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

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

Date: February 7, 2014

Medi-Cal Eligibility Information Letter No.: I 14-13

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY WELFARE ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY HEALTH EXECUTIVES
ALL COUNTY MENTAL HEALTH DIRECTORS
ALL COUNTY MEDS LIAISONS

SUBJECT: MEDI-CAL 250 PERCENT WORKING DISABLED PROGRAM PREMIUM PAYMENT METHODS

The purpose of this letter is to advise counties that the Third Party Liability and Recovery Division (TPLRD) of the Department of Health Care Services recently mailed the attached informational flyer entitled, "IMPORTANT INFORMATION ABOUT MEDI-CAL 250 PERCENT WORKING DISABLED PROGRAM PREMIUM PAYMENT METHODS." **Electronic Funds Transfer Registered User Option."**

Currently, the electronic funds transfer (EFT) payment option requires that the 250 Percent Working Disabled Program (WDP) beneficiary enter their name, address, contact information, bank routing and account numbers each time they want to make an EFT payment. The March 2014 planned upgrade will allow a beneficiary to set up a registered user account with a user name and a password. That will enable the beneficiary to enter their personal information once. If a 250 Percent WDP beneficiary wishes to set up a Registered User account now, he or she can complete the Electronic Funds Transfer (EFT) Registered User Enrollment Form and return it to TPLRD at the address listed on the flyer.

Medi-Cal County eligibility workers are encouraged to direct beneficiaries to use the EFT system which can be found at http://www.paycalifornia.com.

If you have any questions or need more information on 250 Percent WDP payment options, please call TPLRD at (916) 319-9574.

Original Signed By:

Tara Naisbitt, Chief
Medi-Cal Eligibility Division

Attachments

cc: Bob Bonkowski
Assistant Chief
Third Party Liability and Recovery Division

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IMPORTANT INFORMATION ABOUT
MEDI-CAL 250 PERCENT WORKING DISABLED PROGRAM
PREMIUM PAYMENT METHODS

Beneficiary name
Beneficiary address

DHCS Account Number:

Electronic Funds Transfer
Registered User Option

The Department of Health Care Services (DHCS) will soon launch the Electronic Funds Transfer (EFT) Registered User Option. With this new option, you can schedule 250 Percent Working Disabled Program (WDP) payments on the internet. It's easy and it's free! You can securely transfer payment(s) directly to DHCS from your bank account. To get started, complete the enclosed enrollment form using your DHCS Account Number provided above. This option will allow you to save all the necessary information in making payments to DHCS.

Follow the steps below to enroll:

1. Read the enclosed instructions and complete the enrollment form.
2. Submit the completed form by using the enclosed prepaid envelop or mail to:

   Department of Health Care Services
   TPLRD ASU EFT Admin, MS 4718
   P.O. Box 997421
   Sacramento, CA 95899-7421

3. You will receive an email confirmation after you have been registered.
4. Visit http://dhcs.ca.gov/epay and refer to the Quick Reference Links for guides, instructions, and Frequently Asked Questions (FAQ) regarding the Registered User option.

Submit your completed enrollment form on or before January 31, 2014 to be included in the estimated March 2014 implementation.

For more information regarding the 250 Percent WDP, visit our webpage at http://dhcs.ca.gov/WDP.

DHCS Department of Health Care Services

DHCS use
Received:
Completed:

Electronic Funds Transfer (EFT) Registered User Enrollment Form

Section I

General Information- (All fields required except E if applicable)

A. Beneficiary/ Provider Name:	**B. DHCS Account #:** (Refer to Instructions page for format)
C. Mailing Address: (*Number, Street, City, State, Zip code)*	
D. Email Address: (Review for accuracy)	**E. Personal Representative/Contact Person:** (*If applicable*)

Notice: This document is for DHCS internal use only and will not be shared with other entities.
Information provided in this section will only be used for account validation and enrollment in the EFT Registered User option by DHCS staff and its authorized financial institution.
By providing your email address you agree to receive and accept communications regarding EFT via email.

Section II

Authorization

Please read the following Authorization Agreement:

Automated Clearing House (ACH) Debit- I hereby authorize designated Financial Agents of the Department of Health Care Services (DHCS), Third Party Liability and Recovery Division (TPLRD) to initiate debit entries to the financial institution account that I saved in my Registered User Account, for payments owed to the DHCS TPLRD upon my request (beneficiary/ provider) or my representative, using ACH debit method.

Automated Clearing House (ACH) Credit- I hereby authorize the Electronic Funds Transfer (EFT) contact person and the financial institutions involved in processing my EFT payments to receive this confidential information necessary for enrollment in the EFT Enrolled Payer option.

- I authorize the disclosure of my individually identifiable information as described above for the purpose described.
- If I sign this authorization to use or disclose information, I can revoke that authorization at any time, in writing. The revocation will not affect information already used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment or my eligibility for benefits will not be affected if I do not sign this authorization.
- I understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A. Beneficiary/Provider Representative Signature	**B. Date**

(Refer to the instructions on reverse)

Instructions:

Section I - General Information (All information must be completed, except E.)

A. **Beneficiary/ Provider Name:** Enter the complete Medi-Cal Beneficiary or Provider name as shown on DHCS invoice or correspondence.

B. **DHCS Account Number:** To help in processing payments to the correct account, an identifier is added at the beginning of the Beneficiary's Client Index Number (CIN), or the Provider's National Provider Identifier (NPI). Please include the identifier to your account number on the enrollment form.
   1. **Working Disabled Program**: D + CIN (ex: **D**98765432A)
   2. **Estate Recovery**: P + CIN + sequence# (ex: **P**98765432A-001)
   3. **Personal Injury**: C + CIN + sequence# (ex: **C**98765432F-001)
   4. **Overpayments**:
      Providers: V + NPI + sequence# (ex: **V**9876543210-001)
      Beneficiaries: B + CIN + sequence# (ex: **B**987654321-001)
      State Share: G + NPI + sequence# (ex: **G**DME02402F-001)
   5. **Quality Assurance Fee** :
      Skilled Nursing Facilities: Q + SNF + NPI (ex: **QSNF**9876543210)
      Intermediate Care Facilities: Q + ICF + NPI (ex: **QICF**9876543210)

C. **Mailing Address:** Enter your mailing address where DHCS correspondence and forms should be sent.

D. **Email Address:** Enter your email address and review to make sure that it is correct.

E. **Contact Person:** Enter name of the authorized personal representative of the beneficiary, or the name of the contact person for a Provider.

- If you are an authorized personal representative for a beneficiary (e.g. legal guardian, conservator, etc.), please provide proof of authority to sign on behalf of the beneficiary (e.g. letters of conservancy, court order, etc.)

Section II - Authorization – This section must be completed.

A. Signature: The beneficiary or the provider's contact person must sign the form to indicate participation in the EFT Registered User option and agreement with the terms and conditions.

B. Date: Enter the date the form is signed.

Send the completed enrollment form by using the enclosed prepaid envelope or by mailing to:

Department of Health Care Services
TPLRD ASU EFT Admin, MS 4718
P.O. Box 997421
Sacramento, CA 95899-7421

If you need to make payment(s) immediately, please visit www.paycalifornia.com and use the Just Pay It Option.