Medi-Cal Program Guide Letter #713

November 29, 2010

Subject **ARTICLE A – CHANGE TO THE COUNTY MEDICAL SERVICES (CMS) MEDICAL/DENTAL NEED FORM (CMS-127) REQUIREMENT AND REVISION TO THE APPROVAL NOTICES OF ACTION**

Effective Date Upon receipt

Reference County Policy

Purpose To inform staff of the:

- Updated instructions for the form HHSA: CMS-127 CMS Medical/ Dental Need Form.
- Obsolete form and revision to the approval notices of action (NOAs).

Background

Verification of Medical/Dental Need

CMS is not health insurance and only addresses urgent health issues. The CMS-127 is used to verify the beneficiary's ongoing medical/dental need. The CMS-127 must be submitted to the Administrative Services Organization (ASO) prior to the beneficiary's current CMS certification end date.

Recertification Eligibility Appointment

CMS beneficiaries requesting a recertification of benefits must call the CMS Eligibility Appointment Line by the 10th of the month following the CMS expiration month to request a recertification appointment.

Change

Verification of Medical/Dental Need

The verification of the beneficiary's medical/dental need and/or submission of the CMS-127 to ASO is no longer a requirement for scheduling an eligibility appointment.

Recertification Eligibility Appointment

A CMS beneficiary requesting a recertification of benefits must call the CMS Eligibility Appointment Line before their eligibility is due to expire

to request a recertification appointment.

HHSA: CMS-39A Eligibility Approval NOA (Eng/Span) and HHSA: CMS-39S Share of Cost (SOC) Change NOA (Eng/Span)

The CMS eligibility and share of cost change approval NOAs have been revised to remove the CMS-127 requirement. The revisions to the NOAs also include a change as to when the beneficiary must call the CMS Eligibility Appointment Line to request a recertification appointment (Attachments A, B, C & D).

HHSA: CMS-127 CMS Medical/Dental Need Form (Eng/Span)

This form is no longer required to be given to every CMS beneficiary and is now obsolete (Attachments E & F).

Required Action

The County will no longer provide beneficiaries with the CMS-127.

Forms Impact

The table below shows the revised NOAs and obsolete form affected by this letter.

Number	Title	Change	Attachment
HHSA: CMS-39A (Eng/Span)	Eligibility Approval Notice of Action	Revised	Attachment A & B
HHSA: CMS-39S (Eng/Span)	Share of Cost (SOC) Change	Revised	Attachment C & D
HHSA: CMS-127 (Eng/Span)	CMS Medi-Cal/ Dental Need Form	Obsolete	Attachment E & F

The revised NOAs have been uploaded into Xerox Print Services and are available to be ordered. The obsolete form has been removed from Xerox Print Services.

CMS IT System Impact

The revised NOAs have been uploaded into the CMS IT System and the CMS-127 has been removed from the CMS IT System.

ACCESS Impact

No impact.

Quality Assurance Impact

No impact.

Summary of Changes

The table below shows the changes to Article A of the MPG.

Section	Change
A.2.2 & A.2.8	Removed references to the medical/dental need form.
A.7.2	• Removed references to the medical/ dental need form. • Item renumbered.
A.9.1	Removed form CMS-127 from the forms list.

Manager Approval

Sylvia Melena, Assistant Deputy Director
Self-Sufficiency Programs
Strategic Planning and Operational Support Division

JP

COUNTY MEDICAL SERVICES
NOTICE OF ACTION

Date: _____ Member ID#: _____

CMS Representative: _____

To _____ Phone: _____

_____ Location: _____

_____ Address: _____

_____

_____

The following action has been taken on your application for County Medical Services (CMS):

❒ Your application has been approved from _____through_____ with no Monthly Share of Cost.

❒ Your application for CMS Hardship has been approved. You are eligible to CMS with the Monthly Share of Cost listed below from _____through_____.

Your Monthly Share of Cost is: $_____.

Comments: _____

Your Medical Home/Primary Care Clinic (PCC) is listed on your CMS card. Your primary care provider coordinates your medical care, as appropriate. Except for emergencies, always contact your primary care provider for your care.

Share of Cost is the amount you must pay or be obligated to pay toward the cost of your CMS covered health care services each month. In any month you receive CMS services, you will be billed by the County for your share of cost or the amount of CMS services, whichever is less. You will not be billed for any months in which you did not receive CMS services.

If you are eligible for CMS with a monthly Share of Cost and your spouse is eligible for Medi-Cal with a Share of Cost, the money spent to meet the Medi-Cal spouse's SOC may be applied to reduce the CMS SOC amount using CMS rates, as long as the services are within CMS scope of services. To be eligible for a CMS SOC deduction, you must send the itemized statement for services received by the Medi-Cal spouse, proof of the amount paid towards the Medi-Cal SOC amount and billing statement when sending your CMS SOC payment to the County.

❒ You are potentially linked to disability based Medi-Cal. CMS rules require that you apply for and fully complete the Medi-Cal disability application process for full scope Medi-Cal by applying at the **Family Resource Center** in your area. **You must do this within 10 days from the date of this notice.** Failure to do so may result in future ineligibility to the CMS Program. If you need information on how to apply for Medi-Cal, call ACCESS at (866) 262-9881.

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

To continue your CMS coverage past your certification period you must call the CMS Eligibility Appointment Line (800) 587-8118 before your CMS expiration month to request a recertification appointment.

To report changes in your address, income, or any other circumstance, call 1-888-553-5552.

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

COUNTY MEDICAL SERVICES
NOTICE OF ACTION

You may write to:

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

OR

You may call:

CMS CALENDAR CLERK
(858) 492-2200

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

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

CMS Regulations:

COUNTY MEDICAL SERVICES
AVISO DE ACCION

Fecha:_____ No. de Miembro:_____

Representante de CMS:_____

Para:_____ Teléfono:_____

_____ Ubicación:_____

_____ Domicilio:_____

_____

La siguiente acción se ha tomado sobre su solicitud para elegibilidad al programa County Medical Services (CMS):

❒ Su solicitud ha sido aprobada a partir del _____hasta el _____ sin Parte de Costo Mensual.

❒ Su solicitud para la Circunstancia Extrema del Programa CMS ha sido aprobada. Usted es elegible a CMS con Parte de Costo Mensual anotado abajo a partir del_____hasta el _____.

Su Parte de Costo Mensual es: $ _____.

Comentario: _____

Su Centro Médico/Clínica de Cuidado Primario (PCC) está anotado en su tarjeta de CMS. Su proveedor de cuidado primario coordinará su cuidado médico, como sea apropiado. Siempre llame a su proveedor de cuidado primario para su cuidado, excepto en caso de emergencia.

Parte de Costo es la cantidad que usted debe pagar u obligarse a pagar cada mes hacia el costo de sus servicios médicos que cubre CMS. Cualquier mes que usted reciba servicios médicos del programa CMS, el Condado le cobrará la cantidad de su parte de costo o la cantidad de sus servicios médicos, la cantidad que sea menor. Usted no recibirá un cobro por ningún mes en el cual usted no recibió servicios médicos de CMS.

Si es elegible para CMS con parte de costo y su cónyuge es elegible para Medi-Cal con parte de costo, puede ser que la cantidad que se gastó para satisfacer la Parte de Costo del cónyuge elegible a Medi-Cal se aplique para reducir la Parte de Costo de CMS usando la cantidad del precio que usa CMS, siempre y cuando los servicios médicos recibidos son parte del criterio de cobertura del programa CMS. Para ser elegible a la deducción de Parte de Costo de CMS, debe de enviar el estado detallado de los servicios recibidos por su cónyuge elegible a Medi-Cal, prueba de la cantidad pagada hacia la Parte de Costo de Medi-Cal y el estado de cuenta cuando envíe su pago al Condado.

❒ Es posible que usted sea elegible a beneficios basados de Medi-Cal por incapacidad. Los reglamentos de CMS requieren que usted solicite y complete totalmente el proceso de la solicitud para beneficios completos de Medi-Cal por incapacidad. Esta solicitud de Medi-Cal se debe solicitar en el **Centro Familiar de Recursos** en su área. **Usted debe hacer esto dentro de los siguientes diez (10) días de la fecha de este aviso.** Si no cumple con este requisito, puede resultar en no ser elegible al Programa de CMS en el futuro. Si necesita información acerca de cómo solicitar Medi-Cal, llame a ACCESS (866) 262-9881.

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

Para continuar su cobertura del programa CMS usted debe de llamar a la Línea para Citas de Elegibilidad al (800) 587-8118 antes de que su elegibilidad este programada a terminar para solicitar una cita para renovar el programa CMS.

Para reportar cambios de domicilio, ingresos o cualquier otra circunstancia, llame al 1-888-553-5552.

Si usted no esta de acuerdo con esta acción, usted tiene el derecho de pedir una Revisión de Primer Nivel por un Supervisor. Debe solicitar la revisión dentro de catorce (14) días consecutivos después de la fecha de este aviso

COUNTY MEDICAL SERVICES
AVISO DE ACCION

escribiendo o llamando a:

Puede escribir a:

CMS Program (0557E)
FIRST LEVEL SUPERVISORY REVIEW
P.O. BOX 85222
SAN DIEGO, CA 92186-5222

O

Puede llamar a:

CMS CALENDAR CLERK
(858) 492-2200

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

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

CMS Regulations:

COUNTY MEDICAL SERVICES

NOTICE OF ACTION

Date: _____

To _____

_____

_____

Member ID#: _____

CMS Representative: _____

Phone: _____

Location: _____

Address: _____

_____

_____

The following action has been taken on your application for County Medial Services (CMS):

☐ Your Monthly Share of Cost (SOC) has been reduced to $_____ from ___/___/____ through ___/___/____.

☐ Your Monthly Share of Cost (SOC) has been increased to $_____ from ___/___/____ through ___/___/____.

Here's why: _____

Your Share of Cost was calculated as follows:

Gross Income:	$
Allowable Expenses:	$
CMS Net Income:	$
350% FPL:	$
Excess Income/SOC:	$

Share of Cost is the amount you must pay or be obligated to pay toward the cost of your CMS covered health care services each month. In any month you receive CMS services, you will be billed by the County for your share of cost or the amount of CMS services, whichever is less. You will not be billed for any month in which you did not receive CMS services.

Your Medical Home/Primary Care Clinic (PCC) is listed on your CMS card. Your primary care provider coordinates your medical care, as appropriate. Except for emergencies, always contact your primary care provider for your care.

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

To report changes in your address, income, or any other circumstances, call 1-888-553-5552.

To continue your CMS coverage past your certification period you must call the CMS Eligibility Appointment Line 1-800-587-8118 before your CMS expiration month to request a recertification appointment.

If you disagree with this action, you have the right to request a First Level Supervisory Review. You

COUNTY MEDICAL SERVICES

NOTICE OF ACTION

must do this within fourteen (14) calendar days after the date of this notice in writing or by phone:

You may write to:

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

OR

You may call:

CMS CALENDAR CLERK
(858) 492-2200

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

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

CMS Regulations:

COUNTY MEDICAL SERVICES
AVISO DE ACCION

Fecha: _____

Para: _____

_____

_____

No. de Miembro: _____

Representante de CMS: _____

Teléfono: _____

Ubicación: _____

Domicilio: _____

_____

_____

La siguiente acción se ha tomado sobre su solicitud para elegibilidad al programa County Medical Services (CMS):

❒ Su Parte de Costo mensual se ha reducido a la cantidad de $_____a partir del __/__/____ hasta el __/__/__.

❒ Su Parte de Costo mensual se ha aumentado a la cantidad de $_____a partir del __/__/_____ hasta el ____/__/_____.

La razón es: _____

La manera cómo se calculó su Parte de Costo es la siguiente:

Ingreso Bruto:	$
Gastos Permitidos:	$
Ingreso Neto Para CMS:	$
350% FPL:	$
Exceso de Ingreso/Parte de Costo:	$

Parte de Costo es la cantidad que usted debe pagar u obligarse a pagar cada mes hacia el costo de sus servicios médicos que cubre CMS. Cualquier mes que usted reciba servicios médicos del programa CMS, el Condado le cobrará la cantidad de su parte de costo o la cantidad de sus servicios médicos, la cantidad que sea menor. Usted no recibirá un cobro por ningún mes en el cual usted no recibió servicios médicos de CMS.

Su Centro Médico/Clínica de Cuidado Primario (PCC) está anotado en su tarjeta de CMS. Su proveedor de cuidado primario coordinará su cuidado médico, como sea apropiado. Siempre llame a su proveedor de cuidado primario para su cuidado, excepto en caso de emergencia.

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

Para continuar su cobertura del programa CMS usted debe de llamar a la Línea para Citas

COUNTY MEDICAL SERVICES
AVISO DE ACCION

de Elegibilidad al 1-800-587-8118 antes de que su elegibilidad este programada a terminar para solicitar una cita para renovar el programa CMS.

Para reportar cambios de domicilio, ingresos o cualquier otra circunstancia, llame al 1-888-553-5552.

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

Puede escribir a:

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

O

Puede llamar a:

CMS CALENDAR CLERK
(858) 492-2200

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

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

CMS Regulations:

County Medical Services (CMS) Medical/Dental Need Form
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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

PATIENT INFORMATION

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

CMS provides medical/dental services for serious health problems and is not a health insurance program. Your medical/dental need must meet the CMS scope of service criteria.

AUTHORIZATION TO RELEASE INFORMATION

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

_____ of _____

Name of Provider/Physician — Clinic or Medical Group

This information is required by the County to verify an ongoing medical/dental need for a CMS eligibility appointment. **To continue your CMS coverage past your certification period, you must call the CMS Eligibility Appointment Line 1-800-587-8118 after the completed CMS Medical/Dental Need form is submitted to CMS to schedule a CMS recertification appointment.** I may revoke this authorization in writing at any time, except for information that has already been given to CMS. This information will be kept in the case and will not be disclosed without my signed consent for each disclosure unless the disclosure is specifically required or allowed by law. I have read this form (or had it read to me) after it was completed. I am entitled to a copy of this form, if I request one.

Mail or FAX form to :
CMS Program Customer Service Supervisor
PO Box 939016
San Diego, CA 92193
FAX Number: (858) 495-1399

Patient Signature — Date signed

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

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

Section 2 – Statement of Provider/Physician
(to be completed by a licensed or certified health care professional or a designee authorized as appropriate by the health care professional to complete the form)

The information requested is needed to verify ongoing medical/dental need for a CMS eligibility appointment. The patient's medical/dental need must meet the CMS scope of service criteria. Please answer the following questions.

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

Section 3 – Provider/Physician Certification
(to be completed by a licensed or certified health care professional or a designee authorized as appropriate by the health care professional to complete the form)

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

Print Name and Title — Medical License Number

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

Mailing address, if different

County Medical Services (CMS) Medical/Dental Need Form
(Formulario de Necesidad Médica/Dental del Programa County Medical Services (CMS)
AUTHORIZATION TO RELEASE MEDICAL INFORMATION
AUTORIZACION PARA PROPORCIONAR INFORMACION MÉDICA

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

INFORMACION DEL PACIENTE

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

CMS provee servicios médicos/dentales para problemas serios de salud y no es un seguro médico. Su necesidad médica/dental necesita ser parte del criterio de cobertura del programa CMS.

AUTORIZACION PARA PROPORCIONAR INFORMACION

Por este medio yo autorizo que mi médico/proveedor otorgue información acerca de mis necesidades médicas/dentales a County Medical Services (CMS).

_____ o _____

Nombre del Médico/Proveedor — Clínica ó Grupo Médico

Esta información se requiere para que el Condado verifique la necesidad de mi atención médica/dental para poder hacer una cita de elegibilidad de CMS. **Para continuar su cobertura del programa CMS, usted debe de llamar a la Línea de Citas para Elegibilidad al 1-800-587-8118 después de presentar el formulario de Necesitad Medica/Dental completo al programa CMS para solicitar una cita para renovar el CMS.** Yo puedo revocar esta autorización por escrito en cualquier momento, con excepción de la información que ya se ha dado al programa de CMS. Esta información quedará en mi caso y no será revelada sin mi consentimiento por escrito al menos que la revelación específicamente se requiera o sea admitida por ley. Yo he leído esta forma (o me la han leído) después de haber sido completada. Tengo derecho de una copia de esta forma, si la solicito.

Puede enviar por fax o regresar la forma por correo a:
CMS Program Customer Service Supervisor
PO Box 939016
San Diego, CA 92193
Número de Fax: (858) 495-1399

Firma del Paciente — Fecha

Firma del Testigo a la marca, intérprete, o persona representando al paciente — Fecha

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

Section 2 – Statement of Provider/Physician
(to be completed by a licensed or certified health care professional or a designee authorized as appropriate by the health care professional to complete the form)

The information requested is needed to verify ongoing medical/dental need for a CMS eligibility appointment. The patient's medical/dental need must meet the CMS scope of service criteria. Please answer the following questions.

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

Section 3 – Provider/Physician Certification
(to be completed by a licensed or certified health care professional or a designee authorized as appropriate by the health care professional to complete the form)

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

Print Name and Title — Medical License Number

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

Mailing address if different

A.2.2 Hospital Outstation Services (HOS)

F. Notification

The CMS IT System will generate and mail to the applicant the appropriate Notice of Action when certifying or recertifying CMS eligibility. Exceptions to the automatic mailing are listed in A.8.1.

The CMS IT System will upload to the ASO at the end of the business day notifying the IDX System when CMS eligibility is approved or denied. Hospitals are able to view the status of an applicant's eligibility using the CMS IT Systems Provider Online Verification (POV) site.

Workers must also send form HHSA: CMS-4 to the ASO at 0557B to record in IDX COMMENTS any information that needs an explanation/clarification or changes that impact the applicant's/beneficiary's eligibility, including mandatory referrals to another resource such as, but not limited to unconditionally available income, disability based Medi-Cal or Social Security Disability, etc.

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A.2.8 Left Blank Intentionally

A.7.2 Recertification

A. Non-Chronics

Non-chronics may be recertified for up to six months.

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B. Chronics

Chronics are those beneficiaries who have been identified by the ASO as having a chronic medical condition by entering a "**CHRONIC**" indicator on the IDX Eligibility Enrollment Summary Screen. Before recertifying, the worker **must** look for the "**CHRONIC**" indicator. CMS beneficiaries with the "**CHRONIC**" indicator, who recertify or reapply, may be certified for up to 12 months if they continue meet all eligibility requirements and there are no foreseeable changes in circumstances

that affect eligibility during the certification period as described in A.7.2C.

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C. Exceptions

CMS beneficiaries, both chronic and non-chronic, are to be recertified for up to the allowable period with the following exception:

When a beneficiary must comply with program requirements or has a foreseeable change in circumstances that affects eligibility during the recertification period, the recertification period may be less than the allowable period. When the recertification period is less than the allowable, the worker must state the reason in the comment section of the CMS IT automated NOA that certifies CMS and in the case narrative.

EXAMPLE 1:	A CMS beneficiary with the "CHRONIC" indicator on IDX claims or is identified as having a disabling condition that may potentially link him/her to Medi-Cal. The worker refers the beneficiary to apply for Medi-Cal noting "Referred to MC DDSD" in the case narrative. The worker will certify for up to 3 months. This example also applies to a non-chronic CMS beneficiary.
EXAMPLE 2:	A CMS beneficiary with the "CHRONIC" indicator on IDX will turn 65 years old in nine months. The worker will recertify for eight months and note "Turns 65 month/year" in the comment section of the enrollment form. In this example, if the beneficiary is a non-chronic, the worker will recertify for six months and note "Turns 65 month/year" in the case narrative.

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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: HCPA 14-187/ HCPA 14-187 (SP)	Authorization for Release of Information
HHSA: CMS-15/ HHSA: CMS-15 (SP)	Rights & 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/	Decentralized Patient Letter

HHSA: CMS-26 (SP)	
HHSA: CMS-29	Fraud Referral
HHSA: CMS-30/ 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-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-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