supplied by the post office, the county must re-mail the NOA to the new address.
- If the new address indicates out-of-state residence.
- If information is received that the beneficiary has been approved for Medi-Cal in another county.

"Timely notice" is a NOA mailed at least ten days before the date of the action specified in the NOA.

III. NOAs AND AUTHORIZED REPRESENTATIVES

Many times an applicant or beneficiary will designate another person or organization to act as the intermediary to funnel information between the applicant/beneficiary and the county. These "authorized representatives" (ARs) many times request that the county send a copy to them of every NOA which is sent to the applicant/beneficiary.

Per All County Welfare Directors Letter (ACWDL) Nos. 91-98 and 93-84, the AR is only permitted a copy of a NOA which the applicant/beneficiary specifically requests be sent to the AR. The counties are not obligated to issue NOAs on a routine basis to anyone other than the applicant/beneficiary or for those listed in I on page 4U-1 of this procedure.

There is one exception to this policy. The county is required to provide copies to the AR of all NOAs or other correspondence that the county has sent to an applicant/beneficiary in regard to a hearing request or hearing issue if the county has received notification from the applicant/beneficiary that the AR is authorized to represent him/her. (ACWDL 95-30)

IV. MINOR CONSENT AND NOAs

A child applying on the basis of Minor Consent shall be given a NOA in the office at the conclusion of the interview/eligibility determination. MC 239V is the appropriate NOA to use for Minor Consent situations. This NOA has the appropriate section citations pre-printed on the form. The EW should advise the applicant/beneficiary to read and destroy the NOA if confidentiality may be compromised due to their living situation.

A copy of the MC 239V is attached.

MEDI-CAL
NOTICE OF ACTION
APPROVAL OF BENEFITS

(COUNTY STAMP)

CASE NAME: ____________________

CASE NO.: ____________________

DISTRICT: ____________________

THIS AFFECTS: ____________________

Your application for Medi-Cal benefits has been approved.

☐ You are entitled to receive Medi-Cal benefits beginning the first day of ____________. You will receive a Medi-Cal Benefits Identification Card soon. ***Do not throw this card away.*** This card is good as long as you are eligible for Medi-Cal. Take this plastic card to your doctor or other Medi-Cal provider when you request medical services.

☐ Since your income exceeds the amount allowed for living expenses, you have a share of cost to pay or obligate toward your medical care. Your share of cost is $________ beginning ______________. Your share of cost was computed as follows:

Gross Income	$ ____________
Net Nonexempt Income	$ ____________
Maintenance Need	$ ____________
Excess Income/Share of Cost	$ ____________

Your plastic card will show your provider if you have a share of cost to pay. The amount that you must pay or obligate to the provider will be automatically computed. The regulation which requires this action is California Code of Regulations, Title 22, Section 50653.

☐ You are eligible for Medi-Cal benefits for ______________ only because you have applied for Minor Consent Services and must reapply each month that you need Medi-Cal. The regulations which require this action are California Code of Regulations, Title 22, Sections 50147.1 and 50163. You will receive a paper Medi-Cal identification card. Take this card to your medical provider when you obtain care for your Minor Consent need.

☐ You are eligible for Medi-Cal benefits for: ________________________ only because ________________________________. The regulations which require this action are California Code of Regulations, Title 22, Section(s):

☐ You must bring or mail the verification listed below by ______________ or your eligibility for Medi-Cal benefits will be discontinued effective the last day of ________________.

The regulations which require this action are California Code of Regulations, Title 22, Section(s):

______________________ Eligibility Worker ______________ Phone ______________ Date

MC 239V (1/85)

4V – MINOR CONSENT MEDI-CAL SERVICES

1. BACKGROUND

California Family Code provides that a minor may, without parental consent, receive services related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse, and outpatient mental health treatment and counseling.

Minor consent services are categorized by age as follows:

UNDER AGE 12:
- pregnancy and pregnancy-related care
- family planning services
- sexual assault services

AGE 12 YEARS AND OLDER:
- sexually transmitted diseases treatment
- drug and alcohol abuse treatment/counseling
- mental health outpatient care
- pregnancy and pregnancy-related care
- family planning services
- sexual assault services

Methadone treatment, psychotropic drugs, convulsive therapy, psychosurgery, and sterilization are **excluded** from the services which a minor may receive without parental consent. The above-named services which a minor may receive on his/her own will be referred to as "minor consent services."

The Medi-Cal regulations and procedures are different for minor consent Medi-Cal coverage than they are for full-scope Medi-Cal coverage in the areas of:

- parental informing of the child's need for medical care,
- parental consent to Medi-Cal coverage for the child,
- parental consent to medical treatment of the child, and
- parental financial responsibility for the child's medical costs.

State law provides that persons under 21 years may apply for minor consent services Medi-Cal without their parents' consent or knowledge. The statute further provides that the parents shall not be required to contribute to the cost of minor consent services. However, the parents' income and property must be considered in the eligibility determination for Medi-Cal if the child requests other medical services not covered under minor consent services.

State law requires that the parents or guardians of a minor receiving outpatient mental health treatment or counseling, or services for drug or alcohol related problems be contacted and encouraged to participate in the treatment. The parents or guardian may not be contacted if the health care professional treating the minor believes it would not be advantageous to the minor to have parents or guardian involved. If the parents or guardian do participate in the treatment, they are required to pay for their share of any services they participate in – i.e., family counseling or individual/couple counseling for the parent(s).

Although all minor consent cases are confidential, **the parents' or guardian's knowledge of their child's circumstance in no way affects eligibility for minor consent services**, and **no contact shall be directed to the parent(s) or guardian(s)**. A minor must apply for minor consent services. Parent(s) can not apply on behalf of their minor child. However, one parent may accompany a

minor to apply for minor consent services when there is a need or desire to maintain confidentiality with the other parent. The confidentiality requirement is not waived in this situation. Notices of Action (NOAs) shall not be sent to the home address, etc.

2. COUNTY WELFARE DEPARTMENT RESPONSIBILITIES

Minor consent services, other than pregnancy and pregnancy-related services, are supported with State funds only. California received State Plan Amendment approval to claim Federal Financial Participation (FFP) for all pregnancy-related services provided through Minor Consent Services. Effective October 1, 1996, these services are eligible for FFP. For all other Minor Consent Services, no federal funds are claimed since the income and resources of the minor's parents/guardians are not considered in establishing eligibility. Therefore, it is critical that the following criteria be strictly adhered to:

a. Processing of Minor Consent Applicants Under 21 Years Who Are Adults

Persons under 21 years of age who are defined as adults under the definition of regulation Section 50014 are not eligible for minor consent services and should be processed for full-scope Medi-Cal.

b. Processing of Minor Consent Applicants Under 21 Years Who Are Not Physically Living With Their Parent(s).

A minor must be considered living in the home to be eligible for minor consent services.

If they are away temporarily, i.e., school/college, they are considered living in the home. If the minor is living temporarily with another relative or friend they are considered living in their parent(s1 home if their parent(s) are legally and financially responsible for the minor, i.e.; minor is claimed as a dependent for income tax purposes.

If a public agency has legal responsibility for a minor he/she is not eligible for minor consent services. If a minor is a Seriously Emotionally Disturbed (SED) child they are considered living in the home in regard to determining Medi-Cal eligibility. An SED child may apply for minor consent services. However, minor consent Medi-Cal will not cover mental health treatment or counseling that is required by the child's Individual Educational Plan (IEP), whether the SED child is in 24-hour care or a day treatment program.

c. Processing Minor Consent Eligibility

At the initial intake, and when an annual redetermination is required, a new MC 210 and 21 9 must be completed. If a break occurs in the monthly reapplication for minor consent services, a new MC 210 and 21 9 OR MC 210A must be completed**. Minor consent applicants are not required to provide their Social Security number (SSN) for eligibility**. **If the minor provides his/her SSN at application, the county is not to use the SSN for screening purposes or for any eligibility determination.** To do so would compromise the minor's confidentiality. Minor consent applicants do not have to provide the same level of verification as an applicant for full-scope Medi-Cal. **Minor consent applicants are not required to provide any identification.** Section 501 67(D)4 exempts the minor consent applicant from this requirement. In addition, **Section 501671V3(8) exempts the minor consent applicant from the requirement to verify pregnancy.**

If the minor is employed, they must provide pay stubs. Bank account statements are required if they own a bank account and have access to the information.

At intake, and every time a minor recertifies for minor consent services (except for outpatient mental health services, they must complete an MC 4026 (Request For Eligibility Limited Services). The Eligibility Worker (EW) must review the MC 4026 with the minor and verify that the information on the MC 210 has not changed. The revised MC 4026 contains specific rights and responsibilities that the minor must read and sign upon initial application and all subsequent recertifications.

Minor consent eligibility is for a period of one month. Children receiving minor consent services, including outpatient mental health services, are required to report changes, which may impact their eligibility, to their EW in person each month.

d. Identification of Types of Minor Consent Services

Children applying for Medi-Cal minor consent services must specify the type of services for which they are seeking coverage on the MC 4026. The Department of Health Services (DHS) has assigned four specific aid codes to reflect eligible minor consent services. These aid codes are effective September 1, 1997. With the implementation of these aid codes, the "L" codes previously used are eliminated. Listed below are the aid codes and categories of service for each:

AID CODE	CATEGORY OF SERVICE
7M	Restricted to minors who are at least 12 years of age and limited to sexually transmitted diseases, drug and alcohol abuse, family planning, and sexual assault treatment. This aid code is not to be used for outpatient mental health services. This aid code may have a share of cost.
7N	Restricted to pregnant minors of any age, limited to pregnancy and pregnancy-related services. This aid code does not have a share of cost.
7P	Restricted to minors who are at least 12 years of age and limited to sexually transmitted diseases, drug and alcohol abuse, family planning, sexual assault treatment and outpatient mental health treatment and counseling. This aid code may have a share of cost.
7R	Restricted to minors under age 12 and limited to family planning and sexual assault treatment. This aid code is not to be used for outpatient mental health services or drug and alcohol abuse. This aid code may have a share of cost.

When minors present their minor consent Medi-Cal card to a provider, the provider verifies their eligibility through the Point of Service **(POS)** network. The eligibility verification system will return a restricted eligibility service message for the minor consent service entered into Medi-Cal Eligibility Data System (MEDS). The providers have been directed via the provider manual that minors are entitled to the category of service which is transmitted via the eligibility verification system. Providers are also informed that minor consent services are confidential, and parents are not to be contacted regarding their child's receipt of the requested services (provider manual section 100-24).

e. Minors Requesting Outpatient Mental Health Treatment and Counseling

Minors requesting outpatient mental health treatment and counseling must submit to the county welfare department a statement from a mental health professional which states that the child needs mental health treatment or counseling, the estimated length of time treatment will be needed. In addition, the statement must specify that the minor meets **both** of the following:

[Minor] is mature enough to participate intelligently in the mental health treatment or counseling, **and is one of the following:**

(a) In danger of causing serious physical or mental harm to self or others without mental health treatment or counseling; OR

(b) An alleged victim of incest or child abuse.

For purposes of this section, a mental health professional is: a licensed marriage, family and child counselor; licensed clinical social worker; licensed educational psychologist; credentialed school psychologist; clinical psychologist; licensed psychologist; or psychiatrist.

The MC 4026 does not have to be signed each month that the minor is eligible for outpatient mental health services. The minor consent case may be approved each month that is covered in the statement provided by the mental health professional indicating the length of the treatment plan. **However, as in** all **minor consent cases, the minor must been seen and the case must be approved each month and a NOA must be issued.** The **MC 239V NOA should be used for all minor consent cases.**

f. Minor Consent Medi-Cal Card

Minor consent beneficiaries receive a paper ID card that is good for one year from the date of issuance. Counties should not have to issue a new card when a minor reapplies for minor consent services unless it has been 12 months since the last date of issuance, or if the card is lost. When continuing or re-opening a minor consent case the issuance of the Medi-Cal card can be suppressed by typing "LOGS" at the card issue site on the EW 15 screen.

A separate minor consent case does not need to be opened for minors who are already included in a public assistance case; a Medi-Cal Family Budget Unit (MFBU) with no share of cost, or for minors who apply for and receive Aid to Families with Dependent Children (AFDC) cash on the basis of pregnancy. In addition, if a minor is covered under a Managed Care plan the minor should be referred back to the plan for treatment unless the minor is requesting drug/alcohol abuse treatment or mental health treatment. If the minor is enrolled in a Managed Care plan and the minor requests drug/alcohol abuse or mental health treatment, a minor consent application should be taken and processed.

If the minor is included in an MFBU with a share of cost, issue the minor a minor consent Medi-Cal card. If the minor is included in a MFBU without a share of cost, issue a paper immediate need card. If a minor requests services related to pregnancy, the unborn is included in the MFBU as an aided child. The maintenance need for two is used. Once the child is born the minor mother must apply for full-scope Medi-Cal for the child if Medi-Cal coverage is desired for the child. There is no continuing eligibility for the minor's child under minor consent services. A new case must be established for the minor's child. The minor parent is then an ineligible member of the child's MFBU.

g. Reporting of Minor Consent Eligibles

To assure confidentiality, MEDS requires that all minor consent Medi-Cal identification cards be issued by an on-line transaction on a MEDS terminal using pseudo numbers rather than actual SSNs. To ensure that minor consent **applicants/beneficiaries** do not receive mailings from DHS, the county welfare department must ***not*** submit a home address to DHS via MEDS.

h. Other Health Care Coverage

If the minor is included in their parents' MFBU and the child's parent(s) have other health care coverage **(OHC),** the county must remove the OHC code from the minor's paper immediate need card. County departments shall not report other health care coverage information for children who are applying for minor consent services unless the minor has his/her own OHC through and employer or other accessible source.

If an immediate need card is being issued to the minor based on the parent's Medi-Cal case and the minor has an OHC code on MEDS, the county is to use the EW 15 transaction which will immediately and permanently remove the OHC code for that individual. This will avoid any situation in which the Health Insurance System (HIS) will reassert the OHC prior to the minor receiving the limited service that they are seeking. If there is no further need for a limited service, the county will have to reenter the OHC prior to the next month of eligibility on MEDS. This action assures assure that services are correctly tied to the OHC.

i. Confidentiality and Child Abuse Reporting Requirements

State law and regulations on minor consent services prevent the county welfare department from contacting the parents of a child applying for minor consent services only. The Child Abuse Reporting Law requires the county welfare department to report suspected child abuse to child protection agencies, law enforcement agencies, and agencies responsible for investigation of cases involving dependent children. County welfare workers should make reports as required by Penal Code Section 11166.

3. Medi-Cal Provider Responsibilities

California regulations, Title 22. Section 51473.2 states that providers may render services to minors without parental consent only if:

(1) Those services are related to a sexual assault, pregnancy and pregnancy related, family planning, drug or alcohol abuse, sexually transmitted diseases, or outpatient mental health treatment and counseling; OR

(2) The minor is living apart from his/her parent(s) and neither the parent(s) or a public agency will accept legal responsibility for the child.

4. DHS Responsibilities -- Beneficiary Explanation of Medi-Cal Benefits Statements (BEOMBS)

DHS will take necessary precautions to assure that children receiving minor consent services will not receive BEOMBS (see Medi-Cal Eligibility Procedures Manual, Section **16-D**). The Department does not send a BEOMB for any beneficiary who received a sensitive service (i.e.; abortion, drug and alcohol counseling, etc.). Therefore, minors who are issued a paper card copy on their parents' case should not receive a BEOMB.

State of California-Health and Welfare Agency — Department of Health Services

REQUEST FOR ELIGIBILITY LIMITED SERVICES

Name of Applicant (Last, First) — FOR COUNTY USE ONLY-State Number: County | Aid | Serial Number | PSU | Person No.

PART A.

I need/continue to need services related to: (Please check one or more of the following.)

UNDER AGE 12 AND OLDER:

1. ☐ Sexual Assault
2. ☐ Pregnancy or Family Planning

AGE 12 YEARS AND OLDER:

3. ☐ Sexually Transmitted Diseases
4. ☐ Drug or Alcohol Abuse
5. ☐ Outpatient Mental Health*

*If requesting outpatient mental health services, a statement from a mental health professional confirming that you meet the requirements for those services must be presented to your Eligibility Worker.

PART B.

I am requesting medical assistance for the month of: _____/____
Month Year

☐ I choose to receive my Medi-Cal card immediately upon signing this form.

OR ☐ I request that my Medi-Cal card be sent to the following address:

Street Number City ZIP Code

PART C. RIGHTS AND RESPONSIBILITIES

1. I understand that I will receive a paper Medi-Cal ID card that is good for one year from the issue date on the card. This card is for identification only and does not verify eligibility.

2. I understand that my eligibility is good for one month, and each month I need Minor Consent medical services I must come back into the welfare department to recertify my eligibility to at least one of the above services. To allow time for my eligibility worker to process my recertification, I must come in and complete this form as soon as I know I need to see a doctor or need medical care.

3. I understand that if any of the following occurs I must tell my eligibility worker at my next interview when I recertify my eligibility:
   a. I move out of my parent's/guardians' house.
   b. I get married.
   c. My parent(s) stop supporting me or declaring me as a dependent for tax purposes.
   d. I get a job or quit working.
   e. I acquire some property; i.e.; bank accounts, automobile, stocks, bonds, trust funds, etc.
   f. I give birth or my pregnancy ends for any reason.

4. I will receive this card and the medical services I have requested without my parents/guardian being contacted.

Signature of Applicant — Date

Signature of County Representative — Date

MC 4026 (11/95)

MEDI-CAL
NOTICE OF ACTION
APPROVAL OF BENEFITS

CASE NAME: _____
CASE NO.: _____
DISTRICT: _____
THIS AFFECTS: _____
_____

Your application for Medi-Cal benefits has been approved

☐ You are entitled to receive Medi-Cal benefits beginning the first day of _____. You will receive a Medi-Cal Benefits Identification Card soon. *Do not throw this card away.* This card is good as long as you are eligible for Medi-Cal. Take this plastic card to your doctor or other Medi-Cal provider when you request medical services.

☐ Since your income exceeds the amount allowed for living expenses, you have a share of cost to pay or obligate toward your medical care. Your share of cost is $_____ beginning _____. Your share of cost was computed as follows:

Gross Income	$_____
Net Nonexempt Income	$_____
Maintenance Need	$_____
Excess Income/Share of Cost	$_____

Your plastic card will show your provider if you have a share of cost to pay. The amount that you must pay or obligate to the provider will be automatically computed. The regulation which requires this action is California Code of Regulations, Title 22, Section 50653.

☐ You are eligible for Medi-Cal benefits for _____ only because you have applied for Minor Consent Services and must reapply each month that you need Medi-Cal. The regulations which require this action are California Code of Regulations, Title 22, Sections 50147.1 and 50163. You will receive a paper Medi-Cal identification card. Take this card to your medical provider when you obtain care for your Minor Consent need.

☐ You are eligible for Medi-Cal benefits for _____ only because _____. The regulations which require this action are California Code of Regulations, Title 22, Section(s)

☐ You must bring or mail the verification listed below by _____ or your eligibility for Medi-Cal benefits will be discontinued effective the last day of _____

The regulations which require this action are California Code of Regulations, Title 22, Section(s)

_____ _____ _____
Eligibility Worker Phone Date

4X-Single Point of Entry Processing and Referrals to/from the Healthy Families Program

I. BACKGROUND

Welfare and Institutions (W&I) Code Section 14011.1 mandates a simplified Medi-Cal application package and mail-in process for pregnant women and children. The intent of this law is to provide easy access for this population to apply for and receive Medi-Cal benefits as quickly as possible. A joint mail-in application (MC 321) for the Healthy Families Program (HFP) and Medi-Cal for Children and pregnant women was developed. The joint application is mailed to a single administrative vendor to be screened for income eligibility. This entity is referred to as the Single Point of Entry (SPE). The SPE administrative vendor is also the enrollment vendor for the HFP and in that role is referred to as the Healthy Families Administrative Vendor (HFAV). Because the application process between SPE, the HFP, and counties has evolved over the past several years, the purpose of this section of the procedures is to provide counties with a comprehensive guide to the current SPE and HFP policies and procedures.

II. The Application

A. Application Formats

1. MC 321

The HFP/Medi-Cal for Children and Pregnant Women application (MC 321) is a mail-in application, to be used in lieu of the MC 210. The MC 321 is available in ten languages (English, Spanish, Vietnamese, Cambodian, Hmong, Armenian, Cantonese, Korean, Russian, and Farsi). Counties may request the application in these languages using the HFP/Medi-Cal application order form available on the California Department of Health Services (CDHS) website. The website address is as follows: www.dhs.ca.gov/mcs/medi-calhome/HFApp.htm.

2. Health-e-App

Health-e- App (HeA) is a web-based application designed to parallel the MC 321 application process. HeA is available for use by Certified Application Assistants (CAA) and counties. It is not available for use by the general public. Applying with HeA is a two-step process. The first step is completing the application information via a secured Internet site as text data. The second

step entails faxing all supporting information and signature pages to fax servers at SPE. The CAAs are to fax the signature page and all supporting documentation within 24 hours from the time they transmit the HeA. The above timelines are to allow the SPE to send all information together to the CWD.

3. Telephone application

Application by telephone is a third way an applicant can complete the MC 321. The applicant can call SPE at 1-800-880-5305 and have a customer service representative electronically complete the application. The form is mailed to the applicant for signature. The applicant will need to confirm that the information is correct, sign the application, and mail the application back to SPE along with copies of the required documents, such as proof of income and deductions, proof of citizenship/immigration status and the first month's premium.

B. Opt-Out

The MC 321 application informs applicants that based on the information submitted the children will be enrolled in the program they qualify for. A question on the MC 321allows applicants an opportunity to choose to enroll in only Medi-Cal or only Healthy Families by checking the box of the program they do **not** want to be enrolled in. This is considered "opting-out".

C. Assistance with the application

If applicants need help in completing the application, they may call 1-800-880-5305 to receive help in their language. Operators at the toll free number can also provide applicants with the name and telephone number of a trained CAA in their community.

III. SCREENING PROCESS AT THE SINGLE POINT OF ENTRY FOR MAIL-IN APPLICATIONS

A. Processing Timeframes

SPE has four business days to screen the initial application to no-cost Medi-Cal or HFP. This includes contacting the applicant for additional or missing information (if necessary for file clearance), file clearance, reporting Accelerated Enrollment (AE), if applicable, and transmitting application information to Medi-Cal Eligibility Data System (MEDS). If

enough information is available to screen to no-cost Medi-Cal, but not enough information is available to assign a Client Index Number (CIN), the application is forwarded to the County Welfare Department (CWD) without AE being issued. If there is not enough information to screen the application to no-cost Medi-Cal, the application is forwarded to HFP for additional research.

B. Screening Process Description

1. SPE Mailroom Operations

Applicants submit the MC 321, joint application form, in a pre-addressed envelope to SPE. Once received at the SPE mailroom, the application and all accompanying documents are assigned a document control number (DCN) stamped with the date of receipt and are electronically imaged (scanned) into the vendor's automated system. Applications processed through the web-based HeA are electronically transmitted to SPE, and are processed identically to the paper mail-in applications that are scanned into the system, with the exception that the date does not appear on the HeA application. Instead the date of receipt appears on the cover sheet entitled, "Maximus Document Separator Sheet" that accompanies the application.

2. Screening Procedures

a. Initially, SPE screens all applications for the age-appropriate no-cost Medi-Cal, Federal Poverty Level (FPL) program for infants and children. The SPE income screening process is based on Section 8F-11 of the Medi-Cal Eligibility Procedures Manual (MEPM) and includes establishing the Medi-Cal Family Budget Unit (MFBU), responsible relative determinations, and income calculations applying all Medi-Cal income deductions.

b. To screen for no-cost Medi-Cal, SPE conducts an age and income screening only, based upon the information stated on the application. The screening does not review immigration status. Income documentation, if provided with the application, is used for the income screening. Also, if the child's birth certificate is provided, it is used to determine the age and paternity of the child.

c. The SPE screening does not verify information that is provided by the applicant, such as income or immigration. SPE is not required to verify any of the information provided with the application. It is possible that sibling children on the same application will not be screened to the same program.

Note: It is the responsibility of county Medi-Cal staff to request any required verifications from the applicant for children screened to Medi-Cal, and the responsibility of HFP staff to request any required verification from the applicant for children screened to the HFP.

3. File clearance

SPE conducts a file clearance on each applicant child and pregnant woman, following guidelines provided by CDHS. SPE does not request Social Security Numbers (SSN) or cards. If the SSN is provided, it is used in the file clearance process. Based on the results of the file clearance, SPE either assigns a CIN to individuals that do not have a CIN, or uses an existing CIN for individuals known to MEDS. If file clearance results in multiple CINs for an individual, designated staff research the records and complete a MEDS transaction to combine the duplicate records.

4. Accelerated Enrollment (AE)

If the screening process indicates potential eligibility for no-cost Medi-Cal, and there is no current or future month eligibility on MEDS, SPE reports AE eligibility to MEDS. AE coverage begins the first day of the month in which the child was screened to no-cost Medi-Cal and will continue until the CWD makes the final determination. SPE cannot discontinue AE.

5. Applications Forwarded to the Counties

The HeA and supporting documents are intended to be mailed together. SPE forwards a transmittal, the original mail-in application or a copy of the HeA application and all supporting documents received with the application to the county of residence in any of the following circumstances (See Section F for detailed information on transmittals). However, if SPE did not get the supporting documentation timely, the application will be mailed first and then SPE sends the verifications to the CWD as soon as they

received. The field “Date original application forwarded to CWD” is entered on the transmittal.

a. The screening process indicates potential eligibility for no-cost Medi-Cal for any of the applicant children and the applicant did not opt-out of Medi-Cal. These children will have an “M” in the “Screened for” field on the detail transmittal form.
b. Children age 19-20 applying for benefits.
c. Question number 16 on the joint application, "I do not want Healthy Families" is checked.
d. Question number 34 on the joint application, “Are any family members who are living in the home pregnant?” is marked yes or Section 2, questions 17-32 are answered under the last column marked, “Pregnant Woman”.
e. Question number 36 on the joint application, "Do any of the people listed in this section, or any of the parents listed in Section 2, want Medi-Cal" is marked yes.
f. Question number 49 on the joint application, “Does the pregnant woman and/or child want to apply for Medi-Cal coverage for any expenses in the last three months?” (Retroactive Medi-Cal) is marked yes.

NOTE: In some instances, SPE screens all of the applicant children to the HFP, but because the parents or older siblings want Medi-Cal, or there were medical expenses in prior months and retroactive Medi-Cal is requested, the application is forwarded to the county of residence. The "screened for" indicator on the detail transmittal for those children screened to HFP will be set to 'H.' The CWD does not need to determine Medi-Cal eligibility for these children. The county should only explore Medi-Cal eligibility for other family members, and/or retroactive Medi-Cal. No paperwork should be returned to the HFP.

6. Transmittals

SPE sends a detail transmittal with each application forwarded to counties. A transmittal is a computer-generated form, which gives detailed information for the reason each application is referred to the CWD by SPE and the outcome of the income screening for each person that requests health coverage. The application date is the date received at SPE. This date is found on the detail transmittal.

See Section F below for an explanation and detailed description of the transmittal process.

7. Applications Forwarded to HFP

SPE forwards to the HFP the application and supporting documentation received with the application for applicants up to age 19 that did not opt-out of HFP in any of the following circumstances:

a. Any child(ren) with countable income above no-cost Medi-Cal limits.
b. A pregnant child up to age 19 with countable family income over the 200 percent Federal Poverty Level (FPL).
c. Question number 16 on the joint application, "I do not want Medi-Cal" is checked.
d. A county returns an application with the determination of not eligible to no-cost Medi-Cal.

8. Notification

SPE sends a letter to applicants advising them that their application was forwarded to the CWD of residence for a Medi-Cal eligibility determination, to the HFP or both CWD and HFP. If the child is granted AE, a Benefit Issuance Card (BIC) and information on how to utilize Medi-Cal services are sent to the family.

C. Program Opt-Out Actions

1. Healthy Families Opt-Out

If the opt-out question of the application indicates that HFP is not desired, SPE does not conduct an income screening, however, SPE will conduct a file clearance, assign a CIN for each applicant, screen for AE and forward the application and all supporting documentation to the CWD of residence. The county must process the application even if the income is too high for no-cost Medi-Cal. The county must then make a share-of-cost Medi-Cal determination, including a property evaluation. In this instance, the county should explain to the applicant that the children might be eligible to HFP, and ask them to reconsider their choice. This consent can be either a signed statement or a verbal request. The written authorization from the applicant must accompany the

application. If the applicant's consent to have the application forwarded to the HFP is verbal, the CWD should record this in their Medi-Cal record and also indicate this in the 'Comments' section of the transmittal and send it to the HFP. Because the HFAV has the application and documentation scanned into its automated system, the county does **not** need to return the application or paperwork that accompanied the transmittal from SPE/HFP. The county should include any new verification, the budget sheet and/or NOA.

2. Medi-Cal Opt-Out

If the opt-out question of the application indicates that Medi-Cal is not desired, SPE will forward the application to HFP. HFP requests any necessary information and verifications in order to complete an eligibility determination. If the eligibility determination finds the applicant potentially eligible to no-cost Medi-Cal, HFP sends a letter to the applicant asking that Medi-Cal be reconsidered. The applicant has 90 days in which to reply to the reconsideration letter. If the applicant returns the reconsideration letter consenting to forward the application to the CWD within 90 days, the HFP evaluates for AE eligibility, forwards the original application, the signed reconsideration letter, and all the supporting documentation to the CWD. The Medi-Cal application date is the "date referred" on the detail transmittal. If the reconsideration letter is received beyond the 90 days, the applicant will need to submit a new application with current verification.

D. County Responsibility

1. Processing Timeframes

The CWD has 45 days to make a Medi-Cal eligibility determination. The Medi-Cal application date is described in Section F below.

2. Eligibility Determination

NOTE: SPE does not require verifications when screening applications. If the applicant sends in verification, it will be used in the screening process. If no verification is received with the application, SPE will screen children based on income amounts listed on the application.

Upon receiving an application from SPE or HFP, the CWD is responsible for completing the Medi-Cal eligibility determination based upon Medi-Cal regulations. Counties are to determine eligibility for children and pregnant women without delay. If other family members request Medi-Cal, the CWD is not to delay the determination for children and/or pregnant women while obtaining the necessary information from the other members. If additional information is needed for an accurate eligibility determination, the CWD shall use information/verification contained in open public assistance (PA) case records and/or case records closed within the last 45 days. If the above is not available, then the CWD shall gather all required information/verifications from the applicant. The county must report the outcome of all applications (grants and denials) to MEDS in order to shut down the AE or Child Health and Disability Prevention (CHDP) Gateway eligibility.

The CWD must request any necessary information from the applicant for other family members requesting Medi-Cal or retroactive Medi-Cal and complete the determination based upon Medi-Cal regulations.

3. Rights and Responsibilities

The MC 321 contains a short list of Medi-Cal Rights and Responsibilities. Counties must send the applicant an MC 219 upon receipt of the referral from SPE. A returned, signed copy of the MC 219 is not required; however, the counties must document that the MC 219 was mailed and the date mailed in the case file.

4. Immigration Status

Question 25 on the MC 321, asks if the person requesting coverage is a U.S. citizen or National? If the question is answered “no,” the applicant must provide verification of his/her satisfactory immigration status (SIS). The verification may be sent in with the MC 321 or within 30 days. If counties have all other information necessary to make an eligibility determination and the child is found to be otherwise eligible for no-cost Medi-Cal, the child must be approved for Medi-Cal with full-scope benefits. Once the verification of SIS is received, the CWD must run the Systematic Alien Verification for Entitlements (SAVE). SAVE will ultimately determine an alien’s immigration status. If the immigration verification is not received within the 30 days, the CWD shall

reduce benefits to restricted scope coverage after a ten-day notice of action period. If the CWD receives verification that the applicant is **not** eligible to full-scope Medi-Cal, the CWD shall issue a ten-day notice and reduce benefits to restricted scope coverage.

5. Brochures/Forms

The following program brochures/forms are not included with the revised mail-in application and instructions. Upon receipt of the mail-in application, counties are to send the following brochures/forms to the applicant:

- The CHDP Informational Publication.
- MC 007 "Medi-Cal General Property Limitations."
- Medi-Cal Brochure (Pub 68)
- MC 003 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Brochure.

The above items may be mailed at the same time as the MC 219.

6. Application tracking

W&I Code Section 14011.9 mandates the department to issue instructions to CWDs via an all-county letter to establish an automated system for tracking the status of applications received by a CWD via SPE. As a result, All County Welfare Directors Letter (ACWDL) 03-08 instructed counties to submit separate transactions for each individual listed on the application. Two MEDS transactions are designed for this purpose, AP18 and AP34.

a. AP18 – Reports the receipt of an application. In instances where the CWD can determine the disposition of the application at the point of initial processing (e.g., denial due to duplicate application), the denial/referral can be submitted via the AP18.
b. AP34 – Updates pending application information, reports the denial of an application or updates the status on a pending application previously reported to MEDS via an AP18. This transaction is also used to report a HFP referral.

7. County Returns to SPE

If after making the determination, the CWD finds that the child(ren) is not eligible for no-cost Medi-Cal, the CWD is to return the Healthy Families Administrative Vendor (HFAV) Transmittal Form with the "County Response Area" completed and the necessary enclosures. The only exception to the above are undocumented children. These children do not meet the eligibility criteria for HFP. See Section F of this procedures manual below for an explanation and detailed description of the transmittal process.

IV. HFP ACTIONS

A. Processing Timeframes

HFP has ten calendar days from the date the application is received from SPE to complete the application review of a complete application and 20 calendar days from date of receipt for applications needing further information or documentation (i.e., incomplete applications).

B. Applications screened to the HFP by SPE

In order for the HFP staff to determine eligibility for the HFP, all the necessary verifications, health plan choice, and premium payments must be processed prior to HFP enrollment. Once eligibility has been established, health coverage begins in ten calendar days. Once eligibility is established, children are covered for 12 months unless the child turns 19, is disenrolled for nonpayment of premiums, or the family submits a written disenrollment request. If eligibility is not established within 20 calendar days from the date the application was received by HFP, the applicant is denied HFP and the applicant is sent the appropriate denial letter with appeal rights.

C. Initial applications forwarded to the CWD by the HFP

If the HFP determines that one or more of the children are potentially eligible for no-cost Medi-Cal, the application and supporting documents will be forwarded, under cover of a transmittal, to the CWD of residence. If all factors have been met for AE, the children's AE eligibility will be reported to MEDS by SPE. The Medi-Cal application date is the date the application was received at SPE. This date is found on the detail transmittal.

D. Annual Eligibility Review (AER)

Each year the family must submit an AER packet in order for the HFP to make a redetermination of eligibility. HFP mails the packet not more than 75 days and not less than 60 days prior to the subscriber's anniversary date with the program. The due date displayed on the AER packet is the subscriber's anniversary date in the HFP. AER packets are generally accepted all the way up until the last day of the anniversary month. If at AER, the HFP determines that one or more of the children are potentially eligible for no-cost Medi-Cal and the family authorized the AER to be sent to Medi-Cal, the AER application and supporting documents will be forwarded, under cover of a transmittal, to the CWD of residence. These children will receive two months of Bridging. The Bridging program provides an additional two months of HFP for the child(ren) thus allowing the CWD time to make a Medi-Cal determination. The Medi-Cal application date is the "Date referred" on the detail transmittal.

E. Add-A-Person Applications – non-AER

Sometimes, an Add-a-Person application is received at the HFP during the 12-month eligibility period, not at the AER, and the children screen to no-cost Medi-Cal. In these instances, if the family authorized the application to be sent to Medi-Cal, the Add-a-Person form, the last application or AER on file with HFP, and all supporting documentation will be forwarded to the CWD of residence. If all factors have been met for AE, this eligibility will be reported to MEDS by SPE. The Medi-Cal application date is the date the add-a-person application was received at HFP. This date is found on the detail transmittal. Only the person on the add-a-person form will be evaluated for eligibility.

F. Add-A-Person Applications – AER

An Add-a-Person application can be received at HFP with the AER packet. This may cause all the children or some of the children to be screened to no-cost Medi-Cal. In these instances, if the family authorized the application to be sent to Medi-Cal, the Add-a-Person form, the AER, and all supporting documentation will be forwarded to the CWD of residence. If all factors have been met for AE, this AE eligibility for the added child will be reported to MEDS by SPE. The other children on the AER form who are determined to have income below the HFP income level will be granted an additional two months of Bridging HFP coverage while their application is forwarded to the CWD or the Reconsider Medi-Cal letter is sent. The Medi-Cal application date is the "Date referred" on the detail transmittal.

G. Re-enrollment Form

If a child is disenrolled from HFP, the family may complete a re-enrollment form within 60 days of disenrollment. HFP disenrollment always occurs on the last day of the month. The re-enrollment form must be accompanied by proof of income and deductions as well as the first month's premium and any past due amount. If the HFP determines that one or more of the children are potentially eligible for no-cost Medi-Cal, and the family authorized the application to be sent to Medi-Cal, the re-enrollment form, the last application received and all current supporting documents will be forwarded, under cover of a transmittal, to the CWD of residence. If all factors have been met for AE, the children's eligibility will be reported to MEDS by SPE. The Medi-Cal application date is the "Date referred" on the detail transmittal.

H. Premium Re-evaluation Form

At any time of the year, a member may ask for a Premium Re-evaluation Form in order to request HFP to reevaluate the monthly premium. This form must be accompanied by proof of income and deductions. If the HFP determines that one or more of the children are potentially eligible for no-cost Medi-Cal and the family authorized the application to be sent to Medi-Cal, the Premium Re-evaluation, the last application or AER form received and all current supporting documents will be forwarded, under cover of a transmittal, to the CWD of residence. The children who have been on HFP will be bridged for two months in order to allow the CWD adequate time to make an eligibility determination. The Medi-Cal application date is the "Date referred" on the detail transmittal.

V. CWD Forwarding to HFP

A. New applications

If the CWD determines that the applicant child(ren) is eligible for share-of-cost Medi-Cal or is denied Medi-Cal, the family income is below 250 percent FPL and the parent/caretaker consents, then the case will be forwarded to the HFP. The most current application, supporting documents, copy of the NOA sent to the client showing the SOC amount or denial reason and a copy of the Medi-Cal Budget Computation Worksheet (unless the complete budget computation is found on the NOA) will be forwarded, under cover of a transmittal, to the HFP.

B. Redeterminations

If at the annual redetermination the family's income is found to be above the child's FPL for no-cost Medi-Cal, but within the HFP income guidelines, and the applicant authorizes the application to be forwarded to HFP, then the CWD will forward the application to the HFP. The packet must include the most current application, supporting documents, copy of the NOA sent to the client showing the SOC amount and a copy of the Medi-Cal Budget Computation Worksheet (unless the complete budget computation is found on the NOA) under cover of a transmittal, to the HFP. These children will receive one month of Bridging. The Bridging program provides an additional month of no-cost Medi-Cal for the child(ren) thus allowing adequate time for the child to apply for HFP. **Note:** If the family has given the CWD authorization to forward the application to HFP, the CWD must forward the application to HFP for a determination and not request the family to send in a new application to the HFP.

VI. TRANSMITTALS

Transmittal forms are the main form of communication between SPE, HFP, and the CWDs. For this purpose there are four transmittals. They are the HFAV Summary Transmittal; HFAV Detail Transmittal; County Summary Transmittal, and County Detail Transmittal. Below are instructions on completing and reading each of the transmittals.

A. HFAV Summary Transmittal

1. Description

This is a computer-generated summary of all applications being referred to the CWD. The CWD shall review the HFAV Summary Transmittal for accuracy prior to assigning the cases. If CWDs discover a discrepancy between the number of applications listed and the actual applications sent, the CWDs are to contact the SPE Liaisons immediately (See Section G below regarding SPE Liaisons).

2. Explanation of Fields

i.	**County Name**	This identifies the County to which the applications belong. Please review the transmittal to ensure the county identification is

		correct. If it does not belong to your county, please return it immediately to: Healthy Families Attn: SPE P.O. Box 138005 Sacramento, CA 95813-8005
ii.	**Courier Number**	SPE use only.
iii.	**Total Apps**	Total number of new applications (same as intake at CWD).
iv.	**Total PREs**	Total number of cases determined to be potentially eligible to Medi-Cal at the time the Premium Re-evaluation form is evaluated.
v.	**Total AERs**	Total number of cases determined to be potentially eligible to Medi-Cal at the Annual Eligibility Review (same as redeterminations at CWD).
vi.	**Total AAPs**	Total number of add-a persons (same as CWD).
vii.	**Total Addl**	Total number of cases having sent in additional information or verification since the original application was forwarded to the CWD.
viii.	**Total Transmittals**	Grand total of applications sent and should be the total of above 5 categories (iii-vii).
ix.	**Family Number (FMN)**	This is the SPE/HFP case number. It is also known as the Case Control Number (CCN). This number is needed when CWDs contact HFAV with questions regarding a case. This FMN can also be used as a search option in MEDS via IAPP screen to track an application.
x.	**Transfer Type**	Specifies the type of document, such as new application AER, AAP, Addl…or Pre
xi.	**AE Eligible**	A "Y" in this column means the child was granted AE.
xii.	**DCN**	Document Control Number (DCN): a tracking number used by SPE

B. HFAV Detail Transmittal

1. Description

This is a computer-generated form that accompanies each application referred to the CWD by either SPE or the HFP. The transmittal is a summary of each application sent and advises the CWD how the application was screened by summarizing items, such as how each person is screened, the family composition, and income used.

2. Explanation of fields

a. Case Level Information

County Name	This identifies the designated County. Please review the transmittal to ensure the county identification is correct. If it does not belong to your county, please return it immediately to: Healthy Families Attn: SPE P.O. Box 138005 Sacramento, CA 95813-8005
Date original application forwarded to CWD	If this field contains a date it is because SPE or the HFP had previously sent the original application. SPE/HFP are now forwarding changes, new verification or new information on one or more members of the application. Use this date to track when the original application was forwarded to the CWD.
Case Control Number (CCN)	This is the same as the FMN on the Summary Transmittal. This is the SPE/HFP case number.
Date Received	**This is the date SPE received the original application. Use this date as the Medi-Cal application date for new applications and for Add-A-Person applications not associated with the AER.**
Date Referred	This is the date the HFP determines an application should be referred to Medi-Cal. Use this as the Medi-Cal application date for HFP AER, Add-a-Person applications associated with the AER, Premium Re-evaluation Form, Re-enrollment Form and when a family opts out of Medi-Cal and then signs a reconsideration letter.

Opt-out of HF	Y= Family does not want HFP. The county must process the application even if the income is too high for no-cost Medi-Cal. The county must then make a share-of-cost Medi-Cal determination, including a property evaluation. The county should explain to the applicant that the child(ren) might be eligible for the HFP, and ask if they want to reconsider their choice. The family's consent can be either a signed statement or a verbal request. If the consent to have the application forwarded to the HFP is verbal, indicate this in the 'Comments' section of the transmittal and return it to the HFP.
Unlisted Member Wants Medi-Cal	Y= Question number 36 on the joint application, "Do any of the people listed in this section, or any of the parents listed in Section 2, want Medi-Cal" is marked yes. The CWD will make a Medi-Cal determination for these individuals. N = No other family members are requesting Medi-Cal.
Retro MC Requested	Y = Question number 49 on the joint application," Does the pregnant woman and/or child want to apply for Medi-Cal coverage for any expenses in the last three months?" (Retroactive Medi-Cal) is marked yes. The CWD will make a determination for retro Medi-Cal based on the regulations for retro Medi-Cal. N = Applicant is not requesting retro Medi-Cal.
Type	This designates the type of application being forwarded: SPE: A new case that was screened to Medi-Cal through Single Point of Entry. HF: A case that was screened to Medi-Cal by an Eligibility Enrollment Specialist (EES) through Healthy Families (This would include initial applications screened to HFP originally but further verification screens them to Medi-Cal, Re-enrollment). AER: This case was screened to Medi-Cal during the Annual Eligibility Review. ADD: This case was screened to Medi-Cal while an Add-a-Person form was worked on by HFP. PRE: This case was screened to Medi-Cal while a Premium Re-evaluation form was worked on by HFP.

b. Individual Level Information

<table>
<tr><td>Member</td><td>Numeric number assigned to each member of the application. (Same as person number in the CWD).
1=Applicant
2-99 All other persons</td></tr>
<tr><td>CIN#</td><td>This is the Client Identification Number (CIN) that SPE has assigned to this individual.</td></tr>
<tr><td>Names</td><td>Last Name; First Name; Middle Initial: This should list all the names of individuals listed on the application. CWD should review for accuracy.</td></tr>
<tr><td>Relation to Applicant</td><td>This indicates the individual's relationship to the applicant as determined by SPE or HFP.
<table>
<tr><td>1 *</td><td>Applicant's child</td><td>M *</td><td>Adopted child</td></tr>
<tr><td>2 *</td><td>Second adult's child</td><td>N</td><td>Niece or nephew</td></tr>
<tr><td>3 *</td><td>Significant other</td><td>O</td><td>Other</td></tr>
<tr><td>A</td><td>Aunt or uncle</td><td>P</td><td>Parent</td></tr>
<tr><td>B</td><td>Step-child</td><td>Q *</td><td>Cousin</td></tr>
<tr><td>C</td><td>Common child</td><td>S</td><td>Spouse</td></tr>
<tr><td>D *</td><td>Son or daughter-in-law</td><td>T</td><td>Stepfather</td></tr>
<tr><td>F</td><td>Foster child</td><td>U *</td><td>Unborn</td></tr>
<tr><td>G</td><td>Grandparent</td><td>V</td><td>Stepmother</td></tr>
<tr><td>H *</td><td>Dependent of a minor dependent</td><td>W</td><td>Ward</td></tr>
<tr><td>J</td><td>Brother or sister</td><td>X *</td><td>Ex-spouse</td></tr>
<tr><td>K</td><td>Grandchild</td><td>Y</td><td>Self</td></tr>
</table>
</td></tr>
</table>

	L	Legal guardianship		
Date of Birth	The date of birth for each individual. CWD should review for accuracy.			
SSN	The social security number for each individual, if provided. CWD should review for accuracy.			
Screened for	This field indicates which program the individual has been screened to: M = Medi-Cal H = Healthy Families N = Not screened to either program			
Pregnant Indicator	Y = Question number 34 on the joint application, "Are any family members who are living in the home pregnant?" is marked yes or Section 2 questions 17-32 are answered under the last column marked, "Pregnant Woman". N = Not pregnant **Counties shall expedite eligibility determinations for all pregnant applicants.**			
AE Start Date	Effective date of Accelerated Enrollment. The AE effective date is the first day of the month in which eligibility is determined. **This eligibility is only terminated when the county reports a Medi-Cal eligibility determination (approval or denial) on MEDS.**			
Budget Unit	The budget unit the individual belongs to per SPE/HFP screening.			

* These relationship codes are not used at this time. CDHS will advise county staff if these codes will be used in the future.

c. Income/Budget Unit Section

Member	The member number to whom the income is associated.
Frequency of Income	A = Weekly B = Bi-weekly C= Bi-monthly D = Monthly E = Yearly
Type of Income	SPE/HFP assigns a number or letter to each type of income.

	1	Employee pay stub	G	RSDI
	2	Federal tax form	H	Veterans
	3	Award letter	I	Railroad Retirement
	4	W2 (not accepted by HFP)	J	SDI
	5	Bank statement with direct deposit	K	Worker's Compensation
	6	Employer statement	L	Unemployment
	7	Quarterly P&L statement	M	Pension/retirement
	8	NOA	N	Grants
	9	Child support	O	Settlements
	A	Alimony	P	Gift
	B	SSA	Q	Lottery/bingo
	C	Self-employment statement (not accepted by HFP	R	Other

	F	Affidavit		

Income Type Amount	The gross amount of income associated with this member, income type and frequency as determined by HFAV.
Budget Unit	The Budget Unit number that HFAV associates with the corresponding income and individual. Not used by CWD.
Family Size	The total number of family members on the case used by HFAV to determine income levels for the corresponding Budget Unit. (Same as MFBU in CWD).
Total Gross Income	Total monthly income, before deductions, as determined by HFAV.
Deductions	The total amount of deductions allowed by HFAV for the corresponding Budget Unit. This includes the $90 deduction for work, when appropriate.
Total Net Income	This is the Total Gross Income minus deductions.
Percent FPL	This is the percentage of the Federal Poverty Level for the corresponding Budget Unit, as determined by HFAV.
Members	These are the members who are part of this Budget Unit. (Same as MBU in CWD).

d. County Return Section

Case Name	CWD enters the case name.
Case Number	CWD enters the county case number.
County Representative	CWD enters the name of the person completing the transmittal.
Phone Number	CWD enters the phone number for the above person.
Date Referred	CWD enters the date the transmittal is being completed for return to SPE.
Reasons for Return to SPE	CWD checks the appropriate box(es) for why the transmittal is being returned.

	Applicant checked "I do not want Healthy Families." Applicant now wants Healthy Families.	If the applicant has given written permission to forward the application to HFP, then forward the written statement. If authorization was over the phone, use the comment section to record the authorization.
	CIN was missing, now located or a new one assigned.	Check this box if a new CIN is assigned, the wrong CIN was listed on top portion or if there are CIN merges needed.
	Amount of child support or child care expense shown on application not verified.	Check this box if the verification is not being provided, and this results in the member(s) having a SOC. CWD must indicate the member, the SOC amount and provide the NOA and budget sheets.
	Changes in household membership.	Check this box if the CWD has a change in family composition, which results in a different eligibility determination.

	Not eligible for Medi-Cal.	Check this box if it applies and use the next few boxes to further explain.
Member Changes	For the person(s) who is affected, use the same member number at top portion of transmittal.	
County Assigned CIN#	List the CIN that the CWD found as the correct number.	
Active Case Individual on…	If SPE/HFP included a person who is active on a PA program, list the program they are active on.	
Not Eligible for Medi-Cal…	Not currently in use. This field was placed on the transmittal for Parental Expansion which has not been implemented.	
Comments	Include any additional information that affected the eligibility determination.	
Enclosures	Check the appropriate boxes. CWD must include NOA and budget worksheets.	

C. County Summary Transmittal

1. Description

This is the summary of all applications being referred from the CWD to HFP. The transmittal can be completed on line at www.dhs.ca.gov/publications/forms/medi-cal/eligibilityby number.htm. The form number is MC 363S.

a. Explanation of Fields

County Name	This field identifies the sending CWD.
Number of Referrals	The number of referrals must agree with the total number of applications listed on this transmittal as well as with the total number of applications sent.
Contact Person	Name of person to be contacted at the CWD regarding the applications.
Telephone	Telephone number of the person listed above.

Case Name	List the case names of all the applications that will be forwarded with the transmittal.
Case Number	List the corresponding county case number for each case listed.

D. County Detail Transmittal

1. Description

This transmittal is to be used with county initiated applications only. The County Detail Transmittal can be completed on line at www.dhs.ca.gov/publications/forms/medi-cal/eligibilitybynumber.htm. The form number is MC 363. Do not use this transmittal for County returns of applications that originated at the HFAV. For county returns, only use the County Response Section of the HFAV detail transmittal.

2. Explanation of Fields

County Name	This field identifies the sending CWD.
County Representative	Name of person to be contacted at the CWD regarding the applications.
Telephone Number	Telephone number of the person listed above.
Date Referred	The date the CWD mails the application to. HFAV.
Case Name	List the case name of the application that will be forwarded with this transmittal.
Case Number	List the corresponding county case number for the above case.
Applicant Name	Name of the person identified as the applicant. This can differ from the case name.
Language Spoken	Applicant's primary spoken language, if known.
Language Written	Applicant's primary written language, if known.
Applicant Phone Number	Phone number for the applicant.
One or more individuals	**Changed mind about not wanting Healthy Families:** The applicant originally opted-out of HFP but has subsequently requested HFP. If the applicant gave the authorization to forward the application in writing, please include the authorization with the application. If the authorization was verbal, please make a

	notation in the "Comments" section of the transmittal. **Were determined ineligible for Medi-Cal (see comments):** If anyone listed on the application is not eligible for no-cost Medi-Cal for reasons other than having a SOC, please notate the person(s) and the reason under the "Comments" section**.** **Were determined to have a SOC (see below):** For any individual found to have a SOC, please check this box and enter the information in the section below.
Type of Application	**Food stamps only application:** Starting 07/01/03, HFP accepts these applications. **School lunch application:** Starting 07/01/05, HFP accepts these applications. HFP will still need to contact the applicant to obtain health plan information and the premiums. **Redetermination (RV):** Check this box if you are forwarding the MC 210RV. HFP will still need to contact the applicant to obtain health plan information and the premiums.
HF Requested	Yes = This individual has requested HF benefits No = This individual has not requested HF benefits, but is included in the MFBU for budgeting purposes.
M/C FBU	Yes = This individual is included in the MFBU for budgeting purposes. No = This individual is not included in the MFBU for budgeting purposes.
List all Household Members	List all the household members by name.
CIN Number	List the CIN attached to this individual. HFAV will use the CIN provided. Please ensure that any CIN discrepancies have been resolved.
Social Security Number	List the Social Security Number for this individual, if available.
Sex	Identify the individual's gender.
Date of Birth	List the date of birth for this individual.
Relationship to Applicant	List the relationship of individual identified to the applicant.

Individual Gross Income	List the gross income used in the budget for each individual. If the individual has more than one source of income, list each source of income on separate lines.
Type of Income	Identify the type of income known for this individual. If the individual has more than one source of income, list each type of income on separate lines.
Share-of-Cost Amount	Enter the SOC amount for this individual.
Enclosures	**The CWD must include:** Medi-Cal NOA, Medi-Cal budget worksheet and a copy of the application (MC 210 or MC 210RV). **The CWD may include, if available:** Birth certificates, Immigration verification, verification of residency, and any other verification pertinent to eligibility.
Comments	Explain why the application is being forwarded to HFP. Identify any individuals who are receiving Public Assistance (SSI, CalWORKS, etc.)

VII. COUNTY LIAISONS

There are two different types of liaisons available to CWDs to ensure that SPE and/or HFP issues and problems are resolved.

A. County Liaisons at SPE

SPE retains three County Liaisons with experience in determining Medi-Cal eligibility. They have two main functions.

1. SPE Eligibility Issues

SPE liaisons handle questions regarding SPE screening, transmittals, HFP eligibility, and/or CWD return applications. Effective January 1, 2004, the SPE County Liaisons can be reached at (916) 673-4602 or via e-mail at SPELiaisons@maximus.com.

2. MEDS Issues

The liaisons also handle CWD questions and requests regarding MEDS discrepancies. They can be reached via e-mail at HFPMEDS@maximus.com.

Note: The contact information provided above is solely for the use of County and State personnel. Please do not give out to the public.

B. County Liaisons at DHS

CDHS has analyst positions appointed to be liaisons between SPE/HFP and CWD. DHS liaisons can be contacted if problems and/or issues cannot be resolved at the SPE liaison level.