Medi-Cal Program Guide Letter #621

December 19, 2007

Subject — **County Medical Services (CMS) Certification Period, Medical Need Verification at Recertification, and Clarification Regarding Transfer of Property Period of Ineligibility.**

Effective Date — December 01, 2007

Reference — County Policy

Purpose

The purpose of this letter is to provide staff with instructions regarding:

- the standard certification period for the CMS Program,
- a new requirement to verify medical need at CMS recertification, and
- a clarification regarding transfers of property which result in a period of ineligibility.

Background

Certification Period:

Effective December 1, 2006, CMS certifications were temporarily amended to a:

- 3-Month certification for those patients referred to apply for:
  - o DAPD (clinic only), and
  - o UIB, SDI, SSA Retirement, or other unconditional available income, where if included in budget, the applicant would be income ineligible.
- 6-Month certification for those patients:
  - o referred to apply for UIB, SDI, SSA Retirement, or other unconditional available income, where if included in the budget, the applicant would not be income ineligible.
  - o recertifying with an expired or lost I-551 immigration document
  - o residing in a Drug Rehabilitation Center.
- 12-Month certification for those patients who:
  - o have applied for UIB, SDI, SSA Retirement, or other unconditional available income (and the anticipated income does not create income ineligibility),
  - o have provided all necessary verifications and
  - o have no foreseeable change in circumstances which affects eligibility. ***Note:*** No changes were made to the 12-month certification for "Chronic" patients.

Background (continued)

Medical Need:
The CMS Program is defined as a program of last resort for indigent individuals who have a serious medical need. CMS is not health insurance, as it is meant to only be accessed to address urgent health issues for individuals who are not eligible to any other program and who do not have insurance to cover the medically needed service.

Period of Ineligibility:
Article A currently states that CMS requires the evaluation of all situations where the applicant transferred property without adequate consideration and that property transferred more than 2 years prior to the date of application will not affect eligibility.

Article A does not specifically state that property transferred without adequate consideration within 2 years of the application date shall result in ineligibility. Clarification is therefore required.

Change

Certification:
Effective 12/01/07, the standard CMS certification period is a maximum of 3 months, if otherwise eligible. No changes are made to the 12-month certification for "Chronic" patients identified in IDX with a "Chronic" indicator. The temporary use of 6 month and 12 month (non-chronic) certification is discontinued effective 12/01/07.

On December 3, 2007, Health Care Policy Administration (HCPA) emailed Health Coverage Access (HCA) staff informing them of the new standard certification for the CMS Program. The email instructed staff to revert back to 3 month standard certification period and only continue a 12 month certification period for those patients identified as chronics by AmeriChoice.

Medical Need:
At certification, the worker shall provide all CMS patients with a medical need form (in addition to referring the patient to apply for Medi-Cal DAPD and/or unconditional available income). The worker will advise the patient that if they have an ongoing medical need and they require CMS coverage past the certification period, the medical need form must be completed by their physician and mailed to the CMS Administrative Services Organization (AmeriChoice) prior to scheduling their next recertification appointment. This form is a requirement for the next recertification appointment. The patient will not be given an eligibility appointment if the completed form is not received. The worker shall narrate the explanation to the applicant in the case file.

Change (continued)

HCPA staff will be identifying those patients certified CMS in the month of December (prior to the issuance of MPG Letter #621) who were not advised of the new requirement to verify the medical need at recertification and were not given the CMS Medical Need Form. HCPA staff will mail a letter to these patients along with the CMS Medical Need Form (HHSA: CMS-127) advising them of the new requirement for recertification. A copy of the letter will be given to HCA for workers to file in affected cases.

Period of Ineligibility:
As clarification, the MPG, Article A now specifies that property transferred without adequate consideration *within* two years of the application date will result in a period of ineligibility. Please see Article A-5-3E (2).

Verification Requirement

CMS Medical Need Form (HHSA: CMS-127) will be required before a recertification appointment is provided to the beneficiary. A recertification cannot be approved without a complete CMS-127 indicating a provider's verification of continued medical need.

Automation Impact

None.

Forms

CMS Medical Need Form (HHSA-CMS-127) are ordered directly from and kept in stock by HCA

Form	Name
HHSA:CMS-127/HHSA:CMS-127 (SP)	County Medical Services (CMS) Medical Need Form
HHSA:CMS-39A/HHSA:CMS-39A (SP)	Notice of Action

Quality Assurance Impact

Effective with the January review month, Quality Assurance will cite with the appropriate error any case that does not comply with the requirements of this letter.

Appeals Impact

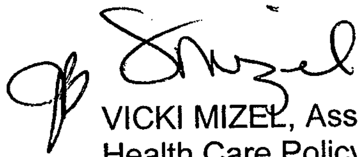
There is no change from the current appeal process for all issues regarding eligibility.

Filing Instructions

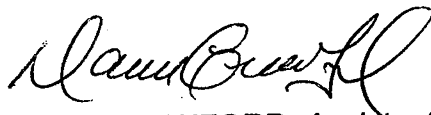
The table below shows how to file the MPG material.

Remove pages:	Replace with pages:
Article A-2-i Article A-2-5 Article A-2-9 Article A-2-12 Article A-5-i Article A-5-4 Article A-5-7	Article A-2-i Article A-2-5 Article A-2-9 Article A-2-12 Article A-5-i Article A-5-4 Article A-5-7
Article A-7-i Article A-7-1 through A-7-2 Article A-7-4	Article A-7-i Article A-7-1 through A-7-2 Article A-7-4
Article A-9-i Article A-9-3	Article A-9-i Article A-9-3 Appendix B

Managers Approval



VICKI MIZEL, Assistant Deputy Director
Health Care Policy Administration
Strategic Planning and Operational Support Division



DANN CRAWFORD, Assistant Deputy Director
Medi-Cal, General Relief and CAPI Program Administration
Strategic Planning and Operational Support Division
TO GS 122107 ADV "YES"

Manager Contact

Julia Palmer
(858) 492-2240

County Medical Services (CMS) Medical Need Form

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

SECTION 1 – PATIENT INFORMATION AND AUTHORIZATION TO RELEASE INFORMATION (to be completed by patient)

PATIENT INFORMATION

Patient Name:					
Address:					
City:		State:	CA	Zip code:	
SSN:		DOB:			
Phone Number:				Sex:	M / F

AUTHORIZATION TO RELEASE INFORMATION

I authorize the provider/physician listed below to release my ongoing medical need information to the County of San Diego County Medical Services

______________________________ of ______________________________

Name of Provider/Physician — Clinic or Medical Group

This information is required by the County to verify ongoing medical need for a CMS eligibility appointment. I may revoke this authorization in writing at any time, except for information that has already been given to CMS. This information will be kept in the case and will not be disclosed without my signed consent for each disclosure unless the disclosure is specifically required or allowed by law. I have read this form (or had it read to me) after it was completed. I am entitled to a copy of this form, if I request one.

Mail form to :
CMS Program Customer Service Supervisor
PO Box 939016
San Diego, CA 92193

____
Patient Signature — Date signed

____
Signature of Witness to mark, interpreter, or person acting for patient — Date signed

____
Print name of Witness to mark, interpreter, or person acting for patient — Relationship to patient, if not self

Section 2 – Statement of Provider/Physician
(to be completed by a health care professional licensed or certified by the State to diagnose/treat medical conditions)

The information requested is needed to verify ongoing medical need for a CMS eligibility appointment. Please answer the following questions.

1. Does the patient have a medically verifiable condition? ☐ Yes ☐ No
   If yes, complete the rest of this form, as appropriate. If no, complete the provider certification section.
2. Diagnosis:______________________________
3. The patient's condition is ☐ Chronic or ☐ Acute
4. The patient's treatment is expected to last until ______________________________
   Date

Section 3 – Provider/Physician Certification
(to be completed by a health care professional licensed or certified by the State to diagnose/treat medical conditions)

____
Signature of Provider/Physician (or Authorized Representative) — Date Signed

____
Print Name and Title — Medical License Number

____
Street Address, City, State, Zip Code — Phone Number

____
Mailing address, if different

ATTACHMENT A

County Medical Services (CMS) Medical Need Form

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

SECCION 1 – INFORMACION DEL PACIENTE Y AUTORIZACION PARA PROPORCIONAR INFORMACION (debe ser completado por el paciente)

INFORMACION DEL PACIENTE

Nombre del Paciente:						
Dirección:						
Ciudad:		Estado	CA	Zona Postal:		
No. De Seguro Social:		Fecha de Nacimiento				
Numero de Teléfono:					Sexo:	M / F

AUTORIZACION PARA PROPORCIONAR INFORMACION

Por este medio yo autorizo que mi médico/proveedor otorge información acerca de mis necesidades médicas a los Servicios Medicos del Condado (CMS).

_________________________________ o _________________________________

Nombre del Médico/Proveedor — Clínica ó Grupo Médico

Esta información se requiere para que el Condado verifique la necesidad de mi atención médica para poder hacer una cita de elegibilidad de CMS. Yo puedo revocar esta autorización por escrito en cualquier momento, con excepción de la información que ya se ha dado al programa de CMS. Esta información quedara en mi caso y no será revelado sin mi consentimiento por escrito al menos que la revelación específicamente se requiere o sea admitida por ley. Yo he leído esta forma (o me la han leído) después de haber sido completada. Tengo derecho de una copia de esta forma, si solicito una.

Regrese la forma por correo a:
CMS Program Customer Service Supervisor
PO Box 939016
San Diego, CA 92193

____
Firma del Paciente — Fecha

____
Firma del Testigo a la marca, interprete, o persona representando al paciente — Fecha:

____
Nombre del Testigo a la marca, interprete, o persona representando al paciente — Relación al paciente, si no es mismo

Section 2 – Statement of Provider/Physician
(to be completed by a health care professional licensed or certified by the State to diagnose/treat medical conditions)

The information requested is needed to verify ongoing medical need for a CMS eligibility appointment. Please answer the following questions.

1. Does the patient have a medically verifiable condition? ☐ Yes ☐ No
   If yes, complete the rest of this form, as appropriate. If no, complete the provider certification section.
2. Diagnosis:_________________________
3. The patient's condition is ☐ Chronic or ☐ Acute
4. The patient's treatment is expected to last until _________________
   Date

Section 3 – Provider/Physician Certification
(to be completed by a health care professional licensed or certified by the State to diagnose/treat medical conditions)

____
Signature of Provider/Physician (or Authorized Representative) — Date Signed

____
Print Name and Title — Medical License Number

____
Street Address, City, State, Zip Code — Phone Number

____
Mailing address if different

ATTACHMENT A

COUNTY MEDICAL SERVICES
NOTICE OF ACTION

Date: ______________________________ Case#: ______________________________

CMS Representative: ______________________________

To ______________________________ Phone: ______________________________

______________________________ Location: ______________________________

______________________________ Address: ______________________________

____

The following action has been taken on your application for CMS:

- ☐ Your application has been approved from __________ through __________ for the CMS Program. This approval is granted under the standard CMS eligibility category with no co-payments for CMS covered services/medications.

- ☐ Your application has been approved from __________ through __________ for the CMS Expansion Program. You will have a co-payment for the medical/pharmacy services you receive.

  YOUR CMS PROVIDER OR PHARMACY WILL COLLECT YOUR CO-PAYMENT AT TIME OF SERVICE. CO-PAYMENTS ARE NEVER COLLECTED BY COUNTY STAFF.

CMS provides medical services for serious health problems. This approval does not imply that all services are covered by CMS. A medical determination for each health care service you receive will be made each time you visit the CMS health care provider.

- ☐ If co-payments are a hardship, you may request a co-payment Financial Hardship Waiver evaluation. The CMS Hardship Waiver packet is enclosed for your convenience. If you would like to request a financial waiver of co-payments, you must return the completed packet within 10 days from the date of this notice.

- ☐ You are potentially linked to disability based Medi-Cal. CMS rules require that you apply for and fully complete the Medi-Cal disability application process by applying at the **Family Resource Center** in your area. **You must do this within 10 days from the date of this notice.** Failure to do so may result in future ineligibility to the CMS Program. If you need information on how to apply for Medi-Cal, call the CMS representative listed at the top of this notice. (Form HHSA: CMS-5 should be attached to this notice).

If you have an ongoing medical need and require CMS coverage past the certification period, your physician must complete the CMS Medical Need Form (HHSA: CMS-127) provided to you today. Mail the completed CMS Medical Need form to: **CMS Program Customer Service Supervisor, PO Box 939016, San Diego, CA 92193.** This completed form must be received by CMS before you call to schedule your CMS recertification appointment.

If you disagree with this action, you have the right to request a First Level Supervisory Review. You must do this within fourteen (14) calendar days after the date of this notice in writing or by phone:

You may write to:
CMS Program (O557E)
FIRST LEVEL SUPERVISORY REVIEW
P.O. BOX 85222
SAN DIEGO, CA 92186-5222

OR

You may call:
CMS CALENDAR CLERK
(858) 492-2200

Requests submitted after 14 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: ______________________________

HHSA:CMS-39A (12/07) Eligibility Approval
Distribution: ORIGINAL TO APPLICANT; COPY TO CASE RECORD

County of San Diego
Health and Human Services Agency

SERVICIOS MEDICOS DEL CONDADO

AVISO DE ACCION

Fecha:______________________

Para:______________________

____

____

Numero de Caso:______________________

Representante de CMS:______________________

Teléfono:______________________

Ubicación:______________________

Domicilio:______________________

____

La siguiente acción se ha tomado sobre su solicitud para elegibilidad de CMS:

☐ Su solicitud ha sido aprobada de ______________hasta______________ para el programa de CMS. Esta aprobación es concedida, como elegibilidad regular de CMS sin co-pagos para servicios médicos/medicamentos cubierto por CMS.

☐ Su solicitud ha sido aprobada de ______________hasta ______________para el Programa de Expansión de CMS. Usted tendrá un co-pago para servicios médicos/farmacia que reciba.

SU PROVEEDOR DE CMS O FARMACIA COBRARA SU COPAGO AL MOMENTO DE SU SERVICIO. CO-PAGOS NUNCA SON COBRADOS POR PERSONAL DEL CONDADO.

☐ Si se le dificulta hacer su co-pago, usted puede solicitar una evaluación de Exclusión de Co-Pago Por Circunstancias Extrema de CMS. El paquete de la Exclusión de Co-Pago Por Circunstancias Extrema de CMS, esta incluida para su conveniencia. Si usted quisiera solicitar una exclusión de co-pago por circunstancia extrema de CMS, usted debe hacer esto en un lapso de no más de diez (10) días de la fecha de esta notificación.

CMS provee servicios médicos para problemas serios de salud. Esta aprobación no implica que todos los servicios serán cubiertos por CMS. Se hará una determinación médica por cada servicio de cuidado médico que usted reciba cada vez que usted visite al proveedor de salud de CMS.

☐ Es posible que usted sea elegible a beneficios basados de Medi-Cal por incapacidad. Los reglamentos de CMS requieren que usted solicite y complete totalmente el proceso de la solicitud para beneficios de Medi-Cal por incapacidad. Esta solicitud de Medi-Cal se debe solicitar en el **Centro Familiar de Recursos** en su área. **Usted debe hacer esto dentro de los siguientes diez (10) días de la fecha de esta notificación.** Si no cumple puede resultar en no ser elegible al Programa de CMS en el futuro. Si necesita información acerca de cómo solicitar Medi-Cal, llame al Representante de CMS anotado arriba. (Formulario HHSA:CMS-5 debe de ser incluido con este aviso).

Si usted tiene una necesidad médica continua y requiere cobertura del programa CMS después del período de certificación, su médico debe llenar el Formulario de Necesidad Médica para el Programa CMS (HHSA: CMS-127) que se le ha proporcionado hoy. Envíe por correo el formulario completo a: **CMS Program Customer Service Supervisor, PO BOX 939016, San Diego, CA 92193.** El programa de CMS debe recibir este formulario completo antes de que usted llame para programar su cita para renovar su certificación de CMS.

Si usted no esta de acuerdo con esta acción, usted tiene el derecho de pedir una revisión de primer nivel por un supervisor. **Debe solicitar la revisión dentro de catorce (14) días consecutivos después de la fecha de este aviso escribiendo o llamando a.**

Puede escribir a:
CMS Program (O557E)
FIRST LEVEL SUPERVISORY REVIEW
P.O. BOX 85222
SAN DIEGO, CA 92186-5222

O

Puede llamar a:
CMS CALENDAR CLERK
(858) 492-2200

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.

Reglamentos de CMS:______________________

HHSA:CMS-39 (SP) (12/07) Eligibility Approval
Distribution: ORIGINAL TO APPLICANT; COPY TO CASE RECORD

County of San Diego
Health and Human Services Agency

ATTACHMENT B

ARTICLE A
SECTION 2

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CMS should not be certified if there is a pending fraud investigation on the Medi-Cal application. The date the DAPD packet was sent must be recorded on the CalWIN Disability screen within 30 days from the date of application.

Reminder: Per MPG 5-4.2, DAPD's must be submitted within 10 days of receipt of the Statement of Facts.

Note: If CalWIN Disability Screen input is not completed within 30 days from the date of application, all CalWIN entries will fail. The worker records the CMS certification period and the date the DAPD packet was sent in the narrative of the CMS and Medi-Cal case as well as on the Comments section of the CMS-4 for input to the patient's IDX record. Example: CMS 5/05-10/05, MC P (xx/xx application date) DAPD sent 6/12/05. This entry alerts the DAPD Recovery Specialist that there is potential reimbursement from Medi-Cal to CMS. The HOS worker then sends the Medi-Cal case to the DAPD Unit at the Mission Valley Family Resource Center (FRC). IDX screen prints reflecting CMS eligibility and IDX comments must be in the case file as referenced in MPG Article 4, Section 2.7(C). Upon approval or denial of Medi-Cal, the DAPD FRC worker sends form 14-10 HHSA to the ASO at O557B. The CMS case is sent to HQ for filing in the Record Library.

F. Notification

HOS workers must send the appropriate Notices of Action to applicants, including the Notice of Privacy Practices (Article A-2-7) when certifying or recertifying CMS eligibility. At certification, workers shall provide all CMS patients with the CMS Medical Need Form (HHSA-CMS-127). Refer to MPG Article A-2-8.

HOS workers must also notify the hospital and the ASO when CMS eligibility is approved or denied by sending form HHSA: CMS-4 to the ASO at O-557B (see Article A, Section 9, Appendix 9A for completion instructions).

The HOS worker must send form CMS-4 to the ASO when:

1) A Medi-Cal application has been granted or denied, and the application was the result of a HHSA: CMS-5 referral. The completed form HHSA: CMS-5 must be returned to the worker who initiated it.

2) A Medi-Cal application is being processed for a CMS beneficiary who was certified CMS at another site.

3) The CMS applicant or beneficiary has a Social Security Disability or SSI application pending (H80 on MEDS), approved, or denied and/or has an appeals decision pending with the Social Security Administration.

4) A CMS application has been granted or denied. Separate CMS-4 forms shall be submitted for each denial or certification action taken. Upon approval of CMS, the HOS worker issues the appropriate CMS card and a Patient Handbook.

5) A CMS application has been granted with a Medi-Cal case pending a DAPD determination. In these cases, two notifications are required. One at the time CMS is granted, and another at the time Medi-Cal is granted or denied.

6) A CMS application has been denied erroneously and the denial action is being rescinded.

Workers process mail-in applications in the same manner as HOS. See Article A-2-2C(2).

C. Rights and Responsibilities

Applicant Rights and Responsibilities are the same as HOS. See Article A-2-2D.

D. Case Handling

1) Case Folder

Workers create a manual non-automated CMS case folder in the same manner as HOS. Refer to Article A-2-2E(1a) and A-2-2E(1c).

2) Denial/Failure to Provide Requirements

CMS follows Medi-Cal rules as outlined in Article 4, Section 13 of the MPG. If required verifications have not been provided after the initial 10 days have passed as outlined in MPG 4-13-3B(1), the worker uses the manual CMS letter Reminder Request for Verifications, HHSA: CMS-22. This letter must be sent as a reminder notice to CMS applicants to inform them that they have an additional 10 days to provide verifications that were not provided during the initial 10-day period.

3) Denial – Excess Income

Workers are to follow the same process as HOS. Refer to MPG Article A, Section 2, Item 2.E (3).

4) Approved – Medi-Cal Disability Evaluation (DAPD) Pending

Workers at Primary Care Clinics and Public Health Centers, may approve a standard CMS certification after directing an applicant/beneficiary to apply for Medi-Cal using the HHSA: CMS-5 form. The worker must specify on the CMS-5 the beginning month for the Medi-Cal DAPD application and retroactive months as needed. Retroactive Medi-Cal is needed when the applicant/beneficiary has had CMS coverage in the retroactive period. Workers shall assist those who need help completing the Statement of Facts (MC 210) and Supplemental Statement of Facts (MC 223), etc. The worker must inform the applicant verbally and on the Notice of Action that CMS will not be recertified until they fully complete the Medi-Cal application process. After the three-month period, CMS cannot be approved until the worker verifies the applicant/beneficiary has fully complied in completing the Medi-Cal application process; met all Medi-Cal eligibility and verification requirements; and the Medi-Cal application is pending on CalWIN with the date the DAPD packet was sent. (See Medi-Cal Linkage in Article A Section 2 Item 6 for more instructions.)

E. Notification

Workers must send Notices of Action to applicants, including the Notice of Privacy Practices (Article A-2-7) when certifying or recertifying CMS eligibility. Refer to MPG Article A-2-8.

CMS workers must also send form HHSA: CMS-4 to the ASO at O557B to enter eligibility information into IDX (see Article A, Section 9, Appendix 9A for CMS-4 instructions).

C. Deceased Person

Because CMS is the program of last resort, it will not consider applications made on behalf of a deceased person. CMS denies all provider claims for services given to a CMS beneficiary who dies while in the hospital. In this situation, the beneficiary is 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".

D. Cash Assistance Program for Immigrants (CAPI) Applicants

CAPI is a cash program for certain immigrants who are ineligible to SSI/SSP solely due to their immigration status. All CAPI applications and redeterminations are processed in the Mission Valley Family Resource Center. A DAPD has to be processed for CAPI applicants. The DAPD process for CAPI is the same as Medi-Cal, however a separate Medi-Cal application has to be requested by the applicant. A CMS applicant who has a pending CAPI application **must also** apply for Medi-Cal and may be granted CMS pending the DAPD decision. A CMS applicant who has an active CAPI case is linked to Medi-Cal and is not eligible to CMS.

7. <u>NOTICE OF PRIVACY PRACTICES</u>

Workers shall give the "Notice of Privacy Practices" to all individuals who are certified or re-certified for CMS. This is a federal requirement under the Health Insurance Portability and Accountability Act (HIPAA). The worker must note on the case narrative the date the notice was given.

8. <u>CMS MEDICAL NEED FORM (HHSA:CMS-127)</u>

At certification, the worker shall provide the CMS patient with a medical need form. The worker will advise the patient that if they have an ongoing medical need and they require CMS coverage past the certification period, the medical need form must be completed by their physician and mailed to the CMS Administrative Services Organization (AmeriChoice) prior to scheduling their next certification appointment. The patient will not be given an eligibility appointment if the completed form is not received. The worker shall narrate this explanation in the case file.

Patients mail CMS Medical Need Form (HHSA:CMS-127) to:
CMS Program Customer Service Supervisor
PO Box 939016
San Diego, CA 92193

ARTICLE A
SECTION 5

FINANCIAL ELIGIBILITY

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1) Initial Application

At initial application, CMS only applicants are not required to apply for unconditionally available income prior to the approval of CMS benefits. The worker may approve a standard CMS certification when all other program requirements are met and must direct the applicant to apply for the unconditionally available income. However, in any subsequent application filed within one (1) year of the current application date or upon recertification, applicants and beneficiaries are required to provide verification of having applied for the unconditionally available income prior to approval of CMS benefits. The worker **must** inform the applicant about this requirement both verbally and on the NOA that certifies CMS. **NOTE**: Applicants or beneficiaries who do not have a potential claim present on the IEVS EDD on-line real time match should not be referred to EDD to apply for UIB or DIB (State Disability) unless it is an out of state claim. **A copy of the screen is required for documentation**.

2) Dual CMS/Medi-Cal DAPD Applicants

CMS applicants who also have a Medi-Cal DAPD application being processed by an HOS worker must apply for and provide verification of having applied for unconditionally available income to meet Medi-Cal eligibility requirements. CMS is NOT approved until all eligibility and verification requirements have been met for the Medi-Cal application.

3) SSA Early Retirement

Applicants age 62 through 64 must apply for SSA Retirement benefits. If they do not want to apply at age 62, but prefer to wait until age 65 to receive a larger amount, the worker shall allow them to verify the amount of SSA Retirement they would receive now in order to apply that amount in the CMS budget.

4) Recovery Home Residents

Recovery home residents who are not allowed to seek employment during their drug treatment program are not required to apply for UIB. EDD requires a person to be actively seeking employment in order to get UIB benefits. In these situations, the worker is to inquire and document how long the applicant is prohibited from seeking employment. The worker must inform the applicant that upon release to seek employment, the applicant must apply for UIB before CMS benefits are recertified.

J. Income Verification

CMS income verification requirements differ slightly from Medi-Cal requirements. For CMS, income verification must be provided to accurately determine current monthly income. One pay stub may not provide enough information about the frequency and the amount of pay needed to determine the monthly amount. Workers must assist CMS applicants and beneficiaries in obtaining verifications by using the information available on systems such as MEDS, IEVS or in cases that are with other workers. A copy of the screen is required for documentation. When verifications are not available, workers will follow Medi-Cal procedure in MPG Article 4, Section 7, Item 9. For CMS, income must be verified:

1) At application and reapplication;
2) At recertification;
3) Whenever a change is reported.
   EXCEPTION: Income from SSA or VA must be verified the first time it is reported and verified if there is a change. If there is no change, the income does not have to be verified at recertification.

property was received, and was legal at the time and place the transfer occurred. Adequate consideration also includes:

(1) Satisfying a legal debt, and

(2) Reimbursing someone, other than a responsible relative, for care or benefits provided. There must be a prior written agreement or understanding specifying the type of care to be given, the rate of pay, and that reimbursement would be made. Applicants must provide evidence to establish that the value of the care or benefits provided was equivalent to or greater than the value of the transferred property.

e) Transfer of property when foreclosure or repossession of the property was imminent at the time of transfer and there is no evidence of collusion.

f) Transfer of property when the applicant received an enforceable life care contract that does not include complete medical care. In this case, each full item of need provided under the life care contract is considered income in kind.

g) Transfer of property made without receipt of adequate consideration, but the applicant provides convincing evidence to the worker that shows that the transfer was not made to qualify for CMS.

h) Transfer of property when there is a written transmutation of a married couple's nonexempt community property into equal shares of separate property through an interspousal agreement.

i) Transfer of property if denial of CMS would cause undue hardship as described in MPG Article 9, Section 7, Item E4.

2) Transfers Resulting in Ineligibility

The following transfers result in ineligibility:

a) Applicant receives an enforceable life care contract that includes complete medical care.

b) Transfer of property without adequate consideration within two years from the application date. See previous section 1d regarding adequate consideration.

c) Adequate consideration was not received for the transfer of non-exempt property. It is presumed that transfers of non-exempt property without adequate consideration are made to become eligible to CMS. The applicant may overcome this presumption by providing convincing evidence, including a written subjective statement, that shows the sole purpose of the transfer was for reasons other than to become eligible to CMS. This may include, but is not limited to, evidence that the transfer was made to avoid probate and/or the applicant had no knowledge of CMS or its benefits at the time of transfer.

3) Documentation

The worker documents the decision about the effect of the transfer on eligibility, including the reasons for the decisions in the case narrative. When a period of ineligibility occurs because of a property transfer, the application or recertification is denied. The worker

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ARTICLE A
SECTION 7

CERTIFICATION PERIODS

This section contains guidelines for determining certification periods for CMS applications processed via a County worker at a CMS eligibility site or by a HOS worker for patients **admitted** to the hospital through the emergency room.

1. CERTIFICATION

   A. Beginning Month

      The applicant must meet all eligibility criteria before certification. The first month of the certification period depends upon when the applicant has met all eligibility criteria. If all criteria are met for the application month, then the certification period begins that month. If all criteria are not met until the following month, the certification begins the month following the application month.

      EXAMPLE: The applicant is admitted to the hospital on July 28 and discharged on August 5. His net non-exempt income for July exceeds the CMS income limit, and his estimated net non-exempt income for August is below the CMS income limit. The beginning month of the certification period is August.

      EXAMPLE: The applicant is admitted to the hospital on June 15 and discharged on June 20. In June, her net non-exempt property exceeds the CMS property limit. She has thirty days from the denial notice of action to spend the excess property down to within the limit. On July 10, she provides proof that she spent the property appropriately. The beginning month of the certification period is June.

      EXAMPLE: The applicant received treatment at a Primary Care Clinic or Hospital Emergency Room on June 15. They had no current CMS eligibility at the time the treatment was provided but are now requesting CMS coverage for that uncertified visit. If within 30 days from the date of the uncertified visit, the patient contacts the ASO to schedule the CMS intake interview, and if all other eligibility factors are met, the beginning month of the certification period is June. If the phone call was made more than 30 days from the date of the uncertified visit, or if patient does not meet all other eligibility factors for the month of the uncertified visit, the beginning month of eligibility is the month of July. Refer to Article A, Sections 2-2.A and 2-3.A for additional information.

   B. Ending Month

      The standard certification period for applicants is three months. When a foreseeable change in circumstances that affects eligibility is expected during the certification period, the certification period may be less than three months. The last month of the certification period is the last month when all eligibility criteria are met. When the certification period is less than three months, the worker must state the reason in the comment section of the CMS enrollment form and on the NOA that certifies CMS.

      EXAMPLE: The applicant's net non-exempt income is below the income limit in the month of application, but is expected to exceed the income limit the following month. The certification period is one month.

EXAMPLE: The applicant lives in San Diego County in the month of application, but says he is moving out of county the next month. The certification period is one month.

EXAMPLE: The applicant's INS document expires in three months. The certification period is three months.

EXAMPLE: The applicant needs to see a doctor or fill a prescription within 72 hours and is unable to get a bank statement. The worker can call the bank to verify the account balance and certify one month. Upon receipt of the bank statement, the worker may extend the certification period.

EXAMPLE: The applicant applies in the month of May and is receiving bi-weekly gross earned income of $595. Based on the paydays, the applicant will receive two paychecks per month for the period of May through August and will get a third paycheck in September. The gross income totals $1,289.36 when converted to a monthly amount using the 2.167 factor. The net non-exempt income is $1,199.36 after deducting the $90 standard work expense, which puts the applicant over the CMS MNL. The worker will re-compute eligibility using the actual income of $595 x 2 paydays in the month. This equals a net countable income of $1,100 after deducting the $90. The worker will certify for the months of May through August.

2. RECERTIFICATION

Recertification is a determination that a beneficiary continues to meet the CMS eligibility criteria. CMS has two standards for recertification; standard and chronic.

A. Recertification Eligibility Appointments

All CMS beneficiaries who wish to recertify must submit a completed CMS Medical Need Form (HHSA:CMS-127) to the ASO prior to requesting an eligibility appointment. The beneficiary will not be given an eligibility appointment if the completed form has not been received by the ASO.

B. Non-Chronics

Non-chronics may be recertified for three months.

C. Chronics

Chronics may be recertified up to twelve months. Chronics are those beneficiaries who have been identified by the ASO as having a chronic medical condition by entering a "**CHRONIC**" indicator on the IDX Eligibility Enrollment Summary Screen. Before recertifying, the worker **must** look for the "**CHRONIC**" indicator. CMS beneficiaries with the "**CHRONIC**" indicator, who fail to recertify timely, may still be certified for a 12-month period if they apply no later than two months from the last month of CMS eligibility and meet all eligibility requirements.

D. Exceptions

CMS beneficiaries, both chronic and non-chronic, are to be recertified for the standard period with the following exceptions:

When a beneficiary must comply with program requirements or has a foreseeable change in circumstances that affects eligibility during the recertification period, the recertification period may be less than the standard. When the recertification period is less than the standard, the worker must state the reason in the comment section of the CMS enrollment form and on the

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HHSA: CMS-100 / HHSA: CMS-100 (SP)	Statement of Facts
HHSA: CMS-116	Overpayment Payment and Collection Letter
HHSA: CMS-117	Overpayment Collection Letter
HHSA: CMS-119	Referral to BRCTP
HHSA: CMS-120	Health Services Information for Native Americans
HHSA: CMS-122/HHSA: CMS-122 (SP)	CMS Grant of Lien
HHSA: CMS-123/HHSA: CMS-123 (SP)	CMS Lien Information
HHSA: CMS-127	County Medical Services Medical Need Form
MC 175 Series	Sneede Forms
MC 176M and MC 176W	SOC Determination (CFBU) includes ABD Spouse or Parent)
MC 176P	Property Reserve Work Sheet
MC 210	Statement of Facts
None	Fair Hearing Decision

2. NOTICES OF ACTION

	MANUAL
HHSA: CMS-39 / HHSA: CMS-39 (SP)	Notice of Action
HHSA: CMS-39P	Period of Ineligibility
HHSA: CMS-125A/HHSA: CMS-125A (SP)	Notice of Action (Hardship Waiver Approval)
HHSA: CMS-125D/HHSA: CMS-125D (SP)	Notice of Action (Hardship Waiver Denial)
HHSA: CMS-126/HHSA: CMS-126 (SP)	Notice of Action (Hardship Co-Payment Waiver)