Medi-Cal Program Guide Letter #704

June 28, 2010

Subject **ARTICLE A – COUNTY MEDICAL SERVICES (CMS) FORMS/ NOTICE, CLARIFICATION REGARDING PROPERTY SPENDDOWN AND FAILURE TO PROVIDE REQUIREMENT UPDATE**

Effective Date Upon receipt

Reference County Policy

Purpose To inform staff of the:

- Added instructions for the use and revision of form HHSA: CMS-107 (Eng/Span) Image Verification Checklist.
- Revision of and clarification regarding form HHSA: CMS-007 (Eng/Span) General Property Limitations.
- Obsolete notice HHSA: CMS-109 Informational Notice: The County's Legal Right and Limitations on Repayment.
- Addition of form HHSA: CMS-112 (Eng/Span) Q & A's to the mail-in recertification packets.
- Clarification regarding property spenddown.
- Update to the failure to provide requirement.
- Revision of form HHSA: CMS-101A (Eng/Span) Recertification Cover Letter.
- Revision of and Spanish version of the form HHSA: CMS-69 (Eng/Span) Health Insurance Questionnaire.

Background

HHSA: CMS-107 (Eng/Span) Image Verification Checklist

The purpose of this form was to eliminate the scanning of forms HHSA: CMS-15 (Eng/Span) Rights and Responsibilities, HHSA: CMS-23 (Eng/Span) Coverage Information, HHSA: CMS-69 Health Insurance Questionnaire, HHSA: CMS-007 (Eng/Span) General Property Limitations, HHSA: CMS-123 CMS Lien Information and HHSA: CMS-123A Lien Acknowledgement Statement into to the CMS IT System at initial application, recertification and reapplication. Currently, certain sections in Article A require that the applicant/beneficiary sign and return the originals of these forms.

HHSA: CMS-007 (Eng/Span) General Property Limitations

This form was created to provide all CMS applicants/beneficiaries a general overview of the CMS property requirements. The worker was instructed to give the form to the applicant to read and sign at each initial application, recertification and reapplication, and to inform the applicant of the CMS property limit for the applicable CFBU size, the method of computing the excess property amount, and the spenddown rules for reducing excess property in order to become eligible to CMS coverage.

Notice HHSA: CMS-109 Informational Notice: The County's Legal Right and Limitations on Repayment

This notice informs the applicant of the County's legal rights and limitations to enforce a repayment agreement and must be given to every CMS Hardship applicant who receives a Reimbursement Agreement (CMS-106).

HHSA: CMS-112 (Eng/Span) Q & A's

This document was created to assist workers and to answer common questions asked by applicants/beneficiaries regarding Share of Cost, Reimbursement Agreement, and Lien requirement. This form must be given to all CMS applicants.

Property Spenddown

Currently, Article A does not specifically state that the applicant/ beneficiary is not required to spenddown for any month which the applicant/beneficiary was not informed of the CMS excess property limit and rules for reducing excess property in order to become eligible to CMS coverage.

Failure to Provide Requirement

Article A currently states that if the required verifications have not been provided after the initial 10 days have passed, the applicant is informed that they have an additional 10 days to provide the verifications that were not provided during the initial 10-day period.

Change

HHSA: CMS-107 (Eng/Span) Image Verification Checklist

As clarification, instructions have been added to Article A, Sections 2 and 5 which specify that the CMS applicant/beneficiary can either sign the original forms CMS-15, CMS-23, CMS-007, CMS-123 and CMS-

123A (SP), or sign the CMS-107 in lieu of signing the forms listed above. The applicant's/beneficiary's signature on the CMS-107 acknowledges that they have received, reviewed and fully understand the content of the forms listed on the CMS-107.

Form HHSA: CMS-69 Health Insurance Questionnaire was listed on the CMS-107 in error. This form has been removed from the CMS-107. Applicants indicating that they have other health coverage must complete the CMS-69. In addition, the form was revised to replace the "PSS" and "Clinic" with the "Member ID#" and "CMS Representative" and the Spanish translation of the form is now available.

HHSA: CMS-007/CMS-007 (SP) General Property Limitations

The applicant/beneficiary shall be given this form to read and sign at each initial application, recertification and reapplication. The applicant's/beneficiary's signature on the CMS-007 or on the CMS-107 acknowledges that they have received the CMS-007 and fully understand its content. The signed CMS-007 shall be considered to be sufficient evidence that the applicant read and understood the information provided in the CMS-007. Verbiage has been added instructing the applicant/beneficiary to call their CMS Representative if they have any questions regarding this information notice.

Notice HHSA: CMS-109 Informational Notice: The County's Legal Right and Limitations on Repayment

This notice has been eliminated and is no longer required to be given to every CMS Hardship applicant who receives a Reimbursement Agreement (CMS-106), and has been removed from the forms listed on the CMS-101A.

Form HHSA: CMS-112 (Eng/Span) Q & A's

This form has been added to the forms listed on CMS-101A (Eng/Span) and shall be included in the mail-in recertification packet.

Property Spenddown

Language has been added to Article A to clarify that the applicant/beneficiary is not required to complete a spenddown for any month in which the applicant/beneficiary was not informed of the CMS excess property reduction requirements. If otherwise eligible, the applicant/beneficiary shall be approved CMS benefits **only** for any month prior to the month in which he/she was informed of the requirement.

Failure to Provide Requirement

As clarification, Article A now states that if the requested information is not returned within the standard ten-ten (10/10) timeline and good cause is not determined, the worker will deny the application failure to provide.

Required Action

Staff must:

- Replace the prior version of forms CMS-101A (Eng/Span), CMS-007 (Eng/Span), and CMS-107 (Eng/Span) from all pre-assembled mail-in recertification packets with the new revision of the forms;
- Add form CMS-112 (Eng/Span) to all pre-assembled mail-in recertification packets; and
- Remove and recycle notice CMS-109 (Eng/Span) from all pre-assembled mail-in recertification packets.

Forms Impact

The table below shows the new and revised forms, and the obsolete notice.

Form #	Title	Action	Attachment
CMS-007 (Eng/Span)	General Property Limitations	Revised	A & B
CMS-69	Health Insurance Questionnaire	Revised	C
CMS-69 (SP)	Health Insurance Questionnaire	New	D
CMS-101A (Eng/Span)	Recertification Cover Letter	Revised	E & F
CMS-107 (Eng/Span)	Image Verification Checklist	Revised	G & H
CMS-109 (Eng/Span)	Informational Notice: The County's Legal Right and Limitations on Repayment	Obsolete	I & J

The new and revised forms have been uploaded into iWay and are available to be ordered.

CMS IT System Impact

The new and revised forms will be uploaded into the CMS IT System and can be found under the **FORMS** tab.

Quality Assurance

Effective with the August 2010 sample month, Quality Assurance will cite the appropriate error on any case that does not comply with the

Impact requirements outlined in this letter.

Summary of Changes The table below shows the changes made to the Program Guide.

Article	Changes
Article A, Section 1, Item 1	• Removed reference to the notice CMS-109.
Article A, Section 2, Item 2, 3, & 9	• Added instructions regarding the use of form CMS-107. • Updated the failure to provide requirement. • Removed reference to the notice CMS-109.
Article A, Section 5, Item 3, 5 & 6	• Added clarification regarding form CMS-007 and property spenddown. • Added instructions regarding the use of form CMS-107. • Removed instructions regarding the use of the notice CMS-109.
Article A, Section 9, Item 1	• Added form CMS-69 (SP) to the list of forms. • Removed notice CMS-109 (Eng/Span) from the list of forms.
Article A, Section 13, Item 1 & 3	• Removed reference to the notice CMS-109.
Article A, Section 14, Item 3	• Added form CMS-112 to the list of forms included in the mail-in recertification packet. • Removed notice CMS-109 from the list of forms included in the mail-in recertification packet.

Manager Approval

Janya Bowman, Assistant Deputy Director
Health Care Policy Administration
Strategic Planning and Operational Support Division

JP

COUNTY MEDICAL SERVICES (CMS) GENERAL PROPERTY LIMITATIONS

This information notice provides a general overview of CMS property requirements for all CMS applicants and beneficiaries.

Property is defined as “real property” and “personal property.”

- “Real property” is land, buildings, mobile homes which are taxed as real property, life estates in real property, mortgages, promissory notes, and deeds of trust.
- “Personal property” is any kind of liquid or nonliquid asset, i.e., cars, jewelry, stocks, bonds, financial institution accounts, boats, trucks, trailers, etc.

Property that is not counted in determining your eligibility is called “exempt” or “unavailable” property.

Countable property (property which is not exempt or unavailable) is included in the “property reserve.”

Your countable property must not exceed the property reserve limit. Any amount over the property reserve limit will make you ineligible for CMS.

To be eligible for CMS, you must reduce your property to the property reserve limit within 30 days from the date you were notified in writing by County staff that you exceeded the property reserve limit for the month(s) you are requesting CMS.

To be eligible for CMS, your countable property may not exceed the following property reserve limits:

Number of Persons	Property Limit
1	$ 2,000
2	$ 3,000
3	$ 3,150
4	$ 3,300
5	$ 3,450
6	$ 3,600
7	$ 3,750
8	$ 3,900
9	$ 4,050
10	$ 4,200

REDUCTION OF PROPERTY TO WITHIN PROPERTY LIMITS

The property reserve must be reduced to an amount at or below the property limit within 30 days from the date you were notified in writing by County staff that you exceeded the property reserve limit before CMS can be approved for the month(s) you are requesting CMS.

CMS eligibility cannot be approved for the month(s) that you are requesting CMS unless countable property is at or below the property limit at some time within 30 days from the date you were notified in writing by County staff that you exceeded the property reserve limit.

Ways to reduce nonexempt property without incurring a period of ineligibility for CMS:

- ✓ Pay actual CMS medical expenses bills;
- ✓ Pay current month rent or mortgage;
- ✓ Pay current month utilities, excluding cable TV

TRANSFERS OF PROPERTY NOT RESULTING IN INELIGIBILITY

Transfers of property that have occurred under any of the following conditions do not result in ineligibility:

- Transfers of property occurring more than two years before the date of application are not evaluated, regardless of the circumstances surrounding the transfer.
- Transfer of property that was exempt at the time of the transfer. Property, which is determined to be exempt based on specific conditions, loses exempt status once the conditions are no longer met.
- Transfer of property whose net market value when included in the property reserve does not cause ineligibility. The value of the transferred property at the time of the transfer will no longer be counted in the property reserve.
- Transfer of property which received adequate consideration. Adequate consideration means that cash or property that was of equal value to that of the transferred property was received, and was legal at the time and place the transfer occurred. Adequate consideration also includes:
  - o satisfying a legal debt, and
  - o reimbursing someone, other than a responsible relative, for care or benefits provided. There must be a prior written agreement or understanding specifying the type of care to be given, the rate of pay, and that reimbursement would be made. Applicants must provide evidence to establish that the value of the care or benefits provided was equivalent to the value of the transferred property.
- Transfer of property when foreclosure or repossession of the property was imminent at the time of transfer and there is no evidence of collusion.
- Transfer of property when the applicant received an enforceable life care contract that does not include complete medical care. In this case, each full item of need provided under the life care contract is considered income in kind.
- Transfer of property made without receipt of adequate consideration, but the applicant provides convincing evidence to the worker that shows that the transfer was not made to qualify for CMS.
- Transfer of property when there is a written transmutation of a married couple's nonexempt community property into equal shares of separate property through an interspousal agreement.

TRANSFERS OF PROPERTY RESULTING IN INELIGIBILITY

The following transfers result in ineligibility:

- Applicant receives an enforceable life care contract that includes complete medical care.
- Transfer of property without adequate consideration within two years from the application date.
- Adequate consideration was not received for the transfer of non-exempt property.

CMS PROGRAM PROPERTY EXEMPTIONS

Real Property

- Principal residence. Property used as a home is exempt (not counted in determining eligibility for CMS). When an applicant or beneficiary is absent from the home for any reason, including institutionalization, the home will remain exempt if the applicant or beneficiary intends to return home some day. Money received from the sale of a home can be exempt for six months if the money is going to be used for the purchase of another home.
- Other real property. Up to $6,000 of the equity value in non-business real estate (excluding the home), mortgages, deeds of trust, or other promissory notes may be exempt. Any amount in excess of $6000 shall be counted in the property reserve.
- **Real property used in a business or trade.** Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Personal Property

- **One motor vehicle.**
- **Personal property used in a trade or business.**
- **Personal effects.** This includes clothing, heirlooms, wedding and engagement rings, and other jewelry with a net value of under $100.
- **Household items.**
- **Irrevocable burial trusts or irrevocable prepaid burial contracts.**
- **One revocable burial fund or revocable prepaid burial contract** with a value of up to $1,500 plus accrued interest per person.
- **Burial space items.**
- **Musical instruments.**
- **Recreation items** including TVs, VCRs, computers, guns, collections, etc.
- **Livestock, poultry, or crops.**
- **Countable property equal to the amount of benefits paid under a state-certified, long-term care insurance policy.**
- **Life insurance policies.** Each person may have life insurance policies with a combined face value of $1,500 or less plus accrued interest and dividends.

NON-EXEMPT PROPERTY

Personal Property

IRAs, KEOGHs, and other work- related pension plans. These funds held in the applicant's name or in the name of the applicant's spouse are counted in the property reserve even if the family member whose name it is in is not eligible or does not choose to receive CMS or Medi-Cal.

IF YOU HAVE ANY QUESTIONS REGARDING THIS INFORMATION NOTICE, PLEASE CALL YOUR CMS REPRESENTATIVE.

I HAVE RECEIVED FORM HHSA: CMS-007 AND UNDERSTAND ITS CONTENTS REGARDING PROPERTY REQUIREMENTS, RESERVE LIMITS AND CMS RULES FOR REDUCING EXCESS PROPERTY TO WITHIN THE PROPERTY RESERVE LIMIT IN ORDER TO BECOME ELIGIBLE FOR CMS COVERAGE.

Applicant or Representative Signature **Date**

LIMITACIONES GENERALES DE PROPIEDAD DEL PROGRAMA
COUNTY MEDICAL SERVICES (CMS)

Este aviso informativo da un repaso general de los requisitos de propiedad para todos los solicitantes y beneficiarios del programa CMS.

Propiedad se define como “bienes inmuebles” y “bienes personales.”

- “Bienes inmuebles” son tierras, edificios, casas móviles a las que se les impone impuestos como bienes raíces, caudales hereditarios en bienes raíces, hipotecas, pagarés y escrituras fiduciarias.
- “Bienes personales” son cualquier propiedad de valor activo o no activo, por ejemplo, automóviles, joyas, acciones, bonos, cuentas en instituciones financieras, barcos, camiones, remolques, etc.

Los bienes que no se cuentan para determinar su elegibilidad se conocen como bienes “exentos” o “no disponibles”.

Los bienes que se cuentan (bienes que no están exentos o no disponibles) se incluyen en la “reserva de bienes”.

Sus bienes contables no pueden exceder el límite de reserva de bienes. Cualquier cantidad en exceso del límite de reserva de bienes causará que no sea elegible al programa CMS.

Para ser elegible al mes (a los meses) que usted está solicitando cobertura de CMS, usted necesita reducir sus bienes al límite de reserva de bienes dentro de 30 días a partir de la fecha en que el trabajador del Condado le notificó por escrito que usted excedió el límite de reserva de propiedad.

Pare ser elegible al CMS, sus bienes contables no pueden exceder el siguiente límite de reserva de bienes:

Número de Personas	Límite de Bienes
1	$ 2,000
2	$ 3,000
3	$ 3,150
4	$ 3,300
5	$ 3,450
6	$ 3,600
7	$ 3,750
8	$ 3,900
9	$ 4,050
10	$ 4,200

REDUCCION DE BIENES PARA QUE ESTEN DENTRO DEL LIMITE DE BIENES

Antes de que se le apruebe el mes (los meses) que usted está solicitando cobertura de CMS, la reserva de bienes debe ser reducida a una cantidad en o debajo del límite de reserva de bienes dentro de 30 días a partir de la fecha que el trabajador del Condado le notificó por escrito que usted excedió el límite de reserva de propiedad.

La elegibilidad al CMS no puede ser aprobada para el mes (los meses) que usted está solicitando al menos que los bienes contables estén en o debajo del limite de reserva de bienes durante los 30 días a partir de la fecha en que el trabajador de Condado le notificó por escrito que usted excedió el límite de reserva de propiedad.

Maneras de reducir bienes no exentos sin incurrir un periodo de inelegibilidad para CMS:

- ✓ Pagando por servicios médicos recibido que cubre CMS,
- ✓ Pagando la renta o hipoteca del mes actual,
- ✓ Pagando por servicios públicos del mes actual, excluyendo pago de televisión por cable

TRASPASO DE BIENES QUE NO RESULTAN EN INELEGIBILIDAD

Los traspasos de bienes que hayan ocurrido bajo cualquiera de las siguientes condiciones no resultan en inelegibilidad:

- Los traspasos de bienes que ocurrieron más de dos años antes de la fecha de la solicitud no son evaluados, sin importar las circunstancias del traspaso.
- Los traspasos de bienes que estaban exentos en el momento del traspaso. Los bienes, los cuales se exentan en base a condiciones específicas, pierden el estado exento una vez que ya no se cumplan las condiciones.
- El traspaso de bienes cuyo valor neto cuando se incluye en la reserva de bienes no causa inelegibilidad. El valor de bienes traspasados en ese momento no será contado en la reserva de bienes.
- El traspaso de propiedad que ha recibido consideración adecuada. Consideración adecuada significa que se recibió dinero en efectivo o propiedad del valor igual al de aquella propiedad, y fue legal en el momento y lugar en que ocurrió el traspaso. La consideración adecuada incluye:
  - o satisfacer una deuda legal, y
  - o reembolsar a alguien, aparte de un pariente responsable, por proporcionar algún cuidado o servicio. Debe haber un previo acuerdo en escrito o entendimiento especificando el tipo del cuidado que se va a proporcionar, la cantidad que se va a pagar, y que se hará un reembolso. Los solicitantes deben proporcionar pruebas para establecer que el valor del cuidado o servicio proporcionado es equivalente al valor de la propiedad traspasada.
- El traspaso de propiedad cuando el redimir el contrato de hipoteca o la recuperación de la propiedad era inminente en el momento del traspaso y no hay ninguna prueba de colusión.
- El traspaso de propiedad cuando el solicitante recibió un contrato de cuidado de vida ejecutable que no incluye asistencia médica completa. En este caso, cada artículo que se proporciona a una necesidad conforme al contracto de vida ejecutorio es considerado como ingreso.
- El traspaso de propiedad hecho sin un recibo de consideración adecuada, pero el solicitante proporciona prueba convincente que muestra que el traspaso no fue hecho para ser elegible al programa CMS.
- El traspaso de propiedad cuando hay una transmutación escrita de la propiedad en común no exenta de la pareja casada dividida en partes iguales por un acuerdo interconyugal.

TRASPASOS DE BIENES QUE RESULTAN EN UN PERIODO DE INELEGIBILIDAD

Los siguientes traspasos resultan en inelegibilidad:

- El solicitante recibe un contrato de cuidado de vida ejecutable que incluye cuidado médico completo.
- El traspaso de propiedad sin consideración adecuada dentro de dos años a partir de la fecha de la solicitud.
- No se recibió consideración adecuada para el traspaso de la propiedad no exenta.

PROPIEDAD EXENTA DEL PROGRAMA CMS

Bienes Inmuebles

- **Residencia principal.** La propiedad utilizada como una casa está exenta (no se cuenta al determinar la elegibilidad para CMS). Cuando un(a) solicitante o beneficiario(a) esté ausente del hogar por cualquier razón, incluyendo la institucionalización, la casa permanecerá exenta si el/la solicitante o beneficiario(a) tiene la intención de regresar a la casa algún día. Cualquier dinero que se reciba de la venta de una casa se puede exentar por seis meses, si el dinero se utilizará para comprar otra casa.
- **Otros bienes inmuebles.** Hasta un máximo de $6,000 del valor líquido de capital de bienes raíces que no son comerciales (excluyendo la casa), hipotecas, escrituras fiduciarias u otros pagarés podrían estar exentos. Cualquier cantidad que se pase de $6000 se considerará en la reserva de propiedad.
- **Bienes inmuebles utilizados en un negocio o comercio.** Bienes raíces utilizados en un comercio o negocio están exentos, independientemente de su valor capital y si produce ingresos.

Bienes Personales

- **Un carro.**
- **Bienes personales usados en un comercio o negocio.**
- **Objetos personales.** Esto incluye ropa, reliquias, anillos de matrimonio o de compromiso, y otras joyas con un valor neto menos de $100.
- **Artículos para el hogar.**
- **Fondos irrevocables para entierro o contratos de entierro irrevocables pagados con anticipación.**
- **Un fondo de entierro revocable o contrato de entierro irrevocable pagado con anticipación** con un valor máximo de $1,500 más interés acumulado por persona.
- **Artículos para el espacio de sepultura.**
- **Instrumentos musicales.**
- **Artículos de recreo** incluyendo televisores, grabadoras de video, computadoras, pistolas, colecciones, etc.
- **Ganado, aves de corral, o cosechas.**
- **Bienes contables equivalentes a la cantidad de beneficios pagados bajo una póliza de seguro de atención a largo plazo, certificada por el estado.**
- **Pólizas de seguro de vida.** Cada persona puede tener pólizas de seguro de vida con un valor nominal combinado de $1,500 o menos, más interés y dividendos acumulados.

BIENES QUE SE CUENTAN

Bienes Personales

lRAs, KEOGHs, y otros planes de pensión relacionados con el trabajo. Estos fondos sostenidos a nombre del solicitante o a nombre del cónyuge del solicitante se consideran en la reserva de propiedad aún si el miembro de familia en cuyo nombre esto está no es elegible o no desea recibir beneficios del programa CMS o Medi-Cal.

SI TIENE ALGUNA PREGUNTA EN CUANTO ESTE AVISO INFORMATIVO, FAVOR DE LLAMAR A SU REPRESENTANTE DE CMS.

HE RECIBIDO LA FORMA HHSA: CMS-007 Y ENTIENDO SU CONTENIDO EN CUANTO A LOS REQUISITOS DE PROPIEDAD, LIMITES DE LA RESERVA DE BIENES Y LAS REGLAS DEL PROGRAMA CMS DE COMO REDUCIR LOS BIENES EN EXCESO DENTRO DEL LIMITE DE RESERVA DE BIENES PARA PODER SER ELEGIBLE PARA LA COBERTURA DE CMS.

Firma del Solicitante o Representante **Fecha**

COUNTY MEDICAL SERVICES

HEALTH INSURANCE QUESTIONNAIRE

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

Complete this form for any health insurance, including Medicare Supplements, Prepaid Health Plans/Health Maintenance Organizations, or CHAMPUS. Having private health insurance may not affect your County Medical Services (CMS) eligibility. However, failure to report other health insurance may cause your CMS eligibility to stop.

Member ID#:	CMS Representative

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

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

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

I hereby authorize the County Medical Services Program to obtain, if needed, any information about my private insurance coverage.

Applicant Signature	Date

COUNTY MEDICAL SERVICES

CUESTIONARIO SOBRE EL SEGURO MEDICO

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

Complete este formulario para cualquier seguro médico, incluyendo suplementos de Medicare, Planes de Salud Prepagados/Organizaciones de Mantenimiento Para la Salud, o CHAMPUS. El tener un seguro médico particular no afecta su elegibilidad al programa County Medical Services (CMS). Sin embargo, no revelar que tiene otro seguro médico puede causar que su elegibilidad al programa CMS termine.

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

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

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

1. ¿Cuál es el nombre, domicilio y teléfono de la compañía de su seguro médico? No use abreviaturas.
   Nombre _____
   Domicilio _____
   Ciudad, Estado, Código Postal _____ No. de Teléfono _____

2. ¿Tiene usted que obtener servicios médicos de un lugar específico o de un grupo de proveedores? (PHP/HMO/PPO) ❒ Sí ❒ No

3. ¿A dónde envía sus reclamos?
   Nombre _____
   Domicilio _____
   Ciudad, Estado, Código Postal _____

4. ¿Cuál es el nombre completo, domicilio, numero de teléfono, y numero de Seguro Social (SSN) del individuo, trabajador, miembro de unión, o persona en cuyo nombre se formó la póliza de seguro?
   Nombre _____ SSN _____
   Domicilio _____ No. de Teléfono _____
   Ciudad, Estado, Código Postal _____ ¿Cónyuge suyo? ❒ Sí ❒ No

5. ¿Cuál es el número de la póliza? _____

6. ¿Cuáles son/fueron las fechas de su póliza? ¿Fecha en que empezó? _____ ¿Fecha que terminó? _____

7. Cantidad de la Prima $ _____ ❒ Mensual ❒ Trimestral ❒ Anual
   ¿Cómo se paga la Prima? ❒ Por el Asegurado a la Compañía Aseguradora ❒ Por el Empleador ❒ Deducida del Salario

8. ¿Provee o paga su seguro médico por (marque todo lo que aplica)?:
   ❒ Servicios externos para pacientes no hospitalizados (e.g., pruebas de laboratorio/terapia física) ❒ Medicinas con receta
   ❒ Cuidado de Largo Plazo/en una Residencia Médica ❒ Hospitalizaciones ❒ Cuidado Dental ❒ Visitas al Médico
   ❒ Cuidado de la Vista ❒ Solamente alguna enfermedad especifica _____

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

Firma del Solicitante	Fecha

COUNTY MEDICAL SERVICES
RECERTIFICATION COVER LETTER

Date: _____

To: _____

_____

_____

CMS Mail-In Recertification Unit
PO Box 85222 MS: O557E
San Diego CA 92186-5222

You are receiving this letter because you requested a recertification of your CMS eligibility. Enclosed with this letter are the following forms we need from you to process your recertification to CMS:

- HHSA: CMS-101 County Medical Services Mail-In Recertification Form
- HHSA: CMS-107 County Medical Services Image Verification Checklist
- HHSA: CMS-99 County Medical Services Credit Check Authorization
- HHSA: CMS-106 County Medical Services Reimbursement Agreement**
- HHSA: CMS-01 County Medical Services Hardship Application **
- HHSA: HCPA 14-187 Authorization for Release of Information
- Postage-paid Return Envelope

** CMS Hardship Application (CMS-01) and the Reimbursement Agreement (CMS-106) forms will need to be completed and submitted to apply for CMS Hardship **only** in the event that your net countable monthly income is between 165% and 350% of Federal Poverty Income Level (effective July 1, 2009: $1490 to $3161 per month for one (1) person). Applying for a CMS Hardship evaluation is strictly voluntary. If you wish to apply, we may ask for more information from you at a later time to complete this evaluation. If you do not wish to apply for CMS Hardship, no further action is required.

NOTE: The HHSA: CMS-15 Rights and Responsibilities for Applicants, HHSA: CMS-23 Coverage Information and HHSA: CMS-007 CMS General Property Limitations do not have to be returned to CMS, just sign-off on the HHSA: CMS-107 acknowledging these forms were received, reviewed and understood. The HHSA: CMS-112 CMS Question and Answers and CMS Health Plan NPP-002 CMS Notice of Privacy Practices are being provided as information only and do not have to be returned to CMS.

You must complete and return the above forms along with any required verifications and/or documentation **within 15 days** of the date listed at the top of the Mail-in Recertification Form to be evaluated for ongoing CMS coverage. A postage-paid return envelope is enclosed for your convenience. If the Mail-in Recertification Form is not received by the 15-day deadline, you will need to call the CMS Eligibility Appointment Line at 1-800-587-8118 to schedule a face-to-face eligibility interview.

A Notice of Action informing you of your approval or denial for ongoing CMS coverage will be mailed to you.

If you have any questions, please call the CMS Mail-In Recertification Unit at (858) 492-2200.

COUNTY MEDICAL SERVICES

CARTA EXPLICATORIA PARA RENOVAR EL PROGRAMA CMS

Fecha: _____

Para: _____

_____

_____

CMS Mail-In Recertification Unit
PO Box 85222 MS: O557E
San Diego CA 92186-5222

Usted recibe esta carta porque desea renovar su elegibilidad para el programa CMS. Junto con esta carta están las siguientes formas que necesitamos para procesar la nueva certificación al programa CMS:

- HHSA: CMS-101 Formulario Para Renovar Por Correo Los Beneficios County Medical Services
- HHSA: CMS-107 County Medical Services Lista de Verificación de Imagen
- HHSA: CMS-99 County Medical Services Autorización Para Examinar Crédito
- HHSA: CMS-106 County Medical Services Acuerdo de Reembolsar el Condado de San Diego**
- HHSA: CMS-01 County Medical Services Solicitud por Circunstancia Extrema de CMS**
- HHSA :HCPA 14-187(SP) Autorización Para Proporcionar Información
- Sobre de Porte Pagado

La solicitud por Circunstancia Extrema de CMS (CMS-01) y la forma del Acuerdo de Reembolsar el Condado de San Diego (CMS-106) tendrán que ser completadas y regresadas para solicitar la evaluación por Circunstancia Extrema del Programa CMS **solamente en caso que su ingreso neto mensual es entre 165% y 350% del Nivel de Pobreza Federal (FPL) de ingreso (efectivo 1 de Julio 2009: $1490 a $3161 por mes para una (1) persona). La solicitud por Circunstancia Extrema del Programa CMS es estrictamente voluntaria. Si desea solicitarla, puede ser que después se le pida información adicional para completar esta evaluación. Si no desea solicitarla, no se requiere ninguna acción de su parte.

NOTA: Formas HHSA: CMS-15 Derechos y Responsabilidades del Solicitante, HHSA: CMS-23 Información de Cobertura y HHSA: CMS-007 Limitaciones Generales de Propiedad del Programa CMS no tienen que ser regresadas al programa CMS, solo se pide que reconozca que las formas fueron recibidas, examinadas y entendidas firmando/iniciando la forma CMS-107. Forma HHSA: CMS-112 CMS Preguntas y Respuestas y CMS Health Plan NPP-002 Aviso Sobre Practicas de Privacidad de CMS se proporcionan para información solamente y no tienen que regresarse al programa CMS.

Usted debe de completar y regresar las formas junto con cualquier verificación y/o documentación requerida **dentro de 15 días** de la fecha anotada arriba del Formulario Para Renovar Los Beneficios County Medical Services para evaluar su cobertura al programa CMS. Un sobre de porte pagado está incluido para su conveniencia. Si el Formulario Para Renovar Los Beneficios County Medical Services no se recibe dentro del plazo de 15 días, va a necesitar llamar a la Línea para Cita de Elegibilidad al 1-800-587-8118 para programar su cita.

Se le enviará por correo un Aviso de Acción donde se le informa que fue aprobado(a) o si se le negó su cobertura para continuar si elegibilidad al programa CMS.

Si usted tiene alguna pregunta, favor de comunicarse con la Unidad Para Renovar los Beneficios del Programa CMS al (858) 492-2200.

COUNTY MEDICAL SERVICES (CMS) PROGRAM
IMAGE VERIFICATION CHECKLIST

Name: _____

Member ID #: _____

Worker Name: _____

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

You Initial Here	Spouse Initials Here	
		CMS-15 Rights and Responsibilities (9/08)
		CMS-23 Coverage Information (7/08)
		CMS-007 CMS General Property Limitations (06/10)
		CMS-123 CMS Lien Information (7/08)**
		CMS-123A CMS Lien Acknowledge Statement (1/08)**

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

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

_____ _____
Signature of Applicant Date

_____ _____
Signature of Spouse Date

_____ _____
Signature of Authorized Representative Date

COUNTY MEDICAL SERVICES (CMS) PROGRAM
LISTA DE VERIFICACION DE IMAGEN

Nombre: _____

No. de Miembro: _____

Nombre del/la Trabajador/a: _____

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

Sus Iniciales	Iniciales de su Cónyuge	
		CMS-15 Derechos y Responsabilidades del Solicitante (9/08)
		CMS-23 Información de Cobertura (7/08)
		CMS-007 Limitaciones Generales de Propiedad del Programa CMS (06/10)
		CMS-123 Información de Gravamen (CMS) (7/08)**
		CMS-123A (SP) Declaración de Reconocimiento de Gravamen de CMS (1/08)**

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

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

_____ _____
Firma del Solicitante Fecha

_____ _____
Firma del Esposo(a) Fecha

_____ _____
Firma del Representante Autorizado Fecha

COUNTY MEDICAL SERVICES

INFORMATIONAL NOTICE: THE COUNTY'S LEGAL RIGHTS AND LIMITATIONS ON REPAYMENT

The following sections of the Welfare & Institutions Code may apply to the lien and repayment agreement: §17109, §17400, §17401, §17402, §17403, §17403.1, §17404, §17405, §17406, §17407, §17408, §17409.

You can read more about these sections at: http://www.leginfo.ca.gov/calaw.html

If you have questions, contact Western Center on Law and Poverty toll-free at 1-800-405-8759 or by mail at:

Western Center on Law and Poverty
Attn: CMS Repayment
3701 Wilshire Boulevard, Suite 208
Los Angeles, CA 90010

COUNTY MEDICAL SERVICES

AVISO INFORMATIVO: DERECHOS LEGALES DEL CONDADO Y LIMITACIONES DEL REEMBOLSO

Las siguientes secciones del Código Welfare & Institutions pueden aplicarse al acuerdo del gravamen y reembolso: §17109, §17400, §17401, §17402, §17403, §17403.1, §17404, §17405, §17406, §17407, §17408, §17409.

Usted puede leer más sobre estas secciones en: http://www.leginfo.ca.gov/calaw.html

Si tiene preguntas, póngase en contacto con el Centro Western en Ley y Pobreza llamando al 1-800-405-8759 (llamada gratuita) o por escrito a:

Western Center on Law and Poverty
Attn: CMS Repayment
3701 Wilshire Boulevard, Suite 208
Los Angeles, CA 90010

A.1.1

Program Overview

1. Program Description

County Medical Services is a health care program for indigent adults. CMS is not health insurance; it is the program of last resort for eligible adults, which covers only certain medically necessary medical services. CMS is the County's safety net program covering adults who are not eligible for Medi-Cal. San Diego County does not provide direct services. Services are provided by primary care clinics, local hospitals, and physicians that contract with San Diego County to provide medical care.

A modification to the CMS Program was approved by the San Diego County Board of Supervisors on 05/13/08. As a result, CMS Program benefits shall continue to be certified under two separate eligibility categories; CMS and CMS Hardship. CMS provides services at zero cost to individuals who meet CMS eligibility criteria and whose family income does not exceed 165% of the annually adjusted Federal Poverty Level (FPL). Individuals who meet CMS eligibility criteria and whose family income is over 165%, up to and including 350% of the annually adjusted FPL may be required to meet a Share of Cost (SOC) obligation each month. Refer to MPG Article A, Section 5 for additional information regarding income limits.

Individuals who meet all other CMS eligibility criteria and whose family income is over 165%, up to and including 350% of the annually adjusted FPL, will be evaluated for a CMS hardship that may result in zero cost or an adjusted SOC for CMS services. Refer to MPG Article A, Section 13, for additional information regarding hardship evaluations.

Effective 12/1/2007, as a condition of eligibility, all CMS applicants are required to sign the CMS Lien Information form (CMS-123) and CMS Grant of Lien form (CMS-122), naming the County of San Diego as grantee to secure any and all real estate property of the applicant as security for repayment of all claims paid by CMS on their behalf. The lien will be filed against any real property that is currently owned or real property that may be acquired in the future. However, the applicant does not need to sell their current principal residence to qualify. Refer to MPG Article A, Section 5-5 for additional information regarding liens.

Effective with applications dated 7/1/2008, as a condition of

eligibility, CMS applicants whose family income is over 165%, up to and including 350% of the annually adjusted FPL are required to sign the CMS Reimbursement Agreement form (CMS-106). This repayment document requires the CMS applicant to reimburse San Diego County via the Office of Revenue & Recovery for CMS services provided. Refer to MPG Article A, Section 5 for additional information regarding repayment requirements and procedures.

MPG Letter #704 (06/10)

A.2.2

Hospital Outstationed Services (HOS)

B. Statement of Facts/ Grant of Lien Form

HOS workers use the Statement of Facts located on the CMS IT System plus appropriate supplemental forms to determine CMS eligibility. Refer to MPG 4-2-4 for instructions on who may complete and sign the Statement of Facts and information regarding Authorized Representatives. A copy of the signed Statement of Facts signature page shall be maintained in the case record.

When an Individual applies for CMS, the worker will screen for the CI Program first (See A-2-6 below and the CI Program Guide). If the applicant is potentially eligible for CI, the worker will explain the benefits of the CI program and ask the applicant if he/she would like to be evaluated for CI. If yes, the worker will process the CI and CMS applications concurrently, but will enroll the applicant in only the CI program if the applicant qualifies for CI.

Effective 12/01/07, as a condition of eligibility, all applicants are required to sign the CMS Lien Information form (CMS-123) and the CMS Lien Acknowledgement Statement (CMS-123A) or the CMS-107 in lieu of the CMS-123 and CMS-123A), and CMS Grant of Lien form (CMS-122) naming the County of San Diego as grantee to secure any and all real property of the applicant as security for repayment of all claims totaling $5,000 or more paid by the CMS Program on their behalf. The CMS-122 may not be included on the CMS-107. The lien will be filed against <u>any real property that is currently owned</u> or real property that may be purchased in the future. Refer to MPG Article A, Section 5-5 for additional information regarding liens.

MPG Letter #704 (06/10)

D. Rights and Responsibilities/Lien Information /Grant of Lien/ Credit Check Authorization

Applicants must help the worker determine CMS eligibility by:

1) Completing all required forms.
2) Providing all necessary verification.
3) Reporting all pertinent facts within 10 days of their intake appointment.
4) Reading and signing the Rights and Responsibilities form (HHSA: CMS-15) or signing the CMS Image Verification Checklist CMS-107 in lieu of the CMS-15.
5) Reading and signing the CMS Lien Information form (CMS-123), the CMS Lien Acknowledgement Statement (CMS-123A) or the CMS Image Verification Checklist (CMS-107) in lieu of the CMS-123 and CMS-123A, and the CMS Grant of Lien form (CMS-122). Applicants who refuse to provide the signed CMS-122, CMS-123 and CMS-123A or the CMS-107 in lieu of the CMS-123 and CMS-123A are not eligible to CMS and their application will be denied.
6) Effective with applications taken on or after July 1, 2008, as a condition of eligibility applicants/ beneficiaries must sign a Credit Check Authorization Form (CMS-99). The credit checks will be used as a verification tool for financial, property and eligibility information only, which the applicant/beneficiary provided.

MPG Letter #704 (06/10)

E. Case Handling

1) Case Folder

HOS is unique in that workers may be dealing with both an electronic CMS IT system case, as well as a Medi-Cal case, automated through CalWIN. Case handling is different depending on the status of the patient's Medi-Cal eligibility.

a) CMS only FBU

When the FBU contains only adults, the HOS worker creates an electronic case in the CMS IT system. The manual non-automated CMS case folder will be

requested from Record Library (RL) for review only and then returned to RL for storage.

b) When the applicant is an ineligible member of a Medi-Cal case, the HOS worker creates a separate CMS case electronically in the CMS IT system, as stated in item (e) below. The CMS FBU will consist of the CMS applicant, his/her spouse and **all** natural or adoptive minor children living in the home.

c) If there is an existing non-automated case file at another eligibility site, the worker may request the case folder to retrieve previously received verifications. There should not be a new case folder created.

d) Prior to March 2007, CMS only cases were tracked using the case name only. As of March 2007, in order to prepare for the eventual storage of all CMS cases at the County Record Library, case folders shall be manually created and a case number shall be assigned. Workers shall manually create or convert new and existing case folders to a 6-digit case number.

e) As of July 1, 2008, CMS eligibility determinations are automated. Workers will enter applicant information directly into the CMS IT System, there is no paper case file created. The CMS IT System will assign case numbers to each applicant. The applicant will retain this case number throughout the lifetime of the CMS case.

2) Denial/Failure to Provide Requirements

CMS follows Medi-Cal rules as outlined in Article 4, Section 13 of the MPG. If required verifications have not been provided after the initial 10 days have passed as outlined in MPG 04.13.02, the worker prints a second Verification Checklist from the CMS IT System, to inform CMS applicants that they have an additional 10 days to provide the verifications that were not provided during the initial 10-day period. If the requested information is not returned within the standard ten-ten (10/10) timeline and good cause is not determined, the worker will deny the application for failure to provide.

3) Denial – Excess Income

Income is a CMS eligibility factor. The worker inputs the applicant information directly into the CMS IT System, and the

system will determine whether or not the CFBU is within the CMS income limits and to which CMS eligibility category (CMS or CMS Hardship) the patient may be certified for. When the patient is not eligible to CMS due to excess income (more than 165% FPL up to and including 350% FPL) and is otherwise eligible, the patient may apply for a CMS Hardship Evaluation. Refer to Article A, Section 13 for additional information. The worker shall not deny the case, but will continue to evaluate whether the patient is eligible for a CMS Hardship evaluation. The worker shall advise the patient of the repayment agreement and the 10 day deadline in which to provide any pending verifications.

When denying the application for excess income (more than 350% FPL), it is imperative that the correct CFBU size as well as both the total gross and the net countable income used in the determination are reflected. NOA HHSA: CMS-39D is provided to the CMS applicant, indicating reason for denial and the budget used in the determination.

4) CMS Approved – No Medi-Cal Disability Evaluation (DDSD Pending

Workers enter the applicant information directly into the CMS IT System to certify CMS applications. The Notice of Action CMS-39A is used to inform the applicant of the approval and the eligibility category to which they have been approved.

5) CMS Approved – Medi-Cal Disability Evaluation (DDSD) Pending

The worker opens an automated Medi-Cal case on CalWIN and places it in a pending status. The worker must also evaluate for retroactive Medi-Cal when the applicant/beneficiary has had CMS coverage in the retroactive period. The HOS worker shall assist applicants, as needed, with the Medi-Cal application process including helping them complete the Statement of Facts and DDSD packet (see Medi-Cal Linkage in Article A.2.5 for more instructions). **The HOS worker CANNOT approve CMS until the Medi-Cal application and DDSD packet are received fully completed and all eligibility and verification requirements for both Medi-Cal and CMS have been met.**

CMS should not be certified if there is a pending fraud investigation on the Medi-Cal application.

Reminder: Per MPG 5-4.2, DDSD's must be submitted within

10 days of receipt of the Statement of Facts.

Note: If CalWIN Disability Screen input is not completed within 30 days from the date of application, all CalWIN entries will fail. The worker records the CMS certification period and the date the DDSD packet was sent in the case comments of the CMS and Medi-Cal case. Example: CMS 5/05-10/05, MC P (xx/xx application date) DDSD sent 6/12/05. This entry alerts the DDSD Recovery Specialist that there is potential reimbursement from Medi-Cal to CMS. The HOS worker then sends the Medi-Cal case to the DDSD workers at the Family Resource Centers (FRC). IDX screen prints reflecting CMS eligibility and IDX comments must be in the case file as referenced in MPG Article 4, Section 2.7(C). Upon approval or denial of Medi-Cal, the DDSD FRC worker sends form 14-10 HHSA to the ASO at O-557B. The CMS case is sent to HQ for filing in the Record Library.

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K. Coverage Information

Beneficiaries shall sign the form CMS-23 or the form CMS-107 in lieu of the CMS-23, acknowledging that they have reviewed the information and they understand the limitations of CMS coverage and their responsibilities for Share of Cost (SOC) payments when certified for CMS with a SOC. A copy of the signed form CMS-23 or CMS-107 shall be maintained in the case record.

MPG Letter #704 (06/10)

L. Lien Information

Applicants/beneficiaries shall complete the CMS-122 and sign the CMS-123, and the CMS-123A or the CMS-107 in lieu of the CMS-123 and CMS-123A acknowledging that they have reviewed the information and that they understand and agree to the requirements for repayment of any and all claims which are paid for on their behalf by the CMS Program. (Refer to Article A-5-5 for more information). A copy of the signed forms shall be maintained in the case record. The CMS-122 must be appropriately signed and witnessed by either a Deputy County Clerk or Notary Public at initial application.

Upon processing of CMS applications, the worker must take the following actions to determine if a new CMS-122 is required or not required:

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Review all of the applicant’s/beneficiary’s prior CMS IT case records to determine:
<table>
<tr><th>If…</th><th>And if…</th><th>Then…</th></tr>
<tr><td rowspan="2">The CMS-122 on file was appropriately signed and properly witnessed</td><td>There is NO change in the applicant’s/ beneficiary’s marital status</td><td>A new CMS-122 is NOT required to be signed and witnessed at recertification or reapplication.</td></tr>
<tr><td>There IS a change in the applicant’s/ beneficiary’s marital status</td><td>Proceed to Step 2.</td></tr>
<tr><td>The CMS-122 on file was NOT appropriately signed and properly witnessed</td><td>N/A</td><td>A new CMS-122 IS required to be signed and witnessed at recertification or reapplication.</td></tr>
</table></td></tr>
<tr><td>2</td><td>Obtain a new and signed CMS-122:
<table>
<tr><th>If the applicant/beneficiary has…</th><th>Then…</th></tr>
<tr><td>Married, remarried, or reconciled with their absent spouse</td><td>Both the applicant/ beneficiary and their spouse must sign a new CMS-122.</td></tr>
<tr><td>Divorced</td><td>Only the applicant/ beneficiary signs a new CMS-122.</td></tr>
</table></td></tr>
</table>

MPG Letter #704 (06/10)

A.2.3

Primary Care Clinics and Public Health Centers

D. Case Handling

1) Case Folder

Workers create an electronic case in the same manner as HOS. Refer to Article A-2-2E(1a) and A-2-2E(1c).

2) Denial/Failure to Provide Requirements

CMS follows Medi-Cal rules as outlined in Article 4, Section 13 of the MPG. If required verifications have not been provided after the initial 10 days have passed as outlined in MPG 04.13.02, the worker prints the CMS automated letter from the CMS IT System, Reminder Request for Verifications. This letter must be sent as a reminder notice to CMS applicants to inform them that they have an additional 10 days to provide verifications that were not provided during the initial 10-day period. If the requested information is not returned within the standard ten-ten (10/10) timeline and good cause is not determined, the worker will deny the application for failure to provide.

3) Denial – Excess Income

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

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

Workers at Primary Care Clinics and Public Health Centers may certify CMS eligibility for up to three months after directing an applicant/beneficiary to apply for Medi-Cal. The worker will print the MC-210 from the CMS IT System and give it to the applicant. The worker must specify on the MC-210 the beginning month for the Medi-Cal DDSD application and retroactive months as needed. Retroactive Medi-Cal is needed when the applicant/beneficiary has had CMS coverage in the retroactive period. Workers shall assist those who need help completing the Statement of Facts (MC 210) and Supplemental Statement of Facts (MC 223), etc. The worker must inform the applicant verbally and on the Notice of Action that CMS will not be recertified until they fully complete the Medi-Cal application process. After the three-month period, CMS cannot be approved until the worker verifies the applicant/beneficiary has fully complied in completing the Medi-Cal application process; met all Medi-Cal eligibility and verification requirements; and the Medi-Cal application is pending on CalWIN with the date the DDSD

packet was sent. (See Medi-Cal Linkage in Article A Section 2 Item 5 for more instructions.)

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A.5.3

Property/Resources

C. Property Spenddown

Property spenddown rules for CMS and Medi-Cal are different. The applicant/beneficiary will be given notice CMS-007 to read and sign at each initial application, recertification and reapplication. The applicant/beneficiary may sign the Image Verification Checklist (CMS-107) in lieu of the CMS-007. The applicant's/beneficiary's signature on the either form acknowledges that they have received the CMS-007 and understand its content. The signed CMS-007 or CMS-107 shall be considered to be sufficient evidence that the applicant read and understood the information provided in the CMS-007. Staff must be available to answer any questions the applicant/beneficiary may have regarding the CMS-007.

The applicant/beneficiary is not required to complete a spenddown for any month in which the applicant/beneficiary was not informed of the CMS excess property reduction requirements. If otherwise eligible, the applicant/beneficiary shall be approved CMS benefits **only** for any month prior to the month in which he/she was informed of the requirement.

1) Computation

   Workers list the items of property and total their value on the automated HHSA: CMS-39D. The property limit for the CFBU is subtracted from the total value of non-exempt property to arrive at the amount of excess property. This is the amount that must be spent.

2) Allowable Expenses

   The applicant may reduce excess property by paying actual CMS medical expenses, current month rent or mortgage, and current month utilities, excluding cable TV.

3) Worker Action

   The worker sends an automated Notice of Action (CMS-39D) telling

the applicant that CMS has been denied because of excess property and giving the applicant the opportunity to spend the excess. The applicant has 30 days from the date of the notice to pay allowable expenses and to submit receipt(s) to the worker. If the applicant submits receipt(s) within the 30 days, the worker verifies that the property excess has been spent correctly, and is now within the property limit, and rescinds the denial. The certification period begins the month of application as long as all other eligibility factors are met. The worker notes in the comments section of the CMS IT System "spend down medical receipts in the amount of $_____ ." The worker completes a CMS-4 and attaches the receipts to the CMS-4 sent via interoffice mail to ASO Spenddown Data Entry Eligibility Supervisor. The receipts enable the ASO to identify the provider(s) that the applicant has paid. If the receipts are not received within 30 days, the denial stands.

MPG Letter #704 (06/10)

A.5.5

Liens

B. CMS Lien Form Information

Note: A Certificate of Acknowledgement is acceptable in lieu of Notary Public signature on the CMS-122, if the certificate is signed, dated and stamped by a Notary Public and contains the CMS Grant of Lien form title.

Each applicant/beneficiary will complete a CMS Lien Information form (CMS-123) and the CMS Lien Acknowledgement Statement (CMS-123A), or the Image Verification Checklist (CMS-107) in lieu of the CMS-123 and CMS-123A. Failure of the applicant/beneficiary to cooperate will result in denial of aid.

The CMS-123 form explains the repayment terms of the CMS Program. This form must be explained to the applicant/beneficiary prior to his/her signing and acknowledging that they understand the repayment terms.

MPG Letter #704 (06/10)

A.5.6

Reimbursement Agreement (HHSA: CMS-106)

A. Policy

Welfare & Institutions Code (W&IC) Section 17400-17410 and San Diego County Administrative Code, Section 238 authorizes the County to set up repayment account for all claims paid on behalf of a CMS or CMS Hardship beneficiary. HHSA will refer CMS cases to the Office of Revenue and Recovery to pursue appropriate collection activities and proceedings to recover CMS cost.

MPG Letter #704 (06/10)

A.9.1

Forms

A. Forms

FORM NUMBER	FORM TITLE
07-16 HHSA/ 07-16 HHSA (SP)	Request for Withdrawal or Discontinuance of Benefits
07-21 HHSA/ 07-21 HHSA (SP)	Employment Verification
07-27 DSS	Case Narrative
07-227 DSS/ 07-227 DSS (SP)	Statement of Contribution & Declaration of a Loan/Gift
07-66 HHSA/ 07-66 HHSA (SP)	Self Employment Income Statement
14-4 DSS	Medical Services Screening
14-08 DSS	Applicant Notice of Decentralization
14-10 HHSA	Transmittal of CMS/Medi-Cal Information
14-12 DSS	District Notice of Decentralization
16-42 HHSA/ 16-42 HHSA (SP)	Sworn Statement
CW 60/ CW 60 (SP)	Release of Information – Financial Institution
DHS 6155	Health Insurance Questionnaire
HCPA: 14-187/ HCPA: 14-187 (SP)	Authorization for Release of Information
HHSA: CMS-007/ HHSA: CMS-007 (SP)	CMS General Property Limitations Notice
HHSA: CMS-008/ HHSA: CMS-008 (SP)	CMS Resource Handout

HHSA: CMS-2/ HHSA: CMS-2(SP)	CMS SSI Advocacy Referral
HHSA: CMS-3	CMS Weekly Screening Log
HHSA: CMS-4	Registration Information
HHSA: CMS-5	Medi-Cal Referral
HHSA: CMS-7	Third Party Liability Report
HHSA: CMS-9	Sign-in Sheet
HHSA: CMS-13/ HHSA: CMS-13 (SP)	Affidavit Residence (Spanish on Reverse)
HHSA: CMS-14/ HHSA: CMS-14 (SP)	Rights of Applicants
HHSA: HCPA 14-187/ HCPA 14-187 (SP)	Authorization for Release of Information
HHSA: CMS-15/ HHSA: CMS-15 (SP)	Responsibilities of Applicants
HHSA: CMS-16/ HHSA: CMS-16 (SP)	Verification Checklist
HHSA: CMS-17/ HHSA: CMS-17 (SP)	Provider Statement (Spanish on Reverse)
HHSA: CMS-21	Eligibility Narrative Checklist
HHSA: CMS-22/ HHSA: CMS 22 (SP)	Reminder Request for Verifications
HHSA: CMS-23/ HHSA: CMS-23 (SP)	Coverage Information
HHSA: CMS-26/ HHSA: CMS-26 (SP)	Decentralized Patient Letter
HHSA: CMS-29	Fraud Referral
HHSA: CMS-3 / HHSA: CMS-30 (SP)	Request For Information
HHSA: CMS-31/ HHSA: CMS-31 (SP)	Repayment Demand Letter
HHSA: CMS-34/ HHSA: CMS-34 (SP)	Informing Letter
HHSA: CMS-38	Income Work Sheet
HHSA: CMS-38H	Hardship Budget Work Sheet
HHSA: CMS-48	Clinic Screening Sheet
HHSA: CMS-59	Fraud Investigation Referral Narrative
HHSA: CMS-60	General Relief Log
HHSA: CMS-69/ HHSA:CMS: 69 (SP)	Health Insurance Questionnaire
HHSA: CMS-71	Urgent Eligibility Request
HHSA: CMS-74	Primary Care Services Transmittal
HHSA: CMS-80	Clinic Statistics

HHSA: CMS-86	Medi-Cal Recovery Project Referral
HHSA: CMS-87	Authorization For Release Of Medical Records
HHSA: CMS-94	Important Information For Veterans
HHSA: CMS-97	IDX Alert Referral
HHSA: CMS-99/ HHSA: CMS-99 (SP)	Credit Check Authorization
HHSA: CMS-100/ HHSA: CMS-100 (SP)	Statement of Facts
HHSA: CMS-106/ HHSA: CMS-106 (SP)	Agreement to Reimburse the County of San Diego
HHSA: CMS-107/ HHSA: CMS-107 (SP)	Image Verification Checklist
HHSA: CMS-108	Share of Cost
HHSA: CMS-111/ HHSA: CMS-111 (SP)	CMS Share of Cost Process Information Sheet
HHSA: CMS-112/ HHSA: CMS-112 (SP)	CMS Questions and Answers
HHSA: CMS-116	Overpayment Payment and Collection Letter
HHSA: CMS-117	Overpayment Collection Letter
HHSA: CMS-119	Referral to BRCTP
HHSA: CMS-120	Health Services Information for Native Americans
HHSA: CMS-122/ HHSA: CMS-122 (SP)	CMS Grant of Lien
HHSA: CMS-123/ HHSA: CMS-123 (SP)	CMS Lien Information
HHSA: CMS-123A	CMS Lien Acknowledgment Statement
HHSA: CMS-127/ HHSA: CMS-127 (SP)	County Medical Services Medical/Dental Need Form
HHSA: CMS-129/ HHSA:CMS: CMS-129 (SP)	Credit Report Discrepancy Notice
MC 176M and MC 176W	SOC Determination (CFBU) includes ABD Spouse or Parent)
MC 176P	Property Reserve Work Sheet
MC 210	Statement of Facts
None	Fair Hearing Decision

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A.13.1

CMS Income Eligibility Criteria

B. Income Over 165% FPL

1. Applicants whose monthly net non-exempt income is over 165% but not more than 350% FPL must complete a CMS Hardship application to determine if they are eligible for CMS with or without a share of cost.

2. Applicants who are being evaluated for a CMS Hardship are required to sign a Reimbursement Agreement (CMS-106) as a condition of CMS Hardship eligibility.

Note: If the CMS applicant fails to complete and sign a Hardship Application or sign the Reimbursement Agreement, the worker will deny the CMS application for failure to provide essential information.

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A.13.3

CMS Hardship For Individuals Over 165% FPL

General

A. If the applicant's net income is over 165% FPL but not over 350% FPL, the worker continues the eligibility process by evaluating for a CMS Hardship as long as the applicant meets all other eligibility requirements.

   1) The worker shall determine whether the applicant's monthly net non-exempt income is at or below 350% FPL.

      a) If the applicant's monthly net non-exempt income is in excess of 350% FPL, deny the case for excess income.

      b) If the applicant's monthly net non-exempt income is 350% FPL or less, the applicant is eligible to apply for a CMS Hardship. The CMS case is to remain in a pending status until the outcome of the CMS Hardship evaluation has been determined.

   2) The worker shall provide to each applicant who has been

determined eligible to apply for a CMS Hardship, a CMS Hardship Packet:

a) CMS Hardship Application (CMS-01)
b) Agreement to Reimburse the County of San Diego (CMS106)

3) The applicant will be given the opportunity to complete and return the completed CMS-01 and CMS-106 during the intake interview to facilitate the CMS Hardship evaluation.

a) If the applicant returns the completed CMS-01 and CMS-106 during the intake interview, the worker shall continue with the CMS Hardship evaluation.

b) If the applicant states they would like additional time to consider the CMS Hardship opportunity, the CMS-01 and/or CMS-106 shall be considered a pending verification(s) and the applicant shall be given 10 calendar days in which to return the competed forms and any supporting documentation. The CMS-01 and/or CMS-106 shall be included on the list of pending verifications provided to the applicant by the worker.

c) If the applicant does not return the CMS-01 and/or CMS-106 within the initial 10 calendar day timeframe, the applicant shall be given an additional 10 calendar days in which to return the competed forms and any supporting documentation. The CMS-01 and/or CMS-106 shall be included on the list of pending verifications provided to the applicant by the worker.

d) If the applicant returns the CMS-01 and CMS-106, but does not return required supporting documentation by the deadline outlined in Article A 13.3.A.3(C) above, the worker shall calculate the hardship budget without giving allowances for any items missing documentation.

(1) Documentation is required for:

(a) Rent

(b) Utilities

(c) Transportation

(d) Taxes

(e) Court ordered support and payments

(f) Payments on previously incurred medical debt

(2) Documentation is not required for:
   (a) Food
   (b) Miscellaneous

4) All eligibility staff are required to evaluate for good cause if the applicant hasn't returned the required documents/verifications by the end of the second 10 day period.

5) All documentation related to CMS Hardship shall be maintained in the case record.

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A.14.0

Mail-in Recertification Process

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3. Mail-in Recertification Packet

HCA staff is responsible for assembling and providing ASO the assembled recertification packet upon request.

The table below lists all of the forms included in the mail-in recertification packet:

Form #	Title
CMS-101A/ CMS-101A(SP)	CMS Recertification Cover Letter
CMS-101/ CMS-101(SP)	CMS Mail-in Recertification Form
CMS-15/ CMS-15(SP)	CMS Rights and Responsibilities of Applicants
CMS-23/ CMS-23(SP)	CMS Coverage Information
CMS-007/ CMS-007(SP)	CMS General Property Limitations
CMS-99/ CMS-99(SP)	CMS Credit Check Authorization
CMS-01/ CMS-01(SP)	CMS Hardship Application
CMS-106/ CMS-106(SP)	CMS Reimbursement Agreement
CMS-107/ CMS-107(SP)	CMS Image Verification Checklist

CMS-112/ CMS-112(SP)	CMS Questions and Answers
HCPA 14-187/ HCPA 14-187(SP)	Authorization for Release of Information
CMS Health Plan NPP-002/ CMS Health Plan NPP-002(SP)	CMS Notice of Privacy Practices
6.5” x 9.5” self-addressed postage-paid return envelope	