Medi-Cal Program Guide (MPG) Letter # 736

November 11, 2011

Subject **UPDATES TO THE MEDI-CAL ANNUAL REDETERMINATION PROCESS**

Effective Date Upon receipt

Reference ACWDL 11-23

Purpose

To provide:

- clarification to the annual redetermination requirements and procedures detailed in MPG Article 4 Section 15.
- A new Medi-Cal form, MC 14-111 that may be used as an informational letter to beneficiaries who submit their RV form within 30 days of discontinuance date.

Background

MPG Article 4 Section 15 provides staff with information and instructions on the Medi-Cal annual redetermination requirements. MPG Article 4 Section 7 details procedures for requesting additional information and/or verifications at annual redetermination.

Clarification Highlights

The following table highlights updates to the Medi-Cal annual redetermination process:

Topic	Summary of Updates
Adding a person	Forms that are required to add a person at annual redetermination.
DDSD-SP disability based application	Annual redetermination requirements when the DDSD-SP decision is received in the month prior to the RV month or later.
Performance Standards	The 60-day processing timeframe starts from the last day of the RV month.
RV form received within 30 days of discontinuance date	When a beneficiary submits an incomplete RV form within 30 days of the discontinuance date and additional information/verifications are needed, the worker must request for the missing items. The beneficiary will remain in

	discontinued status until the requested information/verifications are received and the worker determines that continued eligibility exists. The MC 14-111 form may be used as an informational letter to beneficiaries who submit their RV form within 30 days of discontinuance date.
RV mail month	RV packet must be mailed to the beneficiary no earlier than the 10th month and no later than the 11th month from the RV month.
RV month	Events that will trigger or not trigger a change to the annual redetermination month.
RV packet	Updated listing for forms that must be included in the RV packet.

Automation Impact

No impact.

ACCESS Impact

No impact.

Forms Impact

MC 14-111 is available in CalWIN. The letter may be used as an informational letter to beneficiaries who submit their RV form within 30 days of discontinuance date.

Imaging Impact

No impact.

Quality Assurance Impact

Effective with August 2011 sample month, Quality Assurance will cite with the appropriate error any case that does not follow the requirements of this LTR.

Summary of Change

Article	Description of Change
Article 5, Section 4	• Refer staff to MPG Article 4 Section 15 for annual redetermination policy on DDSD-SP cases.
Article 4, Section 7	• Refer staff to MPG Article 4 Section 15 when requesting additional

	information/verifications at annual redetermination.
Article 4, Section 15	• Updates to the Medi-Cal annual redetermination policy and procedures. • Incorporate procedures for requesting additional information/verifications at annual redetermination previously located in Article 4 Section 7.
Article 20, Section 1	Clarifies that the 60 days processing timeframe starts with the last day of the RV month.

Manager Approval

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

KT

COUNTY OF SAN DIEGO

INFORMATIONAL LETTER

Date

Case Name

Case Number

This letter is to inform you that the County is not able to process your Medi-Cal annual redetermination because of the following reason(s):

_____
_____
_____

You are not eligible for Medi-Cal if you received a Notice of Action informing you that your Medi-Cal benefits have been discontinued.

If you have any questions regarding this letter, please contact our ACCESS Customer Service Center at 1-800-262-9881.

Article 4, Section 15 – Annual Redetermination

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4.15.1 Overview of Requirements

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A. Frequency

All Medi-Cal beneficiaries must have their eligibility for Medi-Cal redetermined every 12 months. It is the worker's responsibility to complete the annual redetermination within 12 months of the approval of eligibility on any application, reapplication or restoration, which required a SOF or within 12 months of the last annual redetermination. ACWDL 06-16 11-23

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B. Process

All annual redeterminations are completed by mail, except when the:

- beneficiary requests for a face-to-face interview; or
- worker determines good cause exists to require a face-to-face interview upon receipt and review of the annual redetermination form.

Examples of good cause include, but are not limited to:

- questionable information on the redetermination form or verification(s) provided;
- individual/family has no visible means of support such as in-kind income or means of support is not reported for the individual;
- obvious discrepancies between information reported on the redetermination form and assets or income on IEVS; or
- a self-employed individual whose income and expenses do not match reported income and that questionable information could not be resolved with follow-up telephone contact and/or mail.

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C. SOF

As part of the annual redetermination process, the beneficiary or person acting on behalf of an incompetent beneficiary is required to complete a new SOF. Acceptable SOFs for the annual

redetermination process are listed in MPG 4.15.3a.

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D. Information to be Verified

The following information must be verified at annual redetermination.

- Incapacity
- Legal responsibility for a child applying alone
- Refusal of the parent to apply for an 18-21 year old child
- Income, except income received from the United States Government or when the current benefit amount has been previously verified
- Status and value of non-exempt property
- Immigration status, except for beneficiaries receiving restricted benefits.

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E. SSN

It is not necessary to re-verify the SSN at annual redetermination. However, if during the annual redetermination process, the worker discovers that the SSN of a beneficiary has not been previously verified, inform the beneficiary that he/she has 60 days to provide acceptable verification of the SSN or evidence of application for the SSN. Refer to Article 4, Section 11 for SSN referral/verification.

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F. Citizenship and Identity

When a beneficiary reports a change in their citizenship status at annual redetermination, the redetermination shall be certified as complete with no reduction in benefits if the only outstanding verifications are for citizenship and/or identity and the beneficiary is otherwise eligible and is making a good faith effort to provide the required citizenship and/or identity documents.

Refer to MPG 4.7.9 for instructions on requesting citizenship and/or identity documents.

MPG LTR 631 (5/08)

4.15.2 RV Month

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A. Setting RV Month

The annual redetermination is a full eligibility review that is conducted once every 12 months. The annual redetermination month, herein shall be referred to as the RV month, is generally set 12 months from the first day of the application month. However, if the applicant is not Medi-Cal eligible in the month of application, then the RV month is set 12 months from the approval month. The approval month is the first month in which the applicant meets all eligibility criteria.

Regardless of whether the applicant is granted Retro-Medi-Cal, the table below illustrates when annual redeterminations are due:

IF the applicant is ...	**Then the RV month is set…**
eligible in the application month,	12 months from application month. Example: Application month: 5/10 RV month: 4/11
eligible in the month following the application month,	12 months from the month in which the applicant is eligible. Example: Application month: 3/10 Eligible month: 4/10 RV month: 03/11

When MFBU members have different initial eligibility months, the MFBU members who were determined eligible first shall set the RV month for all MFBU members. Refer to Appendix A for additional

examples of when annual redeterminations are due.

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B. DDSD-SP Applicants

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During the application process, if the applicant alleges a disability, but no other Medi-Cal linkage exists, the worker shall forward the disability packet to the DDSD-SP for a disability evaluation. Upon receipt of the disability determination confirming the applicant's disability, the worker completes the eligibility process.

The worker must complete the annual redetermination as follows:

IF a disability-approved decision is received from DDSD-SP…	**THEN the worker must complete the annual redetermination…**
within 90 days of the application date,	12 months from the month in which the applicant is eligible for Medi-Cal. See example #5 of Appendix A.
after 90 days but prior to the last day of the 11th month,	12 months from the month in which the applicant is eligible for Medi-Cal. See example #6 of Appendix A.
after 11th month,	12 months from the date that the county determined the applicant is eligible for Medi-Cal. See example #7 of Appendix A.

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C. Categorically Eligibles

Parents receiving Medi-Cal only benefits in their children's CalWORKs case shall not be required to complete a separate Medi-Cal only annual redetermination as long as they cooperate with all CalWORKs requirements for reporting changes and completing the CalWORKs annual renewal.

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D. CalWORKs Approved

When a family has Medi-Cal only and later applies and is approved for CalWORKs, the annual redetermination shall be set 12 months from the CalWORKs application month. If there are family members that remain Medi-Cal only, the next annual redetermination will also be set 12 months from the CalWORKs application month.

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E. CalWORKs Discontinued for No Renewals

When a family is discontinued from CalWORKs for failure to complete the CalWORKs annual renewal, the family is placed on Aid Code 38 pending a Medi-Cal only determination. The RV month for the Medi-Cal only case is set 12 months after the month in which the worker completed the Medi-Cal only redetermination.

Example:
CalWORKs discontinued for no renewal: 10/03
Worker completed the Medi-Cal only determination: 12/03
Next Annual Redetermination is due: 12/04

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F. Deemed Eligible Infants

The RV month for infants who are receiving benefits during the continuous eligibility period (also known as deemed eligibility (DE)) is set as follows:

IF other MFBU members are...	**THEN the RV month of the DE infant is...**
receiving Medi-Cal,	the same as that of the other MFBU members.
discontinued from Medi-Cal for failure to complete the annual redetermination,	reset to the month of the infant's first birthday.

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G. Transitional Medi-Cal

Beneficiaries receiving Medi-Cal under TMC are not required to complete an annual redetermination while they are receiving TMC benefits. At the end of their TMC period, the worker shall re-evaluate beneficiaries' eligibility under another Medi-Cal program. The RV month is set as follows:

IF ...	**THEN the worker must….**
all MFBU members are receiving TMC and their annual redetermination is due **before** their TMC period expires,	set the RV month to the last month of the TMC period. Example: Original RV month: 07/11 TMC expires: 10/11 New RV month: 10/11

all MFBU members are receiving TMC and their annual redetermination is due **after** their TMC period expires,	maintain the original RV month.
all MFBU members are receiving TMC with different TMC expiration dates,	set the RV month to the last month of the TMC period that will end first. This RV month shall apply to all other MFBU members. A the end of the other MFBU member's TMC period, the worker must redetermine that individual's Medi-Cal benefits using information available in the existing case.
some MFBU members are receiving TMC and others are not,	maintain the RV month of the other non-TMC MFBU members. This RV month shall apply to all other MFBU members.

Reminder: The worker is required to complete a redetermination of eligibility under other Medi-Cal programs by the last month of the TMC period.

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H. Actions that Do Not Change RV Month

Once the RV month is established, the following events will not change the RV month.

- When adding a person to an ongoing Medi-Cal case
- Beneficiary submits the RV packet within 30 days after Medi-Cal has been terminated AND is found eligible
- Beneficiary submits the RV packet more than 30 days after discontinuance date but good cause exists AND benefits are restored without a break in aid
- Worker completes and processes the RV packet early (in the month(s) prior to the RV month). For example, worker mailed the RV packet in the 10th month and it was completed and returned promptly
- A person who has Medi-Cal and later applies for, but is denied CalWORKs

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4.15.3 Required Forms

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TITLE
A. Acceptable RV Forms
B. Annual Redetermination Packet
C. Mailing Date
D. Due Date

A. Acceptable RV Forms

Workers shall accept any of the following annual redetermination forms, herein to be referred to as RV form, as the SOF for the annual redetermination process.

Form Number	When Used
MC 210 RV	Used for all redeterminations not listed below. Refer to Appendix B & C for details on information collected on the MC 210 RV form and actions that must be taken based on reported information.
MC 262	Used for beneficiaries residing in a LTC facility
MC 321 HFP	Used for those families where the only beneficiaries are children receiving benefits under one of the FPL or Property Disregard programs
MC 250 A	Used for beneficiaries receiving Medi-Cal under Former Foster Care Children (FFCC) Program.
SAWS 2	Accepted as a substitute for any of the above annual redetermination forms.

The Food Stamp Statement of Fact (DFA-A2) is **cannot** be used as a substitute for any of the above forms.

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B. Annual Redetermin-ation Packet

The table below identifies forms that must be included in the Medi-Cal annual redetermination Packet

Form #	Title
MC 210 RV Notice	Medi-Cal Annual Redetermination Notice (also referred to as Annual Redetermination Cover Letter)
MC 210 RV	Medi-Cal Annual Redetermination Form Note: Staff may substitute the MC 210 RV with any of the above acceptable RV forms based on the specifics of a case. (e.g. MC 262 for LTC cases)
MC 219	Important Information for Person Requesting Medi-

	Cal
MC 210 PS	Medi-Cal Property Supplemental Form Note: Form must be completed and returned if beneficiary answers "yes" to Section 5(b) or 5(c).
16-64	Voter Registration Form
Pub 183/184	CHDP Brochure
MC 003	Medi-Cal Information Notice EPSDT
Pub 13	Your Rights Under California Welfare Programs
MC 372	Breast and Cervical Cancer Treatment Program Flyer
MC 4034, GEN 1365	Multilingual Notification regarding Translation Services
Envelope	Postage Paid Envelope
Flyer*	CalFresh Flyer for Medi-Cal (for non-LTC cases)
HHSA HSD 7*	Managed Care Information
20-44 HHSA*	Civil Rights Information

* County Required Forms

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C.
Mailing Date

The first step in the annual redetermination process is to mail the Medi-Cal Annual Redetermination Notice and annual redetermination packet to the beneficiary. The notice and packet must be mailed to the beneficiary:

- No earlier than the 1st day of the 10th month; AND
- No later than the last day of the 11th month

Example:
Annual Redetermination is Due: May 2011
Earliest Mailing Date: March 1, 2011
Latest Mailing Date: April 30, 2011

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D.
Due Date

The worker must allow the beneficiary, at least 20 days from the date that the annual redetermination packet is mailed to complete and submit their annual redetermination form. When the 20th day falls on a Saturday, Sunday, or holiday, the due date shall be extended to the following business day.

The annual redetermination form is considered "timely" as long as the County receives the form from the beneficiary by the last day of the RV month.

4.15.4 RV Returned Timely

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A. General

When the beneficiary returns the RV form timely (by the last day of the RV month), the worker must review the returned RV form for completeness.

The worker must determine if:

- the RV form was signed by the beneficiary; AND
- additional information and/or verifications are needed to complete an accurate Medi-Cal eligibility determination.

Medi-Cal beneficiaries shall continue to receive their Medi-Cal benefits while the worker completes the review and waits for any additional information/verifications or forms that are needed.

Additionally, if the beneficiary returns an incomplete RV form after NOA cutoff but prior to the effective date of the discontinuance, the worker must rescind the failure to complete the annual redetermination discontinuance. The worker must notify the beneficiary that benefits are restored and continue to process the RV form using the procedures specified below.

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B. Unsigned RV Form

When the beneficiary returns the RV form unsigned AND the worker does not need additional information, then the worker will:

STEP	ACTION
1	Mail the unsigned RV form back to the beneficiary and instruct him to sign and return the form within 10 calendar days.
2	

IF beneficiary…	THEN the worker will…
returns RV form signed,	process the annual redetermination specified in MPG 4.15.4c.
fails to return the	discontinue benefits and send timely NOA

	RV form signed,	for failure to cooperate.	

Refer to MPG 4.15.4d when the RV form is unsigned AND additional information/verifications are also needed.

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C. Additional Information Not Needed

When additional information/verifications are not needed, the worker will process the annual redetermination as follows:

IF…	THEN the worker will…
there is no change reported by the beneficiary and on-going eligibility exists,	• certify the beneficiary for a new 12-month period based on the **original** RV month. • check MEDS after the redetermination is complete to be sure that the most recent annual redetermination information was transmitted to MEDS.
reported changes result in beneficiaries moving from zero SOC to SOC Medi-Cal or increased in SOC,	• apply the new or increased SOC to the 1st of the month in which timely notice can be given • provide the beneficiary with a NOA about restoration and the change to SOC • evaluate for Bridging when there is a child going from 0 SOC to SOC and refer to HF if consent was given • check MEDS after the redetermination is complete to be sure that the most recent annual redetermination information was transmitted to MEDS.
Medi-Cal eligibility does not exist,	• send 10-day NOA to discontinue Medi-Cal benefits Discontinuance shall be effective the end of the month in which 10-day NOA requirement is met.

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D. Additional Information Needed

When the beneficiary returns the RV form timely and additional information/verifications are needed, the worker will:

Step 1	Action
1	Conduct *ex parte* review for the needed information/verifications.

IF information/verifications…	THEN the worker will…
were obtained using the *ex*	process the annual

	parte review,	redetermination specified in MPG 4.15.4c.
	are still needed,	Go to Step 2

2 Contact the beneficiary by phone for the missing information/verifications.

IF …	THEN the worker will…
able to obtain the missing info./verifs from beneficiary,	process the annual redetermination as specified above, MPG 4.15.4c.
unable to reach the beneficiary by phone,	go to Step 3.
additional info./verifs are still needed,	

3 Mail the MC 355 to beneficiary to request for the information/verifications. Allow beneficiary 20 days to provide the requested item(s).

4 On the 21st day, determine if beneficiary has provided the requested items.

IF…	THEN the worker will…
all items were provided,	process the annual redetermination as specified above, MPG 4.15.4c.
beneficiary did not respond to request,	• send 10-day NOA to discontinue Medi-Cal benefits for failure to provide. • discontinuance shall be effective the end of the month in which 10-day NOA requirement is met.
partial items were provided,	• mail a 2nd MC 355 to the beneficiary to request for the remaining missing item(s). • allow the beneficiary 10 days to provide the requested item(s). • go to Step 5.

5 Determine if beneficiary responds to 2nd MC 355.

IF …	THEN the worker will…
yes,	process the annual redetermination as specified above, MPG 4.15.4c.
no,	• send 10-day NOA to discontinue Medi-Cal benefits for failure to provide. Discontinuance shall be effective the end of the month in which 10-day NOA requirement is met.

4.15.5 RV Returned Within 30 Days After Discontinuance Date

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A. General

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When the RV form is returned within 30 days after discontinuance date, the worker shall NOT immediately rescind the discontinuance. The worker must determine if the beneficiary is still eligible to Medi-Cal before a rescission is done.

When the beneficiary returns the RV form within 30 days after the discontinuance date, the worker must review the returned RV form for completeness. The worker must determine if:

- the RV form was signed by the beneficiary; AND
- additional information and/or verifications are needed to complete an accurate Medi-Cal eligibility determination.

The worker will follow the procedures outlined below. MC 14-111 may be used as an informational letter to beneficiaries who submit their RV form within 30 days after discontinuance date.

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B. Unsigned RV Form

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When the beneficiary returns the RV form unsigned within 30 days after the discontinuance date AND the worker does not need additional information, then the worker will:

STEP	ACTION
1	Mail the unsigned RV form back to the beneficiary and instruct him to sign and return the form within 10 days. Reminder: The beneficiary's Medi-Cal benefits shall remain discontinued until the worker receives the signed RV form and continued Medi-Cal eligibility is established.
2	<table><tr><th>IF beneficiary…</th><th>THEN the worker will…</th></tr><tr><td>returns RV form</td><td>process the annual redetermination</td></tr></table>

	signed,	specified in MPG 4.15.5c.
	fails to return the RV form signed,	• do not send a 2nd discontinuance NOA. Previous discontinuance NOA stands. • Contact the beneficiary by phone and inform him/her of the following: - the RV form was received unsigned; AND - the previous discontinuance is still valid. If unable to reach the beneficiary by phone, complete MC 14-111 with the above information and mail to beneficiary.
		•

Refer to MPG 4.15.5d when the RV form is unsigned AND additional information/verifications are also needed.

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C. Additional Information Not Needed

When additional information/verifications are not needed, the worker will process the annual redetermination as follows:

IF…	THEN…
there is no change reported by the beneficiary and on-going eligibility exists,	• rescind discontinuance with no break in benefit. • certify the beneficiary for a new 12-month period based on the original RV month.
reported changes result in beneficiaries moving from zero SOC to SOC Medi-Cal or increased in SOC,	• restore the beneficiary's Medi-Cal benefits at the same level prior to the discontinuance. • apply the new or increased SOC to the 1st of the month in which timely notice can be given. • provide the beneficiary with a NOA about restoration and the change to SOC. • evaluate for Bridging when there is a child going from 0 SOC to SOC and refer to HF if consent was given.
Medi-Cal eligibility does not exist	• do not send a 2nd discontinuance NOA. Previous discontinuance NOA stands. • Contact the beneficiary by phone and inform him/her of the following: - the RV form was received and reviewed; - the beneficiary is not eligible to Medi-Cal; AND - the previous discontinuance is still

	valid. If unable to reach the beneficiary by phone, complete MC 14-111 with the above information and mail to beneficiary.

D. Additional Information Needed

The worker will NOT restore Medi-Cal benefits until the worker is able to determine that continued eligibility exists. Hence, when the beneficiary returns the RV form within 30 days after the discontinuance date and additional information/verifications are needed, the worker will:

<table>
<tr><th>Step 1</th><th>Action</th></tr>
<tr><td>1</td><td>Conduct an ex parte review for the needed information/verifications.

<table>
<tr><th>IF information/verifications…</th><th>THEN the worker will…</th></tr>
<tr><td>were obtained using the ex parte review,</td><td>process the annual redetermination as specified above, MPG 4.15.5c.</td></tr>
<tr><td>are still needed,</td><td>go to Step 2.</td></tr>
</table></td></tr>
<tr><td>2</td><td>Contact the beneficiary by phone for the missing information/verifications.

<table>
<tr><th>IF information/verifications…</th><th>THEN the worker will…</th></tr>
<tr><td>were provided by beneficiary over the phone,</td><td>process the annual redetermination as specified above, MPG 4.15.5c.</td></tr>
<tr><td>are still needed,</td><td>go to Step 3</td></tr>
</table></td></tr>
<tr><td>3</td><td>Mail a written request for the missing information/verifications. Allow beneficiary 20 days to provide the requested item(s).

Beneficiary’s Medi-Cal benefits shall remain terminated while the worker waits for the additional information/verifications.</td></tr>
<tr><td>4</td><td>On the 21st day, determine if beneficiary has provided the requested items.

<table>
<tr><th>IF…</th><th>THEN the worker will…</th></tr>
<tr><td>yes,</td><td>process the annual redetermination as specified above, MPG 4.15.5c.</td></tr>
<tr><td>no,</td><td>• not send a 2nd discontinuance NOA. Previous discontinuance NOA stands
• contact the beneficiary by phone and inform him/her of the following:</td></tr>
</table></td></tr>
</table>

		- the RV packet remains incomplete; AND - the previous discontinuance is still valid. If unable to reach the beneficiary by phone, complete MC 14-111 with the above information and mail to beneficiary.

4.15.6 RV Returned More than 30 Days After Discontinuance

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A. Required Procedures

When the redetermination form is returned more than 30 days after the discontinuance date, the worker shall not restore Medi-Cal benefits based on the fact that the RV form was received. The beneficiary's Medi-Cal benefits shall remain discontinued until the worker determines that the beneficiary remains eligible for Medi-Cal.

When the RV form is returned more than 30 days after discontinuance date, the worker will:

Step	Action
1	Evaluate for good cause. Each case must be evaluated separately. There will be situations that are unique to the individual beneficiary.
2	**IF beneficiary…** / **THEN the worker will…** has good cause, → • process the RV form and evaluate the beneficiary for continued Medi-Cal eligibility • restore benefits without a break in aid if beneficiary is otherwise eligible. does not have good cause, → • inform the beneficiary that he/she must reapply for Medi-Cal.

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B. Example of Good Cause

Good cause shall include but not limited to:

- Beneficiary is unable to read or complete the RV form without assistance because the RV form is not available in the written language that he/she understands.
- The postal service fails to deliver the redetermination packet in a timely manner.
- Physical or mental illness or incapacity prevented the beneficiary from submitting the forms in a timely manner.

4.15.7 RV Not Returned Or Returned as Undeliverable

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A. RV Not Returned

When a beneficiary fails to return the RV form to the County by the last day of the RV month and the annual redetermination packet was not returned by the post office as undeliverable, the worker shall send timely 10-day NOA to discontinue Medi-Cal benefits for failure to cooperate with the annual redetermination requirements. The discontinuance action shall be effective the last day of the RV month.

Note:
SB 87 process does not apply in this situation because failure of the beneficiary to complete and return the RV form constitutes a failure to cooperate and not a change in circumstances.

B. No Forwarding Address

When the RV packet is returned without a forwarding address, the worker will:

Step	Action
1	Attempt to locate the beneficiary by way of 1) completing an *ex parte* review; 2) calling the beneficiary by phone.
2	**IF…** / **THEN the worker will…** whereabouts remains unknown, → send timely 10-day NOA to discontinue Medi-Cal benefits for failure to cooperate with the RV requirements to the last known address. Discontinuance shall be effective the end of the month in which 10-day NOA requirement is met. whereabouts is located, → • resend the RV packet to the new address. • allow the beneficiary another 20 days to submit the RV form

	RV form is not received from beneficiary,	• discontinue Medi-Cal with 10-day notice.

C. Returned with a Forwarding Address

When the RV packet is returned with a forwarding address, the worker will:

Step	Action	
1	Resend the RV packet to the new address	
2	Allow the beneficiary another 20 days to submit the RV form	
3	**IF beneficiary…**	**THEN the worker will…**
	does not return the RV form by due date,	• send 10-day NOA to discontinue Medi-Cal benefits for failure to cooperate with the RV requirements. • discontinuance shall be effective the end of the month in which 10-day NOA requirement is met.
	returns the RV form by due date,	• evaluate beneficiary's for continued Medi-Cal eligibility.

4.15.8 Adding a Person at Annual Redetermination

A. Required Procedures

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The MC 210 RV allows the beneficiary to add a person to his/her Medi-Cal case at Annual Redetermination. The worker shall request additional information/verification of the new person to establish eligibility.

IF the person being added to the case …	**THEN the person being added to the case…**
was terminated from Medi-Cal less than 30 days, was terminated from Medi-Cal more than 30 days and good cause exists,	• must provide any information/verifications needed for the worker to determine Medi-Cal eligibility • is not required to complete any form or new application. Note: The original RV month is still in effect.
was terminated from Medi-Cal more than 30 days and good cause does NOT exist, is new to the MFBU,	• is required to complete the MC 371 • is required to provide any needed income, property or other required verifications needed to determine eligibility. Note: Original RV month is still in effect SAWS 2, MC 210, or MC 321 HFP may be accepted in lieu of MC 371.

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4.15.10 Completing Annual Redetermination by Phone

A. General

The County may conduct the annual redetermination over the phone with the beneficiary. Information discussed on the phone must be documented in case file and on the RV form and supplemental forms such as the MC 210 PS. The County must mail the RV form and applicable supplemental form to the beneficiary for review. The beneficiary must sign and return the RV form and applicable supplemental form along with any requested verification by the specified due date. The procedures for requesting additional information/verifications (i.e. *ex parte* review, telephone contact, MC 355) shall continue to apply.

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Appendix A: Examples of When Redeterminations are Due

Example 1: Application approved in application month

1/04	2/04	3/04	4/04	5/04	6/04	7/04	8/04	9/04	10/04	11/04	12/04
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application & approval month									RV mail month	RV return month	RV due month
1/05	**2/05**	**3/05**	**4/05**	**5/04**	**6/05**	**7/05**	**8/05**	**9/05**	**10/05**	**11/05**	**12/05**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Benefits re-determined for 2nd year									RV mail month	RV return month	RV due month

Example 2: Application with Retroactive Months

										11/03	12/03
										Retro Eligible	Retro Eligible
1/04	**2/04**	**3/04**	**4/04**	**5/04**	**6/04**	**7/04**	**8/04**	**9/04**	**10/04**	**11/04**	**12/04**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application Month Eligible	Month Eligible								RV mail month	RV return month	RV due month
1/05	**2/05**	**3/05**	**4/05**	**5/05**	**6/05**	**7/05**	**8/05**	**9/05**	**10/05**	**11/05**	**12/05**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Benefits re-determined for 2nd year									RV mail month	RV return month	RV due month

Example 3: Eligibility Criteria Not Met in Month of Application

1/05	2/05	3/05	4/05	5/05	6/05	7/05	8/05	9/05	10/05	11/05	12/05
	One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven
Application Month	Month Eligible									Annual RV mail month	Annual RV return month
1/06	**2/06**	**3/06**	**4/06**	**5/06**	**6/06**	**7/06**	**8/06**	**9/06**	**10/06**	**11/06**	**12/06**
Twelve	One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven
Annual RV due month	Benefits re-determined for 2nd year									Annual RV mail month	Annual RV return month

Example 4: Family Members Have Different Initial Eligibility Dates

1/05	2/05	3/05	4/05	5/05	6/05	7/05	8/05	9/05	10/05	11/05	12/05
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve

Application Month Children Eligible Parents Over Property	Parents Eligible Due to Spend-Down								RV mail month	RV return month	RV due month
1/06	**2/06**	**3/06**	**4/06**	**5/06**	**6/06**	**7/06**	**8/06**	**9/06**	**10/06**	**11/06**	**12/06**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Benefits re-determined for 2nd year									RV mail month	RV return month	RV due month

Example 5: DDSD-SP disability decision received within 90 days

1/04	**2/04**	**3/04**	**4/04**	**5/04**	**6/04**	**7/04**	**8/04**	**9/04**	**10/04**	**11/04**	**12/04**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application month & Eligible Month		DDSD-SP Decision Rec'd – Disability Onset Date: 1/04							RV mail month	RV return month	RV due month
1/05	**2/05**	**3/05**	**4/05**	**5/04**	**6/05**	**7/05**	**8/05**	**9/05**	**10/05**	**11/05**	**12/05**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Benefits re-determined for 2nd year									RV mail month	RV return month	RV due month

Example 6: DDSD-SP disability decision received after 90 days but prior to the 12th month

1/04	**2/04**	**3/04**	**4/04**	**5/04**	**6/04**	**7/04**	**8/04**	**9/04**	**10/04**	**11/04**	**12/04**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application month & Eligible Month									RV mail month	DDSD-SP Decision Rec'd – Disability Onset Date: 1/04 RV return month	RV due month
1/05	**2/05**	**3/05**	**4/05**	**5/04**	**6/05**	**7/05**	**8/05**	**9/05**	**10/05**	**11/05**	**12/05**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Benefits re-determined for 2nd year									RV mail month	RV return month	RV due month

Example 7: DDSD-SP disability decision received after the 11th month

1/04	**2/04**	**3/04**	**4/04**	**5/04**	**6/04**	**7/04**	**8/04**	**9/04**	**10/04**	**11/04**	**12/04**

Application month	Case in pending status										Does not have to complete the annual redetermin-ation
1/05	**2/05**	**3/05**	**4/05**	**5/04**	**6/05**	**7/05**	**8/05**	**9/05**	**10/05**	**11/05**	**12/05**
		One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten
DDSD-SP Decision Rec'd – Disability Onset Date: 1/04		Worker completes eligibility determin-ation									RV mail month
1/06	**2/06**	**3/06**									
Eleven	Twelve										
RV return month	RV due month										

Example 8: MFBU with 3 children eligible for CEC Program and two different CEC periods

1/04	**2/04**	**3/04**	**4/04**	**5/04**	**6/04**	**7/04**	**8/04**	**9/04**	**10/04**	**11/04**	**12/04**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
Application Month Parents and child 1 & 2 MFBU eligible with no SOC	Approval month			Child 3 returns home with own CEC period					RV mail month	RV return month	RV due month CEC ends for children 1 & 2
1/05	**2/05**	**3/05**	**4/05**	**5/05**	**6/05**	**7/05**	**8/05**	**9/05**	**10/05**	**11/05**	**12/05**
One	Two	Three	Four	Five	Six	Seven	Eight	Nine	Ten	Eleven	Twelve
CEC continues for child 3	CEC continues for child 3	CEC ends for child 3							RV mail month	RV return month	RV due month

Example 9: Resetting the annual redetermination date from a CalWORKs case

									10/05	**11/05**	***12/05***
									CW RV overdue Disc	MC RV Pending	MC RV Completed
1/06	**2/06**	**3/06**	**4/06**	**5/06**	**6/06**	**7/06**	**8/06**	**9/06**	**10/06**	**11/06**	**12/06**
New 12-month Begins											MC RV Due

Appendix B: MC 210 RV Form

In addition to the case identifying information located at the top of the form, the MC 210 RV is divided into eight sections. Each section asks the beneficiary to provide information on specific subject matters with simple instructions and examples. The beneficiary is asked to attach supporting documentation of information reported on the MC 210 RV. The following table highlights the purposes of each section:

Section	Title	Purpose
1	Income	Applies to income received by all MFBU members living in the home or temporarily away from home.
2	Expenses and Deductions	Applies to expenses MFBU members have to pay from income received. The beneficiary must provide supporting documentation before the allowable expense can be deducted from income.
3	Other Health Insurance	Applies to other health insurance that MFBU members may have.
4	Living Situation	Provides information on household changes that may affect linkage, program eligibility, and share of cost (SOC).
5	Real and Personal Property	Applies to all MFBU members who are receiving Medi-Cal. However, if the case contains only children or pregnant women receiving Medi-Cal under the FPL program and property information or documentation is not provided, these children and pregnant women, if eligible, must have their eligibility review completed without delay. For families that provide the real and personal property information, workers must first evaluate the family for 1931(b) eligibility before putting the children in the FPL programs.
6	Immigration or Citizenship Status Change	Applies to family members in the home who have a change in citizenship or immigration status. The beneficiary is not required to report the immigration or citizenship status of family members who are not in receipt of Medi-Cal.
7	Blindness/ Disability/ Incapacity	Allows the beneficiary to report any disabling condition not previously known or reported to the county.
8	Other Health Program Information and Referrals	Serves as a request for additional information on, or referral to, other programs and services available to low-income families.

Appendix C: Acting on the MC 210RV

The table below shows the actions that the worker must take on the information reported in each section of the MC 210 RV.

1) Income	
Income is reported, then the beneficiary is asked to provide documentation of all income received,	Review the source of income and treatment of that income for exemption and deductions.
In-kind income is reported,	• Contact the beneficiary to determine if the in-kind income is to be counted in the budget, • Allow applicable work-related deductions for earned in-kind income, and • Use the In-Kind Income and Housing Verification form (MC 210 S-I) if the beneficiary does not agree with the chart value of in-kind income.
2) Expenses and Deductions	
The beneficiary reports expenses, but supporting documentation is not provided with the MC 210 RV, and the expense was previously reported and the amount has not changed,	Review the existing case file for the documentation.
No supporting documentation is no file for the expense claimed,	• Contact the beneficiary and request documentation. • Continue to process the Annual Redetermination and not terminate benefits even if the beneficiary fails to provide the necessary documentation. • Certify the MFBU for another 12-month period and not allow the deduction(s) from income if all other eligibility factors are met.
Payment for health care is reported and it was not previously reported,	Review information in Section 3, Other Health Insurance, for follow-up.
Documentation is provided on health care insurance and premium payment,	Allow the deduction and continue to process the requirements for other health insurance.
3) Other Health Insurance	
The beneficiary reports other health coverage,	Compare the information with the case file.
The health coverage plan has not changed,	Not request the beneficiary to complete a new DHS 6155.
The health care coverage is new	Send a new DHS 6155 to the beneficiary to

or has changed,	complete and update the change in health care coverage on MEDS.
The beneficiary reports no change in health insurance being provided to a child who has an absent parent,	Not require the beneficiary to complete a new medical support questionnaire or other medical support information.
An individual is receiving Medi-Cal kidney dialysis-related services,	Request a copy of the SSA statement of Medicare status, or any evidence of eligibility if he/she has not provided such evidence previously.
The individual receiving Medi-Cal kidney-dialysis related services is not already receiving Medicare coverage,	Refer the individual to apply for Medicare coverage and provide evidence of application status.
4) Living Situation	
The beneficiary reports that someone has moved into or out of the home,	Review the case file to determine if the person is or is not an MFBU member.
The person is an MFBU member,	The family's eligibility and/or benefit level may be affected by this change.
A new MFBU member is requesting Medi-Cal and being added to the case,	The beneficiary must provide information on the new person, such as income, property, health insurance, and immigration status before he/she can be added to the existing case. This requires a new application for the individual. The MC 210 RV cannot be used as an application for Medi-Cal benefits.
A newborn is reported and he/she is an MFBU member, and the parent has provided the newborn's place of birth (city and country),	Add the newborn to the existing case as the parent has completed the requirement of declaring the newborn's citizenship and satisfactory immigration status under penalty of perjury. The parent is not required to complete an MC 13 for the newborn. Also, no birth certificate is required to aid the infant.
An MFBU member is reported to be residing in a nursing facility or medical institution such as a board and care facility,	• Contact the beneficiary for more information. • Review income and property allocation as well as put the individual in his/her own MFBU.
A pregnant woman is reported living in the home,	Determine if that individual is an MFBU member.
If the pregnant woman is…	**Then…**
An MFBU member,	The worker must add the unborn to the MFBU and request that the pregnant woman provide pregnancy verification within 60 days.
An MFBU member not currently receiving Medi-Cal and requests pregnancy related services only,	She is allowed to self-declare her pregnancy has been medically verified if she is income eligible to the Income Disregard Program.
Not an MFBU member and requests Medi-Cal	The worker must contact the beneficiary and inform him/her that a Medi-Cal application will be mailed to

	the pregnant woman.
5) Real and Personal Property	
The MFBU members are children or pregnant women receiving Medi-Cal under the federal poverty level (FPL) programs and property information or documentation is not provided,	Complete the eligibility review for these programs without delay.
The family provides property information and documentation,	Evaluate for 1931(b) before the FPL programs.
The MFBU contains adults and children from ages 19-21 who are also receiving Medi-Cal benefits,	Request property information for those individuals who are not eligible for the FPL programs. They must meet the property limits for Medi-Cal benefits to continue.
The family answers, "Yes" to questions 5(b) or 5(c) on the MC 210 RV,	Send out the MC 210 PS, Medi-Cal Property Supplement, for the beneficiary to complete.
The value of the reported property will affect eligibility,	• Contact the beneficiary and explain the spend-down provisions and require verification of the spend-down for eligibility to continue. • Document the disposition of any property sold or given away and the impact on the beneficiary's eligibility
Real or personal property was sold or transferred,	Ensure that the property was disposed of in a manner consistent with Medi-Cal policies and procedures.
Real or personal property has been previously reported and no information is reported to the worker on the disposition of the property,	Contact the beneficiary to clarify the change.
6) Immigration or Citizenship Status Change	
An immigration or citizenship status change is reported,	Review the case file to determine if the person with the status change is an MFBU member.
The reported change is for an MFBU member who is receiving Medi-Cal,	Mail an MC 13 for completion by that individual or representative.
The MFBU member claims a satisfactory immigration status (SIS) on the MC 13,	Grant full-scope Medi-Cal based on the redetermination date if the person was otherwise eligible at that time, and he/she was receiving restricted benefits prior to the redetermination.
The beneficiary completing the redetermination form is the person whose status has changed,	Not wait for receipt of the MC 13 to grant full scope Medi-Cal benefits, if otherwise eligible, but a new MC 13 must be provided for the case file. A beneficiary who claims a change from a restricted

	scope status to a full-scope status must provide evidence of their new status within 30 days of the claim or the time it takes to complete the redetermination process, whichever is longer.
An excluded MFBU member is not receiving Medi-Cal but now wants Medi-Cal	• Add the individual to the MFBU when the worker receives all appropriate information and verification on that individual. • Not delay the redetermination process for the MFBU pending the additional information or verification on the individual. The individual will remain excluded until all necessary documentation has been provided.
A non-MFBU member is reported to have a change to his/her immigration status and he/she is not receiving any type of Medi-Cal benefits,	Contact the beneficiary to determine if that person wants Medi-Cal.
If that individual is not…	**Then the worker must…**
An MFBU member and wants Medi-Cal,	Mail a Medi-Cal application to the household and inform them that he/she must complete the application and eligibility determination process.
An MFBU member and wants Medi-Cal,	Mail a Medi-Cal application to the household and inform them that he/she must complete the application and eligibility determination process.
7) Blindness/Disability/Incapacity	
The person claiming to have a disability is not currently receiving disability-linked Medi-Cal,	Contact the beneficiary to clarify the condition of the person reported as having the disability.
The person considers himself/herself to be blind or disabled,	• Send out the forms necessary to initiate a referral to the State Programs-Disability and Adult Programs Division (SP-DAPD) for evaluation. • Not make an independent determination that the condition is not severe enough to qualify the person as blind or disabled.
The beneficiary no longer has linkage to a Medi-Cal program, such as the last child has left home, and he/she claims to be disabled,	Continue the individual's Medi-Cal benefits during the disability evaluation process at the same benefit level that he/she was previously receiving.
A non-Medi-Cal parent in the home reports that he/she is incapacitated,	Contact the parent to determine if he/she wants Medi-Cal and document the results of that contact.
The beneficiary reports a person in the home has physical, mental, or health problems as a	Contact the beneficiary and follow the procedures in Article 15, Section 3.

result of an injury or accident,	
8) Other Health Program Information and Referrals	
The box is not checked indicating that the family does not want their child's information to be shared with Healthy Families (HF) and their child is determined to have a SOC,	• Share their information with the HF program. • Review the Medi-Cal to HF Bridging program for the SOC child.
The beneficiary requests CHDP services or additional CHDP information,	Complete a CHDP referral.
Information on a referral to Woman, Infants, and Children (WIC) is requested,	Contact the beneficiary to follow-up and document the referral process in the case file.
The beneficiary requests IHSS information,	Contact the beneficiary and provide the IHSS program telephone number.
The box is not checked indicating that the family does not want their child's information to be shared with Healthy Families (HF) and their child is determined to have a SOC,	• Share their information with the HF program. • Review the Medi-Cal to HF Bridging program for the SOC child.

Appendix D: Example of When to Apply SOC

Example #1 – beneficiary whose eligibility changed from no SOC to SOC

The County discontinued the beneficiary's Medi-Cal on February 28, 2010 because the beneficiary did not return the RV form. On March 26, the beneficiary returns the RV form along with verification. On March 27, the County rescinds the discontinuance and determine on-going eligibility with SOC. As the County does not have sufficient time to provide 10-day notice before April 1, the County will send out a timely NOA prior to April 20 indicating that the beneficiary has 0 SOC Medi-Cal for March 20101 and April 2010 and SOC Medi-Cal beginning May 2010.

Compliance Requirements

includes the percentage of cases that must meet the standards in order for the county to be in compliance with the CPS requirements. Article 25

Performance Standard	Components	%
Application processing	• Regular Applications – within 45 days of application • Applications based on disability – within 90 days of application	90
Annual Redetermination (RV) processing	• RV form mailed to recipient by anniversary date • RV completed within 60 days starting from the last day of the annual redetermination month. • NOA mailed within 45 days after redetermination form was due	90
Bridging	The following must occur within 5 days of the share of cost determination for eligible children: • Notice sent informing family of Healthy Families Program (HF) • RV forms sent to HF if parent consents • Request to consent sent if parent has not consented	90
MEDS Alerts processing	• MEDS daily and renewal alerts • MEDS reconciliation/worker alerts	90 95

ACWDL 11-23

MPG Letter #736 (9/11)

C. Review Schedule

Self-Certification Schedule

Performance Standard	Schedule
Application and RV processing	Every two years beginning in October 2009.
Bridging	Every two years beginning October 2008.
MEDS Alerts processing	There is no self-certification process at this time

ACWDL 03-42

ACWDL 07-03

State Review

DHCS Program Review Section (PRS) also completes independent performance evaluations of the CPS. At this time, they do have a specified schedule for these reviews. PRS sends a notification of

20.01.02 Eligibility Determinations and Redeterminations

A. General

DHCS established performance standards, which measure whether counties are meeting the Medi-Cal application and annual redetermination timelines mandated by Federal law. ACWDL 03-42

Federal law requires that:

- Applications for Medi-Cal must be processed within 90 days for applications that are disability based, requiring a DDSD evaluation and 45 days for all other applications; and
- Eligibility for Medi-Cal must be reevaluated on a yearly basis.

Note: The process time can be extended if unusual circumstances occur and the worker cannot reach a determination of eligibility because of delays caused by the applicant, DDSD, examining physician, or other factors not within the worker's control.

Counties are required to report to DHCS the percentage of applications and redeterminations which have been processed within the timeframes specified by Federal law. The reported information will be evaluated for compliance and will require corrective action and counties will be subject to sanctions if not in compliance.

MPG Letter #667 (4/09)

B. Eligibility Determin-a tions

The Medi-Cal application performance standards require: ACWDL 03-42

- General Medi-Cal applications to be processed within 45 days of the application date; and
- Applications based on disability (a DDSD evaluation is required) to be processed within 90 days of the application date.

Applications are excluded from the 45/90-day processing requirement if:

- The applicant provides partial information/verification, is attempting to comply and requests additional time to provide; or
- DDSD has received the application prior to the 90 day timeframe, but is unable to provide a determination within 90 days of the application date.

MPG Letter #667 (4/09)

C.

The Medi-Cal redetermination performance standards require: ACWDL 03-42

Redetermin-ations

Annual redetermination forms to be mailed to the beneficiary by the due date (the first day of the month in which the redetermination is due);

- Annual redeterminations, which are **complete** and have been returned **timely**, to be processed within 60 days starting from the last day of the annual redetermination month (RV month). ACWDL 11-23
- Annual redeterminations for which the packets have not been returned, to have a Notice of Action (NOA) mailed to the beneficiary within 45 days after the date the forms were due.

For the purpose of these redetermination performance standards:

- "**Complete**" means all questions on the RV form were answered, all verifications were provided, and no further action is required from the recipient. Only County action is required because the County has the information necessary to make a determination.
- "**Timely**" means that the recipient has returned the RV form by the due date specified on the RV notice. Use an RV due in October for example: October 1 (10/01/07) or by the last day of the month that the RV is to be completed by the recipient (October 31, 2007).

Redeterminations will be excluded from the 60-day requirement if:

- Redetermination forms/verifications are incomplete and the SB 87 process results in a delay or if the beneficiary requests additional time to provide and is given good cause.
- Redetermination forms/verifications are returned complete within 30 days of the discontinuance date.

MPG Letter #736 (9/11)

D. Required Actions

Applications ACWDL 03-42

Workers are required to:

Step	Action
1	Complete the eligibility determination within the 45 day timeline.
2	Document delays caused by unusual circumstances in the case file narrative.
3	Complete entries in the automated system to assist in the monitoring and tracking of the performance standards (see appendix A for monitoring and tracking information).

Redeterminations

	change of an AR.
11	Applicant becomes incarcerated (include date of incarceration, name, address and telephone number of facility. Indicate that the disability evaluation is still needed for the months beginning with any retroactive months through the month of incarceration. The case must remain in pending status while the DDSD evaluation is completed.
12	Any other information which may affect DDSD's action on the pending case.

State Clarification

5.4.8 DDSD Response

A. DDSD Response

The State DDSD analyst will send all MC 221's and disability determinations to CMS recovery. CMS Recovery will copy the MC 221 and disability determination then forward to the associated FRC DDSD liaison within 3 business days. County Policy 2/11

The FRC DDSD Specialist will process the disability determination following the procedures outlined below.

B. Disability Not Approved

The DDSD analyst will return the MC 221 with the disability determination attached when the applicant does not meet MN disability criteria based on DDSD's vocational and medical evaluation. DDSD will attach a notice explaining the basis for their determination. See Appendix C. If the DDSD rationale notice does not explain the basis for the determination, the worker must request the information from DDSD. ACWDL 00-46

When the DDSD analyst sends a rationale notice explaining the basis for the determination, the worker will attach the rationale to the denial or discontinuance NOA. Do not send a copy of form MC 221 to the applicant. DHCS Clarification

If PD has been granted, DDSD subsequently adopts SSA's disability denial and the beneficiary files an appeal with SSA, benefits will continue through the appeal process. DDSD will indicate Code "Z53" on the MC 221 if SSA's denial is adopted.

If PD has not been granted or the PD individual has not requested SSA's denial, the worker will evaluate eligibility under any other Medi-Cal linkage. If disability is the only linkage to Medi-Cal, the applicant will be denied.

The worker will:	
1	Deny the case.
2	Attach the DDSD rationale which explains the basis of the determination to the denial NOA and mail it to the applicant.
3	Image the MC 221 and the rationale to the case file.
4	Send form 14-10 HHSA to notify the hospital of the Medi-Cal denial if the applicant was certified CMS pending the disability evaluation.
5	Enter denial information into case comments.
6	Enter DDSD determination in Display Disability/Medical Conditions Summary screens in CalWIN.

MPG LTR 717 (02/11)

C. Disability Granted by DDSD

DDSD will attach the disability evaluation results to the MC 221. If DDSD determines the applicant is disabled, the applicant is disabled under MN criteria. The onset date provided will take into consideration any request for up to three months retroactive coverage prior to the date of application as long as the worker has requested retro onset on form MC 221. Refer to MPG Article 4, Section 15 for guidelines on annual redetermination for DDSD-SP cases.

ACWDL 00-46

ACWDL 11-23

The worker will:	
1	Approve the application as disabled or reclassify the beneficiary as disabled MN.
2	The effective date will be the disability onset date or application date, as appropriate.
3	Send form 14-10 HHSA to notify the hospital of the Medi-Cal approval if the applicant was certified CMS pending the disability evaluation.
4	Enter approval information into case comments, including onset and re-exam date.
5	Enter DDSD determination in Display Disability/Medical Conditions Summary screens in CalWIN.
6	Set a case alert for referral 30 days prior to the re-exam date, if one is indicated on form MC 221.
7	Image the MC 221 to the case file.
9.	Convert aid code “53” to aid code “63”, if applicable.

MPG LTR 796 (9/11)

D. DDSD Adopts SSA Allowance

When the applicant has applied for benefits with SSA. SSA evaluates the applicant’s disability before they evaluate any other eligibility factors. If the SSI/SSP application is denied because they do not meet federal disability criteria, DDSD will “adopt” the SSA’s determination.

DHCS Clarification

If SSA has determined the applicant is not disabled, DDSD will return form MC 221 with an attachment indicating the applicant is not disabled. The form will indicate that SSA has determined the applicant is not disabled. Worker will deny the application following procedures outlined in MPG 5.4.9.A.

ACWDL 00-46

If SSA has determined the applicant is disabled, DDSD will return form MC 221 with an attachment indicating the applicant is disabled and will give the onset date. Worker will approve the application following procedures outlined in MPG 5.4.9.B.

MEM Proc 22C-9.2