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

April 17, 2001

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
All County Health Executives
All County Mental Health Directors
All 250 Percent Working Disabled County Coordinators

Letter No.: 01-26

THE 250 PERCENT WORKING DISABLED PROGRAM FORMS AND NOTICES

This is to inform the counties that the following 250 Percent Working Disabled program forms and notices are now available for order from the State Warehouse:

- **MC 338**- 250 Percent Income Test Work Sheet for the 250 Percent Working Disabled Program-Adults
- **MC 338 Instructions**- Instructions 250 Percent Income Test Work Sheet for the 250 Percent Working Disabled Program-Adults
- **MC 388 A**- SSI/SSP Income Test Work Sheet for the 250 Percent Working Disabled Program-Adults
- **MC 388 B**- 250 Percent and SSI/SSP Income Test Work Sheet for the
- 250 Percent Working Disabled Program-Child Applying With or Without Ineligible Parent(s)
- **MC 388 C**- SSI/SSP Property Test Work Sheet for the 250 Percent Working Disabled Program Adults and Child Applicants
- **MC 338 D**- MEDI-CAL NOTICE OF ACTION Approval for Benefits as a 250 Percent Working Disabled Individual or Couple
- **MC 388 E**- MEDI-CAL NOTICE OF ACTION Change of Premium Payment Amount in the 250 Percent Working Disabled Program
- **MC 338 F**- MEDI-CAL NOTICE OF ACTION Discontinuance for Failure to Pay Full Premiums in the 250 Percent Working Disabled Program

- **MC 338 G Informing Notice**- 250 Percent Working Disabled Program Premium Payment Information

- **MC 338 H**- MEDI-CAL NOTICE OF ACTION Application for Retroactive Eligibility for the 250 Percent Working Disabled Program

- **MC 338 J 250 Percent WD Program Premium Differential**- Premium Differential Work Sheet in the 250 Percent Working Disabled Program

Refer to the All County Welfare Director's Letter 00-16 for the interim 250 Percent Working Disabled Program procedures. The MC 338 J, not included in the interim procedures, is to determine the impact of spousal or parental deeming on the individual's premium amount. Any increase in premium due to such deeming is an income deduction against the spouses' income in computing eligibility or share of cost in other Medi-Cal programs.

In addition to this letter, we are sending camera-ready copies of these forms and notices to each of the 250 Percent Working Disabled Program Coordinators under separate cover. When the Spanish version of these forms and notices are available, camera-ready copies will also be mailed to you.

Please direct any questions regarding these forms and notices to Ms.Vicki Partington at (916) 654-5909 or E-Mail.Vparting@dhs.ca.gov.

ORIGINAL SIGNED BY
SHAR SCHROEPFER
Shar Schroepfer, Chief
Medi-Cal Eligibility Branch

Enclosures

250 PERCENT INCOME TEST WORK SHEET FOR THE 250 PERCENT WORKING DISABLED PROGRAM—ADULTS

Case name	Case number
Applicant(s) name(s)	

I. Income of Potential 250 Percent Individual or Couple and Income From the Ineligible Spouse With or Without Children

A. Nonexempt Unearned Income	(a) Individual or Couple Applicant(s)	(b) Ineligible Spouse
1. Applicant's retirement and survivor's social security. Do not include social security disability income.		
2. Social Security (RSDI) ineligible spouse.		
3. Net income from property.		
4. Other—itemize. Exempt any other disability income of applicant(s).		
5. Add lines 1 through 4 to get subtotal(s).		

STOP HERE and complete Sections II and III for the ineligible spouse. Then complete the remainder of this section for the applicant(s) and, if spousal deeming applies, complete the remainder for the ineligible spouse.

6. Allocation to ineligible children from ineligible spouse (Section II, line 5).		
7. Subtract line 6(b) from line 5(b). If minus, enter amount, without the minus sign, on line 12(b) and zero (0) on line 7(b). Otherwise, enter amount on line 7(b).		
8. Add unearned income from line 5(a) and, if spousal deeming applies, from line 7(b).		
9. Any income deduction.	-$20	
10. Subtract line 9 from line 8 to get countable unearned income. If minus amount, enter amount, without minus sign, in instruction box on line 17.		
B. Nonexempt Earned Income		
11. Enter gross earned income of applicant(s) and, if deeming applies, from ineligible spouse.		
12. Per line 7(b), unused portion of allocation to ineligible children.		
13. Subtract line 12(b) from line 11(b). If minus, enter zero.		
14. Add line 11(a) and line 13(b) to get combined earned income.		
15. Enter any IRWE of potential 250 percent applicant(s).		
16. Subtract line 15 from line 14.		
17. Enter $65 earned income deduction plus $_____ of unused $20.		
18. Subtract line 17 from line 16.		
19. Divide line 18 by 2 to get countable earned income.		
20. Add line 10 and line 19 to get total countable income. Also enter this amount on Section IV, line 1.		

II. Allocation to Minor Child(ren) from the Ineligible Spouse. DO NOT allocate from applicant(s). DO NOT include children on SSI/SSP or children eligible for the 250 Percent Program.

(Use additional sheet if more than three children.)	(a) Child One	(b) Child Two	(c) Child Three
1. Name.			
2. Standard SSI allocation.			
3. Enter ineligible minor child's gross income. Evaluate for student deduction. Allow student a $400 monthly disregard from earned income, up to $1,620 per year.			
4. Subtract line 3 from line 2 to determine the allocation to each child. Enter zero if a minus.			

5. Add columns 4(a), 4(b), and 4(c) to get allocation to ineligible children. Enter here and in Section III, line 4. $ _____

III. Ineligible Spouse Income Exemption Determination. This section used for evaluation purposes only.

1. Enter gross unearned amount for ineligible spouse from Section I, line 5(b).	
2. Enter amount of gross earned income of ineligible spouse.	
3. Add lines 1 and 2.	
4. Allocation to ineligible children entered from Section II, line 5.	
5. Subtract line 4 from line 3 to get remainder.	
6. If line 5 is less than the current standard SSI allocation, STOP. There is no spousal deeming. Do not complete any more boxes in Section I, column (b). If there is spousal deeming, complete Section I, column (b).	Please check (✔) one ❒ Spousal deeming ❒ No spousal deeming

IV. 250 Percent Income Eligibility Determination

1. Enter amount from Section I, line 20, rounded to nearest dollar.	
2. List 250 percent of the current federal poverty level (FPL). NOTE: If there is spousal deeming or a couple is applying, use the FPL for two. If only the income of the applicant is used, use the FPL for one.	
3. If line 1 is less than line 2, the applicant(s) (individual or couple) are eligible. If a couple is ineligible, redo form with only one applicant and an ineligible spouse.	

INSTRUCTIONS
250 PERCENT INCOME TEST WORK SHEET FOR THE 250 PERCENT WORKING DISABLED PROGRAM—ADULTS

Form MC 338, 250 Percent Income Test Work Sheet for the 250 Percent Working Disabled Program—ADULTS, is used to determine whether the ADULT applicant (individual) or applicants (couple) meet the income requirement for coverage under the 250 Percent Working Disabled program. This form is completed at the time of a new application, restoration, redetermination, change in income, or other circumstances affecting the income or correction of the income.

Instructions for Completion
Note: The term applicant includes a recipient for whom a redetermination is being completed.

Identification Section
Enter: Case name, case number, and the name of the applicant or names of both applicants if a couple is applying.

Net nonexempt income of ineligible spouses and ineligible children is determined in accordance with the provisions outlined in Title 22, Article 5 and current All County Welfare Directors Letters, except that no in-kind or support and maintenance income is counted; there is no $50 child support disregard; ineligible children are allowed the student deduction from earned income.

Section I. Income of Potential 250 Percent Individual/Couple and Income of Ineligible Spouse With or Without Children
Note: In Section I, Column a is used for the applicant and Column b is used for the ineligible spouse, if applicable. If a couple is applying, the amounts in Column a are a combination of the couple's income.

A. Nonexempt Unearned Income

Line 1. Enter any social security retirement and survivors insurance income of the applicant(s). Do NOT include any Title II disability income.

Line 2. Enter any retirement, survivors, or disability insurance income of the ineligible spouse.

Line 3. Enter any net income from property.

Line 4. Enter all other unearned income. If there is unearned income based on the SSI in-kind support and maintenance requirement, enter that amount here. Do not count any other kinds of disability income of the applicant(s).

Line 5. Add the amounts in Section I, Column a, lines 1, 3, and 4. This is a subtotal of gross unearned income of the 250 Percent applicant(s). Add the amounts in Section I, Column b, lines 2, 3, and 4. This is a subtotal of the gross unearned income of the ineligible spouse. Also enter the subtotal for the ineligible spouse in Section III, line 1.

- Stop here and complete Sections II and III for the ineligible spouse to determine whether spousal deeming applies. If spousal deeming does not apply, do not complete the remainder of Column b for the ineligible spouse. Cross out boxes 6(b), 7(b), 11(b), 12(b), and 13(b) to ensure that no income of the ineligible spouse is combined with that of applicant(s).
- Complete the remainder of this section for the applicant(s). If spousal deeming applies, complete the remainder of Column b for the ineligible spouse.

Line 6. Enter on line 6(b) the total amount allocated to the minor child(ren) from the ineligible spouse. This amount is found in Section II, line 5. NOTE: Income can only be allocated from an ineligible spouse.

Line 7. Subtract line 6(b) from line 5(b) and enter this amount on line 7(b). If line 7(b) is a minus figure, enter zero on line 7(b) and enter the amount (without the minus sign) on line 12(b). Otherwise, enter the actual amount onto line 7(b).

Line 8. Add lines 5(a) and 7(b). This is the combined unearned income of the applicant(s) and if spousal deeming applies, that of the ineligible spouse.

Line 9. No entry. This shows the $20 any income deduction.

Line 10. Subtract line 9 from line 8. This is the total countable unearned income. If the countable unearned income is a minus figure, enter zero on line 10 and enter the minus figure without the minus sign, which is the unused portion of the $20 any income deduction, on the blank line in the instruction box on line 17.

B. Nonexempt Earned Income

Line 11. Enter the gross earned income.

Line 12. This is the amount of any allocation for any ineligible minor child(ren) that is not offset by countable unearned income. (This amount was entered pursuant to line 7(b).)

Line 13. Subtract line 12(b) from line 11(b). Enter the remainder on line 13(b). Exception: Enter zero on line 13(b) if line 12(b) is greater or equal to line 11(b).

Line 14. Add lines 11(a) and 13(b). This is the combined nonexempt earned income of the applicant(s) and ineligible spouse if there is spousal deeming.

Line 15. Enter any impairment related work expenses the potential applicant may have.

Line 16. Subtract line 15 from line 14 and enter this amount on line 16. Exception: Enter zero on line 16 if line 15 is greater than or equal to line 14.

Line 17. Enter the $65 of the $65 and one-half deduction plus any unused portion of the $20 any income deduction.

Line 18. Subtract line 17 from line 16 and enter the difference on line 18. If line 17 is greater than or equal to line 16, enter zero.

Line 19. Divide line 18 by 2. The figure equals the countable earned income.

Line 20. Add lines 10 and 19 and enter on line 20 and on line 1 of Section IV. This is the total countable income of the applicant(s).

Section II. Allocation to Minor Child(ren) from the Ineligible Spouse (Do NOT Allocate from Applicants)

Line 1. Enter the name(s) of ineligible child(ren). Do not include any SSI/SSP child or children eligible for the 250 Percent Working Disabled program.

Line 2. Enter the current year's standard SSI allocation which is the difference between the SSI federal benefit rate for a couple and for an individual. These amounts are sent out by DHS annually. If no child(ren), enter zero on line 5 and in Section I, line 6(b).

Line 3. Enter the income amount for each child, excluding the student deduction (up to $400 per month or $1,620 per year from the student's earned income).

Line 4. Subtract line 3 from line 2. This is the allocation to each ineligible child. Enter zero if a minus.

Line 5. Total the allocation to each child. This is the total allocation to ineligible child(ren). Enter in Section III, line 4 and also complete all of Section III to determine whether this figure is also to be entered in Section I, line 6(b). If Section III, line 5 is less than the current year's standard SSI allocation, stop and do not enter in Section I, line 6(b). Otherwise, continue to complete Section I, Column (b).

Section III. Ineligible Spouse Income Exemption Determination

Line 1. Enter gross unearned income of the ineligible spouse from Section I, line 5(b). Do not include public assistance.

Line 2. Enter the gross earned income of the ineligible spouse.

Line 3. Add and enter the total of lines 1 and 2.

Line 4. Enter the allocation to ineligible minor children from Section II, line 5.

Line 5. Subtract line 4 from line 3 to determine the ineligible spouse's net income.

Line 6. If line 5 is less than the current standard SSI allocation amount, this income is exempt and there is no spousal deeming. Enter the federal poverty level (FPL) for one in Section IV, line 2. Check the box "No spousal deeming" on line 6.

DO NOT complete the remainder of Section I, column (b) and cross out lines 6(b), 7(b), 11(b), 12(b), and 13(b). Complete Section I, column (a) for the applicant.

If line 5 equals or is greater than the current standard SSI allocation amount, there is spousal deeming. Enter the FPL for two in Section IV, line 2. Check the box, "Spousal deeming" on line 6. Complete the remainder of Section I, including Column (b).

Section IV. 250 Percent Income Eligibility Determination

Line 1. Enter the total countable income from Section I, line 20.

Line 2. Enter 250 percent of the current federal poverty level (FPL). Enter the FPL for a family size of one if a single individual is applying or if there is no deeming from the ineligible spouse. If a couple is applying or there is spousal deeming, use the FPL for a family size of two.

Line 3. If line 1 is less than line 2, the individual or couple is eligible for the 250 Percent Working Disabled Program. If line 1 is greater or equal to line 2 and the determination was for a couple, complete this form again for one member of the couple and make the other spouse an ineligible spouse.

Remaining Information

The eligibility worker must sign this form, enter his/her county number, if one exists, and the date this form was completed. Completion of the county use box is optional.

SSI/SSP INCOME TEST WORK SHEET FOR THE 250 PERCENT WORKING DISABLED PROGRAM—ADULTS

Case name	Case number
Applicant(s) name(s)	

Complete the MC 338 250 Percent Income Test Work Sheet before completing this form. Determine whether spousal deeming applies by reviewing Part III, line 6, of the MC 338. ***Note: Earnings of the applicant are exempt.***

Complete Part I or Part II as appropriate.

Part I. Spousal Deeming Applies	
1. Enter the amount from line 10, MC 338 to determine total countable unearned income.	
2. Enter the amount from line 13, MC 338, to determine ineligible spouse's earned income after allocation to ineligible children.	
3. Enter the amount from line 17, MC 338.	
4. Subtract line 3 from line 2. If a minus, enter zero.	
5. Divide line 4 by 2 to get ineligible spouse's net earned income.	
6. Add line 1 and line 5 to get total countable income. Enter in Part III, line 8. Enter the SSI/SSP payment level for two in Part III, line 9.	
Part II. Spousal Deeming Does Not Apply	
7. Enter amount from line 10, MC 338, to get applicant(s) unearned income. Also, enter this amount in Part III, line 8.	
Part III. SSI/SSP Income Test	
8. This is the total income entered pursuant to Part I, line 6, or Part II, line 7.	
9. Enter the SSI/SSP payment level for: • one, if only a single applicant is applying or if an individual with an ineligible spouse is applying and spousal deeming does not apply, ***or*** • two, if a couple is applying or if an individual with an ineligible spouse is applying and spousal deeming applies.	
10. If line 8 is less than line 9, the applicant(s) are SSI income eligible. Otherwise, the applicant(s) are ineligible. If a couple is ineligible, redo with only one applicant.	

Eligibility Worker signature	Worker number	Computation Date	***County Use***

250 PERCENT AND SSI/SSP INCOME TEST WORK SHEET FOR THE 250 PERCENT WORKING DISABLED PROGRAM—CHILD APPLYING WITH OR WITHOUT INELIGIBLE PARENT(S)

Case name	Case number
Applicant(s) name(s)	

Note: There is no deeming from an ineligible parent if there also is a parent in the home who is on SSI/SSP or in the 250 Percent Working Disabled Program. Net nonexempt income of ineligible parents and ineligible children is determined in accordance with the provisions outlined in Title 22, Article 5 and current All County Welfare Directors Letters, except that no in-kind or support and maintenance income is counted; there is no $50 child support disregard; ineligible children are allowed the student deduction from earned income.

I. Income of Ineligible Parent(s) of Potential 250 Percent Child	
A. Nonexempt Unearned Income	**Ineligible Parent(s)**
1. Social Security (RSDI)	
2. Net income from property	
3. Other—itemize.	
4. Add lines 1 through 3.	
5. Allocation to ineligible child(ren) entered from Section II, line 5.	
6. Remainder. Subtract line 5 from line 4. If minus amount, enter zero on line 6 and the remainder without the minus sign in the instruction box on line 10.	
7. Any income deduction.	-$20
8. Remainder. Subtract line 7 from line 6. If minus, enter amount without minus in instruction box on line 11 and zero on this line. This is countable unearned income. Enter on line 14.	
B. Nonexempt Earned Income	**Ineligible Parent(s)**
9. Gross earned income.	
10. Unused portion of allocation to ineligible child(ren) _____. Subtract from line 9.	
11. Add $65 earned income deduction plus $_____ amount of unused $20 (any income deduction).	
12. Subtract line 11 from line 10.	
13. Divide by 2 to get countable earned income.	
14. This is countable unearned income from line 8.	
15. Add lines 13 and 14.	
16. Enter parental deduction. (FBR for one if one parent lives in the home or for two if both parents live in the home.)	
17. Subtract line 16 from line 15 for the Allocation to Potential 250 Percent child. If zero or negative, enter zero in Section III, line 1 and zero on this line. **NOTE: If more than one child is applying, the allocation is prorated between the children.**	

II. Parental Allocation to Minor Child(ren) from Ineligible Parent(s). Do not allocate to children on SSI/SSP or children eligible for the 250 percent program. (Use additional sheets if more than three children.)

	(a) Child One	(b) Child Two	(c) Child Three
1. Name			
2. Standard SSI allocation			
3. Enter ineligible minor child's gross income. Evaluate for student deduction. Allow student a $400 per month income disregard from earned income, up to $1,620 per year.			
4. Subtract line 3 from line 2 to determine the allocation to each child. Enter zero if minus.			

5. Add columns 4a, 4b, and 4c to get allocation to ineligible children. Enter in Section I, line 5.

III. Determine Whether Child Meets 250 Percent Test and SSI/SSP Test

A. Child's Net Nonexempt Unearned Income	**Child**
1. This is the allocation from ineligible parent(s) from Section I, line 17.	
2. Enter child's social security income (do NOT include social security disability income).	
3. Enter other unearned income, excluding any other disability income.	
4. Add lines 1 through 3.	
5. Any income deduction.	$20
6. Subtract line 5 from line 4. If a minus, enter amount without minus in instruction box line 9 and zero on this line. Amount on line 6 is net nonexempt unearned income. Enter on line 12 and line 17.	
B. Child's Net Nonexempt Earned Income	**Child**
7. Child's gross earned income.	
8. Subtract dollar amount of IRWE and student deduction.	
9. Add $65 and _____ of the unused portion of the $20 any income deduction.	
10. Subtract line 9 from line 8. If a minus, enter zero.	
11. Divide line 10 by 2 to get net nonexempt earned income.	
12. Net nonexempt unearned income from line 6.	
13. Add line 11 and line 12 to get total net nonexempt income.	
14. List 250 percent of the current federal poverty level for one.	
C. 250 Percent Test	
15. If line 13 is less than line 14, the child meets the 250 percent income test.	
D. SSI/SSP Test—Note: Child's earnings are exempt.	
16. Enter the SSI/SSP payment level for one.	
17. Net nonexempt unearned income from line 6.	
18. If line 17 is less than line 16, the child meets the SSI/SSP income test.	

Eligibility Worker signature	Worker number	Computation date	*County Use*

SSI/SSP PROPERTY TEST WORKSHEET
FOR THE 250 PERCENT WORKING DISABLED PROGRAM
ADULTS AND CHILD APPLICANTS

Case name	Case number

Applicant(s) name(s)

Property is defined under Article 9, Title 22, except that resources in the form of retirement arrangements of the working disabled applicant are exempted. Complete Part I or Part II as appropriate.

I. Applicant(s) Are Adults	
1. Enter only the net nonexempt property of the applicant and spouse. Do not consider the property of any other family members in the home.	$
2. Enter the property limit for one person if there is no spouse or for two persons if there is a spouse.	$
3. If line 1 is less than or equal to line 2, the property requirement is met.	$
II. Applicant Is a Child Who is Unmarried and Under Age 18	
A. Parental Allocation Only consider the net nonexempt property of the parent(s) in the home; do not consider the property of any other family members.	
4. Enter parent(s) net nonexempt property.	$
5. Enter the property limit for one person if only one parent is in the home or for two if two parents are in the home.	$
6. Subtract line 5 from line 4. Enter zero if a minus. This is the total allocation.	$
7. Divide line 6 by the number of 250 percent working disabled children in the home to get each applicant child's share.	$
B. Child's Net Nonexempt Property	
8. Enter child's own net nonexempt property.	$
9. Enter the child's share from line 7.	$
10. Add line 8 and line 9 to get child's net nonexempt property.	$
11. Enter the property limit for one.	$
12. If line 10 is less than or equal to line 11, the property requirement is met.	$
III. Child in Section II Is Ineligible (e.g., Attainment of Age 18 or There is Property Ineligibility) and There Are Additional 250 Percent Child Applicants.	
13. Take the total allocation of the property deemed from the parent(s) in line 6 and redivide it among the remaining 250 percent child applicants in the home.	$
14. Repeat section II B for each of the remaining children.	$

Eligibility Worker signature	Worker number	Computation date	*COUNTY USE*

MEDI-CAL
NOTICE OF ACTION
APPROVAL FOR BENEFITS AS A 250 PERCENT WORKING DISABLED INDIVIDUAL OR COUPLE

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name _____

Worker number: _____

Worker telephone: _____

Worker hours: _____

District: _____

This affects: _____

_____
(Name)

We have reviewed your application/case to see if you are eligible for the 250 Percent Working Disabled program. This program allows eligible individuals and couples to pay premiums for full coverage under Medi-Cal.

We have determined that beginning _____/_____/_____, you meet the basic eligibility requirements for the 250 Percent Working Disabled program. However, before Medi-Cal can begin to cover your medical expenses under this program, you must pay the first continuous month's premium.

If you already have a plastic Benefits Identification Card (BIC), this card will be used for this program. If you do not already have a BIC card, you will receive one soon. Do not throw this card away. This card is good as long as you are eligible for Medi-Cal. Take this plastic card to your doctor or other Medi-Cal provider when you request medical services.

The amount of your monthly premium is $_____. This is based on your net nonexempt income of $_____. We have not counted your disability income in making this determination.

You will receive an invoice from the California Department of Health Services (DHS) with a preaddressed, color-coded, postage-paid envelope for you to use in making this payment. **PLEASE ATTACH THE INVOICE TO YOUR PAYMENT. TO EXPEDITE PROCESSING, ALSO INCLUDE YOUR NAME AND YOUR CLIENT INDEX NUMBER (WHICH IS FOUND ON YOUR INVOICE) ON YOUR PAYMENT.**

To continue your enrollment under this program, you must pay the monthly premium that is due. Each month, DHS will send you a monthly invoice with a preaddressed postage-paid envelope. Your premium payment is due by the fifth of the following month.

This action is required by All County Welfare Directors' Letter 00-16.

Sí Ud. necesita una traducción de este aviso en español, pongase en contacto con su oficina de bienestar del condado.

_____ Eligibility Worker

_____ Phone

_____ Date

PLEASE READ THE REVERSE SIDE OF THIS NOTICE

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
APROBACIÓN DE BENEFICIOS COMO PERSONA O PAREJA INCAPACITADA QUE TRABAJA UN 250 POR CIENTO

(COUNTY STAMP)

Fecha de la notificación: _____

Número del caso: _____

Nombre del/de la trabajador(a): _____

Número del/de la trabajador(a): _____

Teléfono del/de la trabajador(a): _____

Horario del/de la trabajador(a): _____

Distrito: _____

Esto afecta a: _____

_____
(Nombre)

Hemos evaluado su solicitud/caso para determinar si usted reúne los requisitos para el programa de Incapacitados que Trabajan un 250 Por Ciento *(250 Percent Working Disabled program)*. Este programa permite a las personas y parejas que reúnen los requisitos que paguen primas para cobertura completa bajo el programa de Medi-Cal.

Hemos determinado que a partir del _____/_____/_____, usted reúne los requisitos básicos de elegibilidad para el programa de Incapacitados que Trabajan un 250 Por Ciento. Sin embargo, antes de que el programa de Medi-Cal pueda comenzar a cubrir sus gastos médicos bajo este programa, usted tiene que pagar la prima del primer mes continuo.

Si usted ya tiene una Tarjeta de Identificación de Beneficios de plástico *(BIC)*, esta tarjeta se utilizará para este programa. Si usted todavía no tiene una *BIC*, pronto recibirá una. No tire esta tarjeta. Esta tarjeta es válida mientras usted reúna los requisitos del programa de Medi-Cal. Lleve esta tarjeta de plástico consigo cuando solicite servicios médicos de su doctor(a) u otro proveedor de Medi-Cal.

La cantidad de su prima mensual es de $_____. Ésta se basa en sus ingresos netos no exentos de $_____. Al tomar esta determinación, no hemos tomado en cuenta sus ingresos por incapacidad.

Usted recibirá una factura del Departamento de Servicios de Salud de California *(California Department of Health Services—DHS)* con un sobre de un color clave, rotulado previamente y con franqueo pagado, para que lo utilice al hacer su pago. **POR FAVOR, ADJUNTE LA FACTURA CON SU PAGO. PARA AGILIZAR EL TRÁMITE, TAMBIÉN INCLUYA SU NOMBRE Y SU NÚMERO DE ÍNDICE COMO CLIENTE (EL CUAL SE INDICA EN SU FACTURA) CON SU PAGO.**

Para continuar su inscripción en este programa, usted tiene que pagar la prima mensual que se debe. Cada mes, el *DHS* le enviará una factura, con un sobre rotulado previamente con franqueo pagado. El pago de su prima se vence el quinto día del siguiente mes.

La Carta 00-16 de los Directores del Departamento de Bienestar Social de Todos los Condados exige esta acción.

Trabajador(a) de elegibilidad	Teléfono	Fecha

POR FAVOR LEA EL REVERSO DE ESTA NOTIFICACIÓN

MEDI-CAL
NOTICE OF ACTION
CHANGE OF PREMIUM PAYMENT AMOUNT IN THE 250 PERCENT WORKING DISABLED PROGRAM

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name _____

Worker number: _____

Worker telephone: _____

Worker hours: _____

Change in premium for: _____

_____
(Names)

Your premium for enrollment in the 250 Percent Working Disabled program has been changed to $_____ per month beginning _____.
The Department of Health Services (DHS) will put this new amount on your invoice.

The amount of your monthly premium is based on your net nonexempt income of $_____.
We have not counted your disability income in making this determination.

PLEASE BE SURE TO ATTACH YOUR INVOICE TO YOUR PAYMENT. TO EXPEDITE PROCESSING, ALSO INCLUDE YOUR NAME AND YOUR CLIENT INDEX NUMBER (WHICH IS FOUND ON YOUR INVOICE) ON YOUR PAYMENT.

To continue your enrollment under this program, you must pay the monthly premium that is due. Each month, DHS will send you a monthly invoice with a preaddressed, postage-paid envelope. Your premium payment is due by the fifth of the following month.

This action is required by All County Welfare Directors' Letter 00-16.

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL

CAMBIO DE LA CANTIDAD DEL PAGO DE LA PRIMA EN EL PROGRAMA DE INCAPACITADOS QUE TRABAJAN UN 250 POR CIENTO

(COUNTY STAMP)

Fecha de la notificación: _____

Número del caso: _____ - _____

Nombre del/de la trabajador(a): _____

Número del/de la trabajador(a): _____

Teléfono del/de la trabajador(a): _____

Horario del/de la trabajador(a): _____

Cambio de prima para: _____

_____

(nombres)

Su prima de inscripción en el programa de Incapacitados que Trabajan un 250 Por Ciento *(250 Percent Working Disabled program) se ha cambiado a* $_____ al mes, a partir del_____. El Departamento de Servicios de Salud de California *(California Department of Health Services—DHS)* pondrá esta nueva cantidad en su factura.

La cantidad de su prima mensual se basa en sus ingresos netos no exentos de $ _____. Al hacer esta determinación, no hemos tomado en cuenta sus ingresos por incapacidad.

POR FAVOR, ASEGÚRESE DE ADJUNTAR SU FACTURA CON SU PAGO. PARA AGILIZAR EL TRÁMITE, TAMBIÉN INCLUYA SU NOMBRE Y SU NÚMERO DE ÍNDICE COMO CLIENTE (EL CUAL SE INDICA EN SU FACTURA) CON SU PAGO.

Para continuar su inscripción en este programa, usted tiene que pagar la prima mensual que se debe. Cada mes, el *DHS* le enviará una factura, con un sobre rotulado previamente con franqueo pagado. El pago de su prima se vence el quinto día del siguiente mes.

La Carta 00-16 de los Directores del Departamento de Bienestar Social de Todos los Condados exige esta acción.

MEDI-CAL
NOTICE OF ACTION
DISCONTINUANCE FOR FAILURE TO PAY FULL PREMIUMS IN THE 250 PERCENT WORKING DISABLED PROGRAM

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name: _____

District: _____

Worker number: _____

Worker telephone: _____

Worker hours: _____

Discontinuance from the 250 Percent Working Disabled program for: _____

_____
(names)

We have reviewed all information about your payment of premiums in the 250 Percent Working Disabled program and have determined that you have not paid the required premiums for **two months**.

Your enrollment in the 250 Percent Working Disabled program will be discontinued, effective the last day of _____.

If you have any questions about your premium payments, you may call the Department of Health Services, Third Party Liability Branch, at (916) 324-4162.

If you are eligible for Medicare, this means that _____ is the last month the
(month)
State will pay your premium for Part B Medicare supplementary insurance coverage. You will receive a written notice from the Social Security Administration, or you may call your Social Security district office if you have questions about your Medicare status.

This discontinuance action does not affect your eligibility for any other Medi-Cal program. You will receive another notice from your county Department of Social Services concerning any other Medi-Cal coverage for which you may be eligible. If you have any questions about such eligibility, please write or telephone your county eligibility worker.

DO NOT THROW YOUR PLASTIC ID CARD AWAY. You can use it again if you become eligible for Medi-Cal in the future.

This action is required by All County Welfare Directors' Letter 00-16.

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL
DESCONTINUACIÓN POR NO PAGAR LAS PRIMAS COMPLETAS EN EL PROGRAMA DE INCAPACITADOS QUE TRABAJAN UN 250 POR CIENTO

(COUNTY STAMP)

Fecha de la notificación: _____

Número del caso: _____

Nombre del/de la trabajador(a): _____

Distrito: _____

Número del/de la trabajador(a): _____

Teléfono del/de la trabajador(a): _____

Horario del/de la trabajador(a): _____

Descontinuación del programa de Incapacitados que ___

Trabajan un 250 Por Ciento de : _____

_____
(nombres)

Hemos evaluado toda la información acerca de su pago de primas en el programa de Incapacitados que Trabajan un 250 Por Ciento *(250 Percent Working Disabled program)*, y hemos determinado que usted no ha pagado las primas requeridas por **dos meses**.

Su inscripción en el programa de Incapacitados que Trabajan un 250 Por Ciento se descontinuará, a partir del último día de _____.

Si usted tiene alguna pregunta sobre los pagos de sus primas, puede llamar a la Sección de Responsabilidad de Pago de Terceros, del Departamento de Servicios de Salud, al (916) 324-4162.

Si usted reúne los requisitos del programa de Medicare, esto significa que _____ es el último
(mes)
mes en que el estado pagará la prima de la cobertura de seguro suplementaria de la Parte B de Medicare. Usted recibirá una notificación por escrito de la Administración del Seguro Social, o si tiene alguna pregunta sobre su situación en lo que respecta a Medicare, puede llamar a la oficina del Seguro Social del distrito.

Esta acción de descontinuación no afecta su elegibilidad para ningún otro programa de Medi-Cal. Usted recibirá otra notificación del Departamento de Servicios Sociales de su condado, con respecto a cualquier otra cobertura de Medi-Cal para la que posiblemente usted reúna los requisitos. Si tiene alguna pregunta sobre dicha elegibilidad, por favor escriba o llame por teléfono al/a la trabajador(a) de elegibilidad de su condado.

NO TIRE SU TARJETA DE IDENTIFICACIÓN DE PLÁSTICO. Usted puede utilizarla de nuevo, si en el futuro vuelve a reunir los requisitos para el programa de Medi-Cal.

La Carta 00-16 de los Directores del Departamento de Bienestar Social de Todos los Condados exige esta acción.

MEDI-CAL
NOTICE OF ACTION
APPLICATION FOR RETROACTIVE ELIGIBILITY FOR THE 250 PERCENT WORKING DISABLED PROGRAM

(COUNTY STAMP)

Notice date: _____

Case number: _____

Worker name: _____

Worker number: _____

Worker telephone: _____

Worker hours: _____

This affects: _____

_____
(names)

We have reviewed all information available to us about your circumstances and find that effective for the month(s) of _____, you meet the basic eligibility requirements for retroactive coverage under the 250 Percent Working Disabled program. You are responsible for making premium payments for each month in which you want to be enrolled for retroactive coverage.

The amount of your monthly premium for _____ is $ _____.

The amount of your monthly premium for _____ is $ _____.

The amount of your monthly premium for _____ is $ _____.

This is based on your net nonexempt income of $ _____. We have not counted your disability income in making this determination.

You will receive an invoice for these months from the Department of Health Services (DHS) with a pre-addressed, color-coded, postage-paid envelope for you to use in returning your premium payment to DHS.

You may choose to be enrolled for any or all of these retroactive months. You must indicate which month(s) you wish to be enrolled in and pay that month's premium before you are covered for that month(s).

PLEASE ATTACH THE INVOICE TO YOUR PAYMENT. TO EXPEDITE PROCESSING, ALSO INCLUDE YOUR NAME AND CLIENT INDEX NUMBER (WHICH IS FOUND ON YOUR INVOICE) ON YOUR PAYMENT.

Take your plastic card to each medical provider where you received services in the above month(s). If you have paid your premium(s) for these retroactive months, your plastic card will show your provider that you are enrolled.

This action does not affect your application for current and ongoing Medi-Cal. If you have any questions about this action or if there are more facts about your conditions which you have not reported to us, please write or telephone us at _____.

This action is required by All County Welfare Directors' Letter 00-16.

NOTIFICACIÓN DE ACCIÓN DE MEDI-CAL

SOLICITUD PARA LA ELEGIBILIDAD RETROACTIVA PARA EL PROGRAMA DE INCAPACITADOS QUE TRABAJAN UN 250 POR CIENTO

(COUNTY STAMP)

Fecha de la notificación: _____

Número del caso: _____

Nombre del/de la trabajador(a): _____

Número del/de la trabajador(a): _____

Teléfono del/de la trabajador(a): _____

Horario del/de la trabajador(a): _____

Esto afecta a: _____

_____

(nombres)

Hemos evaluado toda la información a nuestra disposición acerca de sus circunstancias, y hemos determinado que a partir del/de los mes(es) de _____, usted reúne los requisitos básicos de elegibilidad para cobertura retroactiva bajo el programa de Incapacitados que Trabajan un 250 Por Ciento *(250 Percent Working Disabled program)*. Usted es responsable de hacer los pagos de las primas de cada mes durante el cual usted desea estar inscrito(a) para cobertura retroactiva.

La cantidad de su prima mensual para _____ es de $ _____.

La cantidad de su prima mensual para _____ es de $ _____.

La cantidad de su prima mensual para _____ es de $ _____.

Esto se basa en sus ingresos netos no exentos de $_____. Al tomar esta determinación, no hemos tomado en cuenta sus ingresos por incapacidad.

Usted recibirá una factura del Departamento de Servicios de Salud de California *(California Department of Health Services—DHS)* con un sobre de un color clave, rotulado previamente y con franqueo pagado, para que lo utilice al enviar su pago al *DHS*.

Usted puede elegir estar inscrito(a) para cualquier o todos estos meses retroactivos. Usted tiene que indicar qué mes(es) desea estar inscrito(a), y pagar la prima de ese mes, antes de que esté cubierto(a) para ese(os) mes(es).

POR FAVOR, ADJUNTE LA FACTURA CON SU PAGO. PARA AGILIZAR EL TRÁMITE, TAMBIÉN INCLUYA SU NOMBRE Y SU NÚMERO DE ÍNDICE COMO CLIENTE (EL CUAL SE INDICA EN SU FACTURA) CON SU PAGO.

Lleve su tarjeta de plástico a cada proveedor médico de donde recibió servicios en el/los mes(es) indicado(s) anteriormente. Si usted ha pagado su(s) prima(s) por estos meses retroactivos, su tarjeta de plástico le demostrará a su proveedor que usted está inscrito(a).

Esta acción no afecta su solicitud para recibir beneficios actuales o continuos de Medi-Cal. Si usted tiene alguna pregunta sobre esta acción, o si hay más información sobre sus condiciones, que usted no nos ha reportado, por favor escríbanos o llámenos al _____.

La Carta 00-16 de los Directores del Departamento de Bienestar Social de Todos los Condados exige esta acción.

PREMIUM DIFFERENTIAL WORK SHEET IN THE 250 PERCENT WORKING DISABLED PROGRAM

Case name | Case number

Applicant(s) name(s)

This form is used to determine the impact of spousal or parental deeming on the premium being charged a 250 Percent Working Disabled (WD) beneficiary. Any increase in premium due to such deeming is an income deduction against the income of the spouse or parent(s) in computing their eligibility or share-of-cost in other Medi-Cal programs.

This determination is not completed if there is no spousal or parental deeming. NOTE: Parental deeming stops in the month after a child turns age 18.

I. Premium Based on Spousal or Parental Deeming

If the 250 Percent beneficiary is an adult, complete the MC 338 with spousal deeming. If the beneficiary is a child under age 18 or in the month of his/her 18th birthday, complete the MC 338 B with parental deeming.

1. Enter total countable income from Section I, line 20 of the MC 338 or Section III, line 13 of the MC 338 B. _____
2. Enter the amount of the premium based on income on line 1. _____

II. Premium Without Spousal or Parental Deeming

Complete the following for only the beneficiary:

3. Enter amount of retirement and survivors social security. Do not include any disability income. _____
4. Enter any other unearned income, including net income from property. _____
5. Add lines 3 and 4. _____
6. Subtract the $20 any income deduction to get ***net nonexempt unearned income***. (-$20) _____
7. Enter gross earned income. _____
8. Subtract $_____ of IRWE. _____
9. Add $65 and $_____ of any unused portion of the any income allocation and enter. _____
10. Subtract line 9 from line 8. Enter zero (0) if a minus. _____
11. Divide line 10 by 2 to get ***net nonexempt earned income***. _____
12. Add amount from line 6 to get ***total net nonexempt income***. _____
13. Enter premium amount based on line 12. _____

Premium Differential

Subtract line 13 from line 2. Enter zero (0) if a minus. _____

~~This is the amount of the income deduction to be applied against the income of the deemor(s).~~