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February 23, 1994

MEDI-CAL ELIGIBILITY MANUAL LETTER NO. 130

TO: All Holders of the Medi-Cal Eligibility Manual

Enclosed is an addition to the procedures portion of the Medi-Cal Eligibility Manual. This addition consolidates Articles 4R and 15G into a new article, Article 23.

The following description identifies the reason for each addition, and when appropriate, identify specific All County Welfare Directors (ACWD) Letters which may be discarded.

Procedure Revision	Description
Article 4R Article 15G Article 23	Procedures for Medical Support Enforcement Program

Filing Instructions:

Remove Pages	Insert Pages
Procedural Table of Contents Article 4, page PTC-5	Procedural Table of Contents Article 4, page PTC-5
Article 4 Table of Contents Pages 3 and 4 Pages 4R-1 through 4R-10	Article 4 Table of Contents Pages 3 and 4
Procedural Table of Contents Article 15, page PTC-15 Article 15, Table of Contents Pages 3 and 4 Pages 15G-1 through 15G-5	Procedural Table of Contents Article 15, page PTC 15 Article 15, Table of Contents Pages 3 and 4
	Procedural Table of Contents Article 23, page PTC-23 Article 23, Table of Contents Pages 23A-1 through 23M-1

If you have any questions concerning a specific revision, please contact Ms. Elena Lara at (916) 657-0712.

Original signed by

Frank S. Martucci, Chief
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23A. INTRODUCTION

1. PURPOSE

The Medical Support Enforcement Program provides that as a condition of eligibility for Medi-Cal, applicants and beneficiaries must cooperate in medical support enforcement when there is an absent parent who may be responsible for their dependent child(ren)'s medical care, or in paternity establishment when there is a child born out of wedlock. These referrals for medical support enforcement will be made for all children under age 18 who are recipients of Medi-Cal or for whom Medi-Cal is being sought.

2. BACKGROUND

Title IV-D of the Social Security Act established the child and spousal support enforcement program. The Federal Deficit Reduction Act of 1989, the Consolidated Omnibus Budget Reconciliation Act of 1985, and the Omnibus Budget Reconciliation Act (OBRA) of 1987 amended sections 1902 and 1912 of the Social Security Act. These legislative changes required that, as a condition of Medi-Cal eligibility, applicants and beneficiaries must cooperate in medical support enforcement and paternity establishment. Assembly Bill 1422 (Chapter 806, Statutes of 1988) added section 14008.6 to the Welfare and Institutions Code to adopt, at the state level, the federal requirements.

Medical Support referrals are made to the Family Support Division/District Attorney (FSD/DA). Under California Civil Code, Section 4726, the court must consider that either the absent parent, custodial parent, or both parents provide medical insurance coverage to the child(ren) when medical insurance is available at no or reasonable cost. Section 4726 also requires the court and FSD/DA to secure health insurance through court and administrative orders in all child and medical support actions. Section 4726.1 permits the court to order the employer of the absent parent or other person providing health insurance to the caretaker parent to enroll the supported child in the available health insurance plan. Welfare & Institutions (W&I) Code, Section 11490, requires that medical insurance information be collected by the county FSD/DA offices and then forwarded to Department of Health Services (DHS).

The FSD/DA is responsible for enforcing medical support, in addition to obtaining information regarding the availability of health insurance when such information is not reported by the county welfare department. Health insurance coverage is required if it is available at no or reasonable cost to the parent(s). Federal regulations define "reasonable cost" health insurance as group or employer related health insurance, regardless of the service delivery mechanism. This includes health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

3. IMPLEMENTATION

The medical support enforcement regulations for DHS's Medi-Cal program were implemented by county welfare departments on July 1, 1993.

23B. CONDITION OF ELIGIBILITY

1. MEDI-CAL ONLY

The county must inform an applicant for or beneficiary of Medi-Cal only that, as a condition of eligibility, the applicant or beneficiary must:

- o Assign to the State the applicant's or beneficiary's rights to any medical support and payments;
- o Cooperate in obtaining medical support and payments;
- o Cooperate in establishing paternity for a child born out of wedlock for whom aid is requested;
- o Cooperate in identifying and locating the absent parent; and
- o Provide information about possible entitlement to medical support and payments available through any third party.

If the applicant or beneficiary is found ineligible for Medi-Cal because of the above, this will not affect the child(ren)'s Medi-Cal eligibility. The applicant can withdraw the application, close the case, or become an ineligible member of the Medi-Cal Family Budget Unit (MFBU).

2. AFDC/Edwards

A recipient of Aid to Families with Dependent Children (AFDC) who is discontinued from AFDC for refusal to cooperate in child support will receive Edwards Medi-Cal.

In **Edwards** cases, upon review of the 210E, if the case is an absent parent situation or there is a child born out of wedlock, the county will **mail** the applicant/caretaker parent the medical support enforcement information. The caretaker parent may then agree to cooperate and sign the documents or can claim good cause for noncooperation. If the caretaker parent refuses to cooperate, follow procedures for noncooperation and refer the child(ren) for medical support enforcement.

Even though the AFDC eligibility worker is responsible for sending the case package of child support forms, the EW is responsible for ensuring that the medical support portions of these forms are filled out correctly for Medi-Cal. If needed, the counties can use the revised forms available in the DHS warehouse.

3. DEPARTMENT OF SOCIAL SERVICES (DSS) CHILD SUPPORT PROCEDURES

DSS child support procedures are to be found in the following:

- o DSS Manual of Policy and Procedures (MPP) Sections 12-100 through 12-908 and 43-200 through 43-203;
- o DSS Family Support Division (FSD) Letter No. 93-08, 3/12/93 Title IV-D Child and Spousal Support Program Procedure Manual.

23C. PATERNITY ESTABLISHMENT

1. PURPOSE

As a condition of Medi-Cal eligibility, an applicant/recipient must cooperate in paternity establishment when there is a child born out of wedlock for whom Medi-Cal is being sought. A referral is made to establish the existence of a father and child relationship and the duty of support.

When two unmarried adults seek Medi-Cal for themselves and their children but do not cooperate with medical support, then the county must make a medical support referral for the children. A referral should be made whenever a child is born out of wedlock. (Title 22, CCR, Section 50101(b).)

2. PATERNITY ESTABLISHMENT BY DISTRICT ATTORNEY

When a medical support referral is made for paternity establishment, the FSD/DA will obtain the identity of the absent father from the applicant/recipient. State law requires the FSD/DA to investigate the question of paternity and take all necessary steps to obtain a paternity determination; however, no questions on paternity will be asked when paternity is not an issue.

The FSD/DA is not required to establish paternity in any case involving forcible rape, incest, or legal proceedings for adoption if such action is not in the child's best interests. (Title 22, CCR, Sec. 50771.5; W&I Code, Art. 7.)

3. TIME FRAMES

Within 90 days of locating the absent father, the FSD/DA will file for paternity or complete service of process to establish paternity or document unsuccessful attempts to serve process. Paternity must be established or the absent parent excluded as a result of genetic tests and/or legal process within one year or the later of successful service of process or the child reaching six months of age.

The FSD/DA will file a Motion for Temporary Support whenever the alleged father refuses to stipulate to paternity. A motion will be filed for blood tests at the request of any party in a contested paternity case as appropriate. If the alleged father is excluded by blood tests, the FSD/DA will review the case to determine whether the mother should be deemed as non-cooperative for failure to provide the name of the natural father of the minor child or a case should be opened against a different individual. If another alleged father is identified, the FSD/DA has 90 days after locating this person to file for paternity or complete service of process to determine paternity. The time frames for establishing paternity for subsequent alleged fathers is the same as for the original alleged absent father. (W&I Code, Art. 7)

23D. PETITION TO THE COURT

The county must notify each applicant or beneficiary placed in the following aid codes that the California Child Support Enforcement (IV-D) Agencies must, by law, petition to the court to include health insurance coverage in support orders when a child receives Medi-Cal. Referral in aid codes cited below will be for children under 18 with an absent parent or when a child is born out of wedlock. HOWEVER, NO UNDOCUMENTED PERSONS, NO PREGNANT WOMEN, AND NO ONE APPLYING FOR MINOR CONSENT SERVICES WILL BE REFERRED. Also, referrals for infants will be made after the 60-day postpartum period. (For explanation of absent parent situations, please refer to MEM Article 1-B.)

In situations where the applicant is filing for retroactive Medi-Cal only, no referral will be made. In situations where the absent parent is already providing health insurance, no referral is necessary.

MEDI-CAL AID CODES

The following aid codes are the ones for which the Medi-Cal Eligibility Worker must refer the children with an absent parent.

7A	27	47	64	79
20	34	51	67	82
24	37	60	72	83

AFDC AID CODES

The following aid codes are the ones for which child support referrals, including medical support, should have already been made by the AFDC or Foster Care Intake Worker for AFDC or foster care cases.

30	33	40	45
32	35	42	

1. PREGNANT WOMEN

Medical support referrals will **NOT** be made on the absent/unmarried parent of an unborn child until the end of the 60-day postpartum period. If the absent/unmarried parent of the unborn has other eligible children in the MFBU, a medical support referral for these children will **NOT** be made until the end of the 60-day postpartum period of the pregnant caretaker parent. If a pregnant caretaker parent has other eligible children in the MFBU with a different absent parent than for the unborn, a medical support referral will **NOT** be made on the children of the absent or unmarried parent(s) until the end of the 60-day postpartum period of the pregnant caretaker parent.

When a woman with a child(ren) has applied for Medi-Cal but refuses to cooperate in medical support and does not claim good cause, she becomes ineligible for Medi-Cal and designated as an ineligible member of the MFBU. The woman's child(ren) may be eligible for Medi-Cal if otherwise eligible and she has not withdrawn the application or asked to close the case. If this caretaker parent then becomes pregnant and applies for Medi-Cal, she may be eligible until her 60-day postpartum period ends. A referral for the caretaker parent and the new child can be made at the completion of the 60-day postpartum period.

If a caretaker parent has a child(ren) and has cooperated with medical support requirements, but then becomes pregnant, the medical support referral process should not be interrupted. The pregnancy should be reported to the FSD/DA, but no referral on the new child should be made until the 60-day postpartum period ends. The rule in on-going medical support cases is if there is any change in the case, it should be reported to the FSD/DA via Form CA 371. The FSD/DA should be advised of any changes (e.g., discontinuance from AFDC, new Medi-Cal case).

An unmarried/absent parent may apply for Medi-Cal and medical support services for the caretaker parent at the hospital if the caretaker parent is unable to fill out an application. Under Title 22, CCR, Section 50143, if a person is unable to file an application for Medi-Cal, "(2) a person who knows of the applicant's need to apply" may file the application. An unmarried/absent person would qualify under this definition.

2. **OBRA REFERRALS**

If the caretaker parent or mother is undocumented and her children are also undocumented, no medical support referral will be made. If the caretaker parent/mother is undocumented and the children are citizens or IRCA's (Immigration Reform and Control Act), a medical support referral will be made. No undocumented children will be referred.

If the caretaker parent has both OBRA children and citizen children and requests that both be referred for medical support enforcement, the county will only make a referral on the citizen children. Medical support enforcement referrals will not be made on the OBRA children. There are no referrals on OBRA children because they receive restricted benefits and the absent parent may not be a citizen or in the United States.

3. **CONTINUING ELIGIBILITY**

Under this program, infants born to Medi-Cal eligible women are automatically "deemed eligible" for one year, provided they continue to live with their mother and the mother remains eligible for Medi-Cal, or would remain eligible if she were still pregnant. There is no parental allocation from the father to the infant during the period of Continued Eligibility; only the mother's income, before any increases, will be allocated to the infant. However, for purposes of medical support enforcement, the father/absent parent still has a legal responsibility for the health and welfare of his children and, at the end of the 60-day postpartum period, a medical support referral must be made.

4. **FOSTER CARE CHILDREN**

Medical support enforcement referrals will not be done by the county Medi-Cal Eligibility Worker on foster care children. The AFDC or Foster Care Intake Workers will make child support referrals, including medical support for all foster care children. Foster care children are automatically eligible for Medi-Cal after utilizing whatever other health coverage is available. This is clarified in Section 903 of the Welfare & Institutions Code, Liability for Costs of Support. This section prohibits any imposition of medical costs upon the natural parent(s) until the county has first exhausted any eligibility the child may have under private insurance coverage, standard or medically indigent Medi-Cal coverage, and the Robert W. Crown California Children's Services Act. If there are any costs over and above 100 percent of the average Medi-Cal payment that are not covered under any of the coverages listed, the county may choose to impose those costs.

The Medi-Cal program automatically grants a Medi-Cal card to children in foster care, and providers are instructed to bill the Medi-Cal program first. Medi-Cal will pay the provider of service. Then Medi-Cal will seek repayment from the other health coverage.

5. **ADULT CHILDREN**

Adult children under Medi-Cal are persons 14 to 18 years of age who are not living in the home of a parent or caretaker relative and who do not have a parent, caretaker relative or legal guardian handling any of their financial affairs (Title 22, CCR, Sec. 50014). Also, the parents do not claim the child as a dependent in order to receive a tax credit or deduction for state or federal income tax purposes. Adult children would not be referred for medical support enforcement.

Disabled Adult Children under the Pickle program are at least 18 years of age or older. They will not be referred for medical support enforcement. Referrals are for those under 18.

6. **TRANSITIONAL MEDI-CAL**

No transitional Medi-Cal cases are to be referred. This includes children in aid codes 39, 54, and 59. These families were initially on AFDC and lost their cash grant due to increased earnings, increased hours of employment, or increased allocation of child/spousal support payments. Transitional Medi-Cal is provided to these families as an aid in helping them become self-sufficient. If they apply for Medi-Cal Only at the end of their transition period, they should be treated as a new case and a referral should be made.

7. **DECEASED ABSENT PARENT**

No medical support enforcement referral will be initiated for deceased absent parents. However, sufficient substantiation of the fact that the absent parent is deceased is required.

EXAMPLES:

1. Woman with three children declares father is deceased and provides birth certificate for children, death certificate for father, and marriage certificate.

   a. Marriage occurred after birth of children and father's name is not on birth certificates. **Question:** Do we do paternity referral? **Response:** Yes. Children born out of wedlock.

   b. Marriage occurred after birth of children and father's name is on birth certificates. **Question:** Do we do paternity referral? **Response:** No. If mother declares he is rightful father and that is why he is on birth certificates.

   c. Marriage occurred before birth of all children and father's name is not on birth certificates. **Question:** Do we do paternity referral? **Response:** No. Children were not born out of wedlock. Presumption is deceased person is father.

d. Marriage occurred before birth of children and father's name is on birth certificate. **Question:** Do we refer since we have a death certificate? Must the FSD/DA validate the death for us? **Response:** No referral when there is no absent parent. He is not absent; he's deceased.

e. Same as Number d, but woman claims that at least one of the children has a father other than the man named on the death certificate. **Question:** Would a referral be sent on this new man even though we have a death certificate on the father? **Response:** Refer if there is no name on birth certificate, but use your best judgment since children were not born out of wedlock.

2. Woman with one child applies and is granted benefits. Prior to completing the approval action, she calls the EW and advises that she has moved to County A. EW completes the disposition and processes for an intercounty transfer (ICT) to County A. **Question:** Case should be referred for medical support if she had stayed in County B, but since she is in County A physically, are we required to send the medical support referral to County B FSD/DA as part of the regulations even knowing that they will be closing because of the change in county address? **Response:** In this case, make sure County A is aware of need for medical support referral in County A in the ICT documents. Since case will be in County A, County A must make the referral.

3. Woman with two children applies and is granted benefits for one month only. Case requires cooperation with medical support. **Question:** At point that benefits are approved and cooperation with medical support referral is okay, do we send the medical support referral to the FSD/DA knowing that the case is closed and that they will do nothing with it. Seems to be a workload that is unnecessary. **Response:** If woman requests child and medical support, then refer. If a woman requests medical support enforcement and is willing to request child support enforcement services also, she may be referred to FSD/DA. If woman wants medical support enforcement services only, she can only receive this service if she is continuing on Medi-Cal. However, since there is no retro enforcement, do not refer unless she specifically wants medical support and child support enforcement services.

23E. GOOD CAUSE FOR NONCOOPERATION

The applicant or beneficiary may claim good cause for noncooperation in establishing paternity, medical support payments, or identifying third party liability if he/she feels there is a risk of emotional or physical harm to himself/herself or a child(ren) if a referral is made for medical support enforcement. The county must determine, based on criteria stipulated in CCR, Title 22, Section 50771.5, if the applicant or beneficiary, in fact, has good cause for failure to cooperate with medical support requirements. (No provision exists for a finding of good cause when the applicant or beneficiary refuses to assign to the State his/her rights to medical support, payments, care, and services.) If the county determines that good cause does not exist (Form CA 51; CCR, Title 22, Section 50101), then the applicant or beneficiary should be given an opportunity to withdraw the application, close the case, or be designated as an ineligible member of the Medi-Cal Family Budget Unit (MFBU) (CCR, Title 22, Sections 50155, 50379).

Once good cause is established, it continues unless the mother/caretaker parent rescinds the claim for good cause and is able to cooperate with medical support enforcement. Review at redetermination to determine if circumstances have changed. It is not necessary to process another claim for good cause.

The CA 51 Good Cause Claim for Noncooperation form calls for statistical reporting. The Office of Child Support has informed us that no statistical reporting will be required of counties for good cause determinations.

1. NONCOOPERATION

When a caretaker parent has refused to cooperate and does not claim good cause, the county should refer the child(ren) for medical support services. Medical support enforcement is a condition of eligibility for Medi-Cal. No one has to make a good cause claim if he/she does not want to cooperate with medical support. It should be noted on the CA 371 that the parent will not cooperate.

The caretaker parent has the right to refuse to cooperate in medical support enforcement for himself/herself and for the child(ren). If this occurs, the caretaker parent is denied or discontinued from Medi-Cal, but the child(ren) may be granted Medi-Cal or continues receiving Medi-Cal, if otherwise eligible, and the caretaker parent does not withdraw the child(ren)'s application. The county would refer the child(ren) for medical support services. Assignment of rights is an automatic process of Medi-Cal eligibility. (Welfare & Inst. Code, Sec. 14008.6.) The caretaker parent can withdraw the application or close the case if he/she does not want a medical support referral on the child(ren). Also, in good cause denials, the county may direct the District Attorney to continue medical support enforcement without the cooperation of the caretaker parent. (Title 22, CCR, Section 50101(b)(3) and 50157(f)(12)(C).

- o If an applicant/recipient applies for Medi-Cal and does not want to cooperate in medical support, the county must deny/discontinue the applicant/recipient. Medical support is a condition of eligibility;
- o If the applicant/recipient applies for Medi-Cal and agrees to cooperate, and the referral is made, but he/she does not cooperate with the FSD/DA, discontinue Medi-Cal; and

- o If the applicant/recipient comes back two months later and agrees to cooperate, do not reinstate applicant/recipient back on Medi-Cal until he/she cooperates with the FSD/DA and brings back a letter of cooperation. Later, if he/she comes in and wants to cooperate and makes an appointment with the DA's office and the appointment is not until the following month, the applicant/recipient will receive retroactive Medi-Cal for the month in which he/she first made the appointment if it is documented by the DA in the letter of cooperation.

2. NOTICES OF ACTION

Good cause in medical support is the process by which someone can make a claim that he/she has good cause for not cooperating in medical support enforcement. The claim is documented by filing a CA 51. The NOAs for good cause are to be used to inform the caretaker parent whether his/her claim has been approved or denied. An applicant may claim good cause if he/she feels that there is a risk of emotional or physical harm to himself/herself or a child(ren) if a referral is made for medical support enforcement. The county will request documentation from the caretaker parent to support the claim of good cause. This information will be sent to the FSD/DA with the CA 51, and the FSD/DA will investigate further and make a recommendation on the claim. The claim is then returned to the county for a final recommendation of approval or denial of good cause. The applicant is informed of this decision through the NOAs for Good Cause.

(For Notices of Action for Approval or Denial of Good Cause Claims, see Section 23H.)

23F. REFERRAL PROCESS

DHS has adopted the Department of Social Services' (DSS') child support procedures, including the forms and referral process, for the Medi-Cal program. The county welfare department shall refer Medi-Cal Only absent parent cases to the Family Support Division/District Attorney (FSD/DA) for applicable support enforcement services. The county welfare department will also make referrals for paternity establishment services to the FSD/DA when there is a child born out of wedlock. These services will be provided without application or application fee.

All new applicants for Medi-Cal in the appropriate aid codes will be referred **within two days** of the Medi-Cal eligibility determination for medical support enforcement services. No referral is to be made until a Medi-Cal determination is approved. Existing cases will be referred at the time of redetermination. These redeterminations will be face-to-face for proper notification and forms completion by the beneficiary. The county welfare department will inform Aid to Families with Dependent Children (AFDC) recipients of changes related to medical support enforcement. Whenever the county becomes aware that an on-going case is an absent parent situation or there is a child born out of wedlock, a medical support referral should be made. Do not wait for redetermination if there is a change in the case.

Please notify the applicant or beneficiary if he or she receives direct payment for medical support for services which were paid for by Medi-Cal. Payments made in this situation should be forwarded to DHS. If payments are not forwarded to DHS, the Department's Third Party Liability Branch will pursue reimbursement from him or her. (Further information can be found in Section 23M.)

Each applicant for Medi-Cal with an absent parent or a child born out of wedlock will be advised of child support services available through the FSD/DA. If a Medi-Cal applicant indicates all child support services are wanted, the case should be handled in the same manner as a non-aid case, except that medical support is assigned to the State. All current child support collected on behalf of Medi-Cal only families must be paid to the family in accordance with the State's non-AFDC policy.

1. FORMS REFERRAL

For application and referral of Medi-Cal cases to the IV-D agencies, the county shall use the following forms:

- **MC 219 (Cover Sheet) (11/93) and MC 210 (8/93)** - Applicant is advised of rights regarding medical support enforcement referrals and third party liability. A copy is given to applicant; the original is placed in file. If the applicant refuses to sign and cooperate, then a notice of action denying Medi-Cal is sent to applicant.

- **Health Insurance Questionnaire (DHS 6155, 10/90)** - Applicant fills out form if there is other health coverage available through the absent parent. County sends a copy both to DHS Third Party Liability Branch and to the FSD/DA.

- **Child/Spousal and Medical Support Notice and Agreement (CA 2.1 Notice and Agreement (12/89))** - Applicant reviews and signs the agreement. If this form is not signed and good cause is claimed, a CA 51 (Child Support - Good Cause Claim for Noncooperation) must be completed and sent to the FSD/DA with evidence of good cause. If form is signed, then medical support process begins and all documents are sent to FSD/DA via CA 371.

- **Child Support Questionnaire (CA 2.1 Q Support Questionnaire (3/93))** - Applicant fills out form, and original is sent to the FSD/DA within two days. The FSD/DA may set up interview with applicant if form is not complete.

- **Child Support - Good Cause Claim for Noncooperation (CA 51 (3/93))** - If applicant claims good cause for failure to cooperate with medical support enforcement requirements, applicant must fill out the form and send the original with evidence of good cause to the FSD/DA. The FSD/DA will return it to the county with a recommendation. The county will make a final decision and, if good cause is denied, the county will give the applicant an opportunity to withdraw the application, close the case, or be designated as an ineligible member of the MFBU. The county will send a copy of the CA 51 to the FSD/DA with the final determination.

- **Child Support Enforcement Program Notice (CS 196 (12/93))** - A copy shall be given to all applicants who claim Medi-Cal for children with absent parent. This is an information notice which explains child and medical support enforcement program, services available, and rights of applicant.

- **Referral to District Attorney (CA 371 (3/93))** - This is a cover sheet to transmit absent parent information to FSD/DA (one form for each absent parent). The county sends a CA 371 to the FSD/DA with originals of CA 2.1 Questionnaire, CA 51 when good cause is claimed (with evidence), and DHS 6155. This form is used to convey any information regarding the status of the case back and forth between the county and the FSD/DA.

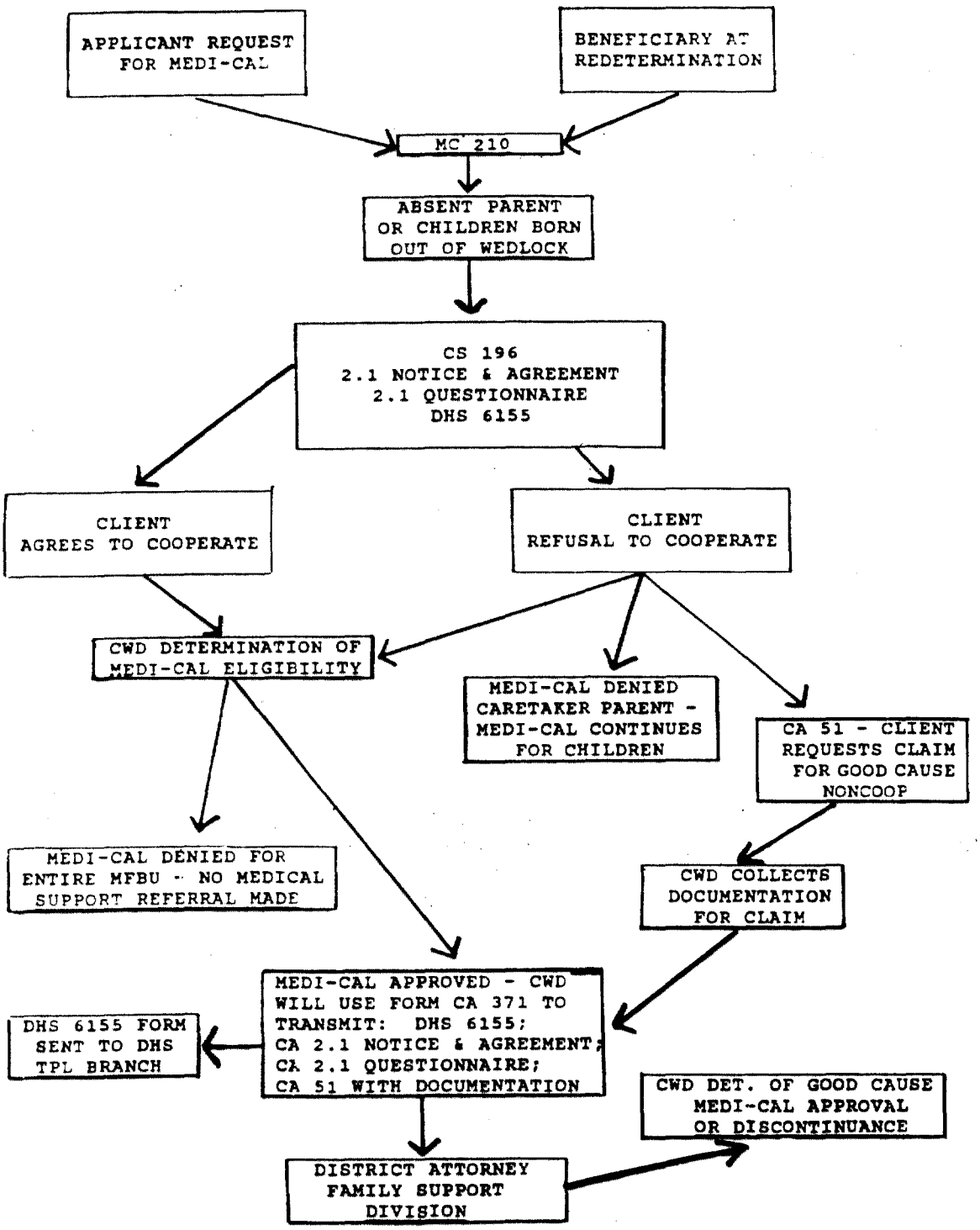
- **Medical Insurance Form (DHS 6110 10/91)** - Applicant fills out this form if there is other health coverage available through the absent parent. The FSD/DA sends the form to DHS Third Party Liability Branch. DHS will then send a copy to county welfare department.

- **Attestation Statement (CS 870)** - The FSD/DA will use the CS 870 to give the applicant an opportunity to attest (swear), under penalty of perjury, that he or she has provided all available information regarding the absent parent. A determination of noncooperation cannot be made without giving the applicant the opportunity to complete this form.

NOTE: The county must ask the applicant or beneficiary to state whether he or she wants child support, medical support, or both, and must indicate services requested on the CA 2.1 Questionnaire and on the CA 371. The CA 371 will be used by the county and FSD to communicate subsequent changes or additional information on the case. **THE COUNTY MUST EMPHASIZE TO THE APPLICANT OR BENEFICIARY THAT, FOR RECEIPT OF MEDI-CAL ONLY, CHILD SUPPORT SERVICES ARE AVAILABLE BUT NOT MANDATORY, AND THAT REFUSAL OF CHILD SUPPORT SERVICES WILL NOT AFFECT MEDI-CAL ELIGIBILITY (CS 196 AND CA 2.1).**

(The above forms are available in the DHS warehouse. Copies of the forms are included in Section 23J.)

2. FORMS REFERRAL CHART



23G. HEALTH INSURANCE ASSIGNMENTS, COST SHARING AND MEDI-CAL COPAYMENTS

As a condition of eligibility for Medi-Cal, a beneficiary must assign to the State his or her rights, and the rights of any other Medi-Cal eligible for whom he or she can legally make an assignment, to medical support, health insurance payments, or other third party payments for medical care. This assignment is completed automatically as part of the application process.

The Medi-Cal beneficiary must cooperate with the county and DHS in obtaining medical support or payments, and cooperate in identifying and providing information to assist medical providers and the State in pursuing third parties who may be liable to pay for medical care and services. Identification of a Medi-Cal beneficiary's other health coverage enables the state to cost avoid medical services and/or to recover from insurance funds previously paid to a provider.

1. HEALTH INSURANCE COST-SHARING

In addition to Medi-Cal, a Medi-Cal beneficiary may also have private health insurance. The private health insurance plan may require a deductible, copayment and/or coinsurance amount.

Following are definitions of deductibles, copayments, and coinsurance:

Deductibles

A deductible is the expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles are generally fixed dollar amounts and are usually tied to some reference period over which they may be incurred, e.g., $100 per calendar year, benefit period, or spell of illness.

Copayments

A copayment is a type of cost sharing whereby an insured or covered person pays a specified flat amount per service (e.g., $5 per prescription; $10 per office visit). Copayment is incurred at the time the service is received.

Coinsurance

Coinsurance is a cost-sharing requirement under a health insurance policy which provides that the insured will assume a percentage of the costs of covered services. The policy provides that the insurer will reimburse a specified percentage (usually 80%) of all or certain services above any deductible. The percent paid may be applied only to a "reasonable" charge. The insured is then liable for the remaining percentage of covered costs and may be liable for charges above those deemed reasonable, until the maximum amount stipulated under the insurance policy is reached.

3. **MEDI-CAL ELIGIBLE'S LIABILITY FOR INSURANCE COST SHARING**

A provider may not require the beneficiary to pay insurance copayments, deductibles, coinsurance or charges above those deemed reasonable if the provider takes a label or photocopy of the Medi-Cal card, obtains proof of eligibility from the Department or bills Medi-Cal.

4. **MEDI-CAL COPAYMENT**

A Medi-Cal beneficiary may be liable for a Medi-Cal copayment (see Copayment Table) if the provider of service requests one. (No Medi-Cal beneficiary is automatically exempt from making a copayment.)

Federal law requires Medi-Cal beneficiaries to make a nominal copayment for most outpatient services, some emergency room services, and prescribed drugs. The copayment amount is to be collected by or obligated to the provider at the time service is rendered. The collection of the copayment by the provider is optional. A provider of service cannot, under law, deny care or services to an individual solely because of that person's inability to copay. The individual does, however, remain liable to the provider for any copayment amount owed.

Copayment Refunds to the Beneficiary

Any Medi-Cal copayment amount collected from the beneficiary should be refunded by the provider if:

a. The provider bills the beneficiary's insurance and chooses not to bill Medi-Cal because he or she knows Medi-Cal will pay no more on the claim;

b. The provider bills the beneficiary's insurance and Medi-Cal and receives notice from Medi-Cal that no additional payment is due. The maximum allowable for this service has been met.

23H. NOTICES OF ACTION:

1. **Notices of Action and Speed Letters**

Two formal Notices of Action (NOA) and two Speed Letters for the Medical Support Enforcement Program will be provided to the counties. They are entitled as follows:

- Medi-Cal Notice of Action - Denial of Medi-Cal Benefits for Noncooperation in Medical Support Enforcement
- Medi-Cal Notice of Action - Discontinuance of Medi-Cal Benefits Due to Denial of Good Cause Claim For Noncooperation in Medical Support Enforcement
- Speed Letters - Approval of Good Cause Claim For Noncooperation in Medical Support Enforcement - One approves Claim and FSD/DA will not proceed with support enforcement; One approves Claim, but FSD/DA will proceed with support enforcement

2. **NA BACK 6**

In order to simplify the notice to Medi-Cal Only applicants when Medi-Cal is denied for reasons other than for conditions of medical support, the Child Support paragraph on Form NA Back 6 which is on the back of all Notices of Action will be amended to read:

> "Other information
>
> "Child and/or medical support: The District Attorney's office will help you collect ~~child~~ support even if you are not on cash aid. There is no cost for this help. If they now collect ~~child~~ support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county."

The NA Back 6 will be available in February of 1994.

23I. OTHER HEALTH COVERAGE OBTAINED THROUGH MEDICAL SUPPORT ENFORCEMENT

This section provides an overview of the Family Support Division/District Attorney's (FSD/DA) offices in the processing of the Medical Insurance Form DHS 6110. Item 1-e, Transmittal Letter, and Item 2, County Welfare Department Action, and Item 3-a, Notification, however, describe the county welfare department's role in this process.

1. FSD/DA REPORTING HEALTH INSURANCE COVERAGE

a. Reporting

The availability of health insurance in Medi-Cal eligible family support cases must be reported to DHS' Third Party Liability Branch, Health Insurance Section. The method used by the FSD/DAs to report the availability of health insurance is the Medical Insurance Form DHS 6110. As part of any court order and family support determination, the parents, employer of the absent parent, other third party providing health insurance to the absent parent, or FSD/DA's office will complete a DHS 6110. The DHS 6110 identifies the availability of medical insurance coverage for the dependent child(ren) on public assistance or for whom Medi-Cal is being sought.

b. Procedures

The FSD/DA will:

1. Secure a completed DHS 6110 for any action against the absent parent in a public assistance case or enforcement proceeding;

2. Ensure the DHS 6110 form is properly completed; and

3. Forward the completed form to DHS for processing.

c. Monitoring, Verifying and Enforcing

The FSD/DA will establish a monitoring system that will ensure that the DHS 6110 forms are completed and returned from the parents, employers, or other third parties who are requested to provide the health insurance information. In addition, verifying the health insurance information will ensure that all dependent children reported to DHS are eligible for coverage under the absent parent's health plan. This information is then used to cost avoid the health insurance benefits or collect from insurance carriers medical payments made by the Medi-Cal program. The FSD/DA must take appropriate action to ensure the responsible parent's obligation to obtain or maintain health insurance for the child(ren) is upheld.

d. **Notifying Custodial Parents**

The FSD/DA, in all child support and medical support cases, is required to provide the custodial parent with the absent parent's health insurance information.

e. **Transmittal Letter**

After DHS uses the health insurance information provided on the DHS 6110 form to update HIS and MEDS, a transmittal letter and the form is sent to the appropriate county welfare department for inclusion in the beneficiary's case file.

2. **COUNTY WELFARE DEPARTMENT ACTION**

When the DHS 6110 and transmittal letter are received from DHS, each county welfare department will take the following actions:

a. Place the Medical Insurance Form (DHS 6110) in the beneficiary's case file.

b. Change the OHC designator in the case file to correspond with the OHC indicator code on MEDS. There is no need to update MEDS because DHS assumes responsibility for updating MEDS in all medical support cases.

c. If the custodial parent of the beneficiary contacts the county to question the health insurance coverage for the dependent child(ren) specified on the Medi-Cal card, explain that the coverage is being provided by the absent parent under court order for child support, and instruct the beneficiary to use the insurance coverage before using Medi-Cal.

3. **LAPSES IN HEALTH COVERAGE**

a. **Notification**

The FSD/DA requests employers of absent parents, county welfare departments, and/or other groups offering health insurance coverage to notify the FSD/DA if there has been a lapse in insurance coverage. In turn, the FSD/DA will notify DHS when it is learned that there is a lapse or change in absent parent health insurance coverage.

b. **Enforcement**

The FSD/DA will take appropriate action, civil or criminal, to enforce the obligation to obtain health insurance when there has been a lapse in insurance coverage or failure by the responsible parent to obtain insurance as ordered by the court.

4. UTILIZATION OF HEALTH COVERAGE

a. Pay and Chase

Under Federal Law (42 U.S.C. Section 1396a(25)) health insurance belonging to a Medi-Cal beneficiary in a child or medical support enforcement case is used by the following method, also referred to as "pay and chase":

The provider of service will bill Medi-Cal. Medi-Cal will pay the provider of service. Thereafter, Medi-Cal will seek reimbursement from the other health coverage.

b. Cost Avoidance

When the other health insurance is a Prepaid Health Plan (PHP) or a Health Maintenance Organization (HMO), however, the dependent must utilize the plan's facilities for regular medical care. Out of area services or emergency care for such dependents are billed to the PHP/HMO.

5. DISTRICT ATTORNEY HEALTH INSURANCE INCENTIVE

a. Policy

Effective October 1, 1993, the California Department of Social Services (CDSS) began paying the FSD/DA's an incentive of $50 for reporting health insurance coverage obtained as a result of enforcement activities for dependent children.

Health insurance includes any third party insurance policy that provides coverage or benefits payable for:

Scope Code	Service Type	Services Covered
O	Outpatient	Hospital outpatient (e.g., lab work or physical therapy)
I	Inpatient	Hospital stays
M	Medical	Medical doctor visits
P	Prescriptions	Prescription drugs
L	Long term care	Long term care (e.g., nursing home) or coverage for a specific illness (e.g., cancer)
D	Dental	Dental coverage
V	Vision	Vision care

(**NOTE**: Health insurance does not include insurance coverage for automobile insurance, indemnity policies or periodic benefits for disability, hospitalization or income protection, coverage limited to a specific circumstance (e.g., accidental injury or dismemberment), Medicare, or Medi-Cal capitated health care plans and initiatives. For a more comprehensive list, please refer to the Medi-Cal Eligibility Manual, Section 50763.)

b. **Reporting Process**

DHS will use the obtained health insurance coverage information reported by the FSD/DA on the Medical Insurance Form (DHS 6110) and provide CDSS with a quarterly county-by-county listing of the number of health insurance carriers which have been added to their computer system. The county-by-county list will be used by CDSS to pay health insurance incentives to the FSD/DAs for the health insurance carrier information reported to DHS and provided to AFDC, FC, and MNO custodial parents.

CDSS will pay these incentives to FSD/DAs on a quarterly basis. If the health insurance coverage information provided by the FSD/DA was previously known by DHS, the duplicate health insurance carrier information will not be counted, and the DHS 6110 form will be destroyed by DHS.

DHS will, however, return to the initiating county the DHS 6110 forms that are rejected because they cannot be entered into the Health Insurance System (HIS). The rejected documents will be returned weekly with a cover letter explaining the rejection reason. (See Section 23J-15 for a copy of the rejection letter.)

The causes for rejection include:

- No MEDS record found: Eligibility has not, as yet, been established on MEDS. The county welfare department must establish Medi-Cal eligibility before re-submission of the DHS 6110.
- Medi-Cal eligibility not established: The record was found on MEDS, but not eligible for Medi-Cal. Re-submit the DHS 6110 only after the county welfare department has determined the case to be eligible for Medi-Cal.
- Incomplete/Illegible form: The DHS 6110 was incomplete or illegible. Re-submit the DHS 6110 after completing or rewriting the items highlighted on the form.
- Other: Non-Codeable Insurance: Insurance could not be coded into the DHS HIS for other reasons (i.e., out of country carrier, initial report of an HMO with a termination date prior to submission, life insurance, etc.)

For additional information on DA Health Insurance Incentives, see FSD/DA Letter No. 93-24 (November 5, 1993.)

23J. MEDICAL SUPPORT FORMS

1. **DHS 6155**

State of California—Health and Welfare Agency — Department of Health Services

HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. Use and attach a copy of your insurance policy, membership card, or any other aid to help complete this questionnaire. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. Additional instructions and information collection and access are on the reverse. If you have any questions about completing this form or require Spanish translation, call toll-free 1-800-952-5294 (7:30 a.m. to 5:00 p.m.

COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING MEDICARE SUPPLEMENTS, PREPAID HEALTH PLANS, HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. HAVING PRIVATE HEALTH INSURANCE DOES NOT AFFECT YOUR MEDI-CAL ELIGIBILITY. HOWEVER, FAILURE TO REPORT OTHER HEALTH INSURANCE MAY BE CAUSE FOR TERMINATION OF YOUR MEDI-CAL ELIGIBILITY.

Case Name	FOR COUNTY USE ONLY		STATE USE ONLY	
	Worker Number		Verified By	
Case Address	Date		Date	Initials
	Worker Telephone Number		Date	Initials
Initial Intake ☐ Redetermination ☐ HIPP ☐	Optional Dist. No.		Scope	CC #

SECTION I Beneficiary Information. *LIST ALL PERSONS, INCLUDING UNBORNS, ON MEDI-CAL AND COVERED BY HEALTH INSURANCE POLICY*

					14-DIGIT MEDI-CAL NUMBER				
OHC	Beneficiary Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Co Code	Aid Code	Case Number	FSU	Pers No
		– –							
		– –							
		– –							
		– –							
		– –							

SECTION II Health Insurance Information

1. What is the name and address of your health insurance company? Include street number, city, state, and ZIP. Do not use abbreviations.
   Name
   Address
   City, State, ZIP
2. Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO/PPO) ☐ Yes ☐ No
3. Where do you send your claims?
   Name
   Address
   City, State, ZIP
4. What is the full name, address, phone number, and SSA number of individual, employee, union member, or person to whom the insurance policy was issued?
   Name — Social Security Number
   Address — Telephone Number ( )
   City, State, ZIP — Absent Parent? ☐ Yes ☐ No
5. What is the policy number?
6. What are/were the dates of your policy? Beginning Date — Ending Date (if applicable)
   ☐ Medical coverage available through employer, but has not been applied for.
7. Premium Amount $ ☐ Monthly ☐ Quarterly ☐ Yearly
   How are premiums paid? ☐ By Insured to Insurance Carrier ☐ By Employer ☐ By Payroll Deduction
8. Give name of union, employer, group, organization, or school, address, and telephone number.
   Name — Local or Group Number
   Address — Telephone Number ( )
   City, State, ZIP
9. Does any covered beneficiary have an acute, chronic, or pre-existing illness that requires him/her to see a physician? ☐ Yes ☐ No
   If yes, please specify the illness:
10. Does your health insurance provide or pay for: (Check all that apply.)
    ☐ Hospital Outpatient (i.e., lab work/ physical therapy) ☐ Prescription Drugs ☐ Long Term Care/Nursing Home
    ☐ Hospital Stays ☐ Dental Care ☐ Only specific illness (i.e., cancer)
    ☐ Doctor Visits ☐ Vision Care — Type of Illness:
11. Is the policy a Medicare Supplement? ☐ Yes ☐ No

Remarks:

By signing this document, I hereby authorize the Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, to be used in determining whether the Department will pay my private health insurance premium.

Signature of Applicant	Home Telephone	Work Telephone	Date
	( )	( )	

RETURN COMPLETED FORM TO: RECOVERY BRANCH, P.O. BOX 1287, SACRAMENTO, CA 95812-1287

Original—State — Yellow—County File — Pink (Extra Copy-District Attorney-Beneficiary)

DHS 6155 (10/93)

INSTRUCTIONS

Section I: Beneficiary Information

List the names (first, middle, last) of all persons on Medi-Cal and covered by the health insurance policy. Also list each person's Social Security number, sex, and date of birth. If any person listed is expecting a child, on the last available line, put "unborn" in the name section and the expected date of arrival in the date of birth section. Enter Medi-Cal numbers if known; otherwise, your eligibility worker will complete that section.

Section II: Health Insurance Information

Item No. 1 — Enter the full name and mailing address of your insurance company (include street address and/or P.O. Box, city, state, and ZIP). DO NOT USE ABBREVIATIONS.

Item No. 2 — Check the appropriate box if you have to obtain medical services from a specific facility or a group of providers. (Prepaid health plans/PHP, Health Maintenance Organizations (HMO), Preferred Providers Organizations (PPO).)

Item No. 3 — Enter the complete name and mailing address where your health insurance claims are sent. Only complete if different from the answer to Item No. 1.

Item No. 4 — Enter the full name, mailing address, telephone number, and Social Security number of the individual: employee, union member, retired employee, or person to whom the insurance policy is or was issued (insured). Check the appropriate box for an absent parent.

Item No. 5 — Enter the number the insurance company needs to identify the policy. This number is sometimes called: subscriber, certificate, account, employee, group, and local number.

Item No. 6 — Enter the date (month/day/year) the insurance policy began and date terminated. If known, enter the policy lapse dates, and check the box if medical coverage is available through an employer which has not been applied for.

Item No. 7 — Enter the premium amount; check the box if they are paid per month, quarter, or year, and how the premiums are paid. Check appropriate box(es).

Item No. 8 — If the policy is purchased through a union, employer group, organization, or school, enter the name, address, telephone number, local or group number if known.

Item No. 9 — Check the box "YES" or "NO" if any covered beneficiary has an acute or chronic pre-existing illness that requires him or her to see a physician. Specify the illness.

Item No. 10 — Read and check items which apply to your insurance coverage.

Item No. 11 — Read and check yes or no.

Signature Section — Please sign the form and give your home and/or work telephone number. If you do not have a telephone, please put a message number in the home telephone box. Also, enter the date when you completed this form.

IMPORTANT. As a condition of eligibility, all Medi-Cal beneficiaries shall assign rights to medical insurance, support or other third party payments to the Medi-Cal program and shall cooperate with the Department of Health Services in obtaining medical support or payments. The assignment of rights to benefits is effective only for services paid for by the Medi-Cal program. Assignment of medical rights allows the Department of Health Services to recover funds from health insurance companies or funds when the Medi-Cal program pays for medical services which should have been billed to such other health insurance coverage. Please note that in order to comply with the Federal *privacy Act (42 USC Section 552a)*, your Social Security number and any information you provide may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Under Welfare and Institutions Code, Section 14100.2 any submitted information is considered confidential and disclosed only as necessary for Medi-Cal program administration purposes.

INFORMATION COLLECTION AND ACCESS

Sections 50761 and 50763 of Title 22, California Code of Regulations (CCR), requires recipients to report other health coverage to which they are entitled.

The information requested is necessary to make possible the recovery of health insurance or other contractual or legal entitlements as provided in *Welfare and Institutions Code, Sections 10020 through 10025, 14024, 14103, and 14124.70*, from persons liable thereunder.

Information concerning your health coverage is maintained by the Chief of the Recovery Branch, by authority of the Welfare and Institutions Code, Section 14011, and Title 22, California Code of Regulations, Section 50769. All information is mandatory.

Section 14023 of the Welfare and Institutions Code provides that any public assistance recipient who has any other contractual or legal entitlement to any health care service and who willfully refuses to disclose this information by withholding important information regarding other medical entitlement is guilty of a misdemeanor. Medi-Cal is the payor of last resort. Additionally, Section 50175 of Title 22 (CCR) provides for denial or discontinuance of benefits if the recipient does not cooperate in providing health insurance information.

2. CA 2.1

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

CHILD/SPOUSAL AND MEDICAL SUPPORT NOTICE AND AGREEMENT

Assignment and Cooperation Requirements

You must assign to the county any rights you may have to child or spousal support payments while you are receiving Aid to Families with Dependent Children (AFDC) and any rights you may have to medical support to the state while you are receiving Medi-Cal. The receipt of an AFDC check and/or a Medi-Cal card will assign the past and present support rights of all persons for whom you are requesting AFDC and/or Medical Assistance. At your request, the county will provide information to you on the amount of support paid to the county by the absent parent(s).

You must cooperate with the County Welfare Department and the District Attorney:

- In identifying and locating any absent parent in your case;
- In establishing the paternity of any child in your case when necessary;
- In obtaining from any absent parent medical support payments and, if you receive AFDC, child/spousal support payments
- By turning over to the county district attorney any medical support payments given to you on or after this date; and if you receive AFDC, any child/spousal support payments given to you on or after this date;
- By informing the county about medical coverage or payment for medical services paid by the absent parent on or after this date.

When requested to do so you must:

- Complete the Child Support Questionnaire (Form CA 2.1).
- Complete a statement (CS 870) under penalty of perjury. If you sign the form and you don't give all the facts or you give the wrong information, you could be fined and/or imprisoned.
- Agree to cooperate in the support enforcement process or to claim good cause for refusing to cooperate.
- Appear at the County Welfare Department or District Attorney's Office to sign papers or provide necessary information.

Benefits of Support Enforcement:

Your cooperation may be of value to you and your child(ren) because finding the absent parent and establishing paternity may give you and your child(ren) rights to future social security, veterans, or other benefits. The District Attorney will continue to help enforce support after you go off AFDC or Medi-Cal unless you make a request in writing to the District Attorney to stop.

You have the right:

- To claim Good Cause if you have an acceptable reason for refusing to cooperate in the support enforcement process. If you feel that cooperating would not be in the best interests of your child(ren), you may refuse to cooperate and claim Good Cause. The back of this form explains your right to claim Good Cause in more detail. If you think you might have Good Cause, ask your eligibility worker to explain it to you before signing below.

- To show you are cooperating by filling out and signing a statement (CS 870) under penalty of perjury that you have given all the facts you know about the absent parent(s).

Penalty Provision:

If you refuse to assign support rights, if you refuse or fail to turn over to the county any support given to you by the absent parent(s), or if you refuse to cooperate in the support enforcement process without Good Cause, the following will apply.

If you are an applicant/recipient of AFDC:

- You will be ineligible for AFDC, but your child(ren) may still be eligible. Their grant will go to another person called a protective payee who will pay the child(ren)'s living expenses, and
- Your case will be referred to the District Attorney.
- You will be ineligible for Medi-Cal benefits, but your child(ren) may still be eligible.

If you are an applicant/recipient of Medi-Cal Only:

- You will be ineligible for Medi-Cal benefits, but your child(ren) may still be eligible.

Agreement:

(CHECK ONE)

- I agree to cooperate with the County Welfare Department and the District Attorney as specified above.
- I claim Good Cause and refuse to cooperate at this time.
- I refuse to assign child/spousal support rights (AFDC).
- I refuse to assign medical support rights (AFDC and Medi-Cal only cases)

I understand my rights and responsibilities as described above, including the requirement that I assign support rights to the county. I also understand my right to claim Good Cause.

Signature of Applicant or Recipient _____ Date _____

I certify that I have notified the applicant or recipient of his or her rights and responsibilities by means of this notice and verbally as needed.

Eligibility Worker's Signature _____ Eligibility Worker Number _____ Date _____

CA 2.1 Notice and Agreement (12/89) Required Form - No Substitutes Permitted QF 5554

YOUR RIGHT TO CLAIM GOOD CAUSE

The only reasons for claiming Good Cause

- Cooperation is expected to result in serious physical harm to the child(ren);
- Cooperation is expected to result in serious emotional harm to the child(ren);
- Cooperation is expected to result in physical harm to you which is so serious that it reduces your ability to care for the child(ren) adequately;
- Cooperation is expected to result in emotional harm to you which is so serious that it reduces your ability to care for the child(ren) adequately;
- The child(ren) were conceived due to incest or forcible rape;
- Court proceedings are going on for the adoption of the child(ren); or
- You are working with a social agency to help you decide whether to place the child(ren) for adoption and the counseling sessions have not gone on for more than three months.

How to Claim Good Cause

If you want to claim Good Cause, you must tell your eligibility worker. You can do this whenever you believe you have Good Cause not to cooperate. You must also complete and sign the Good Cause claim form which your eligibility worker will give to you.

If you claim Good Cause you must:

- Give the County Welfare Department evidence needed to determine if you have Good Cause for refusing to cooperate. (If your reason for claiming Good Cause is your fear of physical harm and it is impossible to obtain evidence, the County Welfare Department may still be able to make a Good Cause determination after investigating your claim.)
- Give the necessary evidence within 20 days of claiming Good Cause. The County Welfare Department will only give you more time when it decides that more than 20 days are required to get the evidence.

What is Acceptable Evidence?

The following are examples of acceptable evidence the County Welfare Department can use to determine if Good Cause exists. If you need help in getting a copy of any of the documents your eligibility worker will help you.

- Birth certificates, or medical or law enforcement records which indicate that the child was conceived due to incest or forcible rape;
- Court documents or other records which indicate that legal proceedings for adoption are pending in court;
- Records which indicate that the absent parent or alleged father might inflict physical or emotional harm on you or the child(ren);
- Medical records which indicate your or your child(ren)'s emotional health history and present health status; or written statements from mental health professionals giving a diagnosis or prognosis on your or your child(ren)'s emotional health.
- A written statement from a social agency confirming that you are being helped to decide whether to place the child for adoption; and,
- Sworn statements from people who know the circumstances of your Good Cause claim. These people could be friends, neighbors, clergymen, social workers and others.

The County Welfare Department Decides Your Claim

The County Welfare Department will:

- Decide your claim based on the evidence you give, or
- Conduct an investigation to verify and decide your claim. (You may be required to give information such as the absent parent or alleged father's name and address. The County Welfare Department will not contact the absent parent or alleged father without first telling you.)

District Attorney's Participation

The District Attorney may review the County Welfare Department's findings and the basis for a Good Cause determination in your case. If you request a hearing on the issue of Good Cause, the District Attorney may participate in that hearing.

If the County Welfare Department decides you have Good Cause for not cooperating, the District Attorney may try to establish paternity or collect support only if the County Welfare Department decides that this can be done without risk to you or your child(ren). This will not be done without first telling you.

The District Attorney will not pursue child support enforcement activities until the final determination regarding your Good Cause claim has been made by the County Welfare Department.

3. **CA 2.1 Q**

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY — DEPARTMENT OF SOCIAL SERVICES

SUPPORT QUESTIONNAIRE

Instructions:

You must answer all questions and fill in all the blanks.
COMPLETE ONE FORM FOR EACH PARENT ABSENT FROM THE HOME OR EACH UNMARRIED FATHER IN THE HOME.
Use ink. Print answer. Check Yes, No, or Unknown.
Use a separate piece of paper if you need more room.

FOR COUNTY USE ONLY

CWD CASE NAME	FBD CASE NAME
CWD CASE NUMBER	FBD CASE NUMBER
CWD WORKER NAME/NO	FBD WORKER NAME/NO
TELEPHONE NUMBER ( )	TELEPHONE NUMBER ( )

SECTION 1 - COMPLETE THE FOLLOWING ABOUT YOURSELF

NAME (FIRST, MIDDLE, LAST) | MAIDEN NAME | SSN | BIRTHDATE | BIRTH PLACE | RACE

HOME STREET ADDRESS, APARTMENT NUMBER | CITY | STATE | ZIP | TELEPHONE NUMBER ( )

YOUR RELATIONSHIP TO CHILDREN | YOUR RELATIONSHIP TO ABSENT PARENT/UNMARRIED FATHER IN THE HOME ☐ Spouse ☐ Ex-Spouse ☐ Friend ☐ Other

SECTION 2 - COMPLETE THE FOLLOWING ABOUT THE PARENT ABSENT FROM THE HOME OR UNMARRIED FATHER IN THE HOME

A. NAME (FIRST, MIDDLE, LAST) | SSN | ☐ MALE ☐ FEMALE | BIRTHDATE | BIRTH PLACE

LAST KNOWN STREET ADDRESS, APARTMENT NUMBER | HEIGHT | WEIGHT | EYE COLOR | HAIR COLOR | RACE

CITY | STATE | ZIP | SCARS, BIRTHMARKS, TATTOOS, NICKNAMES, ETC

WHEN WAS THIS ADDRESS CURRENT? | TELEPHONE NUMBER ( ) | WHEN DID YOU LAST HEAR FROM OR GET MAIL FROM THIS PARENT? | DOES THIS PARENT LIVE WITH YOU? ☐ YES ☐ NO

B. WHAT KIND OF INCOME DOES ABSENT PARENT HAVE? ☐ Earnings ☐ UIB/DIB ☐ Social Security ☐ None ☐ Other

LAST KNOWN EMPLOYER | TELEPHONE NUMBER ( )

STREET ADDRESS | TYPE OF WORK

CITY | STATE | ZIP | UNION MEMBER? ☐ YES, UNION NAME ☐ NO ☐ UNKNOWN

WHEN DID THIS PARENT LAST WORK HERE? | UNION ADDRESS

C. DOES THIS PARENT HAVE HEALTH INSURANCE FOR THE CHILDREN? ☐ YES ☐ NO ☐ UNKNOWN | WHO IS COVERED?

NAME OF INSURANCE | POLICY NUMBER | DATE OF COVERAGE

D. PARENTS ARE ☐ NOT MARRIED ☐ MARRIED ☐ SEPARATED ☐ LIVING TOGETHER ☐ DIVORCED WHEN/WHERE

E. IS THERE A COURT ORDER FOR SUPPORT? ☐ YES ☐ NO ☐ PENDING | AMOUNT ORDERED $ | HOW OFTEN? | DATE OF COURT ORDER | COURT ORDER NUMBER | LOCATION OF COURT (COUNTY & STATE)

HOW DOES THE PARENT PAY? ☐ TO YOU ☐ TO COUNTY ☐ PAYS HOUSEHOLD BILLS ☐ PAYROLL DEDUCTION ☐ OTHER | WHEN DID PARENT LAST PAY? | HOW MUCH? $

F. NAME OF A FRIEND OR RELATIVE OF ABSENT PARENT | RELATIONSHIP TO ABSENT PARENT | TELEPHONE NUMBER ( )

ADDRESS (NUMBER AND STREET) | CITY | STATE | ZIP

G. DOES THIS PARENT OWN ANY MOTOR VEHICLES? ☐ YES ☐ NO ☐ UNKNOWN | MAKE | MODEL | YEAR | LICENSE NO | STATE

H. DOES THIS PARENT OWN A HOUSE, LAND, BUILDINGS, OR BANK ACCOUNTS? ☐ YES ☐ NO ☐ UNKNOWN | WHAT/WHERE

I. IS THIS PARENT CURRENTLY ON PROBATION OR PAROLE? ☐ YES ☐ NO ☐ UNKNOWN | WHAT COUNTY OR STATE?

J. HAS THIS PARENT EVER BEEN IN JAIL OR PRISON? ☐ YES ☐ NO ☐ UNKNOWN | IF YES, WHEN/WHERE

K. HAS THIS PARENT EVER BEEN IN THE MILITARY? ☐ YES ☐ NO ☐ UNKNOWN | IF YES, WHEN/WHAT BRANCH

SECTION 3 - CHILDREN (IN YOUR HOME) OF THIS ABSENT PARENT OR UNMARRIED FATHER

NAME OF CHILD	M F	SSN	BIRTHDATE	BIRTHPLACE	FOR COUNTY USE ONLY MC#
NAME OF CHILD	M F	SSN	BIRTHDATE	BIRTHPLACE	MC#
NAME OF CHILD	M F	SSN	BIRTHDATE	BIRTHPLACE	MC#
NAME OF CHILD	M F	SSN	BIRTHDATE	BIRTHPLACE	MC#

SECTION 4 - SUPPORT ENFORCEMENT SERVICES (MEDI-CAL ONLY)

☐ I don't want other child support enforcement services.

SIGNATURE | DATE

1st Copy – Family Support Division
2nd Copy – County Welfare Department
3rd Copy – Applicant

CA 2.1 (Q) (3/93) Support Questionnaire Required Form–No substitute permitted

4. **CA 51**

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY — DEPARTMENT OF SOCIAL SERVICES

CHILD SUPPORT — GOOD CAUSE CLAIM FOR NONCOOPERATION
MANTENIMIENTO DE HIJOS — RECLAMACION DE MOTIVO JUSTIFICADO PARA NO COOPERAR

I feel that cooperating in establishing paternity and obtaining support would not be in the best interest of the child(ren) for whom aid is requested because:

I expect it to result in: A) ☐ Physical
B) ☐ Emotional harm to the child(ren).

I expect it to result in: C) ☐ Physical
D) ☐ Emotional harm to me which is so serious that it reduces my ability to adequately care for the child(ren).

E. ☐ The child(ren) were conceived due to incest or forcible rape.

F. ☐ Court proceedings are going on for the adoption of the child(ren).

G. ☐ I am working with a social agency helping me decide whether to place the child(ren) for adoption and the counseling sessions have not gone on for more than three months.

Creo que el cooperar para establecer la paternidad y obtener mantenimiento, no seria de optimo beneficio para el niño(s) para el cual se está solicitando asistencia porque:

Estoy segura que resultará en daño: A) ☐ físico
B) ☐ emocional daño para el niño(s).

Estoy segura que resultará en daño: C) ☐ físico
D) ☐ emocional para mi el cual es tan grave que reduce mi capacidad para poder cuidar al niño(s) adecuadamente.

E. ☐ El niño(s) fue concebido como resultado de incesto o violación.

F. ☐ Actualmente se está gestionando en la corte la adopcion del niño(s).

G. ☐ Estoy laborando con una agencia de servicio social para que me ayude a decidir si coloco al niño(s) para adopción, y las sesiones de orientación no se han llevado a cabo durante mas de tres meses.

"I want to claim Good Cause for refusing to cooperate for the reason(s) checked above. I understand that I may be asked to prove that I have Good Cause for refusing to cooperate."

"Quiero invocar un motivo justificado para negarme a cooperar por las razones marcadas arriba. Entiendo que se me puede pedir que demuestre que tengo un motivo justificado para negarme a cooperar."

SIGNATURE OF APPLICANT OR RECIPIENT / FIRMA DEL SOLICITANTE O PERSONA QUE RECIBE LOS BENEFICIOS | DATE / FECHA

County Use Only / Solo para Uso del Condado

CASE NAME

CASE NUMBER

NAME OF CHILD(REN) INVOLVED

ABSENT PARENT INVOLVED

EVIDENCE PROVIDED
- ☐ No investigation
- ☐ No evidence provided
- ☐ Birth certificate
- ☐ Medical records
- ☐ Court documents
- ☐ Social agency letter
- ☐ Mental health professional letter
- ☐ Sworn statement from other person
- ☐ Other

PUTATIVE FATHER CONTACT
- ☐ Applicant/Recipient informed in advance

Applicant/Recipient
- ☐ Provided more evidence
- ☐ Withdrew application
- ☐ Requested discontinuance
- ☐ Requested claim be denied

DATE PUTATIVE FATHER CONTACTED

County Use Only/Solo para Uso del Condado — THIS CLAIM IS FOR ☐ CHILD SUPPORT ☐ MEDICAL SUPPORT

TO: DA REPRESENTATIVE | IF APPLICANT/RECIPIENT IS NOT PARENT INDICATE RELATIONSHIP | DATE OF APPLICATION

PROPOSED DETERMINATION

Good Cause ☐ does not exist ☐ does exist based on (Enter A, or B, or C from above) _____

Support Enforcement: ☐ may ☐ may not proceed without applicant's or recipient's participation

COMMENTS

REPLY TO: COUNTY WELFARE DEPARTMENT REPRESENTATIVE | WORKER NUMBER | DATE

PROPOSED DETERMINATION

Good Cause ☐ does not exist ☐ does exist based on (Enter A, or B, or C from above) _____

Support Enforcement: ☐ may ☐ may not proceed without applicant's or recipient's participation

DA FILE NUMBER

COMMENTS

DA REPRESENTATIVE'S SIGNATURE | TELEPHONE | DATE

FINAL DETERMINATION

Good Cause ☐ does not exist ☐ does exist based on (Enter A, or B, or C from above) _____

Support Enforcement ☐ may ☐ may not proceed without applicant's or recipient's participation

AFDC status at the time of Good Cause determination ☐ Applicant ☐ Recipient ☐ Medi-Cal Only

☐ Applicant has withdrawn application for AFDC ☐ Applicant has withdrawn application for Medi-Cal

☐ This case has been discontinued effective _____ Reason(s) _____

DATE

COUNTY WELFARE DEPARTMENT REPRESENTATIVE SIGNATURE | DATE OF DECISION | SUPERVISOR'S SIGNATURE | DATE OF DECISION

STATISTICAL SUMMARY *(Instructions for completing section are on the back of this page)*

☐ CLAIM OR APPLICATION WITHDRAWN OR AID DISCONTINUED (COMPLETE 1 AND 2 ONLY) | DATE WITHDRAWN

☐ FINAL DETERMINATION (COMPLETE 1 IF GOOD CAUSE EXISTS OR 1,2,7 AND 8 IF GOOD CAUSE DOES NOT EXIST) | DATE OF DETERMINATION

1 STATUS AT TIME OF CLAIM
☐ APPLICANT ☐ RECIPIENT _____ (DATE OF CLAIM)

2 WAS CLAIM BASED ON PHYSICAL HARM WITHOUT EVIDENCE? ☐ YES ☐ NO

3 ☐ GOOD CAUSE EXISTS BASED ON (✓ ONE ONLY)
- A ☐ PHYSICAL HARM TO CHILD(REN)
- B ☐ EMOTIONAL HARM TO CHILD(REN)
- C ☐ PHYSICAL HARM TO CARETAKER
- D ☐ EMOTIONAL HARM TO CARETAKER
- E ☐ INCEST OR FORCIBLE RAPE
- F ☐ LEGAL ADOPTION BEFORE COURT
- G ☐ PREADOPTION SERVICES

4 WAS DETERMINATION BASED ON PHYSICAL HARM WITHOUT EVIDENCE? ☐ YES ☐ NO

5 WAS DETERMINATION BASED SOLELY ON EXAMINATION OF EVIDENCE WITHOUT INVESTIGATION? ☐ YES ☐ NO

6 MAY ENFORCEMENT PROCEED WITHOUT APPLICANT/RECIPIENT PARTICIPATION? ☐ YES ☐ NO

7 ☐ GOOD CAUSE DOES NOT EXIST

8 WAS CLAIMANT AN APPLICANT AT TIME OF CLAIM, BUT A RECIPIENT AT FINAL DETERMINATION? ☐ YES ☐ NO

CA 51 (b) (5/93) REQUIRED FORM — SUBSTITUTE PERMITTED

INSTRUCTIONS

INDIVIDUAL CASE REPORT

The statistical summary section is to be completed when a final claim determination is made or when a claim is withdrawn. A claim is considered withdrawn if the applicant/recipient withdrew the claim; withdrew the application; requested discontinuance; or if the county cancelled or otherwise disposed of the claim **before** a final determination is made.

CLAIM WITHDRAWN - If claim or application was withdrawn or aid discontinued, check (✓) box and enter date when claim was withdrawn. Complete items 1 and 2 and leave rest of items blank.

FINAL DETERMINATION - If a final determination was made, check (✓) box and enter date when the final determination was made. Complete items 1 - 6 if determined that good cause exists or items 1, 2, 7 and 8 if determined that good cause does not exist.

1. Enter date when claim was made and check (✓) appropriate status box
   - check "applicant" for a new application or restoration.
   - check "recipient" for a redetermination or intercounty transfer.

2. Based on the claim made, determine if YES or NO and check (✓) appropriate box
   - check YES if reason given was physical harm to child and/or caretaker and no evidence was available, i.e., evidence does not exist.
   - otherwise, check NO.

   NOTE: If more than one reason was given and one of the reasons was physical harm to child and/or caretaker, then:
   - check YES if the final determination was based **solely** on the physical harm to child and/or caretaker **without** any evidence.
   - otherwise, check NO.

3. If determined that good cause exists, check (✓) box.

3A - 3G. Check (✓) only one box for the good cause circumstance (reason). The good cause circumstance is the one upon which the **county's findings** determines that good cause exists. If based on more than one circumstance, check the most significant.

4. Based on the final determination that good cause exists, determine if YES or NO and check (✓) appropriate box
   - check YES if based **solely** on physical harm to child and/or caretaker **without** any evidence.
   - otherwise check NO.

   NOTE: If checked YES, then item 2 must be checked YES and item 5 must be checked NO.

5. Based on the final determination that good cause exists, determine if YES or NO and check (✓) appropriate box
   - check YES if based on evidence only, i.e., no investigation was conducted
   - otherwise check NO.

   NOTE: If checked YES, then item 2 and 4 must be checked NO.

6. Based on the final determination that good cause exists, determine if YES or NO and check (✓) appropriate box
   - check YES if determined that enforcement may proceed without applicant/recipient participation.
   - otherwise check NO.

   NOTE: If checked YES, then item 2 and 4 must be checked NO.

7. If determined that good cause does not exist, check (✓) box.

8. Based on the final determination that good cause does not exist, determine if YES or NO and check (✓) appropriate box
   - check YES if determined that good cause does not exist but claimant's application or restoration request already had been approved.
   - otherwise check NO.

5. **CS 196**

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF SOCIAL SERVICES

CHILD SUPPORT ENFORCEMENT PROGRAM NOTICE

All children have the right to be supported by both parents. Any person, including a noncustodial parent, whether or not (s)he receives public assistance, can apply for support services. Some of the available services are as follows:

- locating the parent(s) for support enforcement purposes;
- establishing paternity;
- establishing a child and/or medical support (health insurance) order;
- enforcing a child and/or medical support order;
- modifying an existing court order for child and/or medical support;
- enforcing a spousal support order in conjunction with a child support order;
- collecting and distributing support payments.

CUSTODY AND VISITATION SERVICES ARE NOT PROVIDED

THE DISTRICT ATTORNEY/FAMILY SUPORT DIVISION (DA/FSD) PROVIDES SERVICES ON BEHALF OF THE STATE OF CALIFORNIA. THEY DO NOT REPRESENT YOU AND ARE NOT YOUR ATTORNEY. BECAUSE YOU ARE NOT THEIR CLIENT THE INFORMATION YOU PROVIDE IS NOT CONFIDENTIAL UNDER ATTORNEY/CLIENT PRIVILEGE.

The information in the case may be discussed or disclosed to the State, the Department of Social Services, other public agencies that are authorized by law to receive such information, and to the other parent or his/her attorney to the extent required by law. To enroll a child in health insurance may require the release of the child's Social Security Number to the other parent or to the other parent's employer.

When you request services, you must cooperate with the DA/FSD by providing any information or documents needed to establish paternity and/or locate the parent and to get support payments for your child. Once the services of the DA/FSD have been requested, the DA/FSD will determine the appropriate action to take. All support payments must be turned over to the DA/FSD.

The DA/FSD is interested in making sure that parents take care of their child support duties. They will ask you to help them work your case. People who receive welfare must help the DA/FSD work their child support case. If you do not give them that help, they probably cannot work your case.

When you apply/receive support services, you are responsible for promptly informing the DA/FSD of any change in circumstances or information. Some examples are as follows:

- child leaves the home;
- address changes (including a move to another State, County or Country) and telephone number changes;
- discontinuance of welfare;
- name change
- initiation of any divorce or legal proceedings;
- information regarding the noncustodial parent;
- direct receipt of any child and/or spousal support.

You have the right to seek legal advice from a private attorney or legal aid group at your own expense. If you do hire an attorney, you must report this to the DA/FSD.

Each parent subject to a support order in the State has the right to request that the DA/FSD review his/her support order to determine whether the amount of support should be changed based on statewide criteria. If the amount of support does not meet criteria for change, the DA/FSD must provide to either parent, upon request, information on how either parent can get forms to request the court to modify the amount of support ordered.

The DA/FSD must notify you of the initial date, time and purpose of every hearing for paternity or support. You also have a right to inspect the county clerk's file, except for that information which is not considered public and is legally prohibited by confidentiality requirements.

Upon request, the DA/FSD shall provide you with copies of the most recent order entered in your case.

CS 196 (12/93) (Continued on back)

The DA/FSD is required to obtain the consent of a nonwelfare recipient prior to the filing of a stipulation affecting the support order in which that person is named as a party. The DA/FSD is also prohibited from entering into a stipulation that will reduce the amount of past due support when the recipient is owed support arrearages that exceed unreimbursed public assistance without the recipient's consent.

In general, payments received by the DA/FSD are applied in the following order*:

1. Current monthly support;
2. Interest;
3. Arrearages - first welfare arrears, then non-welfare arrears; and
4. Future obligations.

*Federal and State income tax refunds owed to the noncustodial parent may be intercepted by the DA/FSD. By Federal law, these monies cannot be applied to current child/spousal/medical obligations. They must be applied to the arrearages. If a custodial parent has received public assistance, including MEDI-CAL, in the past, the child support debt owed to the State/County will be paid first.

CALIFORNIA DOES NOT CHARGE ANY APPLICATION FEES AND DOES NOT CHARGE FOR THE SERVICES PROVIDED TO APPLICANTS. HOWEVER, SOME STATES DO CHARGE A FEE FOR SERVICES. IF YOUR CASE INVOLVES ONE OF THOSE STATES, THEY MAY DEDUCT THE FEE FROM THE SUPPORT PAYMENTS, OR ADD IT TO THE BALANCE THAT IS OWED. IN ADDITION, IN SOME SITUATIONS, COSTS FOR BLOOD TESTS MAY BE CHARGED.

MEDICAL SUPPORT and MEDI-CAL

Having private health coverage does not prevent you from having MEDI-CAL coverage. If you receive MEDI-CAL and have individual or group health private coverage, you are required by Federal and State law to report this to your local county welfare department, to your health care provider, and/or to the DA/FSD. Failure to provide this information is a misdemeanor. You must report to your welfare worker and/or the DA/FSD within ten days when your private health coverage changes or stops. You must also tell your welfare worker and/or the DA/FSD about any court order providing health insurance.

If you are only receiving MEDI-CAL benefits, you must cooperate in establishing paternity and obtaining medical support as a condition of continued eligibility for MEDI-CAL benefits. Also, you will be provided all child support services, unless you notify us that you do not want to receive those services that are unrelated to obtaining medical support and establishing paternity. Obtaining medical support may reduce the amount of child support you receive.

Under Federal law [42 U.S.C. Section 1396A(25)] health insurance belonging to a MEDI-CAL recipient in a child or medical support enforcement case is used as follows:

> The provider of service will bill MEDI-CAL. MEDI-CAL will pay the provider of service. Then MEDI-CAL will seek repayment from the other health coverage. You will not be liable for any insurance cost-sharing amount (coinsurance or deductible) unless a MEDI-CAL share of cost must be met. If your other health insurance is a Prepaid Health Plan (PHP) or a Health Maintenance Organization (HMO), you must use the plan facilities for regular medical care. Out of area services or emergency care should also be billed to the PHP/HMO.

6. CA 371

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY — DEPARTMENT OF SOCIAL SERVICES

REFERRAL TO DISTRICT ATTORNEY
(Complete one form for each Absent or Unmarried Parent)

DATE OF REFERRAL

☐ TO ☐ FROM DISTRICT ATTORNEY

(SPECIFY COUNTY)

☐ TO ☐ FROM EW NAME EW NUMBER CWD DISTRICT OFFICE

CASE NAME | AID TYPE/CASE NUMBER

APPLICANT/RECIPIENT NAME (LAST, FIRST, MIDDLE) | RELATIONSHIP TO CHILD(REN)

A. This case is referred to you because:
- ☐ Action is necessary to obtain
  - ☐ financial support ☐ medical support ☐ paternity.
- ☐ Recipient is receiving direct support payments. Action needed to transfer payments to county
- ☐ Good Cause has been
  - ☐ claimed ☐ granted ☐ denied (see CA 51 attached).
- ☐ Other (see comments)

B. The following information applies to this case:
- ☐ CA 2 1(Q) Questionnaire is attached
- ☐ Absent parent has health insurance coverage. A copy of the DHS 6155 is attached
- ☐ Medi-Cal eligibility has not been determined.
- ☐ This is a relinquishment for adoption case
- ☐ Previously sanctioned, now agrees to cooperate
- ☐ Child no longer resides with recipient
- ☐ Child added to TCC, was not on AFDC
- ☐ Medi-Cal Only. Applicant/Recipient does not want other child support services
- ☐ Other (see comments)

C. Applicant/recipient has not agreed to:
- ☐ Assign accrued
  - ☐ financial support rights ☐ medical support rights.
- ☐ Cooperate in obtaining
  - ☐ financial support ☐ medical support AND/OR
  - ☐ establishing paternity.
- ☐ Cooperate in establishing Good Cause
- ☐ Forward support payments

D. Information from District Attorney (DA) to CWD.

DA FILE NO.

- ☐ Applicant/recipient has cooperated in accordance with Federal law
- ☐ Applicant/recipient has not cooperated in accordance with Federal Law
  - ☐ Did not appear and/or provide verbal, written or documentary information
  - ☐ Rescheduled appointment on _____ ☐ kept ☐ failed
  - ☐ Refuses to appear as a witness at court or other hearing.
  - ☐ Refuses to transmit child support payment(s) received directly from the absent parent
- ☐ Applicant/recipient has claimed Good Cause for refusal to cooperate and has been provided with a Good Cause claim form
- ☐ This is a notice of renewed cooperation
- ☐ Paternity ☐ has ☐ has not been established.
- ☐ Support order established
- ☐ Other (see comments)

E. TYPE OF APPLICATION
☐ NEW ☐ REAPPLICATION ☐ ADD A CHILD ☐ ICT ☐ RENEWAL

ABSENT PARENT'S NAME | DA FILE NUMBER

CHILD'S NAME | DATE OF BIRTH

CHILD'S NAME | DATE OF BIRTH

CHILD'S NAME | DATE OF BIRTH

CHILD'S NAME | DATE OF BIRTH

F. ☐ APPLICANT STATES AID RECEIVED PREVIOUSLY.
SPECIFY TYPE ☐ CASH AID ☐ MEDI-CAL ONLY ☐ TCC ☐ TMC

PLACE (CITY, COUNTY, STATE) | DATE LAST RECEIVED

G. ☐ INTER-COUNTY TRANSFER/INTERSTATE TRANSFER

FROM (COUNTY/STATE) | PRIOR COUNTY'S DA FILE NUMBER (IF KNOWN)

H. ☐ CASH AID

APPROVAL DATE | ONGOING CASH AID AMOUNT $

DISCONTINUANCE DATE | REASON FOR DISCONTINUANCE/CODE

I. ☐ MEDI-CAL ONLY

DATE MEDI-CAL BEGINS/CONTINUES | DATE DISCONTINUED

REASON FOR DISCONTINUANCE

J. ☐ TRANSITIONAL CHILD CARE

DATE TCC BEGINS | DATE TCC ENDS

Comments

SIGNATURE OF DA REPRESENTATIVE | TITLE | E W SIGNATURE | E W NUMBER | PHONE | DISTRICT OFFICE

CA 371 (3/93) REQUIRED FORM - SUBSTITUTES PERMITTED

7. **DHS 6110**

State of California—Health and Welfare Agency

Department of Health Services

MEDICAL INSURANCE FORM

FOR COUNTY USE ONLY

COMPLETE THIS FORM ONLY IF THE CHILDREN INVOLVED IN THIS ACTION ARE APPLYING FOR OR RECEIVING AFDC OR MEDI-CAL. **SEND TO THE DEPARTMENT OF HEALTH SERVICES ONCE THE ABSENT PARENT HEALTH INSURANCE COVERAGE FOR THE DEPENDENT CHILD(REN) IS OBTAINED AND VERIFIED.**

MAIL TO:

DEPARTMENT OF HEALTH SERVICES
OTHER COVERAGE SECTION #964
P. O. BOX 1287
SACRAMENTO, CA 95812-1287

Date _____

PLEASE TYPE OR PRINT (DO NOT ABBREVIATE)

COUNTY INFORMATION (ITEMS 1 THROUGH 3)

1 County | 2 IV-D Case Number | 3 Phone Number

CUSTODIAL PARENT INFORMATION (ITEMS 4 THROUGH 10)

4 Name (First) (Middle) (Last) | 5 Social Security Number

6 Complete Street Address

City | State | ZIP Code | 7 Home Telephone Number ( )

8 Name of Employer

9 Employer's Complete Street Address

City | State | ZIP Code | 10 Work Telephone Number ( )

DEPENDENT CHILDREN INFORMATION

11 Dependent Children on Medi-Cal Covered by Health Insurance (If more space is needed, complete another form)

Child's Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth Mo	Day	Year	Co Code	Aid Code	Medi-Cal ID Number (Case Number)	F BI	Pers No
	_ _									
	_ _									
	_ _									
	_ _									
	_ _									
	_ _									
	_ _									
	_ _									
	_ _									

ABSENT PARENT INFORMATION (ITEMS 12 THROUGH 19)

12 Name (First) (Middle) (Last) | 13 Date of Birth | 14 Social Security Number

15 Complete Street Address

City | State | ZIP Code | 16 Home Telephone Number ( )

17 Name of Employer

18 Employer's Complete Street Address

City | State | ZIP Code | 19 Work Telephone Number ( )

HEALTH INSURANCE INFORMATION (ITEMS 20 THROUGH 23)

If additional insurance coverage (medical, dental and/or vision) is being provided, please complete the back of this form

20 Health Insurance is Provided by (Check appropriate box)

☐ Absent Parent ☐ Custodial Parent ☐ Other If Other, Please State: _____ Name _____ Relationship

21 Name of Insurance Company or Union | 21a Union Local Number

22 Complete Street Address of Insurance Company or Union (Address where claims are mailed)

City | State | ZIP Code | 23 Policy Number

DHS 6110 (10/91)

14. Type of Coverage: Does the health insurance provide or pay for: (Check all that apply, if information is available.)

☐ Hospital Outpatient (i.e., lab work/ physical therapy) ☐ Doctor Visits ☐ Prescription Drugs
☐ Hospital Stays ☐ Long Term Care/Nursing Home ☐ Dental Care
☐ Vision Care

ADDITIONAL HEALTH INSURANCE POLICY INFORMATION

DENTAL INSURANCE INFORMATION (Please complete if dental coverage is being provided)

1 Name of Insurance Company or Union | 1a Union Local Number

2 Complete Street Address of Insurance Company or Union (Address where claims are mailed)

City | State | ZIP Code | 3 Policy Number

VISION INSURANCE INFORMATION (Please complete if vision coverage is being provided)

1 Name of Insurance Company or Union | 1a Union Local Number

2 Complete Street Address of Insurance Company or Union (Address where claims are mailed)

City | State | ZIP Code | 3 Policy Number

MEDICAL INSURANCE INFORMATION (Please complete if additional medical coverage is being provided)

1 Name of Insurance Company or Union | 1a Union Local Number

2 Complete Street Address of Insurance Company or Union (Address Where Claims are Mailed)

City | State | ZIP Code | 3 Policy Number

REMARKS

IMPORTANT: All Medi-Cal eligibles must irrevocably assign the benefits of any contractual or legal entitlement for health care to the State Department of Health Services. Assignment of medical rights allows the Department of Health Services to code Medi-Cal cards and recover funds from insurance companies when the Medi-Cal program pays for medical services which could be billed to other health insurance plans. IN THE EVENT THAT YOUR PRIVATE HEALTH INSURANCE TERMINATES, NOTIFY YOUR COUNTY WELFARE DEPARTMENT.

INFORMATION COLLECTION AND ACCESS

Information concerning your health coverage is maintained by the Chief of the Recovery Branch, by authority of the Welfare and Institutions Code, Section 14011, and Title 22, California Code of Regulations (CCR), Section 50769. All information is mandatory. The information requested is necessary to effect utilization of health insurance or other contractual or legal entitlements as provided in Welfare and Institutions Code, Sections 10020 through 10025, 11490, 14024, 14103, and 14124.70, with persons liable thereunder. Please note that under the authority of Welfare and Institutions Code, Section 14100.2, and in order to comply with the Federal Privacy Act, Section 7(b), your Social Security number and all of the information you provide are used for identification in contacting insurance companies, providers of health care services, county agencies, or your legal counsel under the authority of Welfare and Institutions Code, Section 14102.

Sections 50761 and 50763 of Title 22, California Code of Regulations, require recipients to use and report other health coverage to which they are entitled. Additionally, Section 50175 of Title 22, provides for denial or discontinuance of benefits if the recipient does not cooperate in providing health insurance information.

Section 14023 of the Welfare and Institutions Code provides that any public assistance recipient who has any other contractual or legal entitlement to any health care service and who willfully refuses to disclose this information by withholding important information regarding other medical entitlement is guilty of a misdemeanor. ***MEDI-CAL IS THE PAYOR OF LAST RESORT.***

DHS 8110 (10/91) 91 62908

8. **CS 870**

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY — DEPARTMENT OF SOCIAL SERVICES

ATTESTATION STATEMENT

ATTESTATION TO LACK OF INFORMATION ABOUT THE PARENT(S) OF

_____ COUNTY NAME

I, _____ have no additional knowledge of the following information about the parent of the child(ren) named in this attestation:

☐ 1. I do not know the identity of the parent of the child(ren) because: (state reason(s))

☐ 2. I have named _____ as the parent of the child(ren). However, I do not know the parent(s') residence and/or employer because: (state reason(s))

☐ 3. I do not have or know any other information that might assist the District Attorney in identifying or locating the parent of the child(ren), because: (state reason(s) if different)

In signing this attestation, I declare, under penalty of perjury under the laws of the State of California that all the in have provided is true, correct and complete. I further understand that Federal and State law provide for penalties of imprisonment or denial of Public Assistance/Medi-Cal if I do not tell the truth when applying for Public Assistance/Mr conceal or fail to disclose facts regarding the identity, whereabouts or other information concerning the child(ren)'s pa

Signed:

_____ _____
Name — Date Signed

Witnessed by:

_____ _____
Family Support Officer — Date Signed

CS 870 (12/89)

9. DHS 6110 REJECTION LETTER

STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
THIRD PARTY LIABILITY BRANCH
HEALTH INSURANCE SECTION
P.O.BOX 1287
SACRAMENTO, CA 95812-1287

Date: _____

COUNTY: _____

The attached Medical Insurance Forms (DHS 6110) were not considered for an incentive payment. The specific reason for this is noted on each form and described below. The Department of Health Services is returning these documents to assist your county in increasing the valid identification of other health coverage based on the Health Insurance Incentive Program that took effect October 1, 1993. Corrected forms may be resubmitted and will be reconsidered for incentive payments.

The return reasons include the following:

1. No MEDS Record found: Clients eligibility should be established on MEDS before resubmissions of the DHS 6110.

2. Medi-Cal eligibility was not established: Client's record was found on MEDS, but ineligible. Resubmit after eligibility is established.

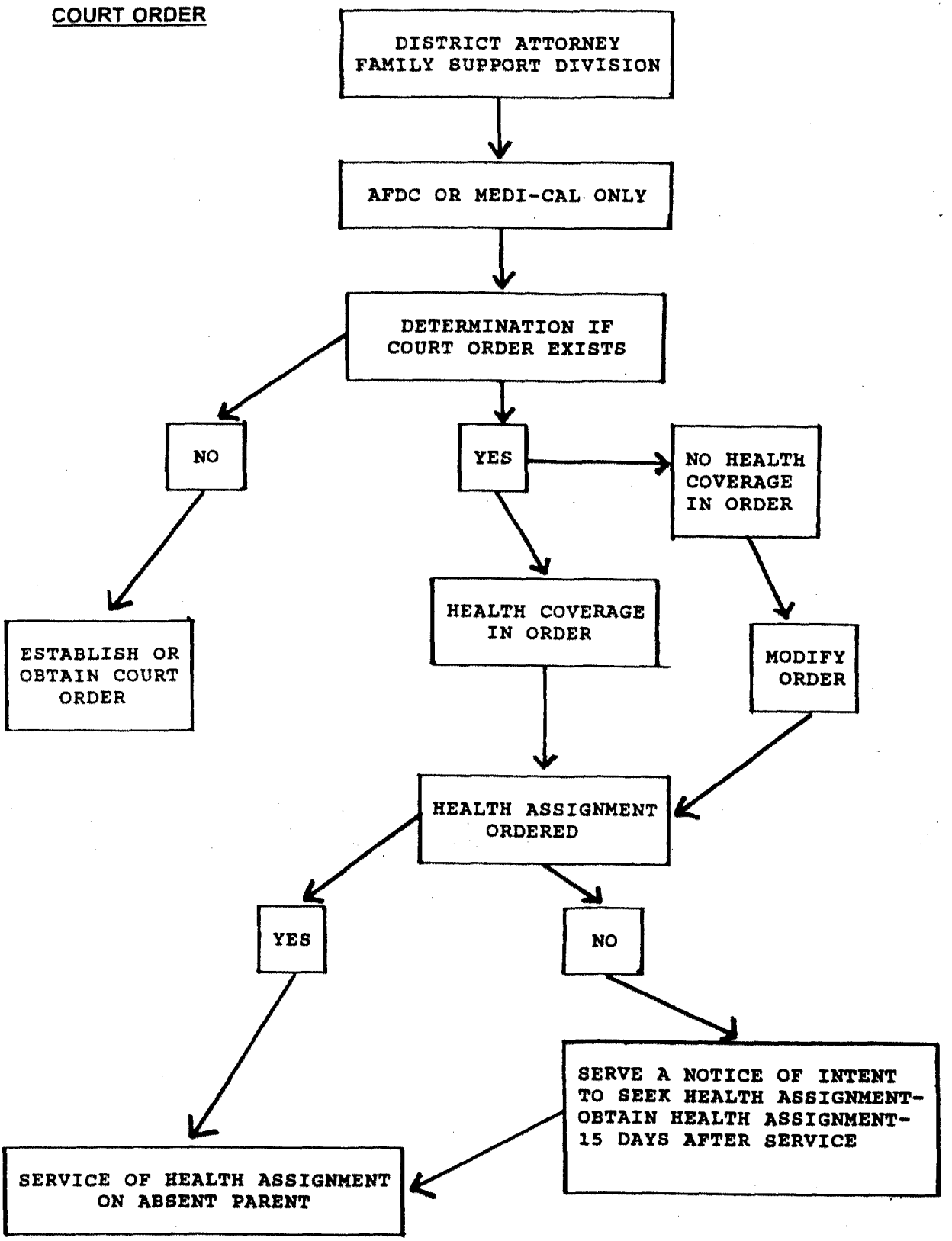
3. Incomplete/Illegible Form: Highlighted items need to be completed or rewritten.

4. Other _____

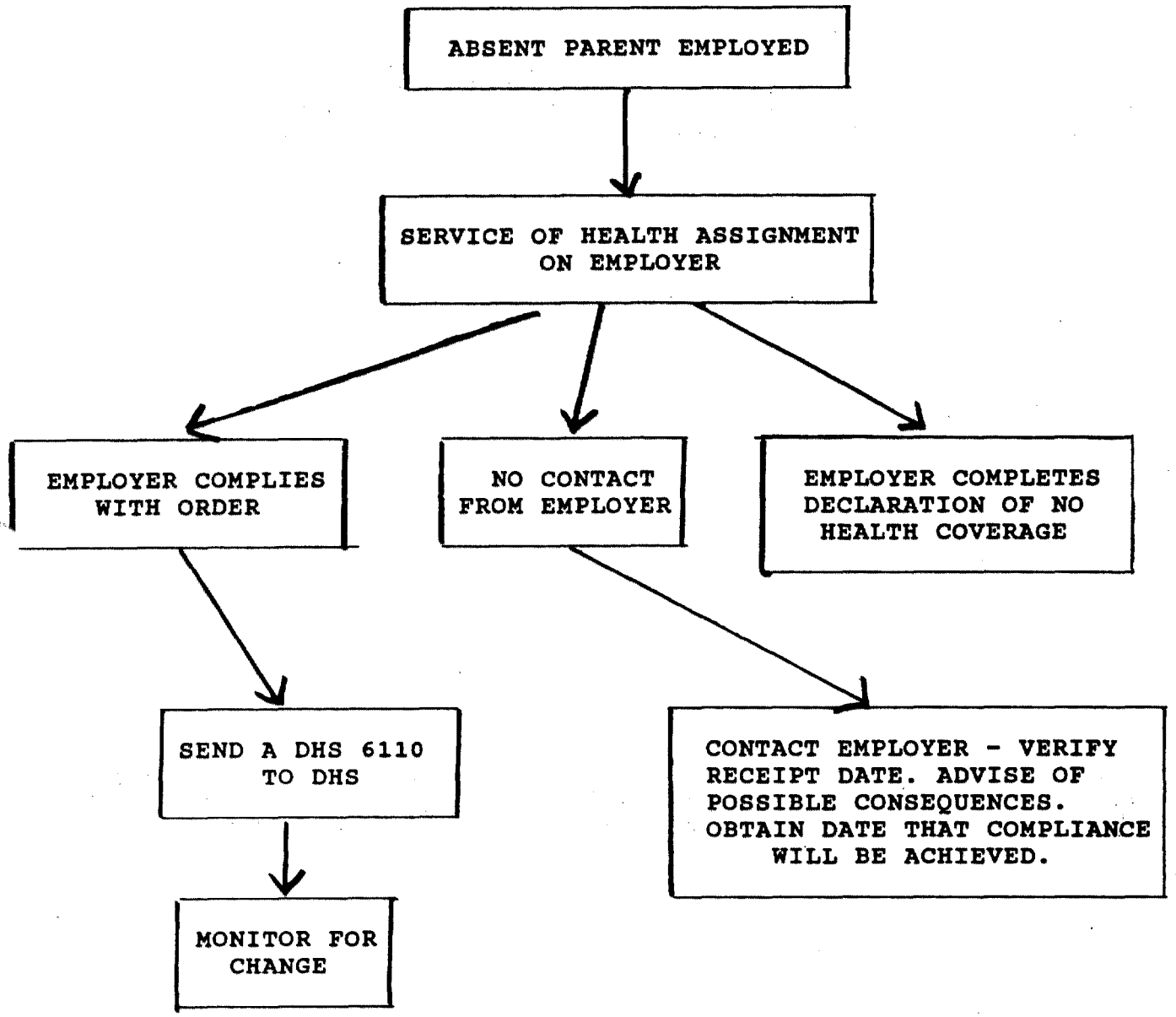
If you have any questions concerning these documents, please contact _____ _____at _____. Thank you.

23K. MEDICAL SUPPORT ENFORCEMENT PROCESS CHARTS

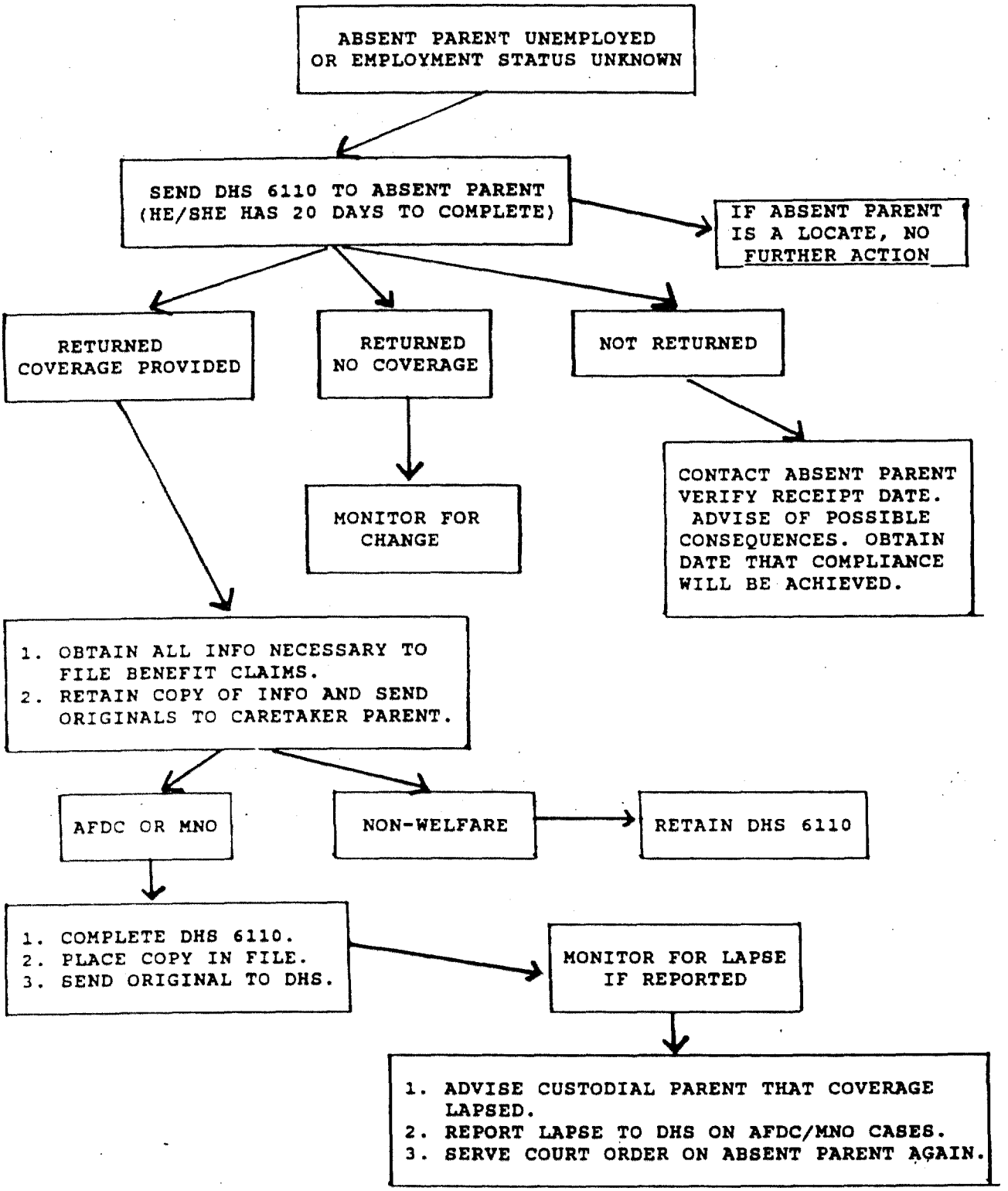
1. COURT ORDER



2. ENFORCEMENT ON EMPLOYED ABSENT PARENT

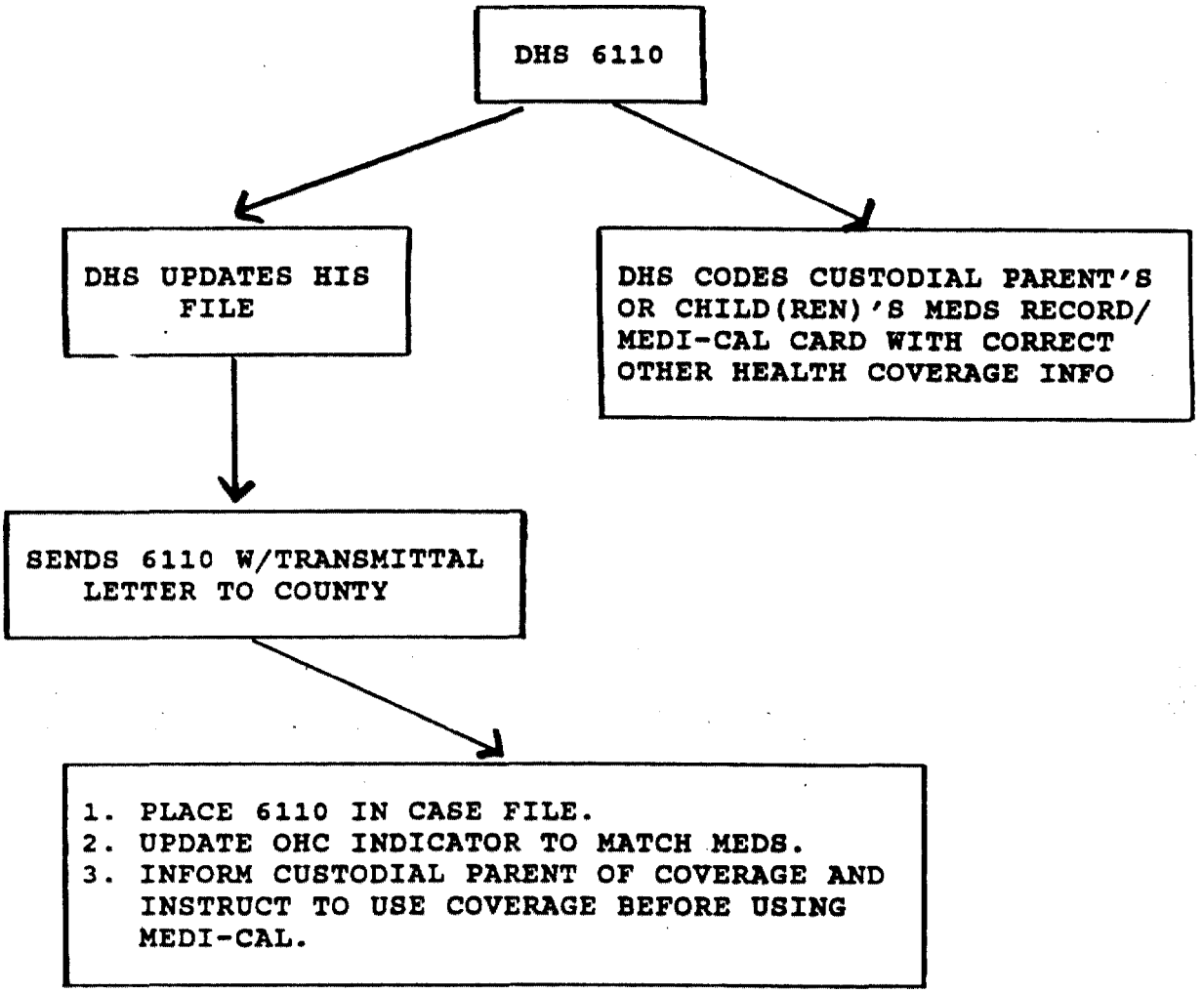


3. ENFORCEMENT ON UNEMPLOYED ABSENT PARENT



4. DHS PROCESSING OF FORM 6110

MEDICAL SUPPORT ENFORCEMENT
DHS PROCESSING OF 6110
AFTER RECEIPT FROM DA/FSD



23L. MEDICAL SUPPORT NOTICES OF ACTION

1. **NOTICES OF ACTION**

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL
NOTICE OF ACTION
DISCONTINUANCE OF MEDI-CAL BENEFITS DUE TO DENIAL OF GOOD CAUSE CLAIM FOR NONCOOPERATION IN MEDICAL SUPPORT ENFORCEMENT

(COUNTY STAMP)

CASE NO.: _____

DISTRICT: _____

DISCONTINUANCE: _____

_____
(names)

Your Medi-Cal benefits will be discontinued effective the last day of _____.

You do not have good cause for refusing to cooperate in medical support enforcement. Good cause can only be granted when it is decided that cooperating with the District Attorney will result in harm or risk to you or your child(ren).

You may reapply at any time, but you will not receive Medi-Cal benefits until the District Attorney's Office has confirmed that you have cooperated with their office. This action does not affect the Medi-Cal benefits of your child(ren). However, your child(ren)'s case will be referred for medical support enforcement without your cooperation. If you have any questions about this action, please contact your Eligibility Worker.

The regulation which requires this action is California Code of Regulations, Title 22, Sections 50167, 50175, and 50771.5.

_____ _____ (____) _____
(Eligibility Worker) (Date) (Phone)

PLEASE READ THE BACK FOR YOUR HEARING RIGHTS AND OTHER IMPORTANT INFORMATION

MC 268 (11/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL
NOTICE OF ACTION
DENIAL OF MEDI-CAL BENEFITS
FOR NONCOOPERATION IN
MEDICAL SUPPORT ENFORCEMENT

(COUNTY STAMP)

CASE NO.: _____

DISTRICT: _____

DENIAL: _____

_____
(names)

You have been denied Medi-Cal benefits because you refused to cooperate in medical support enforcement.

You may reapply at any time, but you will not receive Medi-Cal benefits until the District Attorney's Office has confirmed that you have cooperated with their office. This action does not affect the Medi-Cal benefits of your child(ren). However, your child(ren)'s case will be referred for medical support enforcement without your cooperation. If you have any questions about this action, please contact your Eligibility Worker.

The regulation which requires this action is California Code of Regulations, Title 22, Sections 50167, 50175, and 50771.5.

_____ _____ (____) _____
(Eligibility Worker) (Date) (Phone)

PLEASE READ THE BACK FOR YOUR HEARING RIGHTS AND OTHER IMPORTANT INFORMATION

MC 269 (11/93)

2. **Speed Letters**

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL
SPEED LETTER
APPROVAL OF GOOD CAUSE CLAIM FOR NONCOOPERATION IN MEDICAL SUPPORT ENFORCEMENT

(COUNTY STAMP)

CASE NO.: _____

DISTRICT: _____

APPROVAL: _____

_____
(names)

The County has decided that you have good cause for not cooperating with the District Attorney Family Support Division in obtaining medical support services from your child(ren)'s absent parent. However, it has been decided that the District Attorney can proceed with your case without harm or risk to you or your child(ren). Your child(ren) will be referred for medical support enforcement without your cooperation.

If you have any questions about this action, please contact your Eligibility Worker.

The regulation which requires this action is California Code of Regulations, Title 22, Sections 50167, 50175, and 50771.5.

_____ _____ (____) _____
(Eligibility Worker) (Date) (Phone)

MC 270 (11/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

MEDI-CAL
SPEED LETTER
APPROVAL OF GOOD CAUSE CLAIM
FOR NONCOOPERATION IN
MEDICAL SUPPORT ENFORCEMENT

(COUNTY STAMP)

CASE NO.: _____

DISTRICT: _____

APPROVAL: _____

_____
(names)

The County has decided that you have good cause for not cooperating with the District Attorney Family Support Division in obtaining medical support services from your child(ren)'s absent parent. Therefore, the District Attorney will not proceed with your case.

If you have any questions about this action, please contact your Eligibility Worker.

The regulation which requires this action is California Code of Regulations, Title 22, Sections 50167, 50175, and 50771.5.

_____ _____ (____) _____
(Eligibility Worker) (Date) (Phone)

MC 271 (11/93)

3. NA BACK 6

FROM SSA/ADMINISTRATION 06.29.1993 16:11 NO.21 P.10

YOUR HEARING RIGHTS

To ask for a State Hearing

The right side of this sheet tells how:

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

To Keep Your Same Benefits While You Wait for a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

To Get Help

You can ask out your hearing rights or free legal aid at the state information number.

Call toll free	1-800-952-5253
If you are deaf and use TDD call	1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child support and/or medical: The District Attorney's office will help you collect [redacted] support even if you are not on cash aid. There is no cost for this help. If they now collect [redacted] support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask.

Hearing file: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W & I Code Section

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to:

SSA Appeals Unit
1601 E. Orangewood
P.O. Box 70010
Anaheim, CA 92825-0010
You may also call 1-800-952-5253.

HEARING REQUEST

I want a hearing because of an action by the Welfare Department _____ County about

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal
☐ Other (list) _____

Here's why: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I will bring this person to the hearing to help (name and address, if known)

_____

_____

_____

I need an interpreter at no cost to me. My language or dialect is

My name _____

Address: _____

_____

Phone: _____

My signature _____

23M. MEDICAL SUPPORT COLLECTIONS

1. CHECKS

a. If the County Welfare Department, the Family Support Division/District Attorney's office, or a parent (custodial or non-custodial) receives a specific dollar amount for medical services (sum certain) from any third party, an absent parent, or an insurer, it must be forwarded to the Department of Health Services (DHS) for proper distribution.

b. **How to Send:**

1. Two-party checks must be endorsed by the payee prior to forwarding to DHS.

2. The following information must accompany the check(s) for identification purposes:

- o Name
- o Social Security Number
- o Medi-Cal identification number of the dependent child(ren)
- o The Explanation of Medical Benefits (EOMB) which identifies the medical services rendered

c. **Where to Send:**

Department of Health Services
Third Party Liability Branch
Recovery Section
P.O. Box 2946
Sacramento, California 95812-2946

2. INFORMATION ABOUT PAYMENT

If you receive information about a check sent to an absent parent being cashed, notify DHS in writing at the following address:

Department of Health Services
Third Party Liability Branch
Recovery Section
P.O. Box 2471
Sacramento, California 95812-2471