Medi-Cal Program Guide (MPG) Letter #780

June 20, 2013

Subject

HEALTH CARE OPTIONS (HCO) CLARIFICATION, CALFRESH OUTREACH REQUIREMENTS, AND REDETERMINATION VERIFICATIONS

Effective

July 1, 2013

Reference

- County Policy
- All County Welfare Directors' Letter (ACWDL) 12-28
- Department of Health Care Services (DHCS) clarification

Purpose

To provide the following clarifications:

- All Medi-Cal applicants must be encouraged to attend an HCO presentation
- CalFresh outreach procedures have been updated to make it easier for a Medi-Cal applicant/beneficiary to apply for CalFresh
- Medi-Cal beneficiaries may submit copies of verifications for the annual redetermination
- Incorporate Medi-Cal Program Inquiry dated July 2, 2007

Background

HCO presentations are provided by Healthy San Diego staff to inform Medi-Cal applicants/recipients of their options in choosing a health care plan.

CalFresh outreach is required in order to assist Medi-Cal applicants/beneficiaries who also may need nutrition assistance.

Previous rules required original documentation for redeterminations.

Highlighted Changes

This letter adds the following clarifications to the MPG:

- Staff are reminded to encourage all Medi-Cal applicants/beneficiaries to attend an HCO presentation during the intake process

Continued on next page

Highlighted Changes (continued)

- Forms 09-98 HHSA and DFA 285 A1 must be included in all application packets and all redetermination packets except for those for individuals in Long-Term Care (LTC) (using the MC 262) including Low-Income Subsidy (LIS) referrals
- Photocopies of verifications are acceptable for redeterminations

Automation Impact

No impact.

Forms Impact

Forms 09-98 HHSA and DFA 285 A1 are available to be ordered in Xerox Print Services.

ACCESS Impact

No impact.

Scanning Impact

Form 09-98 HHSA should not be scanned. Form DFA 285 A1 is already known to DoReS.

Other Program Impact

CalFresh applications received through the Medi-Cal application and redetermination processes must be processed according to CFPG 63-103.

Quality Control (QC) Impact

Effective with the July 2013 review month, QC 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 the MPG cites.

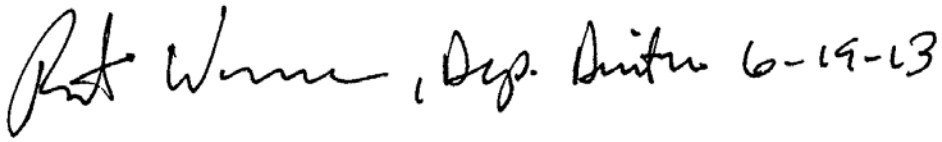
Section	Summary of Change
Article 4, Section 2	• Added HCO Presentation reminder • Added CalFresh outreach clarification

Continued on next page

Summary of Changes (continued)

Section	Summary of Change
Article 4, Section 2, Appendices A through E and G through H	Moved to Article B, Resources and Desk Aids
Article 4, Section 2, Appendix F	Moved to Article C, Processing Guidelines
Article 4, Section 15	• Added CalFresh Outreach clarification • Added verification clarification
Article B	Added the Desk Aids from Article 4, Section 2
Article C	Added the Processing Guidelines for the: • LIS Application Process

Approval for Release



DH

Article 4 Section 2 – Application Processing Requirements

Table of Contents

Resources

Resource	Title

Processing Guideline	• LIS Processing Guideline
Desk Aid	• Authorized Representative (AR) Q&A • Application Handling Q&A for Incompetent LTC Applicants • How to Complete an MC 13 • Retroactive Medi-Cal Q&A • Example of IDX CMS Eligibility Enrollment Summary Screen

04.02.01 Application Procedures

D. Processing Requests for a Face-to-Face Interview

When an applicant requests Medi-Cal at a FRC or outstation site and chooses to attend a face-to-face interview FRC or outstation staff will:

Step	Action
1	Schedule an appointment according to FRC/Outstation procedures.
2	Perform "Application Registration" process.
3	Ask the applicant to sign a SAWS 1.
4	Provide the applicant with a "Basic Packet." (See MPG 4.2.2.C). NOTE: FRC may screen the applicant at time of request and provide any supplemental forms that may be required.
5	Encourage the applicant to attend a Health Care Options (HCO) presentation so that he/she can make an informed choice of health plan.

MPG LTR 780 (6/13)

E. Requests for Mail-In Application

Whether the request for an application is by phone or in person at a FRC the following actions shall be taken to provide the applicant with the necessary information at the time of the request:

Step	Action
1	Explain to the applicant that he/she can apply for Medi-Cal as a mail-in or attend a face-to-face interview.
2	Encourage Mail-In applicants to attend an HCO presentation as it will help the applicant make an informed choice in health coverage and inform the applicants that they will receive an HCO packet by mail.
3	Ask the applicant if he/she would like to apply for CalFresh in addition to Medi-Cal. If the applicant is interested in applying for CalFresh in addition to Medi-Cal or needing expedited services, explain to him/her that a face-to-face interview may provide him/her with faster benefits and is advisable especially if he/she does not have access to a regular source of communication. Inform regular applicants they should expect an interview within 30 days and can choose to do so over the phone (Refer to the CalFresh Program Guide). The CalFresh interview may be scheduled with the Medi-Cal

	application to streamline the application. However, the applicant may still apply for Medi-Cal by mail if he/she chooses.

04.02.02 Application Packet

C. Basic Application Packet

All applicants, including mail-ins and those who wish to apply by attending a face-to-face interview, shall be given or mailed the "Basic Packet." The "Basic Packet" shall be comprised of the following forms:

BASIC PACKET	
FORM NUMBER	**FORM TITLE**
CSF 77	Interview Check List
14-68 HHSA	Mail-In Cover Letter *(for Mail-In applicants only)*
14-75 HHSA	Mental Health Managed Care Notice
16-64 HHSA	NVRA Voter Preference Form (formerly known as the Voter Registration Interest/Declination Form)
N/A	California Voter Registration Form (known also as California Voter Registration Card or VRC)
16-69 HHSA	Public Charge flyer
20-46 HHSA	Language Needs Determination
DHCS 0001	U.S. Citizens and Nationals Applying for Medi-Cal Must Show Proof of Citizenship and Identity
HHSA:HSD 7	Health Care Options
Pub 68	Medi-Cal What It Means to You
Pub 13	Your Rights
MC 007	Medi-Cal Information Notice
MC 13	Statement of Citizenship and Alienage
MC 210	Medi-Cal Mail-In Application *(for Mail-In applicants only)*
MC 219	Important Information for Persons Requesting Medi-Cal
MC 372	Breast and Cervical Cancer Treatment Program (BCCTP) Flyer
09-98 HHSA	CalFresh Outreach Flyer for Medi-Cal (non LTC only)
DFA 285 A1	Application for CalFresh Benefits (non LTC only)
Form 142-732	San Diego Gas & Electric CARE Program Form

MPG LTR 780 (6/13)

04.02.19 Processing LIS Application for Medi-Cal

A. Overview

Only July 15, 2008, Congress enacted the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). One of the provisions under MIPPA requires SSA to refer consented Medicare Low Income Subsidy (LIS) applications for applicants who have consented to have their information shared to the counties to be evaluated for the Medicare Savings Programs (MSP) (i.e., QMB, SLMB or QI-1). The evaluation shall include Medi-Cal and MSP eligibility if the applicant provides his/her consent.

The Medicare LIS Program, also known as "Extra Help," is available to Medicare beneficiaries with limited income and resources. Those who are LIS eligible will receive financial assistance to help pay for their Medicare Part D prescription drug costs.

Some Medicare beneficiaries are automatically or deemed eligible for LIS based on their no-cost Medi-Cal, SSI, or MSP eligibility. Those who are not deemed eligible may still qualify for LIS based on their income, resources, and household sizes.

Non-deemed eligible Medicare beneficiaries may apply for LIS by submitting a LIS application to SSA by mail or on-line. SSA will review their LIS application and notify the Medicare beneficiaries in writing of their LIS eligibility.

B. Referral Process

SSA forwards LIS applications where the applicant has consented to have his/her LIS application forwarded to the County for a Medi-Cal/MSP evaluation. LIS applications are sent to the County via MEDS. The LIS application information shown on the LIS MEDS screens (LIS 1 – LIS 7) shall be used as an application and SOF for Medi-Cal. The worker will obtain the applicant's information by viewing the LIS screens on MEDS.

C. Types of Application

Two types of LIS applications will be received by the County from SSA.

LIS Application Type	Description
Processed	• LIS 1 screen will have an "N" or blank in the "LIS Application – Completed" field • SSA has completed an eligibility determination for

	LIS Extra Help • Applications contain information used by SSA in their LIS Extra Help determination • Application information has been verified by SSA • Will include a denial reason if SSA denied the LIS Extra Help application
Self-Referred	• LIS 1 screen will have a "Y" in the "LIS Application-Completed" field • Applicant self-assess that he/she is ineligible to LIS and requests that the information be forwarded to the County for a Medi-Cal/MSP evaluation • SSA has NOT completed an eligibility determination for LIS Extra Help • Application information has not been verified by SSA

NOTE: SSA will NOT transmit to the County LIS applications where the applicant indicated that he/she does not want his/her information forwarded to the County.

D. Application Date

The date of application for Medi-Cal shall be the date that the LIS application was filed with SSA. This date is located on the ***LIS Application Date*** field on the ***LIS 1*** screen. However, when a Medi-Cal application date already exists for the individual in CalWIN, the worker must determine which application date would be most beneficial to the applicant. See the Application Date section of the LIS Applications Processing Guide for clarification and samples.

NOTE: Retroactive coverage is available to applicants referred via an LIS application.

E. Processing Timeframe

The determination for Medi-Cal, including MSP eligibility, must be made within the 45-day application processing timeline. The 45-day application processing timeline begins the date the County receives the alert (one business day after the date shown on the **County-Referral Date** field on the **LIS 1** screen). Worker must narrate in Case Comment the date the County received the alert and the "County-Referral-Date."

F. MEDS Alerts

All LIS application information received from SSA will be matched against the MEDS data base daily to check for existing MSP and Medi-Cal eligibility and the following MEDS alerts will be generated:

MEDS Alert	Title & Description
9055	**MIPPA LIS Application – Client Not Found on MEDS** Individuals who have no information on MEDS.
9056	**MIPPA LIS – No Current Medi-Cal and MSP eligibility** Individuals who have no current Medi-Cal and MSP eligibility on MEDS.
9057	**MIPPA LIS – Current MSP eligibility, but No Current Medi-Cal Eligibility** Individuals who have current MSP eligibility on MEDS.
9058	**MIPPA LIS – No Current MSP Eligibility, but Current Medi-Cal Eligibility** Individuals who have current Medi-Cal eligibility on MEDS.
9059	**MIPPA LIS –Current MSP and Medi-Cal Eligibility** Individuals who currently have both Medi-Cal and MSP eligibility on MEDS.

NOTE: The Daily LIS Application Report is available in SharePoint.

4.15.1 Overview of Requirements

D. Information to be Verified

The following information must be verified at annual redetermination.

- Incapacity
- Legal responsibility for a child applying alone
- Refusal of a 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

Photocopies of all verifications are acceptable. Workers are not required to view originals of documents.

MPG LTR 780 (4/13)

4.15.3 Required Forms

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 Persons 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 (HHSA)	Voter Preference Form, previously known as the Voter Registration Interest/Declination
Voter Registration	CA Voter Registration Form (also referred to as a Voter Registration Card or VRC)
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
09-98 HHSA*	CalFresh Outreach Flyer for Medi-Cal (for non-LTC cases)
DFA 285 A1*	Application for CalFresh Benefits (for non-LTC cases)
14-116 HHSA	Medi-Cal Redetermination Packet Coversheet
HHSA HSD 7*	Managed Care Information
20-44 HHSA*	Civil Rights Information

*County Required Forms

Authorized Representative (AR) Q&A

AR Form

QUESTION #1	Is the MC306 or other AR authorization used for authorization of "key person"?
ANSWER	No, the term "key person" is not a Medi-Cal term. Some counties refer to "key person" as someone who assumes case management responsibility for incompetent individuals. Form DHCS 7068 is to be used when an incompetent Medi-Cal applicant/beneficiary has a public guardian/conservator or representative acting on his/her behalf. Refer to MPG Article 4, Section 2 for detailed regulatory requirements regarding public guardian/conservator or representative acting on behalf of an incompetent Medi-Cal applicant/beneficiary.
QUESTION #2	What do we do if the applicant/ beneficiary or the AR refuses to sign the authorization?
ANSWER	If the AR or the applicant/beneficiary refuses to sign, then the individual will not be recognized as the AR.
QUESTION #3	Does the authorization take the place of the MC 219 in regard to reporting responsibilities, penalty for fraud, etc.?
ANSWER	No, it does not take the place of the MC 219. The applicant/beneficiary is still the responsible person and the responsibility to provide truthful and accurate information rests with the applicant/beneficiary.
QUESTION #4	Does the case number or Social Security number (SSN) have to be completed on the MC306, and what if the applicant is an undocumented alien?
ANSWER	The case number or SSN line on the form is to allow easier case identification for the county. Both the case number and SSN are optional. If the applicant/beneficiary is undocumented and applying for restricted benefits, then they do not enter a SSN.
QUESTION #5	How is the AR authorization to be completed and where to file it?
ANSWER	While the authorization does not have to be completed in the presence of the worker, it is important that the worker review it with the client. If the AR is an organization, law firm, or group, the individual chosen to receive/submit information on behalf of the client and the AR organization, is entered with the organization named. Three copies of the form will be needed. The client and the AR must each receive a copy of the completed form and one must be scanned in the case record. The worker must complete the *Collect Authorized Representative Detail* window with ARs information. AR forms that are revoked should be kept in the case record.
QUESTION #6	If the applicant/ beneficiary and the AR do not sign the authorization on the same day, what is the effective date of the AR authorization?
ANSWER	The effective date is the later date when all signatures and dates have been completed.
QUESTION #7	If an LTC patient is competent and wants an AR, does he/she have to complete and sign the AR form?
ANSWER	Yes, if the applicant designates someone, other than a family member, to act on his/her behalf, the applicant must complete and sign an AR form. In this situation, the applicant must be given the same rights and responsibilities under the law and Medi-Cal regulations to participate in the application process.

Authorized Representative (AR) Q&A

Appointment and Scope of AR

QUESTION #1	Do current regulations allow the applicant to appoint legal aid or an organization to be his/her AR?
ANSWER	Yes, the regulations referred to are in the Department of Social Services Manual of Policies and Procedures (MPP 22-085) and are concerned with the applicant's right to representation in the hearing process. DHCS has examined these regulations and it is thought that presently an organization, law firm or group MAY be the selected AR. However, an individual from that organization, law firm, or group will still have to be designated on the authorization so that the client and the county will know which person from the organization, law firm or group is the person empowered to be the contact person. If the designated individual no longer works in that capacity then a new authorization will have to be completed to designate another individual.
QUESTION #2	Can a client have more than one AR?
ANSWER	Yes, a client may have any number of persons acting as his/her AR. However, each individual must be designated on a separate Appointment of Representative form and the client and the AR must sign each form.
QUESTION #3	How does the client revoke the AR designation?
ANSWER	The client may revoke the AR designation at any time, either orally or in writing. If the revocation is oral, the county should obtain a written confirmation within a reasonable period of time. If the county has not yet received a written confirmation on the oral revocation, the worker should notate on the authorization that it has been revoked, the date of the revocation along with the name, address, and phone number of the person requesting the revocation. The worker should also write his/her name and phone number after the above notations have been made. The worker must also make a case comment when changes in the AR occur. Should an AR designation be revoked the worker must not permit an exchange of information to continue with the former AR.
QUESTION #4	After the AR and the client complete the authorization, can the AR obtain information directly from other sources, such as bank balances, income, etc., with this form?
ANSWER	No, the AR authorization is not an all-inclusive release of information authorization. It is meant only to allow the AR to work with the client and the County, to assist the client in obtaining benefits, in completing the yearly redetermination or appeal process and to provide verifications to, or obtain information from DDSD. No other powers or authorities are given.
QUESTION #5	Is the AR entitled to receive the client's Benefits Identification Card (BIC)?
ANSWER	Many forms used by organizations acting as ARs state that the AR has the right to obtain the Medi-Cal card, medical records, etc., from the County and other agencies. This is not correct. The Medi-Cal card, or the plastic BIC, can only be issued to the applicant/recipient and the other individuals in the case.
QUESTION #6	What if the client wants the AR to provide additional legal services or gather additional information from third parties on his/her behalf?
ANSWER	The AR authorization is only an authorization for the AR to perform those functions as stated in MPG 4.2.7.C; it has no other authority or purpose. Any other services that the client wants the AR to perform, such as obtaining information from third parties, must be arranged separately among the client, AR and the third party.
QUESTION #7	May a health provider or an AR use the AR authorization to determine if someone has applied for Medi-Cal?
ANSWER	No, if the worker receives a properly signed and dated authorization with a request to determine if the individual has applied for Medi-Cal, the request should be denied. If the AR does not know if an application has been made, it would appear that the applicant was given the form as part of an admission/treatment packet which is not allowed under federal policy. While the MC 306 states the AR may "obtain information from the County and from DHCS or DDSD, regarding the status of the application," it is understood an application should have already been made. The authorization should not be completed until such application has been filed.
QUESTION #8	May the AR be allowed access to the case record if the applicant/beneficiary is not in attendance?
ANSWER	Yes.
QUESTION #9	Can the County refuse to accept a SAWS 1 from anyone other than the applicant?

Authorized Representative (AR) Q&A

ANSWER	No, regulations permit the applicant to file the SAWS 1, or, if the applicant is unable to apply on his/her own behalf, for any reason, the applicant's guardian/ conservator, a public agency representative or a person who knows of the applicant's need to apply may complete and file the SAWS 1 on behalf of the applicant. The County may not refuse to accept the initial application (SAWS 1) from anyone. However, the applicant, if competent, must complete the MC 210, AR authorization, and provide any other document or verification needed to establish eligibility.
QUESTION #10	Has DHCS formulated any type of sanction to be applied to ARs found to be negligent or in willful violation of state/federal law?
ANSWER	Yes, when DHCS becomes aware of ARs, either individuals or groups, who are being negligent in their duties as AR, or found to be coercive or violating DHCS's policy on an on-going basis, DHCS will write a letter informing the AR of DHCS's policy and advising them of the correct way to perform the AR function. If complaints are received after that time, DHCS will advise the County to refer the AR to the State Department of Justice for investigation. DHCS will handle each instance on a case-by-case basis and continue to explore a formal sanction process.
QUESTION #11	Is an AR entitled to receive a Letter of Authorization (LOA) for billing purposes?
ANSWER	No, the LOA is only to be issued to the beneficiary or beneficiary's family. The beneficiary is responsible for providing the LOA to the appropriate provider of service.
QUESTION #12	If a beneficiary wants a neighbor to deliver information to the County or to see the worker to discuss how SOC was determined, does the beneficiary need to complete a written AR authorization?
ANSWER	The beneficiary should call and inform the worker that he/she would like the neighbor to see the worker. In addition, the beneficiary should write and sign a short note authorizing the individual to act on his/her behalf for that specific function and on that specific date.
QUESTION #13	Is it the County's responsibility to prepare and provide a "conflict of interest" waiver when an AR represents the applicant/beneficiary and the medical provider?
ANSWER	No, any "conflict of interest waiver" is the responsibility of the AR and is not required by DHCS. The county should not indicate that one is necessary to an AR who is representing both parties, if the AR thinks that it is in his/her best interest in those cases of double representation.
QUESTION #14	An 18-year old male was in a car accident and hospitalized in County A. An AR firm, which provides AR services for the hospital, had the 18-year old sign the AR authorization designating this firm as his AR. The AR forwards the AR authorization, SAWS1 and MC 210, etc. to County A. It is determined later that the 18-year old was visiting friends in County A, where he was injured, but he actually lives with his parents in County B and is a dependent of his parents. The AR firm knew of this fact but refused to have the parents apply for Medi-Cal in County B. In fact, the parents refused to apply. Should County A accept the AR authorization and other forms and determine Medi-Cal eligibility?
ANSWER	No, the parents are responsible for their child and, if the parents wish to, must apply for him. Also, they may designate an AR. The youth is not able to do so in this case because he is not the person responsible to apply for Medi-Cal. It also appears that the AR firm is attempting to act in lieu of the youth's parent which is not permitted. County A should deny the application and refer the parents to the appropriate county if they would like to apply for benefits. The AR's intervention is denying the parents the right to choose whether or not to apply for Medi-Cal. If the parents apply in County A where their child is hospitalized, County A should accept the application, determine eligibility, and transfer the case to County B where the family lives.
QUESTION #15	Are there any circumstances in which the worker should send a copy of a notice of action (NOA) automatically to the AR?
ANSWER	Yes, copies of all NOAs in conjunction with a hearing must be sent to the AR. MPP Section 22-0104 states: "After a person or organization has been authorized to represent the claimant, the county, after notification of the authorization, shall send copies of any subsequent correspondence that it has with the claimant regarding the state hearing, to the claimant and the authorized representative simultaneously." In other situations, the worker must use good judgment to decide if a NOA should be sent to the AR at the same time it is sent to the applicant/beneficiary. For example, if an applicant/beneficiary does not speak or read English and the county does not have the NOA in the individual's primary language, the worker will send a copy of the NOA to the AR so the applicant/beneficiary is not adversely affected due to circumstances beyond his/her control.

Application handling questions & answers for incompetent LTC individuals …

QUESTION #1	When a nursing facility or other medical provider provides the County with a medical report to substantiate mental incompetency, may the County regard all resources such as bank accounts, etc. as unavailable?
ANSWER	No, the availability of property must be determined separately from the incompetency issue. Even if the applicant is regarded as incompetent (this includes individuals in a comatose or unconscious state) and unable to handle his/her own affairs. If another individual (family member, friend, etc.) can get access to the property then it must be regarded as available. Many elderly persons have friends or relatives listed on bank accounts and this joint access situation should be determined. If the incompetent individual is the only person who has access, the account will be regarded as unavailable.
QUESTION #2	After a LTC applicant has been determined to be incompetent, does he/she have to complete and sign an Appointment of Representative (AR) form?
ANSWER	No, a Medi-Cal applicant who is incompetent is presumably incapable of demonstrating the required knowledge and ability necessary to designate an authorized representative. An AR form would not be appropriate in these instances. No written authorization is required for an individual to assist an incompetent person to apply for benefits.
QUESTION #3	What would be the best course for the worker when it is found out that the representative (key person) has failed to report changes to the department?
ANSWER	The worker shall request all information necessary to determine the applicant's/beneficiary's eligibility/continuing eligibility and/or share of cost from the representative as the worker otherwise would do with any other applicant/beneficiary. If the representative refuses or fails to provide the requested information by the due date, he/she shall be considered non-cooperative. The worker would then follow Diligent Search procedures (see MPG Article 4, Section 9).

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

How To Complete an MC 13

Section A: Medi-Cal Benefits to Citizens and Aliens

This section includes a variety of important information to help applicants understand the citizenship/alienage requirements of the Medi-Cal program including the definition of Satisfactory Immigration Status (SIS). This section also includes information about alien documentation and verification requirements and SSN requirements.

Section B: Citizenship/Immigration Status Declaration

In this section the applicant will indicate whether he/she is a U.S. citizen, national or an alien, without reference to the level of benefits requested. Every applicant is required to answer question 1 indicating if he/she is or is not a citizen or national of the United States.

If the applicant indicates he/she is ...	Then the applicant must write ...
a U.S. citizen or national	his/her place of birth and then skip to Section D
NOT a U.S. citizen or national	information about his/her specific alien status in questions 2 through 4. If none of the alien statuses in questions 2 through 4 is applicable, the applicant shall answer "NO" to EACH of those questions. Aliens who claim to be PRUCOL must indicate which PRUCOL category applies to them in question 5

Section C: Verification of Immigration Status (for Aliens Claiming Satisfactory Immigration Status)

If the applicant answered “Yes” to any question 2 through 4, he/she must complete this section.

Section D: Social Security Number (SSN)

Every applicant must indicate if he/she has a SSN in this section. **However, only applicants who claim to be U.S. citizens or nationals, or aliens with SIS, are required to provide (or apply for) a SSN as a condition of eligibility.** Refer to Article 4, Section 11 for acceptable SSN verification and procedures to be followed when an applicant who is required to provide a SSN but does not have one at the time of application.

Ask an applicant who is otherwise eligible for restricted benefits to provide the SSN, if he/she claims to have one. However, if such an applicant refuses to provide the SSN, restricted benefits must be granted if the applicant is otherwise eligible. The worker should request an investigation if there is reason to believe that the applicant is withholding any information relevant to his/her Medi-Cal eligibility or SOC.

UNDER NO CIRCUMSTANCES SHOULD A WORKER KNOWINGLY SUBMIT AN INCORRECT OR FRAUDULENT SSN TO MEDS.

County Use Section

This section provides space for important information about the citizenship/alien status determination. The worker must provide all of the applicable information requested in this section. The "Action Taken" categories have been expanded to indicate when full benefits are granted pending verification of immigration status. The worker must mark this response when full benefits are granted to an eligible alien during the reasonable opportunity period to provide evidence of SIS and/or while waiting for the INS to verify SIS through SAVE. The MC 13 also adds a section for the worker to indicate which level of benefits the applicant is potentially eligible to receive based on the citizenship/immigration status information provided on this form.

Retroactive Medi-Cal Q&A

QUESTION #1	An individual's SSI/SSP is filed and approved in April 1994. He submits a written request to the County in January 1995 for retro Medi-Cal for January through March, 1994. Can he get retro Medi-Cal for these months?
ANSWER	Yes, January through March 1994 are the three months immediately preceding his SSI month of application. If otherwise eligible, he may receive retroactive Medi-Cal for these months. If the required Medi-Cal linkage is disability and the individual is not receiving or approved for Social Security (Title II) disability benefits for the period in question, a full disability packet to the Disability Determination Services Division (SP-DDSD) will be necessary to determine whether he meets the disability requirements for the retro months. If SP-DDSD approves disability from January 1994, and he is otherwise eligible, he is entitled to Medi-Cal for the retro months.
QUESTION #2	An individual's SSI/SSP application is approved April 1994. He submits a written request to the County in February 1995 for retroactive Medi-Cal for the months of January through March 1994. Can he get retro Medi-Cal for these months?
ANSWER	He can only get retro benefits for February and March 1994. An application for retro Medi-Cal coverage must be submitted within one year of the month for which retro coverage is requested. It is now too late to be found eligible for January 1994 since it exceeds the one year period. The procedures are the same as discussed in Answer 1.
QUESTION #3	An individual submits a written request for retro Medi-Cal in April 1995, for April through June 1994. She applied for SSI in July 1994 but was denied. Can she get retro Medi-Cal for those months?
ANSWER	The individual must verify that she made an application for SSI in July 1994. Once that is verified the worker must determine if she would have been eligible for one of the Medi-Cal programs listed in MPG Article 5, Section 1. If otherwise eligible she may receive retro Medi-Cal for those months. If she is applying on the basis of disability, the worker should check the "SSA Client Referral Chart" in Desk Aid 21 to determine if a disability packet should be sent to SP-DDSD, as there are specific situations where SP-DDSD cannot make an independent decision on a previously denied SSA claim. If SP-DDSD is sent a full disability packet for an independent decision and determines that she is disabled from April 1994, and she is otherwise eligible, the worker can approve Medi-Cal for the retro months.
QUESTION #4	An individual applies for SSI/SSP in January 1995, but is denied in February. She applies for Medi-Cal in March. The county denies her Medi-Cal application because the "SSA Client Referral Chart" shows that SSA has jurisdiction over the claim. However, SSA subsequently approves her SSI/SSP claim in August 1995 with an onset date of January 1995. She informs the county that she still needs retro Medi-Cal for November and December 1994. What action should the worker take?
ANSWER	If she is applying on the basis of disability, the worker shall send a full disability packet, including the SSA award letter to SP-DDSD. If SP-DDSD sets the onset date to November 1994, the worker shall rescind the original Medi-Cal denial and approve retro Medi-Cal if she is otherwise eligible.
QUESTION #5	An individual applies for SSI/SSP based on disability in July 1995 and is approved by SSA with a July 1995 disability onset date. However, SSA found that he had excess income for July and August, so the effective date of his SSI/SSP eligibility is September 1995. He then applies for Medi-Cal stating he needs help with unpaid medical bills from April 1995. What action should the worker take?
ANSWER	Although the client was technically denied by SSA for July and August 1995 on the basis of excess income, since there is verification of a disability onset date of July 1995, he would be eligible for those two months if he was otherwise eligible for Medi-Cal. The worker should send a full disability packet to SP-DDSD requesting a retro onset evaluation for the months of April through June 1995. If SP-DDSD determines that he meets the disability criteria from April 1995 forward, and he is otherwise eligible, the worker can approve retro Medi-Cal effective April 1995.

EXAMPLE OF IDX CMS ELIGIBILITY ENROLLMENT SUMMARY SCREEN

To determine if CMS has been approved, look at the most recent date and stat code (see highlighted example above).

Member: ***Patient Last Name, First Name***

Con	Effective date	Member number	Stat	Mem type	Cont type	PCP/ Site	Subscriber	Employer	Plan
2	Effective: 05/15/2001					Terminated: 11/30/2002			
	(Comment line will appear here only if entries are made)								
	06/01/02 Indiv:	SSN-99-0000	CA	SBS	DSS	161/UNAS Self Group:	ST	2-STANDARD	
	05/16/02 Indiv:	SSN-99-0000	INACT	SBS	DSS	800/UNAS Self Group:	ST	2-STANDARD	
	05/15/02	SSN-99-0000	CA	SBS	ER	161/UNAS Self	ER	1-EMERGENCY	
	05/01/02 Indiv:	SSN-99-0000	INACT	SBS	INA	800/UNAS Self Group:	INAC	8-INACTIVE	
	11/01/01 Indiv:	SSN-99-0000	CA	SBS	DHS	55/NPFHC Self Group:	ST	2-STANDARD	

The following stat codes indicate that CMS has been approved:

CA: CMS approved.

A-A: CMS approved and Medi-Cal approved for restricted and limited services.

A-P: CMS approved and Medi-Cal or SSI pending.

A-R: CMS approved three months referred to apply Medi-Cal.

AUG: Urgent Primary Care approved.

AER: Emergency Room approved.

Processing Guide 09 - LIS Applications

Table of Contents

Purpose

To provide a guide for processing a Low-Income Subsidy (LIS) application.

LIS Application Processing Instructions

Daily LIS Application Report

Applicants identified on the Daily LIS Application Report must be evaluated for Medi-Cal and/or MSP. Staff must review the report daily and process as follows:

If MEDS alert is ...	Go to section titled ...
9055 or 9056	MEDS 9055 or 9056
9057	MEDS 9057
9058	MEDS 9058
9059	MEDS 9059

MEDS Alert 9055 & 9056

Upon receipt of 9055 and 9056 MEDS Alert, the worker shall process the application as follows:

Step	Action
1	Review the LIS screens on MEDS to obtain applicant information
2	Conduct file clearance
3	Determine the date of application as outline below

<table>
<tr><td>4</td><td>Complete “Application Registration” in CalWIN using “LIS Apps” as an application source</td></tr>
<tr><td>5</td><td>Issue a Manual Verification Checklist (16-146), using the address listed on the LIS 2 or LIS 3 screen and allow 10 days to provide the following:

• MC 4604 – “Supplemental Questions for Medi-Cal/Medicare Savings Program Application”
• MC 4605 – “Important Information on Medi-Cal and Medicare Savings Program”
• All forms that are normally included with a new application packet
• CalFresh Flyer for Medi-Cal Applicants

NOTE: LIS application information contained on the LIS screens is an application and SOF for Medi-Cal, staff must not require an MC 210</td></tr>
<tr><td>6</td><td>Determine if the applicant has returned the MC 4604 and MC 4605 within 10 days

<table>
<tr><th>If the applicant …</th><th>Then the worker will …</th></tr>
<tr><td>does not respond</td><td>mail a 2nd set of all documents listed in step 5 and allow the applicant a 2nd 10-days for return
NOTE: Deny application IF client does not respond to the 2nd request</td></tr>
<tr><td>responds</td><td>proceed to Step 7</td></tr>
</table>
</td></tr>
<tr><td>7</td><td>Review the returned MC 4604 and/or MC 4605 and:

<table>
<tr><th>If applicant …</th><th>Then the worker will…</th></tr>
<tr><td>declines Medi-Cal/MSP</td><td>go to Step 8</td></tr>
<tr><td>declines Medi-Cal and MSP</td><td>withdraw the application</td></tr>
<tr><td>wants Medi-Cal and MSP</td><td>go to Step 8</td></tr>
</table>
</td></tr>
<tr><td>8</td><td>Process application by applying ex-parte and including the information on the LIS screens (LIS 1 – LIS 7) in MEDS

<table>
<tr><th>If ...</th><th>Then ...</th></tr>
<tr><td>NO additional verifications are needed</td><td>grant/deny as appropriate</td></tr>
<tr><td>additional verifications are needed</td><td>go to Step 9</td></tr>
</table>

NOTE: Information contained in LIS screens does not require verification if it meets the “Processed” criteria defined in MPG 04.02.19.C</td></tr>
<tr><td>9</td><td>Request additional verification needed and allow the applicant 10 days to respond to the request

<table>
<tr><th>If verifications ...</th><th>Then ...</th></tr>
</table>
</td></tr>
</table>

are provided	grant/deny as appropriate
are not provided	deny case FTP

NOTE: The initial mailing of the MC 4604 and MC 4605 shall constitute the first contact

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MEDS Alert 9057

Upon receipt of 9057 MEDS Alert (applicant receiving MSP but not Medi-Cal), the worker shall take the following actions:

Step	Action
1	Review active MSP case: **If the applicant ...** / **Then ...** was evaluated for MC and the case was appropriately granted/denied/discontinued → go to Step 2 was not evaluated for MC → go to Step 3
2	Confirm the LIS date of application **If the LIS application date is ...** / **Then ...** after the application date in CalWIN → no further action is necessary before the application date in CalWIN → go to Step 3
3	Issue a Manual Verification Checklist (16-146), using the address listed on the LIS 2 or LIS 3 screen and allow 10 days to provide the following: • MC 4604 – "Supplemental Questions for Medi-Cal/Medicare Savings Program Application" • MC 4605 – "Important Information on Medi-Cal and Medicare Savings Program" • CalFresh Flyer for Medi-Cal Applicants
4	Determine if the applicant has returned the MC 4604 and MC 4605 within 10 days **If the applicant …** / **Then the worker will …** does not respond → mail a 2nd set of all documents listed in step 5 and allow the applicant a 2nd 10-days for return **NOTE:** Deny application IF client does not respond to the 2nd request respond → proceed to Step 4
5	Review the returned MC 4604 and/or MC 4605 to determine if the applicant has declined Medi-Cal as follows:

	<table><tr><th>If applicant …</th><th>Then the worker will…</th></tr><tr><td>declines Medi-Cal</td><td>withdraw Medi-Cal application per applicant's request **Note:** Beneficiary's existing MSP benefits are NOT affected</td></tr><tr><td>wants Medi-Cal</td><td>go to Step 5</td></tr></table>
6	Process application by applying *ex-parte* and including the information on the LIS screens (LIS 1 – LIS 7) in MEDS <table><tr><th>If ...</th><th>Then ...</th></tr><tr><td>NO additional verifications are needed</td><td>grant/deny as appropriate</td></tr><tr><td>additional verifications are needed</td><td>go to Step 6</td></tr></table> **NOTE:** Information contained in LIS screens does not require verification if it meets the "Processed" criteria defined in MPG 04.02.19.C
7	Request additional verification needed and allow the applicant 10 days to respond to the request <table><tr><th>If verifications ...</th><th>Then ...</th></tr><tr><td>are provided</td><td>grant/deny as appropriate</td></tr><tr><td>are not provided</td><td>deny case FTP</td></tr></table> **NOTE:** The initial mailing of the MC 4604 and MC 4605 shall constitute the first contact

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MEDS Alert 9058

Upon receipt of 9058 MEDS Alert (applicant receiving Medi-Cal but not MSP), the worker shall take the following actions:

Step	Action
1	Review active Medi-Cal case: <table><tr><th>If the applicant ...</th><th>Then ...</th></tr><tr><td>was evaluated for MSP and the case was appropriately granted/denied/discontinued</td><td>go to Step 2</td></tr><tr><td>was not evaluated for MSP</td><td>go to Step 3</td></tr></table>
2	Confirm the LIS date of application <table><tr><th>If the LIS application date is ...</th><th>Then ...</th></tr><tr><td>after the application date</td><td>no further action is necessary</td></tr><tr><td>before the application date</td><td>go to Step 3</td></tr></table>

3	Process application by applying *ex-parte* and including the information on the LIS screens (LIS 1 – LIS 7) in MEDS **If ...** / **Then ...** NO additional verifications are needed → grant/deny as appropriate additional verifications are needed → go to Step 6 **NOTE:** Information contained in LIS screens does not require verification if it meets the "Processed" criteria defined in MPG 04.02.19.C
4	Request any information/verifications needed to make an accurate eligibility determination, and mail the CalFresh Flyer for Medi-Cal Applicants
5	Approve/Deny benefits as appropriate

MEDS Alert 9059

Upon receipt of 9059 MEDS Alert (applicant receiving Medi-Cal and MSP), the worker shall take the following actions:

Step	Action
1	Determine if the LIS application date is before or after the application date shown in CalWIN **If the LIS application date is ...** / **Then the worker will…** **before** the application date in CalWIN → proceed to Step 2 **after** the application date in CalWIN → narrate in case comment that client is already receiving Medi-Cal benefits
2	Re-evaluate case for requesting month(s) by applying *ex-parte* and including the information on the LIS screens (LIS 1 – LIS 7) in MEDS **If ...** / **Then ...** NO additional verifications are needed → grant/deny as appropriate additional verifications are needed → go to Step 6 **NOTE:** Information contained in LIS screens does not require verification if it meets the "Processed" criteria defined in MPG 04.02.19.C
3	Request any information/verifications needed to make an accurate eligibility determination, and mail the CalFresh Flyer

	for Medi-Cal Applicants.
4	Approve/Deny benefits as appropriate.

Application Dates

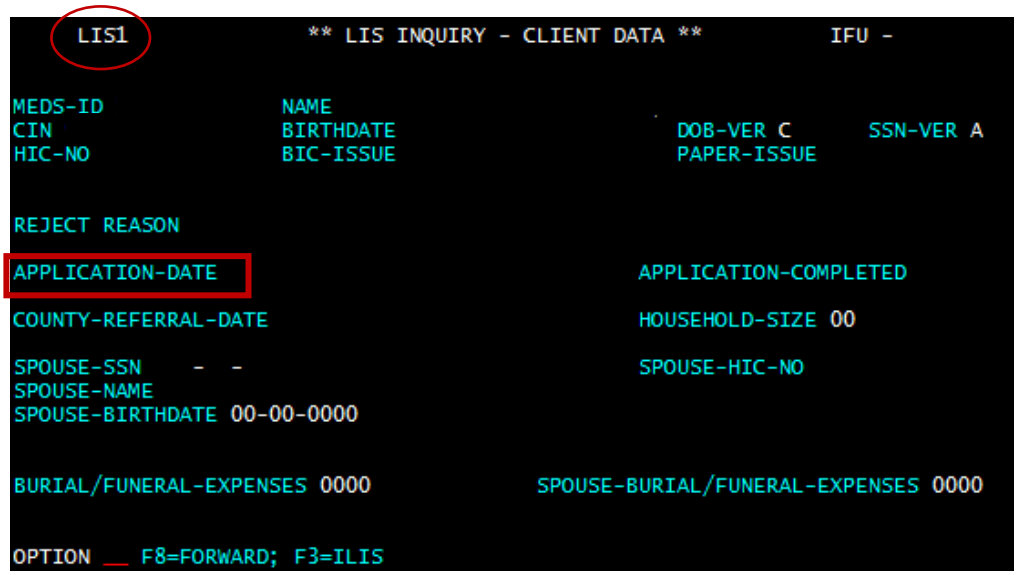
Overview

This section provides staff instructions on how to determine the date of application when processing LIS applications with:

- No prior or current Medi-Cal case
- Pending Medi-Cal application
- Active on Medi-Cal
- Previously discontinued from Medi-Cal
- Previously denied Medi-Cal

No Prior or Current Medi-Cal Case

When the applicant has no prior or current Medi-Cal case in CalWIN, the worker will use the LIS application date shown on the MEDS LIS1 screen (as seen below) as the Medi-Cal date of application.



Pending Medi-Cal Application

When the applicant has a pending Medi-Cal application in CalWIN the worker must:

Step	Action
1	Compare the LIS application date on the MEDS LIS1 screen to the application date shown in CalWIN **If the LIS application date is ...** / **Then ...** **after** the MC application date in CalWIN / maintain the Medi-Cal application date in CalWIN **before** the MC / Go to Step 2

	application date in CalWIN |
2	Review pending application to confirm programs being requested: **If the program being requested is ...** | **Then ...** Medi-Cal | request that the Automation Coordinator change the date in CalWIN to the LIS application date CalWORKs, CalFresh or General Relief | go to Step 3
3	Complete a manual eligibility determination as outlined in the Manual Determination Procedures section below

Active on Medi-Cal

When the applicant has an active Medi-Cal application in CalWIN the worker must:

Step	Action
1	Compare the LIS application date on MEDS to the application shown in CalWIN **If the LIS application date is ...** | **Then ...** **after** the MC application date in CalWIN | maintain the Medi-Cal application date in CalWIN **before** the MC application date in CalWIN | go to Step 2
2	Complete a manual eligibility determination as outlined in the Manual Determination Procedures section below

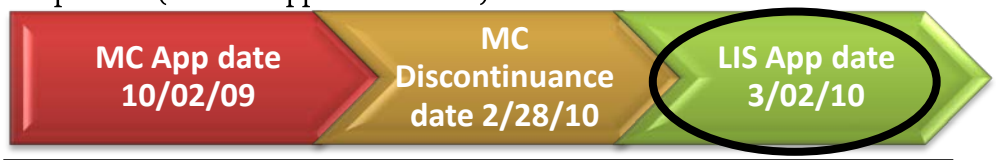
NOTE: If there are only three months between the LIS application month and the application month in CalWIN **AND** the LIS applicant did not request for Retroactive Medi-Cal, the worker may open a Retro Medi-Cal application for each of the three months as long as the current month of eligibility is within 12 months of CalWIN application date. When this method is used, case comments must clearly 1) document the LIS application month and 2) indicate that Retroactive Medi-Cal was not requested based on the LIS application.

Previously Discontinued from Medi-Cal

When the applicant has been previously discontinued from Medi-Cal the worker must:

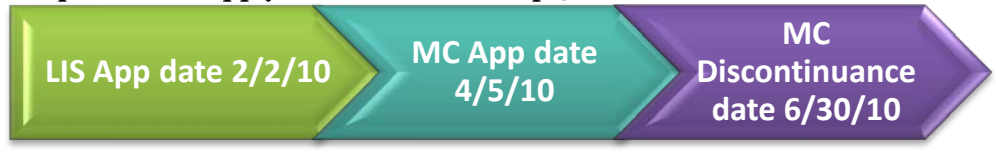
Step	Action
1	Compare the LIS application date on MEDS to the application shown in CalWIN **If the LIS app date is ...** / **Then ...** **after** the MC discontinuance date (sample one) / use the LIS application date **after** the MC application date BUT **before** the discontinuance date (sample two) / go to Step 2 **before** the MC application date in (sample three) / go to Step 3
2	Review the discontinuance accuracy based on information shown on the LIS MEDS screens **If the discontinuance ...** / **Then ...** remains valid / narrate findings is no longer valid / rescind the discontinuance **NOTE:** Information contained in LIS screens does not require verification if it meets the "Processed" criteria defined in MPG 04.02.19.C
3	Complete a manual eligibility determination as outlined in the Manual Determination Procedures section below

Sample One (Use LIS application date.)



Sample Two (Apply instructions in Step 2 above.)

Sample Three (Apply instructions in Step 3 above.)



Previously Denied Medi-Cal

When the applicant has been previously denied from Medi-Cal the worker must:

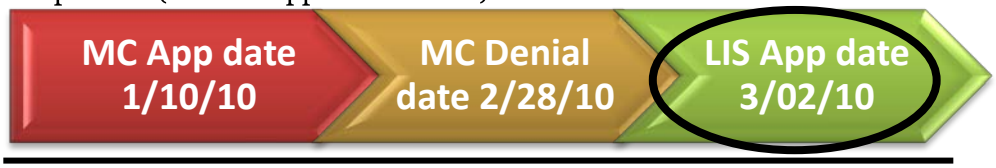
<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Compare the LIS application date on MEDS to the application shown in CalWIN

<table>
<tr><th>If the LIS app date is ...</th><th>Then ...</th></tr>
<tr><td>after the MC denial date (sample one)</td><td>use the LIS application date</td></tr>
<tr><td>after the MC application but before the denial (sample two)</td><td>go to Step 2</td></tr>
<tr><td>before the MC application date (sample three)</td><td>use the LIS application date</td></tr>
</table></td></tr>
<tr><td>2</td><td>Review the denial accuracy based on information shown on the LIS MEDS screens

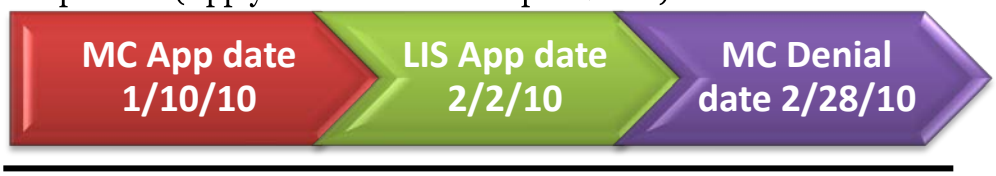
<table>
<tr><th>If the denial ...</th><th>Then ...</th></tr>
<tr><td>remains valid</td><td>narrate findings</td></tr>
<tr><td>is no longer valid</td><td>rescind the denial</td></tr>
</table>
NOTE: Information contained in LIS screens does not require verification if it meets the “Processed” criteria defined in MPG 04.02.19.C</td></tr>
<tr><td>3</td><td>Applying ex-parte and including the information on the LIS screens (LIS 1 – LIS 7) in MEDS, determine the individual’s Medi-Cal and MSP eligibility

<table>
<tr><th>If the applicant is ...</th><th>Then ...</th></tr>
<tr><td>eligible to Medi-Cal and/or MSP</td><td>go to Step 4</td></tr>
<tr><td>ineligible to both Medi-Cal and MSP</td><td>narrate actions and no further action is required</td></tr>
</table></td></tr>
<tr><td>4</td><td>Rescind the denial and issue benefits, beginning with the application date shown in CalWIN</td></tr>
</table>

Sample One (Use LIS application date.)



Sample Two (Apply instructions in Step 2 above.)



Sample Three (Use the LIS application date.)

Manual Determination Procedures

To determine and issue LIS benefits manually workers must:

Step	Action
1	Apply *ex-parte* including the information on the LIS screens (LIS 1 – LIS 7) in MEDS
2	Complete manual income and property budgets for Medi-Cal and/or MSP **If ...** / **Then ...** eligible to MC and/or MSP → go to Step 4 ineligible → go to Step 3
3	Deny and issue a NOA manually, no further action necessary
4	Activate the individual on MEDS with MEDS online transaction(s)
5	Record the individual's MC and/or MSP eligibility information on CalWIN Collect Individual Current/Prior Aid Detail Window
6	Enter a Case Comment and issue NOA manually