

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



California
Department of
Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

October 4, 2005

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL LETTER NO.: 298

TO: ALL HOLDERS OF THE MEDI-CAL ELIGIBILITY PROCEDURES
MANUAL

SUBJECT: CHANGE OF ADDRESS FOR DEPARTMENT OF HEALTH SERVICES

Enclosed are updated pages and forms reflecting new change of address for the Department of Health Services and other minor revisions. The changes and additions are marked with a black line in the right hand margin.

FILING INSTRUCTIONS:

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If you have any questions, please contact Ms. Nichole Hansen at (916) 552-9484.
Original signed by

Richard Brantingham for
Tameron Mitchell, R.D., M.P.H., Chief
Medi-Cal Eligibility Branch

Enclosures

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

4N—TIMELY REPORTING BY PUBLIC GUARDIANS/CONSERVATORS OR BENEFICIARY REPRESENTATIVES

A major cause of eligibility errors reflected in Medi-Cal cases for individuals in Long-Term Care, or others having a conservator, is the failure of the beneficiary or their representative to report changes to the county welfare department (CWD) that may affect Medi-Cal eligibility. The following definitions should be noted to avoid possible confusion in regard to the application processes surrounding persons who have a government representative, conservator, or other representative handling their affairs:

Authorized Representative: A person specifically designated in writing by the applicant/beneficiary to accompany, assist, and represent the applicant/beneficiary in the Medi-Cal application/redetermination or fair hearing process. An **Authorized Representative** cannot act on behalf of an incompetent individual.

Conservator: A person appointed by the court to act as the guardian, custodian, or protector of another.

Public Guardian: A county agency acting as a public entity appointed to act on behalf of persons who have lost their ability, either mentally or physically, to handle their own affairs. The **public guardian** acts as the individual's advocate. No private person is allowed to be a "public guardian." The authority vested to the public guardian is derived from the probate code and, for mental health issues, through the Lanterman-Petric-Short (LPS) Conservatorship Act.

Representative: A person acting on the behalf of another who is incapable of handling his/her own personal or business affairs. The **representative** must have specific and personal knowledge of the incompetent individual's circumstance. The representative may be a friend, relative or someone else that has known the applicant/beneficiary and will act responsibly on his/her behalf.

The public guardian frequently represents aged, blind, and disabled persons for Medi-Cal purposes. The public guardian, or other representatives, often have conservatorship responsibilities but, in many instances, fail to understand the importance of keeping the CWD informed timely when changes occur to the recipients circumstances. Many of these changes are a result of changes to income, property, health coverage, and even death.

Regulations specifically exempt the public guardian from the required face to face interview for application [Title 22, California Code of Regulations (CCR) , Section 50157(b),(d)(2)] and all aged, blind, disabled persons are exempt from the face to face interview at redetermination [Title 22, CCR, Section 50189(d)]. Due to this exemption, it is very important that the public guardian, authorized representative, or conservator be aware of her/his on-going responsibilities.

The DHS 7068, **Responsibilities of Public Guardian/Conservators or Applicant/Beneficiary Representatives**, has been developed and revised to assist the counties to inform the public guardians, conservators, and representatives of their reporting responsibilities. The DHS 7068 is to be given or mailed to the public guardian, conservator, or to the representative at the time of the initial application and at each redetermination. The DHS 7068 is printed on NCR paper. The white copy (top sheet) is to be used at application and redetermination time, and should be filed in the

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case file. The yellow copy (second sheet) is to be kept by the public guardian, conservator, or representative. (Note: Signature, address and telephone number of the public guardian, conservator, or representative is required on this form.)

A copy of the MC 219, Important information for Persons Requesting Medi-Cal, must accompany the DHS 7068. The MC 219 must be signed and dated by the public guardian, conservator, or representative and kept in the case file.

If the CWD mails the DHS 7068 to the representative, the following suggested cover letter may be used.

	SAMPLE	SAMPLE
<input type="radio"/>	<input type="radio"/>	
<input type="radio"/> {address block}	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	DATE: _____
<input type="radio"/>	<input type="radio"/>	

As the Public Guardian/Public Conservator of your county, or as the applicant's or beneficiary's representative, you have the responsibility to act on behalf of the individual you represent.

Title 22, CCR, Section 50185 (a)(4), requires Medi-Cal beneficiaries or persons acting on their behalf to report to the county welfare department any changes in circumstances affecting eligibility or share of cost within ten calendar days following the date the change occurred.

Additionally, in the event of the beneficiary's death, Probate Code, Section 700.1, and Welfare and Institutions Code, Section 14009.5, require you to report the death of the beneficiary within 90 days of the date of death to the following address:

**DHS – Third Party Liability Branch
Recovery Section/Estate Recovery Unit
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425**

The attached DHS 7068 (Responsibilities of Public Guardians/Conservator or applicant/Beneficiary Representatives) serves as your acknowledgement of your responsibilities as the representative of the applicant/beneficiary. Please complete the form and return the white copy to the eligibility worker. You should retain the yellow copy for your files.

If you have any questions regarding this form, you may contact

_____ at _____

SAMPLE

SAMPLE

SAMPLE

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State of California—Health and Human Services Agency

Department of Health Services

RE:

Case name

Case number

Worker number

RESPONSIBILITIES OF PUBLIC GUARDIANS/CONSERVATORS OR APPLICANT/BENEFICIARY REPRESENTATIVES

You have accepted the responsibility to act on behalf of _____
State law and regulation require you to report to the county welfare department any changes in the circumstances of the applicant/beneficiary within ten calendar days following the date the change occurred. You must also cooperate fully on behalf of the beneficiary in any review that may be required for quality control purposes.

Changes which must be reported within ten days include, but are not limited to.

1. A change in the beneficiary's property, including community property.
2. A change in the beneficiary's income.
3. Entitlement to Veteran's Benefits or an increase in Veteran's Benefits.
4. Changes in health insurance coverage including enrollment in available health insurance or the discontinuance of health insurance.
5. A change in the beneficiary's living arrangement, household members, or residence.
6. The death of the applicant/beneficiary.
7. A change in guardianship/conservator or representative status.
8. Any other change in circumstances which may affect eligibility or share of cost.

You are also required (pursuant to Probate Code, Section 700.1, and Welfare and Institutions Code, Section 14009.5) to report the death of the beneficiary within 90 days of the date of death to:

DHS—Third Party Liability Branch
Recovery Section/Estate Recovery Unit
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425

Refer to **"IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL"** (MC 219) for a more complete list of your reporting responsibilities.

I hereby state, under penalty of perjury, that the information on this form has been reviewed by me and that I fully understand my responsibilities as the guardian, conservator or representative of

Name of Beneficiary

Signature of Guardian/Conservator or Representative

Date

Address of Guardian/Conservator or Representative

Telephone number of Guardian/Conservator or Representative

Original—Case File

Copy—Guardian/Conservator or Representative

SECTION NO.:

MANUAL LETTER NO.: 298

DATE: 10/04/05

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4S – Instructions for the MC 210 and Supplements to the MC 210

A. BACKGROUND

Welfare and Institutions Code Section 14011.15 mandates a simplified Medi-Cal application package and mail-in process for adults and families. The intent of this law is to provide easy access for this population to apply for and receive Medi-Cal benefits as quickly as possible.

The purpose of the Procedures section is to provide counties with policies and instructions, which are effective no later than December 1, 2001. These policies and procedures apply to all Medi-Cal applications.

As of July 1, 2000, state law prohibits counties from making a mandatory face-to-face interview a routine application requirement. The law also requires the development and implementation of a simplified application form and procedure, and simplifies the verification requirements for earned income and pregnancy.

B. APPLICATION FORM

1. The MC 210 (Rev. 9/01) (Medi-Cal Mail-In Application) will replace the current MC 210 Statement of Facts (SOF). Counties are instructed to begin using the new MC 210 as soon as administratively possible but no later than December 1st. At that time, counties must discard their existing stock of old MC 210 SOF. However, if an old MC 210 SOF is received, the county must process the application and shall not require the applicant to fill out a new MC 210.
2. Counties shall accept either the MC 210 or the MC 321 HFP application as an application for Medi-Cal. An MC 321 received directly by the County shall be processed the same as and MC 210 application.
3. A signed MC 210 or MC 321 Healthy Families Program (HFP) is an acceptable replacement for the current Statewide Automated Welfare Systems (SAWS) 1 and now constitutes an official request for Medi-Cal benefits. The SAWS 1 can still be used but is not a mandatory form, unless otherwise specified.
4. The HFP will accept the MC 210 application as an application for Healthy Families benefits, when the counties determine a family has a share of cost (SOC) or is otherwise qualified and requests Healthy Families coverage.
5. The SAWS 2A may be used as a Medi-Cal SOF when the applicant has previously completed the form as a request for cash aid. It can be used in lieu of the MC 210 when the applicant has been found ineligible to receive cash aid (i.e. California Work Opportunity and Responsibility to Kids [CalWORKs] denial). If a SAWS 2A is used as a SOF, a signed, dated SAWS 1 must also be filed in the Medi-Cal case

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C. APPLICATION AVAILABILITY

1. Anyone may request an application to be mailed to them by calling their local county welfare department (CWD) office.
2. Applications may be picked up from the local CWD office.
3. In the near future the MC 210 application may be downloaded from the Department website (www.dhs.ca.gov) and either mailed or delivered to the local CWD office.
4. Applications may also be picked up from other sources (i.e. outstations, outreach projects, etc).

REMINDER: Should the applicant request CalWORKs or Food Stamps assistance, they must be told to apply in person. The SAWS 1 for the mail-in process only serves to protect the date of application for Medi-Cal only benefits and retroactive Medi-Cal months.

NOTE: The MC 210 (Rev. 8/01) will be available in eleven threshold languages. Currently, the languages are English, Spanish, Vietnamese, Cambodian, Hmong, American, Cantonese, Korean, Russian, Lao, and Farsi. Counties need to ensure that they have the capability to process an application in any of the aforementioned languages.

D. WHAT MUST BE SENT WITH THE APPLICATION

If the application is requested directly from the county, the following information must be provided to the applicant.

1. The "New Mail-In Application and Instructions" (MC 210 [Rev. 8/01]).
2. Postage paid pre-addressed return envelope.
3. Child Health Disability Prevention (CHDP) Informational Publication.
4. MC 007 "Medi-Cal General Property Limitations."
5. Medi-Cal Brochure (Pub. 68).
6. MC 219 "Important Information For Persons Requesting Medi-Cal."
7. MC 13 (Statement of Citizenship) for each family member applying Medi-Cal benefits.
8. MC 003 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Brochure.
9. DHS 7077 "NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY."
10. DHS 7077-A "Notice Regarding Transfer Of A Home For Both A Married And An Unmarried Applicant/Beneficiary."

E. SUBMITTING THE APPLICATION FORM

1. Counties must not require a face-to-face interview. If counties come in contact with an applicant or Authorized Representative (AR), the county must explain his or her option to apply by mail or to go to the CWD.

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An individual is not charged both VTR and PMV in the same month. If VTR is charged, PMV may not be used. These values are unearned income and used to determine income eligibility.

The following chart describes the most common situations involving ISM. For additional information or to answer questions regarding more specific situations, refer to the Pickle Handbook, Section 14, attached to these procedures.

Living Arrangement	VTR: Count 1/3 of the applicable SSI (but not SSP) payment level as unearned income	PMV: Count 1/3 of the SSI (but not SSP) payment level + \$20 as unearned income
<p>Applicant/beneficiary lives in own home, i.e.,</p> <ul style="list-style-type: none"> ▪ He or she and spouse living in home have ownership or life estate interest or rental liability, ▪ He or she pays pro rata share, or; ▪ All members of the household are receiving public assistance income payments. 	VTR does not apply	Count PMV to the applicant if any combination of food, shelter, or clothing is given by a person who is not a responsible relative.
<p>Applicant and his or her:</p> <ul style="list-style-type: none"> ▪ Spouse; ▪ Minor child; ▪ Ineligible spouse (or ineligible parent if applicant is a child) whose income may be deemed to the applicant; ▪ Live in the household of another person who is not one of these above persons. 	Count VTR as unearned income to the applicant if the other person gives/pays for the applicant's food <u>and</u> shelter.	If VTR does not apply, count PMV as unearned income to the applicant if the other person give/pays for any other combination of the applicant's food, shelter, or clothing.
Applicant lives throughout the whole month in the household of another person who is not his/her eligible or ineligible spouse, parent, or child.	Count VTR if the other person is giving/paying the applicant's/ beneficiary's full food AND shelter.	If no VTR, then count PMV if the other person gives any other combination of food, shelter, or clothing, e.g., the applicant shares in expenses but does not pay pro rata share.

6. PREMIUM COLLECTION SYSTEM DESCRIPTION:

a. Determining Eligibility and Amount of Premiums:

Counties will determine eligibility and the amount of premiums for individuals in the 250 percent WD program and report them to MEDS.

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b. Mailing of invoices:

When the county reports initial eligibility and the amount of premium, DHS will send an invoice and postage-paid envelope to the individual as soon as initial eligibility is reported on MEDS. The invoice will be for the current month of eligibility. DHS will also send a second invoice with amount of premiums due for all history months of eligibility (months in which eligibility is established prior to the current month of eligibility and reported to MEDS by the county).

Once the initial 250 percent WD eligibility is reported and for as long as the individual is not terminated from the program, DHS will generate and send monthly invoices and preaddressed postage paid envelopes to program eligibles based on the monthly premium amount reported to MEDS by the counties. Invoices will be mailed approximately on the 23rd of each month after MEDS renewal and will inform the individual that premiums are due by the 10th of the following month. Notices will include the monthly premium payment amount, the total premium amount due for the current month, and will reflect any credits made to the individual's account.

c. Collection of Premiums:

Premium payments will be returned to:

**Department of Health Services
Recovery Section - PAU
MS 4720, Department 155
P.O. Box 997423
Sacramento, CA 95899-9917**

The Recovery Section will process premiums as they are received. Premiums returned in the pre-addressed, color-coded envelope, with system-generated invoice will be posted within 24 hours of receipt. Premiums returned in any other envelope or without the system generated invoice must be researched and will be posted as soon as possible. If a partial premium for a month is received, it will be deposited and reported to MEDS. MEDS' program logic will be able to recognize both full and partial premiums allowing for multiple payments to be made for each month.

d. Discontinuance for Failure to Pay Premiums:

If full payments have not been paid for two consecutive months, DHS will send a timely Notice of Action (NOA), with appeal rights, to the individual informing him/her of discontinuance from the 250 percent WD program for failure to pay the required premiums. The NOA will also inform the beneficiary that the county will automatically evaluate eligibility under other Medi-Cal programs. DHS will update the MEDS record to show ineligibility and will notify the county via a worker alert of the discontinuance.

During the two month period of non-payment, individuals will continue to be eligible under the 250 percent WD program even though full premiums for these months have not been paid. MEDS will have an eligibility status code showing exception eligibility.

If a beneficiary is discontinued from the 250 percent WD program for failure to pay full premiums for two consecutive months, there will be a six-month penalty period. Should an otherwise eligible person wish to reenroll during the six-month penalty period, he or she will be required to pay the premium for the current month and the two transition months in which he or she was eligible for covered services, but failed to pay full premiums. If an otherwise

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B. PAYMENTS:

1. PREMIUM PAYMENTS MADE BY THE APPLICANT/BENEFICIARY

Payments made by the applicant or beneficiary for any LTC insurance policy or certificate shall be considered an income deduction in accordance with Article 10. (This deduction applies to all health insurance premiums.)

2. INSURANCE PAYMENTS MADE UNDER AN LTC INSURANCE POLICY

Benefit payments under the LTC insurance policy may continue to be made under the policy after the individual is determined eligible for Medi-Cal. In most cases, these payments will be per diem payments. Payments received by the applicant or recipient shall be considered income in accordance with Article 10.

If payments are made under the LTC insurance policy directly to the facility, the county shall code the individual on Medi-Cal Eligibility Data System (MEDS) as having Other Health Insurance and complete the DHS 6155 form.



Note: For share of cost cases when an individual's LTC insurance policy's payment is:

- ✓ less than the private pay rate of the facility, and
- ✓ his/her share of cost is higher than the Medi-Cal payment rate but lower than the private pay rate charged by the facility.

The individual must be informed by the Eligibility Worker (EW) that he/she is allowed to make monthly voluntary payments of his/her share of cost to the county.

The county shall:

- ✓ enter the amount of the voluntary payment on MEDS to certify that the share of cost has been met, and
- ✓ forward the voluntary payment to:

Department of Health Services
Third Party Liability Branch
Recover Section – OP
MS 4720
P.O. Box 997421
Sacramento, CA 95899-7421

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Once the county certifies that the share of cost has been met, the facility will then bill at the Medi-Cal rate. This will protect the applicant/beneficiary from being charged the private-pay rate by the facility and prevent the need to reduce his/her exempt property to pay the provider. The applicant/beneficiary shall provide verification of the facility's private-pay rate to the EW.

C. NOTIFICATION REQUIREMENTS FOR THE COUNTY:

If the "Service Summary" form provided by the insurance company:

- is found to be in error, resulting in the ineligibility of the applicant or beneficiary, or
- the verification provided by the insurance company is found to be in such a condition that the County cannot determine whether the applicant/beneficiary is entitled to an LTC insurance exemption,

the county shall notify DHS so that appropriate action may be taken against the insurance company. The notification should be directed to:

Department of Health Services
California Partnership For Long-Term Care
Mail Stop 4100
P.O. Box 997413
Sacramento, CA 95899-7413

5. ESTATE RECOVERY

A. BACKGROUND

The DHS, Estate Recovery Unit (ERU), implemented an estate recovery program in June 1981, pursuant to Welfare and Institutions Code, Section 14009.5, in which claims are filed against the estates of certain deceased Medi-Cal beneficiaries. The person responsible for the administration of the decedent's estate is required to notify DHS regarding the death of the Medi-Cal beneficiary. Upon receipt of the notification of death, the ERU files a claim against the decedent's estate for the amount of health care premiums and services paid for by Medi-Cal, after the beneficiary's 55th birthday. The recovery amount, however, is limited to the lesser of the claim amount or the value of the assets in the decedent's estate.

The ERU is barred from claiming against:

- The estate during the lifetime of the surviving spouse, and/or
- The proportionate share of the estate passing to a child who is under the age of 21, or who is blind, or who is permanently and totally disabled.

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Upon the death of the surviving spouse, the ERU may bill the estate for either the amount paid by Medi-Cal for medical assistance to the predeceased spouse or the value of the assets received by the surviving spouse, whichever is less. If surviving spouse received Medi-Cal benefits, the ERU will also bill the estate for those services.

B. LONG-TERM CARE INSURANCE EXEMPTION

The ERU will reduce the amount of the estate assets from which the ERU is able to claim against by the sum of qualifying insurance benefits paid through a Partnership-approved LTC insurance policy or certificate for qualifying LTC services on behalf of the deceased Medi-Cal beneficiary.

EXAMPLE:

Husband and wife apply for Medi-Cal for the husband, who is in a LTC facility. The couple have an exempt principle residence, valued at \$150,000; a savings account of \$75,000; other real property, with a net market value of \$100,000; and stock certificates, valued at \$125,000. The husband and wife each own a one-half interest in all assets. The husband owns a Partnership-approved LTC insurance policy. At the time of application, a service summary was provided which verified that \$225,000 was paid out under the policy, for services received by the insured. At the time of his death, Medi-Cal had paid total of \$300,000 in benefits to the husband, after age 55.

QUESTION 1:

When the husband dies, what action will the ERU take?

ANSWER:

The ERU will not take collection action during the lifetime of the surviving spouse. However, when the spouse passes away, the ERU will present a claim, in her estate, for the husband's net recoverable assets. At the time of his death, the husband's one-half interest in the assets were:

Principal Residence	\$ 75,000
Savings Account	37,500
Other Real Property	50,000
Stock Certificates	<u>62,500</u>
Total Assets for Husband	\$225,000
Less Payments from the Partnership Approved LTC insurance company	\$225,000
Net Recoverable Assets	<u>\$ 0</u>

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The ERU would not enforce a claim against the wife's estate for the husband's Medi-Cal usage because \$225,000 of the husband's assets were protected by the payments made from his Partnership-approved LTC insurance policy.

C. REPORTING RESPONSIBILITIES FOR PERSON HANDLING ESTATE

Upon the death of the Medi-Cal beneficiary, the person handling the individual's estate, after notifying DHS, in accordance with Probate Code, Sections 215 and 9202, is responsible for providing the amount of qualified benefits paid by the authorized insurance company, under the Partnership-approved LTC insurance policy or certificate.

In cases where the county accidentally receives verification which is intended for estate recovery purposes, or if a person handling the deceased individual's estate inquiries, the verification should be sent to:

**Department of Health Services
Third Party Liability Branch
Recovery Section – ER
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425**

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9I - REDUCTION OF EXCESS PROPERTY

As stated on form MC 216, Rights of Persons Requesting Medi-Cal, all Medi-Cal applicants and beneficiaries have the right to be told about the rules for reducing excess property during any month, including the month of application. Reduction of excess property is the process of reducing one's nonexempt property to within the property reserve limits by the end of the month so as to qualify for benefits (Title 22, California Administrative Code, Sections 50420 and 50427). The eligibility worker should explain this right regardless of whether he/she thinks the applicant/beneficiary has nonexempt property which might exceed the limits and regardless of whether he/she thinks the reserve could be brought below the limits by the end of the month.


The eligibility worker is also to explain to the applicant/beneficiary that excess property can be reduced by any means other than a transfer of property without adequate consideration. Allowable ways of doing this include:

1. Paying medical bills or other debts.
2. Using the excess funds to buy, for adequate consideration, an asset which would be exempt (clothing, home furnishings, burial trusts, etc.).
3. Paying for some service or benefit providing the value received equals the amount spent.
4. A person in long-term care may voluntarily pay an amount in excess of the property limit to the Department of Health Services to avoid discontinuance from Medi-Cal. This process is described in Procedures Manual, Section 16E-I -- Voluntary Repayment of Excess Property Reserves for Persons in Long-Term Care.


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- d. Maintains a separate account for each beneficiary of the trust (but for purposes of investment and management of funds, the trust pools these accounts), and
- e. Provides that DHS, upon the death of the disabled individual or disabled spouse or upon earlier termination of the trust, receive all amounts remaining in that individual's account, equal to the amount of medical assistance paid on behalf of that individual to the extent that amounts remain in that individual's account and are not retained by the trust to cover the costs of that individual's remaining management and investment fees, outstanding bills that fall within the terms of the trusts, and burial/funeral expenses.

In addition, there is no requirement in State or federal law that DHS is obligated to submit any type of claim in order to be reimbursed, nor is the State required to include reimbursement from this type of trust as part of its estate recovery process. It is the responsibility of the trustee to contact DHS to obtain the dollar amount of medical assistance provided by DHS and then submit that amount, or the amount remaining in the trust, whichever is less, to DHS Recovery Branch. Any trust which contains provisions allowing reimbursement of medical assistance provided only upon submission of a "claim" or a "proper claim," shall not be considered an "Other" trust and shall be treated as an ORBA '93 trust under Procedures Section 9JV.

 **Note:** When a disabled individual or disabled spouse has resided in more than one state, the trust must provide that the funds remaining in the trust be distributed to each state in which the individual received Medicaid, based on the state's proportionate share of the individual.

- f. Each account is established solely for the benefit of the disabled individual or the disabled spouse by the disabled individual, disabled spouse, his or her parents or grandparents, the legal guardian of that individual, or by a court order.
 - (1) The account assets are to benefit no one other than the disabled individual or disabled spouse for whose benefit the account was established, from the time the account was established until DHS' interest has been paid. If the account assets are not solely for the benefit of the disabled individual or disabled spouse, then the trust is to be treated as an OBRA '93 trust pursuant to Section 50489.5. (See Procedure Section 9 JV.)

 **Note:** A beneficiary may be named in the trust, to receive amounts remaining in the trust upon the death of the primary beneficiary, however, the terms of the trust must be clear that the transfer to the secondary beneficiary occurs only after DHS has been reimbursed for the medical assistance provided.

- (2) If funds are to be retained by the trust upon the death of the disabled individual or disabled spouse, for whose benefit the trust was established, for any purpose other than:
 - ✓ the cost of the individuals remaining management and investment fees, or
 - ✓ outstanding bills for the benefit of the disabled individual or disabled spouse that fall within the terms of the trust, or

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- ✓ burial/funeral expenses of the disabled individual or disabled spouse,

the account will not be considered solely for the benefit of the disabled individual or spouse and shall be treated as an OBRA '93 trust pursuant to Section 50489.5. (See Procedure Section 9 JV.)

3. ADDITION OR AUGMENTATION OF INDIVIDUAL OR POOLED TRUSTS

When an Individual or Pooled trust is established for a disabled individual or disabled spouse under the age of 65, the exception from treatment under OBRA '93 continues after that individual or spouse becomes age 65. However, Individual and Pooled trusts cannot be added to, or otherwise augmented with assets of the individual or spouse, after that individual or spouse reaches age 65. Any such addition or augmentation may be considered a disqualifying transfer of assets.

- 📎 *Note:* Parents of a disabled son(s) or daughter(s), regardless of age, may make transfers of assets to their disabled son(s) or daughter(s) directly or to the son's or daughter's Individual or Pooled Trust. Such a transfer by a parent of a disabled son or daughter would not be considered a disqualifying transfer of assets in determining the eligibility of the parents for Medi-Cal.

4. RECOVERY OF COSTS

To ensure that recovery of the costs of medical care occurs, counties shall notify Department of Health Services Third Party Liability (TPL) Branch whenever either one of these two types of trusts is discovered. The TPL Branch should be notified whenever the county finds out that the disabled individual or disabled spouse has died or the trust is being terminated. Send the beneficiary's name, Social Security number, Medi-Cal I.D. number, and photocopies of the trust documents to:

Department of Health Services
Third Party Liability Branch
Recovery Section – PI
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425

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TRUSTS ESTABLISHED ON OR AFTER 8/11/93 FOR DISABLED INDIVIDUALS

Two types of trusts established with the property or property rights of disabled individuals are excepted from the OBRA '93 treatment but must be treated in accordance with these rules. The two types are

- ① Individual Trusts and
- ② Pooled Trusts

The characteristics of those two types of trusts are contained on the chart in the Procedures manual.

📎 **NOTE:** Transfer of assets provisions do not apply to transfers of the disabled individual's or disabled spouse's property or property rights to an Individual or Pooled trust. Although augmentations or additions to such trusts by that individual or spouse after he/she reached the age of 65 may result in a disqualifying transfer.

To ensure that recovery of the costs of medical care occurs, counties shall notify the Department of Health Services, Third Party Liability Branch whenever such a trust is encountered, the disabled individual or disabled spouse dies, or the trust is terminated. Send photocopies of the trust, the Medi-Cal beneficiary's name and Social Security number and Medi-Cal I.D. number to:

Department of Health Services
Third Party Liability Branch
Recovery Section – PI
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425

CALIFORNIA UNIFORM GIFT TO MINORS ACT (CUTMA) / UNIFORM GIFT TO MINORS ACT (UTMA)

This is an **irrevocable gift** to a minor (minor is owner.) The gift is property of the minor even though the person making the gift is often the custodian of the trust. The custodian does not hold legal title like a trustee does. The custodian only manages and invests the gift for the child until the child reaches the age of majority. Many times the custodian chooses to restrict his/her access to the funds by making them available only by an order of the court "upon a showing that the expenditure is necessary for the support, maintenance, or education of the minor".

- ✓ Unless such a restriction appears on the trust, the trust funds are available to the child.
- ✓ If such a restriction is present, the funds are considered unavailable. When made, distributions for the support and maintenance of the individual or spouse are considered income.

☆ OTHER CONSIDERATIONS

SPECIAL NEEDS LANGUAGE

A trust may contain special needs or other exculpatory language. If such a trust was established with the individual's or spouse's property or property rights and falls within the parameters of an MQT, SLD or OBRA '93 trust, that language is ignored because under those rules, the trust is **deemed available** whether or not it is made **actually available**.

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Special needs and exculpatory language may look like this:

"The trustee shall pay to or apply for the benefit of John Smith for his lifetime, such amount from the principal or income of the trust estate, up to the whole thereof, as the trustee in its sole and absolute discretion may deem necessary or advisable for the satisfaction of Joseph's special needs.

No part of the principal or income of the trust shall be used to supplant or replace public assistance benefits of any County, State, Federal or other government entity which has a legal responsibility to serve the beneficiary herein."

- ☞ **NOTE:** If the trust was established as a result of a personal injury settlement, the Department is to be notified of the proposed establishment by the plaintiff's attorney. The Department's legal staff reviews the trust to ensure that the individual can reasonably be expected to benefit from the trust and to ensure that amounts contained in the trust are reasonable given the individual's needs. Although the Department may not oppose the **establishment** of the trust, the special needs and exculpatory language contained in the trust do **not** make the individual eligible for Medi-Cal and do **not** mean that the trust funds will be considered unavailable. **Unless the individual is determined to be disabled and the trust meets all the other characteristics for an excepted Individual or Pooled trust, the trust funds will be considered under the OBRA '93 or MQT provisions.**

SNEEDE TREATMENT

If the MFBU is ineligible due to excess property in a trust or annuity owned by a child, unmarried parent, stepparent, or a non-parent caretaker relative, the county shall complete a Sneed property determination to establish if there is eligibility for other family members.

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In those situations where a provider is unwilling to complete his/her portion of the MC 177S due to workload, inconvenience, or neglect, the following exception process will be acceptable:

- a. The beneficiary shall submit a copy of the bill along with the beneficiary's signature on the MC 177S to the county welfare department.
- b. The bill shall indicate the following: patient's name, date, type of service, total amount due, and the amount billed to the beneficiary.

This procedure shall only be used when the provider is unwilling to complete the MC 177S. The county shall complete the MC 177S entry except for the provider signature and submit the MC 177S to DHS, together with a note explaining that the provider was unwilling to complete the MC 177S.

3. County Submission of Forms

The county shall submit the original MC 177S to DHS when the SOC has been met and the form signed. The completed MC 177S should be sent to:

**Department of Health Services
Information Technology Services Division
ATTN: Key Entry Unit
1615 Capitol Avenue, MS 6303
Sacramento, CA 95814**

4. Certification Processing

Certification by Key Data Entry Unit is the formal process of confirming that beneficiaries are entitled to Medi-Cal benefits within an eligible period. Certification requires review of the MC 177S to:

- a. Ensure that the assigned SOC has been obligated or paid.
- b. Ensure that only medical costs for appropriate persons have been used to meet the SOC.
- c. Determine the certification date, i.e., date on which the beneficiaries met their SOC. Services billed to Medi-Cal for dates prior to the certification date must be reviewed to determine if those services were used to meet the SOC and therefore are not payable by Medi-Cal.

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5. Computerized Verification Procedures

Key Data Entry will attempt to certify each eligible MFBU member listed on the MC 177S on MEDS. All MC 177S documents which fail MEDS edits will be returned to the appropriate county welfare department for correction, along with a copy of the MEDS 5.1.1.1. report (see page 12A-5). The report lists the information entered on the transaction, the conflicting data field contents, and the error message for each transaction. Key Data Entry Unit will review the error reports to ensure that the reject is not due to key entry error prior to returning the reports to the county. The records of family members which were accepted for card issuance will be lined out on the MC 177S. Report entries requiring no county action will be crossed out.

The Notification of Discrepancy, form DHS 2208 (see page 12A-6), will be used when no MEDS report is available; for example, for transactions rejected on on-line edits or when erroneous entries or omissions are identified prior to key entry.

If either a DHS 2208 or a MEDS error report is received with an MC 177S, counties should take prompt action to correct the MC 177S and/or MEDS, as appropriate, and return the MC 177S to the State as soon as possible. In addition, if the county is aware of any reason an SOC case cannot be certified on MEDS, a note should be attached to the MC 177S so that certification will not be attempted on MEDS. For example, MEDS does not allow a change from a non-SOC aid code to an SOC aid code in the same month. Therefore, the following note should be attached to the MC 177S: "Do not attempt to certify this case through MEDS, process through CID." In this example, the State will generate the card(s) through another system (CID).

6. Card Issuance

DHS will issue Medi-Cal cards via MEDS (or CID as noted above) to each beneficiary who is certified as eligible. Routine processing requires one to two weeks after DHS receives the MC 177S from the county. If the county receives inquiries from the beneficiary or from providers after the two weeks, county staff should query the MEDS Full Status Inquiry screen to see if a card was recently issued. Since Key Data Entry Unit is unable to respond to telephone inquiries regarding the status of MC 177S processing, counties may certify the case, using copy of the MC 177S in case file, and issue an immediate need Medi-Cal card per Article 12B.

Eligibility Branch will issue a SYSM message if backlogs develop and MC 177S processing requires more than two weeks.

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(3) Medicare Status/Medicare Identification Number

- (a) For SSI/SSP recipients 65 years or older, positive Medicare status is always placed on the card by the State. The Medicare number on the card comes from data sent to the State from SSA's Medicare (Buy-In) system if that data is available; otherwise, the person's SSN is used. (Note: The State will shortly begin use of the SDX-reported Title II Claim Account Number (CAN) as the Medicare number for persons who are 65 or older, since SSA has confirmed that the two numbers are in fact identical. For those recipients who do not have a CAN reported, SSN will still be used as the Medicare number.)
- (b) For SSI/SSP recipients under 65 years, Medicare status and Medicare numbers are obtained exclusively from data sent to the State by SSA's Medicare (Buy-In system). The State matches the Medicare data to the SSI/SSP eligibility data before CID Medi-Cal cards are produced.
- (c) **Medicare Notes**
 - 1) An aged SSI/SSP recipient who is also receiving regular (Title II) Social Security benefits will be automatically bought in by SSA. If he/she is not receiving regular Title II benefits, his/her SSA district office must still complete an application for Medicare. Accordingly, an SSI/SSP recipient complaint based on nonapplication for Medicare is not a valid complaint.
 - 2) Unlike Medicare information for county-administered recipients, new Medicare status/data for SSI/SSP recipients is automatically sent monthly to the State via SSA's Medicare Buy-In system.

2. Handling of Supplemental Security Income/State Supplementary Payment Medi-Cal Card Problems

a. Form MC 5 (Supplemental Security Income/State Supplementary Payment Medi-Cal Card Problem Notice)

(1) General

Form MC 5 is divided into sections according to the type of problem being reported. In all cases the recipient data portion of the form should be completed.

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Completed MC 5 forms and Medicare-related forms go to:

**Department of Health Services
Medicare Operations Unit
MS 4719
P.O. Box 997422
Sacramento, CA 95899-7422**

Forms of both types should be batched and mailed weekly.

(2) Repeat Submission of Form MC 5 for the Same Case/Problem

Card problems which need to be reported may be correctable through a single systems change, or they may have to be corrected on a case-by-case basis. Under either circumstance, reporting of a given problem for a particular client needs to be done only once. If special action needs to be taken to correct a particular type of problem, e.g., referring all clients with that problem to a Social Security district office, then the Department will advise counties of that need. The Department will also keep counties advised of systems corrections as they are identified and made.

b. Correction of Medi-Cal Card Data Not Taken From the State Data Exchange

(1) Correction of Copay/Other Coverage Data

If codes appearing on SSI/SSP Medi-Cal cards are different from the fixed codes described above, this indicates a state computer systems error. No reporting via MC 5, or case-by-case correction, is called for. Errors in either type of code should be reported to the Department of Health Medi-Cal field representative for your county, along with Medi-Cal ID number, recipient name, and valid month of a representative erroneous card. A photocopy of the erroneous card is also requested.

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15B – MEDI-CAL CASUALTY CLAIMS

County welfare departments are required to notify the Department of Health Services (DHS) when they obtain information that a beneficiary sustained injury for which Medi-Cal may have paid benefits and where the beneficiary or his/her representative has initiated an insurance claim; workers' compensation claim; or wrongful death, malpractice, or similar civil suit against a potentially liable third party.

One important source of information is the Statement of Facts for Medi-Cal (MC 210). Question 9C asks whether an applicant is seeking compensation through an insurance settlement or lawsuit when a physical or emotional problem was caused by an injury. Question 34 also asks whether the applicant or any family member has a pending suit or insurance settlement for accident or injury.

The county must notify DHS of a potential third-party liability claim when:

1. Information on the MC 210 or from other sources indicates potential third-party liability;
2. Eligibility is granted or has been in existence for any length of time; and
3. The beneficiary intends to use Medi-Cal to pay for injury-related services.

All notifications should contain the following information:

1. Medi-Cal beneficiary's name. If a minor, the parents' / guardians' names should also be given.
2. Current address and telephone number.
3. Fourteen-digit Medi-Cal identification number(s) (for example, 19-20-2001246-001). All numbers must be reported; a beneficiary may have had more than one number if the aid category or the Family Budget Unit and person number changed.
4. Social Security Number.
5. Date of Birth.
6. Date of injury.
7. Name, address, and telephone number of third-party recovery source(s) (i.e., attorney, insurance company, etc.).
8. Name, address, and telephone number of treating providers of health care and dates of service (if available).
9. For workers' compensation claims, a copy or the number of the Application for Adjudication of Claim (if available).

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Notifications may be reported by calling (800) 952-5776 or (916) 322-0521, or by writing to:

**Department of Health Services
Casualty/Workers Compensation Section
P.O. Box 2471
Sacramento, CA 95811-2471**

In no event should any county agency place liens upon beneficiaries' judgments, settlements, or other assets or in any way attempt to recover from a beneficiary or his/her attorney any amount reimbursable to Medi-Cal in casualty cases.

When the Casualty/Workers Compensation Section receives payment on an account, a written notification is sent to the welfare department of the county in which the beneficiary resides. This is to alert the county that a settlement was reached which may affect the eligibility of the individual.

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Central Offices to determine whether Medi-Cal eligibles may also qualify for the Medicare program.

B. Verification of Data Reported

Procedures established by CMS require a match of more than one characteristic of an individual's case in order to locate a corresponding record on CMS's Health Insurance Master file. All of the information collected by the county EW must be complete and accurate to be of maximum benefit. It is important to verify that the HIC number is correct by checking the beneficiary's Medicare card. Additionally, when a disabled beneficiary received his/her disability claim number (Title II), it should be reported to MEDS since it can also be used for Buy-In and/or QMB purposes.

C. Dealing with Incomplete Information

If the applicant is unable to provide the county EW with the necessary information (such as age, citizenship, or lawful alien status and residency), the county must assume the burden of establishing the applicant's medical insurance eligibility or refer the case to the Premium Payment Unit. If the applicant refuses to provide information needed to determine Medicare status, the county must deny Medi-Cal eligibility due to lack of cooperation.

D. Informing the Beneficiary

The county EW should advise the applicant of the following:

- (1) By filing an application for Medicare benefits, the individual may establish entitlement to Medicare Part B. If an individual wishes to enroll in the QMB or QDWI programs, he/she must first establish Part A eligibility.
- (2) Refusal to apply for Medicare benefits may result in a denial of Medi-Cal benefits.

E. Establishing Medicare Entitlement

If an applicant has yet to establish Medicare entitlement, the county EW must refer the applicant to the nearest local SSA district office to apply for Medicare benefits. It is very important that the applicant establishes Medicare entitlement so that the State may defer costs of medical services to Medicare.

F. Handling Premium Payment Problems

The Premium Payment Unit is available to assist in resolving county Buy-In, QMB and QDWI problems. Counties are encouraged to use the services of this unit.

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To resolve a Buy-In and/or QMB problem that has been detected by a county, complete and forward form DHS 6166 to:

**Department of Health Services
Medicare Operations Unit
MS 4719
P.O. Box 997422
Sacramento, CA 95899-7422**

To resolve a QDWI problem that has been detected, send all pertinent information to the Premium Payment Unit via the Totally Automated Office (TAO), "E-Mail for QDWI" screen, found in the forms section of TAO.

MEDICARE PREMIUM PAYMENT PROCESSES AND SYSTEMS

Medi-Cal recipients who are eligible for Medicare Part A and/or Part B benefits are identified via the State Medi-Cal Eligibility Data System (MEDS) which is maintained through State, county and federal Social Security Administration (SSA) data input. The State issues a Medi-Cal card each month. From that action, the State Medi-Cal and Medicare Premium Payment systems are alerted and, when appropriate, Premium Payment activity is initiated for eligibility beneficiaries by the State of CMS.

1. MEDICARE PREMIUM PAYMENT SYSTEM

The month-to-month operations of the Medicare Part B Buy-In and Part A QMB programs are accomplished through an automated exchange of data between the State and SSA. The State computer file, containing accretion and deletion records for potential Medicare eligibles who are on a county-administered Medi-Cal Program, is sent to SSA in Baltimore, Maryland, no later than the 25th of each month in order to be included in the next month's Premium Payment update operations.

The Premium Payment Unit maintains the State's Medicare Part B Buy-In and Part A Premium Payment systems which interface with federal Social Security systems and MEDS. These automated systems are designed to pay the Medicare Part B and/or Part A premiums for the Medi-Cal Program. The Qualified Disabled Working individual (QDWI) program is the only program not fully incorporated into MEDS and the automated Buy-In and Premium Payment systems.

2. MEDI-CAL AND MEDI-CAL ELIGIBILITY DATA SYSTEM (MEDS) MEDICARE CODING

The two digit Medicare status codes on MEDS (refer to next page) identify Medicare Part A and/or Part B coverage for eligible Medi-Cal recipients. These codes are translated to a one-digit code on the Medi-Cal card which alerts providers to the type of Medicare coverage available to a beneficiary and is used to determine if Medicare must be billed prior to billing Medi-Cal.

3. COUNTY ALERTS/MESSAGES

County Alerts/Messages are generated to the counties as part of the monthly processing of the Buy-In Response File received from CMS for Medicare Part A and Part B. These Alerts/Messages provide county staff with a quick reference to the updated status of each eligible beneficiary under

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2. MEDICARE CODING ON MEDI-CAL ID CARDS

The Medicare Indicator codes which appear on the Medi-Cal ID cards are shown below. The Automated Eligibility Verification System which answers provider inquiries regarding Medi-Cal eligibility also uses the following codes:

Blank	-	No Medicare Coverage
1	-	Medicare Part A Coverage Only
2	-	Medicare Part B Coverage Only
3	-	Medicare Part A and B Coverage

This coding alerts providers to the type of Medicare coverage for which the recipient is eligible so they can determine if Medicare should be billed prior to billing Medi-Cal. For example, if the recipient's Medi-Cal card shows an indicator of "1" (Part A only), a hospital will know it must bill Medicare for inpatient services.

3. HAND TYPED CARDS

In those rare instances where counties are required to hand type an MC 301 Medi-Cal card, the following procedures should be followed:

- o If the beneficiary is over 65 years old and has not met the 5 year residency requirement, leave the Medicare Indicator blank to indicate no Medicare entitlement. If he or she is not identified as an alien, Medicare Part B eligibility is presumed, so use an indicator of "2";
- o Use a Medicare Indicator of "1" if the beneficiary has proof of entitlement from Medicare Part A only; and,
- o Use a Medicare indicator of "3" if the beneficiary has proof of eligibility from Medicare for both Part A and Part B.

REPORTING PROBLEMS TO THE STATE'S PREMIUM PAYMENT UNIT

The Department of Health Service's Premium Payment Unit is available to assist in resolving county Buy-In problems. Each county is encouraged to use the services of this unit when regular Buy-In procedures do not accomplish the desired result. Prior to reporting problems to the State's Premium Payment Unit, the MEDS INQB "Buy-In and BENDEX Information" screen should be reviewed for the current Buy-In status.

When incorrect information is discovered in any of the screen's fields, attach a printout of the INQB screen to a State Buy-In Problem Report (DHS 6166), enter the nature of the error and the correct information in the "Remarks" section of the form and mail to:

State of California
Department of Health Services
Medicare Operations Unit
P.O. Box 997422
Sacramento, CA 95899-7422

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COUNTY PROCEDURES FOR COUNTY ADMINISTERED PERSON

In order to resolve a Buy-In problem, provide the following information on the DHS 6166. All data is needed to fully describe the case in question and enable the State to determine the appropriate period of Buy-In eligibility.

1. Health Insurance Claim (HIC) number, Social Security, or RR HIC number.
2. Name.
3. Sex.
4. Date of birth.
5. County code, aid code, case number, family budget unit and person's number (use the appropriate 14-digit case identification for each period of eligibility identified for this individual).
6. Beginning effective date (for each closed period of Medi-Cal eligibility in which there is a discrepancy).
7. Ending effective date (for each closed period of Medi-Cal eligibility in which there is a discrepancy).
8. For Medically Needy recipients, we need the eligibility approval date as described in Section 15F "Buy-In Effective Date for Medically Needy (MN) persons".

RESOLUTION TIME

Considerable time is needed to correct Buy-In Medicare coding problems. The time required for a problem resolution results from a long sequence of activities involving the processing of an individual problem through county, State and Social Security Administration (SSA) channels and numerous data processing files.

For example, a beneficiary complaining about a premium should expect a minimum wait of four months from the time of the complaint until the billing is corrected by SSA. Once a problem is resolved, a beneficiary must allow SSA 90 to 120 days to refund erroneously deducted or paid premiums.

SSI BUY-IN PROBLEMS

Refer to Sections 14B and 14E of the Medi-Cal Eligibility Manual for handling of Supplemental Security Income/State Supplementary Payment Medi-Cal card coding problems.

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- (3) If insurance is available through an employer (or family member's employer), but has not been enrolled in and no one in the case has a high cost medical condition.
- (a) Complete the DHS 6155. Indicate the name(s) and Social Security Number(s) of beneficiaries who could be enrolled, the name/address of the employer, the name of the available health insurance, and the name and Social Security Number of the employee who has the insurance available to him/her. Check the #6 box "Medical coverage available through employer, but has not been applied for." In the upper right hand corner of the DHS 6155 form, write the notation "EGHP REFERRAL ONLY". This indicates that the applicant(s)/beneficiary(s) listed do not currently have the insurance and you are completing an EGHP referral so that DHS can determine if it would be cost effective to purchase the employer-related health insurance.
- b. Assure that critical segments of the DHS 6155 (applicant/beneficiary name, Medi-Cal identification number, applicant/beneficiary telephone number, insurance carrier name, union/employer name and telephone number) are complete, accurate, and readable.

SPECIAL NOTE: If the beneficiary cannot be given the form in person and the beneficiary notifies the CWD that his/her health insurance has or is about to terminate, or the beneficiary has not applied for employer-related health insurance, the Eligibility Worker (EW) must send the Health Insurance Questionnaire (DHS 6155) form to the beneficiary to complete, sign, and date. Instructions must be given to the beneficiary to mail the form to the DHS.

- c. Advise the applicant/beneficiary that providing the health insurance information will not interfere with Medi-Cal Eligibility, but if payment for the group or employer-related health insurance plan is approved by the Department, enrollment in the health plan is mandatory. Disenrollment from the plan by the applicant/beneficiary, without the approval of Department of Health Services, is cause for discontinuance of Medi-Cal eligibility.
- d. Advise the applicant/beneficiary that if health insurance coverage is available from any source, (i.e., employer, union), at no cost to the beneficiary, the applicant/beneficiary must enroll. If the applicant/beneficiary fails to cooperate by not enrolling in the plan, the county worker must deny or discontinue Medi-Cal eligibility.
- e. Retain a copy of the Health Insurance Questionnaire (DHS 6155) in the case file.
- f. Mail the completed Health Questionnaire (DHS 6155) within five (5) days to the Department of Health Services. Send the HIPP or EGHP DHS 6155 application form in a separate envelope from all other DHS 6155 forms to:

Department of Health Services
Medi-Cal Third Party Liability Branch
HIPP Unit
MS 4719
P.O. Box 997422
Sacramento, CA 95899-7422

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- g. Notify the Department immediately by calling (866) 298-8443 if the County determines that a beneficiary has withdrawn from enrollment in a plan for which DHS pays premiums under HIPP or EGHP. The Department will direct the County by letter to discontinue Medi-Cal eligibility upon verification of the beneficiary's disenrollment from the plan. The County must notify the beneficiary that eligibility has been withdrawn in accordance with Section 50179(c)(7), Title 22, CCR, when instructed by the Department to discontinue Medi-Cal eligibility.
- h. Review and recompute the beneficiary's Share of Cost as necessary in accordance with Articles 12A and 12B (Share of Cost) of the procedures portion of the Medi-Cal Eligibility Manual.

4. Department of Health Services Responsibilities

Utilizing the HIPP/EGHP qualifying criteria the Department shall:

- a. Review the Health Insurance Questionnaire (DHS 6155), contact applicant/beneficiary for additional documentation and approve the application when it is determined to be cost effective for the State to pay the health insurance premiums.
- b. Notify the County and the beneficiary of State's intent to approve and/or terminate payment of the health insurance coverage.

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16H – COLLECTION RESPONSIBILITIES: DHS THIRD PARTY LIABILITY BRANCH

I. Recovery Section:

Among other responsibilities, the Recovery Section initiates overpayment collections, files liens, and claims for personal injury related expenses, estate recoveries, and accepts voluntary repayments from certain long-term care beneficiaries. Instructions on county responsibilities in these areas are found in this Article of the Manual. The county or the public may contact the Recovery Section by mail or by telephone at:

**Department of Health Services
Recovery Section
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425
(916) 650-0491**

A. Department of Health Services (DHS) Overpayments Unit:

The Overpayments Unit is responsible for enforcing compliance with Medi-Cal laws and regulations for Medi-Cal providers and beneficiaries. Its primary function is to recover funds due the program, thereby reducing the total cost of the program. Beneficiary cases are referred from county agencies (district attorney's offices, probation departments and others), the DHS's Investigations Branch, and the DHS's Health Insurance Section.

Once these sources identify a potential or actual overpayment liability, the referral source writes up and sends the referral, along with the necessary back-up information, to the Unit for collection action. The Unit then establishes an Accounts Receivable and begins with a series of demand letters (the first demand letter provides appeal rights and how to request an appeal (State Hearing) and telephone calls seeking voluntary repayment. If these efforts are unsuccessful, involuntary collection actions commence. These may include interagency offset of State Income Tax refunds or lottery winnings and, if the beneficiary is not judgment-proof, civil action in Small Claims Court or referral to the Attorney General's Office to secure a judgment to levy against the debtor's assets and/or record a real property lien. The Overpayments Unit may be contacted at:

**Department of Health Services
Recovery Section – Overpayments Unit
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425
Phone: (916) 650-0491
FAX: (916) 650-6581
Automated Call Management System: (916) 323-4826**

B. Personal Injury Unit

The Personal Injury Unit recovers Medi-Cal monies expended to treat beneficiaries who have incurred illness or injury for which another person or entity may be liable. Examples of personal injuries are those that result from auto accidents, slip-and-falls, medical malpractice, product liability, premises liability, loss of consortium, loss of society, and legal malpractice as they pertain to personal injury actions. Worker's compensation cases are processed by firms contracting with the Department. The Unit identifies and researches potential personal injury cases, computes injury-related Medi-Cal expenditures, files and negotiates liens, and collects monies due after settling through both voluntary and involuntary methods.

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The unit notifies counties of cases for which lien payments have been received, so that eligibility workers will be aware that beneficiaries have received monetary personal injury settlements which may affect their Medi-Cal eligibility. The Payment Register which is sent to counties on a monthly basis is sorted by Medi-Cal number. County or public questions regarding this report may be directed to the address or phone/FAX below.

**Department of Health Services
Personal Injury Unit
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425
Phone: (916) 650-0490
FAX: (916) 650-6581
Automated Call Management System: (916) 323-4836**

Article 15B provides instructions for reporting personal injury and worker's compensation cases to DHS.

C. Estate Recovery Unit

1. Background

In accordance with the Welfare and Institutions (W & I) Code, Section 14009.5, DHS implemented an estate recovery program in June 1981, whereby creditor's claims are filed against the estates of certain deceased Medi-Cal beneficiaries. These claims are based on the amount of health care premiums and services paid by the program on behalf of these decedents, on or after the age of 55 or the value of the decedents estate, whichever is less. The following information outlines the major points of this program:

a. Notification of a Medi-Cal Beneficiary's Death

It is the responsibility of the heirs, executor, administrator, estate attorney, personal representative, or the persons in possession of any property of the decedent, to notify the Director of the DHS of the death of a Medi-Cal beneficiary. This notification is to be sent to the DHS no later than 90 days after the date of the beneficiary's death (Probate Code, Sections 215 and 9202).

DHS also identifies Medi-Cal decedents, by way of a monthly data search of the Medi-Cal Eligibility Data System (MEDS), to check the eligibility status codes on each beneficiary's file. If the eligibility status shows that the beneficiary was terminated by reason of death, a system-generated questionnaire is sent to their estate at their last known address. The return of the questionnaire, along with a copy of the death certificate and any other requested information, satisfies the notification requirements set forth in Probate Code, Sections 215 and 9202.

b. Filing of Estate Recovery Claims

DHS may file a claim if the Medi-Cal decedent was age 55 or older, if there is no surviving spouse, no surviving child who is under 21 years of age or who is blind or permanently and totally disabled (within the meaning of Section 1614 of the federal Social Security Act, U.S.C., Section 1382c), and there is an estate (W & I Code, Section 14009.5).

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II. Health Insurance Section

The Health Insurance Section's primary responsibility is to ensure that a recipient's private health coverage and/or Medicare benefits are identified and utilized before Medi-Cal. This Section is responsible for the Medicare premium payment program, the Medi-Cal Buy-In Program, and for paying health premiums in certain cost effective situations. This Section is also responsible for recovering Medi-Cal funds when health coverage or Medicare eligibility is identified or established retroactively. This Section consists of four units.

A. Other Health Coverage Unit

This unit is responsible for assuring the identification of all health coverages resources belonging to Medi-Cal beneficiaries. Identification is accomplished through reports from county welfare, Social Security, district attorney offices and from computer matches with health plans or insurance carriers, special mailings to beneficiaries, and other sources. For more information about health coverage identification and reporting, see Article 15A.

This unit also maintains the Health Insurance System (HIS) and Carrier Master File (CMF) which contain recipient specific health insurance information. These databases can be accessed by county staff via the Medi-Cal Eligibility Data System (MEDS). Access instructions along with screen descriptions were issued in All County Welfare Directors Letter 94-50.

B. Cost Avoidance Unit

This unit is responsible for identifying Medi-Cal beneficiaries who qualify for payment of private health coverage premiums through the Health Insurance Premium Payment (HIPP). Unit staff evaluate applications and initiate Medi-Cal payment of the private health coverage premiums when it is determined to be cost effective for Medi-Cal to do so. For more information about this program, see Article 15H. The toll-free number for more information regarding the HIPP Program is 866-298-8443.

A toll-free number is also available for beneficiaries and providers with questions about the identification, termination, and use of other health insurance. The number is 800-952-5294.

C. Analysis and Implementation Unit

This unit is responsible for setting policy and monitoring the claims processing functions to assure that Medi-Cal does not pay for services covered by private health plans. The claims processing systems used the coverage information in the HIS and CMF to identify which claims should be returned to the provider for insurance billing. Requiring providers to bill health insurance or Medicare before Medi-Cal is called cost avoidance.

This unit is also responsible for the post payment recovery of monies paid to providers for services which were later determined to be covered by insurance, or for services which cannot be cost avoided under federal law. Claims are automatically generated by the Medi-Cal fiscal intermediary and mailed to the insurance carrier. Unit staff, follows up on unpaid claims, posting payments and releasing claims as appropriate.

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

D. Medicare Operations Unit

This unit is responsible for identifying Medi-Cal beneficiaries who qualify for State payment of Medicare Part A (hospital insurance) and Part B (medical insurance) premiums. Unit staff add or delete Medi-Cal beneficiaries from various Medicare Programs: Part B Buy-In, Qualified Medicare Beneficiary, Qualified Disabled Working Individual, and Specified Low Income Beneficiary. Unit staff initiates payment of premiums, supplies coverage information to providers and the claims processing system so the coverage can be cost avoided and recovers Medi-Cal expenditures for individuals retroactively enrolled in Medicare. For more information on the Medicare premium payment process, see Article 15F. A toll-free line is available for beneficiaries with questions about Medicare Part A and Part B, the number is 800-227-9863.

The Health Insurance Section may be contacted at:

Department of Health Services
Health Insurance Section
MS 4719
P.O. Box 997422
Sacramento, CA 95899-7422
(916) 650-0490

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

16I - - VOLUNTARY PAYMENT OF EXCESS PROPERTY

1. Voluntary Payment Program – Persons in Long-Term Care (LTC) Facilities

A. Program Description

Medi-Cal beneficiaries in LTC facilities whose property is, or will be, in excess of the property reserve limit for the month may reduce their property reserve to within allowable limits by voluntary payment to the Department of Health Services (DHS) for services. This will permit the beneficiary to avoid discontinuance of Medi-Cal benefits.

PLEASE NOTE: This procedure does not limit the beneficiary's right to spend his/her property as he/she wishes.

Under this program, voluntary payment of excess property for medical services received is only appropriate when all of the following apply:

1. The person is a current Medi-Cal beneficiary.
2. The beneficiary is in LTC.
3. The property exceeds or will exceed the property limit in the month.
4. The beneficiary or the person acting on his/her behalf wishes to participate in the voluntary program.

The payment system described in this procedure is only available to persons in LTC (refer to Article 91 Section 4). Any other individual desiring to pay DHS for services should be referred to the local DHS Investigations office (refer to Article 16F).

B. Beneficiary, Representative, or LTC Facility Action

When the property reserve has increased to the point that it exceeds the property limit, or will exceed that limit during the next month, the beneficiary, the person acting on his/her behalf, or the LTC facility must notify the county welfare department immediately. The notification should be in writing, if possible. The county is encouraged to work with LTC facilities and public guardians to establish local procedures for reporting such cases.

NOTE: Income received in a month, whether or not it is deposited in a checking or savings account, is not considered as property in that month. In addition, lump sum retroactive Supplemental Security Income (SSI) or Title II benefits are not considered in the property determination for six months after the month received.

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

C. County Action

To prevent the disruption of Medi-Cal benefits whenever the beneficiary has excess property, the county shall:

1. Ask the beneficiary or person acting on his/her behalf if he/she wishes to make a voluntary payment of the excess property to DHS's Recovery Section to reduce the property reserve upon notification that the property reserve is near or has exceeded the property limit.
2. If the beneficiary wishes to make a voluntary payment, calculate the voluntary payment amount and direct the beneficiary or person acting on his/her behalf to send the payment to the Recovery Section's Overpayments Unit with the following information:
 - a. Beneficiary's name
 - b. Social Security Number
 - c. Full 14-digit Medi-Cal Number
 - d. Date of birth
 - e. LTC facility name and address
 - f. Amount of excess property
 - g. Reason for excess property
 - h. Name of person acting on the beneficiary's behalf, if applicable, and his or her address and telephone number.

The address to send the LTC voluntary payment check is:

**Department of Health Services
Third Party Liability Branch
Recovery Section – OP
MS 4720
P.O. Box 997421
Sacramento, CA 95899-7421**

3. Recompute the property status of the beneficiary upon receipt of the Acknowledgment Letter sent by the Recovery Section to the county. The effective date of the voluntary payment is the date the payment is postmarked.

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

4. Contact the Recovery Section at the telephone number below when the beneficiary has informed the county that payment has been made, but no Acknowledgment Letter has been received. (See sample of Acknowledgment Letter, Article 16I-4).

Recovery Section

(916) 650-0491 (The county or the public may use this number.)

5. Contact the beneficiary or person acting on his/her behalf if notified by the Recovery Section's Overpayments Unit that no payment has been received. If there is not good cause for failure to carry out the agreed payment action, and property still exceeds the limit, initiate discontinuance action.

PLEASE NOTE: In addition, if a potential overpayment has occurred, submit an overpayment referral to the department's Investigations Branch.

Where the beneficiary has a public guardian, the guardian may contact the Recovery Section's Overpayments Unit by mail or by telephone directly at the address or telephone number below. The public guardian shall notify the county when a voluntary payment is made.

Department of Health Services
Third Party Liability Branch
Recovery Section – OP
MS 4720
P.O. Box 997421
Sacramento, CA 95899-7421
(916) 650-0491

- D. DHS Recovery Section's Overpayments Unit will establish a case in the name of the beneficiary. The case number will be the Social Security number of the beneficiary.

II. Limitation of Effect of Voluntary Payment

If a beneficiary is discontinued due to excess property throughout a full calendar month, a voluntary payment cannot be used to reestablish the individual's eligibility for the month throughout which excess property existed. Eligibility can only be reestablished in the month the property is brought within the property limit unless the provisions contained in All County Welfare Directors Letter, Number 97-41 resulting from Principe v. Belshé apply.

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

State of California Health and Welfare Agency

Arnold Schwarzenegger, Governor

Department of Health Services
Third Party Liability Branch
Recovery Section – Overpayments
MS 4720 P.O. Box 997421
Sacramento, CA 95899-7421

XXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
c/o XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXX, CA XXXXX

Dear XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX:

CASE NAME : XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CASE NUMBER : XXXXXXXXXXXXXXXXXXXXXXX
SSN : XXXXXXXXXX
MEDI-CAL NUMBER : XXXXXXXXXXXXXXXXXXXXXXX
FACILITY :
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

This letter confirms payment of \$XXXXXXXXXXXX dated XXXXXXXXXXXXXXX. For the above-referenced case. If I can be of any further assistance, please call this office at the above number.

XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXX
COLLECTION REPRESENTATIVE
RECOVERY SECTION



MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

20A – SOCIAL SECURITY NUMBER (SSN) VERIFICATION CODE CHANGES

BACKGROUND

The procedures indicated below are to be followed when requesting a change in a validated SSN verification code as shown on the Medi-Cal Eligibility Data System (MEDS), when a county identifies a discrepancy between a birth date, name, sex code, or SSN and county beneficiary information.

COUNTY PROCEDURES

A. Birth Date, Name, and/or Sex Code Changes

The county must first complete form MC 194 (Social Security Administration (SSA) Referral Notice), then refer the client to the local SSA district office for verification of the discrepancy. At the time of referral, the county shall submit a copy of the MC 194 to verify that they have requested the client to contact the SSA district office, along with a request to the state MEDS liaison, to change the SSN verification code on MEDS. The county does not need to wait for verification from the SSA for birth date, name, or sex code changes, nor forward such verification to the Department of Health Services before submitting its request for SSN verification code change.

B. SSN Changes

The county must first complete form MC 194, then refer the client to the local SSA district office for verification of the discrepancy. Counties should then wait for response from SSA, either through the SD 10 Alert (SSN referral process) or a returned MC 194, before submitting a request to the Department to change the SSN verification code based upon a SSN change. At that time, a copy of the SD 10 or MC 194 must be submitted to the Department.

Requests for SSN verification code changes should be submitted to your county MEDS liaison. The county MEDS liaison should review and forward the request to your state MEDS liaison at:

**Department of Health Services
Medi-Cal Eligibility Branch
Attn: MEDS Liaison
MS 4608
P.O. Box 997413
Sacramento, CA 95814-7413**

Once the request for SSN verification code change has been received/reviewed, the SSN verification code on MEDS will be changed within five working days from the date of receipt. Counties should verify via MEDS that the SSN verification code has been changed prior to entering new data into MEDS.



MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

State of California—Health and Human Services Agency

Department of Health Services

DISABILITY LISTING UPDATE

Please indicate which list is to be updated with a check mark

- Medi-Cal liaison(s) for disability issues.
- Medi-Cal liaison(s) for quarterly status listings for pending and closed disability cases.

Please use this form to transmit the name of your county's representative, or in counties where multiple contacts will be necessary, please provide the same information for each representative on a separate form. It would be appreciated if the information is printed or typed

County	Liaison		
Liaison's position title	Liaison's telephone number ()	Alternative telephone number ()	
Office address (number, street)	City	State	Zip code

RETURN TO: Department of Health Services
Medi-Cal Eligibility Branch
Attn: Disability Liaison Coordinator
1501 Capitol Avenue, MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417

MC 4033 (2/05)

State of California—Health and Human Services Agency

Department of Health Services

DISABILITY LISTING UPDATE

Please indicate which list is to be updated with a check mark

- Medi-Cal liaison(s) for disability issues.
- Medi-Cal liaison(s) for quarterly status listings for pending and closed disability cases

Please use this form to transmit the name of your county's representative, or in counties where multiple contacts will be necessary, please provide the same information for each representative on a separate form. It would be appreciated if the information is printed or typed:

County	Liaison		
Liaison's position title	Liaison's telephone number ()	Alternative telephone number ()	
Office address (number, street)	City	State	Zip code

RETURN TO: Department of Health Services
Medi-Cal Eligibility Branch
Attn: Disability Liaison Coordinator
1501 Capitol Avenue, MS 4607
P.O. Box 997417
Sacramento, CA 95899-7417

MC 4033 (2/05)

SECTION NO.: 50167, MANUAL LETTER NO.: 298 DATE: 10/04/05 22C-4.32
50223



MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

State of California—Health and Human Services 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 (8:00 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 Case address	FOR COUNTY USE ONLY		STATE USE ONLY	
	Worker number		Verified by	
	Date		Date	Initials
	Worker telephone number ()		Date	Initials
<input type="checkbox"/> Initial intake <input type="checkbox"/> Redetermination <input type="checkbox"/> HPP		Optional District number	Scope	CC number

SECTION I: Beneficiary Information LIST ALL PERSONS, INCLUDING UNBORNS, ON MEDI-CAL AND COVERED BY HEALTH INSURANCE POLICY						14-DIGIT MEDI-CAL NUMBER			
OHG	Beneficiary Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	Co. Code	Aid Code	Case Number	FBI	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? (PHO/PHMO/RPO) 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, address, and telephone number of union, employer, group, organization or school.
 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 California 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: THIRD PARTY LIABILITY BRANCH, WS 4719, P.O. BOX 987422, SACRAMENTO, CA 95899-7422

Original—State Copy—County File Copy—Beneficiary

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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 California 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 California 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.

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

State of California—Health and Human Services Agency

Department of Health Services

MEDICAL INSURANCE FORM

Complete this form only if the children involved in this action are applying for or receiving AFDC or Medi-Cal. Send to the California Department of Health Services once the noncustodial parent health insurance coverage for the dependent child(ren) is obtained and verified.

Mail to: California Department of Health Services
Other Coverage Unit
MS 4719
P.O. Box 997422
Sacramento, CA 95899 7422

FOR COUNTY USE ONLY

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			County Code	Aid Code	Medi-Cal ID Number (Case Number)	F SU	Pers No
			Month	Day	Year					

NONCUSTODIAL 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)
 Noncustodial parent Custodial parent Other (if other, please state _____)

21. Name of insurance company or union		Name	Relationship
22. Complete street address of insurance company or union (address where claims are mailed)		21 a. Union Local number	
City	State	ZIP code	23. Policy number

DHS 6110 (604)

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

24 Type of Coverage Does the health insurance provide or pay for (Check all that apply, if information is available)		
<input type="checkbox"/> Hospital outpatient (re lab work/physical therapy)	<input type="checkbox"/> Doctor visits	<input type="checkbox"/> Prescription drugs
<input type="checkbox"/> Hospital stays	<input type="checkbox"/> Long term care/nursing home	<input type="checkbox"/> Dental care
		<input type="checkbox"/> 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			1 a 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			1 a 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			1 a 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 California Department of Health Services. Assignment of medical rights allows the California 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 6110 (604)

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

9. DHS 6110 REJECTION LETTER

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



ARNOLD SCHWARZENEGGER
Governor

Date: April 16, 2004

«Title» «FirstName» «LastName»
«JobTitle»
«Company»
«County» County
«Address1»
«Address2»
«City», «State» «PostalCode»

DHS 6110 DOCUMENT/INCENTIVE REJECTION

Dear «Title» «LastName»:

The enclosed Medical Insurance Forms (DHS 6110) were not considered for an incentive payment. The specific reason for this is noted on the Blue Tag stapled to the left side of each returned document.

The Department of Health Services is returning these documents to assist «County» county in increasing the valid identification of other health coverage based on the District Attorney Health Insurance Incentive Program that took effect October 1, 1993.

Corrected forms may be resubmitted and will be reconsidered for incentive payments if they are returned to the Department of Health Services at the address provided above.

If you have any questions concerning these documents, please contact Ms. Deborah Colasanti, at (916) 650-0547.

Thank you.

Enclosures

THIRD PARTY LIABILITY BRANCH, HEALTH INSURANCE SECTION, MS-4719, P.O. BOX 997422,
SACRAMENTO, CA 95899-7422
Internet Address: www.dhs.ca.gov

SECTION NO.: 50765, 50050, 50101, 50185, 50351 50771.5, 50157, 50175, 50227, 50379 MANUAL LETTER NO.: 298 DATE: 10/04/2015-15



MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

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 – OP
MS 4720
P.O. Box 997421
Sacramento, CA 95899-7421**

2. INFORMATION ABOUT PAYMENT

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

**Department of Health Services
Third Party Liability Branch
Recovery Section – OP
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425**

