

**Medi-Cal Program Guide (MPG)  
Letter #719**

**Coverage Initiative Program Guide  
(CIPG) Letter #06**

March 29, 2011

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**Subject**            **ARTICLE A – NEW COUNTY MEDICAL SERVICES  
(CMS)/COVERAGE INITIATIVE (CI) DENIAL REASON**

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**Effective Date**    Upon Receipt

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**Reference**        County Policy

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**Purpose**            To inform staff of the following:

- Addition of a new denial reason for CMS/CI decentralized referrals.
- Revision of notice of action (NOA) and obsolete letter.

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**Background**      Hospital Outstation Services (HOS) contracted hospitals may refer inpatients to the on-site HOS worker to apply for Medi-Cal and/or CMS/CI based on the criteria outlined in the HOS Policy and Procedures Manual (PPM).

Decentralization

Decentralization is the process of sending HOS referrals which do not meet the HOS PPM criteria from HOS to the responsible County office for processing. Decentralized HOS referral applications are sent in a pending status to protect the date of application.

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**Change**            A new denial reason has been created for CMS/CI decentralized referrals where the applicant fails to attend their intake appointment with Clinic Outstation Services (COS) staff. The COS worker will deny the application for "Failed to Attend Appointment".

HHSA: CMS-39D (Eng/Span) Eligibility Denial Notice

Notice CMS-39D has been revised to change denial reason "Failed to Attend Recertification Appointment" to "Failed to Attend Appointment" (Attachments A & B).

HHSA: CMS-26 (Eng/Span) Decentralized Patient Letter

Letter CMS-26 (Attachment C & D) has been replaced with the 14-08

HHSA (09/10) (Eng/Span) Decentralization Informing Letter – To Applicant (Attachments E & F) and is now obsolete.

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**COS Worker  
Required  
Action**

**A. The Applicant Attended the Intake Appointment**

**1. CI/CMS only cases:**

- Determine the disposition of CI/CMS benefits, as appropriate.

**2. CI/CMS and Medi-Cal combination cases:**

- Determine the disposition of CI/CMS benefits, as appropriate.
- May approve CI/CMS for up to 3 months, if otherwise eligible.

**B. The Applicant FAILED to Attend the CI/CMS Intake Appointment**

Deny the application for "Failure to Attend Appointment", if good cause is not determined.

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**Forms Impact**

The table below shows the revised notice and letter affected by this letter.

<b>Form #</b>	<b>Title</b>	<b>Action</b>	<b>Attachment</b>
CMS-39D (Eng/Span)	Eligibility Denial Notice of Action	Revised	A & B
CMS-26 (Eng/Span)	Decentralized Patient Letter	Obsolete	C & D

The revised notice has been uploaded into Xerox Print Services and is available to be ordered. The obsolete form has been removed from Xerox Print Services.

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**CMS IT  
System  
Impact**

The revised CMS-39D and form 14-08 HHSA will be uploaded into the CMS IT system.

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**Quality  
Assurance  
Impact**

Effective with the May 2011 review month, Quality Assurance will cite with the appropriate error any case that does not follow the requirements of this letter.

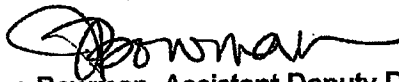
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**Summary of  
Changes**

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

<b>Section</b>	<b>Change</b>
<u>A.1.3</u>	Updated HOS decentralized procedures reference cite.
<u>A.2.3</u>	Added instructions to deny a CMS decentralized referral if the applicant fails to attend the COS Intake interview.
<u>A.9.1</u>	Removed form CMS-26 from the forms list.

**Manager  
Approval**



Janya Bowman, Assistant Deputy Director  
Health Care Policy Administration  
Office of Health Systems Innovation



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

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# COUNTY MEDICAL SERVICES NOTICE OF ACTION

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

Member ID#: \_\_\_\_\_

CMS Representative: \_\_\_\_\_

CMS Representative #: \_\_\_\_\_

To: \_\_\_\_\_

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

Location: \_\_\_\_\_

Address: \_\_\_\_\_

Your application for County Medical Services (CMS) dated \_\_\_/\_\_\_/\_\_\_ is denied for the following reason(s):

- Not a Citizen/Eligible Alien
- Not a County Resident
- Lien Forms Not Completed
- Failed to Attend Appointment
- Recertification Mail-in Packet Not Received Timely
- Coverage Initiative (CI) Linkage
- Your CMS net income is more than 350% of the Federal Poverty Level (FPL)
- Application Withdrawn
- Medi-Cal Linkage
- Whereabouts Unknown
- Failed to Complete Medi-Cal Process
- Credit Report Form Not Completed

Source of Income: \_\_\_\_\_

Gross Income: \$ \_\_\_\_\_

Deductions: \$ \_\_\_\_\_

CMS Net Income: \$ \_\_\_\_\_

Maintenance Need (CMS): \$ \_\_\_\_\_

Excess Income: \$ \_\_\_\_\_

You failed to provide \_\_\_\_\_

SEE IMPORTANT NOTE ON REVERSE



# COUNTY MEDICAL SERVICES NOTICE OF ACTION

Excess Property

Nonexempt Property Items

Net Market Value

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

Total Nonexempt Property	\$ _____
Property Limit	-\$ _____
Excess Property	=\$ _____

To become eligible for CMS, you must spend the amount of your excess property by paying for health care that you received. The health care must be within the CMS scope of services. You may also spend it on current month rent or mortgage and current month utilities excluding cable TV. Talk to the CMS Representative listed above if you want to request this allowance. You must give proof of spending the amount of \_\_\_\_\_ for the month of \_\_\_\_\_ to the CMS Representative listed above within **30 days** of the date of this notice.

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IF YOUR SITUATION CHANGES, YOU MAY REAPPLY FOR CMS AT ANY TIME

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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 of the date of this notice in writing or by phone:

You may write to:	<b>OR</b>	You may call:
CMS Program (O557E)		CMS CALENDAR CLERK
FIRST LEVEL SUPERVISORY REVIEW		(858) 492-2200
P.O. BOX 85222		
SAN DIEGO, CA 92186-5222		

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: \_\_\_\_\_

No. del Representante de CMS: \_\_\_\_\_

Teléfono: \_\_\_\_\_

\_\_\_\_\_

Ubicación: \_\_\_\_\_

\_\_\_\_\_

Domicilio: \_\_\_\_\_

\_\_\_\_\_

Su solicitud para County Medical Services (CMS) con fecha \_\_\_/\_\_\_/\_\_\_ ha sido negada por la(s) siguiente(s) razón(es):

- No es Ciudadano/Extranjero Elegible
- No es Residente del Condado
- Faltó de Completar las Formas de Gravamen
- No Se Presentó a la Entrevista
- El Paquete Para Renovar el Programa CMS No Se Recibió a Tiempo
- Está unido a Coverage Initiative
- Su ingreso neto para el Programa CMS es más de 350% del Nivel de Pobreza Federal (FPL).
- Solicitud Retirada
- Está unido a Medi-Cal
- Se Desconoce Donde Se Encuentra
- No Completó el Proceso del Programa Medi-Cal
- No Completó La Forma del Reporte de Crédito

Fuente de Ingresos: \_\_\_\_\_

Ingreso Bruto: \_\_\_\_\_ \$

Deducciones: \_\_\_\_\_ - \$

Ingreso Neto: \_\_\_\_\_ \$

Necesidad Para Mantenimiento (CMS): \_\_\_\_\_ - \$

Exceso de Ingreso: \_\_\_\_\_ \$

- Falto de proporcionar \_\_\_\_\_

**FAVOR DE VER LA INFORMACION IMPORTANTE AL REVERSO**



# COUNTY MEDICAL SERVICES

## AVISO DE ACCION

Exceso de Propiedad

Artículos de Propiedad no Exentos	Valor Neto de Mercado
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
 Propiedad/recursos no exentos en Total	 \$ _____
Limite de propiedad/recursos	-\$ _____
Propiedad/recursos excedente	=\$ _____

Para poder ser elegible al programa CMS, debe de gastar la cantidad en exceso de su propiedad/ recursos pagando por servicios médicos que haya recibido. Los servicios médicos deben ser parte del criterio de cobertura del programa CMS. También puede gastar la cantidad pagando su renta/ abono de casa o pagando los servicios públicos, excluyendo pago de televisión por cable, para el mes actual. Debe comprobar cómo gastó la cantidad de \$ \_\_\_\_\_ para el mes de \_\_\_\_\_ al Representante de CMS anotado arriba dentro de **30 días** a partir de la fecha de esta notificación.

**SI SU SITUACIÓN CAMBIA, USTED PUEDE VOLVER A SOLICITAR EL CMS EN CUALQUIER MOMENTO.**

Si usted no está 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 de la fecha de éste aviso escribiendo o llamando a:

Puede escribir a: O

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

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**  
**DECENTRALIZED PATIENT LETTER**

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

Si necesita una traducción  
de esto, llame (858) 492-2200

Dear \_\_\_\_\_:

\_\_\_\_\_ referred you to the County Medical Services (CMS) Program to apply for coverage of hospital and physician services.

A CMS application form is enclosed. Please fill in the form before going to the interview scheduled for you. At the bottom of this letter is a list of items you need to bring with you to the interview.

Your interview is on: \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m.

Location: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bring the application form, the items listed below, and this letter and give them to the CMS Representative who will interview you.

If you cannot go to this interview or if you need to reschedule, call (858) 492-2200 and state your case was decentralized. If you are physically unable to go to the interview, tell the person answering the phone.

**If you do not go to your interview and do not reschedule, your application will be denied, and you will be responsible for paying all bills related to your hospital visit. If you are more than 15 minutes late for your interview you will not be seen.**

**Proof of Residence:**

- Rent Receipt/Utility Bills
- Rental Agreement
- Current Mail

**Proof of Identity:**

- Driver's License/ID
- Immigration Papers

**Proof of Property:**

- Bank Statement for \_\_\_\_\_
- Life Insurance Policy(s)
- Other \_\_\_\_\_

**Proof of Income:**

- Pay Stubs (yours/your spouse for \_\_\_\_\_)
- Social Security Income Award Letter/  
Copy of Check
- Unemployment Benefit Printout
- State Disability Printout
- Income Tax Return Form
- Room & Board Statement

**Proof of Insurance:**

- Health Insurance Policy





**COUNTY MEDICAL SERVICES**  
**DECENTRALIZED PATIENT LETTER**

Fecha: \_\_\_\_\_

Estimado/a \_\_\_\_\_:

\_\_\_\_\_ lo refirió al Programa de County Medical Services (CMS) para solicitar cobertura para servicios del hospital y médicos.

Adjunta encontrará una solicitud para CMS. Por favor llene esta forma antes de ir a la entrevista programada para usted. Al final de esta carta encontrará una lista de artículos que necesita traer con usted a la entrevista.

Su entrevista es el: \_\_\_\_\_ a las \_\_\_\_\_ a.m./p.m.

Lugar: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Traiga la solicitud, los artículos mencionados en la lista de abajo, y esta carta, y entréguelos al Representante de CMS que lo entrevistará a usted.

Si usted no puede ir a esta entrevista o si usted necesita cambiar su cita, llame al (858) 492-2200 y diga que su caso fue descentralizado. Si usted físicamente no puede ir a la entrevista, dígaselo a la persona que contesta el teléfono.

**Si usted no va a su entrevista y no hace otra cita, su solicitud será negada y usted será responsable de pagar todos los cobros relacionados a su visita al hospital. Si usted llega más de 15 minutos tarde a la entrevista no será atendido.**

**Prueba De Residencia**

- Recibo De Renta/Cobros De Utilidad
- Contrato De Renta
- Correspondencia Actual

**Prueba De Identidad**

- Licencia De Manejar/Identificación
- Papeles De Inmigración

**Prueba De Propiedad:**

- Estado De Cuenta para \_\_\_\_\_
- Póliza(s) De Seguro De Vida
- Otro \_\_\_\_\_

**Prueba De Ingreso:**

- Talonarios De Cheque (usted/esposo/a) para \_\_\_\_\_
- Carta De Otorgamiento Del Ingreso Del Seguro Social/Copia Del Cheque
- Pago De Beneficio De Desempleo
- Pago De Incapacidad Del Estado
- Forma De Impuestos
- Declaración Sobre Alojamiento

**Prueba De Seguro:**

- Póliza De Seguro De Salud

# COUNTY OF SAN DIEGO

HEALTH & HUMAN SERVICES AGENCY

## DECENTRALIZATION INFORMING LETTER – TO APPLICANT

**DATE:** TODAY'S DATE

**TO:** APPLICANT'S NAME  
STREET ADDRESS  
CITY, STATE AND ZIP CODE

**FROM:** YOUR NAME                      **HOSPITAL:** HOSPITAL REFERRING

**RE:** APPLICATION FOR MEDI-CAL AND/OR COVERAGE INITIATIVE (CI)/  
COUNTY MEDICAL SERVICES (CMS)

Your application for Medi-Cal has been referred to **ENTER FRC'S NAME HERE**. If you do not hear or receive a notice from a Medi-Cal Representative within 15 days from the date of this notice, please call the ACCESS Center at 1-866)-262-9881 or by e-mail [pubassist.HHSA@sdcounty.ca.gov](mailto:pubassist.HHSA@sdcounty.ca.gov). Your Medi-Cal case number is **ENTER MC CASE NUMBER HERE**, make sure you have this number available when calling or e-mailing ACCESS.

You have been scheduled for a CI/CMS intake interview on **ENTER APPOINTMENT DATE & TIME HERE** at **SELECT SITE FROM DROP DOWN MENU**. Bring this letter, the documents listed below, and give them to the County worker who will interview you. The list below is not all inclusive and you may be asked to provide additional information by your worker. You will not be seen if you are more than 15 minutes late for your interview. If you will not be able to attend this interview, please call 1(800) 587-8118 as soon as possible to reschedule.

**Proof of:**

- County Residence
- Identity
- Citizenship/Eligible Alien Status
- Property
- Income

**IMPORTANT**

**If both boxes have been marked above, you are being evaluated for Medi-Cal and CI/CMS. You must comply with both program eligibility requirements.**

14-08 HHSA (03/11)

# COUNTY OF SAN DIEGO

HEALTH & HUMAN SERVICES AGENCY

## CARTA INFORMATIVA DE DECENTRALIZACION – PARA EL APLICANTE

**FECHA: TODAY'S DATE**

**PARA: APPLICANT'S NAME  
STREET ADDRESS  
CITY, STATE AND ZIP CODE**

**REPRESENTANTE: YOUR NAME**

**HOSPITAL: HOSPITAL REFERRING**

**RE: SOLICITUD PARA MEDI-CAL Y/O COVERAGE INITIATIVE (CI)/COUNTY  
MEDICAL SERVICES (CMS)**

Su solicitud para Medi-Cal ha sido referida a la oficina **ENTER FRC'S NAME HERE**. Si usted no recibe una llamada o un aviso de un Representante de Medi-Cal dentro de 15 días de la fecha de esta notificación, favor de comunicarse con el ACCESS Center al 1(866) 262-9881 o por correo electrónico [pubassist.HHSA@sdcounty.ca.gov](mailto:pubassist.HHSA@sdcounty.ca.gov). Su número de caso de Medi-Cal es **ENTER MC CASE NUMBER HERE**, tenga este número disponible cuando llame a o se comunique por correo electrónico con ACCESS.

Usted tiene una cita con CI/CMS para una entrevista programada para el día **ENTER APPOINTMENT DATE & TIME HERE** en **SELECT SITE FROM DROP DOWN MENU**. Traiga esta carta, los documentos anotados abajo, y entréguelos al trabajador de Condado que le entrevistará. La lista de abajo no incluye todo y puede ser que su trabajador(a) le pida que proporcione información adicional. No se le atenderá si llega más de 15 minutos tarde a su entrevista. Si usted no puede asistir a la entrevista, favor de llamar al 1(800) 587-8118 lo más pronto posible para programar otra cita.

### **Prueba de:**

- Residencia del Condado de San Diego
- Identidad
- Ciudadanía/Documentos de Inmigración Elegibles
- Propiedad
- Ingreso

### **IMPORTANTE**

**Si las dos casillas de arriba están marcadas, usted está siendo evaluado para Medi-Cal y para CI/CMS. Usted debe de cumplir con los requisitos de elegibilidad de ambos programas.**

## A.1.3 Access to Eligibility

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### B. Emergency Hospitalization Application Process

Adults admitted through the emergency room can apply while in the hospital if the hospital chooses to refer the patient to the on-sight Hospital Outstationed Services (HOS) worker. The referral may be handled by the HOS worker or decentralized via procedures outlined in the [HOS Policy and Procedures Manual \(PPM\)](#).

[MPG Letter #719 \(03/11\)](#)

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## A.2.3 Primary Care Clinics and Public Health Centers

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### D. Case Processing

#### 1) Case Folder

Workers create an electronic case in the same manner as HOS. Refer to [A.2.2E1a](#) and [A.2.2E1c](#).

#### 2) Denial/Failure to Provide Requirements

CMS follows Medi-Cal rules as outlined in MPG Article [04.13](#).

If required verifications/ information...	Then the worker will...
have not been provided after the initial 10 days have passed as outlined in MPG <a href="#">04.13.02</a> ,	print the CMS automated letter, Reminder Request for Verifications, from the CMS IT System. 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.
information is not returned within the standard ten-ten (10/10) timeline and good cause is not determined,	deny the application for failure to provide.

3) Denial – Excess Income

Workers are to follow the same process as HOS. Refer to [A.2.2.E3](#).

4) Denial – Failure to Attend Appointment

Referrals decentralized from HOS which do not meet the HOS Policy and Procedures Manual (PPM) criteria are scheduled an eligibility appointment with a COS worker. If the applicant fails to show to their scheduled Intake appointment, the worker will deny the application for failure to attend appointment, if good cause is not determined.

5) Coverage Initiative (CI) Eligibility

Refer to [A.2.6](#).

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

Workers at Primary Care Clinics and Public Health Centers...	
1	May certify CMS eligibility for up to three months after directing an applicant/beneficiary to apply for Medi-Cal.
2	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.
3	Shall assist those who need help completing the Statement of Facts (MC 210) and Supplemental Statement of Facts (MC 223), etc.
4	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 in CalWIN with the date the DDSD packet was sent. (See Medi-Cal Linkage in

[A.2.5](#) for more instructions).

MPG LTR #719 (03/11)

## A.9.1 Forms

### Forms

<b>Form Number</b>	<b>Form Title</b>
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-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

MPG Letter #719 (03/11)