STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-0258

January 02, 2001

To: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Mental Health Directors
All County Public Health Directors

Letter No.: 01-02

SECOND YEAR OF TRANSITIONAL MEDI-CAL (TMC) STATUS REPORTING CHANGES

Ref.: All County Welfare Directors (ACWDL) Nos. 98-56 and 99-55

The purpose of this letter is to inform counties that as of January 2001, status reporting for the second year of TMC is no longer required. Senate Bill (SB) 87 Chapter 1088, September 30, 2000, amended Section 14005.81 which deletes those requirements. These changes affect Aid Codes 5X and 5Y. Beneficiaries are still required to report significant changes such as income and family composition within ten days.

SB 87 also requires the Department to seek a federal waiver to delete status reporting for the first year of federally funded TMC. Unless the waiver is approved, reporting is still required for those persons. Families who do not return the status report in the fourth month (without good cause) are not eligible for the second six months of TMC. Families who do not return the status report in the second six-month period (without good cause) or who do not meet the other requirements such as earned income at or beiow 185 percent of the federal poverty level, are also ineligible.

ACWDL No. 98-56 discussed the possibility of reporting second year TMC pregnant women who are eligible for the Income Disregard Program to the Medi-Cal Eligibility Data System (MEDS) to secure federal financial participation. We have been informed that MEDS will now allow counties to report the secondary pregnancy aid codes (44 and 48) to MEDS if the primary aid code is non-federal, Medically Indigent, or a limited scope zero share of cost. Therefore, we are requesting that you report both state only TMC and pregnancy only aid codes to MEDS if the TMC woman is pregnant and eligible for the Income Disregard Program.

We are in the process of modifying the MC 239 TMC second year TMC Notice of Action to delete the references to status reporting. A draft is enclosed for your information. A camera-ready copy in English and Spanish will be sent when they are available.

The MC 176 TMC and the MC 176 TMC A (pin feed form) have been revised so that counties will have more information to determine whether the family is eligible for Section 1931(b) or another program if the family's earned income decreases during the first year of TMC or they are no longer eligible for TMC. Camera-ready copies are enclosed. The Spanish versions will be sent when they are available.

If you have any further questions, please contact Ms. Margie Buzdas of my staff at (916) 657-0726.

Sincerely,

ORIGINAL SIGNED BY

Glenda Arellano
Action Chief
Medi-Cal Eligibility Branch

Enclosure

State of California—Health and Human Services Agency

Department of Health Services

MEDI-CAL
NOTICE OF ACTION
SECOND YEAR OF TRANSITIONAL MEDI-CAL (TMC)
APPROVAL FOR BENEFITS

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name/number: _____

Worker telephone number: _____

This affects: _____

A SECOND YEAR OF TMC IS AVAILABLE TO WORKING PERSONS AGE 19 AND OVER WHO RECEIVED ONE YEAR OF TMC BECAUSE THEY WERE NO LONGER ELIGIBLE FOR THEIR CURRENT MEDI-CAL PROGRAM DUE TO EMPLOYMENT.

☐ You are eligible for up to 12 additional months of TMC at no cost for the period _____ through _____

☐ You are entitled to full benefits.

☐ Your benefits only cover emergency and pregnancy-related services

You must:

- Continue to be employed.
- Have an eligible child in the home.
- Have average earnings minus child care costs at or below 185 percent of the Federal Poverty Level.
- Report any changes in your income or household composition with ten days.

Always present your Benefits Identification Card (BIC) to your medical provider whenever you need care. This card is good as long as you are eligible for Medi-Cal. DO NOT THROW AWAY YOUR BIC.

The regulation which requires this action is California Code of Regulations, Title 22, Section 50244.

TRANSITIONAL MEDI-CAL (TMC)
QUARTERLY STATUS REPORT

This status report is for the months of			Return this form no later than
Month 1	Month 2	Month 3	the 21st day of

IMPORTANT: COMPLETE, SIGN, AND RETURN THIS REPORT TO THE WELFARE DEPARTMENT IN THE ENCLOSED ENVELOPE. Attach proof of your income, actual child care expenses paid, and total hours of employment for the three months noted above. If you have any questions regarding this form or the items to be reported, contact your eligibility worker.

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. For Transitional Medi-Cal (TMC)-You will receive status reports during this period. If you do not complete and return these reports, your eligibility for TMC will be discontinued.

PART A. DISCONTINUANCE REQUEST

I request that my ***Transitional*** ***Medi-Cal*** be stopped on the last day of _____
Month/Year

I know that I can reapply for ***Medi-Cal*** at any time.

Applicant signature _____ Date

IF YOU WANT YOUR TMC ELIGIBILITY TO CONTINUE, PLEASE COMPLETE AND SIGN PART B OF THIS REPORT.

PART B. ELIGIBILITY STATUS INFORMATION

1. Did anyone receive any income, money, or benefits during the report period such as salary, wages, tips, commissions, bonuses, vacation pay? **If yes, attach proof (all pay stubs) for each report month.** ☐ Yes ☐ No

Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			

2. Did you or any family member receive money or benefits from other sources such as disability, unemployment, child support, or social security? **If yes, attach proof (all pay stubs) for each report month.** ☐ Yes ☐ No

Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3. **a.** Did you or any family member **receive free** housing, utilities, food, or clothing in the report month? ☐ Yes ☐ No
   b. Did you or any family member **work for** housing, utilities, food, or clothing in the report month? ☐ Yes ☐ No

If yes to 4a and 4b, you must answer the three questions on the next line.

(1) What was received?	(2) Who received it?	(3) Who provided it?

4. Did you or anyone pay for child care expenses which have not or will not be reimbursed? ☐ Yes ☐ No
   If yes, complete the following:

Name of Child(ren)	Age	Amount Paid for Child Care Expenses			Name of Child Care Provider
		Month 1	Month 2	Month 3	

5. Did you have changes in your family or household during the time specified? (Include change of address, change of child care provider, change of employment, change in property, anyone that moved into or out of your home, is pregnant, or anyone who was born or who died.) ☐ Yes ☐ No
   If yes, complete the following:

Name	Relationship	What Happened	Date

6. a. Do you or anyone have or expect to receive private health, vision, or dental insurance? (This includes insurance paid by an absent parent.) ☐ Yes ☐ No
   b. Do you have or expect to receive health insurance through your employer? ☐ Yes ☐ No
   c. Does your employer offer health insurance for a monthly premium? ☐ Yes ☐ No
   If yes, complete the following:

Name of Insurance	Person(s) Insured

CERTIFICATION

I understand that reported facts may result in benefits being changed or stopped.

I understand that the statements I have made on this form are subject to investigation and verification.

I understand that I must notify my worker within ten days of any change.

I understand that failing to report facts or giving wrong or incomplete facts can result in legal prosecution with penalties of a fine, imprisonment, or both.

I DECLARE UNDERPENALTYOF PERJURYUNDERTHE LAWS OF THE UNITED STATES AND THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUE AND CORRECT AND IS COMPLETE FOR THE ENTIRE REPORT PERIOD.

Signature or mark of applicant	Dale	Phone number
		( )
Signature of witness lo mark, interpreter, or other person	**Date**	**Phone number**

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1. Did anyone receive any income, money, or benefits during the report period such as salary, wages, tips, commissions, bonuses, vacation pay? If yes, attach proof (all pay stubs) for each report month. ☐ Yes ☐ No

Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			
Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			
Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
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Name / Employer/source		Month 1	Month 2	Month 3
	Income received?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Total hours worked:			

2. Did you or any family member receive money or benefits from other sources such as disability, unemployment, child support, or social security? If yes, attach proof (all pay stubs) for each report month. ☐ Yes ☐ No

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If yes, complete the following:

Name	Relationship	What Happened	Date

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b. Do you have or expect to receive health insurance through your employer? ☐ Yes ☐ No
c. Does your employer offer health insurance for a monthly premium? ☐ Yes ☐ No
If yes, complete the following:

Name of Insurance	Person(s) insured

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Signature or mark of applicant	Date	Phone number
		( )
Signature of witness to mark, interpreter, or other person	**Date**	**Phone number**
		( )