County of San Diego, Health and Human Services Agency (HHSA)
County Medical Services (CMS) Program Guide Letter

County Medical Services (CMS) Program Update and Termination of the Low Income Health Program	**Number**	**Page**
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Issue Date:
12/23/2014

Effective Date:
01/09/2015

Purpose:
To inform staff of the following:
- Termination of the Low Income Health Program (LIHP)
- CMS eligibility requirement changes as result of the Affordable Care Act (ACA)

Background:
San Diego's LIHP was a federally funded Medicaid waiver program for eligible individuals with income at or below 133% FPL. LIHP was established as the bridge to health care reform and expired on December 31, 2013. If the CMS applicant met the LIHP eligibility criteria, the applicant was not eligible for CMS.

The Affordable Care Act (ACA) puts into place a comprehensive health insurance reform through the expansion of the Medi-Cal program, creation of the Health Insurance Exchange, and new regulations for health insurance plans. CMS is a program of last resort and only covers certain medical services and is not considered health insurance.

As part of ACA, during open enrollment, affordable subsidized and unsubsidized health insurance can be obtained through *Covered California*. The health insurance plans available through *Covered California* meet the essential health benefits that are required by ACA. CMS does **not** provide or meet the essential health benefits that are required by ACA.

Policy Change:
CMS applicants are no longer evaluated for LIHP.

As a result of ACA, all CMS applicants must first be evaluated for Medi-Cal. A CMS applicant is **NOT** eligible for CMS if s/he meets any of the following:
- Is determined linked to Medi-Cal eligibility
- Is enrolled in Medi-Cal
- Is enrolled in Medicare
- Is enrolled in a Covered California Health Care plan or in any health care coverage plan that meets the Minimum Essential Coverage (MEC) requirement under ACA.

Summary of Changes:
01.01.01: Added ACA information
01.05.01: Added HCR acronyms
02.01.01: Added order of evaluation and updated case clearance and exception to the *Date of Application* conditions requirement
02.05.01: Updated linkage to Medi-Cal process
02.07.01: Obsoleted LIHP Article
04.01.01: Updated Eligible Adult criteria

04.02.01: Updated Eligible Individuals criteria
04.04.01: Removed LTC limited Medi-Cal program item
06.08.01: Updated CMS Q & A document
07.01.01: Updated OHC information and address for the ASO and CMS TPL Program Specialist
15.01.01: Updated reasons for discontinuance of CMS benefits

Changes to the CMS Program Guide are noted with highlighted text within each Article/Section.

Impact:

Forms/Notices of Action (NOAs)

The following forms (Attachment A) have been revised to remove reference to LIHP:

- CMS-2 (E/S) SSI Advocacy Referral
- CMS-5 Medi-Cal Referral
- CMS-7MARES (E/S) Third Party Liability Report
- CMS-16 (E/S) Verification Checklist
- CMS-22 (E/S) Reminder Request for Verifications
- CMS-23 (E/S) Coverage Information
- CMS-107 (E/S) Image Verification Checklist
- CMS Health Plan NPP-002 (E/S) Notice of Privacy Practices
- HCPA 14-187 (E/S) Release of Information
- HCPA 34-A (E/S) MASU DDSD Referral Information Letter
- 14-08 HHSA (E/S) Decentralization Information Letter

The CMS-69 (E/S) Health Insurance Questionnaire (Attachment B) has been revised to remove references to LIHP and to replace references to Mail Stop 0557-B, which has been replaced with the address for the ASO.

The CMS-39D (E/S) Denial NOA and CMS-131(E/S) Discontinuance NOA (Attachment B) have been revised to add the denial/discontinuance reason "*You have enrolled in other health insurance*".

The CMS-112 (E/S) Question and Answers form (Attachment B) has been revised to remove the LIHP and CMS concurrent evaluation information and to update the P. O. Box address for requesting a copy of the signed reimbursement agreement.

Automation:

CMS IT System (AuthMed): The revised CMS NOAs and forms have been uploaded into AuthMed.

Program Affected:

No impact to other program(s).

Quality Control:

QC will cite the appropriate error on any case that does not comply with the requirements outlined in this letter.

References:
None

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

Approval for Release:

12-23-14

Rick Wanne, Director
Eligibility Operations

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

DECENTRALIZATION INFORMING LETTER – TO APPLICANT

DATE: **TODAY'S DATE**

TO: **APPLICANT'S NAME**
STREET ADDRESS
CITY, STATE AND ZIP CODE

FROM: YOUR NAME **HOSPITAL: HOSPITAL REFERRING**

RE: APPLICATION FOR MEDI-CAL AND/OR COUNTY MEDICAL SERVICES (CMS)

☐ Your application for Medi-Cal has been referred to **ENTER FRC'S NAME HERE**. If you do not hear or receive a notice from a Medi-Cal Representative within 15 days from the date of this notice, please call the ACCESS Center at 1-866-262-9881 or by e-mail pubassist.HHSA@sdcounty.ca.gov. Your Medi-Cal case number is **ENTER MC CASE NUMBER HERE.** Make sure you have this number available when calling or e-mailing ACCESS.

☐ You have been scheduled for a CMS intake interview on **ENTER APPOINTMENT DATE & TIME HERE** at **SELECT SITE FROM DROP DOWN MENU .** Bring this letter, the documents listed below, and give them to the County worker who will interview you. The list below is not all inclusive and you may be asked to provide additional information by your worker. You will not be seen if you are more than 15 minutes late for your interview. If you will not be able to attend this interview, please call 1-800-587-8118 as soon as possible to reschedule.

Proof of:

- County Residence
- Identity
- Citizenship/Eligible Alien Status
- Property
- Income

IMPORTANT

If both boxes have been marked above, you are being evaluated for Medi-Cal and CMS. You must comply with both program eligibility requirements.

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003 (Revised 12/2014)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your medical/health information is personal and the County of San Diego's County Medical Services (CMS) program is committed to protecting it. Your medical/health information is also very important to our ability to provide you with quality care, and to comply with certain laws. This Notice describes the privacy practices we and all of our employees and other personnel are required to follow in handling your medical/health information.

We are Legally Required to: Keep your medical/health information, also known as "protected health information" or "PHI," confidential, give you this Notice of our legal duties and privacy practices with respect to your medical/health information, and comply with this Notice.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Right to Inspect and Obtain Copies: With certain exceptions, you have the right to inspect and obtain copies of your medical/health information from our records. To inspect and obtain copies of your medical/health information, you must submit a request in writing to your case manager or the person in charge of your treatment. If you request a copy of your medical/health information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We will not charge you a fee for inspecting your records if you do not request to copy your records.

We may deny your request to inspect and obtain copies of parts of your medical/health information. If you are denied the right to inspect and obtain copies of your medical/health information in our records, you may appeal this decision and request that another licensed health care professional designated by and CMS, who was not involved in your treatment review the denial. (At your request, a form will be provided to you for this request.)

Right to Request an Amendment: If you feel that your medical/health information in our records is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, you must submit a request in writing to your case manager or the person in charge of your treatment. In addition, you must tell us the reason for the amendment. Your request will become part of your record. (At your request, a form and a list of County sites will be provided to you for this purpose.)

We may deny your request if you ask us to amend information that was not created by us, or is part of the information which you were not permitted to inspect and copy, or is deemed accurate and complete by your treatment team.

Right to an Accounting of Disclosures: With the exception of certain disclosures, including those for treatment, payment and health care operations and those authorized by you, you have the right to request a list of the disclosures we have made of your medical/health information. To request this list, you must submit your request in writing to your case manager or the person in charge of your treatment. (At your request, a form will be provided to you for this purpose.)

Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may withdraw or change your request before any costs are incurred.

Right to Request Restrictions: You have the right to request that we follow additional, special restrictions when using or disclosing your medical/health information. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment as determined by your doctor. To request restrictions, you must make your request in writing to your case manager or the person in charge of your treatment. In your request, you must tell us what information you want to limit, the type of limitation, and to whom you want the limitation to apply. An example of such a limitation might be limits on disclosures we may make to your spouse. (At your request, a form will be provided to you for this purpose.)

Right to Request Confidential Communications: You have the right to request that we communicate with you about appointments or other matters related to your treatment in a specific way or at a specific location. For example, you can ask that we only contact you at work, or by mail at a post office box. To request confidential communications, you must make your request in writing to your case manager or the person in charge of your treatment. (At your request, a form will be provided to you for this purpose.) Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You may ask us for a paper copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are entitled to receive a paper copy of this Notice. To obtain a paper copy of this Notice, ask any staff person. You may also obtain a copy of this Notice at our website, http://www.co.san-diego.ca.us/hhsa/programs/sd/hipaa_administration/hipaa_privacy_practices.html

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL/HEALTH INFORMATION

In order to provide you with insurance coverage, we need medical/health information and other personal information about you, and we may obtain that information from many sources, including you, your employer or benefits plan sponsor, other insurers, HMOs or third-party administrators, and health care providers.

For Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We may also use personal information in sending certain information to doctors for patient safety or other treatment-related reasons.

We may use and disclose your medical/health information to contact you with a reminder that you have an appointment for treatment. You have the right to tell us how you want to receive appointment reminders. (At your request, a form will be provided to you for this purpose.)

We may use and disclose your medical/health information to recommend possible treatment options or alternatives that may be of interest to you. Additionally we may use and disclose your medical/health information to tell you about health-related benefits or services that may be of interest to you (for example, Medi-Cal eligibility or Social Security benefits). You have the right to refuse this information.

For Payment: We may use and disclose medical/health information about you so that the treatment and services you receive may be billed to and payment may be collected from you, other insurance companies or a third party. For example, we may need to give your health plan information about psychiatric services you received through or CMS so another health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose medical/health information about you for health care operations. These uses and disclosures are necessary to run CMS and make sure that all of our clients receive quality care. For example, we may use medical/health information to review our treatment and services and to evaluate the performance of doctors providing treatment to you. We may also combine medical/health information about many CMS clients to decide what additional services CMS should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, counselors, medical/health care students, and other agency personnel for review and learning purposes. We may also combine the medical/health information we have with medical/health information from other agencies to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical/health information so others may use it to study medical/health care and medical/health care delivery without learning who the specific clients are.

USES AND DISCLOSURES OF MEDICAL/HEALTH INFORMATION THAT GIVE YOU THE OPPORTUNITY TO OBJECT

Unless you object, we may disclose your medical/health information to a friend or family member, your parent or any other person identified by you who is involved in your health care or payment for your health care. Your objection must be in writing (at your request, a form will be provided to you for this purpose). We will not honor your objection in circumstances where doing so would expose you or someone else to danger, as determined by your treatment team.

In the event of a disaster, we may disclose your medical/health information to a disaster relief agency such as the Red Cross, so that your family can be notified about your condition, status and location.

Unless you object, we may also include some of your medical/health information in a facility directory. The information disclosed will include your name, your location in the facility, your condition described in general terms that do not communicate specific medical information about you and your religious affiliation. This information may be disclosed to members of the clergy, and except for religious affiliation, to other persons who ask for you by name. Your objection must be in writing and you may object to the inclusion of some or all of this information in the facility directory (at your request, a form will be provided to you for this purpose).

USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION

Research: Under certain circumstances, we may use and disclose medical/health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all clients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical/health information, trying to balance the research needs with clients' need for privacy of their medical/health information. Before we use or disclose medical/health information for research, the project will have been approved through this research approval process, but we may, however, disclose medical/health information about you to people preparing to conduct a research project, for example, to help them look for clients with specific medical/health needs, so long as the medical/health information they review does not leave CMS.

As Required By Law: We will use and disclose medical/health information when required to do so by federal or state law or regulation.

To Avert a Serious Threat to Health or Safety: We may use and disclose your medical/health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Workers' Compensation: We may disclose your medical/health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Activities: We may disclose your medical/health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report the abuse or neglect of children, elders and dependent adults;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Abuse, Neglect or Domestic Violence: We may disclose your medical/health information when notifying the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose your medical/health information to a federal or state health oversight agency for activities authorized by law. These oversight activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your medical/health information in response to a court or administrative order. We may also disclose your medical/health information in response to a subpoena, discovery request, or other lawful process by someone else involved in a dispute.

Law Enforcement: We may disclose your medical/health information if asked to do so by law enforcement officials in any of the following circumstances:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at any of our facilities; or
- In emergency circumstances to report a crime; the location of the crime, the victim(s); or the identity, description or location of the person who committed the crime.

Specialized Governmental Functions: We may disclose your medical/health information to authorized federal officials for intelligence and other national security activities authorized by law. For example, we may disclose your medical/health information to federal officials so they

may provide protection to the President of the United States or foreign heads of state, or to conduct special investigations authorized by law.

We may disclose your medical/health information to officials in the Department of State who make decisions regarding your suitability for a security clearance or service abroad.

We may disclose medical/health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical/health information about clients of CMS to funeral directors as necessary to carry out their duties.

If you are an inmate of a correctional institution, you may lose the rights outlined in this Notice. Furthermore, if you are an inmate or are in the lawful custody of a law enforcement official, we may disclose your medical/health information to a law enforcement official.

OTHER USES OF YOUR PROTECTED HEALTH CARE INFORMATION

Other uses and disclosures of your medical/health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your medical/health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your medical/health information for the reasons covered by the authorization, except that, we are unable to take back any disclosures we have already made when the authorization was in effect, and we are required to retain our records of the care that we provided to you.

CHANGES TO THIS NOTICE

We reserve the right to revise or change the terms of this Notice, and to apply those changes to our policies and procedures regarding your medical/health information. You have the right to be notified of any changes to this Notice and to receive a copy of those changes in writing. To obtain a copy of this Notice once it has been changed, you can either ask your treatment provider or any staff person, or go to the County of San Diego's web site at http://www.co.san-diego.ca.us/hhsa/programs/sd/hipaa_administration/hipaa_privacy_practices.html.

COMPLAINTS

You have the right to file a complaint if you believe that CMS staff has not complied with the practices outlined in this Notice. All complaints must be submitted in writing. You will not be penalized in anyway for filing a complaint.

If you believe your privacy rights have been violated you may file a complaint with CMS, or with the Federal Government. To file a complaint with CMS, contact:

Privacy Officer

County of San Diego, Compliance Office
P.O. Box 85524 (Mail Stop: P501)
San Diego, California 92186-5524
(619) 515-4244

To file a compliant with the Federal Government, contact:

U.S. Department of Health and Human Services
Region IX, Office for Civil Rights
50 United Nations Plaza – Room 322
San Francisco, California 94102
Voice Phone: (415) 437-8310
Facsimile: (415) 437-8329
TDD: (415) 437-8311
E-mail: OCRComplaint@hhs.gov

Please contact the privacy officer listed above, if you want specific information for filing a complaint with the federal Office for Civil Rights.

If you have any questions about this Notice, you may contact:

Privacy Officer
County of San Diego, Compliance Office
P.O. Box 85524 (Mail Stop: P501)
San Diego, California 92186-5524
(619) 515-4244

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of the County of San Diego. Our Notice of Privacy Practices provides information about how we may use and disclose your protected medical/health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing the County's web site, http://www.co.san-diego.ca.us/hhsa/programs/sd/hipaa_administration/hipaa_privacy_practices.html or by contacting any staff person involved in your care.

If you have any questions about our Notice of Privacy Practices, please contact the:

Privacy Officer
County of San Diego Compliance Office
P.O. Box 85524 (Mail Stop: P501)
San Diego, CA 92186-5524
(619) 515-4244

I acknowledge receipt of the Notice of Privacy Practices of the County of San Diego.

Signature (CMS Applicant/Beneficiary)	Date

Inability to Obtain Acknowledgement
To be completed only if no signature is obtained. If it is not possible to obtain the client's acknowledgement, describe the good faith efforts made to obtain the client's acknowledgement, and the reasons why the acknowledgement was not obtained:

County Staff Signature	Date

Name and Title Printed

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

AVISO SOBRE PRÁCTICAS DE PRIVACIDAD

Fecha de vigencia: 14 de abril de 2003 (Revisión 12/2014)

ESTE AVISO DESCRIBE CÓMO SU INFORMACIÓN MÉDICA PUEDE SER USADA Y DIVULGADA Y COMO USTED PUEDE OBTENER ACCESO A DICHA INFORMACIÓN. LE SOLICITAMOS QUE LO LEA ATENTAMENTE.

Su información médica y de salud es personal y el programa County Medical Services (CMS, por sus siglas en inglés) se compromete a protegerla. Su información médica y de salud es muy importante para nuestra capacidad de proveer cuidado de calidad, y para cumplir con ciertas leyes. Este Aviso describe las prácticas de privacidad que nosotros y todos nuestros empleados, así como el resto de nuestro personal, tenemos la obligación de seguir con respecto al manejo de su información médica y de salud.

Estamos legalmente obligados a lo siguiente: Mantener la confidencialidad de su información médica y de salud, también denominada "información de salud protegida" (PHI, por sus siglas en inglés), a proporcionarle este Aviso sobre nuestras obligaciones legales y prácticas de privacidad con respecto a su información médica y de salud, y a cumplir con lo establecido en este Aviso.

SUS DERECHOS CON RESPECTO A SU INFORMACIÓN MÉDICA

Derecho de inspeccionar y obtener copias: Con ciertas excepciones, usted tiene el derecho de inspeccionar y obtener copias de su información médica y de salud archivada en nuestros registros. A fin de inspeccionar y obtener copias de su información médica y de salud, usted debe presentar un pedido por escrito a su administrador de caso o a la persona a cargo de su tratamiento. Si usted solicita una copia de su información médica y de salud, nosotros podremos cobrarle un cargo para cubrir los costos de copiado, envío u otros insumos procedentes de su solicitud. Si usted no solicita una copia de sus registros, no le cobraremos ningún cargo por inspeccionarlos.

Podemos rechazar su pedido de inspeccionar y obtener copias de partes de su información médica y de salud. Si a usted se le niega el derecho de inspeccionar y obtener copias de su información médica y de salud archivada en nuestros registros, puede apelar tal decisión y pedir que otro profesional licenciado de cuidado de la salud designado por CMS, que no haya estado involucrado en su tratamiento, reconsidere los motivos del rechazo. (Si usted así lo solicita, le proporcionaremos un formulario para este propósito.)

Derecho de solicitar enmiendas: Si usted considera que su información médica y de salud archivada en nuestros registros es inexacta o incompleta, puede solicitar que enmendemos la información. Usted tiene el derecho de pedir una enmienda mientras la información obre en nuestro poder. Para solicitar una enmienda, debe presentar un pedido por escrito a su administrador de caso o a la persona a cargo de su tratamiento. Además, debe exponer la razón que motiva la enmienda. Su pedido se incorporará a

su registro. (Si usted así lo solicita, le proporcionaremos un formulario y una lista de sitios del Condado para este propósito.)

Podemos rechazar su pedido si usted nos solicita que enmendemos información que no haya sido preparada por nosotros, o que sea parte de información que a usted no se le haya permitido inspeccionar y copiar, o que sea considerada exacta y completa por su equipo de tratamiento.

Derecho a obtener un detalle de las divulgaciones: Con la excepción de ciertas divulgaciones —por ejemplo, aquéllas vinculadas con tratamientos, pagos y actividades administrativas de cuidado de la salud, así como aquéllas autorizadas por usted—, usted tiene el derecho de solicitar una lista de las divulgaciones que hayamos hecho de su información médica y de salud. Para solicitar esta lista, usted debe presentar un pedido por escrito a su administrador de caso o a la persona a cargo de su tratamiento. (Si usted así lo solicita, le proporcionaremos un formulario para este propósito.)

Su pedido debe referirse a un período determinado, que no puede ser mayor de seis años y no puede incluir fechas anteriores al 14 de abril de 2003. La primera lista que solicite en un período de 12 meses sucesivos será sin cargo para usted. Si desea obtener listas adicionales, podremos cobrarle los costos de proporcionarlas. Le notificaremos el costo correspondiente y usted podrá anular o modificar su pedido antes de que incurramos en ningún gasto.

Derecho de solicitar restricciones: Usted tiene el derecho de solicitar que observemos restricciones adicionales y especiales al utilizar o divulgar su información médica y de salud, pero no estamos obligados a dar curso a su pedido. Si aceptamos satisfacerlo, atenderemos su pedido a menos que la información sea necesaria para brindarle tratamiento de emergencia, tal como lo determine su médico. Para solicitar restricciones, usted debe hacer un pedido por escrito a su administrador de caso o a la persona a cargo de su tratamiento. En su solicitud, deberá especificar qué información desea limitar, el tipo de limitación a aplicar, y a quién desea aplicarla. Un ejemplo de tal limitación podría ser establecer restricciones a divulgaciones destinadas a su cónyuge. (Si usted así lo solicita, le proporcionaremos un formulario para este propósito.)

Derecho de solicitar comunicaciones confidenciales: Usted tiene el derecho de solicitar que nos comuniquemos con usted con respecto a citas y otras cuestiones relacionadas con su tratamiento de una manera específica o en un lugar específico. Por ejemplo, puede solicitar que sólo nos comuniquemos con usted en su lugar de trabajo, o mediante correspondencia dirigida a una casilla postal. Para solicitar comunicaciones confidenciales, debe presentar un pedido por escrito a su administrador de caso o la persona a cargo de su tratamiento. (Si usted así lo solicita, le proporcionaremos un formulario para este propósito.) Su pedido debe especificar cómo o dónde desea ser contactado. Procuraremos cumplir con todos los pedidos razonables.

Derecho a obtener una copia impresa de este Aviso: Usted nos puede solicitar una copia impresa de este Aviso en cualquier momento. Aun si hubiera acordado recibir este Aviso electrónicamente, tiene derecho a recibir una copia impresa del mismo. Para obtener una copia impresa de este Aviso, solicítela a cualquier miembro del personal. También puede obtener una copia visitando nuestro sitio web:
http://www.co.san-diego.ca.us/hhsa/programs/sd/hipaa_administration/hipaa_privacy_practices.html

CÓMO PODEMOS USAR Y DIVULGAR SU INFORMACIÓN MÉDICA Y DE SALUD

A fin de proporcionarle cobertura de seguro, necesitamos contar con información médica y de salud, así como con otra información personal sobre usted. Podemos obtener esa información de muchas fuentes, tales como usted mismo, su empleador o patrocinador del plan de beneficios, otros aseguradores, organizaciones HMO o administradores de terceros, y proveedores de cuidado médico.

Con fines de tratamiento: Podemos divulgar información a médicos, dentistas, farmacias, hospitales y otros proveedores de cuidado médico que cuidan de su salud. Por ejemplo, los médicos pueden solicitarnos información médica para complementar sus propios registros. También podemos usar información personal al enviar cierta información a médicos para garantizar la seguridad del paciente, o por otras razones relacionadas con su tratamiento.

Podemos usar y divulgar su información médica y de salud al comunicarnos con usted con fines de recordarle que tiene una cita para su tratamiento. Usted tiene el derecho de decirnos cómo desea recibir los recordatorios de la cita. (Si usted así lo solicita, le proporcionaremos un formulario para este propósito.)

Podemos utilizar y divulgar su información médica y de salud para recomendar posibles opciones o alternativas de tratamiento que podrían interesarle. Adicionalmente, podemos usar y divulgar su información médica y de salud para informarle sobre beneficios o servicios relacionados con la salud que puedan ser de su interés (por ejemplo, elegibilidad para beneficios de Medi-Cal o del Seguro Social). Usted tiene el derecho de rechazar dicha información.

Con fines de efectuar pagos: Podemos utilizar y divulgar información médica y de salud acerca de usted para que los servicios y tratamientos que reciba puedan ser facturados y cobrados a usted, a otras compañías de seguros o a terceros. Por ejemplo, puede ser necesario proporcionar información de su plan de salud acerca de los servicios de psiquiátricos que usted haya recibido por medio de CMS, para que otro plan de salud nos pague o reembolse los costos del tratamiento. También podemos brindar datos a su plan de salud acerca de un tratamiento que usted recibirá en el futuro, a fin de obtener la aprobación previa o para determinar si dicho plan cubre el tratamiento.

Con fines administrativos, relacionados con el cuidado médico: Podemos utilizar y divulgar información médica y de salud acerca de usted con fines de administración del cuidado médico. Estos usos y divulgaciones son necesarios para las actividades de CMS y para asegurar que todos nuestros clientes reciban cuidado de calidad. Por ejemplo, podemos utilizar información médica y de salud para analizar nuestros tratamientos y servicios, así como para evaluar la calidad del tratamiento que los médicos le proporcionen. También podemos combinar información médica y de salud sobre muchos clientes de CMS para decidir qué servicios adicionales CMS deberían ofrecer, qué servicios ya no se necesitan y si ciertos tratamientos nuevos son efectivos o no. Asimismo, podemos divulgar información a médicos, enfermeras, consejeros, estudiantes de medicina y de cuidado de la salud, y otro personal de agencias con fines de revisión y aprendizaje. De modo similar, podemos combinar la información médica y de salud de la que disponemos con la de otras agencias, con el propósito de comparar nuestro funcionamiento y comprender cómo mejorar los servicios y el cuidado que ofrecemos. Podemos eliminar la información que lo identifique a usted en un conjunto de información

médica/de salud a fin de que otros puedan usarla para estudiar el cuidado médico/de salud y su prestación sin saber quiénes son los clientes específicos.

USOS Y DIVULGACIONES DE INFORMACIÓN MÉDICA Y DE SALUD A LOS CUALES USTED PUEDE PRESENTAR OBJECIONES

A menos que usted se oponga, podemos divulgar su información médica y de salud a un familiar o amigo, a sus padres o a cualquier otra persona identificada por usted que participe en el cuidado de su salud o en el pago del mismo. Su objeción debe presentarse por escrito (si usted así lo solicita, le proporcionaremos un formulario para este propósito). No respetaremos su objeción en circunstancias en las que hacerlo expondría a usted o a otra persona a un riesgo, según lo determine su equipo de tratamiento.

En caso de desastre, podemos divulgar su información médica y de salud a una agencia del alivio de desastres, tal como la Cruz Roja, para que su familia pueda ser notificada acerca de su condición, su estado y su ubicación.

A menos que usted se oponga, podemos también incluir parte de su información médica y de salud en una guía de un establecimiento. La información revelada incluirá su nombre, su ubicación en el establecimiento y su condición, descrita en términos generales que no comuniquen información médica específica acerca de usted o de su filiación religiosa. Esta información puede ser revelada a miembros del clero y, con excepción de su filiación religiosa, a otras personas que pregunten por usted por su nombre. Su objeción debe presentarse por escrito y usted puede oponerse a la inclusión de parte o de la totalidad de la información en la guía del establecimiento (si usted así lo solicita, le proporcionaremos un formulario para este propósito).

USOS Y DIVULGACIONES QUE NO REQUIEREN SU AUTORIZACIÓN

Con fines de investigación: En ciertas circunstancias, podemos utilizar y divulgar información médica y de salud acerca de usted para propósitos de investigación. Por ejemplo, un proyecto de investigación puede requerir comparar la salud y la recuperación de todos los clientes que han recibido un medicamento, con las de aquéllos que recibieron otro para tratar una misma condición médica. Sin embargo, todos los proyectos de investigación están sujetos a un proceso especial de aprobación. Este proceso evalúa el proyecto de investigación propuesto y su uso de la información médica y de salud, tratando de equilibrar las necesidades de la investigación con las necesidades de privacidad de la información médica y de salud de los clientes. Antes de usar o divulgar información médica y de salud con fines de investigación, el proyecto tiene que haber sido autorizado por este proceso de aprobación; sin embargo, podemos divulgar información médica y de salud acerca de usted a personas que estén preparando la realización de un proyecto de investigación. Por ejemplo, con el objeto de ayudarlos identificar clientes con necesidades médicas y de salud específicas, siempre que la información médica y de salud que analicen no trasponga el ámbito de CMS.

Casos en que la ley así lo requiera: Usaremos y divulgaremos información médica y de salud cuando así lo exijan las leyes o reglamentaciones federales o estatales.

Con el fin de prevenir una amenaza grave para la salud o la seguridad: Podemos utilizar y divulgar su información médica y de salud cuando esto sea necesario para prevenir una amenaza grave a su salud y seguridad o a la salud y seguridad del público o de otra persona.

Compensación de trabajadores: Podemos divulgar su información médica y de salud a los fines de la compensación de trabajadores o de otros programas similares. Estos programas proporcionan beneficios por lesiones o enfermedades relacionadas con el trabajo.

Actividades de salud pública: Podemos divulgar su información médica y de salud a los fines de las actividades de salud pública. Estas actividades incluyen generalmente los siguientes conceptos:

- prevenir o controlar enfermedades, lesiones o incapacidades;
- reportar nacimientos y muertes;
- informar casos de abuso o negligencia en el cuidado de niños, ancianos y adultos dependientes;
- informar reacciones a medicamentos o problemas con productos;
- notificar al público en general casos de productos que han sido retirados del mercado y que podrían estar usando;
- notificar a una persona que pueda haber estado expuesta a una enfermedad o estar en riesgo de contraer o difundir una enfermedad o condición.

Abuso, negligencia o violencia doméstica: Podemos divulgar su información médica y de salud para notificar a las autoridades apropiadas del gobierno si creemos que usted ha sido víctima de abuso, negligencia o violencia doméstica. Sólo haremos esta divulgación si usted está de acuerdo o cuando así sea requerido o autorizado por la ley.

Actividades de supervisión de la salud: Podemos divulgar su información médica y de salud a una agencia federal o estatal de supervisión de la salud a los fines de que lleven a cabo actividades autorizadas por la ley. Estas actividades de supervisión son necesarias para que el gobierno monitoree el sistema de cuidado de la salud, los programas gubernamentales y el cumplimiento de las leyes de derechos civiles.

Demandas y disputas: Si usted se ve envuelto en un pleito o una disputa, podemos divulgar su información médica y de salud para responder a una orden judicial o administrativa. También podemos divulgar su información médica y de salud en respuesta a una citación, a un pedido de averiguación o a otro proceso legal iniciados por otra persona implicada en una disputa.

Aplicación de la ley: Podemos divulgar su información médica y de salud si la misma es solicitada por oficiales de aplicación de la ley en cualquiera de las siguientes circunstancias:

- como respuesta a una orden judicial, apercibimiento, caución, citación o proceso similar;
- para identificar o localizar a un sospechoso, fugitivo, testigo esencial o persona desaparecida;
- brindar información acerca de la víctima de un delito si, en ciertas circunstancias limitadas, no es posible obtener el consenso de la persona;
- brindar información acerca de una muerte que creemos puede ser resultado de una conducta criminal;
- brindar información acerca de una conducta delictiva en cualquiera de nuestros establecimientos; o

- en casos de emergencia, para reportar un delito, la escena de un crimen, la(s) víctima(s) o la identidad, descripción o ubicación de la persona que cometió el delito.

Funciones gubernamentales especializadas: Podemos divulgar su información médica y de salud a oficiales federales autorizados para realizar actividades de inteligencia y otras tareas relativas a la seguridad nacional autorizadas por la ley. Por ejemplo, podemos divulgar su información médica y de salud a oficiales federales para que puedan proporcionar protección al Presidente de los Estados Unidos o jefes de estado extranjeros, o para conducir investigaciones especiales autorizadas por la ley.

Podemos divulgar su información médica y de salud a oficiales del Departamento del Estado que tomen decisiones con respecto a su aptitud para obtener autorizaciones de seguridad o prestar servicio fuera del país.

Podemos divulgar su información médica y de salud a un médico forense o examinador médico. Esto puede ser necesario, por ejemplo, para identificar a una persona fallecida o para determinar la causa de su muerte. Asimismo, podemos difundir información médica y de salud acerca de clientes de CMS a directores de funerarias, según sea necesario para que desempeñen sus funciones.

Si usted es un presidiario en una institución correccional, también puede perder los derechos descriptos en este Aviso. Además, si usted es presidiario o está bajo la custodia lícita de un oficial de aplicación de la ley, podemos divulgar su información médica y de salud a tales oficiales.

OTROS USOS DE SU INFORMACIÓN PROTEGIDA DEL CUIDADO DE LA SALUD

Otros usos y divulgaciones de su información médica y de salud no cubiertos en este Aviso o por las leyes vigentes, serán llevados a cabo sólo con su autorización escrita. Si usted nos autoriza a utilizar o divulgar su información médica y de salud, puede revocar por escrito su autorización en cualquier momento. Si usted revoca su autorización, ya no utilizaremos o revelaremos su información médica de salud de acuerdo con los motivos expuestos en dicha autorización, con la excepción de que no podremos anular las divulgaciones efectuadas cuando la autorización tenía vigencia. Además, estamos obligados a conservar nuestros registros de los cuidados que le hayamos proporcionado.

CAMBIOS A ESTE AVISO

Nos reservamos el derecho de modificar o cambiar los términos de este Aviso, y de aplicar tales cambios a nuestras políticas y procedimientos con respecto a su información médica y de salud. Usted tiene el derecho de ser notificado sobre cualquier cambio a este Aviso y de recibir una copia escrita de esos cambios. Para obtener una copia de este Aviso una vez que haya sido cambiado, solicítela a su proveedor de tratamiento o a cualquier miembro del personal, o visite el sitio web del Condado de San Diego, http://www.co.san-diego.ca.us/hhsa/programs/sd/hipaa_administration/hipaa_privacy_practices.html

QUEJAS

Usted tiene el derecho de presentar una queja si considera que el personal de CMS no ha cumplido con las prácticas descriptas en este Aviso. Todas las quejas deben ser presentadas por escrito. No se le penalizará de ninguna manera por el hecho de presentar una queja.

Si considera que sus derechos de privacidad han sido violados, puede presentar una queja a CMS o al gobierno federal. Para presentar una queja a CMS, comuníquese con nuestro oficial de privacidad:

Privacy Officer
County of San Diego, Compliance Office
P.O. Box 85524 (Mail Stop: P501)
San Diego, CA 92186-5524
(619) 515-4244

Si desea presentar una queja ante el gobierno federal, comuníquese con el siguiente departamento:

U.S. Department of Health and Human Services
Region IX, Office for Civil Rights
50 United Nations Plaza – Room 322
San Francisco, CA 94102
Teléfono: (415) 437-8310
Fax: (415) 437-8329
TDD: (415) 437-8311
Correo electrónico: OCRComplaint@hhs.gov

Si desea obtener información específica para presentar una queja a la Oficina Federal de Derechos Civiles, notifique al oficial de privacidad mencionado anteriormente.

Si tiene alguna pregunta acerca de este Aviso, comuníquese con nuestro oficial de privacidad:

Privacy Officer
County of San Diego, Compliance Office
P.O. Box 85524 (Mail Stop: P501)
San Diego, California 92186-5524
(619) 515-4244

RECONOCIMIENTO DE RECIBO

Firmando esta forma, usted reconoce que recibe el Aviso Sobre Prácticas de Privacidad del Condado de San Diego. Nuestro Aviso Sobre Prácticas de Privacidad proporciona información de como nosotros podemos usar y revelar su información médica/de salud protegida. Le recomendamos leerla totalmente.

Nuestro Aviso Sobre Prácticas de Privacidad es sujeto a cambios. Si cambiamos nuestro aviso, usted puede obtener una copia del aviso revisado visitando el sitio web del Condado, http://www.co.san-diego.ca.us/hhsa/programs/sd/hipaa_administration/hipaa_privacy_practices.html o poniéndose en contacto con cualquier personal participando con su tratamiento.

Si usted tiene alguna pregunta sobre nuestro Aviso Sobre Prácticas de Privacidad, por favor póngase en contacto con el oficial de privacidad:

Privacy Officer
County of San Diego Compliance Office
P.O. Box 85524 (Mail Stop: P501)
San Diego, CA 92186-5524
(619) 515-4244

Reconozco el recibo del Aviso Sobre Prácticas de Privacidad del Condado de San Diego.

Firma (Solicitante/Beneficiario de CMS)	Fecha

Inability to Obtain Acknowledgement
To be completed only if no signature is obtained. If it is not possible to obtain the client's acknowledgement, describe the good faith efforts made to obtain the client's acknowledgement, and the reasons why the acknowledgement was not obtained:

County Staff Signature	Date

Name and Title Printed

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

SSI ADVOCACY REFERRAL

TO: **Legal Aid SSI Program Mgr**	FROM:	DATE:
1764 San Diego Ave, Suite 200 San Diego, CA 92110 (619) 471-2648; (619) 471-2653 (Fax)	☐ ASO ☐ County Worker Referred by: _____ (Print Name)	TELEPHONE:

CONSUMER INFORMATION		
Name:		
Date of Birth:	**SSN:**	**Telephone:**
Address:	**City:**	**Zip Code:**

SSI ADVOCACY SERVICE

SSI Advocacy Services is to assist you in applying for SSI/SSP. Legal assistance/representation is free to you. I agree to send my information on this referral and cooperate with the SSI Advocate during the SSI application process.

Signature: _____ **Date:** _____

SSI INFORMATION	**MEDI-CAL**	**EXAMPLES OF CRITERIA FOR REFERRAL**
☐ SSI/SS Disability application needed ☐ SSI application filed: _____ ☐ SS Disability application filed: _____ ☐ Initial SSI application denied on: _____ ☐ SSI appeal denied on: ____ ☐ SSI reconsideration denied on: _____ ☐ Hearing date pending ☐ Hearing date: _____ ☐ Needs to reapply Comments:	☐ DDSD referral ☐ Medi-Cal application filed: _____ ☐ Medi-Cal pending **CMS STATUS** ☐ Pending ☐ Granted ☐ Documentation attached	1. Patients with chronic disease diagnosis without co-morbidities recertified for a year. 2. Patients with Stage I or Stage II Cancer undergoing chemotherapy or radiation therapy. 3. Patients who are case managed but still need assistance with SSI paperwork. 4. Patients with cognitive deficits and/or mental health issues. 5. At the discretion of the Case Manager on a case by case basis refer at the point of reconsideration, and consultative exam. 6. Unable to work due to physical or mental illness, disability or impairment that is expected to last longer than 1 year. 7. Declaring to be blind, deaf or disabled. 8. SSA Disability/Social Security Supplemental Income (SSI) denied within 12 months and condition has worsened or has a new medical condition.

REFERRAL INFORMATION

(Provide additional information to the advocate such as…patient representative, general medical condition, behavioral problems, homeless, illiteracy, cultural nuances, history of ETOH and or Drug use, mental health condition, etc.)

SSI ADVOCACY SERVICES INFORMATION

☐ Previously non-cooperative with advocate ☐ Non-cooperative with advocate (Explain) ☐ Successful SSI appeal unlikely (Explain) ☐ Cooperative with advocate ☐ No qualifying SSI disability (Explain)	Explanation:

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

REFERENCIA AL DEFENSOR DE BENEFICIOS DE SSI

TO: **Legal Aid SSI Program Mgr**	FROM:	DATE:
1764 San Diego Ave, Suite 200 San Diego, CA 92110 (619) 471-2648; (619) 471-2653 (Fax)	☐ ASO ☐ County Worker Referred by: _____ (Print Name)	TELEPHONE:

CONSUMER INFORMATION

Name:		
Date of Birth:	**SSN:**	**Telephone:**
Address:	**City:**	**Zip Code:**

LOS SERVICIOS DE DEFENSA PARA BENEFICIOS DE SSI

Los servicios de Defensa para los beneficios de Social Security Suplemental Income (SSI) son para asistirle con la solicitud de SSI. La asistencia legal/representación le es gratuita.

Consiento en enviar mi información en esta referencia y cooperar con el Defensor durante el proceso de la solicitud para beneficios de SSI.

Firma:_____ **Fecha:**_____

SSI INFORMATION	MEDI-CAL	EXAMPLES OF CRITERIA FOR REFERRAL
☐ SSI/SS Disability application needed ☐ SSI application filed: _____ ☐ SS Disability application filed: _____ ☐ Initial SSI application denied on: _____ ☐ SSI appeal denied on: ____ ☐ SSI reconsideration denied on: _____ ☐ Hearing date pending ☐ Hearing date: _____ ☐ Needs to reapply Comments:	☐ DDSD referral ☐ Medi-Cal application filed: _____ ☐ Medi-Cal pending **CMS STATUS** ☐ Pending ☐ Granted ☐ Documentation attached	1. Patients with chronic disease diagnosis without co-morbidities recertified for a year. 2. Patients with Stage I or Stage II Cancer undergoing chemotherapy or radiation therapy. 3. Patients who are case managed but still need assistance with SSI paperwork. 4. Patients with cognitive deficits and/or mental health issues. 5. At the discretion of the Case Manager on a case by case basis refer at the point of reconsideration, and consultative exam. 6. Unable to work due to physical or mental illness, disability or impairment that is expected to last longer than 1 year. 7. Declaring to be blind, deaf or disabled. 8. SSA Disability/Social Security Supplemental Income (SSI) denied within 12 months and condition has worsened or has a new medical condition.

REFERRAL INFORMATION

(Provide additional information to the advocate such as…patient representative, general medical condition, behavioral problems, homeless, illiteracy, cultural nuances, history of ETOH and or Drug use, mental health condition, etc.)

SSI ADVOCACY SERVICES INFORMATION

☐ Previously non-cooperative with advocate ☐ Non-cooperative with advocate (Explain) ☐ Successful SSI appeal unlikely (Explain) ☐ Cooperative with advocate ☐ No qualifying SSI disability (Explain)	Explanation:

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES
MEDI-CAL REFERRAL

To: _____
Family Resource Center (FRC) (Mail Stop)

_____
Address

From: _____
County Representative (Mail Stop)

_____
Facility

_____
Address

(_____) _____
Phone

Date: ____/____/____

Comments: _____

NOTE: If needed, contact the County Representative to obtain eligibility information and verifications from the CMS case.

APPLICANT INFORMATION

Name: _____ SSN: _____
(Last) (First) (MI)

Birth Date: _____ Phone: (_____) _____

Address: _____

City: _____ Zip: _____

Spouse in home:

Name: _____ Birth Date: ____/____/____ SSN: _____
(Last) (First) (MI)

REASON FOR MEDI-CAL REFERRAL

- ❒ Parent of minor child in home
- ❒ Under 21 or over 64 years of age
- ❒ Permanently/indefinitely disabled/blind
- ❒ Refugee/Entrant Program
- ❒ Pregnant
- ❒ Long Term Care
- ❒ DAPD including retro month(s) needed to cover the period of _____through the current month
- ❒ Request Retro for months: _____
- ❒ Other _____

MEDI-CAL APPLICATION DISPOSITION
HSS ACTION – Complete and return to CMS per distribution instructions

❒ Pending DAPD Determination Date DAPD Packet Sent _____	❒ Approved	❒ Denied Reason/Denial Code:

Case Number (include Aid Serial, Aid Type)	Application Date (include retro months)	Effective Date

Other Health Care Coverage? ❒ YES ❒ NO If yes, attach copy of Health Insurance Questionnaire DHS 6155

HSS Name: _____ HSS Number: _____

HSS Phone: (_____) _____ Date: ____/____/____

COMMENTS: _____

_____

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES
THIRD PARTY LIABILITY REPORT

Case Name	Eligibility Site

Complete the following information for all applicants who have medical bills for which another party may be responsible (e.g., auto accident, job injuries, and injuries because of another's negligence). Include area codes for all telephone numbers.

A: Injured Applicant Information			
Name:		Birth Date:	Social Security Number:
Address (Street, Apt., Space):	City:	Zip:	Phone:
Applicant's Representative/Attorney/Insurance Company:			Phone:
Address (Street or P.O. Box):	City:	Zip:	

B: Accident Report			
Date accident/injury occurred:		at (location):	
Initial treatment was given at (name of hospital/clinic):			
Type of accident		Type of injury	
Police report filed? [ ] Yes [ ] No		Did injury occur on the job? [ ] Yes [ ] No	

C: Party who may be responsible for payment for accident/injury			
Name of Insured/Responsible Party:			
Address of Insured/Responsible Party:	City:	Zip:	Phone:
Name of Insurance Company:	Policy Number:		Claim Number:
Address of Insurance Company:	City:	Zip:	Phone:
Name of Attorney:			Phone:
Address of Attorney:	City:	Zip:	
Additional Information:			

I understand that I am responsible for immediately reporting to a County Medical Services (CMS) Representative when there is the possibility of payment of CMS services from 1) my own insurance company or 2) from a third party when a lawsuit is filed and the action results in a judgment awarded to me. I agree to repay CMS for services related to this incident from any proceeds I receive from my own insurance or judgment up to the amount paid by CMS to providers of my medical care. I authorize CMS to release information necessary to resolve this third party claim.

Applicant's Signature _____ Date _____ Worker's Signature _____

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES
REPORTE DE RESPONSABILIDAD DE TERCEROS

Case Name	Eligibility Site

Complete la siguiente información para todo solicitante que tenga cuentas médicas de las cuales otra persona pudiera ser responsable (ej., accidente automovilístico, daño de trabajo, daños por negligencia de otros). Incluya código de área de todos los números de teléfono.

A: Información del Solicitante Herido.		
Nombre:	Fecha de Nacimiento:	Número de Seguro Social:
Domicilio (Calle. Apt., Espacio): Ciudad: Código Postal:		Teléfono:
Representante del Solicitante/Abogado/Compañía de Seguros:		Teléfono:
Domicilio (Calle o Apartado Postal): Ciudad: Código Postal:		

B: Reporte del Accidente	
Fecha de cuándo ocurrió el accidente/la herida : Lugar:	
Los primeros tratamientos se recibieron en (nombre del hospital/clínica):	
Tipo de accidente	Tipo de herida/daño
¿Se presentó un reporte policíaco? [ ] Si [ ] No	¿La herida ocurrió en el trabajo? [ ] Si [ ] No

C: Persona/Entidad que pudiera ser responsable del pago para el accidente/herida			
Nombre de la persona asegurada/responsable:			
Dirección de la persona asegurada/responsable:	Ciudad:	Código Postal:	Teléfono:
Nombre de la Compañía de Seguros:	Número de Póliza:		Número de Reclamo:
Dirección de la Compañía de Seguros:	Ciudad:	Código Postal:	Teléfono:
Nombre del Abogado:			Teléfono:
Dirección del Abogado:	Ciudad:	Código Postal:	
Información adicional:			

Entiendo que soy responsable de reportar inmediatamente al Representante de County Medical Services (CMS, por sus siglas en inglés) cuando exista la posibilidad de pago a CMS de parte de: 1) mi propia compañía de seguros o 2) de una tercera persona responsable cuando se lleve a cabo una demanda judicial y resulte en una orden judicial a mi favor. Estoy de acuerdo con reembolsar a CMS por servicios relacionados con este incidente de cualquier recurso que reciba de mi propio seguro o de la demanda judicial, todo dinero pagado por CMS a instituciones que me proporcionaron atención médica. Por este medio autorizo a CMS que revele información necesaria con el fin de resolver este reclamo a un tercer responsable.

Firma del Solicitante _____ Fecha _____ Firma del Trabajador(a) _____

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES
VERIFICATION CHECKLIST

DATE:		COUNTY REPRESENTATIVE:	
MEMBER ID:		PHONE:	
TO:		LOCATION:	
ADDRESS:		ADDRESS:	

IMPORTANT INFORMATION: We need the following documents to determine your County Medical Services (CMS) eligibility. Please mail or bring all items checked below to the County Representative identified above. If you need help or more time getting them, call the County Representative before the due date listed below.

These items are due by: _____.

[ ] Pay stubs for _____
[ ] Award letter or copy of current check for:
  [ ] Social Security
  [ ] VA Benefits
  [ ] State Disability or unemployment
[ ] Child Support and/or Alimony proof
[ ] Income Tax return
[ ] Bank Statement for _____
[ ] Life insurance policy
[ ] Property tax statement
[ ] Vehicle registration for _____
_____
[ ] CMS Lien forms
[ ] CMS Hardship Application
[ ] Rent receipt
[ ] Utility bills

[ ] Original US citizenship documentation
[ ] Immigration status documentation
[ ] Identity
[ ] Social Security card
[ ] Health insurance information
[ ] Accident report
[ ] Other:
_____
_____
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Comments _____
_____

If you need help, the Consumer Center for Health Education and Advocacy may be able to give you free assistance throughout the CMS application process. Their toll free telephone number is 1 (877) 734-3258.

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES
LISTA DE VERIFICACIONES

FECHA:		REPRESENTANTE DEL CONDADO:	
NO. DE MIEMBRO:		TELEFONO:	
PARA:		UBICACION:	
DOMICILIO:		DOMICILIO:	

INFORMACIÓN IMPORTANTE: Se necesitan los siguientes documentos para determinar su elegibilidad para el programa County Medical Services (CMS, por sus siglas en inglés). Por favor envíe por correo o traiga todos los documentos señalados abajo al Representante de Condado mencionado arriba. Si necesita ayuda o más tiempo para obtenerlos, comuníquese con el Representante del Condado antes de la fecha indicada abajo.

Estos documentos se necesitan para el día ___/___/___.

- [ ] Talón de cheque para _____
- [ ] Carta de otorgamiento o copia del cheque más reciente de:
  - [ ] Seguro Social
  - [ ] Beneficios de Veteranos
  - [ ] Incapacidad Estatal o desempleo
- [ ] Prueba de sostenimiento de hijo y/o cónyuge
- [ ] Devolución de Impuesto
- [ ] Estado de cuenta de _____
- [ ] Póliza de seguro de vida
- [ ] Declaración de impuesto sobre propiedad
- [ ] Registro de carro de _____
  _____
- [ ] Formas del Traspaso de Gravamen de CMS
- [ ] Solicitud por Circunstancia Extrema de CMS
- [ ] Recibo de renta
- [ ] Cuenta de luz y gas
- [ ] Documentación original de ciudadanía
- [ ] Documentación de estado de inmigración
- [ ] Identidad
- [ ] Tarjeta del Seguro Social
- [ ] Información de seguro médico
- [ ] Reporte de accidente
- [ ] Otro:
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____

Comentario _____

_____

Si necesita ayuda, el Centro del Consumidor para la Educación sobre la Salud y Defensa de sus Derechos le puede dar asistencia gratuita durante el proceso de su solicitud para CMS. El número de servicio telefónico gratuito es 1 (877) 734-3258.

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES
REMINDER REQUEST FOR VERIFICATIONS

DATE:	COUNTY REPRESENTATIVE:
MEMBER ID:	PHONE:
TO:	LOCATION:
ADDRESS:	ADDRESS:

This letter is a reminder that you need to provide verifications that are needed to determine your eligibility to County Medical Services (CMS). These verifications were previously requested on ___/___/___.

Please mail or bring the following items to the County Representative listed above.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

These verifications must be received by the County no later than ___/___/___.

If you cannot get the verifications, call the County Representative immediately for assistance. You must explain why you cannot provide the verifications.

You have already been given 10 days to provide the requested items. You now have an additional 10 days, for a total of 20 days to provide the verifications. If you are not able to provide the requested information within this additional 10 day period, and can show good cause, you may be granted additional time to provide the information.

If you do not call, the County Representative will consider this a refusal to cooperate with the County in providing verifications needed to determine your CMS eligibility and your CMS application will be denied.

If you need help, the Consumer Center for Health Education and Advocacy may be able to give you free assistance throughout the CMS application process. Their toll free telephone number is 1 (877) 734-3258.

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES
RECORDATORIO DE VERIFICACIONES PENDIENTES

FECHA:	REPRESENTANTE DEL CONDADO:
NO. DE MIEMBRO:	TELEFONO:
PARA:	UBICACION:
DOMICILIO:	DOMICILIO:

Esta carta es un recordatorio de que necesita proporcionar verificaciones que son necesarias para determinar su elegibilidad para el programa County Medical Services (CMS, por sus siglas en inglés). Estas verificaciones se le pidieron anteriormente el día ____/____/____.

Por favor envíe por correo o traiga los siguientes documentos al Representante del Condado indicado arriba.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Estas verificaciones se deben recibir por el Condado a más tardar para el día ___/___/___.

Si no puede proporcionar las verificaciones, llame inmediatamente a su Representante del Condado para asistencia. Necesita explicar el motivo por el cual no puede obtener las verificaciones.

Se le han dado ya 10 días para proporcionar los documentos necesarios. Usted ahora tiene 10 días más, para un total de 20 días para proporcionar las verificaciones. Si no es capaz de proporcionar la información que se le pide durante el periodo de estos 10 días adicionales, y puede demostrar una buena causa, se le puede conceder tiempo adicional para proporcionar la información.

Si no llama, el Representante del Condado lo considerará como que usted se ha negado a cooperar con el Condado en entregar las verificaciones necesarias para determinar su elegibilidad para el programa CMS y su solicitud para el programa CMS sea negada.

Si necesita ayuda, el Centro del Consumidor para la Educación sobre la Salud y Defensa de sus Derechos le puede dar asistencia gratuita durante el proceso de su solicitud para el programa CMS. El número de servicio telefónico gratuito es 1 (877) 734-3258.

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES
COVERAGE INFORMATION

1. CMS is **NOT** a health insurance program and does not cover all medical problems. CMS do **NOT** cover services such as routine dental and vision care, pregnancy, family planning or infertility services. CMS do **NOT** cover organ, limb and bone marrow transplants and related services, visits to the emergency room (ER) for follow-up and prescription refills, or cosmetic surgery. CMS do **NOT** cover treatment for mental health, alcohol and drug problems. A complete listing of what is and is not covered can be found in the CMS Patient Handbook.
2. If you have been approved CMS with a monthly share-of-cost, you must pay or obligate to pay the amount of your monthly share-of-cost towards the cost of CMS covered health care services in each month you receive CMS services.
3. You must go to your primary care provider at the community health center you selected, except for emergencies. Your primary care provider will provide or arrange for all the care that you need.
4. Medical care that cannot be provided by your primary care provider must be requested by your doctor and approved in advance by CMS medical staff. Your doctor will tell you if CMS has approved the service and may help to make your appointment. **If you receive services that were not approved by CMS, you are responsible for paying the bill.**
5. If you have seen a specialist and your condition is stable, future medical care will continue through your primary care provider.
6. For scheduled hospital admissions, you should verify that the admission is at a CMS contracted hospital; otherwise the hospital may bill you for the services it provides.
7. Emergency room (ER) services are covered by CMS **ONLY:**
   - if your medical problem requires immediate attention,
   - the service you receive is a covered service, and
   - you are CMS certified for the ER visit.

   You should show your CMS Member card to the hospital ER staff before you leave the hospital.
8. CMS provides covered prescription medications. If your physician prescribes a medication that is not covered by CMS, the pharmacist or physician must request approval before filling the prescription. Prescriptions must be filled by a San Diego CMS pharmacy or by your primary care provider. If you fill your prescription at a pharmacy that is not a San Diego CMS pharmacy, or you fill a prescription that CMS did not approve, you are responsible for paying for the medication yourself.
9. CMS pays only for medical services provided within San Diego County.
10. Approval of CMS does not imply that all services will be covered by CMS.
11. The CMS Patient Handbook has other important information about the program and has a list of the clinics, pharmacies, and hospitals contracted with CMS.
    http://www.sdcounty.ca.gov/hhsa/programs/ssp/documents/PatientHandbook-ENG.pdf

I acknowledge that the County Representative reviewed the above information with me, and I fully understand the CMS coverage limitations.

Applicant or Representative	Date
Interpreter (if necessary)	Date
County Representative	Date

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES
INFORMACIÓN DE COBERTURA

1. CMS **NO** es un programa de seguro médico y no cubre todo problema médico. CMS **NO** cubre exámenes físicos rutinarios y cuidado preventivo, cuidados rutinarios dentales y de la visión, servicios de embarazo, planificación familiar o infertilidad. CMS **NO** cubre trasplantes de órganos, extremidades o médula ósea y servicios relacionados, visitas a la sala de emergencia (ER) para cuidados continuos y surtir recetas, o cirugía cosmética. CMS **NO** cubre tratamiento de salud mental, y/o problemas de alcohol y drogas. Una lista completa de lo que es y no es cubierto se encuentra en el manual de pacientes de CMS.
2. Si los beneficios para el programa CMS se han aprobado con una parte de costo mensual, usted necesita pagar u obligarse a pagar la cantidad mensual de su parte de costo cada mes que usted reciba servicios médicos que cubre CMS.
3. Usted debe ir con su proveedor de cuidado primario en el centro de salud de la comunidad que usted seleccionó, a excepción de emergencias. Su proveedor de cuidado primario le proporcionará o hará los arreglos para todo el cuidado que usted necesita.
4. Cualquier cuidado médico que no pueda ser proporcionado por su proveedor de cuidado primario debe ser solicitado por su doctor y aprobado por adelantado por el personal médico de CMS. Su doctor le dirá si CMS ha aprobado el servicio y puede ayudarle a hacer su cita. **Si usted recibe servicios que no fueron aprobados por CMS, usted es responsable de pagar la cuenta.**
5. Si usted ha visto a un especialista y su condición es estable, la futura asistencia médica continuará a través de su proveedor de cuidado primario.
6. Para admisiones programadas de hospital, usted debe de verificar que la admisión es en un hospital contratado con CMS, de lo contrario, el hospital puede cobrarle a usted por los servicios que le proporcionó.
7. Los servicios de la Sala de Emergencia son cubiertos por CMS **UNICAMENTE:**
   - si su problema médico requiere atención inmediata,
   - el servicio que usted recibe es un servicio cubierto, y
   - usted ha sido aprobado para el programa CMS para la visita de la Sala de Emergencia.

   Usted debe mostrar su tarjeta de CMS al personal de la Sala de Emergencia del hospital antes de que usted salga del hospital.
8. CMS cubre medicamentos que requieren receta. Si su médico receta medicamento que no está cubierto por CMS, el farmacéutico o médico tiene que pedir aprobación antes de llenar la receta. Las recetas se tienen que llenar en farmacias contratadas por CMS o por su proveedor primario. Si usted llena su receta en una farmacia no contratada por CMS o si usted llena una receta que CMS no aprobó, usted será responsable por el pago de su receta.
9. CMS únicamente paga por servicios médicos proporcionados dentro del Condado de San Diego.
10. Aprobación al programa CMS no implica que todos los servicios serán cubiertos por CMS.
11. El Manual para Pacientes de CMS tiene información importante adicional sobre este programa y tiene una lista de los centros de salud de la comunidad, farmacias y hospitales que participan con CMS. http://www.sdcounty.ca.gov/hhsa/programs/ssp/documents/PatientHandbook-SPA.pdf

Reconozco que el representante de Condado ha repasado conmigo la información mencionada arriba y yo entiendo completamente las limitaciones de cobertura del programa CMS.

Solicitante o Representante	Fecha
Intérprete (si es necesario)	Fecha
Representante de CMS	Fecha

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES PROGRAM

IMAGE VERIFICATION CHECKLIST

Name: _____

Member ID #: _____

Worker Name: _____

Read all forms then place your initials next to the forms which you have received.

You Initial Here	Spouse Initials Here	
		CMS-15 CMS Rights and Responsibilities of Applicants (07/2011)
		CMS-23 CMS Coverage Information (12/2014)
		CMS-007 CMS General Property Limitations (03/2011)
		CMS-123 CMS Lien Information (2/2011)**
		CMS-123A CMS Lien Acknowledge Statement (1/2008)**
		CMS Health Plan NPP-002 Notice of Privacy Practices (12/2014)

****NOTE:** Forms CMS-123 and CMS-123A are **NOT** included in the recertification mail-in packet.

I/we hereby state that I/we have received all forms listed. I/we acknowledge that I/we have reviewed and fully understand the forms.

_____ _____
Signature of Applicant Date

_____ _____
Signature of Spouse Date

_____ _____
Signature of Authorized Representative Date

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES PROGRAM

LISTA DE VERIFICACION DE IMAGEN

Nombre: _____

No. de Miembro: _____

Nombre del/la Trabajador/a: _____

Lea todas las formas y ponga sus iniciales junto a las formas que ha recibido.

Sus Iniciales	Iniciales de su Cónyuge	
		CMS-15 CMS Derechos y Responsabilidades del Solicitante (07/2011)
		CMS-23 CMS Información de Cobertura (12/2014)
		CMS-007 Limitaciones Generales de Propiedad del Programa CMS (03/2011)
		CMS-123 Información de Gravamen (CMS) (2/2011)**
		CMS-123A (SP) Declaración de Reconocimiento de Gravamen de CMS (1/2008)**
		CMS Health Plan NPP-002 (SP) Aviso Sobre Prácticas de Privacidad (12/2014)

****NOTA:** Forma CMS-123 y CMS-123A (SP) **NO** se incluyen en el paquete para renovar por correo el programa CMS.

Yo/nosotros declaramos por medio de la presente que he/hemos recibido todas las formas en la lista. Yo/nosotros reconozco/reconocemos que he/hemos revisado y entendido perfectamente las formas.

_____ _____
Firma del Solicitante Fecha

_____ _____
Firma del Esposo(a) Fecha

_____ _____
Firma del Representante Autorizado Fecha

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____ hereby voluntarily authorize the County of San Diego Health and Human Services Agency (HHSA) to release the following information to _____.
(NAME OF AGENCY, INSTITUTION, INDIVIDUAL PROVIDER)

The County of San Diego HHSA may release the following information related to this application for Medi-Cal and/or County Medical Services (CMS). (*Check all that apply*):

☐ Copy of notices requesting information and/ or verifications needed to process my Medi-Cal and/or CMS application(s).
☐ Medi-Cal/CMS eligibility status is limited to application pending, application granted, Share of Cost, application denied, and reason for denial.

This information is needed for the purpose of evaluating eligibility for Medi-Cal and/or CMS.

- I understand that my personal health information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the federal privacy regulations.
- This authorization may be revoked and/or modified at any time, exception to the extent that action has already occurred. I understand if I revoke this authorization, I must do so in writing.
- I have the right to request in writing a copy of information being disclosed.
- If applicant is unable to sign this authorization, a legal guardian or other person with lawful authority to act on the applicant's behalf could sign on his/her behalf; and has the right to receive a copy of the authorization signed.
- I am entitled to a copy of this authorization, if I request one.
- This authorization expires 6 months from the initial signing date.

I HAVE READ THIS FORM AND AGREE TO THE DISCLOSURE ABOVE.

APPLICANT'S NAME (PRINT)	APPLICANT'S SSN
APPLICANT'S SIGNATURE	DATE SIGNED
SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR PERSON ACTING FOR APPLICANT	DATE SIGNED
PRINT NAME OF WITNESS TO MARK, INTERPRETER, OR PERSON ACTING FOR APPLICANT	RELATIONSHIP TO APPLICANT, IF NOT SELF

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

AUTORIZACIÓN PARA PROPORCIONAR INFORMACIÓN

Yo, _____ por este medio autorizo voluntariamente que la Agencia de Salud y Servicios Humanos (HHSA, por su sigla en inglés) del Condado de San Diego otorgue la siguiente información a _____.
(NOMBRE DE AGENCIA, INSTITUCIÓN, PROVEEDOR INDIVIDUAL)

La Agencia HHSA del Condado de San Diego puede otorgar la siguiente información relacionada a esta solicitud para el programa Medi-Cal y/o County Medical Services (CMS). (*Marque todo lo que aplica*):

☐ Copia de avisos donde se solicita información y/o las verificaciones necesarias para procesar mi solicitud(es) para el programa de Medi-Cal y/o CMS.
☐ Estado de elegibilidad de la solicitud para el programa de Medi-Cal/CMS es limitado a mi solicitud pendiente, solicitud aprobada, parte de costo, solicitud negada, y la razón por la cual mi solicitud fue negada.

Esta información se necesita para evaluar elegibilidad para el programa Medi-Cal y/o CMS.

- Entiendo que mi información de salud personal revelada de acuerdo con esta autorización puede ser sujeta a revelarse de nuevo al destinatario y ya no será protegida por las regulaciones de privacidad federal.
- Esta autorización puede ser revocada y/o modificada en cualquier momento, con excepción de la acción que ya ocurrió. Entiendo que si revoco esta autorización, debo de hacerlo por escrito.
- Tengo el derecho de solicitar por escrito una copia de la información revelada.
- Si el solicitante es incapaz de firmar esta autorización, un representante legal u otra persona con autoridad legal que actúe en el nombre del solicitante puede firmar en su nombre; y tiene el derecho de recibir una copia de esta autorización firmada.
- Tengo el derecho de una copia de esta autorización, si la solicito.
- Esta autorización vence a los 6 meses de la fecha de su firma.

HE LEÍDO ESTA FORMA Y ESTOY DE ACUERDO CON LA DECLARACIÓN ANOTADA ARRIBA.

NOMBRE DEL SOLICITANTE (LETRA DE MOLDE)	NÚMERO DE SEGURO SOCIAL DEL SOLICITANTE
FIRMA DEL SOLICITANTE	FECHA CUANDO SE FIRMÓ
FIRMA DEL TESTIGO SI FIRMA CON UNA MARCA, INTÉRPRETE, O PERSONA QUE ACTÚA COMO EL SOLICITANTE,	FECHA CUANDO SE FIRMÓ
NOMBRE EN MOLDE DEL TESTIGO SI FIRMA CON UNA MARCA, INTÉRPRETE, O PERSONA QUE ACTÚA COMO EL SOLICITANTE,	RELACIÓN AL SOLICITANTE, SI NO ES SI MISMO

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES
MEDI-CAL REFERRAL INFORMING LETTER

Date: **TODAY'S DATE**

To: **APPLICANT'S NAME**
STREET ADDRESS
CITY, STATE AND ZIP CODE

Member ID#: **MEMBER #**
Social Worker: **MASU NAME**
Phone #: **MASU PHONE #**

REQUEST FOR COUNTY MEDICAL SERVICES (CMS) PROGRAM

You are receiving this letter because you have made an appointment to apply for CMS and are potentially linked to disability based Medi-Cal. Program regulations for CMS require that you apply for and fully complete the Medi-Cal disability application process for full scope Medi-Cal. **Failure to do so will result in a denial of your CMS application.**

To assist you with your application for disability based Medi-Cal, you have been referred to Social Worker **ENTER MASU NAME HERE.** You will be asked to do the following:

- Complete a Medi-Cal application, the disability packet and **all** supplemental forms;
- Call the Social Security Administration at **1-800-772-1213** to apply for Social Security Disability benefits (SSDI)/Supplemental Security Income (SSI); and
- Provide proof of County residence, identity, citizenship/eligible alien status, property and income.

If you have not heard from your Social Worker within 10 calendar days of the date of this letter, please call your Social Worker listed above.

Thank you.

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES
CARTA INFORMATIVA DE REFERENCIA PARA MEDI-CAL

Fecha: **TODAY'S DATE**

Para: **APPLICANT'S NAME**
STREET ADDRESS
CITY, STATE AND ZIP CODE

No. de Miembro: **MEMBER #**
Trabajador(a) Social: **MASU NAME**
No. de Teléfono: **MASU PHONE #**

SOLICITUD PARA EL PROGRAMA COUNTY MEDICAL SERVICES

Usted recibe esta carta porque ha hecho una cita para solicitar el programa County Medical Services (CMS, por sus siglas en inglés) y con la posibilidad de ser elegible a beneficios basados de Medi-Cal por incapacidad. Los reglamentos del programa CMS requiere que usted solicite y complete totalmente el proceso de la solicitud para beneficios completos de Medi-Cal. **No cumplir con este requisito resultará en que su solicitud para CMS sea negada.**

Para asistirle con su solicitud para beneficios basados de Medi-Cal por incapacidad, se le ha referido al Trabajador Social **ENTER MASU NAME HERE.** Se le pedirá que haga lo siguiente:

- Completar la solicitud para el programa Medi-Cal, el paquete de discapacidad y **todas** las formas suplementales;
- Llamar a la oficina del Seguro Social al **1-800-772-1213** para solicitar beneficios por Discapacidad del Seguro Social (SSDI)/Seguridad de Ingreso Suplemental (SSI); y
- Proporcionar verificación de residencia del Condado, identidad, ciudadanía/estado de inmigración, propiedad e ingreso.

Si su Trabajador Social no se ha comunicado con usted dentro de diez días consecutivos de la fecha de esta carta, favor de comunicarse con su Trabajador(a) Social anotado(a) arriba.

Gracias.

County of San Diego

HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

NOTICE OF ACTION

Date: _____ Member ID#: _____

CMS Representative: _____

To: _____ CMS Representative #: _____

_____ Phone: _____

_____ Location: _____

_____ Address: _____

Your application for County Medical Services (CMS) dated ___/___/___ is denied for the following reason(s):

- ☐ Not a Citizen/Eligible Alien
- ☐ Not a County Resident
- ☐ Lien Forms Not Completed
- ☐ Failed to Attend Appointment
- ☐ Recertification Mail-in Packet Not Received Timely
- ☐ You have enrolled in other health insurance
- ☐ Your CMS net income is more than 350% of the Federal Poverty Level (FPL)
- ☐ Application Withdrawn
- ☐ Medi-Cal Linkage
- ☐ Whereabouts Unknown
- ☐ Failed to Complete the Medi-Cal Process
- ☐ Credit Report Form Not Completed

Source of Income:	_____
Gross Income:	$ _____
Deductions:	$ _____
CMS Net Income:	$ _____
Maintenance Need (CMS):	$ _____
Excess Income:	$ _____

☐ You failed to provide _____

_____

SEE IMPORTANT NOTE ON REVERSE

☐ Excess Property

Nonexempt Property Items		Net Market Value
_____	$	_____
_____	$	_____
_____	$	_____
_____	$	_____

Total Nonexempt Property $_____

Property Limit -$_____

Excess Property =$_____

To become eligible for CMS, you must spend the amount of your excess property by paying for health care that you received. The health care must be within the CMS scope of services. You may also spend it on current month rent or mortgage and current month utilities excluding cable TV. Talk to the CMS Representative listed above if you want to request this allowance. You must give proof of spending the amount of _____for the month of _____ to the CMS Representative listed above within **30 days** of the date of this notice.

IF YOUR SITUATION CHANGES, YOU MAY REAPPLY FOR CMS AT ANY TIME

If you disagree with this action, you have the right to request an Administrative Hearing conducted by a County Hearing Officer. You must file your appeal within fourteen (14) calendar days of the date of this notice by writing to or calling (collect calls accepted):

San Diego County Health and Human Services Agency
Appeals Section - GR/CMS Calendar Clerk
1255 Imperial Avenue, Suite 300
San Diego, CA 92101
Phone: (619) 237-8534

Requests submitted after 14 calendar days shall only be considered if you present good cause for missing the deadline.

The Consumer Center for Health Education and Advocacy may be able to offer you free advice on how to handle your appeal. For more information call 1-877-734-3258.

CMS Regulations:

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

NOTICE OF ACTION

Fecha: _____

Para: _____
_____
_____

No. de Miembro: _____
Representante de CMS: _____
No. del Representante de CMS: _____
Teléfono: _____
Ubicación: _____
Domicilio: _____

Su solicitud para County Medical Services (CMS, por sus siglas en inglés) con fecha ___/___/___ ha sido negada por la(s) siguiente(s) razón(es):

- ☐ No es Ciudadano/Extranjero Elegible
- ☐ No es Residente del Condado
- ☐ Faltó de Completar las Formas de Gravamen
- ☐ No Se Presentó a la Entrevista
- ☐ El Paquete Para Renovar el Programa CMS No Se Recibió a Tiempo
- ☐ Se ha inscrito en otro seguro médico
- ☐ Solicitud Retirada
- ☐ Está unido a Medi-Cal
- ☐ Se Desconoce Donde Se Encuentra
- ☐ No Completó el Proceso del Programa Medi-Cal
- ☐ No Completó La Forma del Reporte de Crédito
- ☐ Su ingreso neto para el Programa CMS es más de 350% del Nivel de Pobreza Federal (FPL).

Fuente de Ingresos:	_____
Ingreso Bruto:	$ _____
Deducciones:	- $ _____
Ingreso Neto:	$ _____
Necesidad Para Mantenimiento (CMS):	- $ _____
Exceso de Ingreso:	$ _____

- ☐ Faltó de proporcionar _____

FAVOR DE VER LA INFORMACION IMPORTANTE AL REVERSO

☐ Exceso de Propiedad

Artículos de Propiedad no Exentos		Valor Neto de Mercado
_____	$	_____
_____	$	_____
_____	$	_____
_____	$	_____

Propiedad/recursos no exentos en Total $_____

Limite de propiedad/recursos -$_____

Propiedad/recursos excedente =$_____

Para poder ser elegible al programa CMS, debe de gastar la cantidad en exceso de su propiedad/ recursos pagando por servicios médicos que haya recibido. Los servicios médicos deben ser parte del criterio de cobertura del programa CMS. También puede gastar la cantidad pagando su renta/ abono de casa o pagando los servicios públicos, excluyendo pago de televisión por cable, para el mes actual. Debe comprobar cómo gastó la cantidad de $_____para el mes de _____al Representante de CMS anotado arriba dentro de **30 días** a partir de la fecha de esta notificación.

SI SU SITUACIÓN CAMBIA, USTED PUEDE VOLVER A SOLICITAR EL CMS EN CUALQUIER MOMENTO.

Si usted no está de acuerdo con esta decisión, tiene el derecho de apelar solicitando una Audiencia Administrativa conducida por un Oficial de Audiencia del Condado. Debe solicitar la audiencia dentro de catorce (14) días consecutivos de la fecha de esta carta por escrito o llamando a (se acepta llamadas por cobrar):

San Diego County Health and Human Services Agency
Appeals Section - GR/CMS Calendar Clerk
1255 Imperial Avenue, Suite 300
San Diego, CA 92101
Teléfono: (619) 237-8534

Peticiones recibidas después de 14 días serán consideradas solamente si usted presenta una buena causa que le impidió hacerlo a tiempo.

El Centro Del Consumidor Para Educación Sobre La Salud y Defensa De Sus Derechos puede darle información gratuita de como llevar acabo su apelación. Para más información llame al 1-877-734-3258.

CMS Regulations:

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

HEALTH INSURANCE QUESTIONNAIRE

Please write in all information and return this form to your County Representative. Use and attach a copy of your insurance policy, membership card, or any other aid to help complete this questionnaire. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE.

FOR COUNTY USE ONLY	
Member ID#:	County Representative

Name	Home Phone	Work Phone
Address (Street, Apt., Space):		
City	State	Zip Code

Name (Last, First)	Social Security Number	Sex	Birth Date
Applicant			
Spouse			

1. What is the name, address and phone number of your health insurance company? Do not abbreviate.
   Name _____
   Address _____
   City, State, Zip _____ Phone Number _____
2. Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO/PPO) ❒ Yes ❒ No
3. Where do you send your claims?
   Name _____
   Address _____
   City, State, Zip _____
4. What is the full name, address, phone number, and Social Security Number (SSN) of individual, employee, union member, or person to whom the insurance policy was issued?
   Name _____ SSN _____
   Address _____ Phone Number _____
   City, State, Zip _____ Spouse? ❒ Yes ❒ No
5. What is the policy number? _____
6. What are/were the dates of your policy? Beginning date? _____ Ending date? _____
7. Premium amount $ _____ ❒ Monthly ❒ Quarterly ❒ Yearly
   How are premiums paid? ❒ By Insured to Insurance Carrier ❒ By Employer ❒ By Payroll Deduction
8. Does your health insurance provide or pay for (check all that applies):
   ❒ Hospital Outpatient (e.g., lab/physical therapy) ❒ Prescription Drugs ❒ Long Term Care/Nursing Home
   ❒ Hospital Stays ❒ Dental Care ❒ Doctor Visits ❒ Vision Care ❒ Only specific illness _____

I hereby authorize the CMS programs to obtain, if needed, any information about my private insurance coverage.

Applicant Signature	Date

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

CUESTIONARIO SOBRE EL SEGURO MEDICO

Escriba por favor toda la información y regrese este formulario a su Representante del Condado. Use e incluya una copia de su póliza de seguro, tarjeta de miembro, o cualquier otro documento que pueda ayudarle a completar este cuestionario. FAVOR ESCRIBA A MAQUINA O EN LETRAS DE IMPRENTA. NO USE ABREVIATURAS.

FOR COUNTY USE ONLY (PARA USO SOLAMENTE DEL CONDADO)	
Member ID#:	County Representative

Nombre	No. de Teléfono del Hogar	No. de Teléfono del Trabajo
Domicilio (Calle, Apartamento, Espacio)		
Ciudad	Estado	Código Postal

Nombre (Apellido, Primer Nombre)	No. de Seguro Social	Sexo	Fecha de Nacimiento
Solicitante:			
Cónyuge:			

1. ¿Cuál es el nombre, domicilio y teléfono de la compañía de su seguro médico? No use abreviaturas.
   Nombre_____
   Domicilio_____
   Ciudad, Estado, Código Postal _____ No. de Teléfono _____
2. ¿Tiene usted que obtener servicios médicos de un lugar específico o de un grupo de proveedores? (PHP/HMO/PPO) ❒ Sí ❒ No
3. ¿A dónde envía sus reclamos?
   Nombre_____
   Domicilio _____
   Ciudad, Estado, Código Postal _____
4. ¿Cuál es el nombre completo, domicilio, numero de teléfono, y numero de Seguro Social (SSN) del individuo, trabajador, miembro de unión, o persona en cuyo nombre se formó la póliza de seguro?
   Nombre _____ SSN _____
   Domicilio _____ No. de Teléfono_____
   Ciudad, Estado, Código Postal _____ ¿Cónyuge suyo? ❒ Sí ❒ No
5. ¿Cuál es el número de la póliza? _____
6. ¿Cuáles son/fueron las fechas de su póliza? ¿Fecha en que empezó? _____ ¿Fecha que terminó? _____
7. Cantidad de la Prima $ _____ ❒ Mensual ❒ Trimestral ❒ Anual
   ¿Cómo se paga la Prima? ❒ Por el Asegurado a la Compañía Aseguradora ❒ Por el Empleador ❒ Deducida del Salario
8. ¿Provee o paga su seguro médico por (marque todo lo que aplica)?:
   ❒ Servicios externos para pacientes no hospitalizados (e.g., pruebas de laboratorio/terapia física) ❒ Medicinas con receta
   ❒ Cuidado de Largo Plazo/en una Residencia Médica ❒ Hospitalizaciones ❒ Cuidado Dental ❒ Visitas al Médico
   ❒ Cuidado de la Vista ❒ Solamente alguna enfermedad especifica _____

Autorizo por este medio al programa CMS a obtener, si es necesario, cualquier información sobre mi cobertura de seguro médico privado.

Firma del Solicitante	Fecha

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

QUESTION AND ANSWERS
SHARE OF COST/REIMBURSEMENT AGREEMENT/LIENS

All applicants who apply for County Medical Services (CMS) after April 10, 2008, are required to sign a Lien. As of July 1, 2008, all applicants for CMS Hardship are also required to sign a Reimbursement Agreement. Applicants who get CMS without the Hardship Waiver do not need to sign the Reimbursement Agreement. The Lien and Reimbursement requirements are about when and how you may have to pay back the County after you stop receiving CMS.

Some CMS Hardship applicants will also be sent bills for a Share of Cost for any month they used CMS services. Share of Cost is a regular charge you pay each month you receive CMS services.

This document answers common questions about these three different requirements.

If you have any other questions, ask your CMS worker. You may also ask for help with your CMS application at the Consumer Center for Health Education and Advocacy at 1-877-734-3258.

SHARE OF COST (SOC)

(applies only to those who have applied for the CMS hardship)

Q1: What is Share of Cost (SOC)?
A: Share of Cost is the amount that you must pay or be obligated to pay toward the cost of CMS covered health care services (including CMS approved prescriptions) each month you receive CMS services. This is different from the Reimbursement Agreement and Lien described below, which might not be collected until some time in the future.

Q2: How much will my SOC bill be?
A: Your worker will determine the amount of your monthly SOC, and you will be notified of this amount and how it was calculated.

Q3: Am I required to pay my share of cost every month?
A: Only if you receive CMS services every month. You will not be responsible for paying your share of cost in months you do not receive CMS services. Please do not send payments to CMS until you receive a statement.

Q4: How do I pay my SOC?
A: You will be billed the amount of your SOC or the amount of CMS services, whichever is less. You will not be billed for any months in which you do not receive CMS services. The billing statement will include the address where to send the monthly payment. Do not send payments to CMS until you receive a billing statement. Do not send cash. The County will not accept cash payments.

Q5: When will I be required to make payments?
A: When you receive a bill from the County it is due. If you have questions regarding share of cost billing and collection, you can call our share of cost billing

SHARE OF COST (SOC)

(applies only to those who have applied for the CMS hardship)

representative at 1-877-702-6508.

Q6: I just saw my physician, when will I receive a statement?
A: Once all claims are received from your health care provider.
- If your share of cost has been satisfied for the month, a monthly statement will be sent.
- If your share of cost is not satisfied for the month, a quarterly statement will be sent.

Q7: Can I pay the SOC with credit cards?
A: Yes, the County accepts Master Card, Visa, and Discover. You may also make payments with personal checks, cashiers checks or money orders. The County does not accept cash payments.

Q8: Why did I receive a statement?
A: Based on your recent CMS and CMS Hardship applications, you were approved CMS with a share of cost. You received a statement because you received CMS services and are responsible for paying your share of cost.

Q9: Is interest added on to what I owe?
A: No.

REIMBURSEMENT AGREEMENT

(applies only to those who have applied for the CMS hardship)

Q1: What is the purpose of the Reimbursement Agreement?
A: It allows the County to seek reimbursement from you for:
- Your monthly share of cost obligation for those months which you receive CMS services, and/or
- Any health care related costs CMS paid on your behalf.

Q2: When can I be required to make payments to the County?
A: While you are eligible for CMS you will receive a bill from the County for your SOC for each month you receive CMS services. You are obligated to pay the SOC when you receive a bill. After you are no longer eligible for CMS, you will receive a bill from the County for the balance due on your account for all amounts paid by CMS on your behalf stating that payments are due.

Q3: What is the difference between the Lien and the Reimbursement Agreement?
A:
- Lien – The Lien attaches to real property to secure the amounts owed to the County for payments made by CMS on your behalf.
- Reimbursement Agreement – Once you are no longer eligible for CMS, the County may bill you for the balance due on your account and seek reimbursement from your assets or surplus income.

Q4: If I sign the Reimbursement Agreement do I still have to sign the Lien?
A: If you are applying for a CMS Hardship, then yes, you must sign both documents.

Q5: Can you take my inheritance and/or lottery winnings with the Reimbursement Agreement?

REIMBURSEMENT AGREEMENT

(applies only to those who have applied for the CMS hardship)

A: Yes, if you have surplus money from these sources after meeting your support needs and those of your family. If part of what you inherit is a home that you, your spouse, your minor children, or any dependent child of any age who is incapable of self-support because of a mental or physical disability lives in, the County cannot foreclose on that home.

Q6: When do I have to reimburse the County?

A: When you stop getting CMS or when you die, the County can collect reimbursement from those assets you obtained after you applied for CMS, if there is surplus after meeting the support needs of yourself and your family.

Q7: How will signing the Reimbursement Agreement with the County affect my credit?

A: Signing the Reimbursement Agreement will not affect your credit. It is not a recordable document.

Q8: Will my wages be garnished?

A: No, unless the County obtains a judgment and you fail to pay the judgment. Even then, the County may only garnish your wages if you have surplus money after meeting the support needs of yourself and your family.

Q9: How long does the Reimbursement Agreement last?

A: Until you have fully repaid the amount you owe the County.

Q10: Does the Reimbursement Agreement include my children's assets (property, lottery winnings…)?

A: No.

Q11: Can my children be held responsible for repaying the County?

A: No.

Q12: Do I have to repay the County just because I get a new job?

A: No.

Q13: Is interest added on to what I owe?

A: No, unless the County obtains a judgment.

Q14: Can I pay what I owe the County with credit cards?

A: Yes, the County accepts Master Card, Visa, and Discover. You may also make payments with personal checks, cashiers checks or money orders. The County does not accept cash payments.

Q15: Why am I receiving this bill?

A: When you applied for CMS benefits, you signed the form CMS-106 *Agreement to Reimburse the County of San Diego*. By signing the form, you agreed to repay all the money paid by CMS on your behalf for your care. The bill is the amount you now owe the County.

Q16: Can I make payment arrangements?

A: Yes, you can make arrangements by contacting:

County of San Diego

Office of Revenue Recovery
P.O. Box 129037
San Diego, CA 92112
619-515-6200

Q17: Can I get a copy of the reimbursement agreement I signed?
A: Yes, you can request a copy of the signed reimbursement agreement by sending your signed request to:

County Medical Services
P. O. Box 927110
San Diego, CA 92192

LIENS

Q1: Do I have to sign a lien agreement?
A: Yes. Everyone who applies for CMS starting April 11, 2008, is required to sign a Lien. If you applied for CMS before April 11, 2008, you do not have to sign a Lien. If you are confined to the hospital for tuberculosis ("TB"), you may not have to sign the Lien. If you are confined to the hospital for TB and you are also receiving services not related to TB, you may not have to sign the Lien. If you are in the hospital for other reasons, but are not confined to the hospital for TB, the fact that you have TB does not exempt you from signing the lien.

Q2: What is the purpose of the Lien?
A: It attaches to real property to secure the amounts you owe the County for amounts paid by CMS on your behalf. It allows the County to seek reimbursement for such amounts from your real property.

Q3: If I sign the Lien, do I have to sell my home?
A: No.

Q4: If I sign the Lien, will I be forced to move out of my home?
A: No.

Q5: I am a renter and own no real property. Do I have to sign the Lien?
A: Yes. The Lien will attach to real property you may own in the future.

Q6: Can you take my inheritance and/or lottery winnings with the Lien?
A: No, the Lien is effective only against your real property.

Q7: Can the County foreclose on the Lien on my home while my family lives in our home?
A: No. The County cannot foreclose on your home during your lifetime or your spouse's lifetime. The County also cannot foreclose on your home while your minor children live in your home or during the lifetime of any dependent child of any age who lives in the home who is incapable of self-support because of a mental or physical disability.

Q8: Can I sell my home and buy another one?
A: Yes, you can sell your home and buy another one as long as the County's Lien is transferred to the new home. The County will release the Lien on the original home and transfer it to the new home, provided that it finds its security will not be impaired.

Q9: Can I refinance my home?
A: Yes, as long as the County's Lien is not compromised, you can refinance. You can also use your home for security to borrow money for the purpose of making

LIENS

improvements on your home as long as the County finds that its security will not be impaired.

Q10: How will signing the Lien affect my credit?
A: The recording of a Lien is a matter of public record, and will appear on credit reports the same way a mortgage or other loan is listed.

Q11: Will my wages be garnished?
A: No.

Q12: How long does the Lien last?
A: Until you have repaid the amount owed to the County.

Q13: If I sign the Lien, does it prevent me from buying real property in the future?
A: No, but the Lien would attach to any real property you buy in the future.

Q14: Does the Lien include my children's real property?
A: No.

Q15: What if I own my home with someone else?
A: The lien will not attach to the other person's interest in the home.

Q16: When will I be required to make payments on the Lien?
A: After you are no longer eligible for CMS you may be required to make payments to the County. Such payments would reduce the amount secured by the Lien. The County cannot require you to use equity in your home to pay the Lien. If you sell your home and do not buy a new one that you, your spouse, your minor children, or any dependent child of any age who is incapable of self-support because of a mental or physical disability lives in, or if you refinance your home the lender or the County may require you to pay all or a portion of the amounts owed the County. Also, if real property is purchased after the Lien is signed, the Lien will have priority (based on recording date) over a Deed of Trust issued by the lender. A lender may require that the Lien be satisfied before making the loan.

Q17: Do I have to repay CMS if I get a new job?
A: No.

Q18: Is interest added on to what I owe?
A: No.

Q19: For married couples, do both spouses have to sign the Lien?
A: Yes, the applicant and spouse both have to sign the lien in front of either a Deputy County Clerk or Notary Public so that the form can be properly witnessed. If you are no longer residing with your spouse and are unable to obtain your spouse's signature, notify your worker. Your worker will advise you of alternate documentation that CMS may accept.

Q20: For married couples who are legally separated or divorced, do both spouses have to sign the Lien?
A: No. Only the applicant needs to sign the Lien, but **legal** documentation regarding the legal separation or divorce must be provided. If you are unable to provide legal documentation, notify your worker. Your worker will advise you of alternate documentation that CMS may accept.

Q21: If an unmarried couple owns a home together, do both owners have to sign the Lien or just the applicant?

LIENS

A: Just the applicant.

Q22: If my spouse is deceased, is documentation required?
A: Yes, documentation is required. If you are unable to provide legal documentation, notify your worker. Your worker will advise you of alternate documentation that CMS may accept.

Q23: Can I pay the lien with credit cards?
A: No, payments to clear a Lien must be made by certified funds.

Q24: If a married couple applies for CMS on separate occasions, do the lien forms need to be signed again by both applicant and spouse.
A: Yes.

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

PREGUNTAS Y RESPUESTAS
PARTE DE COSTO/ACUERDO DE REEMBOLSO/GRAVAMEN

Se requiere que todo solicitante que solicita el programa County Medical Services (CMS, por sus siglas en inglés) después del 10 de abril del 2008, firme un Gravamen. A partir del 1º de julio del 2008, también se requiere que todo solicitante de Circunstancia Extrema de CMS firme un Acuerdo de Reembolso. Los solicitantes que califican sin la Circunstancia Extrema de CMS no necesitan firmar el Acuerdo de Reembolso. Los requisitos de Gravamen y de Acuerdo de Reembolso se refieren a cuándo y cómo usted deberá de pagarle al Condado después de que ya no reciba beneficios del programa CMS.

El Condado les enviará a ciertas personas que solicitaron la Circunstancia Extrema de CMS un estado de cuenta por la cantidad de la Parte de Costo para cualquier mes en que recibieron servicios médicos que cubre CMS. La Parte de Costo es una cantidad que usted paga cada mes que usted recibe servicios de CMS.

Este documento responde a preguntas frecuentes acerca estos tres diferentes requisitos.

Si tiene otras preguntas, hable con su trabajador de CMS. También puede ponerse en contacto con el Centro del Consumidor para la Educación sobre la Salud y Defensa de sus Derechos llamando al 1-877-734-3258 si necesita ayuda con su solicitud para el programa CMS.

PARTE DE COSTO (SOC, por sus siglas en inglés)

(sólo aplica a personas que han solicitado la Circunstancia Extrema de CMS)

P1: ¿Qué es Parte de Costo (SOC)?

R: Parte de Costo es la cantidad que usted debe pagar u obligarse a pagar cada mes hacia el costo de servicios médicos (incluyendo medicinas) que cubre CMS. Esto es diferente del Acuerdo de Reembolso y del Gravamen que se describe abajo, el cual es posible que no se colecte hasta el futuro.

P2: ¿Cuánto será la cuenta de mi parte de costo?

R: Su trabajador determinará la cantidad de su parte de costo mensual, y le notificará de esta cantidad y cómo fue calculada.

P3: ¿Se requiere que yo pague mi parte de costo cada mes?

R: Sólo si usted recibe servicios cubiertos por el programa CMS cada mes. Usted no será responsable de pagar su parte de costo en meses en que no recibió servicios del programa CMS. Favor de no mandar ningún pago al programa CMS hasta que reciba un estado de cuenta.

P4: ¿Cómo pago mi parte de costo?

R: Se le cobrará la cantidad de su parte de costo o la cantidad de sus servicios médicos que cubrió CMS, la cantidad que sea menor. Usted no recibirá un cobro por ningún

PARTE DE COSTO (SOC, por sus siglas en inglés)

(sólo aplica a personas que han solicitado la Circunstancia Extrema de CMS)

mes en el cual usted no recibió servicios médicos de CMS. El estado de cuenta incluirá el domicilio a dónde enviar el pago mensual. No envíe ningún pago al programa CMS hasta que reciba el estado de cuenta. No envíe dinero en efectivo. El Condado no acepta pagos en efectivo.

P5: ¿Cuándo se me va a requerir que yo haga pagos?

R: La cuenta se debe cuando usted recibe el estado de cuenta que le envió el Condado. Si tiene alguna pregunta en cuanto al cobro de su parte de costo y su colección, puede llamar a nuestro representante de pagos para parte de costo al 1-877-702-6508.

P6: Acabo de ver a mi médico, ¿cuándo recibiré el estado de cuenta?

R: Una vez que todas las formas de reclamo son recibidas de parte de su proveedor de cuidado de salud.

- Si su parte de costo se ha cumplido para el mes, se le enviará un estado de cuenta mensualmente.
- Si su parte de coso no se ha cumplido para el mes, se le enviará un estado de cuenta cada tres meses.

P7: ¿Puedo pagar mi parte de costo con tarjeta de crédito?

R: Si, el Condado acepta Master Card, Visa, y Discover. También puede hacer pagos con cheques personales, cheques al portador y giros postales. El Condado no acepta pagos en efectivo.

P8: ¿Por qué recibí un estado de cuenta?

R: Basado en la solicitud más reciente de CMS y la solicitud por Circunstancia Extrema de CMS, usted fue aprobado para beneficios de CMS con parte de costo. Ha recibido un estado de cuenta porque usted recibió servicios cubiertos por el programa CMS y es responsable de pagar su parte de costo.

P9: ¿Se añade interés a lo que debo?

R: No.

ACUERDO DE REEMBOLSO

(sólo aplica a personas que han solicitado la Circunstancia Extrema de CMS)

P1: ¿Cuál es el propósito del Acuerdo de Reembolso?

R: Permite que el Condado solicite el reembolso de su parte por:

- Su obligación de su parte de costo mensual para aquellos meses que usted recibe servicios de CMS, y/o
- Cualquier gasto relacionado con servicios médicos que CMS pagó de su parte.

P2: ¿Cuándo se va a requerir que yo haga pagos al Condado?

R: Usted recibirá un estado de cuenta del Condado para su parte de costo por cada mes que usted reciba servicios de CMS mientras usted es elegible al programa CMS. Usted está obligado a pagar su parte de costo cuando reciba el estado de cuenta. Después de que usted ya no sea elegible al programa CMS, usted recibirá un estado de cuenta del Condado por el balance debido en su cuenta donde será declarada

ACUERDO DE REEMBOLSO

(sólo aplica a personas que han solicitado la Circunstancia Extrema de CMS)

toda cantidad que CMS ha pagado de su parte. Todo pago se debe cuando la cuenta se recibe.

P3: ¿Cuál es la diferencia entre el Gravamen y el Acuerdo de Reembolso?

R:
- Gravamen – El Gravamen se adhiere a bienes raíces para asegurar la cantidad por servicios de cuidado médico pagados bajo el programa CMS de mi parte.
- Acuerdo de Reembolso – Una vez que usted ya no es elegible al programa CMS, el Condado puede que le cobre el balance que se debe en su cuenta y puede solicitar el reembolso de sus bienes o ingreso que le sobre.

P4: ¿Si ya firmé el Gravamen, también tengo que firmar el Acuerdo de Reembolso?

R: Si está solicitando el programa por Circunstancia Extrema de CMS, entonces sí, tiene que firmar ambos documentos.

P5: ¿Puede que se me tome mi herencia y/o ganancias de lotería con el Acuerdo de Reembolso?

R: Sí, si tiene dinero sobrante de estas fuentes después de satisfacer sus necesidades y aquellas de su familia. Si parte de lo que usted hereda es una casa en la cual reside usted, su cónyuge, hijos menores, o cualquier hijo dependiente de cualquier edad que es incapaz de su independencia debido a una invalidez mental o física, el Condado no puede redimir esa casa.

P6: ¿Cuándo tengo que reembolsar al Condado?

R: Cuando usted deje de ser elegible al programa CMS o cuando muera, el Condado puede colectar el reembolso de aquellos bienes que usted obtuvo después de que usted solicitó el programa CMS, si hay exceso después de satisfacer sus necesidades y aquellas de su familia.

P7: ¿Cómo va a afectar mi crédito el firmar el Acuerdo de Reembolso con el Condado?

R: La firma del Acuerdo de Reembolso no afectará su crédito. Esto no es un documento que se registra.

P8: ¿Será embargado mi sueldo?

R: No, a menos que el Condado obtenga una orden judicial y usted deje de pagar la orden judicial. Aún así, el Condado sólo puede embargar su sueldo si usted tiene dinero que le sobre después de satisfacer sus necesidades y aquellas de su familia.

P9: ¿Cuánto tiempo dura el Acuerdo de Reembolso?

R: Hasta que usted haya reembolsado totalmente la cantidad que debe al Condado.

P10: ¿Se incluye en el Acuerdo de Reembolso los bienes de mis hijos (propiedad, ganancias de lotería...)?

R: No.

P11: ¿Puede que mis hijos sean sujetos a reembolsar al Condado?

R: No.

P12: ¿Tengo que reembolsarle al Condado sólo porque tengo un nuevo trabajo?

ACUERDO DE REEMBOLSO

(sólo aplica a personas que han solicitado la Circunstancia Extrema de CMS)

R: No.

P13: ¿Se añade interés a lo que debo?

R: No, a menos que el Condado obtenga una orden judicial.

P14: ¿Puedo pagar lo que debo con tarjeta de crédito?

R: Si, el Condado acepta Master Card, Visa, y Discover. También puede hacer pagos con cheques personales, cheque al portador y giros postales. El Condado no acepta pagos en efectivo.

P15: ¿Por qué recibo un estado de cuenta?

R: Cuando solicitó beneficios del programa CMS, usted firmó el formulario CMS-106 Acuerdo de Reembolsar el Condado de San Diego. Al firmar el formulario, usted estuvo de acuerdo en reembolsar todo gasto relacionado a su cuidado médico que CMS pagó de su parte. El estado de cuenta es la cantidad que usted ahora le debe al Condado.

P16: ¿Puedo hacer arreglos de pago?

R: Si, usted puede hacer arreglos de pago poniéndose en contacto con:

County of San Diego
Office of Revenue Recovery
P.O. Box 129037
San Diego, CA 92112
(619) 515-6200

P17: ¿Puedo conseguir una copia del acuerdo de reembolso que firmé?

R: Sí, usted puede solicitar una copia del acuerdo de reembolso que firmó enviando a su petición firmada a:

County Medical Services
P. O. Box 927110
San Diego, CA 92192

GRAVAMEN

P1: ¿Necesito firmar el acuerdo de Gravamen?

R: Sí. Se requiere que toda persona que solicita el programa CMS a partir del 11 de abril del 2008, firme un Gravamen. No tiene que firmar un Gravamen si solicitó CMS antes del 11 de abril del 2008. Si está confinado a un hospital debido a tuberculosis (TB), pueda que no tenga que firmar el Gravamen. Si está confinado a un hospital debido a TB y también recibe servicios no relacionado a TB, pueda que no tenga que firmar el Gravamen. Si está hospitalizado por otros motivos, pero no confinado a un hospital debido a TB, el hecho que usted tenga TB no le excusa de firmar el Gravamen.

P2: ¿Cuál es el motivo del Gravamen?

R: El Gravamen se adhiere a bienes raíces para asegurar la cantidad que usted le debe

GRAVAMEN

al Condado por servicios pagados bajo el programa CMS de su parte. Esto permite al Condado que solicite el reembolso de tal cantidad de sus bienes raíces.

P3: Si firmo el Gravamen, ¿tengo que vender mi hogar?

R: No.

P4: Si firmo el Gravamen, ¿se me obligará a mudarme de mi hogar?

R: No.

P5: Soy un inquilino y no soy dueño de ninguna propiedad. ¿Tengo que firmar el Gravamen?

R: Sí. El Gravamen se adhiere a bienes raíces que usted pueda obtener en el futuro.

P6: ¿Puede que se me tome mi herencia y/o ganancias de lotería con el Gravamen?

R: No, el Gravamen es vigente solamente contra sus bienes raíces.

P7: ¿Puede el Condado redimir el Gravamen de mi hogar mientras mi familia viva ahí?

R: No. El Condado no puede redimir el derecho de su hogar durante su vida o la vida de su cónyuge. El Condado tampoco puede redimir el derecho de su hogar mientras sus hijos menores vivan en el hogar o durante la vida de cualquier hijo dependiente de cualquier edad que viva en el hogar, y quien es incapaz de su independencia debido a una invalidez mental o física.

P8: ¿Puedo vender mi hogar y comprar otro?

R: Sí, usted puede vender su hogar y comprar otro siempre y cuando el Gravamen del Condado se traslade al nuevo hogar. El Condado renunciará el Gravamen contra el hogar original y lo transferirá al nuevo hogar, a condición de que la seguridad del Gravamen no sea impedida.

P9: ¿Puedo financiar de nuevo mi hogar?

R: Sí, siempre y cuando el Gravamen del Condado no sea impedido, usted puede financiar de nuevo. También puede usar su hogar como garantía para pedir un préstamo para mejorar su hogar siempre y cuando el Condado encuentre que su seguridad no será impedida.

P10: ¿Cómo va a afectar mi crédito el firmar el Gravamen?

R: El registro de un Gravamen es un asunto del registro público y aparecerá en los reportes de crédito del mismo modo en que aparece una hipoteca u otro préstamo.

P11: ¿Será embargado mi sueldo?

R: No.

P12: ¿Cuánto tiempo dura el Gravamen?

R: Hasta que usted haya reembolsado la cantidad que le debe al Condado.

P13: Si firmo el Gravamen, ¿me impide esto comprar bienes raíces en el futuro?

R: No, pero el Gravamen se unirá a cualquier bien inmueble usted compre en el futuro.

GRAVAMEN

P14: ¿El Gravamen incluye los bienes inmuebles de mis hijos?

R: No.

P15: ¿Y si soy dueño de un hogar con otra persona?

R: El Gravamen no se adhiere al interés de la casa de la otra persona.

P16: ¿Cuándo se requerirá que yo haga pagos del Gravamen?

R: Después de que usted deje de ser elegible al programa CMS el Condado puede requerir que haga pagos. Tales pagos reducirán la cantidad asegurada por el Gravamen. El Condado no puede requerir que usted use el valor líquido de su hogar para pagar el Gravamen. Si vende su hogar y no compra un nuevo hogar en el cual reside usted, su cónyuge, hijos menores, o cualquier hijo de cualquier edad que es incapaz de su independencia debido a una invalidez mental o física, o si financia de nuevo su casa, el prestamista o el Condado puede requerir que usted pague toda o una parte de las cantidades que se le debe al Condado. También, si compra bienes raíces después de haber firmado el Gravamen, el Gravamen tendrá prioridad (basado en la fecha en se registró) sobre una Escritura de Fideicomiso emitida por el prestamista. Un prestamista puede requerir que el Gravamen sea satisfecho antes de hacer el préstamo.

P17: ¿Tengo que reembolsarle al Condado si tengo un nuevo trabajo?

R: No.

P18: ¿Se le añade interés a lo que debo?

R: No.

P19: Para parejas casadas, ¿ambos cónyuges tienen que firmar el Gravamen?

R: Sí, ambos cónyuges tienen que firmar el Gravamen delante de un Agente Diputado del Condado o de un Notario para atestiguar que la forma fue correctamente firmada como es debido. Avísele a su trabajador(a) si usted ya no reside con su cónyuge y es incapaz de obtener la firma de su cónyuge. Su trabajador(a) le informará qué documentación alterna el programa CMS puede aceptar.

P20: Para parejas casadas que están separadas o divorciadas, ¿ambos cónyuges tienen que firmar el Gravamen?

R: No. Sólo el solicitante necesita firmar el Gravamen, pero se debe proporcionar documentación **legal** sobre la separación o el divorcio. Avísele a su trabajador(a) si no hay documentación legal disponible. Su trabajador(a) le puede aconsejar sobre qué documentación alterna acepta el programa CMS.

P21: Si una pareja no casada es dueña de un hogar, ¿ambos dueños tienen que firmar el Gravamen o solamente el solicitante?

R: Solamente el solicitante.

P22: Si mi cónyuge ha fallecido, ¿se requiere documentación?

R: Sí, se requiere documentación. Comuníquese con su trabajador(a) si es incapaz de proporcionar la documentación legal. Su trabajador(a) le aconsejará sobre documentación alterna que el programa CMS aceptará.

GRAVAMEN

P23: ¿Puedo pagar el Gravamen con tarjeta de crédito?

R: No, los pagos para liquidar el Gravamen deben ser hechos por medio de fondos documentados.

P24: Si una pareja casada solicita el programa CMS en ocasiones separadas, ¿necesitan el solicitante y el cónyuge firmar de nuevo las formas del Gravamen?

R: Sí.

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

NOTICE OF ACTION

Date: _____

To: _____

_____

_____

Member #: _____

Representative: _____

Representative #: _____

Phone: _____

Location: _____

Address: _____

The County Medical Services (CMS) program received information that affects your eligibility. Your case will be discontinued on (DATE) for the following reason(s):

- ☐ You have enrolled in other health insurance
- ☐ You requested to disenroll from the program
- ☐ Beneficiary listed above has been confirmed as deceased
- ☐ Your net income is more than 350% of the Federal Poverty Level (FPL):

Source of Income:	
Gross Income:	$
Deductions:	$
Net Income:	$
CMS Maintenance Need:	$
Excess Income:	$

- ☐ You are enrolled in Medi-Cal
- ☐ You are not a County resident
- ☐ You failed to provide: _____

_____

SEE IMPORTANT NOTE ON REVERSE

☐ Excess Property

Nonexempt Property Items	Net Market Value
_____	$_____
_____	$_____
_____	$_____
_____	$_____

Total Nonexempt Property $_____
Property Limit -$_____
Excess Property =$_____

YOU MAY REAPPLY FOR CMS AT ANY TIME

If you disagree with this action, you have the right to request an Administrative Hearing conducted by a County Hearing Officer. You must file your appeal within fourteen (14) calendar days of the date of this notice by writing to or calling (collect calls accepted):

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
1255 Imperial Avenue, Suite 300
San Diego, CA 92101
Phone: (619) 237-8534

Your CMS benefits may continue during the appeals process if:

- Your eligibility is being terminated;
- Your original certification period has not expired;
- You timely file the appeal (within 10 calendar days of this notice, or the effective date of this notice, whichever is later); **and**
- You request an extension of benefits before the effective discontinuance date of this notice.

The Consumer Center for Health Education and Advocacy may be able to offer you free advice on how to handle your appeal. For more information call 1-877-734-3258.

CMS Regulations:

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

COUNTY MEDICAL SERVICES

NOTICE OF ACTION

Fecha: _____ No. de Miembro: _____

Representante: _____

Para: _____ No. del Representante: _____

_____ Teléfono: _____

_____ Ubicación: _____

_____ Domicilio: _____

El programa County Medical Services (CMS, por sus siglas en inglés) recibió información que afecta su elegibilidad al programa CMS. Su caso se descontinuará el día (DATE) por la(s) siguiente(s) razón(es):

- ☐ Está inscrito en otro seguro médico
- ☐ Usted solicito no continuar el programa
- ☐ Se ha reportado que el beneficiario anotado arriba ha fallecido
- ☐ Su ingreso neto es más de 350% del Nivel de Pobreza Federal (FPL):
- ☐ Está inscrito en el programa Medi-Cal
- ☐ No es residente del Condado

Fuente de Ingresos: _____

_____

Ingreso Bruto:	$
Deducciones:	- $
Ingreso Neto:	$
Necesidad Para Mantenimiento de CMS:	- $
Exceso de Ingreso:	$

☐ Faltó de proporcionar: _____

_____

FAVOR DE VER LA INFORMACION IMPORTANTE AL REVERSO

☐ Exceso de Propiedad

Artículos de Propiedad no Exentos	Valor Neto de Mercado
_____	$_____
_____	$_____
_____	$_____
_____	$_____

Propiedad/recursos no exentos en Total $_____
Límite de propiedad/recursos -$_____
Propiedad/recursos excedente =$_____

USTED PUEDE VOLVER A SOLICITAR EL CMS EN CUALQUIER MOMENTO

Si usted no está de acuerdo con esta decisión, tiene el derecho de apelar solicitando una Audiencia Administrativa conducida por un Oficial de Audiencia del Condado. Debe solicitar la audiencia dentro de catorce (14) días consecutivos de la fecha de esta carta por escrito o llamando a (se acepta llamadas por cobrar):

San Diego County Health and Human Services Agency
Appeals Section - GR/CMS Calendar Clerk
1255 Imperial Avenue, Suite 300
San Diego, CA 92101
Teléfono: (619) 237-8534

Sus beneficios de CMS pueden continuar durante el proceso de apelación si:

- Su elegibilidad es terminada;
- El periodo de su certificación original no ha vencido;
- Usted solicita la apelación de manera oportuna (dentro de 10 días consecutivos de la fecha de este aviso, o antes de la fecha prevista de la acción de este aviso, lo que ocurra más tarde); **y**
- Pide una extensión de beneficios antes de la fecha efectiva de descontinuación de este aviso.

El Centro Del Consumidor Para Educación Sobre La Salud y Defensa De Sus Derechos puede darle información gratuita de cómo llevar acabo su apelación. Para más información llame al 1-877-734-3258.

CMS Regulations:

County of San Diego
HEALTH AND HUMAN SERVICES AGENCY

CARTA INFORMATIVA DE DECENTRALIZACION – PARA EL APLICANTE

FECHA: TODAY'S DATE

PARA: APPLICANT'S NAME
STREET ADDRESS
CITY, STATE AND ZIP CODE

REPRESENTANTE: YOUR NAME **HOSPITAL: HOSPITAL REFERRING**

RE: SOLICITUD PARA MEDI-CAL Y/O COUNTY MEDICAL SERVICES (CMS, por sus siglas en inglés)

☐ Su solicitud para Medi-Cal ha sido referida a la oficina **ENTER FRC'S NAME HERE**. Si usted no recibe una llamada o un aviso de un Representante de Medi-Cal dentro de 15 días de la fecha de esta notificación, favor de comunicarse con el ACCESS Center al 1-866-262-9881 o por correo electrónico pubassist.HHSA@sdcounty.ca.gov. Su número de caso de Medi-Cal es **ENTER MC CASE NUMBER HERE.** Tenga este número disponible cuando llame a o se comunique por correo electrónico con ACCESS.

☐ Usted tiene una cita con CMS para una entrevista programada para el día **ENTER APPOINTMENT DATE & TIME HERE** en **SELECT SITE FROM DROP DOWN MENU.** Traiga esta carta, los documentos anotados abajo, y entréguelos al trabajador de Condado que le entrevistará. La lista de abajo no incluye todo y puede ser que su trabajador(a) le pida que proporcione información adicional. No se le atenderá si llega más de 15 minutos tarde a su entrevista. Si usted no puede asistir a la entrevista, favor de llamar al 1-800-587-8118 lo más pronto posible para programar otra cita.

Prueba de:
- Residencia del Condado de San Diego
- Identidad
- Ciudadanía/Documentos de Inmigración Elegibles
- Propiedad
- Ingreso

IMPORTANTE
Si las dos casillas de arriba están marcadas, usted está siendo evaluado para Medi-Cal y para CMS. Usted debe de cumplir con los requisitos de elegibilidad de ambos programas.

Background

County Medical Services (CMS) is a program for indigent adults. CMS is a program of last resort and only covers certain medical services and is not considered health insurance. CMS does **not** pay insurance premiums, deductibles or co-payments. CMS does **not** meet the Minimum Essential Coverage (MEC) required by the Affordable Care Act (ACA). CMS is the County's safety net program covering adults who are **NOT:**

- Determined linked to Medi-Cal eligibility
- Enrolled in Medi-Cal
- Enrolled in Medicare
- Enrolled in a Covered California Health Care Plan or in any health care plan that meets the MEC requirement under ACA

San Diego County does not provide direct services. Services are provided by primary care clinics, local hospitals, and physicians that contract with San Diego County to provide medical care.

Policy:

01.01.01A Eligibility Categories

CMS

An individual who meets the CMS eligibility criteria and whose family income does not exceed 165% of the annually adjusted Federal Poverty Level (FPL) receives services at zero cost.

CMS Hardship

An individual who meets the CMS eligibility criteria and whose family income is over 165%, up to and including 350% FPL, will be evaluated for CMS Hardship. The individual may be required to meet a Share of Cost (SOC) obligation for each month they receive CMS services. Refer to 06.02 for income limits and 13.03 for CMS Hardship evaluations.

01.01.01B Grant of Lien Requirement

As a condition of eligibility, all CMS applicants are required to complete and sign the CMS Lien information form (CMS-123) and CMS Grant of Lien form (CMS-122), naming the County of San Diego as grantee to secure any and all real estate property of the applicant as security for repayment of all claims paid by CMS on their behalf. The lien will be filed against any real property that is currently owned or real property that may be acquired in the future. However, the applicant does not need to sell their current principal residence to qualify. Refer to 06.06 for additional information regarding liens.

01.01.01C Reimbursement Agreement Requirement

Effective with applications dated on or after 7/1/2008, as a condition of eligibility, CMS Hardship applicants are required to sign the CMS Reimbursement Agreement form (CMS-106). This repayment document requires the CMS applicant to reimburse San Diego County via the Office of Revenue & Recovery (ORR) for CMS services provided. Refer to 06.07 for additional information regarding repayment requirements and procedures.

Impact:

No impact to other program(s).

Reference(s):
None

Release Date:
December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

Acronyms and Terms Definitions	Number	Page
	01.05.01	1 of 1

Background:
The acronyms and terms used throughout the CMS Program Guide are available in Desk Guide 01 Acronyms and Terms Definitions.

Impact:
No impact to other program(s)

Reference(s):
None

Release Date:
December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

Background:

An adult requesting CMS or CMS Hardship may live alone, with a spouse, or with family members who are eligible to Medi-Cal.

The CMS IT System (AuthMed) gathers information to determine CMS eligibility. Refer to 02.02.01 for instructions on who may complete and sign the Statement of Facts (SOF) and information regarding an Authorized Representative (AR).

When a CMS case is established in AuthMed, all documentation and verifications used to determine eligibility to and level of coverage within the CMS Program, including CMS forms completed by the applicant, Authorized Representative (AR), hospital, and eligibility staff must be imaged and saved in AuthMed. The Image Verification Checklist (CMS-107) may be used to eliminate the scanning of some forms during the application process.

Policy/Procedure:

02.01.01A Order of Evaluation Requirement

All CMS applicants must first be evaluated for Medi-Cal.

A CMS applicant is **NOT** eligible for CMS if s/he meets any of the following:

- Is determined linked to Medi-Cal eligibility
- Is enrolled in Medi-Cal
- Is enrolled in Medicare
- Is enrolled in a Covered California Health Care plan or in any health care coverage plan that meets the Minimum Essential Coverage (MEC) requirement under ACA

02.01.01B Application Process Requirements

Good Cause

At each application, recertification, or reapplication:

- evaluate for good cause **prior** to taking an eligibility adverse action when the applicant is unable to comply with eligibility requirements within the required timeframe
- narrate in case comments that good cause was evaluated, whether good cause was found or not, and the reason why the good cause determination was made
- establish a new due date, if needed, based on case situation. Inform the applicant and narrate in case comments of the new due date
- inform the applicant and narrate in case comments of any acceptable alternative verification(s)

Good cause includes but is not limited to:

- Physical or mental illness or incapacity of the applicant which prevents him/her from contacting the County and/or obtaining/submitting the required documents/verifications within the required timeframe
- A level of literacy, in conjunction with other social and language barriers, of the applicant that would prevent him/her from meeting the established due date
- A delay in the receipt of information and the delay is beyond the control of the applicant
- Obtaining the documents/verifications would cause harm to the individual

Timely Reporting
The applicant is responsible for reporting changes in a timely manner. Any changes in income, assets, or living situation that pertain to the determination of eligibility or SOC are to be reported within 10 calendar days.

Case Narrative
Narrate all case actions. Narratives can support case documentation; however, case narratives are **not** required as a condition of eligibility.

Case Clearance
Use the systems below to clear the applicant's Social Security Number (SSN) or name **prior** to the issuance of CMS benefits to prevent duplicate or erroneous issuance of benefits.

Clearances shall include, but are not limited to, the following systems:

System	Window	Description
CMS IT System (AuthMed)	APPLICATION WORKLIST - Member Alerts	Recording of comments/alerts/case activities
MEDS	INQN	Applicant inquiry by name and date of birth
	INQM	Primary Medi-Cal/CMSP Information
	INQP	Pending/Denied SSI application and appeals information
	INQT	Bendex Title II information
	INQX	Title XVI-SSI/SSP
	INQ1, 2, & 3	Medi-Cal/SSP- Special Programs 1, 2, and 3 information
	IEVS - EDD Real-Time Match	Unemployment and State Disability Claim information
CalWIN	Inquiry	Inquire on individual
	Case Details	Programs, application list, and case members.
CalHEERS	Enrollment Summary by Person	Plan enrollment by person
IDX	Enrollment Screen	Displays certification period enrollment status
	Claims Screen	Displays claims submitted

02.01.01C Establishing the Date of Application
HOS Applications

When the AuthMed referral is received…	
within 10 business days of the date of admission,	the application date is the date you receive the application referral or the date of admission to the hospital, whichever is earlier.
more than 10 business days after the date of admission,	the application date is the date you receive the application referral.

Non-HOS Applications

The application date is established on the date the applicant's information is entered in AuthMed. On the date of the intake interview:

- enter the applicant's information in AuthMed
- print the signature page of the SOF
- have the applicant sign and date the form
- scan the SOF into AuthMed to verify the application date

Exceptions to the Date of Application

An applicant requesting coverage for an uncertified date of service **prior** to the date of the intake interview may establish the date of the uncertified visit as their application date. Eligibility will be effective the first on the month of the date of the uncertified visit if **all** of the following conditions below are met. If all of the conditions are **not** met, this exception does not apply.

The applicant…	
1	Was **not** determined linked to Medi-Cal eligibility, **not** enrolled in Medi-Cal or Medicare, or **not** enrolled in a Covered California Health Care plan or in any health care coverage plan that meets the Minimum Essential Coverage (MEC) requirement under ACA at the time they received medical treatment.
2	• Contacts the ASO within 30 calendar days of the date of the uncertified visit to schedule the intake interview; • Is referred to an HOS worker by an HOS hospital; • Receives an HOS referral within 30 calendar days of the date of the uncertified visit; or • Has applied for Medi-Cal within 30 calendar days of the date of the uncertified visit. **Note:** The 30 day time period starts the day after the date of the uncertified visit.
3	Provides verification of the date of the uncertified visit. The date of the uncertified visit, once verified, then becomes the date of application.
4	Provides all of the information and required verifications needed to determine eligibility for the month of the uncertified visit.
5	Meets all other eligibility requirements for the month of the uncertified visit.
6	May request coverage for a maximum of two uncertified visits per year.
7	Has 10 business days from the date of the missed appointment to call the ASO to reschedule. Only one reschedule will be allowed for applicants requesting coverage of a past month's ER visit. The application date for an applicant with more than one reschedule shall be the date of the intake appointment and **not** earlier.

Note: When evaluating for a prior month's uncertified ER or clinic visit, indicate the date of application being used and confirm in case comments that appropriate verification for the uncertified ER or clinic visit was received and reviewed.

Impact:

No impact to other program(s)

Reference(s):

None

Release Date:
December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

Background

CMS requires all applicants to be evaluated for Medi-Cal, as a condition of eligibility for CMS. If the applicant is determined linked to Medi-Cal eligibility and refuses to apply for or accept Medi-Cal coverage, they are **not** eligible for CMS. CMS benefits **must** be discontinued when the recipient becomes enrolled in Medi-Cal as outlined in 15.01.

Policy/Procedure:

02.05.01A CalWORKs Linkage

Refer parents of minor children who are disabled, incapacitated, or unemployed to CalWORKs. Evaluate linkage based upon the definition described in MPG 05.02. Refer to 08.05 for case processing if the parent is denied CalWORKs.

02.05.01B Potential Medi-Cal Linkage

Disability Determination Services Division (DDSD) Referral

If the CMS applicant is **not** enrolled in Medi-Cal and declares a disabling condition, process the Medi-Cal DDSD and CMS applications concurrently. If the applicant refuses to apply for or comply with the entire Medi-Cal DDSD application process, the applicant is **not** eligible for CMS.

Previous Medi-Cal DDSD Application Denied: Returning CMS Applicant

Review the denial reason when a CMS applicant is denied disability linked Medi-Cal (DDSD) and returns to apply for CMS within 90 days of the Medi-Cal DDSD denial.
If the:

- denial reason is correct and is not due to no show, failure to provide, or failure to cooperate:
  - certify CMS for up to the allowable period, if otherwise eligible; and
  - cocument the Medi-Cal DDSD denial reason in case comments.
- denial reason is questionable (e.g. SSI denied for reasons other than **no** disability; 250% Working Disabled Program **not** evaluated for working individual, etc.):
  - refer the individual to appeal the Medi-Cal DDSD denial; and
  - approve CMS for the allowable period ONCE the applicant has complied with the Medi-Cal DDSD appeal process, if otherwise eligible.
- 90 day appeal timeframe has expired:
  - process the Medi-Cal DDSD application and retroactive month(s) as needed, and CMS applications concurrently; and
  - approve CMS for the allowable period once the applicant has fully complied in completing the Medi-Cal DDSD application process, has met **all** Medi-Cal eligibility and verification requirements, and the DDSD packet has been imaged into the CalWIN Electronic Records Management System (CERMS), if otherwise eligible. **Note:** The DDSD decision is **not** required **prior** to the approval of CMS benefits.

Previous Medi-Cal DDSD Application Denied: New CMS Applicant

Evaluate if the denial is within the Medi-Cal 90 day appeal timeframe when a new CMS applicant was denied Medi-Cal DDSD because s/he is **not** linked and yet continues to declare a disabling condition.
If the:

- denial is within the appeal timeframe:
  - refer the applicant to appeal the denial; and
  - approve CMS for the allowable period once the applicant has complied with the Medi-Cal DDSD appeal process, if otherwise eligible.

- appeal timeframe has expired:
  - process the Medi-Cal DDSD application and retroactive month(s) as needed and CMS applications concurrently; and
  - approve CMS for the allowable period once the applicant has fully complied with the Medi-Cal DDSD application process, has met **all** Medi-Cal eligibility and verification requirements, and the DDSD packet has been imaged into CERMS, if otherwise eligible. **Note:** The DDSD decision is **not** required **prior** to the approval of CMS benefits.

Previous Medi-Cal DDSD Application Denied: Unrelated to Disability
If the Medi-Cal DDSD application is denied for a reason unrelated to disability, such as no show, failure to provide, or failure to cooperate, **do not** approve CMS benefits until s/he has fully complied in completing the entire Medi-Cal DDSD application process.

Cash Assistance Program for Immigrants (CAPI) Applicants
CAPI is a cash program for certain immigrants who are not eligible to SSI/SSP solely due to their immigration status. **Do not** approve CMS benefits to an applicant who has an **active** CAPI case CMS benefits because the applicant is linked to Medi-Cal.

A CMS applicant who has a **pending** CAPI application must also apply for Medi-Cal DDSD and may be approved CMS for the allowable period while the DDSD decision is pending, if otherwise eligible. The DDSD process for CAPI is the same as Medi-Cal. However, a separate Medi-Cal DDSD application has to be requested by the applicant.

02.05.01C Pending SSI/SSA Disability Application/Appeal
A CMS applicant **not** enrolled in Medi-Cal who has a pending SSDI/SSI application or appeal decision should have applied for Medi-Cal DDSD at the time s/he applied for SSDI/SSI. If the applicant did **not** apply for Medi-Cal DDSD, in order to protect the Medi-Cal filing date, process the Medi-Cal DDSD, including any retro months, and CMS applications concurrently as instructed in 02.10.

Note: You may deny the Medi-Cal DDSD application on the basis of no disability in CalWIN for applicants appealing an SSDI/SSI denial issued within the last 12 months for not having a disabling condition. This denial action protects the Medi-Cal DDSD filing date so that if the final SSDI/SSI appeal decision is favorable to the CMS recipient, CMS Recovery staff will initiate corrective action to rescind the Medi-Cal DDSD application denial and receive reimbursement from Medi-Cal.

Legal Aid SSI Advocate Referral
A CMS applicant who has been identified as potentially eligible to SSI may be referred to the Legal Aid SSI Advocate for assistance in applying/reapplying for SSI benefits or assisting with the process of filing an SSI appeal. Complete and fax or mail the SSI Advocate Referral (CMS-2) form to the SSI Advocate and note in case comments that an SSI Advocate referral was made. Refer to 08.06 for additional information.

02.05.01D Deceased Person
Because CMS is the program of last resort, **do not** consider an application for CMS made on the behalf of a deceased person. CMS denies all provider claims for services given to a CMS applicant who passes away while in the hospital. Deceased applicants are linked to Medi-Cal because Medi-

Cal defines disability as *"the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death."*

02.05.01E Medi-Cal Disability Linkage Established
A CMS applicant/recipient is **not** eligible for CMS if s/he is determined to be federally disabled according to the criteria in Title II or XVI of the Social Security Act or by State DDSD. Following a determination that a CMS applicant/recipient has been determined disabled, a Member Alert will be placed in AuthMed by CMS Recovery.

A CMS recipient who has applied for Medi-Cal has the responsibility to complete the entire Medi-Cal application process. If the applicant has been determined disabled but fails to finish the entire Medi-Cal eligibility determination process, s/he **CANNOT** return to CMS.

Impact:
No impact to other program(s)

Reference(s):
None

Release Date:
December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

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	02.07.01	1 of 1

This section was made obsolete with CMSPG Letter #34.

Background:
CMS is a program of last resort for indigent adults.

Policy:
04.01.01A Eligible Adults
The CMS applicant must:

- Be 21 through 64 years of age. CMS coverage begins the month following the 21st birthday and ends the last day of the month before the 65th birthday
- Be a U.S. citizen (Refer to 05.03) or a non–citizen who meets the eligible alien criteria (Refer to 05.04)
- Be a San Diego County resident (Refer to 05.02)
- **Not** be determined linked to Medi-Cal eligibility
- **Not** be enrolled in Medi-Cal (Except for limited benefits as defined in 04.04)
- **Not** be enrolled in Medicare
- **Not** be enrolled in a Covered California Health Care Plan or in any health care coverage plan that meets the MEC requirement under ACA
- Be within the CMS income (Refer to 06.02) and property limits (Refer to 06.04)

Impact:
No impact to other program(s)

Reference(s):
None

Release Date:
December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

Background:
CMS is a program of last resort for indigent adults.

Policy:
04.02.01A General Relief (GR) Recipients
Approve CMS benefits to a GR recipient (age 21-64) who is **NOT**:
- Determined linked to Medi-Cal eligibility
- Enrolled in Medi-Cal
- Enrolled in Medicare
- Enrolled in a Covered California Health Care Plan or in any health care coverage plan that meets the MEC requirement under ACA

The GR recipient does not have to complete a CMS application. Refer to 08.04 for additional instructions.

04.02.01B Cash Assistance Program for Immigrants (CAPI) Applicants
Process a Medi-Cal DDSD application and a CMS application concurrently for a CMS applicant with a **pending** CAPI application who is **NOT:**
- Determined linked to Medi-Cal eligibility
- Enrolled in Medi-Cal
- Enrolled in Medicare
- Enrolled in a Covered California Health Care Plan or in any health care coverage plan that meets the MEC requirement under ACA

Approve CMS benefits while the DDSD decision is pending, if otherwise eligible. **Note:** If CAPI is **approved** or if there is an **active** CAPI case, the applicant is **not** eligible for CMS. Refer to 02.05 for additional information.

04.02.01C Refugees and Immigrants
Approve CMS benefits to a Refugee or Immigrant who is **NOT**:
- Determined linked to Medi-Cal eligibility
- Enrolled in Medi-Cal
- Enrolled in Medicare
- Enrolled in a Covered California Health Care Plan or in any health care coverage plan that meets the MEC requirement under ACA

04.02.01D Veterans
Approve CMS benefits to veterans, if otherwise eligible. However, veterans should be encouraged to use all medical services available to them through the Veterans Administration.

Impact:
No impact to other program(s).

Reference(s):
None

Release Date:
December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

Limited Medi-Cal	Number	Page
	04.04.01	1 of 1

Background
Certain adults (21–64) may be eligible to CMS and limited Medi-Cal at the same time.

Policy:
04.04.01A Tuberculosis (TB) Program
CMS does **not** cover outpatient TB-related services for adults eligible to the Medi-Cal Tuberculosis (TB) Program. These services are covered by Medi-Cal under aid code 7H (Refer to MPG 5.17). Process the TB-Cal and CMS applications concurrently and approve CMS, if otherwise eligible.

Impact:
No impact to other program(s)

Reference(s):
None

Release Date:
December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

Questions and Answers	**Number**	**Page**
	06.08.01	1 of 1

Background
A CMS Question and Answer (Q&A) (CMS-112) document has been created to assist staff and update applicants/beneficiaries on the modifications to the CMS program. The Q&A document includes questions and answers for Share of Cost, Reimbursement Agreement and Liens. (Refer to Appendix 6.08A).

Policy:
Give the CMS-112 **must** to every individual who applies for CMS.

Impact:
No impact to other program(s)

Reference(s):
None

Release Date:
December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

COUNTY MEDICAL SERVICES

QUESTION AND ANSWERS
SHARE OF COST/REIMBURSEMENT AGREEMENT/LIENS

All applicants who apply for County Medical Services (CMS) after April 10, 2008, are required to sign a Lien. As of July 1, 2008, all applicants for CMS Hardship are also required to sign a Reimbursement Agreement. Applicants who get CMS without the Hardship Waiver do not need to sign the Reimbursement Agreement. The Lien and Reimbursement requirements are about when and how you may have to pay back the County after you stop receiving CMS.

Some CMS Hardship applicants will also be sent bills for a Share of Cost for any month they used CMS services. Share of Cost is a regular charge you pay each month you receive CMS services.

This document answers common questions about these three different requirements.

If you have any other questions, ask your CMS worker. You may also ask for help with your CMS application at the Consumer Center for Health Education and Advocacy at 1-877-734-3258.

SHARE OF COST (SOC)

(applies only to those who have applied for the CMS hardship)

Q1: What is Share of Cost ("SOC")?
A: Share of Cost is the amount that you must pay or be obligated to pay toward the cost of CMS covered health care services (including CMS approved prescriptions) each month you receive CMS services. This is different from the Reimbursement Agreement and Lien described below, which might not be collected until sometime in the future.

Q2: How much will my SOC bill be?
A: Your worker will determine the amount of your monthly SOC, and you will be notified of this amount and how it was calculated.

Q3: Am I required to pay my share of cost every month?
A: Only if you receive CMS services every month. You will not be responsible for paying your share of cost in months you do not receive CMS services. Please do not send payments to CMS until you receive a statement.

Q4: How do I pay my SOC?
A: You will be billed the amount of your SOC or the amount of CMS services, whichever is less. You will not be billed for any months in which you do not receive CMS services. The billing statement will include the address where to send the monthly payment. Do not send payments to CMS until you receive a billing statement. Do not send cash. The County will not accept cash payments.

Q5: When will I be required to make payments?
A: When you receive a bill from the County it is due. If you have questions regarding share of cost billing and collection, you can call our share of cost billing representative at 1-877-702-6508.

Q6: I just saw my physician, when will I receive a statement?
A: Once all claims are received from your health care provider. If your share of cost has been satisfied for the month, a monthly statement will be sent. If your share of cost is not satisfied for the month, a quarterly statement will be sent.

Q7: Can I pay the SOC with credit cards?
A: Yes, the County accepts Master Card, Visa, and Discover. You may also make payments with personal checks, cashier checks or money orders. The County does not accept cash payments.

Q8: Why did I receive a statement?
A: Based on your recent CMS and CMS Hardship applications, you were approved CMS with a share of cost. You received a statement because you received CMS services and are responsible for paying your share of cost.

Q9: Is interest added on to what I owe?
A: No.

REIMBURSEMENT AGREEMENT

(applies only to those who have applied for the CMS hardship)

Q1: What is the purpose of the Reimbursement Agreement?
A: It allows the County to seek reimbursement from you for:
- Your monthly share of cost obligation for those months which you receive CMS services, and/or
- Any health care related costs CMS paid on your behalf.

Q2: When can I be required to make payments to the County?
A: While you are eligible for CMS you will receive a bill from the County for your SOC for each month you receive CMS services. You are obligated to pay the SOC when you receive a bill. After you are no longer eligible for CMS, you will receive a bill from the County for the balance due on your account for all amounts paid by CMS on your behalf stating that payments are due.

Q3: What is the difference between the Lien and the Reimbursement Agreement?
A: Lien – The Lien attaches to real property to secure the amounts owed to the County for payments made by CMS on your behalf.

Reimbursement Agreement – Once you are no longer eligible for CMS, the County may bill you for the balance due on your account and seek reimbursement from your

Q4: If I sign the Reimbursement Agreement do I still have to sign the Lien?
A: If you are applying for a CMS Hardship, then yes, you must sign both documents.

Q5: Can you take my inheritance and/or lottery winnings with the Reimbursement Agreement?
A: Yes, if you have surplus money from these sources after meeting your support needs and those of your family. If part of what you inherit is a home that you, your spouse, your minor children, or any dependent child of any age who is incapable of self-support because of a mental or physical disability lives in, the County cannot foreclose on that home.

Q6: When do I have to reimburse the County?
A: When you stop getting CMS or when you die, the County can collect reimbursement from those assets you obtained after you applied for CMS, if there is surplus after meeting the support needs of yourself and your family.

Q7: How will signing the Reimbursement Agreement with the County affect my credit?
A: Signing the Reimbursement Agreement will not affect your credit. It is not a recordable document.

Q8: Will my wages be garnished?
A: No, unless the County obtains a judgment and you fail to pay the judgment. Even then, the County may only garnish your wages if you have surplus money after meeting the support needs of yourself and your family.

Q9: How long does the Reimbursement Agreement last?
A: Until you have fully repaid the amount you owe the County.

Q10: Does the Reimbursement Agreement include my children's assets (property, lottery winnings…)?
A: No.

Q11: Can my children be held responsible for repaying the County?
A: No.

Q12: Do I have to repay the County just because I get a new job?
A: No.

Q13: Is interest added on to what I owe?
A: No, unless the County obtains a judgment.

Q14: Can I pay what I owe the County with credit cards?
A: Yes, the County accepts Master Card, Visa, and Discover. You may also make payments with personal checks, cashiers checks or money orders. The County does not accept cash payments.

Q15: Why am I receiving a bill from the County?
A: When you applied for CMS benefits, you signed the form CMS-106 *Agreement to Reimburse the County of San Diego.* By signing the form, you agreed to repay all the money paid by CMS on your behalf for your care. The bill is the amount you now owe the County.

Q16: Can I make payment arrangements?
A: Yes, you can make arrangements by contacting:

County of San Diego
Office of Revenue Recovery
P.O. Box 129037
San Diego, CA 92112
(619) 515-6200

Q17: Can I get a copy of the reimbursement agreement I signed?
A: Yes, you can request a copy of the signed reimbursement agreement by sending your signed request to:

County Medical Services
P.O. Box 927110
San Diego, CA 92192

LIENS

Q1: Do I have to sign a lien agreement?
A: Yes. Everyone who applies for CMS starting April 11, 2008, is required to sign a Lien. If you applied for CMS before April 11, 2008, you do not have to sign a Lien. If you are confined to the hospital for tuberculosis ("TB"), you may not have to sign the Lien. If you are confined to the hospital for TB and you are also receiving services not related to TB, you may not have to sign the Lien. If you are in the hospital for other reasons, but are not confined to the hospital for TB, the fact that you have TB does not exempt you from signing the lien.

Q2: What is the purpose of the Lien?
A: It attaches to real property to secure the amounts you owe the County for amounts paid by CMS on your behalf. It allows the County to seek reimbursement for such amounts from your real property.

Q3: If I sign the Lien, do I have to sell my home?
A: No.

Q4: If I sign the Lien, will I be forced to move out of my home?

A: No.

Q5: I am a renter and own no real property. Do I have to sign the Lien?
A: Yes. The Lien will attach to real property you may own in the future.

Q6: Can you take my inheritance and/or lottery winnings with the Lien?
A: No. The Lien is effective only against your real property.

Q7: Can the County foreclose on the Lien on my home while my family lives in our home?
A: No. The County cannot foreclose on your home during your lifetime or your spouse's lifetime. The County also cannot foreclose on your home while your minor children live in your home or during the lifetime of any dependent child of any age who lives in the home who is incapable of self-support because of a mental or physical disability.

Q8: Can I sell my home and buy another one?
A: Yes. You can sell your home and buy another one as long as the County's Lien is transferred to the new home. The County will release the Lien on the original home and transfer it to the new home, provided that it finds its security will not be impaired.

Q9: Can I refinance my home?
A: Yes, as long as the County's Lien is not compromised, you can refinance. You can also use your home for security to borrow money for the purpose of making improvements on your home as long as the County finds that its security will not be impaired.

Q10: How will signing the Lien affect my credit?
A: The recording of a Lien is a matter of public record, and will appear on credit reports the same way a mortgage or other loan is listed.

Q11: Will my wages be garnished?
A: No.

Q12: How long does the Lien last?
A: Until you have repaid the amount owed to the County.

Q13: If I sign the Lien, does it prevent me from buying real property in the future?

A: No, but the Lien would attach to any real property you buy in the future.

Q14: Does the Lien include my children's real property?
A: No.

Q15: What if I own my home with someone else?
A: The lien will not attach to the other person's interest in the home.

Q16: When will I be required to make payments on the Lien?
A: After you are no longer eligible for CMS you may be required to make payments to the County. Such payments would reduce the amount secured by the Lien. The County cannot require you to use equity in your home to pay the Lien. If you sell your home and do not buy a new one that you, your spouse, your minor children, or any dependent child of any age who is incapable of self-support because of a mental or physical disability lives in, or if you refinance your home the lender or the County may require you to pay all or a portion of the amounts owed the County. Also, if real property is purchased after the Lien is signed, the Lien will have priority (based on recording date) over a Deed of Trust issued by the lender. A lender may require that the Lien be satisfied before making the loan.

Q17: Do I have to repay CMS if I get a new job?
A: No.

Q18: Is interest added on to what I owe?
A: No.

Q19: For married couples, do both spouses have to sign the Lien?
A: Yes. The applicant and spouse both have to sign the lien in front of either a Deputy County Clerk or Notary Public so that the form can be properly witnessed. If you are no longer residing with your spouse and are unable to obtain your spouse's signature, notify your worker. Your worker will advise you of alternate documentation that CMS may accept.

Q20: For married couples who are legally separated or divorced, do both spouses have to sign the Lien?
A: No. Only the applicant needs to sign the Lien, but **legal** documentation regarding the legal separation or divorce must be provided. If you are unable to provide legal documentation, notify your worker. Your worker will advise you of alternate documentation that CMS may accept.

Q21: If an unmarried couple owns a home together, do both owners have to sign the Lien or just the applicant?
A: Just the applicant.

Q22: If my spouse is deceased, is documentation required?
A: Yes, documentation is required.

Q23: Can I pay the lien with credit cards?
A: No. Payments to clear a Lien must be made by certified funds.

Q24: If a married couple applies for CMS on separate occasions, do the lien forms need to be signed again by both applicant and spouse?
A: Yes.

Release Date:
December 23, 2014

Background

Applicants are required to report entitlement to and use other available health care coverage, if eligible. CMS is the payer of last resort. CMS does **not** pay insurance premiums, deductibles or co-payments. Veterans are encouraged to use all medical services available to them through the Veterans Administration.

A CMS recipient must reimburse CMS from any settlement received for health care services provided by CMS for which another party may be responsible.

Policy:

07.01.01A Other Health Coverage (OHC)

Applicants indicating that they have other health care coverage, which does **not** meet the MEC requirement under ACA, must complete the Health Insurance Questionnaire (CMS-69) at initial application, recertification, and reapplication as a condition of eligibility. Veterans must complete the CMS-69 if they have other health care coverage through private insurance.

Prior to the approval of CMS benefits:

- have the applicant complete the CMS-69
- check for completeness of the form and verify that a phone number for the insurance company is given, the policyholder's social security number is provided, and the form is signed and dated
- scan the form into AuthMed
- send the original CMS: 69 to the ASO at P.O. Box 927110 San Diego, CA 92192

07.01.01B Third Party Liability (TPL)

A CMS recipient must reimburse CMS from any settlement received (including a settlement from the recipient's own insurance) for health care services provided by CMS, for which another party may be responsible (e.g., vehicle accident, job injuries, injuries caused by a third party's action).

TPL Report (CMS-7)

The Third Party Liability Report (CMS-7) report is used to ensure that all necessary information is reported to CMS and acknowledges the recipient's responsibility to reimburse the CMS program. The CMS-7 is part of the permanent case record. It is not necessary to complete the report if the applicant received a settlement before applying for CMS, has spent the money, and now qualifies for CMS. The applicant must fill out the CMS-7 as fully as possible. Refer to Processing Guide 01 for instructions on how the recipient completes the report.

Once the CMS-7 is completed and signed, review the completed report to ensure that it is legible and contains all information needed and send the CMS-7 to the CMS TPL Program Specialist at MS W 414.

Impact:

No impact to other program(s)

Reference(s):

None

Release Date:

December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.

Background:

A CMS discontinuance policy has been established to:

- Discontinue benefits for individuals who are not eligible for or who wish to discontinue their CMS benefits
- Provide correct CMS eligibility information on the Provider Online Verification (POV) website

Policy:

15.01.01A Discontinuance Requirement

Discontinue CMS benefits if the recipient:

- requests their benefits be discontinued
- is enrolled in Medi-Cal
- is enrolled Medicare
- is enrolled in a Covered California Health Care Plan or in any health care coverage plan that meets the MEC requirement under ACA
- lives/moved outside San Diego County
- has income and/or property which exceeds program limits
- has been confirmed as deceased
- failed to provide requested and required verifications that are otherwise unavailable to HHSA staff (refer to 02.06.03)

15.01.01B Discontinuance: Request by the Recipient

A recipient may request discontinuance of CMS benefits at any time by:

- Submitting a signed statement indicating the request for discontinuance
- Making a verbal request for discontinuance

Ask that the request for discontinuance be made in writing; however, is not necessary to wait for the written request before the case is discontinued.

15.01.01C Timely Notice Requirement

Unless an exception applies, when an action is taken to discontinue benefits, notify the recipient timely and with an adequate NOA. Issue CMS Discontinuance Notice of Action (CMS-131) at least 10 calendar days **prior** to the end of the month in which the CMS certification is to end. (Refer to 15.01.01E for NOA deadline).

Exceptions

A 10 day notice is **not** required under these circumstances; however, an adequate notice is required.

The recipient:

- has provided written/verbal request to discontinue their benefits
- is enrolled in Medi-Cal
- is enrolled in Medicare
- is enrolled in a Covered California Health Care Plan or in any health care coverage plan that meets the MEC requirement under ACA
- has been confirmed as deceased
- is not a San Diego County resident

15.01.01D Adequate Notice Requirement
A written notice that informs the recipient of the following:
- Action the County intends to take
- Reason(s) for the intended action
- Specific regulation(s) supporting such action
- Explanation of the claimant's right to request a county appeal hearing
- Circumstance(s) under which benefits will be continued if a hearing is requested

15.01.01E NOA Cut-off Date Requirement
The CMS discontinuance (CMS-131) NOA must be mailed by the following deadline:

Calendar Day	Month
18th	All months; except February
16th	February
Note: If the deadline falls on a holiday or weekend, the NOA must be mailed and dated the workday **prior** to the deadline date.	

Procedure:
Discontinuance
Upon receipt of information that causes a recipient to become ineligible for CMS or the recipient requests their CMS benefits be discontinued:
- obtain supporting documentation as appropriate
- discontinue the case as outline in How To #1003 by updating the CMS IT system (AuthMed) with the discontinuance information
- narrate in case comments the circumstance supporting the case discontinuance. Information should include, but is not limited to the reason(s) for discontinuance and the effective date of discontinuance
- ensure the recipient is given timely notice, as appropriate, of the discontinuance

Discontinuance Action Not Required
Check AuthMed to verify the existing certification period end date. If the certification period is due to end at the same time the discontinuance NOA would be effective, you **do not** need to discontinue the case. However, you must enter the information related to the reason(s) for ineligibility in case comments.

Applicant Contact
Take the following actions when contact by the recipient is made **after** a discontinuance action:

When contact is made…	
prior to the date of discontinuance,	rescind the discontinuance.
after the date of discontinuance,	advise the recipient of the option to submit an appeal to dispute the action and/or reapply. However, you may rescind the discontinuance if good cause is determined.

Rescission of Discontinuance
Upon receipt of information that requires the reinstatement of benefits:

- rescind the discontinuance as outline in How To #1003
- notify the recipient by sending Rescind Notice (CMS-110R) when any of the following conditions apply:
  - a County Administrative Hearing decision orders a reevaluation of CMS benefits;
  - recipient contacts the County prior to or after the discontinuance date on the NOA and good cause is found;
  - the recipient is eligible to Aid Paid Pending (APP); or
  - it has been determined that the discontinuance was in error.
- re-evaluate the case based on CMS eligibility criteria

Impact:
No impact to other program(s).

Reference(s):
None

Release Date:
December 23, 2014

Sunset Date:
This policy will be reviewed for continuance by January 1, 2017.