Medi-Cal Program Guide (MPG) Letter #677

August 26th, 2009

Subject **DOCUMENTATION REQUIRED FOR HEALTHY FAMILIES PROGRAM (HF) REFERRALS AND HF FORM NUMBER CHANGE**

Effective Upon receipt

Reference ACWDL 08-58, MEDIL 09-03

Purpose The purpose of this letter is to inform staff of additional requirements for HF referrals and a change to the form number for the MC 321 HFP AP form.

Background A referral to HF is required at application when a child under age 19 is determined not eligible to zero share of cost (SOC) Medi-Cal but appears to be eligible for HF and has consented to the referral. A HF referral is required when a child becomes ineligible to zero SOC Medi-Cal at redetermination, the child is eligible for HF and the family consented to the HF referral.

ACWDL 08-58 contains an updated list of documents the county is required to send to HF to make the referral.

The MC 321 HFP AP form is used to add individuals to an active Medi-Cal case. The Medi-Cal form MC 210 S-C also serves the same purpose.

Summary of Changes The following additional documentation is required in HF referrals:

1	A copy of the stand-alone consent form or a notation in the comment section of the MC 363 that states consent was given verbally. **NOTE:** This is only required if the most recent application, redetermination, or MSR form does not give consent.
2	A copy of the most recent application or redetermination form.
3	A copy of the most recent notice of action (NOA) showing the

	income calculation for the Medi-Cal Family Budget Unit (MFBU) with the SOC amount.
4	A copy of the most recent discontinuance NOA with the reason the child has been determined ineligible for zero SOC Medi-Cal.
5	A copy of any proof of income dated within 45 days of the referral.
6	A copy of the current MFBU budget worksheet. HF can use the MFBU budget computation worksheet as supporting income documentation. Workers must print a copy of the CalWIN '**display SOC/Financial eligibility determination**' window that displays the budget that moved the child from zero SOC to a SOC.
7	A copy of the following documents if available in the case file: 1 Birth Certificate (if citizenship was validated by the automated birth record match in MEDS, indicate such on the MC 363). 2 Proof of acceptable citizenship or identity documents (DHCS 0011) 3 Proof of Tribal affiliation (for American Indians and Alaska Natives).

In an effort to streamline the process of adding individuals to Medi-Cal cases, DHCS discontinued redundant forms MC 321 HFP AP and the MC 210 S-C effective 8/14/09 and replaced them with the MC 371.

Automation Impact

None.

Forms Impact

MC 371 – Additional Family Members Requesting Medi-Cal is now available for order from the DHCS warehouse.

Quality Assurance Impact

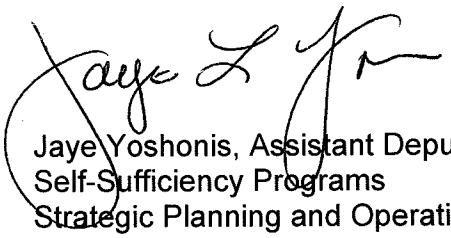
Effective with the September 2009 review month, Quality Assurance will cite with the appropriate error any case that does not follow the requirement of this letter.

Summary of Change

The table below shows the changes made in the MPG.

Section	Summary of Change
Article 4, Section 20	Added the new documentation requirements and changed references to MC 321 HFP AP to MC 371

Manager Approval



Jaye Yoshonis, Assistant Deputy Director
Self-Sufficiency Programs
Strategic Planning and Operational Support

MK

Article 4, Section 20 – Healthy Families and Medi-Cal Mail-in Application for Children and Pregnant Women

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04.20.01 Accelerated Enrollment

A. Accelerated Enrollment Background

Effective July 1, 2002, the California Department of Health Care Services (DHCS) implemented a state plan under Title XIX to initiate an Accelerated Enrollment (AE) program. The purpose of AE is to accelerate temporary, fee-for-service, full-scope, no-cost Medi-Cal coverage for children under the age of 19 who are new to Medi-Cal, applied for Medi-Cal through Single Point of Entry (SPE) and are likely to be eligible for a Medi-Cal Percent Program based on screening by SPE. Applications may be received from SPE with children who are approved for AE and/or family members who are not and will be processed using the established procedures described in item 04.20.02.C below. ACWDL 02-36

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B. Individuals Ineligible to AE

The following individuals are ineligible to AE:

- who will be 19 years of age or over in the application month;
- with an active Medi-Cal case as shown on MEDS in either the current, pending or application month; ACWDL 02-36
- without California residency;
- whose application does not provide enough information so that a client identification number (CIN) can be assigned;
- who are in the Bridging Program the month of or the month prior to

the month AE would be established;

- who are HF eligible on the data base of the HF administrative vendor or MEDS;

- who do not appear eligible for no-cost Medi-Cal when current screening procedures are used;

- whose application does not provide enough information at screening to establish eligibility; and

- who have been reported as deceased on MEDS with a death date present.

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C. Processing an AE approved child

When a child is approved by SPE for AE:

- SPE activates the child on MEDS with the AE aid code in the Special Program segment. The 14 digit County-ID for an AE individual will be formatted: residence county number, aid code, "9", and CIN.

- Eligibility begins the first day of the month of the date SPE receives the application.

- MEDS issues a BIC with the AE County ID, even if the child was previously on Medi-Cal and a BIC was issued to that child. **NOTE: It is the county responsibility to notify SPE of the correct CIN prior to the granting/ denial action if incorrectly assigned by SPE.**

After screening and activation of AE on MEDS:

- The application of the AE child is sent to the county per the established process for mail-in applications or Health-e-App applications as described in item 04.20.02.C below. **NOTE: It is critical that a thorough file clearance be done to ensure application information is reported correctly to MEDS. If incorrect information is found on MEDS, workers must match MEDS prior to granting, then make necessary corrections the next day to update MEDS with the correct information.**

- AE continues until the County reports eligibility to another Medi-Cal program on MEDS or denies the application using the MEDS on-line AP18 transaction.

After the Medi-Cal Determination:

If the AE child...	Then ...
is approved for regular Medi-Cal benefits	• the worker will approve the case as usual, beginning with the first day of eligibility based on the application date and other eligibility factors. • MEDS will terminate the AE aid code once a child is approved for ongoing Medi-Cal benefits.
Denied regular Medi-Cal Benefits	• The worker will deny the case as usual. • There is no 10-day NOA requirement when AE is terminated, but the worker must still notify the beneficiary that benefits under AE will be discontinued. See Appendix 4-20-L for NOA codes.

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NOTE: AE benefits granted to a child who is later determined to be ineligible to ongoing Medi-Cal benefits is not considered an overpayment.

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D. Aid Code and Automation

The aid code for AE is **8E**. This is a zero share of cost, full-scope fee-for-service aid code. For other automation information, see Appendix 4-20-K.

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04.20.02 Mail-In Applications

A. Introduction

As mandated by Senate Bill (SB) 903 and Assembly Bill (AB) 1126, the DHCS has developed a simplified mail-in application process for the Medi-Cal and HF.

Under the Medi-Cal program, the mail-in application process is for children under the age of 19 and for pregnant women under the 200% program. A face-to-face interview for this population is not required except at the client's request or if the FRC determines it is necessary for good cause, suspicion of fraud or for completion of the application process.

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B. Application Packets

The common Medi-Cal and/or HF application form is available in booklet form through community-based organizations (CBOs), county

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welfare offices, HF, schools, neighborhood businesses and other agencies. General information, an explanation of the Medi-Cal and HF, and instructions for completing the application are included in the booklet. The booklet also includes an envelope to send the application to SPE. Electronic Data Systems (EDS) is the administrative vendor of SPE and is also the enrollment vendor for the HF. The address on the envelope is SPE's address. If the applicant sends the application to ACCESS it will be forwarded to the appropriate Family Resource Center.

When submitting a mail-in Medi-Cal application, the applicant must include the four-page MC 321 HFP and the CA 2.1 and CA 2.1 (Q) if required. The CA 2.1 and CA 2.1 (Q) are not included in the booklet, but are available separately at the same locations as the application booklets. Verification of income, income deductions and residency shall also be mailed with the application forms.

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C. Process when applications are received from SPE

When Applications are received from the SPE:

Step	Action
1	ACCESS will date stamp the application, enter the date received and client's name on the tracking log and forward the application to the appropriate FRC intake scheduling supervisor on the same day. NOTE: If the application is received late in the day and it is impossible to forward to the FRC on the same day, ACCESS shall forward it to the FRC no later than the next working day.
2	<table><tr><th>If…</th><th>Then</th></tr><tr><td>The application is submitted or mailed directly to the county</td><td>The application date is the date the application is received by the FRC</td></tr><tr><td>The application is received from SPE via ACCESS</td><td>The application date is the date on the transmittal form (please refer to below section 'application forwarded to CWD transmittal form)</td></tr></table>

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When FRCs Receive the applications from ACCESS or directly from the applicant the intake scheduling supervisor shall:

Step	Action
1	Assign the case to an intake worker
2	Log in each application packet received noting: • The applicant's name • The date the packet was received • The worker assigned

This procedure is needed to control assignments of these applications, as they do not appear on the FRC's daily intake appointment log.

Worker Actions upon receipt of the packet:

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Step	Action
1	Determine eligibility for the child(ren) or pregnant woman based on the criteria for Percent programs. Workers must: • Not ask for property information or verification when evaluating for the Percent programs. • Obtain any additional information that is required by telephone, if possible, or by mail. • Follow-up may be made with other potentially eligible family members who requested Medi-Cal after the initial eligibility determination for the child(ren) and pregnant woman is made and processed.
2	

If…	Then the worker must …
The child or pregnant woman is ineligible for zero SOC due to income exceeding the appropriate percentage level (100%, 133% or 200% depending on the child's age, and 200% for pregnant women)	Send the applicant Automated Letter #936 and a MC 322 (Real and Personal Property Supplement to Medi-Cal Mail-In Application) since resources are not disregarded when determining eligibility under regular Medi-Cal.
The child or pregnant woman is eligible to zero SOC Medi-Cal	Send approval notices.
The family has requested to be evaluated for HF if not eligible to zero SOC Medi-Cal and the worker has determined the children are not eligible to zero SOC benefits and are potentially eligible to HF.	Copy the application, income verification, budget worksheet and the NOA. And send the application and all copied items back to SPE for evaluation. **NOTE:** A child may be

		eligible for SOC Medi-Cal while also active under the HF, or vice versa. Children are ineligible for HF only if they are eligible for zero SOC Medi-Cal. Also, a family may send an application to Medi-Cal for one child and an application to HF for another.
3	Complete the Medi-Cal Determination	
4	When the Medi-Cal eligibility determination is completed, an approval or denial notice must be sent to the applicant. Information about the HF program has been included in denial/discontinuance and SOC NOAs.	

The allowable processing time is the same as with any regular Medi-Cal application. Pregnancy and other urgent care needs are still to be processed expeditiously under existing immediate need guidelines. The procedure for retroactive Medi-Cal also remains unchanged.

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D. Medi-Cal Applications for Other Family Members

Families wishing to apply for Medi-Cal for everyone in the family, including adults and children, must complete the MC 210. However, if the family has already completed the MC 321 HFP (Application for Health Care - Healthy Families and/or Medi-Cal), they may only need to complete the supplementary forms required, such as the MC 371 - Additional Family Members Requesting Medi-Cal, MC 322 Real and Personal Property Supplement to Medi-Cal Mail-In Application. **The forms MC 321 HFP and MC 322 may substitute for the MC 210, and SAWS 1 to add persons to the Healthy Families Application.**

The MC 13 Statement of Citizenship, Alienage, and Immigration Status is required for all non-citizens being added to the case. U.S. Citizens may make the citizenship declaration on the MC 210, MC 321 HFP, or a sworn statement (See MPG 4-2-5 for more information on the MC 13 and the requirements for declaration of citizen/national status).

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To identify a teen's spouse or pregnant woman's husband, the worker must review the responses to the Family Size questions #26-28. The applicant will list all family members who live in the home including children under 21, stepparents, and the spouse of any teenager or pregnant woman who lives in the home. The applicant will identify the name, gender, date of birth, and how this person is related to the family member listed in question #1. The worker will contact the applicant to

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identify the teen's spouse or pregnant woman's husband if this information is not clearly stated. The Percent Programs approvals NOAs include a box that can be checked to request additional information needed to determine eligibility for other family members.

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E. Medi-Cal Applications for Non-Family Members

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If a review of questions #26-28 reveals any non-family members requesting Medi-Cal, a separate MC 210 form should be completed for this person. If a separate MC 210 form is required, the worker will complete a SAWS 1 form on behalf of the person requesting Medi-Cal to preserve the application date and forward an application package to the person for completion. The date of the Medi-Cal application will be the date that the application was received at SPE.

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F. Disability-Based Medi-Cal Applications

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Question #39 has been added to the MC 321 HFP Application to assist the worker in screening for disability-based Medi-Cal benefits:

- [ ] Does any person in the home have a physical, mental, emotional or developmental disability and want Medi-Cal? If Yes, who? (If you answer "Yes", we will contact you to see if you qualify.)

The worker will follow the procedures in MPG Article 5, Section 4, regarding DDSD referrals. If a child enrolled in P is determined eligible for no-cost Medi-Cal based on a disability, the worker will inform the family that in order to access free Medi-Cal services the parent/guardian must write a letter asking to end the child's enrollment in P. The letter requesting discontinued enrollment can be faxed to 1-866-848-4974 or mailed to the following address:

Healthy Families
ATTN: Eligibility
P.O. Box 138005
Sacramento, CA 95813-8005

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G. Verification Process for Mail-ins

<u>The following chart contains an outline of the verification process for Medi-Cal Mail-ins</u>

Satisfactory Immigration Status (SIS)	An MC 13 Statement of Citizenship, Alienage, and Immigration Status is **not** required for children on the MC 321 HFP.

<table>
<tr><td>SIS</td><td>The applicant must answer question 19 on the MC 321 HFP and send proof of SIS if appropriate.</td></tr>
<tr><td>SIS</td><td>If all the information necessary for an eligibility determination is received and the applicants are otherwise eligible, full-scope benefits must be approved. Applicants have 30 days to provide SIS documentation.

<table><tr><th>If…</th><th>Then…</th></tr><tr><td>If all the information necessary for an eligibility determination is received and the applicants are otherwise eligible</td><td>full-scope benefits must be approved. Applicants have 30 days to provide SIS documentation.</td></tr><tr><td>worker does not receive documentation of SIS within 30 days</td><td>reduce benefits to restricted scope coverage after a ten-day Notice of Action.</td></tr></table></td></tr>
<tr><td>Social Security Number</td><td>Applicants have up to 60 days to provide a social security number for persons applying for full-scope benefits.</td></tr>
<tr><td>Pregnancy</td><td>Pregnant applicants have up to 60 days to send the county verification of pregnancy when applying for full-scope benefits. No pregnancy verification is required when applying for restricted, pregnancy-related services.</td></tr>
<tr><td>Rights and Responsi-bilities</td><td>The MC 219 Rights and Responsibilities must be mailed to the applicant upon receipt of the MC 321 HFP. The worker must narrate that it was sent. The applicant is not required to return it.</td></tr>
<tr><td>CHDP</td><td>The Child Health Disability and Prevention (CHDP) Program brochure must be sent to the applicant upon receipt of the mail-in application.</td></tr>
<tr><td>Citizenship and Identity</td><td>For Medi-Cal purposes, refer to MPG Article 4, Section 7 for detailed information regarding identity and citizenship verification requirements for U.S. citizens/nationals.

The mail-in application instructs applicants to send copies of proof of citizenship. For Medi-Cal, only original documents or copies certified by the issuing agency may be accepted as proof of citizenship, national status, and identity. Copies of CA birth certificates may be used to initiate a Birth Record Data Match.</td></tr>
</table>

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Income	The most recent pay stub may be accepted as verification of income rather than requiring an entire month's pay stubs. Workers may still request additional pay stubs if there is any discrepancy between the amount reported on the application and the pay stub submitted as verification. A copy of the previous year's income tax return is also acceptable proof of income. Applicants are instructed in the application booklet to explain any future fluctuations in income on a separate sheet of paper.
Residence	Pay stubs showing the employer's address are generally acceptable as proof of residence, unless the applicant's employment is out of state or residence is otherwise questionable.
Other Health Care Coverage	If the applicant reports other health, dental or vision insurance or a pending lawsuit due to accident or injury, the worker may contact the applicant by phone for needed information and complete a DHS 6155 Health Insurance Questionnaire for the applicant without the applicant's signature.

H. Mail-ins received from the absent parent

The absent parent may initiate a Healthy Families application for his/her child because Family Support has told them of their responsibility to pay for the child's medical expenses. However, the absent parent cannot complete the Statement of Facts unless the custodial parent is mentally incompetent. Medi-Cal eligibility is based on the circumstances of the custodial parent, not the absent parent. The following procedures will be used when an absent parent submits an application (HF or mail-in Medi-Cal) for his/her child and the custodial parent is mentally competent.

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- The MC 321 HFP will be viewed as the application (SAWS 1) only and not the Statement of Facts when completed by the absent parent.
- The worker will request a new Statement of Facts (MC 321 HFP or MC 210) from the custodial parent when the absent parent signs the MC 321 HFP or SAWS 1. However, if the information on the MC 321 HFP is about the custodial parent, then the worker may send him/her the MC 321 HFP, completed by the absent parent, for review and signature.
- A denial notice of action (NOA) (see Appendix 4-20-L) will be

sent to the absent parent if the custodial parent does not return the completed Statement of Facts. **All other notices will be sent to the custodial parent**.

- A denial NOA (see Appendix 4-20-L) will be sent to the **custodial parent** if the worker determines that the children are already receiving Medi-Cal. The notice will explain that a Medi-Cal application was made on behalf of the children and is being denied because the children are already receiving Medi-Cal. This information will not be given to the absent parent.

- Information regarding the status of the application, if requested by the absent parent, may not be shared with the absent parent except in C above. Explain that all NOAs will be mailed to the custodial parent.

- Information provided by the absent parent may be shared with the custodial parent if it is related to eligibility determination. Otherwise, the information will be protected as confidential.

- Information from the custodial parent cannot be shared with the absent parent.

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04.20.03 CHDP Gateway

A. CHDP Gateway Process

The following describes the CHDP Gateway process. ACWDL 03-33

CHDP Providers	Prescreen children for potential eligibility to either zero SOC Medi-Cal or HF.
CHDP Providers	If the results of the prescreening indicate that a child under 19 has family income under 200% FPL: The provider enters the child's information into the Gateway system in order for the SPE to pre-enroll the child into a temporary (up to two months) zero SOC Medi-Cal.
SPE	If the parent(s) of the child requests an evaluation for ongoing Medi-Cal benefits: • SPE sends a joint Medi-Cal/HF application and informs the parent that if they want their child to receive ongoing Medi-Cal or HF coverage. • they must return the completed application to SPE.

ACWDL 05-02

<table>
<tr><td></td><td>(Application is not required for a deemed eligible infant enrolled through CHDP Gateway. See MPG 5-15-1.)</td></tr>
<tr><td>SPE</td><td>
<table>
<tr><th>If…</th><th>Then…</th></tr>
<tr><td>the application is not received back by SPE by the end of the second month</td><td>the pre-enrollment eligibility will be terminated by SPE at the end of the second month.</td></tr>
<tr><td>the application is received by SPE by the end of the second month</td><td>SPE will extend the child’s initial two-month pre-enrollment period until an eligibility determination is reported by the worker to MEDS.</td></tr>
</table>
</td></tr>
<tr><td>Workers</td><td>CHDP Gateway Medi-Cal applications received by SPE are sent to the County per the established process for mail-in applications or Health-e-App applications as described in item 04.20.02.C above.

It is critical that a full file clearance be done to ensure application information is reported correctly to MEDS. If incorrect information is found on MEDS, workers must match MEDS prior to granting, then make necessary corrections the next day to update MEDS with the correct information.</td></tr>
<tr><td>Workers</td><td>If a child has been pre-enrolled into Medi-Cal via the Gateway (active on MEDS in aid code 8W) but the application is submitted directly to the County without going through SPE, the worker must submit a 14-28 online request to extend the CHDP pre-enrollment eligibility period. See Appendix 4-2-L for instructions.</td></tr>
<tr><td>Workers</td><td>The child’s extended eligibility continues until the County reports eligibility to another Medi-Cal program on MEDS or denies the application.</td></tr>
<tr><td>Workers</td><td>There is no 10-day NOA requirement when CHDP Gateway coverage is terminated, but the worker must notify the child that the CHDP Gateway benefits will be discontinued. See Appendix 4-20-L for the discontinuance NOA.</td></tr>
<tr><td>Workers</td><td>If a CHDP Gateway child is approved for regular Medi-Cal benefits, the worker will approve the case as usual. MEDS will terminate the temporary CHDP Gateway eligibility once a child is approved for ongoing Medi-Cal eligibility.</td></tr>
<tr><td>Workers</td><td>Because denials are not automatically reported to</td></tr>
</table>

	MEDS, workers are required to report a denial of ongoing benefits for a CHDP Gateway child on MEDS by submitting a 14-28 to request a MEDS on-line AP18 transaction. See Appendix 4-20-L for instructions on how to report this information to MEDS.

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B. CHDP Gateway Aid codes and automation

The aid codes for CHDP Gateway are:

8W: Zero, SOC full scope, fee-for-service aid code assigned by SPE to children who appear eligible to ongoing zero share of cost Medi-Cal.

8X: Zero SOC, full scope, fee-for-service aid code assigned by SPE to children who appear eligible to HF.

8Y: Zero SOC restricted Medi-Cal and CHDP eligibility aid code assigned by SPE to undocumented alien children who were already active in a restricted aid code.

For automation information see Appendix 4-20-L.

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C. Retroactive Coverage

If a CHDP Gateway child applies for Medi-Cal or HF and also applies for retroactive Medi-Cal coverage, the retroactive period includes the period of Gateway eligibility. For example, if there was Gateway eligibility in June and July, and ongoing benefits are granted in August, retroactive benefits could only be granted for May.

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D. OHC override

When a child is enrolled through the CHDP Gateway and assigned either aid code 8W or 8X, MEDS will automatically assign the child an OHC code of “N” (no other health coverage) regardless of whether there is OHC or not. The OHC code on MEDS will remain an “N” until ongoing eligibility to Medi-Cal or HF is approved or denied. If the child is approved for ongoing Medi-Cal, and the worker enters the OHC code, MEDS will automatically change the OHC code for the future month to the newly reported OHC code.

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If a CHDP Gateway is child assigned a restricted aid code of 8Y, and the child reports OHC, MEDS will assign the child an OHC code of “A” (pay and chase) as long as the child remains in aid code 8Y and continues to have OHC.

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E. CHDP issuance of new BIC

If a parent of a child who is prescreened through the CHDP Gateway reports that the child needs a replacement BIC, the provider can order the replacement BIC for the child. This includes children who are already active on zero SOC full-scope Medi-Cal at the time of the prescreening and thus ineligible to pre-enrollment through the CHDP Gateway. The new BIC will be sent to the child within two days.

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04.20.04 Healthy Families

A. Healthy Families Program (HF) Introduction

The HF is an insurance program (as opposed to the Medi-Cal program) which:

- Was created under Assembly Bill (AB) 1126. HF Booklet
- Is administered by the Managed Risk Medical Insurance Board (MRMIB) effective June 1, 1998, (with benefits starting on July 1, 1998).
- Offers low monthly premiums from as low as $4 per child to a maximum of $51 per family. HF Booklet
- Limits co-payments to $250 per year per family for health services and has a $5 co-payment for each non-preventive services (no co-payments for preventive services, such as immunizations).
- Covers children without medical coverage and those with SOC Medi-Cal.
- Has eligibility determined annually (by MRMIB) based on the family's income.
- Does not consider the family's resources.
- Does not cover children who are currently covered, or have been covered in the past 90 days, by an employer's health plan.
- Does not cover undocumented aliens. ACWDL 98-74
- Provides low-cost health, dental and vision insurance for children under the age of 19.
- Has a family income limit of 250% of Federal Poverty Level (FPL). ACWDL 98-19

HF premiums can be used to reduce other family members' SOC.

The phone number for Healthy Families general information is **1-800-880-5305**.

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B. Healthy Families Mail-In Application Form MC 321

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Parents applying on behalf of a child must be allowed the option to consent to having the joint application and the child's information forwarded to the HF at a future time when the child's Medi-Cal status changes from no-cost Medi-Cal to SOC Medi-Cal (i.e., at annual redetermination). Example: 15-year-old child; family income above 100% but under 250% of the FPL; and the child is ineligible for Medi-Cal due to family resources. Since HF has an income limit of 250% of the FPL and disregards resources, this child appears to be potentially eligible for HF. Consent is given unless the parent elects to opt out by checking box #44, page A4, of the MC 321:

- [ ] Medi-Cal will share your child's application with Healthy Families if your child no longer qualifies for free Medi-Cal in the future. If you do not want us to send it, check here.

If the parent does not opt-out by checking this box, the worker must forward a copy of the application form (keeping the original for the case record), along with copies of verifications received, the budget worksheet, and NOA, to HF (P.O. Box 138005, Sacramento, CA 95813-9984) unless the applicant checks the box indicating he/she does not want to be evaluated for HF. The determination for SOC Medi-Cal must be completed and the case must be granted, if eligible.

HF will also forward applications to Medi-Cal if eligibility is denied for that program and the applicant wishes to have the children evaluated for Medi-Cal.

If the application is received by HF first and forwarded to the county, the date stamped on the form by HF is the Medi-Cal application date.

To protect the county in the event the application remains pending beyond the 45-day limit, FRCs shall also date stamp applications received from HF to indicate the date the application is actually received by the FRC.

County Policy

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C. Transmittal

ACWDL 99-38

Each application sent to the county, from the SPE, or from HF is listed on a transmittal. SPE and HF each have their own separate and

Forms

different transmittal to attach to applications sent to the county. There is also a transmittal form that county eligibility staff are to use to forward or return a Medi-Cal/HF application to HF. The transmittal forms used to send applications from SPE or HF to the county as well as from the county to HF are as follows: MEBIL I-00-05

HF Administrative Vendor (HFAV) Summary Transmittal Form

This is a computer-generated coversheet. This coversheet lists all applications that have been forwarded to the county for a specific day. If Access notices that a listed application is not in the packet, or an additional application is included in the packet but not on the list, Access will contact SPE at (916) 636-2950 or by email at SPELiaisons@eds.com. ACWDL 03-05

Application Forwarded to CWD Form.

This computer-generated transmittal is used by HF to send Medi-Cal/HF applications to the county when HF has determined that the person(s) referred is not eligible for HF, or other persons request Medi-Cal, or retroactive Medi-Cal coverage. The transmittal accompanies each application referred to the county for Medi-Cal processing. The transmittal has a county response section,which is used to:

- Respond to HF with CIN corrections.
- Refer HF applications for children who the ET determines were referred to Medi-Cal erroneously.

This transmittal includes two dates which are used for the Medi-Cal application date in different situations:

- Date Received. This is the date the application was received by HF. This date is the application for all referrals that are not associated with AER.
- Date Referred to County. This is the date that HF refers the application/AER to the county. This is the application date for all applications associated with AER.

The worker is to complete the county response section to: ACWDL 03-05

- Inform HF when corrections have been made to the CIN, including instances where HF used an incorrect CIN, or a CIN is created in error for an applicant.
- Inform HF of a CIN for a new applicant when it was not available to HF.
- Refer an application back to HF when the worker determines that a child was erroneously referred for a Medi-Cal determination based on the income and SOC computation.

MC 363 S County Summary Transmittal Form

This coversheet will be used by the county when referring applications to SPE for a given day. This transmittal will list the following information:

- county of origin,
- contact person's name and phone number,
- the number of referrals, and
- the county case name and case number for each referral.

MC 363 Medi-Cal to Healthy Families Transmittal Form

ACWDL 08-58

This transmittal is used to forward a Medi-Cal application to HF when the responsibible adult has consented to the application being forwarded to HF and the child is either:

1	Bridged to HF, or
2	Determined not eligible for zero SOC Medi-Cal at intake because their income is over the Federal Poverty Level (FPL) for that child's age group and they appear to be income eligible for HF.

ACWDL 08-58

The Medi-Cal to Healthy Families referral will include the completed MC 363 and the following information:

1	Case identifying information such as county, worker name and phone number, case name and case number and household members (including the parents, step parents and all children including step children and unborn (s).
2	Medi-Cal denial reason (if applicable).
3	Reason and type of referral.
4	Individual Information including last name, first name, SSN, CIN, gender, date of birth, relationship, individual gross income, type of income, allowable deductions, and SOC amount (if assessed).
5	Comments to describe any unusual situation to assist HF in making the correct determination.
6	A copy of the 'stand alone' consent form or a worker notation in the consent section of the MC 363 that states family consent was given verbally.
7	A copy of the most recent application or RV form (if available).
8	A copy of the most recent Medi-Cal NOA showing the income calculation for the MFBU with the SOC amount. HF does not accept the Sneede NOA as income verification.
9	A copy of the most recent discontinuance NOA with the reason the child has been determined ineligible for zero SOC Medi-Cal.

10	A copy of any proof of income, dated within 45 days.
11	A copy of the current MFBU budget worksheet. HF can use the MFBU budget computation worksheet as supporting income documentation. Workers must print a copy of the CalWIN '**display SOC/Financial eligibility determination'** window that displays the budget that moved the child from zero SOC to a SOC.
12	A photocopy of the following documents if they are in the case file: • Birth Certificate (if the child's US citizenship was validated through a birth record match in MEDS, please indicate such on the MC 363). • Immigration verification or Proof of Acceptable Citizenship or Identity documents (DHCS 0011). • Proof of tribal affiliation (American Indian or Alaska Native).

The underlying principle of referring applications to HF is to provide a seamless process to refer a child from Medi-Cal to HF.

MPG Letter 677 (08/09)

D. HF Annual Eligibility Review (AER) Process

ACWDLS 99-16 99-48 00-19

HF offers a continuous 12-month eligibility period based on the last enrollment date of a child in the household. This is called the "anniversary date." HF will mail the applicant the AER and the Add New Children form sixty days before the anniversary date. This form contains pre-printed information, such as the names of adults and children living in the household and their address. The application asks that the applicant provide current information on the household size and income of family members. The family can also apply for additional children by completing the Add New Children form. The general process for this review is as follows:

Step	Action
	HF
1	Reviews the information provided on the AER to determine if the children are eligible for another 12 months of HF benefits.
2	If the income is too low for the HF and the family has so authorized, HF will forward the AER to the county contact site for a Medi-Cal determination. The contact site for San Diego County is ACCESS.
3	The AER and the Add New Children form will be sent to PAI with a transmittal form that is very similar to the transmittal that accompanies the applications sent from the single point of entry. The single point of entry is the Electronics Data

<table>
<tr><td></td><td>Systems (EDS) central clearinghouse. (Refer to Appendixes B through E2 for samples of the AER cover letter, the AER and the Add New Children form.)</td></tr>
<tr><td></td><td>PAI</td></tr>
<tr><td>4</td><td>Date stamps the AER form, enters the date received and the client's name on the tracking log and forwards the AER forms to the appropriate FRC's intake-scheduling supervisor on the same day.</td></tr>
<tr><td></td><td>FRC Intake-Scheduling Supervisor</td></tr>
<tr><td>5</td><td>When the FRC's intake-scheduling supervisor receives the AER form from PAI or directly from the applicant, he/she must assign the case to a worker and log in each AER form received noting the applicant's name, date received and the worker assigned.

NOTE: The AER may be received directly from the applicant as a walk-in, by mail, or from PAI. The AER and Add New Children forms received by the county are NOT to be sent to the EDS clearinghouse.</td></tr>
<tr><td></td><td>Worker</td></tr>
<tr><td>6</td><td>Accept the AER and the Add New Children form as an application for Medi-Cal.</td></tr>
<tr><td>7</td><td>Use the AER in lieu of the MC 210 or mail-in application for children and pregnant women. The date of application is the date the AER is referred to the county from HF.

NOTE: The AER form does not include a question about the child's citizenship or immigration status, therefore, an MC 13 is required applicants using the AER form as an application for Medi-Cal.</td></tr>
<tr><td>8</td><td>Process the AER using the mail-in application instructions for verification requirements, follow-up for other potentially eligible family members and further case actions as outlined in MPG 04.20.02 D and E.

NOTE: Workers must not require more information or verification beyond what is specified in these sections (with the exception of requiring the MC 13).</td></tr>
<tr><td>9</td><td>
<table>
<tr><th>If the children are found...</th><th>Then The worker must ...</th></tr>
<tr><td>Eligible for Medi-Cal with a SOC</td><td>• Refer them to HF by forwarding a copy of the AER form (keeping the original for the case record), along with copies of the verifications and the Medi-Cal NOA(s) to HF, P. O. Box 138005, Sacramento, CA 95813-9984.

• Complete the Medi-Cal SOC</td></tr>
</table>
</td></tr>
</table>

ACWDL 03-01

	determination and grant the case, if eligible.
Ineligible for Medi-Cal but potentially eligible for HF	Refer the child to HF as above.

E. Add New Children Forms

There are two forms used by HF to add new children to a HF case. Refer to Appendices E1 through E5 for samples of these forms. ACWDL 00-52

Form Name	Description
The Add New Children Form (**no number**),	Used as part of the AER process and must be processed as outlined in 04.20.04. D above.
The Add New Children Form (**7/13/00 non-AER**)	Was developed to add a child to an existing HF case at any time during the year rather than having the applicant complete another HF/Medi-Cal Application for Children (MC 321 HFP). • Workers must accept the Add New Children Form (7/13/00 non-AER) as an application to add a child to an existing Medi-Cal case. • The date of application is the date the form was date stamped at PAI. • The application must be processed following the mail-in application instructions as outlined in 04.20.02.C above.

If the children are found...	Then The worker must ...	
Eligible for Medi-Cal with a SOC	• Refer the child back to HF using a completed MC 363 Medi-Cal to HF Transmittal Form attached to a **copy** of the Add New Children Form (7/13/00 non-AER) and mail it along with copies of any verification, and the Medi-Cal NOA(s), to the address on the	

		transmittal. • File the original Add New Children Form (7/13/00 non-AER) the case file. • Complete the Medi-Cal SOC determination.	
	Ineligible for Medi-Cal but potentially eligible for HF	Refer the child to HF as above.	

- If the worker determines that a child on the Add New Children Form (7/13/00 non-AER) is eligible to Medi-Cal with a SOC or is not eligible to Medi-Cal but potentially eligible to The original Add New Children Form (7/13/00 non-AER) must be filed in the case file.

F. HF Application Forms and supplements

ACWDL 99-16

Form Name	Description
MC 321: HF Application	• This four-page form is the common application form for both HF and Medi-Cal. • It is available as part of a booklet and as a loose form.
MC 322: Real and Personal Property, Supplement to Medi-Cal Mail-In Application	When children or pregnant women are not eligible for the Percent programs, the family's resources are not disregarded and therefore, property information and verification are required to determine eligibility for SOC Medi-Cal. This supplemental form to the Medi-Cal mail-in is application used when: • The family's income exceeds the federal poverty level limits for no SOC Medi-Cal under the Percent programs • The family also requests Medi-Cal for other adult family members. This form combines questions from the MC 210 and MC 210 S-P. It is to be used in conjunction with the mail-in process only.
MC371 : Additional	A supplement to the Medi-Cal Mail-In Application - MC 321 HFP. This form is to be used with the MC

Family Members Requesting Medi-Cal	321 HFP Medi-Cal mail-in application when additional family members request Medi-Cal. The MC 321 HFP is not used to collect information necessary to determine eligibility from other family members who wish to apply for Medi-Cal. The MC 321 is used to obtain such information for children as well as adult family members.

MPG Letter 586 (11/05)

04.20.05 Access for Infants and Mothers

A. Introduction

The AIM program is an insurance program (as opposed to the Medi-Cal Program) which:

ACWDLS 00-24 00-40

- Is administered by Managed Risk Medical Insurance Board (MRMIB).
- Provides comprehensive health care to uninsured moderate income (200%-300% of the FPL) pregnant women and their newborns up to the age of two.
- Has a total cost to applicants of 2% of gross annual income, with no co-payments and no deductibles.
- Covers women and their infants who are not eligible for zero share of cost Medi-Cal or who have a co-pay, through a private insurance, of greater than $500.
- Does not consider the pregnant woman or infant families' resources when evaluating for eligibility.
- Does not require verification of social security number.

The AIM Program does not cover women over 30 weeks pregnant. The AIM general information number is 1-800-433-2611.

MPG Letter 586 (11/05)

B. AIM Application

In an effort to provide a seamless application process, DHS and MRMIB have agreed to take steps to link the application process. AIM applications for pregnant women that have been denied due to insufficient income, i.e., net nonexempt income at or below 200% of FPL, will be forwarded to the appropriate county for processing as a Medi-Cal application for the 200% Program. The AIM application will be used to determine the pregnant woman's eligibility to the Income

Disregard Program (200% Program), postpartum benefits and deemed eligibility for the newborn. Additional information will need to be requested by the worker upon receipt of the AIM application. If the applicant requests full-scope Medi-Cal, he/she will be responsible for providing further information and verifications.

AIM contractors forward denied AIM applications that have been denied solely due to income below program limits (at or below 200% FPL) to SPE. SPE will forward all denied AIM applications to PAI, as they currently do with HF applications.

MPG Letter 586 (11/05)

C. AIM Application Processing

The following chart is an outline of the AIM application process.

PAI Actions	
1	Ensure that the AIM application was sent to the appropriate county. If the applicant is not a resident of San Diego County, ACCESS will: • Complete a Medi-Cal/ AIM Application Transmittal, • Forward the AIM application to the correct county. • Send a copy of the transmittal to SPE informing them that the AIM application was sent to the incorrect county.
2	Clear all people on the application packet for an active Medi-Cal case. If none exist, ACCESS will forward the AIM application to the appropriate FRC (based on zip code) on a daily basis.
FRC Intake Scheduling	
1	Open pend the application in the assigned worker's number. **The application date is the date that the FRC receives the AIM application. This is different from the way the Medi-Cal mail in application date is determined.** The redetermination date may not exceed 12 months from the date the AIM application was signed.
2	Treat AIM applications the same as a face-to-face appointment for the purposes of scheduling intakes and assigning to workers.
3	Consider AIM applications an Immediate Need request, which must be processed within three days of receipt.
Worker Actions	
1	Follow Medi-Cal application processing requirements described in Medi-Cal Program Guide Article 4, Section 2 when processing AIM applications for eligibility to the Income Disregard Program (200% Program).
2	Follow the ten-ten-ten timeline requirement for the client to provide the MC 13, Social Security Number (if appropriate) and any additional verification required.
3	Send Speed Letter 780-1 – AIM Contact Letter to the applicant along with a MC 13, MC 210 A, and the informational notice "Medi-Cal Rights and Responsibilities." **NOTE: The applicant**

<table>
<tr><td></td><td>is not required to return a signed MC 219.</td></tr>
<tr><td>4</td><td>Use the signed Declaration of Residency on the AIM application as sufficient verification of residency for pregnancy related services only.</td></tr>
<tr><td>5</td><td>
<table>
<tr><th>If the applicant…</th><th>Then…</th></tr>
<tr><td>Requests an evaluation for full-scope Medi-Cal</td><td>• Request further information/verification to process the request for full-scope Medi-Cal
• Allow the applicant ten days to provide the requested information.
• Evaluate for Section 1931(b) eligibility first.</td></tr>
<tr><td>Requests full-scope Medi-Cal, but does not provide the additional information and/or documentation requested:</td><td>• Process the application as a request for the 200% Program only.

• The applicant must provide a completed MC 13 and Social Security Number (if appropriate) in order for the AIM application to be considered complete when granting the applicant Medi-Cal under the 200% Program.

• Send a fail to provide denial NOA.</td></tr>
<tr><td>Is ineligible to the 200% Program because of excess income,</td><td>Refer back to AIM via the AIM/Medi-Cal transmittal form.
<table>
<tr><th>If the applicant …</th><th>Then</th></tr>
<tr><td>Requested pregnancy -related services only</td><td>Send denial notice #185 to the applicant indicating that the application will be referred back to AIM for eligibility processing.</td></tr>
<tr><td>Requested full-scope Medi-Cal and has</td><td>Process the case with a SOC and send appropriate</td></tr>
</table>
</td></tr>
</table>
</td></tr>
</table>

		provided the necessary verification	NOAs.

MPG Letter 586 (11/05)

D. AIM Verification Rquirements

The following is a list of verification requirements unique for AIM applications:

1	A MC 13 Statement of Citizenship, Alienage and Immigration Status is required in order to determine the applicant's eligibility to the correct level of coverage.
2	A Social Security Number (SSN) is required from all applicants, unless an applicant declares in the MC 13 to be undocumented, or otherwise not legally present in the United States.
3	Form MC 219 Rights and Responsibilities must be mailed to the applicant upon receipt of the AIM application. The worker must narrate that it was sent. The applicant is not required to return it.
4	Verification of identity is not required.
5	The signed AIM application is considered as verification of residency, unless the applicant's employment is out of state or residence is otherwise questionable.
6	Property verification is not required when determining eligibility to the 200% Program. However, property must be verified in order to determine eligibility to zero SOC Medi-Cal.
7	If the applicant reports other health insurance or a pending lawsuit due to accident or injury, the worker may contact the applicant by phone for needed information and complete the other health coverage screens.

MPG Letter 586 (11/05)

E. Interaction Between AIM and Medi-Cal

An AIM/Medi-Cal Transmittal form 14-71 HHSA (9/00) is used to assist and facilitate the communication process. This transmittal will be used by PAI when forwarding erroneously received AIM applications to the correct county. The intake workers will also use the transmittal forms to forward the AIM application for reevaluation by AIM.

A copy of the AIM application must remain in the case record. The transmittal must clearly state why the AIM application is being forwarded and a copy of SOC granting Notice of Action (NOA) or denial NOA must accompany the transmittal. Keep a copy of the transmittal in the case record.

MPG Letter 586 (11/05)

APPENDIX A.

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APPENDIX B. AER LETTER

«ltrdate»

Warning. If you do not return the enclosed forms, your child(ren) will lose coverage with the Healthy Families Program.

«ltrfirst» «ltrlast»
«ltradrs1»
«ltradrs2»
«ltrcity», «ltrstate» «ltrZIP»

Dear Applicant,

The Healthy Families Program offers your child(ren) health, dental, and vision coverage for 12 months. The end of this 12 month period will be here soon. To qualify for another 12 months of coverage, we must verify that your family still meets Healthy Families eligibility guidelines.

In order to re-qualify your child(ren) for Healthy Families, you must fill out the enclosed Annual Eligibility Review Form and send it with all required income documents no later than <<Anniversary Date – minus 1 day>>. Please see the enclosed Household Information Worksheet for a list of acceptable income documents to send. **If we do not receive these documents, your child(ren) will be disenrolled on <<Anniversary Date end of month>>.** If your child is disenrolled and receives health, dental, or vision services through the Healthy Families Program after the disenrollment date, you may have to pay for the cost of the services provided.

After your documents have been processed, you will receive a letter stating whether your child qualifies for another 12 months of coverage. If your child no longer qualifies for Healthy Families, you will receive a letter with the reason.

Do you wish to add additional children to the Healthy Families Program? If you would like to apply for additional children whose names do not appear on the Annual Eligibility Review Form, please fill out the enclosed Add New Children Form. Then, return the Add New Children Form along with the Annual Eligibility Review Form in the enclosed postage paid envelope.

If you have any questions, or would like to find a Certified Application Assistant in your area, call 1-888-439-4741, Monday – Friday 8:00 A.M. – 8:00 P.M. Certified Application Assistants will assist you with these forms at no cost to you.

Sincerely,
Healthy Families Program

DUE BY: «Anniversary-1day».

- Please note: The Healthy Families Program and Medi-Cal are two separate programs. If you have other children enrolled in no-cost Medi-Cal, your Medi-Cal eligibility worker will send you a separate Annual Eligibility Redetermination Packet

APPENDIX C. HOUSEHOLD INFORMATION WORKSHEET

Household Information Worksheet

1. Who counts as a family member living in the home with the child?

Adults:

- Natural or adoptive parents of the child to receive benefits
- A minor living on his or her own

Children:

- Unborn child
- All children under age 21 living in the home
- All children under age 21 away at school and claimed as tax dependents

2. What Income counts?

- Earnings from a job
- Self-employment net profits
- Child support
- Alimony/Spousal Support
- Pension and retirement benefits
- Government benefits such as Social Security, Retirement Survivor Disability Insurance (RSDI), Veterans, Disability, Workers' Compensation, Unemployment, etc.
- Other income such as: grants for living expenses, settlement benefits, net profit from rentals, gifts, lottery/bingo winnings, interest income

3. What income does NOT count?

- Earnings from a job of a child under age 14 or a child who attends school
- Supplementary Security Income/State Supplementary Program (SSI/SSP) Payments
- Foster Care Payments
- CalWORKs payments (replaces AFDC)
- General Relief
- Certain other government benefits
- Grants or scholarships
- Loans
- College Work Study

4. Acceptable Income Documents:

- Copy of the most recent paystub. If a paystub is not available, get a signed statement from your employer. Gross monthly income and the dates received should be on the statement.
- Copy of last year's federal income tax return.

Other proof of income you may send:

- If a person is self-employed, send last year's federal income tax return (including the Schedule C) or the last 3 month's profit and loss statements.
- If a person has income such as disability or retirement, send copies of award letters or bank statements showing the direct deposits.
- If anyone gets child support and/or alimony or spousal support, send copies of the checks received or statements from the District Attorney's Family Support Division, for the last month.
- A Medi-Cal "Share-of-Cost-Notice of Action" received in the last 30 days which shows the child has share-of-cost may be used if it lists your income.

5. What is Medi-Cal?

Medi-Cal offers no-cost comprehensive health, dental and vision services to children. If your family income is below the Healthy Families guidelines, your child(ren) may be eligible for no-cost Medi-Cal. If you authorize us, we will forward your AER information to Medi-Cal if your children do not qualify for Healthy Families.

Medi-Cal Privacy Notice

Federal and State Law requires us to provide the following information: Welfare and Institutions Code §14011. Requires Medi-Cal applicants to provide the information requested in this application. It may be shared with federal, state and local agencies for purposes of verifying eligibility, and for verification of the immigration status of those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.) It will also be used to process Medi-Cal claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application. Information required by this form is mandatory. Social Security numbers are required by §1144(a)(1) of the Social Security Act unless applying for emergency or pregnancy benefits only.

6. Deductions

The income deductions in Section 7 of the Annual Eligibility Review help us determine what amounts we may use to lower your family's income. If anyone receives child support and/or alimony or spousal support, send copies of the checks received or statements from the District Attorney's Family Support Division for the last month. Also, send copies of receipts or cancelled checks for child or dependent care expenses paid during the last month.

If you have any questions or would like the location of a Certified Application Assistant in your area, call 1-888-439-4741, Monday – Friday, 8:00 A.M. – 8:00 P.M. A Certified Application Assistant will help you with these forms at no cost.

APPENDIX D1. AER FORM

ANNUAL ELIGIBILITY REVIEW FORM

Please return this form immediately to continue coverage for your children

Family Member Number «ltrCASE»
«ltrfirst» «ltrlast»
«ltradrs1»
«ltradrs2»
«ltrcity», «ltrstate» «ltrZIP»

If any of the pre-printed information on this form is incorrect, please cross it out and write the correct information.

Questions?
Call 1-888-439-4741 Monday - Friday, 8:00 a.m. to 8:00 p.m.

1. Children Currently Enrolled in Healthy Families

Fill in child(ren)'s Monthly Income and Relationship to Applicant. Cross out any children who no longer live in the household.

Enrolled Child	Date of Birth	Child's Monthly Income (if any)	Relationship to <<Applicant>>
«M_1Cfirst» «M_1Clast» «M_1Caddress» «M_1Ccity», «M_1Cstate» «M_1CZIP»	«M_1Cbirth»	$ Document Required	__ Child __ Stepchild __ Other
«M_2Cfirst» «M_2Clast» «M_2Caddress» «M_2Ccity», «M_2Cstate» «M_2CZIP»	«M_2Cbirth»	$ Document Required	__ Child __ Stepchild __ Other
«M_3Cfirst» «M_3Clast» «M_3Caddress» «M_3Ccity», «M_3Cstate» «M_3CZIP»	«M_3Cbirth»	$ Document Required	__ Child __ Stepchild __ Other
«M_4Cfirst» «M_4Clast» «M_4Caddress» «M_4Ccity», «M_4Cstate» «M_4CZIP»	«M_4Cbirth»	$ Document Required	__ Child __ Stepchild __ Other
«M_5Cfirst» «M_5Clast» «M_5Caddress» «M_5Ccity», «M_5Cstate» «M_5CZIP»	«M_5Cbirth»	$ Document Required	__ Child __ Stepchild __ Other
«M_6Cfirst» «M_6Clast» «M_6Caddress» «M_6Ccity», «M_6Cstate» «M_6CZIP»	«M_6Cbirth»	$ Document Required	__ Child __ Stepchild __ Other
«M_7Cfirst» «M_7Clast» «M_7Caddress» «M_7Ccity», «M_7Cstate» «M_7CZIP»	«M_7Cbirth»	$ Document Required	__ Child __ Stepchild __ Other

2. Are any of these children now enrolled in employer sponsored health insurance?

☐Yes ☐No

If yes, please list the children:_____

3. Adults in the Household

Fill in the following sections. Refer to the Household Information Worksheet to determine what income counts and who counts as a family member.

Adult Family Members living with the Children	Relationship to <<Applicant>>	Relationship to Children	How often received:	How much Gross Income
<<Applicant Name>>	[redacted]	[redacted]	__ once every week __ every two weeks __ twice a month __ once a month	$
	__ Spouse __ Other_____	__ Parent __ Stepparent __ Other_____	__ once every week __ every two weeks __ twice a month __ once a month	$

Most recent income documents MUST be attached.

APPENDIX D1. AER FORM(CONT)

4. Children living in the household NOT enrolled in Healthy Families

Fill in the child(ren)'s Monthly Income and Relationship to Applicant. Cross out any children who no longer live in the household. Check the box by the child's name if you now want to enroll the child in Healthy Families. If you wish to enroll children whose names are not listed, you must fill out and return the ADD NEW CHILDREN Form.

Child	Date of Birth	Child's Monthly Income (if any)	Relationship to <<Applicant>>
☐ «NC1first» «NC1last»	«NC1birth»	$ Document Required	__ Child __ Stepchild __ Other
☐ «NC2first» «NC2last»	«NC2birth»	$ Document Required	__ Child __ Stepchild __ Other
☐ «NC3first» «NC3last»	«NC3birth»	$ Document Required	__ Child __ Stepchild __ Other
☐ «NC4first» «NC4last»	«NC4birth»	$ Document Required	__ Child __ Stepchild __ Other
☐ «NC5first» «NC5last»	«NC5birth»	$ Document Required	__ Child __ Stepchild __ Other

5. Other Children living in the Household who you do not wish to apply for Healthy Families.

Refer to the Household Information worksheet to determine which children to list. If there is an unborn child, write "Unborn Child" in the space for Child Name. Attach a separate sheet if necessary.

Child Name	Date of Birth	Monthly Income if any	Relationship to <<Applicant>>
	- -	$ Document Required	__ Child __ Stepchild __ Other

6. Is the applicant or anyone else in the home pregnant? ☐ Yes ☐ No

If Yes, please list name_____

7. Income Deductions (Remember to send documentation for the following, if applicable)

The parent(s) *who the child(ren) live with* must answer the following:

Monthly child care expenses you pay for children under age 2. The maximum amount allowed is $200.	$
Monthly child care expenses you pay for children age 2 and over. The maximum amount allowed is $175.	$
Monthly disabled dependent care expenses you pay. The maximum amount allowed is $175.	$
Monthly court ordered alimony you pay.	$
Monthly court ordered child support you pay.	$

For each working parent, we will deduct up to $90 for work-related expenses.

I, the applicant, certify that the information provided is true and correct. I understand that a change in income from last year may result in a higher monthly premium or may make my child(ren) ineligible for the Healthy Families Program.

Applicant Signature X_____ Date:_____

Authorization to Forward AER to Medi-Cal

If my child is ineligible for Healthy Families, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief. Please provide Social Security numbers of children applying for full scope Medi-Cal benefits.

Write the Social Security number next to the child's name in Section 1.

Applicant Signature X_____ Date:_____

Reimbursement for Application Assistance. For Certified Application Assistant use only.

I certify that I had help completing this form by the Certified Application Assistant listed below. This CAA help was Free of charge. The state will not issue a reimbursement unless this section is completely filled out at the time this form is submitted.

Applicant Signature X_____ Date:_____

CAA#_____ EE#_____ CAA Signature X_____

APPENDIX E1. ADD NEW CHILDREN FORM

ADD NEW CHILDREN FORM

APPLICANT NAME	PHONE NUMBER

FAMILY MEMBER NUMBER											

Please fill out all information for the child(ren) you would like to add to Healthy Families. To add more than 4 children, make a photocopy of this form if necessary. If a pregnant woman is within 90 days of the estimated date of delivery, she may pre-enroll the unborn child in the Healthy Families Program. Healthy Families insurance coverage will become effective 13 days after documentation of birth is received. This information must be received within 30 days of birth.

	Child 1 (or unborn)	Child 2	Child 3	Child 4
Name: Last				
First				
Middle				
Birthname: Last				
(if different from above) First				
Middle				
If the child's address is NOT the same as the Applicant, give address	Street City ZIP	Street City ZIP	Street City ZIP	Street City ZIP
Relationship to Applicant:				
Sex:	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
Date of Birth (or estimated date of delivery)	/ / MO DAY YEAR	/ / MO DAY YEAR	/ / MO DAY YEAR	/ / MO DAY YEAR
Place of Birth: California County, State or Country				
Ethnicity Code				

1	White	2	Hispanic	3	Black/African American	4	Asian
5a	American Indian	5b	Alaskan Native	7	Filipino	A	Amerasian
C	Chinese	H	Cambodian	J	Japanese	M	Samoan
N	Asian Indian	P	Hawaiian	R	Guamanian	T	Laotian
V	Vietnamese	K	Korean	Z	Other		

U.S. Citizen or National? If no, please write date of entry into U.S.	❑ Yes ❑ No / / MO DAY YEAR	❑ Yes ❑ No / / MO DAY YEAR	❑ Yes ❑ No / / MO DAY YEAR	❑ Yes ❑ No / / MO DAY YEAR
Social Security # *(optional)*	- -	- -	- -	- -
Mother's Name: Last				
First				
Does the mother live in the home?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Father's Name: Last				
First				

APPENDIX E2. ADD NEW CHILDREN FORM

CONTINUED	Child 1 (or unborn)	Child 2	Child 3	Child 4
Does the father live in the home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does this child have no cost Medi-Cal? If yes, give date coverage will end.	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR	☐ Yes ☐ No / / MO DAY YEAR
Was the child insured by an employer in the last 90 days? If yes, check the main reason why insurance stopped and give the date it stopped.	☐ Yes ☐ No ☐ Lost job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other ____________ ____________ / / MO DAY YEAR	☐ Yes ☐ No ☐ Lost job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other ____________ ____________ / / MO DAY YEAR	☐ Yes ☐ No ☐ Lost job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other ____________ ____________ / / MO DAY YEAR	☐ Yes ☐ No ☐ Lost job ☐ Moved and no insurance available ☐ Employer ended benefits to all employees ☐ COBRA coverage ended ☐ Other ____________ ____________ / / MO DAY YEAR
Monthly countable income of the child	$ From where?	$ From where?	$ From where?	$ From where?
Monthly countable income of the applicant and the other adult in the household (including frequency of payment) and from where the income is received. For example: Applicant $500.00 per week From where? Job Relationship to children: Father			Applicant $__________ From where? Relationship to children:	Other Adult $__________ From where? Relationship to children:
Monthly income deductions	Child care expenses: $	Dependent care expenses: $	Monthly court ordered payment of child support or alimony: $	

- *See the Household Information instructions for a list of what income counts and acceptable income and deduction documentation.*
- *You must include a birth certificate for each child (within 60 days of enrollment) and documentation of birth for a newborn (within 30 days of birth) or;*
- *An immigration status document for each child (within 30 days of enrollment)*

I, the applicant, certify that the information provided is true and correct. I understand that adding additional family members may result in a higher monthly premium.

Applicant Signature X______________________________ Date:____________________

Authorization to Forward to Medi-Cal

If my child is ineligible for Healthy Families, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief. Please provide Social Security numbers of children applying for full scope Medi-Cal benefits.

Applicant Signature X____________________________________
Date:____________________

Please mail to: Healthy Families Attn: Add Form
P.O. Box 138005
Sacramento, CA 95813-9984

APPENDIX E3. HOUSEHOLD INFORMATION INSTRUCTIONS

Household Information Instructions

Who counts as a family member living in the home with the child?

Adults:

- Natural or adoptive parents of the child to receive benefits
- A minor living on his or her own

Child:

- Unborn child
- All children under age 21 living in the home
- All children under age 21 away at school and claimed as tax dependents

What Income counts?

- Earnings from a job
- Self-employment net profits
- Child support
- Alimony/Spousal Support
- Pension and retirement benefits
- Government benefits such as Social Security, Retirement Survivor Disability Insurance (RSDI), Veterans, Disability, Workers' Compensation, Unemployment, etc.
- Other income such as: grants for living expenses, settlement benefits, net profit from rentals, gifts, lottery/bingo winnings, interest income

What income does NOT count?

- **Earnings from a job of a child under age 14 or a child who attends school**
- Supplementary Security Income/State Supplementary Program (SSI/SSP) Payments
- Foster Care Payments
- CalWORKs payments (replaces AFDC)
- General Relief
- Certain other government benefits
- Grants or scholarships
- Loans

Acceptable Income Documents:

- Copy of the most recent paystub. If a paystub is not available, get a signed statement from your employer. Gross monthly income and the dates received should be on the statement.
- Copy of last year's federal income tax return.

Other proof of income you may send:

- If a person is self-employed, send last year's federal income tax return (including the Schedule C) or the last 3 month's profit and loss statements.
- If a person has income such as disability or retirement, send copies of award letters or bank statements showing the direct deposits.
- If anyone gets child support and/or alimony or spousal support, send copies of the checks received or statements from the District Attorney's Family Support Division, for the last month.
- A Medi-Cal "Share-of-Cost-Notice of Action" received in the last 30 days which shows the child has share-of-cost may be used if it lists your income.

Deductions

The income deductions help us determine what amounts we may use to lower your family's income. If anyone receives child support and/or alimony or spousal support, send copies of the checks received or statements from the District Attorney's Family Support Division for the last month. Also, send copies of receipts or cancelled checks for child or dependent care expenses paid during the last month.

What is Medi-Cal?

Medi-Cal offers no-cost comprehensive health, dental and vision services to children. If your family income is below the Healthy Families guidelines, your child(ren) may be eligible for no-cost Medi-Cal. If you authorize us, we will forward your information to Medi-Cal if your children do not qualify for Healthy Families.

Medi-Cal Privacy Notice

Federal and State Law requires us to provide the following information: Welfare and Institutions Code §14011. Requires Medi-Cal applicants to provide the information requested in this application. It may be shared with federal, state and local agencies for purposes of verifying eligibility, and for verification of the immigration status of those persons seeking full scope Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except cases of fraud.) It will also be used to process Medi-Cal claims and make Benefits Identification Cards (BICs). Failure to provide the required information may result in denial of the application. Information required by this form is mandatory. Social Security numbers are required by §1144(a)(1) of the Social Security Act unless applying for emergency or pregnancy benefits only.

7/13/00 non-AER

If you have any questions or would like the location of a Certified Application Assistant in your area, call 1-800-880-5305, Monday – Friday, 8:00 A.M. – 8:00 P.M.

A Certified Application Assistant will help you with these forms at no cost.

APPENDIX F1. JULIAN DATE CALENDAR

(PERPETUAL)

Day	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

FOR LEAP YEAR USE REVERSE SIDE

APPENDIX F2. JULIAN DATE CALENDAR (LEAP YEAR)

FOR LEAP YEARS ONLY

Day	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31

USE IN 1984, 1988, 1992, etc.)

APPENDIX G. HF TRANSMITTAL

HFAV Summary Transmittal (HF LT 79)

Applications Forwarded to CWD

County: ENTER COUNTY NAME

Case Control Number	Opt out of HF	Retro Medi-Cal	Others Want Medi-Cal	Type
00000000000	N	N	N	SPE

Member	Last Name	First Name	Screened For	Pregnant Indicator
1	ENTER LAST NAME	ENTER FIRST NAME	M	N
2	ENTER LAST NAME	ENTER FIRST NAME	M	N
3	ENTER LAST NAME	ENTER FIRST NAME	M	N
4	ENTER LAST NAME	ENTER FIRST NAME	M	N
5	ENTER LAST NAME	ENTER FIRST NAME	M	N

Case Control Number	Opt out of HF	Retro Medi-Cal	Others Want Medi-Cal	Type
00000000000	N	N	N	SPE

Member	Last Name	First Name	Screened For	Pregnant Indicator
1	ENTER LAST NAME	ENTER FIRST NAME	M	N
2	ENTER LAST NAME	ENTER FIRST NAME	M	N
3	ENTER LAST NAME	ENTER FIRST NAME	M	N
4	ENTER LAST NAME	ENTER FIRST NAME	M	N
5	ENTER LAST NAME	ENTER FIRST NAME	M	N

Total Cases Transmitted: 2

End of Transmittal

APPENDIX H. HF FM 80

Application Forwarded to CWD

County: **ENTER THE COUNTY NAME** **Date Original Application Forwarded to CWD mm/dd/yyyy**

Case Control Number	Date Received	Date Referred	Opt out of HF	Unlisted Member Wants Medi-Cal	Retro MC Requested	Type
00000000000	mm/dd/yyyy	mm/dd/yyyy	N	N	N	SPE

Member	CIN #	Last Name	First Name	Middle Initial	Relation to Applicant	Date of Birth	SSN	Screened For	Pregnant Indicator	AE Start Date	Budget Unit
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		Y	mm/dd/yyyy	000-00-0000	N	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#
#	00000000A	ENTER LAST NAME	ENTER FIRST NAME		C	mm/dd/yyyy	000-00-0000	H	N	01/01/2001	#

Member	Frequency of Income	Type of Income	Income Type Amount
#	C	Enter code. For help, press F1.	0,00
#	C	Enter code. For help, press F1.	0.00

Budget Unit	Family Size	Total Gross Income	Deductions	Total Net Income	% FPL	Members
#	#	0.00	0.00	0.00	100	#
#	#	0.00	0.00	0.00	100	#
#	#	0.00	0.00	0.00	100	#
#	#	0.00	0.00	0.00	100	#

County Response Area (*only complete if returning application for Healthy Families to reassess or to report a CIN is changing*)

Case Name:

County Representative:

Reasons for return to SPE: (*check all appropriate boxes*)

Case Number: 00000000000

Telephone Number: (000) 000-0000

Date Referred:

- ☐ Applicant checked "I do not want Healthy Families." Applicant now wants Healthy Families
- ☐ CIN was missing, now located or new one assigned
- ☐ Amount of child support or child care expense shown on application not verified
- ☐ Changes in household membership
- ☐ Not eligible to Medi-Cal (see below)
- ☐ Case returned as household contains individual eligible to Medi-Cal as a PA recipient (see below)
- ☐ Case returned as Share of Cost Determined (see below)

Member Changes (*enter member number from above for person with change*)	**County Assigned CIN #** (*if missing above*)	**Active Case Individual on** (*CalWORKs, SSI/SSP, 1931b, Foster Care*)	**Not Eligible to Medi-Cal** (*check appropriate box*) **<100% of FPL and denied Medi-Cal for**	
			excess property	**no deprivation**
#	00000000A	Enter case	☐	☐
#	00000000A	Enter case	☐	☐
#	00000000A	Enter case	☐	☐

Comments: Explain why county is returning the application. Example: change in family composition, income, income documentation/sources provided to the county are different from what was used at SPE screening.

Enclosures: The following documents are enclosed which were not included with the original application or reflect updated information

- ☐ Medi-Cal Notices of Action (Mandatory for cases ineligible to Medi-Cal)
- ☐ Medi-Cal Budget Worksheets (Mandatory if not displayed on NOA)
- ☐ Immigration
- ☐ Residency
- ☐ Birth Certificate
- ☐ Other________________

APPENDIX I. MC 363 S - COUNTY SUMMARY TRANSMITTAL

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

COUNTY SUMMARY TRANSMITTAL

County Name:_____ Number of Referrals:_____

Contact Person:_____ Telephone:_____

Case Name	Case Number

MC 363 S (9/02)

APPENDIX J. MC 363 MEDI-CAL TO HEALTHY FAMILIES TRANSMITTAL

State of California – Health and Human Services Agency

Department of Health Services

MEDI-CAL TO HEALTHY FAMILIES TRANSMITTAL

Healthy Families
P.O. Box 138005
Sacramento, CA 95813-9984

County name	
County representative	
Telephone number	
Date referred	

Case name (last) (first)	Case number	Applicant name (last) (first)
Language Spoken: ---------- Written:		Applicant phone number

One or more individuals (*check all applicable boxes*):

❒ Changed mind about not wanting Healthy Families
❒ Were determined ineligible for Medi-Cal (see comments)
❒ Were determined to have a share-of-cost (see below)

Type of application (*check all applicable boxes*):

❒ Food stamps only application
❒ School lunch application
❒ Redetermination (RV)

HF Requested		M/C FBU		LIST ALL HOUSEHOLD MEMBERS		CIN Number	Social Security Number	Sex		Date of Birth	Relationship to Applicant	Individual Gross Income	Type of Income (UIB, SDI)	Share-of-Cost Amount
Yes	No	Yes	No	Last Name	First Name			Male	Female					

ENCLOSURES: the following documents are enclosed with the application (check all applicable boxes).

***Mandatory*:** ❒ Medi-Cal NOA(s) and Medi-Cal Budgets (if not on NOA) ❒ Copy of appropriate application

***If available*:** ❒ Birth certificate ❒ Immigration ❒ Residency ❒ Other ----------

Comments: Explain why county is forwarding the application. If a member of the household is on CalWORKs, SSI, or Foster Care, please indicate person(s) and type(s) of assistance.

MC 363 (7/02)

APPENDIX K. ACCELLERATED ENROLLMENT AUTOMATION

WORKER ACTION:

- Review file clearance information on MEDS/SCI.
  - AE aid code is 8E
  - AE county ID will be 37-8E-9 (10 digit CIN #)
  - Verify correct CIN #

- Ensure SPE is notified of correct CIN # prior to grant/deny action using HF transmittal form.

- Granting actions taken by the county before **or after** MEDS renewal will cause MEDS to automatically terminate the AE record at the end of the calendar month in which the approval is posted to MEDS. Eligibility for the month of application and ongoing will be recorded under the county ID on MEDS. Once granted, both the AE aid code and the regular Medi-Cal program aid code will show dual eligibility on MEDS for the month of application and ongoing eligibility under the regular Medi-Cal aid code only.

- If denying the application, the worker must submit a 14-28 HHSA MEDS Network On-Line Request form with a MEDS screen print of the AE record from INQ1 screen to MEDS Operator with the following information:

  - 14 digit county ID (using IE as aid code – 37-IE-seven digit county case serial-last digit FBU-person number)
  - Birth date
  - MEDS ID (SSN or pseudo – same as AE {8E aid code} record on MEDS)
  - CIN #
  - Application date (same as AE record/found on INQP screen)
  - Application flag (valid county value is P)
  - Denial date
  - Denial reason (see attachment)
  - If not known to MEDS, the worker must also submit recipient name and sex.

Workers will send AL 923-3 to notify the client that temporary AE benefits have discontinued, or that temporary AE benefits have discontinued and ongoing eligibility has been established under another Medi-Cal program.

Workers will send NOA 148, from negative action code 148, when the absent parent submits an application for a child already receiving Medi-Cal. Negative Code 130 will be sent to the custodial parent when the custodial parent does not return the application after the absent parent submitted an application.

MEDS will produce monthly (Renewal) workers alerts to reflect the time an “AE” beneficiary remains in aid code 8E.

MEDS OPERATOR ACTION:

MEDS Operators will process the 14-28 and submit the AP18 on-line transaction to report the denial with the information listed above from the worker.

APPENDIX L. ACCELLERATED ENROLLMENT AUTOMATION

WORKER ACTION:

Step	Action
1	Review file clearance information on MEDS/SCI • CHDP aid codes are 8W, 8X, and 8Y • CHDP county ID will be 37-8W-9(10 digit CIN#) • Verify correct CIN#
2	Ensure SPE is notified of correct CIN# prior to grant/deny action using HF transmittal form.
3	To report an application received directly by the county and extend the CHDP pre-enrollment period, the worker must submit a 14-28 HHSA MEDS Network On-Line Request form to the MEDS Operator with the following information: • 14 digit county id (using IE as aid code) • birth date • MEDS id (SSN or pseudo – same as CHDP record on MEDS) • CIN# • Application date (same as CHDP record/found on INQP screen) • Application flag (valid county value is P) • If not known to MEDS, the worker must also submit recipient name, and sex.
4	Granting actions taken by the county before **or after** MEDS renewal will cause MEDS to automatically terminate the CHDP pre-enrollment record at the end of current month and record ongoing eligibility effective the month of completion of the Medi-Cal evaluation forward under the County ID. Once granted, both the CHDP aid code and the Medi-Cal program aid code will show dual eligibility for the month of application.
5	If denying the application, the worker must submit a 14-28 HHSA MEDS Network On-Line Request form to the MEDS Operator with the following information: • 14 digit county id (using IE as aid code) • birth date • MEDS ID (SSN or pseudo – same as CHDP record on MEDS) • CIN# • Application date (same as CHDP record/found on INQP screen) • Application flag (valid county value is P) • Denial date • Denial reason (see attachment) • If not known to MEDS, the worker must also submit recipient name, and sex.
6	Workers will send NOA 923 to notify the client that CHDP pre-enrollment benefits have discontinued, or that CHDP pre-enrollment benefits have discontinued and ongoing eligibility has been established under another Medi-Cal program.
7	Workers will send NOA 148, from negative action code 148, when the absent parent submits an application for a child already receiving Medi-Cal. Negative Code 130 will be sent to the custodial parent when the custodial parent does not return the application after the absent parent submitted an application.

MEDS OPERATORS

- MEDS Operator will process the 14-28 and submit the AP18 on-line transaction to report an application received directly by the county, or to report the denial (if no AP18 was previously submitted for this application) with the information listed above from the worker.

- The MEDS Operator will process the 14-28 and submit an AP34 on-line transaction to report a denial **if the county has previously submitted an AP18** transaction for this application.