STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
6) 445-1912

July 21, 1981

To: All County Welfare Directors

Medi-Cal Eligibility Letter No. 81-30
CHDP Program Letter No. 81-10

NEW CHILD HEALTH AND DISABILITY PREVENTION (CHDP) REFERRAL FORM FOR MEDI-CAL-ONLY APPLICANTS AND BENEFICIARIES

The purpose of this letter is to introduce the new CHDP Referral Form PM 357 (attached) and to give a brief explanation of the process for informing and referring Medi-Cal-only eligibles for CHDP services. Revised CHDP documentation and referral procedures will be issued shortly and will replace Section 4D of the Medi-Cal Eligibility Procedural Manual. The new form (PM 357) is already in use in the Aid to Families with Dependent Children program and is to be implemented for Medi-Cal-only eligibles effective August 1, 1981.

The referral form is designed to ensure that all information required by the Federal Government is made available to the local CHDP/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Use of PM 357 is mandatory, although certain modifications to the form or process may be made with prior written approval of the Department of Health Services. Modification requests should be submitted to the Department of Health Services/Child Health and Disability Prevention Branch, 714 P Street Room 1792, Sacramento, CA 95814.

Basic CHDP Informing and Documentation Requirements

Title 22, California Administrative Code, Sections 50157, 50184, and 50189, require the eligibility worker to explain the CHDP Program to all Medi-Cal applicants/beneficiaries under 21, or to the parents of children under 21 years of age. An explanation of CHDP and an approved CHDP brochure are to be given at the initial face-to-face interview and at the annual redetermination. The box in the margin opposite Question 34 on MC 210 should be checked to show that the CHDP brochure has been given to the applicant or beneficiary. The date of the interview should be entered immediately below the checked box.

Use of CHDP Referral Form (PM 357)

Form PM 357 should be completed whenever the applicant or beneficiary wants CHDP services or requests more information about the CHDP Program after the basic explanation and brochure described above have been given.

Part A of the PM 357 is to be completed by the eligibility worker (EW). Line item instructions are on the reverse side of the second (pink) copy of the three part form. All three copies of PM 357 are to be retained in the applicant's or beneficiary's case record until initial or ongoing eligibility for Medi-Cal has been determined. Once eligibility is established, the EW is to send the original and the yellow copy to the local EPSDT Unit/CHDP Program for further processing. The pink copy is to be retained in the case record. When the beneficiary is referred to the CHDP Program, the "CHDP Referral" box opposite Question 34 on the MC 210 should be checked. Form PM 357 has been produced on NCR carbonless paper for your convenience. Counties may order the PM 357 with the HAS 1390, include two shipping labels, and allow a 21-day turnaround time for their order to be filled. Send to:

Forms Clerk
Child Health and Disability Prevention
Branch
Department of Health Services
714 P Street, Room 1792
Sacramento, CA 95814

Do not send the HAS 1390 directly to the warehouse, and limit your forms request to the PM 357 only.

If you have any questions regarding the new form or process, contact your Medi-Cal program consultant.

Sincerely,

Original signed by

Siegried A. Centerwall, M.D., Chief
Child Health and Disability
Prevention Branch

Sincerely,

Original signed by

Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

State of California—Health and Welfare Agency

Department of Health Services

CHDP REFERRAL FORM

All Medi-Cal Eligible Persons Under 21 Years of Age Can Receive a Health and Dental Check-Up.
Client: Fill In Unshaded Area Only

PART A: COMPLETE FOR ALL CASES REQUESTING SERVICES OR ADDITIONAL INFORMATION

1. Case Name (Last, First, Middle)	2. Co. Code	3. Aid Code	4. Case Number

5. ☐ Requested Additional Information, But No Services

REQUESTED MEDICAL SERVICES (Health Assessment)

6. Services ☐ Yes ☐ No
7. Transportation ☐ Yes ☐ No
8. Scheduling ☐ Yes ☐ No

REQUESTED DENTAL SERVICES

9. Services ☐ Yes ☐ No
10. Transportation ☐ Yes ☐ No
11. Scheduling ☐ Yes ☐ No

12. ☐ New Application
13. ☐ Redetermination
14. ☐ Self-Referral
15. ☐ AFDC
16. ☐ AFDC Foster Care
17. ☐ Medi-Cal Only
18. ☐ Share of Cost

19. Primary Language, If Other Than English _____

20. Other Circumstances _____

	Person No.	Client(s) Name (Last, First, Middle)	Birthdate Month	Day	Year	Age	
21		Parent or Caretaker Name					If PHP, Give Name of Plan
22		Other Parent in Home					If PHP, Give Name of Plan
23		Child's Name					If PHP, Give Name of Plan
24		Child's Name					If PHP, Give Name of Plan
25		Child's Name					If PHP, Give Name of Plan
26		Child's Name					If PHP, Give Name of Plan
27		Child's Name					If PHP, Give Name of Plan
28		Other Person in Home					If PHP, Give Name of Plan

29	Residence Address Zip Code CA	30. Home Phone
31	Mailing Address Zip Code CA	32. Message Phone
33	Family or Children's Doctor (Optional)	34. Family or Children's Dentist (Optional)

This information is requested to meet Federal reporting requirements (Federal Register CFR 42, Part 441) and to inform you of services available. The county is required by law to keep this information confidential except as provided in state or federal law or regulation. Further information is available at your local welfare or CHDP offices.

COMMENTS:

35. Worker Signature	36 Worker Number	37 Worker Phone	38 Date Eligibility Determined

Copy 1—County CHDP; Copy 2—County CHDP; Copy 3—Client Case Record (Welfare Department)

CHDP REFERRAL AND CASE MANAGEMENT FORM

Required Form
M 357 (2/81)

15097-449 750 M TRIP - 08P