Medi-Cal Program Guide Letter #722

May 20, 2011

Subject **ARTICLE A- COUNTY MEDICAL SERVICES (CMS) ELIGIBILITY APPEALS PROCESS, FORM AND NOTICES OF ACTION (NOAs)**

Effective Date Upon receipt.

Reference County Policy, Welfare & Institutions Code (W&IC) § 10950 and Title 45 Code of Federal Regulations § 205.10.

Purpose To inform staff of the:

- Modification to the CMS Eligibility Appeals process;
- New form HHSA: CMS-16SR (Eng/Span) Verification Checklist for Re-evaluations and NOA HHSA: CMS-110R (Eng/Span) Rescind Denial Notice;
- Revision of NOAs; and
- Revision to the listing of forms and NOAs.

Background Any applicant/beneficiary in receipt of Public Assistance is entitled to due process and afforded an opportunity for a fair hearing per W&IC § 10950 and Title 45 Code of Federal Regulations § 205.10. Currently, there are two formal levels for the CMS eligibility appeals process: First Level Supervisory Review and County Administrative Hearing. Both levels currently provide a formal written decision. Applicants/beneficiaries have the option of proceeding directly to the County Administrative Hearing. If an applicant/beneficiary chooses to proceed directly to the County Administrative Hearing, a First Level Supervisory Review does not occur. If the applicant/beneficiary chooses to proceed with the First Level Supervisory Review and they are dissatisfied with the First Level Supervisory Review decision, they have the right to appeal and have their case reviewed by a County Hearing Officer at a County Administrative Hearing. The current process related to First Level Supervisory Review was carried over from when CMS was administered by the former County Department of Health Services (DHS) (Attachment A). The change described in this letter is being made in a continuing effort to improve the CMS program by eliminating duplicate processes.

Change

A Supervisor Review will now be required on all cases prior to going to Appeals for a County Administrative Hearing. Supervisors will continue to attempt to resolve issues and concerns from applicants/beneficiaries before the County Administrative Hearing. The Supervisor Review, however, will no longer provide a formal written decision. Upon receipt of this letter, there will be one formal level in the CMS eligibility appeals process. This process is now modified to more closely align with the appeals process in other Public Assistance programs, and provides 100% Supervisory Review prior to cases going to a County Administrative Hearing. This modification provides the opportunity to resolve erroneous case actions more quickly and efficiently, and expedites a final disposition providing better customer service. The option to appeal the County Hearing Officer's decision in San Diego County Superior Court remains unchanged (Attachment B).

All NOAs that reference First Level Supervisory Review have been modified to reflect this change and advise applicants to request a County Administrative Hearing if they disagree with the County's action.

CMS-16SR (Eng/Span)

This form was created to request any additional required verifications as identified through the Supervisor Review (Attachments E & F).

CMS-110R (Eng/Span)

This NOA was created to inform the applicant/beneficiary that a Supervisory Review regarding the NOA denial of their application for CMS was conducted and as a result of the review:

- the County has rescinded the NOA denial;
- a new NOA will be sent regarding the new eligibility determination; and
- to contact the CMS/GR Calendar Clerk if the applicant/beneficiary chooses to cancel their request for a County Administrative Hearing (Attachments G & H).

Required Action

The table below shows the actions that must be taken for a CMS Appeal.

Step	Who	Action
1	CMS/GR Calendar Clerk	Notifies HCA staff within one (1) work day of the request for a County Administrative Hearing and scheduled hearing date.

<table>
<tr><td>2</td><td>HCA Supervisor</td><td>Conducts a Supervisor Review of the case record within three (3) work days of the CMS/GR Calendar Clerk notification to ensure the worker followed proper program procedures.
<table>
<tr><th>If the HCA supervisor determines there is…</th><th>Then the supervisor narrates in case comments the results of the Supervisor Review and...</th></tr>
<tr><td>no County error,</td><td>the case proceeds to a County Administrative Hearing.</td></tr>
<tr><td>a County error,</td><td>returns the case to the last worker of record to resolve the issue before the County Administrative Hearing.</td></tr>
</table></td></tr>
<tr><td>3</td><td>Worker</td><td>
<table>
<tr><td>1</td><td>Rescinds the previous denial. This will put the case into a “pending” status.</td></tr>
<tr><td>2</td><td>Sends the CMS-110R to the applicant/beneficiary informing them that:
the previous denial NOA has been rescinded;
a new NOA will be sent regarding the new eligibility determination; and
to contact Appeals if they choose to cancel their request for an Administrative Hearing.</td></tr>
<tr><td>3</td><td>Proceeds to Step 4.</td></tr>
</table></td></tr>
<tr><td>4</td><td>Worker</td><td>
<table>
<tr><td>1</td><td>Contacts the applicant/beneficiary to correct the error and/or request in writing any additional required verifications.</td></tr>
<tr><td>2</td><td>Proceeds to Step 5.</td></tr>
</table></td></tr>
<tr><td>5</td><td>Worker</td><td>
<table>
<tr><td>1</td><td>Re-evaluates to determine CMS</td></tr>
</table></td></tr>
</table>

			eligibility.
		2	Issues the CMS-39A if approving the previously denied application or the CMS-39D if re-denying the previous application, as appropriate

CMS IT System

The CMS IT System will allow the worker to rescind, re-evaluate, approve, and re-deny previously denied cases. The worker must review all information/verification received to make the appropriate corrections in the CMS IT System while the case is in a "pending" status.

The new form and NOA, and revised NOAs will be uploaded into the CMS IT System.

Appeals Impact

As stated in this letter.

Forms Impact

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

Forms	Name	Action	Attachment
HHSA: CMS-10 (Eng/Span)	First Level Supervisory Review Decision NOA	Obsolete	C & D
HHSA: CMS-16SR (Eng/Span)	Verification Checklist For Re-evaluations	New	E & F
HHSA: CMS-110R (Eng/Span)	Rescind Denial NOA	New	G & H
HHSA: CMS-31 (Eng/Span)	Repayment Demand Letter NOA	Revised	I & J
HHSA: CMS-34R (Eng/Span)	Rescind Approval NOA	Revised	K & L
HHSA: CMS-39A (Eng/Span)	Eligibility Approval NOA	Revised	M & N
HHSA: CMS-39D (Eng/Span)	Eligibility Denial NOA	Revised	O & P
HHSA: CMS-39P (Eng)	Period of Ineligibility NOA	Revised	Q

HHSA: CMS-39S (Eng/Span)	SOC Change NOA	Revised	R & S

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

QA Impact

Effective with the June 2011 review month, Quality Assurance will cite the appropriate error on any case that does not comply with the requirements outlined in this letter.

Summary of Changes

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

Article	Changes
A.1.5	Removed reference to the First Level Supervisory Review.
A.9.1 & A.9.2	Revision to the listing of forms and NOAs.
A.12.0	Modification of the First Level Supervisory Review and County Administrative Hearing process.

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

JP

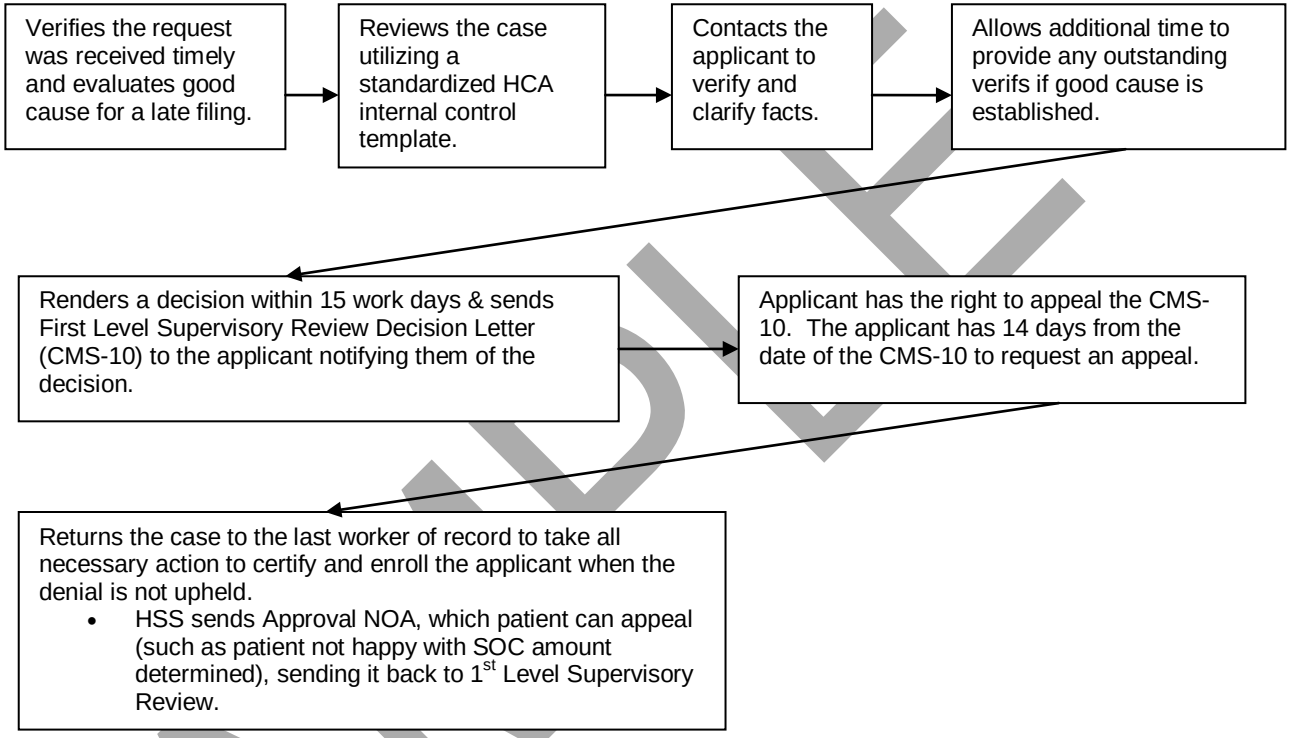
COUNTY MEDICAL SERVICES (CMS) ELIGIBILITY CURRENT APPEALS PROCESS

Current Process

- 1st Level Supervisory Reviews are not required prior to hearing.
- For FTP denials the applicant is given additional time to provide via the 1st Level Supervisory Review process if good cause is established.
- All NOAs state: 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 by writing to or calling (HCA contact info provided).
- If the applicant bypasses the 1st Level Supervisory Review and goes directly to Appeals, then the 1st Level Supervisory Review does not occur, and Appeals hears the case.

HSS	**Initial Eligibility Determination** Gives applicant 10/10 to provide. → Evaluates for Good Cause & extends due date as appropriate. → Determines eligibility (approves/denies as appropriate) utilizing a standardized HCA internal control template.
Applicant	Requests a 1st Level Supervisory Review within 14 days of the NOA's date.
HCA Clerk	Records the request . → Forwards request to the next supervisor on the up-order.

COUNTY MEDICAL SERVICES (CMS) ELIGIBILITY CURRENT APPEALS PROCESS

Supervisor	**First Level Supervisory Review** 
Viewridge	**County Administrative Hearing** Hears the case and renders a decision.

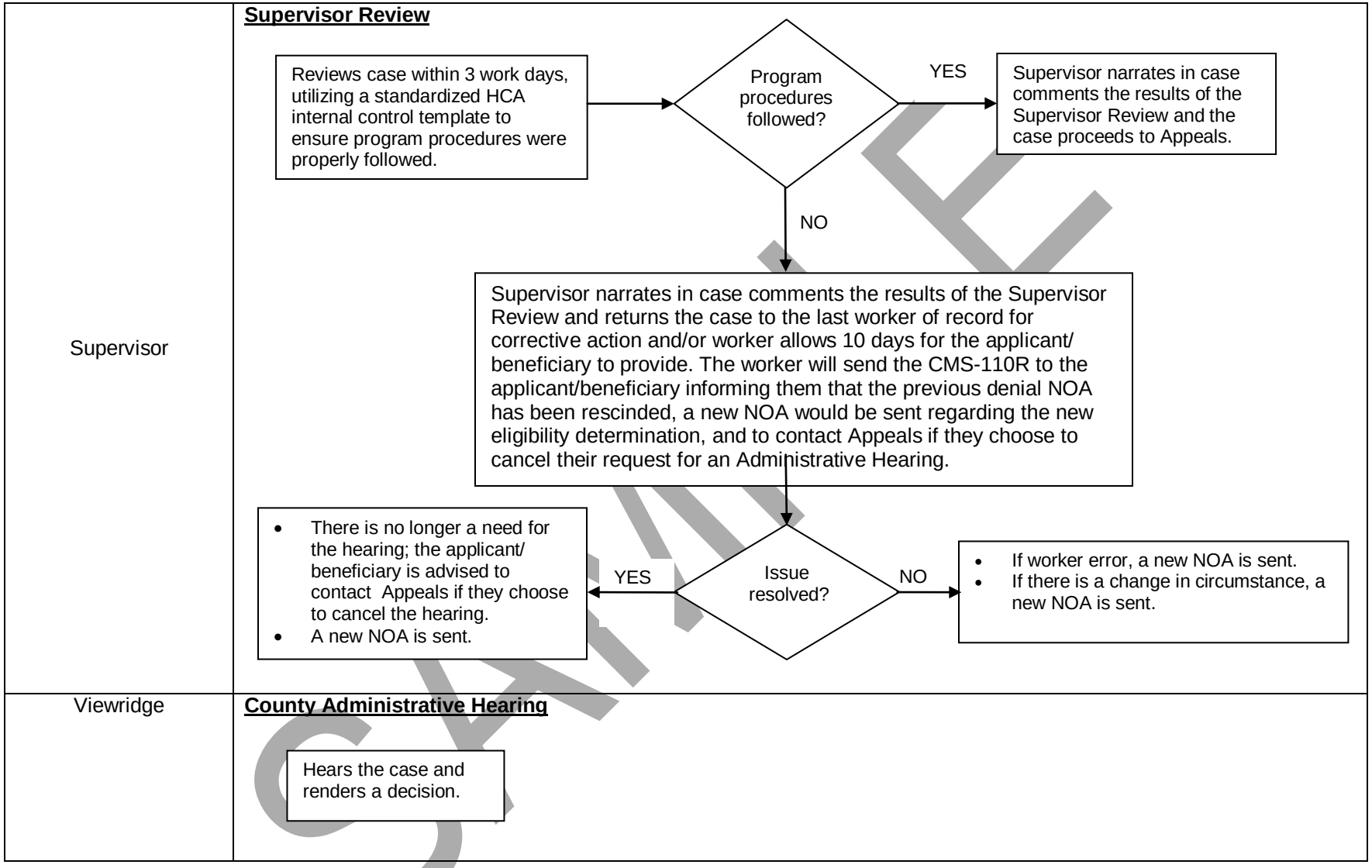
COUNTY MEDICAL SERVICES (CMS) ELIGIBILITY REVISED APPEALS PROCESS

Revised Process

- Supervisor Reviews will be required prior to hearing.
- Purpose of the Supervisor Review: to ensure procedures were followed properly.
- All NOAs will state that if the applicant/beneficiary disagrees with the action they have the right to request an Administrative Hearing. The request for a hearing must be made within 14 calendar days of the NOA's date.

HSS	**Initial Eligibility Determination** Gives applicant 10/10 to provide. → Evaluates for Good Cause & extends due date as appropriate. → Determines eligibility (approves/denies as appropriate) utilizing a standardized HCA internal control template.
Applicant/beneficiary	Requests an Administrative Hearing within 14 days of the NOA's date.
Viewridge Clerk	Notifies HCA of the hearing request within 1 work day of the appeal request.
HCA Staff	Notifies the assigned supervisor of the appeal request within 1 work day of receiving the information from the CMS/GR Calendar Clerk.

COUNTY MEDICAL SERVICES (CMS) ELIGIBILITY REVISED APPEALS PROCESS



COUNTY MEDICAL SERVICES

NOTICE OF ACTION

Date _____

CMS Program
Supervisory Review
P.O. Box 85222
San Diego, CA 92186-5222

Dear:

SSN: _____-_____-_____

On _____ I received your request for a First Level Supervisory Review of your County Medical Services (CMS) application dated _____. After reviewing the case I have decided the following:

☐ The eligibility determination is correct.

☐ The eligibility determination is not correct. Your application will be reevaluated and a Notice of Action will be sent you regarding the new eligibility determination.

☐ Other

This is the reason for my decision :

_____

If you do not agree with this decision you have the right to appeal by requesting an Administrative Hearing conducted by a County Hearing Officer. You must file your appeal within fourteen (14) calendar days after the date of this letter by writing to or calling :

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

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

If you need help filing your request the Consumer Center For Health Education and Advocacy may be able to give you free assistance throughout the appeal of your case. Their toll free telephone number is 1-877-734-3258.

Sincerely,

_____
CMS Supervisor
Telephone: (858) 492-2200

CMS Regulations:

COUNTY MEDICAL SERVICES

AVISO DE ACCION

Fecha _____

CMS Program
Supervisory Review
P.O. Box 85222
San Diego, CA 92186-5222

Estimado: SSN: ____ - ____ - ____

En _____ recibí su petición para que un Supervisor revisara la determinación de elegibilidad de su solicitud para el programa de County Medical Services con fecha de _____. Después de revisar la determinación de elegibilidad, he decidido lo siguiente:

☐ La determinación de elegibilidad es correcta.

☐ La determinación de elegibilidad no es correcta. Su solicitud se reevaluará y se le enviará un Aviso de Acción sobre la nueva determinación de elegibilidad.

☐ Otro

La razón de mi decisión es :

_____

Si usted no está de acuerdo con esta decisión, tiene el derecho de apelar solicitando una Audiencia Administrativa conducida por un Oficial de Audiencia del Condado. Debe solicitar la audiencia dentro de catorce (14) días consecutivos después de la fecha de esta carta, por escrito o llamando:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Las peticiones que se reciban después de 14 días se considerarán solamente si usted presenta una buena causa que le impidió hacerlo a tiempo.

Si necesita ayuda para hacer su petición, el Centro del Consumido para Educación sobre la Salud y Defensa de sus Derechos le puede dar asistencia gratuita durante la apelación de su caso. El número de teléfono sin costo es 1-877-734-3258.

Sinceramente,

_____
Supervisor de CMS
Teléfono: (858) 492-2200

Regula de CMS:

COUNTY MEDICAL SERVICES
VERIFICATION CHECKLIST FOR RE-EVALUATION

Date: _____ Member ID #: _____

Name: _____ CMS Representative: _____

Address: _____ Phone: _____

_____ Facility: _____

Address: _____

_____

You are receiving this Notice because your County Medical Services (CMS) application dated __/__/__ previously denied on __/__/__ is being re-evaluated.

We need additional information to determine your CMS eligibility. If you need help or more time getting the information, call the CMS Representative listed on this notice before the due date listed below.

Please provide the items listed below by ___/___/___, or your CMS application will be re-denied.

If you need help, the Consumer Center for Health Education and Advocacy may be able to give you free assistance throughout the CMS application process. Their toll free telephone number is 1-877-734-3258.

COUNTY MEDICAL SERVICES
LISTA DE VERIFICACION PARA NUEVA EVALUACION

Fecha: _____ No. de Miembro: _____

Nombre: _____ Representante de CMS: _____

Domicilio: _____ Teléfono: _____

_____ Ubicación: _____

Domicilio: _____

_____

Usted recibe este Aviso porque su solicitud para el programa County Medical Services (CMS, por sus siglas en inglés) con fecha ___/___/___ anteriormente negada el día ___/___/___ se ha reexaminado.

Necesitamos información adicional para determinar su elegibilidad al programa CMS. Si necesita ayuda o más tiempo para obtener esta información, llame al Representante de CMS mencionado arriba antes de la fecha anotada abajo.

Favor de proporcionar los siguientes documentos anotados abajo para el día ___/___/___, de lo contrario, su elegibilidad para CMS será negada de nuevo.

Si necesita ayuda, el Centro del Consumidor para la Educación sobre la Salud y Defensa de sus Derechos le puede dar asistencia gratuita durante el proceso de su solicitud para CMS. El número de teléfono sin costo es 1-877-734-3258.

COUNTY MEDICAL SERVICES

NOTICE OF ACTION

Date: _____ Member ID #: _____

CMS Representative: _____

To _____ Phone: _____

_____ Location: _____

_____ Address: _____

_____

_____

A Supervisory Review regarding the denial of the Notice of Action dated ____ for your County Medical Services (CMS) application dated ____ has been conducted. After reviewing the case record, the County has rescinded this Notice of Action. Your CMS application will be re-evaluated and a new Notice of Action will be sent to you regarding the new eligibility determination.

If you have requested an Administrative Hearing and you choose to cancel your hearing, you can contact the Appeals Section-GR/CMS Calendar Clerk at (858) 514-6887 to notify the Appeals Section of the cancellation of the Administrative Hearing.

If you have any questions regarding this notice, please call the CMS Representative listed above.

If you disagree with this action, you have the right to request an Administrative Hearing conducted by a County Hearing Officer. You must file your appeal within fourteen (14) calendar days of the date of this notice by writing to or calling:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Requests submitted after 14 calendar 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:_____

_____

Se ha llevado a cabo una revisión por un Supervisor con respecto al Aviso de Acción con fecha del ____ donde se le descontinuó/negó su solicitud para el programa County Medical Services (CMS, por sus siglas en inglés) con fecha del ____. Después de haber revisado su caso, el Condado ha revocado este Aviso de Acción. Su solicitud será reexaminada y un nuevo Aviso de Acción sobre la nueva determinación de elegibilidad será enviado.

Si ha solicitado una Audiencia Administrativa y desea cancelar su audiencia, usted puede ponerse en contacto con la oficina de peticiones Appeals Section-GR/CMS Calendar Clerk al (858) 514-6887 para notificar a la oficina de peticiones de la cancelación de la Audiencia Administrativa.

Si tiene alguna pregunta sobre esta carta, por favor llame al representante de CMS anotado arriba.

Si usted no está de acuerdo con esta decisión, tiene el derecho de apelar solicitando una Audiencia Administrativa conducida por un Oficial de Audiencia del Condado. Debe solicitar la audiencia dentro de catorce (14) días consecutivos de la fecha de esta carta por escrito o llamando a:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

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

El Centro del Consumidor para la Educación sobre la Salud y Defensa de sus Derechos puede darle información gratuita de cómo llevar acabo su apelación. Para más información, llame al 1-877-734-3258.

CMS Regulations:

COUNTY MEDICAL SERVICES

NOTICE OF ACTION

Date: _____

_____

_____

_____

CMS PROGRAM (MS: 0557E)
P. O. BOX 85222
SAN DIEGO, CA 92186-5222

Dear _____: Member ID # :_____

Based upon information reported to the County Medical Services (CMS) Program you were not eligible to receive coverage for medical services from CMS because: _____

_____

_____.

Attached is a list of the amounts paid to medical providers for medical services you received. The amount that you must pay back to the CMS Program is $_____.

If the reason you were not eligible for CMS is because you had property valued above the CMS limit the amount to be reimbursed is the amount of the excess property or the amount of the CMS benefits received during the period of ineligibility whichever is less.

To discuss a manageable payment schedule, please contact the County at (858) 492-2247 or send check/money order for $_____ made payable to **County Medical Services** to:

County Medical Services (MS: 0557A)
P.O. Box 85524
San Diego, CA 92186-5524

If you disagree with this action, you have the right to request an Administrative Hearing conducted by a County Hearing Officer. You must file your appeal within fourteen (14) calendar days of the date of this notice by writing to or calling:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Requests submitted after 14 calendar 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.

Sincerely,

_____
Human Services Specialist
Telephone:_____
Attachment

CMS Regulations:

COUNTY MEDICAL SERVICES

AVISO DE ACCIÓN

Fecha: _____

_____

_____

_____

CMS PROGRAM (MS: 0557E)
P. O. BOX 85222
SAN DIEGO, CA 92186-5222

Estimado/a _____: No. de Miembro: _____

El Programa County Medical Services (CMS, por sus siglas en inglés) ha recibido información que indica que usted no fue elegible para recibir servicios médicos de CMS porque:_____
_____.

Adjunta a esta carta, encontrará una lista de la cantidad de dinero que fue pagada por CMS por sus servicios médicos. La cantidad que usted tiene que rembolsar al programa de CMS es $_____.

Si usted no fue elegible al programa por razones de "exceso de propiedad", usted debe de pagar la cantidad indicada como "exceso de propiedad" o pagar la cantidad indicada arriba. Pague la cantidad de menos valor.

Para hablar de cómo hacer pagos manejables, por favor de ponerse en contacto con el Condado al (858) 492-2247 o mande su cheque/giro postal por $_____ a nombre de **County Medical Services** a:

County Medical Services (MS: 0557A)
P.O. Box 85524
San Diego, CA 92186-5524

Si usted no está de acuerdo con esta decisión, tiene el derecho de apelar solicitando una Audiencia Administrativa conducida por un Oficial de Audiencia del Condado. Debe solicitar la audiencia dentro de catorce (14) días consecutivos de la fecha de esta carta por escrito o llamando a:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Peticiones recibidas después de 14 días consecutivos 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 más información, llame al 1-877-734-3258.

Sinceramente,

_____
Human Services Specialist
Teléfono:_____
Adjunto

CMS Regulations:

COUNTY MEDICAL SERVICES

NOTICE OF ACTION

Date: _____ Member ID #: _____

CMS Representative: _____

To _____ Phone: _____

_____ Location: _____

_____ Address: PO BOX 85222 (MS: O557E)
SAN DIEGO, CA 92186-5222

We received information on _____ that affects your eligibility to County Medical Services (CMS).

The information that affects your CMS eligibility is described below:

☐ _____

As a result of the information received, you are **not eligible** for CMS and the following action is being taken:

☐ The approval of CMS benefits effective _____ through _____ is rescinded. The CMS notice of action dated _____ has been rescinded. Please return your CMS card to the worker listed above, or to the address listed below. If you continue to use your CMS card after the date shown on the top of this notice, you will be responsible for payment for any services you receive.

☐ Your CMS benefits will end on _____. Please return your CMS card to the worker listed above, or to the address listed below. If you continue to use your CMS card after the date shown on the top of this notice, you will be responsible for payment of any services you receive.

If the information mentioned above has changed, and you have a continued medical need, you may reapply for CMS at any time.

If you have any questions regarding this letter, please call the CMS Representative listed above.

If you disagree with this action, you have the right to request an Administrative Hearing conducted by a County Hearing Officer. You must file your appeal within fourteen (14) calendar days of the date of this notice by writing to or calling:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Requests submitted after 14 calendar 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 regarding this notice. 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: _____

Dirección: PO BOX 85222 (MS: O557E)
SAN DIEGO, CA 92186-5222

Recibimos información el día _____ que afecta su elegibilidad para el programa County Medical Services (CMS, por sus siglas en inglés).

La información que afecta su elegibilidad para CMS se describe a continuación:

☐ _____

Como resultado de la información recibida, usted **no es elegible** para recibir CMS y se tomará la siguiente acción:

☐ La aprobación de beneficios de CMS en efecto del _____ al _____ se ha revocado. El aviso de acción de CMS con fecha de _____ se ha revocado. Por favor regrese su tarjeta de CMS al representante de CMS mencionado arriba, o envíela por correo a la dirección anotada abajo. Si continúa usando su tarjeta CMS después de la fecha que está anotado arriba de este aviso, usted será responsable de pagar cualquier servicio que reciba.

☐ Sus beneficios de CMS terminarán el _____. Por favor regrese su tarjeta de CMS al Representante de CMS mencionado arriba, o envíela por correo a la dirección anotada abajo. Si continúa usando su tarjeta CMS después de la fecha que está anotado arriba de este aviso, usted será responsable de pagar cualquier servicio que reciba.

Si su situación cambia y tiene una necesidad médica continua, usted puede volver a solicitar para el programa CMS en cualquier momento.

Si tiene alguna pregunta sobre este aviso, por favor llame al representante de CMS mencionado arriba.

Si usted no está de acuerdo con esta decisión, tiene el derecho de apelar solicitando una Audiencia Administrativa conducida por un Oficial de Audiencia del Condado. Debe solicitar la audiencia dentro de catorce (14) días consecutivos de la fecha de esta carta por escrito o llamando a:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Las peticiones que se reciban después de 14 días consecutivos serán consideradas solamente si usted presenta una buena causa que le impidió hacerlo a tiempo.

El Centro del Consumidor para la Educación sobre la Salud y Defensa de sus Derechos puede darle consejo gratuito acerca de esta noticia. Para más información, llame al 1-877-734-3258.

CMS Regulations:

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.

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 an Administrative Hearing conducted by a County Hearing Officer. You must file your appeal within fourteen (14) calendar days of the date of this notice by writing to

or calling:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Requests submitted after 14 calendar 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, por sus siglas en inglés):

❒ 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.

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 está de acuerdo con esta decisión, tiene el derecho de apelar solicitando una Audiencia Administrativa conducida por un Oficial de Audiencia del Condado. Debe solicitar la audiencia dentro de catorce (14) días consecutivos de la fecha de esta carta por escrito o llamando a:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Peticiones recibidas después de 14 días consecutivos 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 más información, llame al 1-877-734-3258.

CMS Regulations:

COUNTY MEDICAL SERVICES
NOTICE OF ACTION

Date: _____

To: _____

_____

_____

Member ID#: _____

CMS Representative: _____

CMS Representative #: _____

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
- ☐ Application Withdrawn
- ☐ Medi-Cal Linkage
- ☐ Whereabouts Unknown
- ☐ Failed to Complete Medi-Cal Process
- ☐ Credit Report Form Not Completed
- ☐ Your CMS net income is more than 350% of the Federal Poverty Level (FPL)

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.

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

If you disagree with this action, you have the right to request an Administrative Hearing conducted by a County Hearing Officer. You must file your appeal within fourteen (14) calendar days of the date of this notice by writing to or calling:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Requests submitted after 14 calendar 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: _____

No. del Representante de CMS: _____

Teléfono: _____

Ubicación: _____

Domicilio: _____

Su solicitud para County Medical Services (CMS, por sus siglas en inglés) 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
- ☐ 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
- ☐ Su ingreso neto para el Programa CMS es más de 350% del Nivel de Pobreza Federal (FPL).

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 decisión, tiene el derecho de apelar solicitando una Audiencia Administrativa conducida por un Oficial de Audiencia del Condado. Debe solicitar la audiencia dentro de catorce (14) días consecutivos de la fecha de esta carta por escrito o llamando a:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

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

NOTICE OF ACTION

Date:_____ Member ID#: _____

CMS Representative:_____

To:_____ Phone:_____

_____ Location:_____

_____ Address:_____

_____

___ Your application for County Medical Services (CMS) was denied on _____. You had property and/or resources more than the allowable limit for CMS. The amount of your excess property/resources for the month of _____ computed as follows:

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 on current month rent or mortgage and current month utilities excluding cable TV. You were given the CMS property spend down rules on the HHSA: CMS-007 and HHSA: CMS-39D (copy attached) and you were told to give proof of spending the amount of $ _____ to the CMS Representative by _____. Because you did not give CMS this proof, your application was denied on _____.

You applied again for CMS on _____ with property/resources in the amount of $ _____. You did not spend the excess property by the rules explained to you on the HHSA: CMS-007 and HHSA: CMS-39D. Instead you spent the property on _____. Your action makes you ineligible to CMS for a period computed as follows:

	_____	net market value of property transferred
–	_____	unused portion of property reserve
=	_____	net value of excess property transferred
–	_____	CMS Hardship maintenance need level
=	_____	number of ineligible months

___ You are ineligible beginning _____ and ending _____. You may reapply for CMS after _____.

If you disagree with this action, you have the right to request an Administrative Hearing conducted by a County Hearing Officer. You must do this within fourteen (14) calendar days of the date of this notice by writing to or calling:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Requests submitted after 14 calendar 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

NOTICE OF ACTION

Date: _____ Member ID#: _____

CMS Representative: _____

To _____ 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.

COUNTY MEDICAL SERVICES

NOTICE OF ACTION

If you disagree with this action, you have the right to request an Administrative Hearing conducted by a County Hearing Officer. You must file your appeal within fourteen (14) calendar days of the date of this notice by writing to or calling:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123
PHONE: (858) 514-6887

Requests submitted after 14 calendar 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, por sus siglas en inglés):

❒ Su Parte de Costo mensual se ha reducido a la cantidad de $ _____ 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

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 está de acuerdo con esta decisión, tiene el derecho de apelar solicitando una Audiencia Administrativa conducida por un Oficial de Audiencia del Condado. Debe solicitar la audiencia dentro de catorce (14) días consecutivos de la fecha de esta carta por escrito o llamando a:

SAN DIEGO COUNTY HEALTH AND HUMAN SERVICES AGENCY
APPEALS SECTION-GR/CMS CALENDAR CLERK
4990 VIEWRIDGE AVENUE
SAN DIEGO, CA 92123

Peticiones recibidas después de 14 días consecutivos 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:

A.1.5

Administrative Responsibilities

A. Health Coverage Access (HCA)

This section within HHSA contains a Manager overseeing eligibility staff located at hospitals, public health centers and community clinics. HCA is responsible for:

1. Evaluating eligibility for Medi-Cal and CMS;
2. Ensuring that CMS is the program of last resort;
3. Helping applicants through the eligibility process;
4. Teaching beneficiaries how to receive covered services and how to resolve access to health care problems;
5. Referring applicants and beneficiaries to other resources, e.g., Medi-Cal, State Disability, General Relief, community-based organizations, etc.; and
6. Providing CMS applicants and beneficiaries with other program information that is appropriate to their circumstances at the time eligibility to CMS is established or denied.

MPG LTR #722 (05/11)

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 HHSA	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-7Mares/ HHSA:CMS-7Mares (SP)	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-16SR/	Verification Checklist for

HHSA: CMS-16SR (SP)	Re-evaluations
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/	CMS Questions and Answers

HHSA: CMS-112 (SP)	
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 LTR #722 (05/11)

A.9.2 Notices of Action (NOAs)

A. NOAs

NOA Number	NOA Title
HHSA: CMS-31/ HHSA: CMS-31(SP)	Repayment Demand Letter
HHSA: CMS-34R/ HHSA: CMS-34R(SP)	Rescind Approval Notice
HHSA: CMS-39A/ HHSA: CMS-39A (SP)	Notice Of Action (Approval)
HHSA: CMS-39D/ HHSA: CMS-39D (SP)	Notice of Action (Denial)
HHSA: CMS-39P	Period of Ineligibility
HHSA: CMS-39S/ HHSA: CMS-39S (SP)	Notice of Action (Share of Cost Change)
HHSA: CMS-110R/ HHSA: CMS-110R (SP)	Rescind Denial Notice

MPG LTR#722 (05/11)

A.12.0 CMS Eligibility Appeals Process

General

This section contains procedures for handling requests for an administrative hearing for the CMS Program.

MPG LTR 722 (05/11)

A.12.1 Policy

B. Eligibility Determination

Applicants/beneficiaries have the right to request an administrative hearing.

1. Individuals, who disagree with the eligibility determination of CMS, have the right to appeal the denial by filing a County Administrative Hearing.
2. If dissatisfied with the County Hearing Officer's decision, the applicant/beneficiary may file an appeal with the San Diego County Superior Court.

MPG LTR 722 (05/11)

A.12.2 This Section Intentionally Left Blank

A.12.3 County Administrative Hearings

General

Applicants/beneficiaries who disagree with the CMS eligibility determination have the right to request a County Administrative Hearing.

MPG LTR 722 (05/11)

A. Notifying the Applicant

All CMS Notices of Action (NOAs) inform applicants/beneficiaries that a County Administrative Hearing may be requested in writing or by phone, and contain the telephone number and address of the GR/CMS Calendar Clerk. The deadline for filing the request is described in A.12.5 below. Where the applicant/beneficiary either does not speak English or is unable to effectively communicate in English because it is not his/her native language and his/her native language is a **threshold language**, the Notice of Hearing date is provided in the applicant's/beneficiary's native language. **(Refer to A.1.6.B for definition of threshold language.)**

MPG LTR 722 (05/11)

B. Recording the Request

The GR/CMS Calendar Clerk schedules the hearing date. With the implementation of the CMS IT System, case records are no longer requested and tracked by the GR/CMS Calendar Clerk. The County Hearing Officer will be able to view the case electronically.

MPG LTR 722 (05/11)

C. Reporting the Request

The GR/CMS Calendar Clerk:

1) Notifies HCA via email within one (1) work day of the appeal request.
2) Provides HCA with the applicant's/beneficiary's name, social security number (SSN) or member ID number, address, telephone number, CMS application date and scheduled hearing date.

HCA:

1) Notifies the next Supervisor on the up-order of record of the appeal request within one (1) work day from the date the request was reported by the GR/CMS Calendar Clerk.

D. Conducting the Review

The table below shows the actions that must be taken when conducting a review of a case record.

<table>
<tr><th>Step</th><th>Who</th><th>Action</th></tr>
<tr><td>1</td><td>HCA Supervisor</td><td>Conducts a Supervisor Review of the case record within three (3) work days of the CMS/GR Calendar Clerk notification to ensure the worker followed proper program procedures.
<table>
<tr><th>If the HCA supervisor determines there is…</th><th>Then the Supervisor narrates in case comments the results of the Supervisor Review and…</th></tr>
<tr><td>no County error,</td><td>the case proceeds to a County Administrative Hearing.</td></tr>
<tr><td>a County error,</td><td>returns the case to the last worker of record to resolve the issue before the County Administrative Hearing.</td></tr>
</table></td></tr>
<tr><td>2</td><td>Worker</td><td>
<table>
<tr><td>1</td><td>Rescinds the previous denial. This will put the case into a “pending” status.</td></tr>
<tr><td>2</td><td>Sends the CMS-110R to the applicant/beneficiary informing them that:
the previous denial NOA has been rescinded;
a new NOA will be sent regarding the new eligibility determination; and
to contact Appeals if they choose to cancel their request for an Administrative Hearing.</td></tr>
<tr><td>3</td><td>Proceeds to Step 3.</td></tr>
</table>
</td></tr>
</table>

3		1 Contacts the applicant/ beneficiary to correct the error and/or request in writing any additional required verifications. 2 Proceeds to Step 4.
4		1 Re-evaluates to determine CMS eligibility. 2 Issues the CMS-39A if approving the previously denied application or the CMS-39D if re-denying the previous application, as appropriate

MPG LTR 722 (05/11)

E. Conducting the Hearing

The County Hearing Officer conducts the hearing and within fifteen (15) work days renders a written decision and notifies the applicant/beneficiary. All hearing decisions are emailed to the HCA Manager and CMS Program Manager.

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F. Authorized Representative (AR) at the hearing

Applicants/beneficiaries may designate an AR for hearing purposes. Such designation must be made in writing, and the designation must be signed and dated by the applicant/beneficiary on or after the date of the action or inaction with which the applicant/beneficiary is dissatisfied.

If the applicant/beneficiary wants to designate an AR to accompany and assist with all aspects of the hearing process, the applicant/beneficiary and AR must sign and date the Appointment of Representative form MC 306/MC 306(SP) or any other written statement to that effect at any time during the application process.

If the applicant/beneficiary is or is not present at the hearing and wants to designate an AR to act on their behalf with all aspects of the hearing process, they must sign and date the Authorized Representative form DPA 19/DPA 19(SP) or any other written statement to that effect on or after the date of the action or inaction with which the applicant is dissatisfied. DPA 19/DPA 19 (SP) or any other written statement to that affect will only be recognized through the hearing/appeals process.

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G. Interpreters at the Hearing

A hearing officer will not proceed without an interpreter in cases in which the applicant/beneficiary cannot effectively communicate in English because it is not his/her native language, and his/her native language is a **threshold language**. Where the hearing officer determines that an interpreter is necessary and cannot be obtained, the hearing will be postponed. In order to assist the applicant/beneficiary during the hearing, the County will provide either a bilingual interpreter who has passed the technical portion of the County's bilingual proficiency evaluation, or an interpreter who is certified by the state, federal government or by the California Department of Social Services. In cases where the County provides a bilingual employee to serve as an interpreter or an uncertified interpreter, the hearing officer will:

1) Examine the qualifications and competency of the interpreter;
2) Disqualify any interpreter determined by the hearing officer not to be competent for interpretation purposes;
3) Assure objective interpretation by, at his/her discretion, disqualifying interpreters who are:
    a) the applicant's/beneficiary's relatives, friends, or an authorized representative;

b) County staff who participated in making the decision complained of;
c) the County Hearing Officer; or
d) any other individual determined by the hearing officer to be detrimental to the hearing process or having a bias or the appearance of being biased.

The hearing officer administers the following oath to the interpreter:

"Do you solemnly swear to interpret from [identify language] to English and English to [identify language] without adding to or detracting from the testimony given and further swear to respect the confidentiality of matters presented in these proceedings?"

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If the person's foreign language qualifications have not been previously examined, the hearing officer will qualify the interpreter in the manner prescribed below.

1) In what language (and/or dialect, if applicable) do you claim to be qualified to serve as interpreter?
2) Can you read and write in both that language and in English?
3) How did you acquire your proficiency in:
   a. _____ English
   b. _____ (language and dialect)?
4) Have you had any experience interpreting for people in formal or informal proceedings?
5) Have you previously acted as a(n) _____ (language) interpreter for state hearings with the Department of Social Services, hearings with the County, state or federal government, other administrative hearings, or in court proceedings? If so, how many proceedings and in what kind? Did the hearing officer or judge ever disqualify you from serving?
6) Do you have any interest in the outcome of this hearing?
7) Do you understand that it is your responsibility to interpret literally, adding or subtracting nothing? Do you understand that you must inform the hearing officer if you are unable to understand the words used, or keep up with the speed at which the individuals are speaking?

A.12.4 Monitoring Compliance

General

HCA keeps a copy and a log of all Administrative Hearing decisions received in order to monitor decision deadlines and compliance. CMS eligibility staff completes all required actions within thirty (30) calendar days from the decision date and sends a copy of the NOA notating “Appeals Compliance” at thetop of the form to the HCA designated staff at O557E.

A. HCA updates the log with the information received.

B. If there are extenuating circumstances which keep the worker from meeting the deadline imposed per a County Administrative Hearing decision, the worker must notify their Supervisor who, in turn, notifies the HCA designated staff in writing, stating the reason for the delay and the date action is expected to be taken. The HCA designated staff records the extension and reason on the appropriate compliance log. The worker records verification of the extension in the case comments.

C. The HCA designated staff will notify the Supervisor of any hearing decisions that have not met the compliance deadline. The Supervisor takes action necessary to be sure the worker is able to comply with the decision.

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A.12.5 Filing Deadline

General

The applicant’s/beneficiary’s request for a County Administrative Hearing must be received within fourteen (14) calendar days from the date of the denial NOA.

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A.12.6 Good Cause for Late Filing

General

The County Hearing Officer will evaluate Good Cause when the applicant/beneficiary requests a County Administrative Hearing after the filing deadline. If Good Cause exists for late filing, then a County Administrative Hearing is conducted. If Good Cause does not exist, the hearing is conducted but a decision is rendered only on the matter of no jurisdiction due date filing and no good cause and the applicant/beneficiary is informed in the decision of his/her appeal rights in Superior Court. The final decision of the good cause evaluation must be recorded in the case comments.

Good Cause shall include:

A. An evaluation of relevant circumstances including the applicant's/beneficiary's physical, mental, educational, literacy or linguistic limitations;

B. Adequate notice not provided. Adequate notice is defined as a written notice informing the applicant/beneficiary of the action the County intends to take, the reason for the intended action, the specific regulations supporting the action, and an explanation of the applicant's/beneficiary's right to request a County Administrative Hearing;

C. Verification that sufficient time to respond was not possible because the notice was delayed or returned to the County as undeliverable, therefore, not received by the complainant; and/or

D. In addition to the above, examples of Good Cause include, but are not limited to, a bonafide good faith effort in complying with the appeal procedures.