

# Medi-Cal Program Guide Letter #684

August 31, 2009

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**Subject**           **UPDATES TO CONTACT REQUIREMENT FOR MEDI-CAL MAIL-IN AND NON-MAIL-IN APPLICATIONS, AND ANNUAL REDETERMINATION AND RETROACTIVE COVERAGE FOR PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN.**

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**Effective Date**   Upon Receipt

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**Reference**        ACWDL 08-07, 08-27, 08-27E, 06-16

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**Purpose**            The purpose of this Letter is to inform staff of the:

- requirement to provide Medi-Cal applicants who are identified as Presumptive Eligibility (PE) recipients with information on how to apply for Medi-Cal and the timeframes for applying for retroactive Medi-Cal coverage;
- change to the request for verification requirement for Mail-In applications;
- elimination of the two phone contacts requirement prior to denying a Medi-Cal applicant for failure to provide essential information; and
- elimination of the phone contact requirement for beneficiaries that fail to send in their annual redetermination packet and the packet was not returned by the postal service as “undeliverable.”

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**Background**      Presumptive Eligibility

The PE program allows qualified providers to grant immediate temporary Medi-Cal coverage, to low-income pregnant patients pending their formal Medi-Cal application. Since PE coverage is limited to prenatal care services, most PE recipients will require retroactive Medi-Cal to cover some services received during the PE eligibility period.

Mail-In Applications

For mail-in applicants, MPG Article 4 Section 2 required the mailing of Automated Letter (AL) 746 (herein to be referred to as 14-85 HHSA

form). The 14-85 HHS form (Attachment A) served not only as a reminder to the applicant to submit their application within fifteen days from the date of request but also as the first request for verifications.

#### Phone Contact at Application

In addition to the two requests for verification requirement, MPG Article 4 Section 13 required workers to attempt two phone calls prior to denying an application for failure to provide.

#### Annual Redeterminations

MPG Letter 596 provided updated instructions for completing annual redeterminations. The instruction required staff to attempt to contact the beneficiary by phone when the beneficiary failed to send in their redetermination packet and the packet was not returned by the postal service as “undeliverable.”

### **Highlighted Changes**

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#### Presumptive Eligibility

When the worker becomes aware that an applicant is a PE recipient, he/she is to provide the applicant with information on how to apply for Medi-Cal and the timeframes for applying for retroactive Medi-Cal coverage. Staff may continue to refer to MPG Article 5 Section 16 for more detailed information on the PE program, such as way to identify when someone is on PE.

#### Mail-In Applications

DHCS clarified that other applicant contacts made prior to receipt of Medi-Cal Statement of Facts (SOF) may not be used to meet the two contact requirements prior to denial. While the 14-85 HHS form will continue to be mailed to applicant to remind him/her to submit the Medi-Cal mail-in application, it will no longer be considered the first request for verifications for Medi-Cal mail-in applications.

Instead, the first request for verifications shall be sent upon receipt and review of the mail-in MC 210 Statement of Facts. When the deadline has passed and if verifications are still missing, the worker will follow-up with a second request for verification and allow another ten calendar days for the applicant to provide the verifications. If, at the end of the second deadline, there is no contact from the applicant and verifications are still missing, the worker will deny the application for failure to provide essential information.

Phone Contact at Application

Included in the procedures for mail-in and non-mail applications, the first and second request for verification shall satisfy the two contacts requirement prior to denial. Therefore, the requirement of two phone contacts prior to denying an applicant for failure to provide essential information has been eliminated.

Redeterminations

When a beneficiary fails to return the redetermination packet and the packet was not returned by the postal service as “undeliverable,” the worker will provide adequate and timely notice to terminate benefits. In this instance, the SB 87 process does not apply and the worker is no longer required to make two phone contacts prior to discontinuing the case for no redetermination.

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**Automation Impact**

Current CalWIN functionalities support the program requirements detailed in this Letter.

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**Forms Impact**

The 14-85 HHS form has been translated in Spanish and both English and Spanish versions have been added to CalWIN. The form is also available for order on iWAY. Staff will only use shelf-stock when CalWIN is unavailable.

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**Quality Assurance Impact**

Effective with the October 2009 review month, Quality Assurance will cite the appropriate error on any case that does not comply with the requirements of this letter.

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**Summary of Change**

With this Letter, the following updates have been made to the MPG.

<b>Section</b>	<b>Summary of Change</b>
Article 4, Section 2	• Add Retroactive Medi-Cal for Presumptive Eligibility recipients.
Article 4, Section 7	• Update first request for verification for mail-in applications by eliminating the language which states that the 14-85 serves as a first request for verification.

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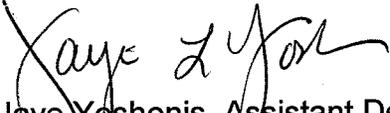
**Summary of Change**  
(continued)

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<b>Section</b>	<b>Summary of Change</b>
Article 4, Section 13	<ul style="list-style-type: none"><li>• Eliminate the two phone contacts requirement when beneficiary fails to complete and return the annual redetermination packet and the packet was not returned by the postal service as "undeliverable."</li><li>• Eliminate the two phone contacts requirement prior to denial for mail-in and non-mail-in applications.</li></ul>

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**Manager's Approval**

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

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**COUNTY OF SAN DIEGO**

Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

Worker Name/Number: \_\_\_\_\_

Worker Phone: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you for applying for Medi-Cal. This is a reminder that you have 15 days from the date you applied, \_\_\_\_\_, to return the information/forms in your application packet. Please return them in the envelope you received with your packet. No stamps are necessary.

If you have questions or have problems getting any information you need, please call ACCESS at 1-866-262-9881.

If we do not hear from you within 15 days of the day you applied (see above date), we will be unable to consider your request, and we will have to deny your Medi-Cal application. You may reapply at any time.

We need the following forms and information from you in order to evaluate your family's eligibility to Medi-Cal:

1. MC 210, Statement of Facts,
2. MC 13, Declaration of Citizenship (complete one for each person requesting Medi-Cal),
3. Identification card for adult applicant (picture ID preferred),
4. Most current residency verification (rent or utility receipt, or any other form of residency verification),
5. Proof of all household income or means of support (most current pay stub from work, unemployment insurance benefits (UIB), Social Security Administration (SSA), child support, or alimony),
6. Proof of property you own (most current bank account statement, car registration form(s), and your property tax bill if you own a home),
7. If pregnant, you must provide a verification, and
8. Other \_\_\_\_\_.

You will receive a notice of action within 45 days telling you if your request for Medi-Cal has been approved. If you are approved, you will receive a Medi-Cal Benefits Identification Card (BIC) in the mail. You will need to show it to your doctor/provider when you need medical services. If you already have a BIC card, you may use it. A new card will not be sent out again. If you lose your card, please call ACCESS as soon as possible for a new one.

If you have questions about choosing a doctor or health plan, call a Health Care Options (HCO) Enrollment Counselor listed on the HCO flyer that came in your application packet.

We are looking forward to hearing from you!

14-85 (07/09) Medi-Cal Mail-In Reminder Notice

## 04.02.10 Application for Retroactive Medi-Cal

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### A. General

An applicant/beneficiary (including a minor consent applicant) may request retroactive Medi-Cal for any of the three months preceding the month of application. If not requested at application, the request for retroactive Medi-Cal coverage must be made within one year of the month for which retroactive coverage is requested. QMB only applicants/beneficiaries are not eligible to retroactive Medi-Cal.

MPG LTR 526 (12/03)

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### B. Requesting Retroactive Medi-Cal

A request for retroactive Medi-Cal may be made:

- On the application form;
- On the SOF; or
- By submitting a written request.

Upon receipt of the request, the worker will require the applicant to complete the MC 210A, Supplement to Statement of Facts, for the retroactive months.

When the applicant requests retroactive Medi-Cal only, the applicant completes the MC 210 for the earliest retroactive month. The MC 210A is completed for each additional retroactive month.

MPG LTR 526 (12/03)

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### C. Retroactive Medi-Cal for PE Recipients

The PE program allows qualified providers to grant immediate temporary Medi-Cal coverage, which is limited to prenatal care, to low-income pregnant patients pending their formal Medi-Cal application. Because of the limited scope of benefits that PE covers, most PE recipients will require retroactive Medi-Cal to cover some services received during their PE eligibility period.

When the worker becomes aware that an applicant is a PE recipient, he/she must provide the applicant with information on how to apply for Medi-Cal and the timeframes for applying for retroactive Medi-Cal coverage. PE recipients shall be informed that they may apply for retroactive Medi-Cal coverage within one year of the month for which retroactive coverage is needed. Additionally, they do not have to apply for or be approved for on-going Medi-Cal in order to apply for retroactive coverage.

MPG LTR 684 (8/09)

ACWDL  
08-27E

## 04.02.12 Processing Mail-In Applications

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### A. General

Applicants who request a mail-in application packet shall be given fifteen days from the date of the request to complete and return the application form. At the time of the request, a SAWS 1 will be completed, either by the applicant if the request is made in person at a FRC or by ACCESS staff if the request is by phone. Day one is the day that the SAWS 1 is dated. The date of receipt is the date the application packet is received by the County (either by ACCESS or the FRC).

When the mail-in application is an MC 321 HFP (Healthy Families/Medi-Cal Joint Application), staff shall refer to Article 4 Section 20 for processing instructions.

MPG LTR 535 (9/03)

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### B. Packet Not Returned by Applicant

FRC's are encouraged to attempt a reminder phone contact prior to denial with those families who do not submit the application packet. When application packet is not received by the 15<sup>th</sup> day after the application date (SAWS 1 date), clerical will deny the application.

MPG LTR 535 (9/03)

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### C. Packet Received

Upon receipt of application packet by the FRC, the application shall be assigned to a worker to be processed. The worker shall review the application for completeness.

If application is...	Then the worker will...
Complete	Evaluate for eligibility and notify applicant of determinations. Eligibility determination shall be completed within the 45 or 60 days period specified in <a href="#">MPG 04.02.17</a> .
Incomplete	Follow the 10-10 timeline specified in <a href="#">MPG 04.07.12</a> to request for the needed information/verification.

Workers are reminded that an application may not be denied for failure to provide prior to the worker following the 10-10 timeline for requests for information/verification and completing an *ex parte* review.

MPG Letter 684 (8/09)

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## 04.07.01 Verification Requirements

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**A. Applicant/Beneficiary Responsibility** Medi-Cal applicants/beneficiaries are responsible for making available all documents needed for the determination of eligibility. MEM 50185  
MPG Letter 11 (2/91)

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**B. Worker Responsibility** As part of the application/redetermination process, workers are responsible for explaining verification requirements to the applicant/beneficiary, evaluating the applicant's/beneficiary's ability to obtain verifications, and providing assistance in obtaining the verifications whenever necessary. MEM 50101 50167

Worker assistance may be necessary whenever the applicant/beneficiary or key person:

- has a low level of literacy or language difficulty;
- is homebound or institutionalized;
- is homeless;
- is physically or mentally handicapped;
- has no funds for postage or transportation; or
- indicates that verification is not available due to loss or destruction of records, non-cooperation by the source of the verification, or similar reasons.

The type of worker assistance required varies depending on the limitations of the applicant/beneficiary or key person. In some situations, assistance in identifying the address of the verification source may be all that is needed. In others, the worker may need to obtain the applicant's/beneficiary's authorization and request the verification of behalf of the applicant/beneficiary.

Additionally, workers are responsible for providing reasonable and heightened assistance as specified in [MPG 4.07.13D](#) to applicants/beneficiaries in obtaining acceptable evidence of U.S. citizenship and identity required under the Deficit Reduction Act of 2005. ACWDL 07-12

Lastly, workers must ensure that verifications used in determining an applicant or beneficiary eligibility to Medi-Cal shall be documented in case file. Unless otherwise specified, acceptable documentation may include an imaged copy of the verification, information entered on relevant CalWIN window(s) and/or in case comments. For imaging guidelines, refer to the Imaging EEOG.

## 04.07.12 Requests for Additional Information/Verification

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### A. General

When the worker needs to contact the applicant/beneficiary for additional information, the date, method of contact and result of the contact must be documented in the case file. Workers are allowed to clarify information over the phone. If the reason for a contact is to clarify by phone information that is missing on forms (including the statement of facts), the worker shall narrate the contact in the narrative section of the case, and make a note on the statement of facts using different color ink from the applicant/beneficiary's entries to "see Narrative."

When the applicant/recipient fails to respond to the first contact, the worker shall conduct a second contact, either by telephone and/or written notice, and document this extra effort in the file.

The written notification should include the date of the prior client contact and the requested information/verification, the time frame for responding to this second notification, and the consequences for not providing the requested information within the allotted time.

When the request is for verification of citizenship and identity documents required under DRA 2005, refer to MPG 04.07.13 for specific procedures.

MPG Letter 651 (01/09)

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### B. *Ex Parte* Process Overview

The *ex parte* process is used when determining Medi-Cal eligibility at application, redetermination, or when changes in circumstances occur that affect Medi-Cal eligibility. "*Ex parte*" is the process whereby a Medi-Cal only determination is made without the involvement of the applicant/beneficiary.

The *ex parte* process requirements follow:

- The worker shall attempt to complete the Medi-Cal evaluation based on information/verification contained in open, or closed within 45 days, Other PA case records of beneficiaries and their immediate family members, or in county assessable automated systems. (See items 8A and 8B above.)
- Information/verification used from an Other PA case must have been obtained or reaffirmed within the last 12 months and not subject to change.

Medi-Cal workers must always attempt to obtain needed

information/verification by means of the *ex parte* process prior to:

- Denying a case for failure to provide for applicants.
- Requesting the information/verification from beneficiaries.

MPG Letter 520 (01/04)

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**C.  
Ex Parte for  
Applicants**

For applicants, the workers are allowed to request needed information/verification prior to initiating an *ex parte* review. If the applicant does not respond by the due date of the 2<sup>nd</sup> request, the worker must do an *ex parte* review to attempt to find the needed information.

<b>If the worker...</b>	<b>Then...</b>
locates the needed information/verification through the <i>ex parte</i> review,	notify the applicant that the information/verification is no longer needed and benefits are to be granted, if otherwise eligible.
is not able to locate the information/verification	the application shall be denied for failure to provide.

The worker may not deny a case for failure to provide BEFORE completing an *ex parte* review.

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MPG Letter 520 (01/04)

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**D.  
Ex Parte for  
Beneficiaries**

When a change that affects ongoing eligibility is reported, the worker must always attempt to locate needed information/verification by means of an *ex parte* review, prior to requesting it from the beneficiary.

If the *ex parte* review results in insufficient information/verification for an accurate determination of eligibility, then:

- the beneficiary must then be contacted to request the needed verification; and
- the exact reason for contacting the beneficiary must be narrated in the case file.

When the *ex parte* process reveals a change in circumstances that requires a referral or updating of information to other agencies, the beneficiary must complete the appropriate forms. Examples of these forms are Medical Support Forms and CWC 6041 Potential Third Party

Liability.

MPG Letter 520 (01/04)

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**E.  
At Application**

The following procedures shall apply to Mail-In and Non-Mail-In applications.

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**1. First Request for Verification**

Upon review of the mail-in application packet or during the face-to-face interview, the worker will generate a Verification Checklist (CSF 78) if additional information and/or verification are needed. Applicants shall be given at least 10 calendar days to provide items listed on the Verification Checklist.

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If the requested verification is subsequently found in an Other PA cases or through County available systems, the applicant must be notified that he/she does not need to provide the requested items.

**2. Second Request for Verification**

If the due date for the return of the initial Verification Checklist passes with no response from the applicant, a second Verification Checklist will be sent to the applicant. The applicant is allowed another 10 calendar days to provide the requested verification.

If the second due date passes with no responses and the worker is unable to obtain the needed verification through the *ex parte* review, the worker will issue a notice to deny Medi-Cal benefits. Cases are NOT to be denied for failure to provide until Other PA cases, either active or closed within 45 days, are reviewed for needed verification.

**3. Applicant provides and/or contacts worker after denial NOA was mailed**

If the applicant contacts the worker before the due date of the denial NOA indicating that the requested item cannot be obtained by the due date with good cause, the due date may then be extended. (Example of good cause: the individual has requested a statement from the insurance company to verify his/her current life insurance cash surrender value, but the issuance of such statement/ verification was delayed by the insurance company, etc.)

If the applicant provides the requested verification within 30 days of the case denial date, evaluate for ongoing eligibility, and if appropriate,

rescind the denial and approve ongoing benefits.

MPG Letter 684 (08/09)

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**F.  
When  
Changes Are  
Reported**

When a change that affects ongoing eligibility is reported, the worker must always attempt to locate needed information/verification by means of an *ex parte* review, prior to requesting verification from the beneficiary.

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If the worker is unable to locate needed verification and the beneficiary has provided a phone number, the worker shall attempt to contact the beneficiary by phone to request the information. If phone contact is made but the beneficiary is unable to provide adequate verification over the phone, or when a phone contact is not achieved, send the MC 355 requesting the needed verification; allow 20 days for its return.

If the beneficiary:

- Does not provide the requested verification, attempt a second phone contact on the 20<sup>th</sup> day after the MC 355 was mailed. On the same day, mail an adequate and timely discontinuance NOA to the last known address of the beneficiary.
- Provides partial verification within the first MC 355, mail a second MC 355 requesting the verification that is still needed. On the same day that the MC 355 is sent, a courtesy phone contact may be made to the beneficiary if time allows. If the beneficiary does not provide the requested verification within 10 days, send an adequate and timely NOA to discontinue the case.

When the requested verification is received within 30 days of the discontinuance, evaluate for ongoing eligibility and rescind the discontinuance if appropriate.

MPG Letter 520 (01/04)

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**G.  
At Re-  
Determination**

For the annual redetermination process, workers must follow the steps described below.

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- Mail the beneficiary the MC 210 RV annual redetermination statement of facts. Include the AL 784 coversheet, which instructs the beneficiary to mail in verification of the information provided on the MC 210 RV.
- If the MC 210 RV is returned without the necessary verifications, complete an *ex parte* review.
- If the *ex parte* review results in insufficient information to complete the redetermination, cases are not to be discontinued for failure to complete the redetermination until Other PA records have been

reviewed per the *ex parte* rules above.

- If the MC 210 RV was not submitted in month the annual redetermination is due and the packet was not returned by the postal service as “undeliverable,” the case shall be discontinued for no redetermination and adequate and timely NOA shall be issued.
- If the packet was returned by the postal service as “undeliverable,” the worker shall complete an *ex parte* review and attempt to contact the beneficiary prior to discontinuing the case for no redetermination.
- If partial items are provided, mail the MC 355 and attempt a phone contact. Attempt a second phone contact on the fifth business day after MC 355 was mailed.
- If no response to the MC 355 is received in 20 days, discontinue Medi-Cal with a timely NOA.
- If partial items are provided after the first MC 355, mail a second MC 355 and allow 10 days for the beneficiary to submit the needed information. A courtesy phone contact may be made at this time.
- If items are still not provided, discontinue Medi-Cal with a timely NOA.
- If the requested item is received within 30 days from the date of the discontinuance, evaluate for ongoing eligibility and rescind the discontinuance if appropriate.

Reminder: Workers shall not request information which:

- has been previously provided within 12 months from the date the eligibility determination was made;
- is not subject to change;
- is available for verification by the worker; and
- is not necessary to make an eligibility determination.

MPG Letter 684 (08/09)

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## **H. At Conclusion of Investigation**

When a beneficiary is under investigation and the investigator completes the report, it is forwarded to the worker for review and potential actions. If the investigation report reveals facts which were not reported by the client (example: the absent parent is now living at home), the worker will attempt to contact the beneficiary by phone or in writing to request the needed information/verification. The worker is to narrate in the case file the results of all attempted phone contacts. The worker is to send the beneficiary MC 355 requesting the information/verification and allow the beneficiary 20 days to return. If the requested information/verification is not received by the due date without good cause, the person or case will be discontinued effective the last day of the current month, or the last day of the following month if the 10-day notice requirement cannot be met for the current month.

Note: If the investigator made a recommendation on the report and the

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## 04.13.02 Denial/Discontinuance Due to Lack of Information

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### A. General

Applications are NOT to be denied solely because the worker has not received all required verifications within given deadlines unless the applicant/beneficiary is not cooperating within his/her ability or limitations.

The following procedures must be followed when Medi-Cal benefits are to be denied or discontinued due to lack of information.

MPG LTR 631 (5/08)

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### B. Worker Assistance

In addition to following the 10/10 timeframe when requesting for information/verifications necessary to complete eligibility determination, the worker is required to review the applicant/beneficiary's ability to obtain the required verifications and offer assistance as necessary in obtaining verifications.

The type of worker assistance required varies depending on the limitation of the applicant/beneficiary. In some situations, assistance in identifying the address of the verification source may be all that is needed. In others, the worker may need to obtain the applicant/beneficiary's written authorization and request the verification on behalf of the applicant.

MPG LTR 631 (5/08)

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### C. Denials Due to Lack of Information

Prior to denying an applicant for failure to provide essential information, the worker must have:

Step	Action
1	Provide the applicant with a list of outstanding verifications and allow the applicant at least 10 calendar days to provide. The worker must extend the 10-day deadline if the applicant indicates that he/she may have difficulty in providing the verifications by the given deadline. If an extended deadline is agreed to, the worker will document that fact in CalWIN.
2	When the deadline has passed and verifications are still missing, provide the applicant with a 2 <sup>nd</sup> request

	for information/verifications. Allow the applicant another 10 calendar days to provide.
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If, at the end of the second deadline, there is no contact from the applicant and no apparent reason of a need for a longer period in which to obtain the verifications, the worker will deny the application failure to provide essential information. When denying the application for failure to provide essential information, the worker must:

- Determine which member of the MFBU lacks the required information AND whether the denial action applies 1) solely to that person or 2) to that person AND those for whom he/she is responsible, or 3) to the entire MFBU; AND
- Determine whether the remaining MFBU members are still linked to the program. If not, then they will be denied as Medi-Cal linkage does not exist.

MPG Letter 684 (08/09)

**D.  
Applicant  
Provides After  
Denial**

The following procedures shall apply when applicant contacts the County after denial within a specified timeframe.

<b>When...</b>	<b>Then...</b>
Applicant contacts within 10 days of denial notice date AND request for more time	Evaluate the applicant's reason fore requiring additional time. The worker will allow additional time if it appears that the applicant is making a good faith effort to obtain the verifications, and/or the delay is beyond the applicant's control. The contact with the applicant and the worker decision must be documented in the case file. If an extended period is allowed and verifications are not provided by the deadline, a second denial NOA is to be sent. If the verifications are provided and eligibility exists, the original denial is to be rescinded.
Verifications are received within 10 days of denial notice date	Consider the verifications as timely and rescind the denial, if otherwise eligible. If some verifications are still missing, the worker must document the case file and send a