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

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE: February 5, 2015

Medi-Cal Eligibility Division Information Letter No.: I 15-01

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS

SUBJECT: County Compliance for Medi-Cal Renewal Assistance Allocations

The purpose of this Medi-Cal Eligibility Division Information Letter (MEDIL) is to inform counties of policy instruction and guidance for renewal assistance allocations pursuant to Senate Bill (SB) 18. The Department of Health Care Services (DHCS) accepted contributions by The California Endowment and will seek federal matching funds to distribute to selected counties for Medi-Cal renewal assistance activities. This renewal assistance funding is provided to assist current Medi-Cal beneficiaries with renewing their coverage starting January 1, 2015 through December 31, 2016.

Renewal Assistance Efforts

In compliance with the newly mandated Patient Protection and Affordable Care Act (ACA), the Medi-Cal renewal process and forms have changed. Beneficiaries that had Medi-Cal pre-ACA or those that are new to Medi-Cal could benefit from renewal assistance. Counties have assisted Californians to enroll in health coverage and will need to educate them on the renewal process. While previous private foundation funds were used to support Medi-Cal outreach and enrollment (O & E), SB 18 allows for additional private foundation funding for the purposes of renewal and retention assistance in years 2015 and 2016.

Eligible Counties

To be eligible, a county must have participated in the AB 82, Section 71 O & E efforts. To be receiving renewal funding, counties must submit a letter to DHCS by confirming their intention to participate in the renewal assistance effort.

The letter must identify whether the renewal assistance will be performed in the same county or jointly with other counties, all letters must be submitted to DHCS at DHCSOutreach@dhcs.ca.gov no later than February 20, 2015.

Allocation of Funds

The renewal assistance funds are paid to counties utilizing an allocation process. The final funding amount will be determined based on the number of participating counties and the amount of funding those counties received from the AB 82, Section 71 allocations. DHCS requires completion and submission of specific deliverables before funds can be provided to counties. Approval from the county's Board of Supervisors is not required unless it is the county's prescribed protocol for accepting renewal assistance funding. Counties are required to comply with renewal assistance funding terms and demonstrate that the individual signing the Allocation documents is authorized to act on the county's behalf. (Attachment 7)

This MEDIL and the Allocation documents outlines the requirements and provisions of the renewal assistance funding, required deliverable templates, and timeframes for submitting deliverables. The Allocation documents include the funding amount awarded specifically to each county, a schedule for quarterly invoices, deliverables and payments, and a description of each deliverable. All referenced allocation documents are attached to this MEDIL.

A written request must be submitted to DHCS if an extension for any deliverable or progress schedule is needed. All approvals are to be reviewed on a case-by-case basis. Counties must also comply with DHCS policy directives regarding renewal assistance funding as issued in the frequently asked questions, which can be found at: http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/OEworkgroup.aspx.

Use of Funds by Counties

The funding for Medi-Cal renewal assistance efforts shall supplement, not supplant, existing local, state, and foundation funding of county renewal assistance activities. The amount provided to counties, under the Allocation Agreement, may be disbursed as follows:

1. To community-based organizations (CBOs): The county shall disperse at least 90 percent of the Allocation Amount. The county is required to partner with one or more CBOs to develop, conduct, and implement effective tools and methods to expand Medi-Cal renewal assistance efforts. The county is not required to immediately contract with CBOs in light of the timelines that may be necessary for contracting processes. However, the county will need to demonstrate through quarterly reporting activities on the progress of contracting with CBOs.

2. The county shall retain no more than 10 percent of the Allocation Amount for indirect administrative costs, including planning, plan documentation, and other administrative costs.

Project Documentation

Budget Plan

Counties are required to use the Budget Plan (Attachment 1). A Budget Plan must be submitted to DHCS to receive the initial payment allocation of at least 20 percent of the Total Allocation Award. Counties must also provide a detailed description of planned administrative costs as part of the Budget Plan.

Work Plan

Counties are required to use the Work Plan (Attachment 2). A Work Plan must be submitted to DHCS to receive renewal assistance funding. The Work Plan shall include strategies, milestones, and time frames for renewal assistance activities completed by the county and it's contracted CBOs. Counties must also identify the specific CBOs and the work they are funding by the CBO in the Work Plan.

Renewal Assistance Quarterly Invoice

Counties are required to use the Renewal Assistance Quarterly Invoice (Attachment 3). Invoices must be submitted by the county on a quarterly basis. The Invoice must include detailed budget activity and expenditures for the specific quarter, as well as signatures from both the Project Financial Officer and the county renewal assistance Project Director.

The Invoice must be accompanied by the Quarterly Progress Report (Attachment 4). Additionally, payments cannot be distributed until DHCS receives the Payee Data Record Form (Attachment 6). This document is used to establish or verify a vendor number and address to where payments will be sent.

Please note: To receive any funds from the Allocation Award, county must submit a Budget Plan, Invoice, and Payee Data Record Form.

Quarterly Progress Report

Counties are required to submit a Quarterly Progress Report (Attachment 4). Counties must provide a progress report to measure and document progress to-date on the work plan objectives and performance goals. DHCS reserves the right to require reports more frequently than on a quarterly basis if necessary, but no more than once a month.

Annual Budget Report
Counties are required to submit an Annual Budget Report (Attachment 5) at the end of every State fiscal year and at the end of the project, as outlined in the following schedule:

- Due July 15, 2015 – Report period January 1, 2015 through June 30, 2015
- Due July 15, 2016 – Report period July 1, 2015 through June 30, 2016
- Due January 15, 2017 – Report period July 1, 2016 through December 31, 2016

Federal Funding

The full Allocation fund amount is contingent upon State dollars being matched with federal funds. If federal funding for the current year and/or any subsequent year covered under the Agreement does not appropriate sufficient funds for the program, DHCS will not be liable for paying the federal portion to the counties under the Allocation Agreement and the counties shall not be obligated to perform any provisions of this agreement. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS shall have the option to either cancel the Allocation with no liability occurring to DHCS, or offer an amendment to the Allocation to the counties to reflect the reduced amount.

Withdrawal or Changes to Allocation

Counties must submit any deviation from the attached Work Plan to the State in writing for approval prior to implementation of changes. Counties may withdraw from the renewal assistance allocation funding by notifying the State in writing at any time of their request to withdraw from further participation. Once the withdraw request is received, the State will contact the county to complete close out tasks.

If you have any questions or need further information on Medi-Cal renewal assistance funding, please contact Stryder Morissette (916) 552-9602 or by email at DHCSOutreach@dhcs.ca.gov.

Original Signed By

Alice Mak, Acting Chief
Medi-Cal Eligibility Division

Enclosures

(COUNTY)
MEDI-CAL RENEWAL ASSISTANCE BUDGET PLAN

- List all personnel positions and the corresponding time base for each staff member (i.e. full time = 1.0, half time = .50).
- Identify the projected budget amount for each line item per fiscal year and the projected total amounts.
- Identify the costs of benefits for each fiscal year and project the total amount.
- List all non-personnel expenses which may include, but not limited to, operating costs, program supplies, travel, technology equipment, and subcontractors.
- Provide a projection for each fiscal year and the total projected amounts.

Please identify your specific timeframes of your contract per fiscal year, modify if necessary (i.e. Fiscal Year 1 = 01/01/15 – 06/30/15; Fiscal Year 2 = 07/01/15 – 06/30/16; Fiscal Year 3 = 07/01/16 – 12/31/16). Furthermore, for each fiscal year of your contract, include total costs and overall costs for Total Personnel, Total Non-Personnel, Total Direct Costs (projects: i.e. equipment specific for renewal assistance), and Total Indirect Costs (overhead: i.e. health insurance) and identify the percentage, and the Grand Total amounts.

Medi-Cal Renewal Assistance SB 18	Time Base	FY 1 1/1/15 - 6/30/15	FY 2 7/1/15 - 6/30/16	FY 3 7/1/16 - 12/31/16	Total Amounts
Personnel Staff		$	$	$	$
		$	$	$	$
		$	$	$	$
		$	$	$	$
		$	$	$	$
		$	$	$	$
Benefits		$	$	$	$
		$	$	$	$
Total Personnel Expenses		**$**	**$**	**$**	**$**
Non-Personnel – Direct Costs					
-Office Expenses		$	$	$	$

-Equipment		$	$	$	$
-Travel		$	$	$	$
-Training		$	$	$	$
-Conference/ Meeting		$	$	$	$
-Outreach Material		$	$	$	$
-Total Budget for All CBOs		$	$	$	$
-Other Costs [itemize expenses in an attachment]		$	$	$	$
Total Direct Costs		**$**	**$**	**$**	**$**
Non-Personnel – Indirect Costs					
-Health Insurance		$	$	$	$
-Other Costs [itemize expenses in an attachment]		$	$	$	$
Total Indirect Costs		**$**	**$**	**$**	**$**
Total Personnel Expenses		**$**	**$**	**$**	**$**
Total Direct Costs		**$**	**$**	**$**	**$**
Total Indirect Costs at ___%		**$**	**$**	**$**	**$**
Grand Total		**$ -**	**$ -**	**$ -**	**$ -**

Activity 1 – Program Planning and Startup

Activity 1: Identify major renewal assistance planning and startup milestones, strategies, and activities. Identify the SB 18 renewal assistance efforts *(e.g., the extent permissible for training, testing, certifying, supporting and compensating persons and entities providing renewal assistance and any other permissible renewal assistance related activities)***, how many you intend to renew** *(e.g. increase the renewal response rate and ensure continuity of care for Medi-Cal beneficiaries)***.**

MILESTONE: For each objective, list each partner separately and indicate the number of individuals that they plan to renew Medi-Cal benefits for.

DESCRIPTION OF STRATEGY/ACTIVITY:
Describe below what and or how each partner plans on achieving the objectives identified in the adjacent milestones. What methods/means will be used to achieve these objectives? How long will it take you to achieve the objective (timeline), and who is responsible for ensuring the objectives are met on time.

MILESTONES	STRATEGIES/ACTIVITIES	TIMELINE	WHO IS RESPONSIBLE

Activity 2 – Renewal Assistance Activities

Activity 2: **Identify major renewal assistance activities. Identify how many individuals you intend to keep on Medi-Cal.**

MILESTONE: List each partner separately and indicate the number of individuals they plan to renew Medi-Cal benefits for.

DESCRIPTION OF STRATEGY/ACTIVITY: Describe below what and or how each partner plans on achieving the objectives identified in the adjacent milestones. What methods/means will be used to achieve these objectives? How long will it take you to achieve the objective (timeline), and who is responsible for ensuring the objectives are met on time.

MILESTONES	STRATEGIES/ACTIVITIES	TIMELINE	WHO IS RESPONSIBLE

Activity 3 – Tracking and Reporting

Activity 3**: Identify your intent and list how you intend to renew Medi-Cal for existing beneficiaries.**

DESCRIPTION OF ACTIVITY: Describe below what and or how each partner plans on tracking and reporting renewal activities. What methods/means will be used to track and report renewal activities?

Beginning & Ending Dates: Identify the timeframe in which reports will be submitted and who is responsible to submit the report.

STRATEGIES/ACTIVITIES	TIMELINE	WHO IS RESPONSIBLE

County Grant Payment
Quarterly Invoice

County: _____ **Authorization #:** SB 18

Fiscal Year: _____ **Invoice #:** _____

Billing Period: _____ **County/CBO Name:** _____

Vendor ID #: _____

BUDGET CATEGORIES *(per contract)*	Approved Budget	Prior Amount Expended	Expenses Billed this Quarter	DHCS Use Only: Adjustment	DHCS Use Only: Approved Amount	Amount Expended to Date	Remaining Balance
PERSONNEL EXPENSES							
Full-Time Staff							
Part-Time Staff							
Benefits _____%							
TOTAL PERSONNEL EXPENSES							
OPERATING EXPENSES							
Office Expenses							
Equipment							
Travel							
Training							
Conferences/Meetings							
Outreach Materials							
Other Costs [itemize each expense]							
Total Budget for all CBO's							
Indirect Costs _____%*							
TOTAL OPERATING EXPENSES							

* Cannot exceed 15% of total funds allocated

BUDGET CATEGORIES *(per contract)*	Approved Budget	Prior Amount Expended	Expenses Billed this Quarter	Adjustment	Approved Amount	Amount Expended to Date	Remaining Balance
OTHER EXPENSES							
CBO Name							
CBO Name							
CBO Name							
CBO Name							
CBO Name							
CBO Name							
TOTAL OTHER EXPENSES							
TOTAL OF ALL EXPENSES							

I certify that the expenditures claimed represent actual expenses for the service performed under this allocation.

Sign in blue ink only

County Project Financial Officer (print) _____ **Signature** _____

Date _____

Sign in blue ink only

County Project Director (print) _____ **Signature** _____

Date _____

SB 18 Section 1. (a) (1) The State Department of Health Care Services shall accept contributions by private foundations in the amount of at least six million dollars ($6,000,000) for the purpose of providing Medi-Cal renewal assistance payments starting January 1, 2015. These contributions shall be deposited in the Healthcare Outreach and Medi-Cal Enrollment Account that has been created in the Special Deposit Fund within the State Treasury for the purposes specified in this section.

Explanation of Adjustments/Corrections or Revisions (please bold any adjustments, corrections, or revisions for ease of identification):

Please submit invoices from CBOs if applicable.

Renewal Assistance Quarterly Progress Report

County: _____ **Quarter:** _____

Instructions: Report the progress your county achieved during the quarter and year-to-date (YTD) towards each work plan objective. This report is comprised of a brief narrative and completion of the chart described below for each renewal assistance objective.

Narrative (2-10 pages depending on the complexity of your renewal assistance efforts):

- Describe the activities carried out this reporting period to meet the objectives, as described in your work plan. Briefly describe indicators or benchmarks used and progress to date. If you worked with any community-based organizations (CBOs), please indicate who they are and what did they do for the project.
    - What did you accomplish during this reporting period? Did you use indicators or benchmarks to determine your progress? How many Medi-Cal renewals resulted from your Medi-Cal renewal assistance efforts?

- Describe any practices or innovative strategies that were successful and can serve as a model for others or that your county can build upon.

- Describe project activities or successes not identified in the work plan that were a spin off of work plan activities.

- Describe which, if any, proposed activities were not completed.
    - If the activities completed differ from your proposal, what caused these changes? Were activities delayed and if so, why? Will these activities be completed? When and how? Are there any activities you will not be able to complete during the course of your allocation?

- Describe any products developed and data sources used.

- Describe any challenges or barriers encountered and proposed solutions.

- Describe whether your department/agency or partnering organizations received funding from other foundations, corporations, or government bodies for Medi-Cal renewal assistance efforts currently being supported by this allocation funding opportunity.
    - If applicable, please give each funder's name, the amount of funding provided, and when it was provided. If the support is in-kind and you can estimate the dollar amount, provide that figure; if it is in-kind and you cannot estimate the amount, do not include it.

- Describe whether DHCS assisted or failed to assist you in any way during this time period.
    - Have DHCS' instructions and messages been consistent or have you gotten different messages from different DHCS staff?

- If you chose to do so, describe anything else you would like to share with DHCS pertaining to this Medi-Cal renewal assistance initiative.
    - Please include an addendum to the report, if needed. Feel free to tell us about any other unexpected issues, concerns, or successes you have had during this reporting period.

Exhibit 1

- Using your approved work plan as a blueprint, discuss the progress made on each of your objectives. Quantify your progress whenever possible (e.g., number of people assisted, renewal percentages, etc.).

Exhibit 2

- Provide information for all items that apply to the progress made during the current quarter.
- Provide year-to-date totals.

Renewal Assistance Quarterly Progress Report Template

County: _____ **Reporting Period:** _____

Major Deliverables and Activities	Staff and/or CBOs Used	Status	Performance Measures and Data Collection
Include reference to the major outcome objectives indicated in your work plan.	*Indicate staff responsible and/or CBOs used.*	*Indicate the completion date. If not completed, indicate the projected completion date. Provide a reason if date is different than on the approved work plan.*	*Provide achievements, percentages, and numbers for the quarter and YTD that document achievements.*

Renewal Assistance Quarterly Progress Report

County: _____ **Quarter: _____**

Numbers Specific to Renewal Assistance Activities ONLY

	Current Quarter	Year-to-date
Amount Billed		
Number of SB 18 beneficiaries assisted with annual eligibility review (AER) and/or Medi-Cal renewal		
Number of SB 18 beneficiaries that retained Medi-Cal coverage as a result of the renewal assistance efforts		

Fiscal Year 1
(01/01/2015 through 06/30/2015)

Personnel [Itemize all expenses]

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
_____	____	$XXX,XXX - $XXX,XXX	___%	$
_____	____	$XXX,XXX - $XXX,XXX	___%	$
_____	____	$XXX,XXX - $XXX,XXX	___%	$
Total Salary				$
Fringe Benefits (____%)				$

Total Personnel $

Office Expenses [Itemize all expenses]

_____ $_____
_____ $_____
_____ $_____
_____ $_____
Total Operating Expenses $

Equipment [Itemize equipment expenses i.e., items with a unit cost of $5,000 or more]

_____ $_____
_____ $_____
Total Equipment Expenses $

Travel Total Travel $

Community-Based Organizations (CBOs) [List all CBOs and their itemized budgets, add additional CBOs as necessary]

CBO Name:_____

Personnel	Office Expenses	Travel	Equipment	Indirect Costs	Other Costs	**Total Costs**
$_____	$_____	$_____	$_____	$_____	$_____	$_____

Total CBOs $

Other Costs [Itemize each expense]

_____ $_____
_____ $_____
Total Other Costs $

Indirect Costs [Itemize each expense] **Total Indirect Costs** $

_____ $_____
_____ $_____

Annual Budget Total $

Fiscal Year 2
(07/01/2015 through 06/30/2016)

Personnel [Itemize all expenses]

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
_____	____	$XXX,XXX - $XXX,XXX	___%	$
_____	____	$XXX,XXX - $XXX,XXX	___%	$
_____	____	$XXX,XXX - $XXX,XXX	___%	$
Total Salary				$
Fringe Benefits (____%)				$

Total Personnel $

Office Expenses [Itemize all expenses]

_____ $_____
_____ $_____
_____ $_____
_____ $_____
Total Operating Expenses $

Equipment [Itemize equipment expenses i.e., items with a unit cost of $5,000 or more]

_____ $_____
_____ $_____
Total Equipment Expenses $

Travel Total Travel $

Community-Based Organizations (CBOs) [List all CBOs and their itemized budgets, add additional CBOs as necessary]

CBO Name:_____

Personnel	Office Expenses	Travel	Equipment	Indirect Costs	Other Costs	**Total Costs**
$_____	$_____	$_____	$_____	$_____	$_____	$_____

Total CBOs $

Other Costs [Itemize each expense]

_____ $_____
_____ $_____
Total Other Costs $

Indirect Costs [Itemize each expense] **Total Indirect Costs** $

_____ $_____
_____ $_____

Annual Budget Total $

Fiscal Year 3
(07/01/2016 through 12/31/2016)

Personnel [Itemize all expenses]

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
_____	____	$XXX,XXX - $XXX,XXX	___%	$
_____	____	$XXX,XXX - $XXX,XXX	___%	$
_____	____	$XXX,XXX - $XXX,XXX	___%	$
Total Salary				$
Fringe Benefits (____%)				$
Total Personnel				$

Office Expenses [Itemize all expenses]

_____	$_____	
_____	$_____	
_____	$_____	
_____	$_____	
Total Operating Expenses		$

Equipment [Itemize equipment expenses i.e., items with a unit cost of $5,000 or more]

_____	$_____	
_____	$_____	
Total Equipment Expenses		$

Travel — Total Travel — $

Community-Based Organizations (CBOs) [List all CBOs and their itemized budgets, add additional CBOs as necessary]

CBO Name:_____

Personnel	Office Expenses	Travel	Equipment	Indirect Costs	Other Costs	**Total Costs**
$_____	$_____	$_____	$_____	$_____	$_____	$_____

Total CBOs — $

Other Costs [Itemize each expense]

_____	$_____	
_____	$_____	
Total Other Costs		$

Indirect Costs [Itemize each expense] — **Total Indirect Costs** — $

_____	$_____
_____	$_____

Annual Budget Total — $

State of California—Department of Health Care Services

PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9)

STD. 204 (Rev. 5/06)_DHCS

1

INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this **fully completed** form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement.

NOTE: Governmental entities, federal, state, and local (including school districts), are not required to submit this form.

2

PAYEE'S LEGAL BUSINESS NAME (Type or Print)

County of

SOLE PROPRIETOR—ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)	E-MAIL ADDRESS
MAILING ADDRESS	BUSINESS ADDRESS
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE

3

PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): ☐☐ – ☐☐☐☐☐☐☐

☐ **PARTNERSHIP**

☐ **ESTATE OR TRUST**

CORPORATION:

☐ **MEDICAL** (e.g., dentistry, psychotherapy, chiropractic, etc.)

☐ **LEGAL** (e.g., attorney services)

☐ **EXEMPT** (nonprofit)

☐ **ALL OTHERS**

☐ **INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER:** ☐☐☐ – ☐☐ – ☐☐☐☐

(SSN required by authority of California Revenue and Tax Code Section 18646)

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

4

PAYEE RESIDENCY TYPE

☒ California resident—qualified to do business in California or maintains a permanent place of business in California.

☐ California nonresident (see reverse side)—Payments to nonresidents for services may be subject to State income tax withholding.

- ☐ No services performed in California.
- ☐ Copy of Franchise Tax Board waiver of State withholding attached.

5

I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the State agency below.

AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)	TITLE	
SIGNATURE	DATE	TELEPHONE ( )

6

Please return completed form to:

Department/Office: Department of Health Care Services

Unit/Section: Outreach & Enrollment, Attn: Stryder Morissette

Mailing Address: 1501 Capitol Avenue, MS 4607, PO Box 997417

City/State/ZIP: Sacramento, CA 95899-7417

Telephone: (916) 552-9602 **FAX:** (916) 440-5690

E-Mail Address: DHCSOutreach@dhcs.ca.gov

PAYEE DATA RECORD

1	**Requirement to Complete Payee Data Record, STD. 204** A completed Payee Data Record, STD. 204, is required for payments to all non-governmental entities and will be kept on file at each State agency. Since each State agency with which you do business must have a separate STD. 204 on file, it is possible for a payee to receive this form from various State agencies. Payees who do not wish to complete the STD. 204 may elect to not do business with the State. If the payee does not complete the STD. 204 and the required payee data is not otherwise provided, payment may be reduced for federal backup withholding and nonresident State income tax withholding. Amounts reported on Information Returns (1099) are in accordance with the Internal Revenue Code and the California Revenue and Taxation Code.
2	Enter the payee's legal business name. Sole proprietorships must also include the owner's full name. An individual must list his/her full name. The mailing address should be the address at which the payee chooses to receive correspondence. Do not enter payment address or lock box information here.
3	Check the box that corresponds to the payee business type. Check only one box. Corporations must check the box that identifies the type of corporation. The State of California requires that all parties entering into business transactions that may lead to payment(s) from the State provide their Taxpayer Identification Number (TIN). The TIN is required by the California Revenue and Taxation Code Section 18646 to facilitate tax compliance enforcement activities and the preparation of Form 1099 and other information returns as required by the Internal Revenue Code Section 6109(a). The TIN for individuals and sole proprietorships is the Social Security Number (SSN). Only partnerships, estates, trusts, and corporations will enter their Federal Employer Identification Number (FEIN).
4	**Are you a California resident or nonresident?** A corporation will be defined as a "resident" if it has a permanent place of business in California or is qualified through the Secretary of State to do business in California. A partnership is considered a resident partnership if it has a permanent place of business in California. An estate is a resident if the decedent was a California resident at time of death. A trust is a resident if at least one trustee is a California resident. For individuals and sole proprietors, the term "resident" includes every individual who is in California for other than a temporary or transitory purpose and any individual domiciled in California who is absent for a temporary or transitory purpose. Generally, an individual who comes to California for a purpose that will extend over a long or indefinite period will be considered a resident. However, an individual who comes to perform a particular contract of short duration will be considered a nonresident. Payments to all nonresidents may be subject to withholding. Nonresident payees performing services in California or receiving rent, lease, or royalty payments from property (real or personal) located in California will have 7% of their total payments withheld for State income taxes. However, no withholding is required if total payments to the payee are $1,500 or less for the calendar year. For information on Nonresident Withholding, contact the Franchise Tax Board at the numbers listed below: Withholding Services and Compliance Section: 1-888-792-4900 E-mail address: wscs.gen@ftb.ca.gov For hearing impaired with TDD, call: 1-800-822-6268 Website: www.ftb.ca.gov
5	Provide the name, title, signature, and telephone number of the individual completing this form. Provide the date the form was completed.
6	This section must be completed by the State agency requesting the STD. 204.

Privacy Statement

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency, which requests an individual to disclose their social security account number, shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

It is mandatory to furnish the information requested. Federal law requires that payment for which the requested information is not provided is subject to federal backup withholding and State law imposes noncompliance penalties of up to $20,000.

You have the right to access records containing your personal information, such as your SSN. To exercise that right, please contact the business services unit or the accounts payable unit of the State agency(ies) with which you transact that business.

All questions should be referred to the requesting State agency listed on the bottom front of this form.

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

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

<DATE>

Name
Title
Agency Name
County
Street
City, State, Zip

SUBJECT: DEPARTMENT OF HEALTH CARE SERVICES MEDI-CAL RENEWAL ASSISTANCE ALLOCATION AGREEMENT (ALLOCATION)

Dear Mr. <NAME>:

As a recipient of the Department of Health Care Services (DHCS), Medi-Cal Renewal Assistance Allocation (Allocation) funding authorized by Senate Bill (SB) 18, your organization is required to sign and comply with the attached Allocation.

The Allocation funds will be paid to your organization utilizing an allocation process. In order to receive Allocation funds, your organization is not required to obtain Board of Supervisor's Approval unless that is the prescribed protocol for accepting allocation funding. The Allocation outlines the requirements and provisions of the allocation funding, required deliverable templates and the timeframes for submitting required deliverables.

Please contact your DHCS Outreach and Enrollment Liaison at DHCSOutreach@dhcs.ca.gov upon receipt of the Allocation Agreement to provide details regarding the process that your organization is required to follow in order to obtain allocation approval. You must sign and electronically return Page 1 of the Allocation Agreement to DHCSOutreach@dhcs.ca.gov upon receipt. A wet signature is also required and shall be sent back to DHCS. Once that information is provided, your DHCS liaison will work with you directly in regards to the Quarterly Invoice and Deliverable Schedule.

We look forward to working with your organization and appreciate your commitment to Medi-Cal Renewal Assistance efforts in your community. If you have additional questions or need clarification regarding the Allocation, please contact your DHCS Outreach and Enrollment Liaison.

Sincerely,

Alice Mak, Division Chief
Department of Health Care Services

LARGE COUNTY ALLOCATION SAMPLE

ALLOCATION FOR MEDI-CAL RENEWAL ASSISTANCE

State of California – Department of Health Care Services

COUNTY	«County»		
PROJECT TITLE	Medi-Cal Renewal Assistance		
PERFORMANCE PERIOD	January 1, 2015	through	December 31, 2016

Under the terms and conditions of this Allocation, the County agrees to complete renewal assistance efforts as described in the project description, and the State of California, through its Director of the Department of Health Care Services pursuant to Senate Bill (SB) 18, Section 1, agrees to fund the County up to the Allocation Amount.

PROJECT DESCRIPTION

The County agrees to provide Medi-Cal renewal assistance, pursuant to SB 18. SB 18 provides counties and community-based organizations (CBOs) funding to assist current Medi-Cal beneficiaries in renewing their coverage in years 2015 and 2016. In compliance with the newly mandated Patient Protection and Affordable Care Act (ACA), the Medi-Cal renewal process and forms have changed. Beneficiaries that had Medi-Cal pre-ACA or are new to Medi-Cal could benefit from renewal assistance. The funds allocated under this allocation shall be used only for Medi-Cal renewal assistance activities and may supplement, but shall not supplant, existing local, state, and foundation funding of county renewal assistance activities.

TOTAL ALLOCATION AMOUNT NOT TO EXCEED	«Allocation_Amount»
The General and Special Provisions attached are made a part of and incorporated into the Allocation.	
«County Agency»	**DEPARTMENT OF HEALTH CARE SERVICES STATE OF CALIFORNIA**
«Address_Line_1»«Address_Line_2»	
BY (AUTHORIZED SIGNATURE):	BY (AUTHORIZED SIGNATURE): Original Signed by Alice Mak
PRINTED NAME AND TITLE OF PERSON SIGNING:	PRINTED NAME AND TITLE OF PERSON SIGNING: Alice Mak, Division Chief
DATE SIGNED:	DATE SIGNED: <DATE>

CERTIFICATION OF FUNDING (FOR STATE USE ONLY)

AMOUNT OF ALLOCATION $«Allocation_Amount».00		Allocation NUMBER «Allocation_Number»		FUND –		
ADJ. INCREASING ENCUMBERANCE		APPROPRIATION				
ADJ. DECREASING ENCUMBERANCE		FUNCTION				
TOTAL ALLOCATION AMOUNT $«Allocation_Amount».00		LINE ITEM ALLOTMENT		CHAPTER	STATUTE	FISCAL YEAR
T.B.A NO.	B.R. NO.	INDEX	OBJ.	PCA	PROJECT/WORK PHASE	

I hereby certify upon my personal knowledge that budgeted funds are available for this encumbrance

SIGNATURE OF ACCOUNTING OFFICER	DATE

ALLOCATION FOR
MEDI-CAL RENEWAL ASSISTANCE
COUNTY OF _____
State of California – Department of Health Care Services

TERMS AND CONDITIONS OF ALLOCATION

The County shall be responsible for the performance of the work as set forth herein below and for the preparation of deliverables and reports as specified in this Allocation. The County's Project Representative shall promptly notify the State of events or proposed changes that could affect the Work Plan for this Allocation.

General Provisions

A. Definitions

1. The term “Allocation” as used herein means the document between the State and County specifying the payment of Allocation Amount by the State for the performance of Work Plan within the Project Performance Period by the County.

2. The term “County” as used herein means the party described as the County on page one (1) of this Allocation.

3. The term “Allocation Amount” as used herein means the Renewal Assistance Allocation funding authorized by SB 18 funds awarded to the County by the State.

4. The term “Project Performance Period” as used herein means the period of time that the Allocation Amount is available as described on page one (1) of this Allocation.

5. The term "Project Representative" as used herein means the person authorized by the County to be responsible for the Allocation and is capable of making daily management decisions.

6. The term “State” as used herein means the Department of Health Care Services.

7. The term “Community Based Organization,” or “CBO,” as used herein means a public or private nonprofit organization of demonstrated effectiveness that is representative of a community or significant segments of a community, and provides educational or related services to individuals in the community, as stated in 20 U.S.C.A § 7801(6).

B. Allocation Execution

1. County agrees to complete the activities in accordance with the time of the Allocation Performance Period and under the terms and conditions of this Allocation.

2. County, and the agents and employees of County, in the performance of this outreach efforts funded through the Allocation, shall act in an independent capacity and not as officers or employees or agents of the State.

3. County shall complete all work in accordance with an approved Work Plan which will be included in this Allocation as Attachment 2. County agrees to submit in writing any deviation from the attached Work Plan to the State for approval prior to implementation of changes.

4. County shall comply with the provisions of SB 18 and any policies & procedures by DHCS interpreting it.

5. Rights in Data and Reporting: The County agrees that all data and reports produced in the performance of this Allocation are subject to the rights of the State as set forth in this section. The State shall have the right to reproduce, publish, and use all such data and reports, or any part thereof, in any manner and for any purposes whatsoever and to authorize others to do so.

C. Allocation Costs

Subject to the availability of Allocation Amount, the State hereby grants to the County [insert Allocation Amount] not to exceed the amount stated on page one (1) of this Agreement in consideration of and on condition that the sum be expended in carrying out the purpose as set forth in the Work Plan and under the terms and conditions set forth in this Allocation.

The Allocation Amount to be provided to the County, under this Allocation, may be disbursed as follows:

1. To Community Based Organizations (CBOs): County shall disperse at least 90% of the Allocation Amount. The County is required to partner with one or more CBOs to develop, conduct and implement effective tools and methods to expand Medi-Cal renewal assistance efforts. The County is not required to immediately contract with CBOs in light of the timelines that may be necessary for contracting processes. However, the County will need to demonstrate through quarterly reporting activities on the progress of contracting with CBOs.

2. The County shall retain no more than 10% of the Allocation Amount for indirect administrative costs, including planning, plan documentation, and other administrative costs.

D. Federal Funding

The full Allocation fund amount is contingent upon State dollars being matched with federal funds. If federal funding for the current year and/or any subsequent year covered under the Allocation does not appropriate sufficient funds for the program, DHCS will not be liable for paying the federal portion to the counties under this Allocation and the counties shall not be obligated to perform any provisions of this agreement. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS shall have the option to either cancel the Allocation with no liability occurring to DHCS, or offer an amendment to the Allocation to the counties to reflect the reduced amount.

E. Payment Documentation

1. All payment requests must be submitted by the County on a quarterly basis using a completed Renewal Assistance Quarterly Invoice, Attachment 3. The invoice and the deliverables noted below must accompany the invoice as outlined in the Quarterly Invoice, Deliverables and Payment Schedule noted on Page 4.

    Budget Plan, Attachment 1
    Work Plan, Attachment 2
    Renewal Assistance Quarterly Invoice, Attachment 3
    Quarterly Progress Report, Attachment 4
    Annual Budget Report, Attachment 5

2. County shall submit all documentation for Allocation completion and final reimbursement within 90 days of Allocation completion, but no later than the end of the Project Performance Period as shown on page one (1).

3. Payments shall be on the basis of costs incurred.

4. Be certified by the County prior to its submission to DHCS. This certification must be in compliance with current federal certification requirements.

5. Advance payment for the Allocation Amount is not allowed.

QUARTERLY INVOICE, DELIVERABLES, AND PAYMENT SCHEDULE 2015-2016		
DUE DATE OF DELIVERABLES	**COUNTY DELIVERABLES**	**QUARTER FOR INVOICING EXPENDITURES**
03/01/2015	BUDGET PLAN	Invoice for development of Budget Plan
03/01/2015	WORK PLAN	N/A
04/06/2015	INVOICE and PROGRESS REPORT	January, February, March 2015
07/02/2015	INVOICE and PROGRESS REPORT	April, May, June 2015
10/02/2015	INVOICES and PROGRESS REPORT	July, August, September 2015
01/04/2016	ANNUAL BUDGET REPORT, INVOICE, and PROGRESS REPORT	October, November, December 2015
04/04/2016	INVOICE and PROGRESS REPORT	January, February, March 2016
07/05/2016	INVOICE and PROGRESS REPORT	April, May, June 2016
10/03/2016	INVOICE and PROGRESS REPORT	July, August, September 2016
01/02/2017	ANNUAL BUDGET REPORT, INVOICE, and PROGRESS REPORT	October, November, December 2016

Budget Plan

County is required to use the Budget Plan, Attachment 1. As outlined in the Quarterly Invoice, Deliverables and Payment Schedule above, a Budget Plan must be submitted to DHCS in order to receive the initial payment allocation of at least 20% of the Total Allocation Award. Counties must also provide a detailed description of planned administrative costs as part of the Budget Plan.

Work Plan

County is required to use the Work Plan, Attachment 2. As outlined in the Quarterly Invoice, Deliverable and Payment Schedule noted above, a Work Plan must be submitted to DHCS in order to receive the second quarterly payment. The Work Plan shall include strategies, milestones, and time frames for renewal assistance activities completed by the County and its contracted CBOs.

Renewal Assistance Quarterly Invoice

County is required to use the Renewal Assistance Quarterly Invoice, Attachment 3. Invoices must be submitted by the County on a quarterly basis as outlined in the Quarterly Payment and Deliverable Schedule noted above. The Invoice must include detailed budget activity and expenditures for the specific quarter.

Quarterly Progress Report

County is required to submit a Quarterly Progress Report, Attachment 4. As outlined in the Quarterly Invoice, Deliverables and Payment Schedule noted above, Quarterly Progress reports will be required starting with the third quarter reporting period. The County must provide a progress report to measure and document progress-to-date on the work plan objectives and performance goals. The State reserves the right to require reports more frequently than on a quarterly basis if necessary, but no more than once a month.

Annual Budget Report
County is required to submit an Annual Budget Report, Attachment 5, at the end of every State fiscal year and at the end of the project, as outlined in the following schedule:

- Due July 15, 2015 – Report period January 1, 2015 through June 30, 2015
- Due July 15, 2016 – Report period July 1, 2015 through June 30, 2016
- Due January 15, 2017 – Report period July 1, 2016 through December 31, 2016

F. Allocation Termination or Withdrawal

1. County may withdraw from the Renewal Assistance Allocation Funding by notifying the State in writing at any time of the request to withdraw from further participation. Once the withdraw request is received, the State will contact the County to complete close out tasks.

2. Failure by the County to comply with the requirements of the Renewal Assistance program may be cause for terminating all obligations of the State for additional Allocation payments.

G. Loss of Allocation Amount

The following actions may result in a loss or part of all Allocation Amount allocated to the County.

1. A County fails to return a signed Agreement to DHCS within 60 days of receipt of the Agreement.

2. A County fails to produce satisfactory Invoices and Deliverables as outlined in the Quarterly Invoice and Deliverable Schedule noted on Page 5.

3. A County withdraws from the renewal program funded through this Allocation.

   i. This action shall result in a 50% reduction of the total Allocation Amount.

H. Hold Harmless

Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, suppliers, laborers, and any other person, firm or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by Contractor in the performance of this Agreement.

I. Financial Records

1. County agrees to maintain satisfactory financial accounts, documents and records for the Allocation and to make them available to the State for auditing at reasonable times. County also agrees to retain such financial accounts, documents and records for three years following Allocation termination or completion.

2. County and State agree that during regular office hours each of the parties hereto and their duly authorized representative shall have the right to inspect and make copies of any books, records or reports of the other party pertaining to this Allocation or matters related thereto. County agrees to maintain and make available for inspection by the State accurate records of all of its costs, disbursements and receipts with respect to its activities under this Allocation.

3. County agrees to use a generally accepted accounting system.

J. Audit

1. Allocations are subject to audit by the State for three years following the final payment of Allocation Amount. The purpose of this audit is to verify that Allocation expenditures were properly documented. Counties will be contacted at least 30 days in advance of an audit.

2. Audit will include all books, papers, accounts, documents, or other records of the County, as they relate to the Allocation for which the State authorized Allocation Amount. The County shall have the Allocation records, including the sources documents and cancelled warrants, readily available to the State.

3. County must also provide an employee having knowledge of the Allocation and the accounting procedure or system to assist the State's auditor. The County shall provide a copy of any document, paper, record, or the like requested by the State.

4. All Allocation records must be retained for at least one year following an audit or final disputed audit findings.

K. Nondiscrimination

1. County shall not discriminate against any person on the basis of sex, race, color, national region, age, religion, ancestry, or physical handicap when conducting renewal assistance efforts pursuant to this Allocation and in compliance with the Americans with Disabilities Act.

2. County shall ensure the security, privacy and confidentiality of each enrollee.

L. Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

1. Counties shall ensure security of privacy and confidentiality of each consumer application and comply with HIPAA requirements as set forth by law.

M. Disputes

1. County shall continue with the responsibilities under this Allocation during any dispute.

2. The nonenforcement or other waiver of any provision of this Allocation shall not be construed as a continuing waiver or as a waiver of any other provision of this Allocation.