

DEPARTMENT OF HEALTH SERVICES

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SACRAMENTO, CA 95814

(16) 445-1912



November 4, 1981

To: All County Welfare Directors

Letter No. 81-51

QUARTERLY SHARE OF COST (SOC) AB 251 MANDATE

Reference: CWD Letter No. 81-39

This letter provides you with sufficient information to begin the design of county system and operational changes necessary to implement quarterly SOC by the March 1982 target date. Although it is realized that this is a comparatively costly administrative change, the anticipated program savings by far exceed the administrative costs. Therefore, it is imperative, given Medi-Cal funding constraints, that this change be implemented as soon as possible.

Background

In Letter No. 81-39 you were advised that AB 251 mandated quarterly SOC for all Medi-Cal-only eligibles except for persons in long-term care (LTC), providing a federal waiver was obtained. We have recently been advised by federal staff that such a process may be permissible under the Medicaid changes in the Omnibus Reconciliation Act of 1981 (PL 97-35). Based upon this information, we submitted a Medicaid State Plan amendment which was approved by the Federal Government on October 16, 1981.

Since the county responses to Letter No. 81-39 indicated that many counties will require three to six months to have in place the changes necessary to implement quarterly SOC, we are transmitting the following information to you at this time:

1. Draft regulations which:
 - a. Define the SOC period.
 - b. Describe actions to be taken when a change occurs.
 - c. Explain Record of Health Care Costs (MC 177S) and Medi-Cal card issuance procedures.
2. Revised forms, except that a sample of the penfed MC 177S is not yet available. It will mirror the 177S included in the attachments except it will be designed using standard penfed specifications.

SOC Process Changes from All County Letter (ACL) No. 81-39

The quarterly SOC concepts in the attached draft regulations, procedures, and forms are the same as were described in ACL No. 81-39. County response to that letter indicated satisfaction with those concepts, given the constraints

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of a quarterly SOC process. One issue was left open in that letter, whether future month cards for cases that lost certified status during a quarter, should be suppressed by counties after those cards were shipped to the counties, or suppressed via county phone call to the State. The decision, based on county impact, is to hold cards at the state level and suppress based on county calls. We will arrange for a toll-free number for those calls.

Filing of Regulations

Although we do not anticipate that the new system can be operational before March 1982, a decision has been made to proceed with the filing of emergency regulations now. There are two reasons for this decision:

1. The Governor has recently signed SB 216, which, coupled with the fact that a federal waiver to have different SOC periods for LTC versus non-LTC eligibles is no longer necessary, requires the Department to file emergency regulations before November 15, 1981. Basically, SB 216 gives the Department until November 15 to file regulations implementing those provisions of AB 251 which do not require a federal waiver.
2. Filing regulations at this point provides assurances to county staff and the public that the Department is committed to a quarterly SOC system.

Thus, the attached regulations will be published in Title 22 sometime in December or January. We will not be issuing the changes in the Medi-Cal Eligibility Manual until closer to implementation.

Implementation Schedules

The major milestones at the state level are as follows:

<u>Task</u>	<u>Date</u>
1. Regional Training for Counties (Including Training on BRU/MEDS/ CID Interface Changes).	Early December 1981.
2. Deliver Initial Supply of Revised Forms to Counties.	January 1982.
3. Distribute Emergency Regulations/ Procedures in Medi-Cal Eligibility Manual Effective March 1, 1982.	February 1982.

Conversion Methodology

The SOC process as described in the attached regulations will be employed at Intake as soon as the regulations are effective.

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To minimize the administrative time required to convert existing cases, the implementation for existing cases will be as follows:

1. Convert to new process by multiplying current SOC by three.
2. Existing caseload conversion can be staggered so that quarterly period for all cases does not begin and end at the same time.
3. Convert to process described in regulations, including completion of revised MC 176M, when a change which impacts the SOC is reported or a redetermination is completed, whichever comes first.

Implementation Progress

In order for us to effectively follow the progress of implementation at the county level, we are requesting that each county develop and submit to its state Medi-Cal program consultant a county major milestone workplan. This plan should be submitted to your Medi-Cal program consultant by November 30, 1981. Include target dates for such things as computer systems changes, writing of internal procedures and forms modification, staff training, and county implementation. We realize that other programs administered by the county are also undergoing eligibility changes which require systems changes. Once the county workplans have been received and reviewed, state staff will be assisting counties individually, as required, in order to meet the established target implementation date.

Systems Change Funding/County Administrative Costs

Administrative costs associated with implementation of the new SOC regulations and procedures are reimbursable within existing allocations whether they are salary or approved electronic data processing (EDP) costs. AB 251 did not appropriate additional funding for county quarterly SOC activities. The Department, however, intends to reimburse such costs, and has requested funding through Fiscal Year (FY) 1981-82 Budget Revisions. Although we anticipate a reduction in total caseload size once the new SOC system is operational, we realize that the amount of time spent per case may increase. We plan to study the impact of quarterly SOC and make any ongoing funding adjustments accordingly.

If you have any questions, contact your Medi-Cal program consultant.

Sincerely,

Original signed by

Barbara V. Carr for
Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: May 31, 1982

50137. Intercounty Transfer -- Effective Date of Discontinuance/ Eligibility.

(a) In a change in county of responsibility, the effective date of discontinuance as determined by the initiating county department shall be the last day of the second month following the month in which the initiating county department notified the new county of the change in county of responsibility except that:

(1) If the initiating county department determines the person or family is no longer eligible, the last day of the month in which the determination of ineligibility is made, provided a 10 day notice is given or is waived. Otherwise, discontinuance is effective on the last day of the month in which the 10 day notice is given.

(2) If the person or family is receiving Medi-Cal under the Four Month Continuing Eligibility category, the last day of the final month in which four month continuing eligibility exists.

(3) If the person or family is in an MFBU with a multimonth share of cost period the effective date of discontinuance shall coincide with the last day of the period.

(b) If the county department in the new county of responsibility determined that a person or family is eligible for Medi-Cal, the effective date of eligibility shall be the first day of the month following the month in which the initiating county department discontinues eligibility.

(c) Counties involved in an intercounty transfer may, by mutual agreement, establish a different effective date of discontinuance, if the initiating county department can suppress card issuance for the following month.

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50191. Status Reports. (a) The county department shall require the completion of a Medi-Cal Status Report, Form MC 176S, no later than the third month following the month of Medi-Cal eligibility approval of an application, ~~reapplication or reevaluation~~ and at three month intervals as specified in (c) ~~therefore~~, for all MFBU's which contain at least one AFDC/MN or MI person. The requirement to complete status reports shall not apply to the following:

- (1) Persons who receive Medi-Cal through the Aid for Adoption of Children program.
- (2) Persons who have a government representative, such as a public guardian, acting on their behalf.
- (3) MI children who are not living with parent or relative and for whom a public agency is assuming financial responsibility in whole or in part.
- (4) Children who are requesting Medi-Cal in accordance with Section 50147.1.
- (5) Persons who receive county General Assistance Benefits and whose Medi-Cal eligibility factors are monitored at least quarterly by the county department under its general assistance program.

(b) In addition to the status reports required in accordance with (a), the county department, consistent with Article 2, may require persons or families to complete status reports at more frequent intervals.

(c) The completion of form MC 176S shall be required:

(1) During the third month of the share of cost period for the MFBU established in accordance with Section 50652(a).

(2) No later than the second share of cost period following the effective date of eligibility established in accordance with Section 50701(c).

50517. Apportionment of Income Over Time. (a) Income shall be considered available in the month received, unless it is apportioned over time in accordance with the following:

(1) Income earned and received in more than eight but less than twelve months under an annual contract of employment shall be apportioned equally over the period of the contract beginning with the first month of the contract.

(2) Interest income which is received less frequently than monthly and is not exempt as specified in Section 50542 shall be apportioned as follows:

(A) Determine the number of months of the period during which the interest accrued.

(B) Divide the interest income by the number of months in the interest period.

(C) Consider the amount determined in (B) as income in each of the months of the next interest period.

(2) (3) Income received ~~either~~ more frequently than monthly or ^{semi-}monthly shall be converted to monthly income in accordance with (4) if ~~all~~ both of the following conditions are met:

(A) The beneficiary wishes to receive Medi-Cal for more than two months, or the beneficiary is included in an MFBU with a multimonth share of cost period pursuant to Section 50652(a).

(B) The beneficiary is to receive the income for a full month.

(C) The income is nonfluctuating.

(3) (4) Income shall be converted to monthly income by the following methods:

(A) Multiply weekly income by 4.33 or $4 \frac{1}{3}$.

(B) Multiply income received every two weeks by 2.167 or $2 \frac{1}{6}$.

(C) Divide quarterly income by 3.

(D) Divide income received every two months by 2.

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(4) Income received less frequently than monthly shall be converted to monthly income by the following methods for MFBU's with a one month share of cost pursuant to Section 50652(b).

(A) Divide quarterly income by three.

(B) Divide income received every two months by two.

(5) Income from self-employment, as determined in accordance with Section 50505, shall be determined on an annual basis and apportioned monthly.

(6) Loans which do not require repayment and are not exempt in accordance with Section 50533, and which specify that they are to cover a certain period of time shall be apportioned over that period of time.

(7) Interest income from a deed of trust or contract of sale shall be determined on an annual basis and apportioned monthly.

90565. Changes Which Affect Income Determination. (a) In situations where a change in income or other circumstances which affects the income determination is reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall:

(1) For any decrease in income:

(A) Determine what the share of cost should have been for the months in which the decrease in income occurred.

(B) Make necessary changes in the ongoing share of cost by the first of the month following the month in which the change was reported.

(C) Implement the beneficiary's choice of either of the following:

1. Having an adjustment made in future months, in accordance with Section 50567, for the months in which income in excess of the correct share of cost was paid or obligated toward medical bills.

2. Having the correct form MC 177S or Medi-Cal card with a share of cost issued and processed for the months in which the share of cost should have been lower.

(2) For increases in income, make necessary changes in the ongoing share of cost effective:

(A) Immediately if the increase in income is due to the inclusion of a previously excluded family member.

(B) The first of the month following the month in which the change was reported, if a 10-day notice can be given.

(C) The first of the second month following the month in which the change was reported, if the change cannot be made in accordance with (B).

(b) In situations where a change in income or other circumstances is not reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall:

(1) For any decrease in income:

(A) Make necessary changes in the ongoing share of cost by the first of the month following the month in which the change was reported.

(B) Not make an adjustment for the excess income the beneficiary may have paid or obligated prior to county action specified in (A).

(2) For any increase in income:

(A) Determine what the share of cost should have been for the months in which the increase occurred.

(B) Make necessary changes in the ongoing share of cost effective:

1. The first of the month following the month in which the change was reported, if a 10-day notice can be given.

2. The first of the second month following the month in which the change was reported, if a 10-day notice cannot be given.

(C) Report a potential overpayment in accordance with Section 50781, if the beneficiary:

1. Received a Medi-Cal card and should have had a share of cost.

2. Met a share of cost which was less than the corrected share of cost.

50565. Projection of Anticipated Income. (a) Income shall be determined in accordance with the following for MFBUs with a multimonth share of cost period pursuant to Section 50652(a).

(1) Income for each month of the share of cost period shall be projected separately.

(2) Anticipated charges shall be considered in determining the amount of income projected for each month. Anticipated charges shall include, but are not limited to:

(A) Return to work after recovery from a medical condition.

(B) Application for and receipt of unconditionally available income.

(b) Nonreceipt of anticipated income shall be considered as a decrease in income and treated in accordance with Section 50653.3 unless the county department determines that an administrative error occurred in the income projection. In those instances the provisions of Section 50653.7(a) shall apply.

~~50567. Adjustment for Decreases in Income. (a) When it is determined, in accordance with Section 50565, that there has been a decrease in income which is to be adjusted, the adjustment shall be made in accordance with the following:~~

~~(1) The period of adjustment shall begin with the month the county department takes action in accordance with Section 50565(a)(1)(B), and shall terminate when the total adjustment has been made.~~

~~(2) The amount of income to be adjusted is the difference between the original share of cost and the corrected share of cost.~~

~~(3) The amount of the adjustment or a portion of the adjustment equal to the share of cost shall be subtracted from the share of cost each month until the adjustment is completed.~~

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~~50560. County Failure to Change Income. If the county fails to take action on an increase in income within the time frame specified in Section 50565 (a) (2) and (b) (2), excess income received after the time the county department should have taken action shall not be reported as a potential overpayment.~~

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50652. Share of Cost Period. (a) The share of cost for an MFBU which does not include a person in LTC shall cover a three month period unless otherwise specified in this subsection. The share of cost period shall be determined in accordance with (1), (2) and (3).

(1) The share of cost period for months of retroactive eligibility determined in accordance with Section 50701 shall include all three months immediately preceding the month of application, reapplication or restoration unless either of the following conditions exist:

(A) The persons requesting retroactive eligibility were PA or other PA recipients in any of the three months immediately preceding the month of application, reapplication or restoration. The share of cost period shall consist of only those retroactive months in which a Medi-Cal card was not received.

(B) At least one of the three months immediately preceding the month of

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application, reapplication or restoration was included in a prior share of cost period. There shall be two share of cost periods which shall be determined as follows:

1. The share of cost period for any retroactive month included in a prior share of cost period shall be that prior share of cost period.

2. The second share of cost period shall consist of those retroactive months not included in a prior share of cost period.

(2) The initial share of cost period, in all other instances, shall include the month in which eligibility begins in accordance with Section 50701(c) and the two immediately following months, unless the beginning month of eligibility was included in a prior share of cost period. In those instances the share of cost periods shall be determined as follows:

(A) For those beginning months of eligibility which were included in a prior share of cost period, the share of cost period for those months shall be that prior share of cost period.

(B) The second share of cost period shall begin with the first month of eligibility not included in a prior share of cost period and shall include the two immediately following months.

(3) Three month share of cost periods shall follow consecutively after the initial share of cost period for persons continuously eligible for Medi-Cal.

(4) A share of cost period determined in accordance with (1), (2) and (3)

shall:

(A) Not be interrupted nor altered by either of the following:

1. The applicant's or beneficiary's failure to meet all the conditions of eligibility in any month during the three month share of cost period.

2. The applicant's or beneficiary's request to have eligibility determined for only one or two months during the three month period.

(B) Be modified in accordance with (b) when a member of the MFBU enters LTC.

(b) The share of cost for an MFBU which includes a person in LTC shall cover a one month period. If eligibility is being or has been determined for a three month period, and a member of the MFBU enters LTC during that period, the share of cost period determined in accordance with (a) shall include only those months in which the person did not have LTC status.

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50653. Determination of Share of Cost. (a) The share of cost covers a one month period and is shall be determined as follows:

(1) For MFBU which do not include a person in LTC:

(A) Determine the net nonexempt income anticipated to be available to the members of the MFBU during each month of the share of cost period.

(B) Round the total net nonexempt income for each month determined in (A) to the nearest dollar, with amounts ending in 50 cents or more rounded to the next highest dollar. Add these amounts.

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(C) Determine the appropriate maintenance need for the MFBU for each month during the share of cost period in accordance with Section 50603. Add these amounts.

(D) Subtract the combined maintenance need from the total rounded net nonexempt income for the share of cost period. The remainder, if any, is the share of cost.

(2) For MFBUs which include a person in LTC:

(A) Determine the total countable income available to the MFBU in the month.

(B) Add to the total countable income any amounts previously deducted in accordance with Sections 50547 through 50554.

(C) Subtract from the amount determined in (B) the deductions and allocations specified in Sections 50555.1 through 50555.4 and 50563. This is the net non-exempt income available to the MFBU.

(D) Round the total net nonexempt income determined in (C) to the nearest dollar with amounts ending in 50 cents or more to the next highest dollar.

(E) Determine the appropriate maintenance need in accordance with Section 50601.

(F) Subtract the amount determined in (E) from the amount determined in (D). This amount, if any, is the share of cost.

(b) The share of cost shall be determined:

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- (1) At the time of applications, reapplication or restoration.

- (2) When there is a change in income, family composition or any other factor affecting the share of cost. In these instances the share of cost shall be determined in accordance with Sections 50653.3 and 50655.5.

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50653.3. Changes Which Decrease the Share of Cost. (a) In situations where a change in income or other circumstances, which results in a decrease in the share of cost, is reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall:

(1) Make the necessary changes in the ongoing share of cost by the first of the share of cost period following the period in which the change was reported.

(2) Determine what the share of cost should have been for the share of cost period in which the change occurred.

(3) Implement the beneficiary's choice of either of the following:

(A) Having an adjustment made in future share of cost periods in accordance with (c) for the periods in which income in excess of the correct share of cost was paid or obligated toward medical bills.

(B) Having the correct form MC 1775 or Medi-Cal card with a share of cost issued and processed for the share of cost periods in which the share of cost should have been lower.

(b) In situations where a change in income or other circumstances, which results

in a decrease in the share of cost, is not reported by the beneficiary in a

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timely manner, as specified in Section 50185, the county department shall:

(1) For MFBUs with a one month share of cost period:

(A) Make the necessary changes in the ongoing share of cost by the first of the month following the month in which the change was reported.

(B) Not make an adjustment for the excess income the beneficiary may have paid or obligated prior to county action specified in (A) unless the county department determines that there was good cause for failure to report in a timely manner.

(2) For MFBUs with a multimonth share of cost period and the change is reported during the last month of the period:

(A) Make necessary changes in the ongoing share of cost by the first of the following share of cost period.

(B) Not make an adjustment for the excess income the beneficiary may have paid or obligated prior to county action specified in (A) unless the county department determines that there was good cause for failure to report in a timely manner.

(3) For MFBUs with a multimonth share of cost period and the change is reported prior to the last month of the period:

(A) Make the necessary changes in the ongoing share of cost by the first of the following share of cost period.

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(B) Determine what the share of cost should have been for the share of cost period in which the change occurred by:

1. Making the necessary changes effective the first of the month, within the share of cost period, following the month in which the change was reported.

2. Not making any adjustments to reflect the changes in any month prior to the county action specified in 1. unless the county department determines that there was good cause for failure to report the change in a timely manner.

(C) Implement the beneficiary's choice of either of the following:

1. Having an adjustment made in future share of cost periods in accordance with (c) for the periods in which income in excess of the correct share of cost was paid or obligated toward medical bills.

2. Having the correct form MC 177S issued and processed for the share of cost periods in which the share of cost should have been lower.

(c) When it is determined in accordance with (a) or (b) that there has been a decrease in the share of cost which is to be adjusted, the adjustment shall be made in accordance with the following:

(1) The period of adjustment shall begin with the month the county department takes action in accordance with (a) or (b), and shall terminate when the total adjustment has been made.

(2) The amount of the adjustment is the difference between the original share

of cost and the corrected share of cost.

(3) The amount of the adjustment or a portion of the adjustment equal to the share of cost shall be subtracted from the share of cost each month until the adjustment is completed.

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50653.5. Changes Which Increase the Share of Cost Determination. (a) In situations where a change in income or other circumstances, which results in an increase in the share of cost, is reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall make necessary changes effective:

(1) Immediately, if the increase is due to the inclusion of a previously excluded family member who has income:

(2) For MFBU's with a one month share of cost period:

(A) The first of the month following the month in which the change was reported, if a 10 day notice can be given.

(B) The first of the second month following the month in which the change was reported, if the change cannot be made in accordance with (A).

(3) For MFBU's with a multimonth share of cost period and the change is reported during the last month of a share of cost period:

(A) The first month of the following share of cost period, if a 10 day notice can be given.

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(B) The second month of the following share of cost period, if the change cannot be made in accordance with (A).

For
(4) The MFBU's with a multimonth share of cost period and the change is reported prior to the last month of the share of cost period:

(A) The first of the month within the share of cost period following the issuance of a 10 day notice. The share of cost for the period shall be adjusted in accordance with (c).

(B) The first month of the following share of cost period, if the change cannot be made in accordance with (A).

(b) In situations where a change in income or other circumstances, which results in an increase in the share of cost determination, is not reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall:

(1) Make the changes to the ongoing share of cost in accordance with (a).

(2) Determine what the share of cost should have been for the share of cost periods in which the increase occurred.

(3) Report a potential overpayment in accordance with Section 50781, if the beneficiary:

(A) Received a Medi-Cal card and should have had a share of cost.

(B) Met a share of cost which was less than the corrected share of cost.

(c) When there has been an increase in the share of cost which is to be adjusted within the share of cost period, the county department shall:

(1) For MFBUs which have already met the share of cost and have been certified as eligible:

(A) Determine what the share of cost should be in accordance with (a)(4)(A).

(B) Determine the amount of the adjustment by subtracting the original share of cost from the amount determined in (1).

(C) Issue a supplemental form MC 1776 in the amount of the adjustment for those months within the share of cost period for which the beneficiary has not received a Medi-Cal card.

(2) For MFBUs which have not yet met the share of cost:

(A) Determine what the share of cost should be in accordance with (a)(4)(A).

(B) Issue an additional form MC 177S in the amount as determined in (A).

50653.7. Changes in Share of Cost Determination Due to Administrative Error.

(a) An administrative error which causes the share of cost amount to be in excess of the correct share of cost amount shall be adjusted in accordance with Section 50653.3(a).

(b) If the county fails to take action on an increase in income within the time frames specified in Section 50653.5, excess income received after the time the county department should have taken action shall not be reported as a potential overpayment.

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50657. Completion of Form MC 177S. (a) Form MC 177S shall be completed as follows:

(1) The identifying information shall be completed by the county department. The only persons who shall be listed on form MC 177S as eligible to have the cost of their health services sued to meet the share of cost are those:

(A) Included in the MFBU who have not received a full complement Medi-Cal card as a member of that MFBU or as four month continuing eligibles.

(B) Ineligible members of the MFBU in accordance with Section 50379.

(2) Form MC 177S shall be issued to the beneficiary for each period month during which the beneficiary must meet a share of cost.

(A) For continuing beneficiaries, form MC 177S shall be issued prior to the first of the month of ~~eligibility.~~ the share of cost period.

(B) For new and restored beneficiaries, form MC 177S shall be issued at the time the approval notice of action is issued.

(3) An additional or supplemental form MC 177S shall be issued when the share of cost is increased during a share of cost period as specified in

Section 50653.5.

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(4) (3) The beneficiary shall present form MC 177S to each provider when the cost of services provided will be used to meet the share of cost.

(5) (4) The provider will list on the form MC 177S health services which have been provided and meet all of the following criteria:

(A) Were provided in the month period specified on form MC 177S. Services are considered to have been provided in the month period if the date of service is within the month period. The date of service for:

1. Health services provided under a Global Billing Agreement is the date the last service under the agreement is rendered or the date of delivery, if the global billing is for pregnancy and delivery.
2. Dental prosthesis, prosthetic and orthotic appliances, and eye appliances is the date the item is actually ordered from the fabricating laboratory.
3. Prescription drugs is the date the item was actually received.
4. All other health services is the date the service was actually rendered.

(B) Have not been submitted as a claim against the Medi-Cal program.

(C) Have not been paid by Medicare, other health care coverage, or any other party, and the provider does not anticipate reimbursement from such sources for the amounts listed on form MC 177S.

(D) Have not been paid by the beneficiary to meet the sppendown of property

Section 50421(c) shall be listed only on Record of Health Care Costs --

Spenddown, form MC 177P. The provisions of (4)(A) through (C) and (5) shall apply to the completion of form MC 177P.

(6) ~~(5)~~ For each service listed the provider shall include:

(A) The date of service in accordance with (a)(4)(A).

(B) The total cost of the service provided.

(C) The amount billed to the patient.

(7) ~~(6)~~ The provider shall sign form MC 177S and enter the provider number or Social Security number.

(8) ~~(7)~~ When the amount in the Billed Patient column of form MC 177S equals or exceeds the share of cost, the beneficiary or the beneficiary's representative shall:

(A) Sign the form indicating that the beneficiary has assumed legal responsibility for the amount shown in the Billed Patient column.

(B) Return the form to the county department.

(b) For purposes of this section, health services means the medical services, social services, supplies, devices, drugs and any other medical care provided to an eligible person by a Med-Cal provider or any licensed practitioner meeting the criteria of a Medi-Cal provider in accordance with Article 3, Chapter 3.

50658. Form MC 177S Processing. (a) When the share of cost has been met, the beneficiary shall return the signed form MC 177S to the county department. The county department shall review form MC 177S to ensure that:

- (1) The case description portion of the form is complete.
- (2) The services listed were provided to persons listed on form MC 177S.
- (3) Each service listed was provided within the ~~month~~ period specified on the form.
- (4) There is a provider number of Social Security number, and a provider signature for each service listed.
- (5) The procedure number, prescription number, or the name of each service is listed.
- (6) The total of the Billed patient column equals the share of cost.
- (7) The beneficiary or the beneficiary's representative has signed the form.
- (8) The increased share of cost has been met in those instances where an additional form MC 177S has been issued in accordance with Section 50653.5(c)(2).

(b) If the items specified above are not completed correctly, the following action shall be taken:

- (1) The county department shall attempt to obtain the information necessary for
MC 177S from either of the following:

- (A) The beneficiary.
- (B) The provider.
- (2) If the information necessary to correct form MC 177S cannot be obtained verbally the county department shall:
- (A) Identify the information needed.
- (B) Return the form to the beneficiary.
- (3) When the amount shown in the Billed Patient column is in excess of the share of cost amount, the county department shall:
- (A) Explain to the beneficiary that the amount shown in the Billed Patient column is the amount for which he has assumed legal responsibility.
- (B) Attempt to correct the error in accordance with (b)(1) and (2) if the beneficiary states that the assumption of legal responsibility for the cost of services in excess of the share of cost was not intentional.
- (c) After form MC 177S has been determined to be correct and complete, the following action shall be taken, unless the conditions specified in (d) are met.
- (1) Form MC 177S is submitted to Benefits Review Unit (BRU) along with a copy of form MC 176M, if form MC 176M is necessary in accordance with Department procedures.

- (2) Benefits Review Unit will certify that the share of cost has been met.
- (3) The Department will issue Medi-Cal cards to the persons included in the MFBU.
- (d) If the beneficiary signs a Certification of Medical Need/Request for Medi-Cal Card, MC 113, which indicates a need for medical services prior to normal anticipated receipt of a Department issued Medi-Cal card, the county department shall:
- (1) Enter the date of certification for claims clearance on form MC 177S.
 - (2) Issue a Medi-Cal card to each person who has been listed on form MC 113 as having an immediate need. Card issuance procedures specified in Article 14 shall be followed.
 - (3) Indicate on form MC 177S and form MC 176M the persons who have been issued a card.
 - (4) Forward form MC 177S and form MC 176M, if necessary, to BRU.

✓
50737. Format of Medi-Cal Card. (a) A Medi-Cal card issued by the Department or by the county department in accordance with these regulations shall be used to authorize services.

(b) The Medi-Cal card for persons with no share of cost shall contain:

(1) Complete and accurate information identifying the beneficiary, the program

(continued on next page)

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under which eligibility has been established and other health care coverage entitlement.

- (2) Valid month and year and whether it is a past month Medi-Cal card.
- (3) Information on limited service or PHP status, if applicable.
- (4) Two MEDI labels, if the card is a full complement card.
- (5) Proof of eligibility (POE) labels.

(c) The Medi-Cal card for persons who have met their share of cost and are required to complete form MC 177S, shall contain:

- (1) The items listed in (b).
- (2) The date of certification for claims clearance. The date of certification shall be:
 - (A) For the month during the share of cost period in which the share of cost is met, the last date of service listed on form MC 177S.
 - (B) For any prior month during the share of cost period, the last day of that month.
 - (C) For any subsequent month during the share of cost period, the first day of that month, providing the beneficiary remains eligible and certified.

(d) The Medi-Cal card for persons in long-term care, with a share of cost less than or equal to the monthly cost of care at the Medi-Cal reimbursement rate for the long-term care facility, shall contain:

- (1) The items listed in (b).
- (2) The amount of the share of cost.

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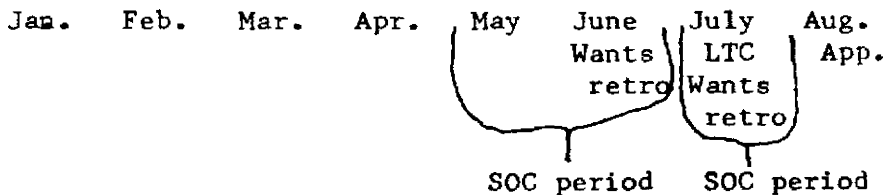
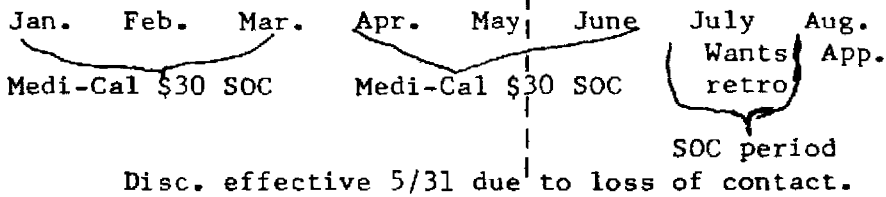
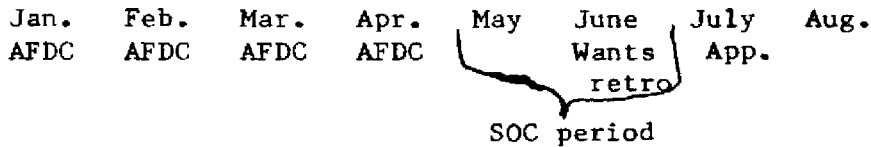
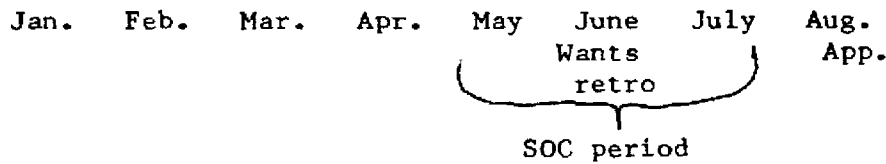
DETERMINING SHARE-OF-COST PERIODS

RETROACTIVE ELIGIBILITY:

The share of cost period includes all three retro months unless:

- A. The MFBU received Medi-Cal as PA or OTHER PA in one or more of the retro months.
- B. One or more of the retro months was included in a previous share-of-cost period.
- C. A member of the MFBU had LTC status during one or more of the retro months.

Examples:

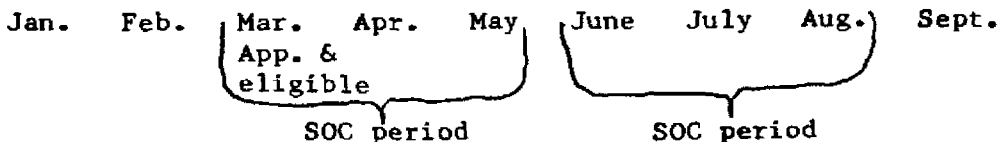


CONTINUING ELIGIBILITY:

The share of cost period begins with the month of application, if eligibility exists; or the first of the following month if ineligible throughout month of application.

Exception: For restorations occurring within two months of discontinuance, the share of cost period begins with the first month of eligibility which has not been included in a previous share of cost determination.

Examples:



Jan. Feb. Mar. Apr. May June July Aug. Sept.)
 App. Eligible
 not el-
 igible
 SOC period SOC period

Jan. Feb. Mar. Apr. May June July (Aug. Sept. Oct.)
 Medi-Cal 0 SOC. Medi-Cal 0 SOC app & eligible SOC period

Disc. effective 5/31 at clients request.

July's SOC will be based upon May, June and July income. Since discontinuance occurred May 31, any changes in income for June and July can be reflected in the July SOC determination.

Article 12 - SHARE OF COST

12A - DEPARTMENT OF HEALTH PROCESSING FOR PERSONS WITH A SHARE OF COST OR PROPERTY SPENDDOWN

1. County Submission of Forms
2. Certification Processing
3. Card Production and Mailing Procedures
4. Computerized Verification Procedures
5. Computer Rejection of Duplicate Card Requests
6. Replacement Cards

12B - COUNTY CERTIFICATION AND MEDI-CAL CARD ISSUANCE FOR ELIGIBLES WITH A SHARE OF COST

1. Client's Certification of Medical Need
2. Certification Processing by the County
3. Date of Certification
4. Issuance and Reporting of MC 301s for Certified Eligibles
5. Submission of Form MC 177-S to the State
6. Delayed Requests for MC 301 Cards
7. Proper Certification of Share of Cost (Attachment 1)

12C - PROCESSING CASES WHEN A SHARE OF COST HAS BEEN REDUCED RECTROACTIVELY

- A. Background
- B. Case Situations
- C. Submitting Revised MC 177-S Form to Department of Health Services

Adjustments of Share of Cost and Provider Reimbursement (Chart)

12D - PROCESSING CASES WHEN AN ADJUSTMENT IN A FUTURE SHARE OF COST IS NECESSARY

- A. Background

- B. Case Situation
- C. Code-A-Phone Procedures -- Reporting Increases in Share-of-Cost Amounts
- D. Submitting Supplemental MC 177 Form to Benefits Review Unit

12A - DEPARTMENT OF HEALTH PROCESSING FOR PERSONS
WITH A SHARE OF COST AND/OR PROPERTY SPENDDOWN

Benefits Review Unit (BRU) is currently responsible for certifying most medically needy (MN) and medically indigent (MI) persons with a share of cost and/or property spenddown.

1. County Submission of Forms

The county shall submit the MC 177S to BRU when the share of cost has been met and the forms signed.

Medi-Cal cards will be issued from the information contained on the MC 177S. Therefore, the forms must be filled out accurately and completely. The following information for eligible members of the Medi-Cal Family Budget Unit (MFBU) should be printed or typed and be clear and legible:

- a. Share-of-cost amount.
- b. Name (last name first on the MC 177 documents).
- c. Address (do not abbreviate city).
- d. County code, Medi-Cal ID number (complete 14-digit).
- e. Correct persons number (identical aid codes and ID numbers must have different persons numbers).
- f. The months included in the share-of-cost period and the eligibility status for each of those months.
- g. Birth date, sex.
- h. Valid one-digit other coverage code.
- i. Retro eligibility should be clearly marked at the top if applicable.

The following information should be listed for ineligible members of the MFBU:

- a. Name.
- b. State number -- enter either "I.E." or "00" in the aid code field to designate an ineligible person. This will ensure that a Medi-Cal card is not issued by BRU for this person.

A minor parent living with his/her parents is normally an ineligible member of the MFBU which includes his/her child and would, therefore, be designated on the MC 177 as "I.E." or "00". However, when the minor parent will receive minor consent services as part

of the child's MFBU, he/she should appear on the MC 177 as an eligible person in that MFBU with a full case number including aid code and persons number. When the share of cost has been met, the appropriate limited service status code should be added to the MC 177 after the minor parent's name. If the county issues the limited service card, the notation "CI" (card issued) must be placed to the left of the person's identification line on the MC 177S. If this is done, the BRU staff will know that a card should not be generated for that person. Remember to also circle the minor parent's name if he/she is also a member of the parent's MFBU and that MFBU has a share of cost.

The name of an unmarried minor parent who is listed on two MC 177 forms must be circled on both MC 177s before either/both form(s) is submitted to BRU. This is the only indicator that will alert BRU that incoming claims for the individual must be checked against share-of-cost documents for two separate cases.

All forms MC 177P shall be submitted to BRU for certification and card issuance. If a person has a spenddown of property and a share of cost, the MC 177P and MC 177S must be submitted together. An MC 176M must be attached to every MC 177P submitted.

2. Certification Processing

Certification by BRU is the formal process of confirming that beneficiaries are entitled to Medi-Cal benefits within an eligible period. Certification requires review of the MC 177 to:

- a. Ensure that the assigned share of cost has been obligated or paid and/or that the spenddown of property has been met.
- b. Ensure that only medical costs for appropriate persons have been used to meet the share-of-cost/spenddown of property.
- c. Determine the certification date, i.e., date on which the beneficiaries met their share of cost or spenddown of property. Services billed to Medi-Cal for dates prior to the certification date are reviewed by BRU to determine if those services were used to meet the share of cost or spenddown of property and, therefore, not payable by Medi-Cal.

3. Card Production

All information necessary for Medi-Cal ID card preparation is key entered from the MC 177 document.

4. Computerized Verification Procedures

Records (MC 177 documents) rejected by the computer system will be returned by BRU to the appropriate county welfare department for correction. A copy of the MC 177 and, if appropriate, MC 176 will be

returned along with a computer error listing, entitled "QLB002 Edit Error Listing" (see attached). This listing will indicate errors found on the MC 177 forms. It will be the county's responsibility to correct the errors and resubmit the documents to BRU for card issuance.

In some instances, errors that are detected on MC 176/177 documents during the certification process will be returned to the county along with an MC 2002 (Error Letter) (see attached). Erroneous documents and the MC 2002 will be included with the computer rejection listing sent to the county. Documents rejected which are listed on an MC 2002 will not appear on the computer rejection listing.

Counties may refer to the Medi-Cal card register listing and to the rejected card request listings that they receive, to determine those individuals who did or did not receive a Medi-Cal ID card.

5. Computer Rejection of Duplicate Card Requests

The Department of Health Services computer system detects cases where Medi-Cal eligibility for a given beneficiary and each valid period is being reported both through the Central Issuance Division (CID) system and to BRU by the MC 177.

MC 177 records will be compared to the CID "Dupcheck" file on the basis of beneficiary ID number and each valid period. Documents which, if accepted, would result in duplicate Medi-Cal card issuance according to the "Dupcheck" file, will be rejected. These records will be printed on a "Rejected QL Duplicates of CID Cards" report (see attached). This report will be sent to counties on a flow basis, along with the MC 177 at the time duplicate records are identified.

One of the following messages will be printed on the report for each rejected record to indicate the source of the original Medi-Cal eligibility record which has caused the rejection:

MEDI-CAL CARD PRINTED BY CID MAIN RUN

MEDI-CAL CARD PRINTED BY CID SUPP RUN

BENEFICIARY ENROLLED IN PHP

Enrollment in a prepaid health plan (PHP) indicates that an eligibility record has been received from the county in a CID main run.

The SIX MONTHS STATUS HISTORY, printed beside each rejected record on the "Duplicates" report indicates, by status codes, Medi-Cal eligibility status for the current CID main run and the previous five months, with the current month on the left. The error message printed with each rejected record is determined by the status code which corresponds to the valid month of the record. The status codes can be interpreted as follows:

<u>Status Code</u>	<u>Meaning</u>
0	NOT REPORTED ELIGIBLE FOR MEDI-CAL
1	MEDI-CAL CARD PRINTED BY CID MAIN RUN
2	MEDI-CAL CARD PRINTED BY CID SUPP RUN
3	MEDI-CAL CARD PRINTED BY PREVIOUS QL RUN
4	BENEFICIARY ENROLLED IN A PHP

These cases should be reexamined to determine whether or not the beneficiaries actually have a share of cost to meet before receiving Medi-Cal cards. If so, steps should be taken to prevent issuance of Medi-Cal cards through the CID system.

The "Rejected QL Duplicates of CID Cards" report and associated documents will be sent to the same address as the QL Register Listing. If this listing should be sent to a different address, please notify:

Chief
Benefits Review Unit
Department of Health
P. O. Box 668
Sacramento, CA 95804

6. Replacement Cards

When the county department determines that a beneficiary was issued a CID card when they actually had a share of cost, the county should attempt to retrieve the erroneously issued card. If the CID card is retrieved, an MC 177 should be sent to BRU indicating that a "replacement" card should be issued. If "replacement" card is not indicated, the case will be rejected, or rerejected, by the computer system.

MEMO-DPL ID CARD EXCEPTION LIST FOR ROUTE

COUNTY 04 PATH PROGRAM 10127 03/28/75 PAGE 2

AID CASE NO	PRE	POST	SEX	DOB	MIC-R/R-SSA	LIAB	O.COV	CEPT	COMPY	VAL	DATE	DIST	C	USE	TRAM
INVALID CERT/VERF DATE															
23	000030	1	M	07/06/10		00516	0040	02/24/75	N	1270		8110	1		94540
ALAN P JOHNSON 1234 SOME DRIVE															
AID CODE/ASMT/DATE INCOMPATIBLE															
65	000036	1	M	01/25/65		00516	0040	02/24/75	N	0275		8110	1		94500
MARY B JOHNSON 1234 SOME DRIVE															
TRANS CODE NOT 1 OR 4															
27	000010	1	M	07/08/10		00516	0040	02/20/75	N	0275		8110	2		94500
WILLIAM O SAMPLE 1234 BLANK STREET															
AID CODE/ASMT/DATE INCOMPATIBLE															
04	000020	0	F	09/23/30		00002	0040	02/12/75	N	0173		8170	4		11111
MARY WATFALL 1234 SOMERSET AVE															
INVALID AID CODE															
24	000210	0	M	04/23/30		00002	0040	02/12/75	N	0375		8170	0		94507
WILLIAM O SAMPLE 4321 HIGH WAY															
INVALID PRE/POST IND															
27	000030	0	F	01/10/60		00002	0040	02/12/75	N	0275		8170	0		94507
KAREN JOHNSON 1234 OUR PLACE															
JEANIE JOHNSON															
PRE/POST IND / VALID PERIOD INCOMPATIBLE															
63	000020	0	M	01/10/60		00002	0040	03/01/70	N	0170		8170	0		23450
JOSEPH FUJIMURA 9876 BLANK DRIVE															
INVALID AID CODE / PRE/POST IND INCOMPATIBLE															
69	000020	0	M	01/20/61		00002	0040	02/12/75	N	0275		8170	0		33333
CLYDE FUJIMURA 1234 SOME STREET															

RECEIVED
 03/28/75
 10127
 03/28/75
 10127

STATEMENT OF ERROR

*** REJECTED ERROR SUMMARY ***

AID CODE	INVALID TRANS	COUNTY NUMBER	INVALID AID ERROR	AID DATE	INVALID SERIAL NUMBER	INVALID FNU/PERSON	INVALID NAME	NO ADDRESS	INVALID VALID MONTH/YR	INVALID LIABILITY	INVALID CERT/ERR DATE	DUPE RECORD	TOTAL REJECTED ERRORS
100	1						1	1	1	1	1	1	13
							INVALID PRE/PST	AID CODE PRE/PST					1
							IND PERIOD INCOMPATIBLE						
100							1	1	1				

*** ACCEPTED ERROR SUMMARY ***

AID CODE	INVALID SPA	INVALID OTHER COVERAGE	INVALID BIRTHDATE	INVALID COPY	INVALID FFP	INVALID SSN/IC/RR NUMBER	INVALID ALIEN	TOTAL ACCEPTED ERRORS
100	1	1		1		2	1	5

RECORDS READ	TRANS 1	TRANS 0	ERRORS	TOTAL PROCESSED
27	11	0	10	27

OTHER COVERAGE STATISTICS FOR TRANSACTIONS 1 AND 0

TOTAL POPULATION	TOTAL YES	TOTAL NO	TOTAL BLANK	YES SPECIFIC	YES NON-SPEC	WRONG CODES
17		12				1

COMPUTER ASSISTED REPORT
 REPORT 5 OF 5
 PAGE 3
 FILE NAME: BUTTE.MED
 RECORD FORMAT: SDCORRMT

REJECTED O L DUPLICATES OF CID CARDS

FOR ALAMEDA

COUNTY 01 PROGRAM 018009 AS OF 03/02/76 TIME 11 28

PAGE 3

CASE-NO	FBU	PERS-NO	BENEFICIARY-NAME	PRE-POST	SEX	DOB	MIC-R/R-SSA	LIAB	D.COY	CERT	VAL-DATE	DIST	C-USE	TRAN
I-CAL CARD PRINTED BY CID MAIN RUN														
0006200	0	02	AMANDA JONES	1		2 19/10/73								
3456 SOME LANE SECOND FLOOR ANYWHERE, CA														
SIX MONTHS STATUS HISTORY: 100000 CID NO: 06-0000200-0-02														
00000 0000 01/15/76 01/76 ABCD 1														
91605														
I-CAL CARD PRINTED BY CID SUPP RUN														
0000000	2	01	MARY JANE	0		2 05/15/48								
6789 THAT WAY														
SIX MONTHS STATUS HISTORY: 020000 CID NO: 38-0000400-2-01														
00000 0000 12/18/75 12/75 ABCD 5														
MONT BE, CA 23456														
BENEFICIARY ENROLLED IN A PMP														
0000000	1	02	BARBARA BARRETT	2		2 04/14/28	11123333A							
C/O JOE BARRETT 0901 THIS AVE														
SIX MONTHS STATUS HISTORY: 000000 CID NO: 47-0000400-1-02														
00000 0000 01/21/77 11/75 ABCD 1														
MOPACE, CA 23456														
I-CAL CARD PRINTED BY CID MAIN RUN														
0000000	2	02	DOLORES DANE	1		2 01/14/70								
0123 DONNER LANE														
SIX MONTHS STATUS HISTORY: 000100 CID NO: 09-0000000-2-02														
00000 0000 01/11/76 10/75 ABCD 5														
MITION CA 45678														

COUNTY 01 TOTAL DUPLICATE CARDS REJECTED

STATEMENT OF PERSON SHARE OF COST CARD WAS NOT PRODUCED

STATUS CODES FOR LAST SIX MONTHS

**NOTIFICATION OF DISCREPANCY
MC-176 M AND RECORD OF HEALTH CARE COSTS**

County _____ Month/Quarter _____

District _____ ID Number _____ Name _____

The attached is being returned to you for the following reason(s). Please return this form when resubmitting the MC-176 M and/or Record of Health Care Costs.

1. Following omitted/incomplete/invalid/incompatible. State number/aid code/name/FBU number/persons number/ status/birthdate/other coverage code, complete address, city, zip code/medical expense month/share of cost amount.
2. BRU processes monthly LTC cases only when the share of cost equals or exceeds the facility's Medi-Cal monthly reimbursement rate. All other LTC cases are processed by the county through the CID system.
3. Need MC-176 M for month of eligibility listed on the MC-177 P.
4. Need MC-177 S for each month client has a share of cost in addition to the spenddown of property, including LONG TERM CARE cases.
5. Record of Health Care Costs not completed. Need provider name/Medi-Cal provider number (if none, indicate Social Security number) /signature. Need name of patient receiving service.
6. Patient(s) listed are not eligible to have their medical expenses used to meet the share of cost/spenddown.
7. Need original signature of applicant. Photo or carbon copies of signatures are not acceptable on the Record of Health Care Costs. (If deceased, please indicate).
8. BRU can accept only services provided within the month/year of eligibility. We cannot accept services which have not yet been rendered. Total charges for O.B. care and delivery cannot be billed before termination of pregnancy. If baby has been delivered, please give person's number, status, name and birthdate.
9. Specific date/hospitalization "thru" dates to meet share of cost/spenddown/types of service/name or prescription number of drug/amount(s) billed patient must be indicated in the billed patient column. When all amounts are totaled, they must equal share of cost/spenddown.
10. Aid code "89" cards cannot be issued for any month during a three-month retroactive period.
11. Medi-Cal card issued by county. Please make correction(s) on attached copy of MC-177S and return to BRU.

Comments:

Verifier's Initials _____

Date _____

12B - COUNTY CERTIFICATION AND MEDI-CAL CARD ISSUANCE FOR
ELIGIBLES WITH A SHARE OF COST

1. Client's Certification of Medical Need

Persons who are eligible and have met their share of cost may request that an MC 301 or Medi-Cal Eligibility Data System (MEDS) generated MC 302 (temporary Medi-Cal ID card) be issued by the county department. To receive one, the eligible person must certify, on form MC 110, Certification of Medical Need/Request for Medi-Cal Card, that he/she requires the card in order to receive needed services between the date of request and normally expected receipt date of a card issued by Benefits Review Unit (BRU).

Original MC 110 forms should be retained by the county for a period of 26 months.

2. Certification Processing by the County

If the beneficiary signs form MC 110, the county department shall review the MC 177S to certify:

- a. That the case description portion of the form is complete (name, Medi-Cal ID number, etc.).
- b. That the person named in the "patient" field of service is eligible to have the cost of services counted toward meeting the share of cost.
- c. That each qualifying services listed on the MC 177S was rendered within the period of eligibility shown.
- d. That the service date of each listed service is on or before the date that the completed MC 177S was submitted to the county by the applicant.
- e. That the provider number or Social Security number and provider signature for each service listed is present. (Stamped provider signatures are not acceptable unless initialed by the provider.)
- f. That a descriptive name or procedure number is shown for each service listed.
- g. That a drug name or prescription number is shown for each prescription listed.
- h. That the total of all "Billed Patient" amounts equal the share of cost shown at the top of the MC 177S.
- i. The presence of an original signature of the beneficiary or person acting on behalf of the beneficiary.

3. Date of Certification

For share-of-cost cases, the certification date will be:

- a. Month in which the share of cost is met -- day on which the share of cost is met.
- b. For prior months in the quarter -- last day of the month.
- c. For future months -- first day of the month. (See Attachment 1 for further information.)

If any of the services listed on the MC 177S were not required to meet the client's share of cost, the county should follow the procedures specified in Section 50658 (b) (3).

If the most recent services for the period in which the share of cost was met was not required to meet the client's share of cost, but agreement between the provider, county, and beneficiary cannot be reached to remove that service from the MC 177S, the date of that service must be used as the certification date.

The certification date is to ensure that all claims for services provided on or before that date are subject to the Department's review in order to prevent payment by Medi-Cal of those services actually used to meet the share of cost.

4. Issuance and Reporting of MC 301s for Certified Eligibles (Non-MEDS Counties)

Data to be put on MC 301 Medi-Cal cards for persons with a share of cost, who are certified by the county, is in the same format as for other eligibles, except that the date of certification is shown on cards and labels. (Refer to Procedure Manual, Article 14A, for placement of the certification date on MC 301s.)

MC 301 cards should be issued only for eligibles who have certified a medical need for them on form MC 110. Upon receipt of the signed MC 110 and certification that the share of cost has been met, the county department shall issue current month Medi-Cal cards with MEDI and POE labels to persons indicated on the MC 110. PAST MONTHS CARDS SHALL NOT BE ISSUED BY THE COUNTY DEPARTMENT, except under the following conditions: (a) It has been at least ten months since the month of eligibility in question and a card is needed so that a provider can submit a Medi-Cal claim within one year of the date of service, or (b) the provider refuses to see the beneficiary until a POE for a past month's service is made available. In both situations a card shall be issued only if the beneficiary has met the share of cost for the period in question. Furthermore, the county department shall not issue cards to all members of the Medi-Cal Family Budget Unit (MFBU) unless it has been certified on the MC 110 that all members of MFBU

require cards in order to receive needed services prior to the receipt of a BRU issued card. FUTURE MONTHS CARDS SHALL NOT BE ISSUED BY THE COUNTY DEPARTMENT except as described in No. 1 above.

For eligibles who are issued MC 301 cards, the certification date must be placed beneath the appropriate month(s) included in the share-of-cost period at the top of the MC 177 form. In addition, the notation "CI" (card issued) must be placed to the left of the person's identification line on the MC 177S and a circle around the months for which county cards were issued in the identification line field. For example:

RECORD OF HEALTH CARE COSTS - SHARE OF COST

State of California Health and Welfare Agency
Medi-Cal Program

Department of Health Services

CO DIST 99 COUNTY U 0101

RECORD OF HEALTH CARE COSTS - SHARE OF COST

LEAD INSTRUCTIONS ON BACK BEFORE COMPLETING

Only Medical expenses in the following months may be listed below.						Share of Cost	Page
Month A	Month B	Month C				The amount that you must pay or obligate is:	Retro. E
12/81	1/82	2/82				\$ 300.00	
Mo.	Yr. Mo.	Yr. Mo.	Yr.				(Yes/No)
CERTIFICATION DATE							
12-31-81	1-15-82	2-1-82					
Mo. Day Yr.	Mo. Day Yr.	Mo. Day Yr.					

Name JOHN DOE
Address 123 ANY STREET
City/State/Zip ANYTOWN, CA 95814
County Code 59

Medical expenses of family members listed below may be used to meet Share of Cost

Aid	7 Digit Serial No.	FBU	Pers.	Name - Last, First	Eligible In			Birthdate	Sex	Other Cov. Code	Social Security No.	MHC or RR No.
					A	B	C					
37	1234567	1	01	DOE, JOHN	X	X	X	01 01 00	M	N	999-99-9999	
37	1234567	1	02	DOE, MARY	X	X	X	02 02 01	F	N	000-00-0000	
37	1234567	1	03	DOE, JOE	X	X	X	03 03 80	M	N	111-11-1111	

The "CI" and circle around the month(s) for which MC 301s have been issued alerts BRU that a county issued card has been produced and prevents central issuance of another card to the beneficiary.

If a beneficiary requests an MC 301 card because he/she needs a replacement card, and he/she was originally certified by the Department of Health Services for the period in question, the county may use the computer-printed register listings of departmentally issued cards provided by BRU as proof of certification. The register listings show the proper certification date to put on the MC 301 card. See Title 22, California Administrative Code, Section 50739, for determining proper replacement card issuance.

If a certified eligible requests an MC 301 card because he/she has exhausted all labels on the card, additional POE labels may be requested from BRU instead of the county providing another MC 301 card. Providers may also photocopy the ID portion of the Medi-Cal card as proof of eligibility.

5. Submission of Form MC 177S to the State

MC 177S forms for persons certified by the county must be forwarded to BRU within seven working days from issuance of card.

This is to permit:

- a. BRU issuance of those Medi-Cal cards for family members who did not have cards issued to them by the county.
- b. BRU issuance of replacement cards for certified eligibles.
- c. BRU review of provider Medi-Cal claims for eligibles with a share of cost, in order to prevent Medi-Cal payment of services which were paid or obligated by the share of cost.

6. Delayed Requests for MC 301 Cards

If the county has forwarded the MC 177S to BRU for certification of a case, and the client then requests an MC 301 Medi-Cal card before the centrally issued cards have been received, the county should:

- a. Telephone BRU (telephone number (916) 445-1450) to determine status of certification and expected date of card receipt.
- b. Determine whether the card receipt time frame will meet the client's need. If not, the county should request suppression of the BRU issued cards and perform the client need statement, county certification, and card issuance process.
- c. If for some reason it appears that the client will receive both a county issued and a BRU issued card, instruct the client to return BRU issued cards to the county upon receipt.

PROPER CERTIFICATION OF
SHARE-OF-COST CASES

CASE SITUATIONS	Period of Eligibility Certification Date		
	July	August	September
1. Client was determined eligible for July, August, and September with a share of cost. Client met the share of cost on August 15.	7/31/81	8/15/81	9/1/81

2. Client was determined eligible for July, August, and September with a share of cost. Client met share of cost July 28. On August 1, client reported increased earnings which increased the share of cost by \$200. Client met additional share of cost on September 13.	7/28/81	8/1/81	9/13/81

3. Client was determined eligible for July, August, and September with a \$300 share of cost. Client met the share of cost July 10 and was certified. Client entered a long-term care facility on July 25, and is expected to remain indefinitely. County is able to change status of beneficiary to a monthly share of cost effective September 1.	7/10/81	8/1/81	County should have reported LTC eligibility via CID/MEDS.

12C - PROCESSING CASES WHEN A SHARE OF COST
HAS BEEN REDUCED RETROACTIVELY

A. Background

California Administrative Code (CAC), Title 22, Sections 50565 and 50567, discuss the options available to eligible persons retroactively determined, after recomputation, to have a lower Medi-Cal share of cost for a given month(s) than was originally computed. Such a person has the option of:

1. Having future share-of-costs amounts adjusted by the county; or
2. Adjusting with providers, the amounts obligated or paid to those providers to meet the overstated portion of the original share of cost.

If an individual is seeking an adjustment of a future share of cost and transfers to another county prior to receiving the full adjustment, the former county of responsibility must inform the new county of the adjustment amount that is still due.

Beneficiaries whose future share of cost is zero before an adjustment is applied, must be advised that the only recourse is to seek reimbursement from the provider. In any situation where a beneficiary chooses to seek reimbursement from a provider, it must first be determined whether the provider has billed Medi-Cal for any portion of the service for which reimbursement is requested. This may be determined by reviewing the original MC 177. If the "Total Bill" amount is greater than the "Patient Billed" amount or if there is an amount shown in the "Billed Medi-Cal" column, it should be assumed that the provider has billed Medi-Cal. If the "Billed Medi-Cal" column is blank or the "Billed Patient" column is equal to the "Total Bill" column, it should be assumed that the provider has not previously billed the Medi-Cal program.

Prior to seeking reimbursement from the provider, clients shall be instructed by the county to give the provider a revised MC 177S and a "Share of Cost Medi-Cal Provider Letter" (MC 1054 -- see Attachment II) so that the provider may bill the Medi-Cal program and reimburse the client the appropriate share-of-cost amount. If the county or the client is in possession of the original MC 177S, the county may modify that form rather than prepare a revised one. The "Share of Cost Medi-Cal Provider Letter" will explain the reimbursement and billing procedures and the recomputation of the share of cost. So that the provider may be informed of the proper procedures to follow, counties shall check the box appropriate to the client's situation.

The MC 1054 may be ordered through the normal Department forms ordering process described in the forms section of the Medi-Cal Eligibility Manual, page F-1.

Individuals needing a Medi-Cal identification card in order to accomplish the adjustment process should be given POE labels only, except for individuals who did not meet their original share of cost. Those beneficiaries who did not meet their original share of cost will receive a full complement card from Benefits Review Unit (BRU) when the MC 177 is completed and processed. If any individual used services to meet the share of cost which would require a "MEDI" label, the provider may use the POE label, along with the MC 1054 to bill the program. This letter will alert the fiscal intermediary (FI) that the case is being adjusted and to waive the "MEDI" label requirement for the specific services listed on the claim; in addition, a Treatment Authorization Request (TAR) will not be necessary for claims submitted with this letter for services normally requiring a TAR.

B. Case Situations

The following procedures describe the adjustment process and the different methods for working with various case situations in recomputing the share of cost.

Adjustment of Share-of-Cost Amount

Case Situation 1 -- Client was determined eligible for July, August, and September with a share of cost and met the share of cost. It is later determined that the share-of-cost period should have been lower. Clients requests adjustment of future share-of-cost amounts.

Case Processing Steps

- a. The county shall recompute the share-of-cost period and prepare a new MC 176M (latest revision) for the case file. (The difference between the original and recomputed share of cost for the quarter is the amount of the adjustment.)
- b. On the MC 176M for October, November, and December (the future months in which the share of cost is to be adjusted), enter the share-of-cost amount in part III, line 15, and enter the amount of the adjustment in line 16. Subtract line 16 from line 15 to determine the new adjusted share-of-cost amount and enter the amount in line 17. If the amount of the adjustment (line 17) is greater than the new share-of-cost amount (line 15), the client is not required to meet a share of cost for that period. If necessary, repeat this step for subsequent periods until the entire adjustment is made.

If the status of the beneficiary is changed from a three-month share of cost to a monthly share of cost, the adjustment shall be in the subsequent month or months.

- c. For the October through December quarter and other future periods of eligibility, the county shall prepare an MC 177S showing the adjusted share-of-cost amount and submit to the client. The MC 177S must be completed by the provider showing the amount of the new adjusted share of cost for which the client is responsible.
- d. Upon completion of the MC 177S by the provider, the client must sign and return the form to the county which, in turn, shall send it to: Department of Health Services, Benefits Review Unit, P.O. Box 668, Sacramento, CA 95803, for card issuance.

Case Situation 2 -- Client was determined eligible for October, November, and December with a share of cost, but did not meet the share-of-cost amount in full. It is later determined that the share of cost should have been lower. Client requests adjustment of the future share of cost.

Case Processing Steps

- a. Obtain documentation from the client for the amount that was paid or obligated toward services received in October through December period (documentation may be cancelled checks, a statement of charges from the provider, or the original MC 177S for October through December period showing amounts paid or obligated to the provider). If no documentation exists, the client may choose to have the provider complete a new MC 177S.
- b. If it is determined that the client paid or obligated more than the recomputed share of cost, the difference between the amount paid or obligated and the recomputed share of cost will be the amount to be adjusted (e.g., client's original share of cost is \$100, client paid \$75; the recomputed share of cost is \$50, the amount to be adjusted for future periods is \$25).
- c. Process case according to steps listed for items a-d in Case Situation 1. The client should be provided a new MC 177S for each period in question, indicating the adjusted share of cost.
- d. If the amount already paid or obligated in the period is less than the recomputed share of cost, no adjustment is necessary.

Provider Reimbursement of Share-of-Cost Amount

Case Situation 3 -- Client was determined eligible for the November, December, and January period with a share of cost and met the share of cost. A recomputation indicates the share of cost should have been zero. Client wants a reimbursement of the share-of-cost amount paid to the provider(s). The provider(s) billed Medi-Cal for a portion of the service(s).

Case Processing Steps

- a. The county shall recompute the November through January share of cost and prepare the MC 176M for the case file.
- b. The county shall also prepare an MC 1054 explaining the share-of-cost adjustment, give it to the client, and send a copy to BRU for its record.
- c. The client should give the MC 1054 to the provider.
- d. The provider should then submit a claim along with a copy of the MC 1054 to the appropriate Medi-Cal FI.
- e. The FI will reimburse the provider the appropriate adjusted amount.
- f. The provider(s) should then pass the difference in the share-of-cost amount on to the client.

Case Situation 4 -- Client was determined eligible for September, October, and November with a share of cost and met the share of cost. A recomputation indicates the share of cost should have been lower. Client wants reimbursement for the excess share-of-cost amount paid. The provider(s) billed Medi-Cal for a portion of the service(s).

Case Processing Steps

- a. The county shall recompute the share-of-cost period and prepare the MC 176M for the case file.
- b. The county shall also prepare a revised MC 177S showing the recomputed share-of-cost amount and give it to the client along with a completed copy of the MC 1054.
- c. The client should submit to the provider form MC 177S and the MC 1054 which explain the adjustments made.
- d. Upon completion of the MC 177S by the provider, the client must sign and return the form to the county.
- e. The county will send form MC 177S to Department of Health Services, BRU.
- f. BRU will adjust any previous claims submitted by the providers and return the claims to the FI.
- g. The FI will reimburse the provider the appropriate amount.
- h. Provider(s) should then pass the difference in the share-of-cost amount on to the client.

Case Situation 5 -- Client was determined eligible for the January, February, and March period to have a share of cost and met the share of cost. A recomputation indicates the share of cost should have been lower. Client wants a reimbursement of the excess share-of-cost amount previously paid. Client's provider(s) did not previously bill the Medi-Cal program.

Case Processing Steps

- a. For processing MC forms 176M and 177S, follow steps a-e in Case Situation 4.
- b. BRU will request preparation of Medi-Cal cards with POE labels only. The card will be mailed directly to the client by the Department of Health Services.
- c. The client should return the POE labels to the provider who should reimburse the client and use the labels to bill the program.

Case Situation 6 -- Client was determined eligible for the June, July, and August period with a share of cost and met the share of cost. A recomputation indicates the share of cost should have been zero. Client wants a reimbursement of the share-of-cost amount paid to the provider(s). The provider(s) did not previously bill the Medi-Cal program.

Case Processing Steps

- a. The county shall recompute the share-of-cost period, prepare the MC 176M for the case file.
- b. The county shall prepare for the client the MC 1054 explaining the share-of-cost adjustment and request that Medi-Cal cards be issued by BRU.
- c. The client should present the Medi-Cal card and the MC 1054 to the provider.
- d. The provider should then submit a claim along with a copy of this letter to the Medi-Cal FI.
- e. The FI will reimburse the provider the appropriate amount.
- f. The provider(s) should then pass the difference in the share-of-cost amount on to the client.

Case Situation 7 -- Client was determined eligible for the July, August, and September period with a share of cost. The client meets the share of cost in early August but dies later in that same month. A recomputation indicates the share of cost should have been zero or lower. If there is an estate for the beneficiary, reimbursement may be handled by following Case Situation 3, 4, 5, or 6, depending upon whether the provider has billed the program.

If the beneficiary did not meet the original share of cost but did meet the recomputed share of cost, follow the case processing steps in Case Situation 2.

The above examples are all based upon a quarterly share-of-cost period. They could, however, apply to a shorter period depending upon the case situation. Regardless, the adjustment process remains the same.

C. Submitting Revised MC 177S Form to Department of Health Services

In order to ensure proper processing of recomputed share-of-cost cases by BRU, it will be necessary for county welfare departments to properly identify these cases. The following procedures shall be followed:

1. In case situations where the provider has billed the Medi-Cal program previously and the client still, after recomputation, has a share of cost and does not want a reimbursement, counties shall indicate at the top of the revised MC 177S "Adjustment -- Billed".
2. In case situations where the provider has billed the Medi-Cal program and the client, after recomputation, has a lower share of cost and wants a reimbursement, the county shall indicate on the top of the revised MC 177S "Adjust Previous Claims".
3. In case situations where the client met the share of cost and the provider did not bill the program because the share of cost equaled the amount of the bill and the client, after recomputation, has a lower share of cost, the county shall indicate at the top of the MC 177S -- "Adjustment -- Not Billed". For these cases, BRU will prepare Medi-Cal identification cards, POE labels only, and mail them directly to the beneficiary.
4. In case situations where the client met the share of cost, the recomputed share of cost is zero and the provider did not previously bill the program, the county shall prepare for the client an MC 1054. If the client needs additional POE labels, the county may prepare such cards and give them directly to the beneficiary.
5. In case situations where the client did not meet the original share of cost in part or in full, and the client still, after recomputation, has a share of cost, the county shall process the case using the current MC 177S procedures described in Section 12A of the Medi-Cal Eligibility Manual. When the MC 177S is received by BRU, full complement Medi-Cal identification cards will be issued and sent directly to the beneficiary.

County welfare departments must "batch" the MC 177S forms separately for each of the specific case situations described. These "batches" should not be combined with regular share-of-cost cases being sent to BRU except for those cases described in 5 above. To expedite processing of recomputed share-of-cost cases and to ensure proper processing, it is extremely important that these procedures be followed.

ADJUSTMENTS OF SHARE OF COST
AND PROVIDER REIMBURSEMENT

Summary Chart

Case Situation	Case Processing			
	Prepare new 176 for case file and/or BRU	Prepare 177 for provider completion	Give "Share of Cost Medi- Cal Provider Letter" form MC 1054 to provider	Send 177/176 to BRU County or BRU preparation of Medi-Cal ID card
1. Client <u>met</u> original share of cost. Share of cost should be <u>lower</u> . Client requests adjustment of future share-of-cost amounts.	X	X		X
2. Client <u>did not meet</u> original share of cost. Share of cost should be <u>lower</u> . Client requests adjustment of share-of-cost amount.	X	X		X
3. Client <u>met</u> original share of cost. Share of cost should have been <u>zero</u> . Provider(s) billed Medi-Cal. Client requests reimbursement from provider.	X		X	X

ADJUSTMENTS OF SHARE OF COST
AND PROVIDER REIMBURSEMENT

Summary Chart

[EB-8]

Case Situation	Case Processing				
	Prepare new 176 for case file and/or BRU	Prepare 177 for provider completion	Give "Share of Cost Medi-Cal Provider Letter" form MC 1054 to provider	Send 177/176 to BRU	County or BRU preparation of Medi-Cal ID card
4. Client <u>met</u> original share of cost. Share of cost should have been lower. Provider(s) <u>billed</u> Medi-Cal. Client requests reimbursement from provider.	X	X	X	X	
5. Client <u>met</u> original share of cost. Share of cost should have been lower. Provider(s) <u>did not bill</u> Medi-Cal. Client requests reimbursement from provider.	X	X	X	X	X (POE labels only)
6. Client <u>met</u> original share of cost. Share of cost should have been zero. Provider(s) did not bill Medi-Cal. Client requests reimbursement from provider.	X		X	X	X (POE labels only)

RE-OF-COST MEDI-CAL PROVIDER LETTER

•
•
•
•
•

•
•
•
•
•

(Provider Address)

(County Address)

RE: _____

The individual(s) shown above had been determined eligible for Medi-Cal for the period(s) of _____ with a quarterly share of cost of _____. Upon review, it has been determined that the share of cost for the month(s) indicated should have been only _____. Accordingly, the beneficiary is due a reimbursement of the difference between the share-of-cost amount paid to you and the recomputed share of cost. This amount must be passed along to the beneficiary by the provider in accordance with California Administrative Code, Title 22, Section 51471.1. The following information is to assist you in making the required reimbursement.

If the beneficiary actually paid the original share-of-cost amount to you and you billed Medi-Cal for the balance of the charges, you may be eligible to receive an adjustment from the Medi-Cal fiscal intermediary. Once you have billed the program, you are obligated to pay the beneficiary the excess share-of-cost amount previously paid to you.

If the beneficiary actually paid the original share-of-cost amount to you, and you did not bill the program because the charges equaled the original share-of-cost amount, you may now bill the program for the difference between your usual fee and the recomputed share of cost. Again, you are obligated to pay the beneficiary the excess share-of-cost amount previously paid to you.

If the beneficiary has not paid, but obligated to pay the original share of cost, the new adjusted amount should be used to reduce the obligation.

If you were unable to bill the program because the beneficiary has not paid or obligated the full amount of the original share of cost, you may now do so by submitting this form and a claim with a Medi-Cal label to the Medi-Cal fiscal intermediary.

The items checked below must be accomplished in order to complete the reimbursement process.

- Complete the MC 177S based on the revised share-of-cost amount. If the beneficiary meets the recomputed share of cost, he/she will be issued a Medi-Cal card. Any outstanding balance may be billed to Medi-Cal.
- It is not necessary for you to rebill the Medi-Cal program for the services listed on the MC 177S. An adjustment to your previous claim will be made by the Department of Health Services.
- It will be necessary for you to bill the Medi-Cal program. You must attach this form letter to your claim. The beneficiary listed above is responsible for presenting you with a Medi-Cal identification card or label to attach to your claim. If you are billing the Medi-Cal program and you rendered a service requiring a MEDI label or "prior authorization", this form, along with the Medi-Cal identification card (POE) label attached to your claim, will allow the fiscal intermediary to process the claim without those items.

Eligibility Worker's Signature

Eligibility Worker's Phone Number

12D - PROCESSING CASES WHEN AN INCREASE
IN SHARE OF COST IS DETERMINED

A. Background

The following procedures describe how cases should be processed when the county determines an increase in share of cost is necessary. These procedures must be followed to ensure proper Medi-Cal certification and state claims processing.

B. Case Situations

Case Situation 1 -- Client was determined eligible for July, August, and September without a share of cost. On August 5, client became employed. A recomputation indicates a share of cost should be established for the quarter. The county is able to send proper notice of action increasing the share of cost for the July through September period.

Case Processing Steps

- a. The county shall compute the July through September share-of-cost amount and revise the MC 176M for the case file. The change in income is reflected for September only as a ten-day notice must be given.
- b. The county shall prepare an MC 177S showing the share of cost for September. Since the client received cards for July and August, only September expenses should be applied toward share of cost.
- c. The client should have his/her providers complete the MC 177S.
- d. Upon completion of the MC 177S by the provider, the client must sign and return the form to the county.
- e. The county will forward the MC 177S to the Department's Benefits Review Unit (BRU) for certification and Medi-Cal card issuance.

Case Situation 2 -- Client is determined to have a share of cost for June, July, and August of \$300. Client meets the \$300 share of cost on June 5, and has been certified. On June 25, the county receives information that will increase the share of cost. The county is able to recompute the share of cost and send proper notification to the beneficiary, increasing the share of cost to \$500 effective August 1.

Case Processing Steps

- a. Recompute the share of cost for June, July, and August. The change in income is reflected for August only as a ten-day notice must be given.

- b. Contact BRU as described in c below.
- c. Prepare a supplemental MC 177S for August only showing the share of cost as \$200 (difference between old and new recomputed share of cost).
- d. The client should have his/her providers complete the MC 177S.
- e. Upon completion by the provider, the client must sign and return the form to the county.
- f. The county will forward the MC 177S to the Department's BRU for certification of the remaining month in the period and issue a Medi-Cal card.

The above case processing will also apply if an increase is made in the second month of the share-of-cost period.

Case Situation 3 -- Client is determined to have a share of cost for June, July, and August of \$300. On June 25, the county receives information that will increase the share of cost. Client has not met the original share of cost. The county is able to recompute the share of cost and send proper notification to the beneficiary increasing the share of cost to \$500 for the quarter.

Case Processing Steps

- a. Recompute the share of cost for June, July, and August. The change in income is reflected for August only as a ten-day notice must be given.
- b. Prepare a new MC 177S or revise the original (if available) showing the recomputed share of cost.
- c. The client should have his/her providers complete the MC 177S.
- d. Upon completion by the provider, the client must sign and return the form to the county.
- e. The county will forward the MC 177S to the Department's BRU for certification and card issuance.

C. Code-a-Phone Procedures -- Reporting Increases in Share-of-Cost Amounts

When the county welfare department submits the share-of-cost form MC 177 to BRU, BRU will certify the case and produce all cards for the share-of-cost period. Prior and current month Medi-Cal cards will be mailed to the beneficiary; however, future month cards will be held by BRU and mailed just prior to the first of the valid month.

As described in the case situations above, if an increase in share of cost can be made for a future month, the county must notify BRU immediately so that the future month(s) card(s) can be held. The beneficiary will not be entitled to Medi-Cal card(s) until such time as he/she has met the increased share of cost and been certified by the county or State.

To place a hold on a future month card, the county shall, immediately upon recomputation of the share of cost, call the toll free code-a-phone number (916) _____ and report the following:

- a. Case Name -- this should be the name appearing in the address portion on the MC 177. Spell out the last name of the case name.
- b. Complete beneficiaries' ID number(s) -- this must be the complete 14-digit ID number, i.e., county code (two digits), aid code (two digits), serial number (seven digits), Family Budget Unit (one digit), and person number (two digits).
- c. Indicate month(s) for which Medi-Cal card(s) should be held.
- d. Indicate name and telephone number (including area code) of person calling.

BRU will remove the "held" Medi-Cal cards from the pending file and await receipt of the revised MC 177. Upon receipt and certification, BRU will generate a new Medi-Cal card(s) and release the appropriate card(s) to the beneficiary. "Hold" cards will be destroyed.

D. Submitting Supplemental MC 177 Forms to BRU

For individuals who have met their original share of cost and have been issued a supplemental MC 177 because of an increase in share of cost, the county shall:

1. Contact BRU as indicated in Section C.
2. Indicate on the top of the MC 177 "SUPPLEMENTAL INCREASED SOC" and forward to BRU.

Upon receipt by BRU of the Supplemental MC 177, BRU will certify the remaining month(s) in the quarter and issue the Medi-Cal card(s).

All other forms shall be forwarded to BRU as described in the Medi-Cal Eligibility Manual.

14A - COUNTY ISSUANCE OF MEDI-CAL IDENTIFICATION CARD,
MC 301 AND MC 301 RED

These procedures are to be used only when a Medi-Cal card is to be manually issued.

1. Obtaining Blank Identification Cards (MC 301 and MC 301 RED)

Blank temporary Medi-Cal cards, MC 301 and MC 301 RED, may be ordered by the counties as needed by submitting forms request MC 1 (or HCS 1) to:

Department of Health Services
Warehouse
1723 20th Street
Sacramento, CA 95814

When ordering MC 301 RED temporary Medi-Cal cards, counties must underline the word "RED" on the order so Department of Health Services (DHS) will not confuse the order with the MC 301 green Medi-Cal ID card stock.

2. Authorizing Issuance of MC 301 and MC 301 RED

- a. Both MC 301 and MC 301 RED with MEDI and POE labels may be issued to beneficiaries in accordance with Section 50739. MC 301 REDs are issued to those persons with limited or expanded service status, i.e., persons enrolled in a pilot project or noncomprehensive prepaid health plan (PHP), eligible to receive minor consent services only, or whose ability to obtain drug services or office visits has been restricted (see Articles 19A and 19C for details). The office visit restriction program is currently operating in Contra Costa, Orange, Riverside, and San Bernardino Counties. Other counties will be periodically added to the program as can be accommodated.
- b. Prior to authorizing issuance of an MC 301 or MC 301 RED, the Medi-Cal Limited Services Status Register must be checked to determine whether the beneficiary is enrolled in a PHP, or on restricted drug status. Restricted office visit status cannot be verified by the limited services status register at this time. In the interim, those counties where the office restriction program is operating, will be notified of each beneficiary who is put on restricted office visit status and will be responsible for maintaining the information such that only restricted Medi-Cal cards are issued.
- c. If a resident of another county requests a Medi-Cal card, the card or labels should not be issued until the county of residence is contacted to ensure that the person is eligible and to determine whether the person should receive a limited or expanded service

Medi-Cal card or no Medi-Cal card due to enrollment in a comprehensive PHP.

- d. When an MC 301 or MC 301 RED is being issued to a resident of another county, use beneficiary identification number, including the county code assigned by the county of residence.

The county department may also issue, or request that the Department issue, current or past month Medi-Cal cards with POE labels only to any provider who provided a service to a beneficiary who is now deceased.

3. Preparation of Medi-Cal Card (MC 301 and MC 301 RED)

The MC 301 and MC 301 RED (full complement or POEs only) prepared by the county department must include all the information specified below. Required information must be typed without errors or corrections of any kind. Cards or labels with errors must be voided. Provider claims will be rejected by the Medi-Cal fiscal intermediary if they are accompanied by MC 301 or MC 301 RED cards or labels that have errors or corrections.

- a. MC 301 and MC 301 RED Schematic.

2180741

MEDI-CAL IDENTIFICATION CARD

THE PERSON NAMED ON THIS CARD IS ELIGIBLE TO RECEIVE BENEFITS UNDER MEDI-CAL PROVIDED THAT BENEFITS UNDER OTHER COVERAGE INCLUDING MEDICARE ARE USED FIRST

Kaiser Health Plan
SSA# 012-34-4578
3-27-70

For Dental Services Only
19-37-0000012-0-03**0
Young Sample
0000 'J' Street
Sacramento, CA 95814

- SAFEGUARD THIS CARD -
LOSS WILL RESULT IN DELAYS
WHEN YOU NEED MEDICAL ATTENTION

YOUNG SAMPLE
1937-0000012-003
0178 0 *70F
NL7 P81 CRT010178

YOUNG SAMPLE
1937-0000012-003
0178 0 *70F
NL7 P81 CRT010178

PROVIDER OF SERVICE

REMOVE APPROPRIATE LABEL AND ATTACH TO YOUR CLAIM

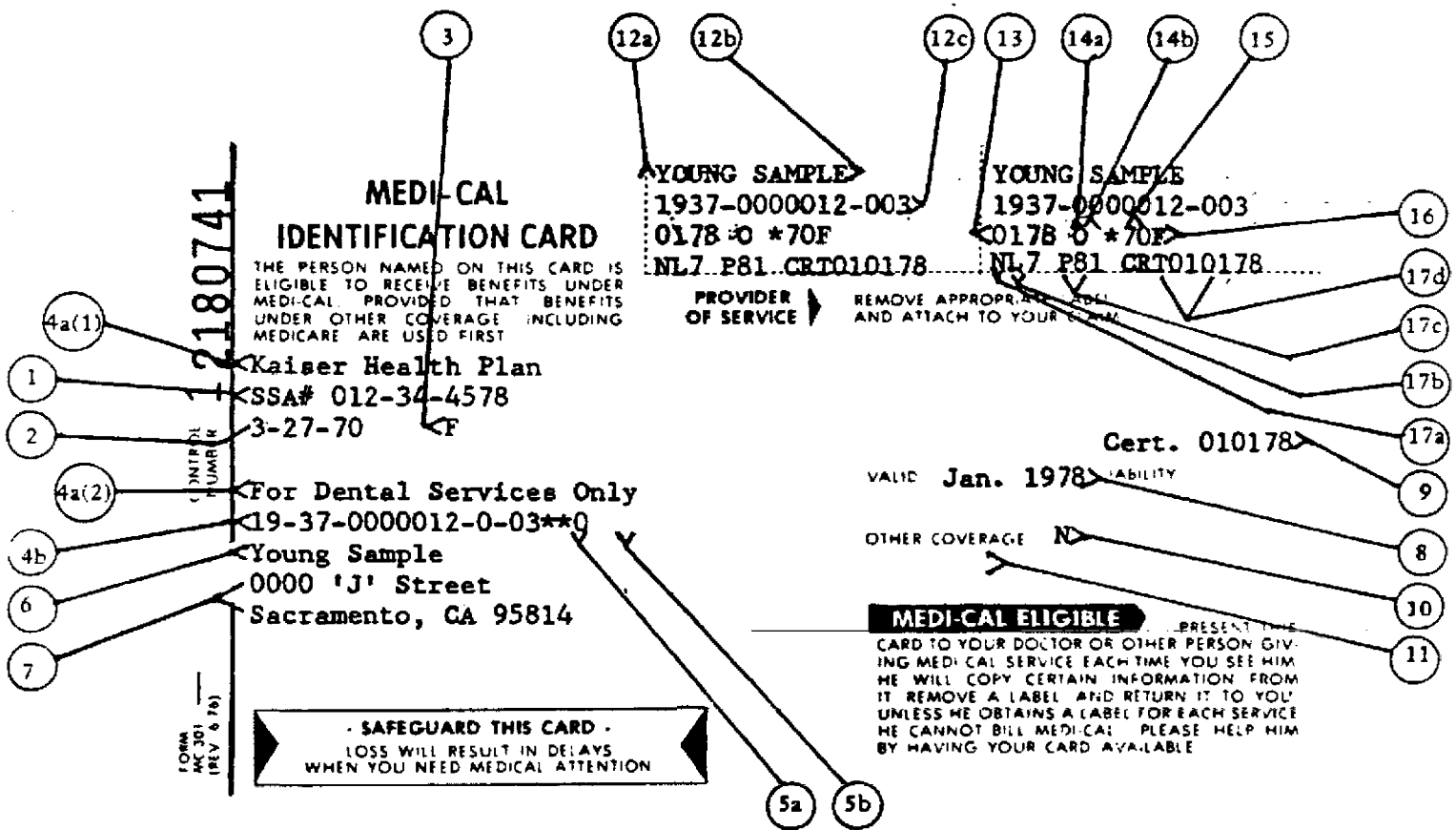
Cert. 010178

VALID Jan. 1978

OTHER COVERAGE

MEDI-CAL ELIGIBLE

PRESENT THIS CARD TO YOUR DOCTOR OR OTHER PERSON GIVING MEDICAL SERVICE EACH TIME YOU SEE HIM. HE WILL COPY CERTAIN INFORMATION FROM IT. REMOVE A LABEL AND RETURN IT TO YOU. UNLESS HE OBTAINS A LABEL FOR EACH SERVICE HE CANNOT BILL MEDI-CAL. PLEASE HELP HIM BY HAVING YOUR CARD AVAILABLE.



b. MC 301 Schematic Explanation

Basic Section

<u>Item #</u>	<u>Description</u>												
1	The beneficiary's HIC# (Health Insurance Claim number) or RR# (Railroad Retirement number). If no HIC# or RR#, then enter the Social Security number. Otherwise, leave blank.												
2	Beneficiary's date of birth.												
3	Sex of recipient: "M" or "F".												
4a (1)	Only for PHP and pilot project enrollees. Insert message as indicated in c (1).												
4a (2)	Only for limited or expanded services beneficiaries. Insert message as indicated in c (1), (2), and (3).												
4b	<table><tbody><tr><td>Beneficiary's Medi-Cal ID #:</td><td>SSI/SSP Recipients:</td></tr><tr><td>County (2 digits)</td><td>County (2 digits)</td></tr><tr><td>Aid (2 digits)</td><td>Aid (2 digits)</td></tr><tr><td>Serial # (7 digits)</td><td>Constant 9</td></tr><tr><td>FBU or MFBU (1 digit)</td><td>Serial (9-digit Social Security Number)</td></tr><tr><td>Persons # (2 digits)</td><td></td></tr></tbody></table>	Beneficiary's Medi-Cal ID #:	SSI/SSP Recipients:	County (2 digits)	County (2 digits)	Aid (2 digits)	Aid (2 digits)	Serial # (7 digits)	Constant 9	FBU or MFBU (1 digit)	Serial (9-digit Social Security Number)	Persons # (2 digits)	
Beneficiary's Medi-Cal ID #:	SSI/SSP Recipients:												
County (2 digits)	County (2 digits)												
Aid (2 digits)	Aid (2 digits)												
Serial # (7 digits)	Constant 9												
FBU or MFBU (1 digit)	Serial (9-digit Social Security Number)												
Persons # (2 digits)													
5a	Pre/Post Indicator: "0", "1", or "2". 0 = Routine Medi-Cal Eligibility. 1 = Three-Month Retroactive Eligibility. 2 = AFDC Three-Month Continuing Eligibility.												
5b	County use area; precede with asterisks.												
6	Beneficiary name.												
7	Beneficiary address area: include "C/O (addressee name)" if needed. In those instances where the county department has been instructed not to include a beneficiary home address (see Sections 16D 6. and 19B 2.a.), the county department address may be substituted here.												

<u>Item #</u>	<u>Description</u>
8	Valid month of card. Type "RETRO" above if valid month is before current month. (See 14A.9 for definition of "Retro".)
9	Dollar amount of share of cost for LTC patients only. Certification date for persons who met a share of cost. Refer to Article 12B for proper certification date to be entered for month in question.
10	Other coverage. (see Article 15A)

Label Section

<u>Item #</u>	<u>Description</u>
12a	Medicare Status: "2*" shows Medicare entitlement; "Ø*" shows lack of Medicare entitlement. (Note: Ø means blank space.)
12b	Beneficiary Name: normal sequence, or last name first or abbreviated (as needed) to still uniquely identify person as much as possible.
12c	Beneficiary ID.
13	Valid month of card. Precede with "R" or "1" if card is "retro" card. (See 14A.9 for definition of "Retro".)
14	Pre/Post Indicator: "0", "1", or "2". (see 5a)
15	Year of beneficiary birth; last two digits only.
16	Sex of beneficiary.
17a	Other Coverage Code. (see Article 15A)

<u>Item #</u>	<u>Description</u>
17b	Only for limited or expanded services beneficiaries. See c (2), (3), and (4) below for proper codes.
17c	Only for Pilot Project/PHP codes. See c (1) below for codes.
17d	Dollar amount of share of cost for persons in LTC. Certification date for persons who have met a share of cost. This is a multi-use field. If applicable, this field should be coded as follows: <ol style="list-style-type: none"> (1) With the dollars amount of share of cost for persons in LTC. (2) With the certification date for persons who have met a share of cost. (Refer to Article 12B for proper certification date to be entered for the month in question). (3) With the word "Restricted" if the beneficiary's Medi-Cal coverage is restricted under the programs in Articles 19A and 19C.

c. Special Coding for MC 301 RED Medi-Cal Cards

(1) PHP/Pilot Projects

<u>County</u>	<u>Plan/Project Name</u> (Item 4a(1) on MC 301 Schematic)	<u>Plan Number</u> (Item 17c on MC 301 Schematic)	<u>Restricted Message</u> (Item 4a(2) on MC 301 Schematic)
Los Angeles	Kaiser Health Plan	P28	For dental services only
	Family Health Services	P33	For dental services only
Orange	Kaiser Health Plan	P76	For dental services only
	Family Health Services	P83	For dental services only
Placer	Health Care	P88	For dental services only
Riverside	Family Health Services	P34	For dental services only
	Kaiser Health Plan	P77	For dental services only

<u>County</u>	<u>Plan/Project Name</u>	<u>Plan Number</u>	<u>Restricted Message</u>
	(Item 4a(1) on MC 301 Schematic)	(Item 17c on MC 301 Schematic)	(Item 4a(2) on MC 301 Schematic)
	Riverside Community Health Plan	P95	
Sacramento	Health Care	P86	For dental services only
San Bernardino	Family Health Services	P60	For dental services only
	Kaiser Health Services	P78	For dental services only
San Diego	Protective Health Services	P04	For dental services only
	Kaiser Health Plan	P79	For dental services only
San Francisco	On-Lok Senior Health Services	P75	
	Kaiser Health Plan	P90	For dental services only
Yolo	Health Care	P89	For dental services only
Lake, Sonoma, Mendocino	Redwood Health Project	PP3	

(2) Minor Consent Services

<u>Services Related to:</u>	<u>Special Coding</u>	<u>Restriction Message</u>
	(Item 17b on MC 301 Schematic)	(Item 4a(2) on MC 301 Schematic)
Sexual Assault	16	LIMITED SERVICES ONLY
Drug or Alcohol Abuse (at least 12 years of age)	L7	LIMITED SERVICES ONLY
Pregnancy, or Family Planning (other than for pregnant minors)	L8	LIMITED SERVICES ONLY
Venereal Disease (at Least 12 years of age)	L9	LIMITED SERVICES ONLY

If the minor is applying for services related to more than one of the areas listed, use the code for the service that is listed first. -

(3) Restricted Services

<u>Services</u>	<u>Special Coding</u>	<u>Restriction Message</u>
	(Item 17b on MC 301 Schematic)	(Item 4a(2) on MC 301 Schematic)
Individuals on restricted service status	R1 R5 R11	RESTRICTED DRUGS RESTRICTED SCHED. DRUGS RESTRICTED M.D. VISITS

4. Recording and Reporting the Issuance of MC 301 and MC 301 RED Medi-Cal Cards

- a. For eligible persons requesting an immediate need card, counties shall issue a "Full Complement" or "POE" only card. For all persons except those meeting their share of cost via the MC 177 process, the county shall then request state card issuance via the Central Issuance Division (CID) supplementary process.

For persons meeting their share of cost via the MC 177 process, the county must forward the MC 177 to Benefits Review Unit (BRU) within seven days from county card generation.

Although counties will still have to monitor and control card stock, counties will not have to manually prepare the HAS 2007, Temporary Medi-Cal Card Control Log, for those new or restored eligibles.

- b. In lieu of process a., counties able to do so should submit county card issuance log data via magnetic tapes. Counties which computer generate cards must submit log data via the magnetic tape process. This tape reduces the Department's key entry workload and relieves the counties from manual preparation of the HAS 2007. It gives the Department more timely data in order to update the fiscal intermediaries Recipient Eligibility History File (REHF). This file is used to verify eligibility prior to provider claims payment.
- c. Those counties who do not have the capabilities of preparing CID supplemental files or magnetic tapes must continue to use the HAS 2007 to report MC 301 issuance. Counties shall complete form HAS 2007 by following the detailed instructions contained in the "FORMS" section of the Medi-Cal Eligibility Manual.

5. Voiding MC 301s and MC 301 REDS

If it is found that an MC 301/301 RED should not have been prepared or was incorrectly prepared, the corresponding entry on the control log should be lined out and the MC 301/301 RED temporary card destroyed. Only if the log is no longer available for correction should the card be marked "VOID" and forwarded to DHS. Voiding should not obscure either the recipient ID number or the valid month shown on the card.

6. Summary Reporting

For those counties using the HAS 2007 to report MC 301 card issuance, each month those counties shall submit an "MC 301 Issuance Report" (MC 402) to the Department by the seventh working day of the month following the month for which the county is reporting. The form should be sent to Department of Health Services, Data Processing Control Unit, 744 P Street, Sacramento, CA 95814. The MC 402 summary sheets will be used to monitor MC 301 card stock and to check for losses in mail delivery. The beginning and remaining stock counts verify receipt of new card stock. The monthly usage figure will be used to monitor the quantity of cards issued to ensure that sufficient card stock is available to replenish county supplies. The counts of cards issued help to assure we have received all the logs.

7. The MC 300 and MC 300 RED are used by DHS to computer print and mail Medi-Cal cards to those individuals reported eligible to receive cards by the county welfare departments, and to persons eligible for Supplemental Security Income/State Supplementary Payment (SSI/SSP) as reported to the Department by the Social Security Administration. In addition, some counties, upon Department approval, are using the MC 300 and MC 300 RED card stock to produce county issued replacement and POE only cards through the county's data processing system. The data printed on the Department issued MC 300 and MC 300 RED card stock is taken from the data supplied by the counties via the CID System, the Paper County Process (MC 208 input), and by the Social Security Administration via the State Data Exchange (SDX) process. Department issued cards for share-of-cost beneficiaries meeting their share of cost through the MC 177 (Record of Health Care Costs) process is based on the information provided by the county on the MC 177. Data regarding PHP, Pilot Project, Restricted Services, Expanded Services, or Medicare status are obtained from various other sources. For example, applicable PHP or Pilot Project information is extracted and printed on the cards from the enrollment reports received from the PHPs and Pilot Projects by the Department.

8. Following is a schematic drawing of the Department issued MC 300 Medi-Cal card.

Below is a schematic drawing of the MC 300 and MC 300 RED.

MEDICAL IDENTIFICATION

--- AN APPROPRIATE LABEL ON A PROTECTIVE COPY OF THIS CARD MUST ACCOMPANY EACH CLAIM ---

<p>RETROACTIVE INDICATOR</p> <p>MONTH AND YEAR OF ELIGIBILITY</p> <p>DATE OF BIRTH</p> <p>CENTURY INDICATOR</p> <p>BENEFICIARY SEX</p>	<p>RETRO: JUN 80 11/04/948 M</p> <p>MEDICARE# 923456789A 2</p> <p>REDWOOD HEALTH PILOT PROJECT</p> <p>19-30-1111147-3-03-9</p> <p>FIRSTNAME LASTNAME</p> <p>C/O NAME</p> <p>0084 BLANK COURT LOS ANGELES CA 34578</p> <p>MEDSID 923456789 -----*12 123A</p> <p>SOC: S O/C: N 19301111147303908A</p> <p>MC300 C/8 791</p>	<p>LASTNAME FIRS9 19301111147303 20680M48MNP3</p> <p>LASTNAME FIRS9 19301111147303 20680M48MNP3</p> <p>LASTNAME FIRS9 19301111147303 20680P48MNP3</p> <p>LASTNAME FIRS9 19301111147303 20680P48MNP3</p> <p>LASTNAME FIRS9 19301111147303 20680P48MNP3</p>
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UIC #
SS NUMBER

PILOT PROJECT NAME

BENEFICIARY ID NUMBER

BENEFICIARY NAME

BENEFICIARY ADDRESS

COUNTY CODING

SHARE OF COST

STATE CODING

OTHER COVERAGE CODE

BENEFICIARY NAME

BENEFICIARY ID NUMBER

MEDICARE STATUS
B: ARE MEANS
NON ENTITLEMENT

VALID MONTH | BENEFICIARY YEAR OF BIRTH
YEAR OF BIRTH

PILOT PROJECT CODE

TYPE OF LABEL | SEX
OTHER COVERAGE

THE PERSON NAMED ON THIS CARD IS ELIGIBLE TO RECEIVE BENEFITS UNDER MEDICAL. THE PROGRAM REQUIRES THAT PRO-THURS BILL CHAMPUS RAISED, AND LOSS LOS BEFORE MEDICAL CAN BE BILLED PROVIDERS ARE ENCOURAGED TO BILL ALL OTHER HEALTH COVERAGE CARRIERS DIRECTLY.

9. Retroactive Coding

Cards issued by the county for past months of eligibility when an original card was issued during the month of eligibility shall not be coded "Retro". The "Retro" indicator shall be used only in the following situations:

- a. When cards are being issued for retroactive months of eligibility as defined under California Administrative Code (CAC), Title 22, Section 50710.
- b. When cards are being issued for prior months eligibility when the eligibility determination or the report of eligibility to the State for a card issuance was delayed beyond the month of eligibility.
- c. When the share-of-cost certification of eligibility does not occur until after the month of eligibility.
- d. When full complement or proof of eligibility (POE) only replacement cards are being issued for cards originally issued under the circumstance noted in a-c above.

10. Returned Medi-Cal Cards

The purpose of returning cards to the State is to remove the previously reported eligibility data from the State's Eligibility History File (EHF). Therefore, counties should return only those Medi-Cal cards where eligibility was properly discontinued and the individual was not entitled to Medi-Cal benefits.

Changes in identification information, i.e., address, name, should be reported correctly the following month via the normal eligibility data processing. All other cards should be destroyed at the county welfare department.

STATEMENT OF COST DETERMINATION – MFBUs WHICH DO NOT INCLUDE LTC PERSONS

Name				County District	County Use		
<input type="checkbox"/> Application <input type="checkbox"/> Redetermination <input type="checkbox"/> Change <input type="checkbox"/> Retroactive Elig. <input type="checkbox"/> Correction				Effective Eligibility Date for this Budget			
				Mo.	Yr.		
State Number			Name – First, Middle, Last	Birthdate Mo. Day Yr.	Sex	(1) Social Security No. and (2) Health Insurance Claim No. or Railroad Retirement No.	Other Coverage
Aid	7 Digit Serial No.	MFBU No.					
						(1)	
						(2)	
						(1)	
						(2)	
						(1)	
						(2)	
						(1)	
						(2)	
						(1)	
						(2)	

I. Income of MFBUs applying as ABD plus income of spouse or parent (except PA or other PA)
 II. Income of MFBUs not listed in I. (except PA or other PA)

NONEXEMPT UNEARNED INCOME						
	Month 1		Month 2		Month 3	
	a. ABD-MN	b. Spouse or Parent	a. ABD-MN	b. Spouse or Parent	a. ABD-MN	b. Spouse or Parent
1. Social Security						
2. Net Income from Property						
3. Other—Itemize						
4. Total (add 1 thru 4)						
5. Deductions						
6. Remainder (5 minus 5)	a.	b.	a.	b.	a.	b.
7. Combined unearned income (add 7a and 7b)						
8. Any income deduction	-\$20		-\$20		-\$20	
9. Countable unearned income (8 minus 9)						

A. NONEXEMPT UNEARNED INCOME			
	Month 1	Month 2	Month 3
1. Social Security			
2. Net Income from property			
3. Other—Itemize			
4.			
5. Total unearned income (add 1 thru 4)			
6. Deductions			
7. Countable unearned income (5 minus 6)			

B. NONEXEMPT EARNED INCOME						
	Month 1		Month 2		Month 3	
	a. ABD-MN	b. Spouse or Parent	a. ABD-MN	b. Spouse or Parent	a. ABD-MN	b. Spouse or Parent
11. Gross Earned Income						
12. Deductions						
13. Remainder (11 minus 12)	a.	b.	a.	b.	a.	b.
14. Combined earned income (add 13a & 13b)						
15. \$65 earned inc. deduction plus \$ unused \$20 remainder (14 minus 15)						
16. Countable earned income (divide 16 by 2)						

B. NONEXEMPT EARNED INCOME			
	Month 1	Month 2	Month 3
8. Gross earned income			
9a. If CG in last 4 mos, enter \$30			
9b. 1/3 remainder			
10.			
11.			
12. Total deduct. (add 9, 10, & 11)			
13. Countable earned income			

C. TOTAL COUNTABLE INCOME			
	Month 1	Month 2	Month 3
14. Subtotal (add 7 and 13)			
15. Child support/alimony			
16. Total countable income			

				Case Name:	
	Month 1	Month 2	Month 3		
1. Countable Income from I 18					
2. Countable Income from II 18					
c. allocated from LTC/B&C person to family members at home (176W, Part IV)					
4. Combined countable Income (add 1, 2, and 3)					
ALLOCATIONS AND DEDUCTIONS					
5. Allocation to excluded children (176W, Part I)					
6. Special deduction (176W, Part II)					
7. Income to determine PA Eligibility					
8. Health Insurance					
9.					
10.					
11. Total allocations/deductions (add 5 through 10)					
12. Total net nonexempt income (4 minus 11)				SHARE OF COST	
13. Total net nonexempt income rounded				13a. Total of Mos 1, 2, and 3	
14. Maintenance need				14a. Total of Mos. 1, 2, and 3	
				15. Share of cost (13a. minus 14a.)	
				16. Underpayment adjustment	
				17. Adjusted Share of Cost (15 minus 16)	

XEMPT INCOME

V. EXPLANATION OF CHANGES WITHIN SOC PERIOD

Eligibility Worker Signature	Worker Number	Computation Date	County Use
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INSTRUCTIONS
SHARE OF COST DETERMINATION, MFBUs WHICH DO NOT INCLUDE
LTC PERSONS
FORM MC 176-M

Form MC 176-M, Share of Cost Determination, is used to complete the share of cost for all MFBUs which do not include a person in LTC. This form is completed at the time of new application, restoration, reapplication, change affecting the share of cost, or correction in the three-month retroactive period. The share of cost period is determined in accordance with Title 22, Section 50652.

Instructions for Completion

Identification Section

1. Enter Case Name.
2. County District. If the county has districts, identify the district.
3. County Use. Make any entries the county department has designated it wants, such as caseload numbers for automatic sorting and return. Coding for this space is worked out with the Center for Health Statistics, Department of Health Services.
4. Check the appropriate box which gives information concerning the reason for the computation. The box "new application" includes restorations and reapplications.
5. Effective Eligibility Date for this Budget. Enter the months in the share-of-cost period for which this budget is computed.
6. State Number. For family members who are applying as MN or MI, and included in the Medi-Cal Family Budget Unit (MFBU), enter the county code, appropriate aid code, seven-digit number, MFBU number, and the persons number. If the county does not use a seven digit serial number, enter zeros in front of the serial number until there are seven digits. For the family members who are not included in the MFBU, enter their status under state number, in accordance with the following:

PA-----For Public Assistance Recipients.

Other PA-----For Other Public Assistance Recipients except Four Month Continuing.

Four Mo. Cont.--For family members eligible for Four Month Continuing Eligibility.

Excluded-----For children with income or property of their own excluded from the MFBU.

I.E.-----For members of the MFBU who are ineligible to receive a Medi-Cal card.

S/F-----For family members in the stepparent unit when only the parent and the parent's children are included in the MFBU.

Title II Disregard Member---For aged, blind, or disabled family members who were discontinued from SSI/SSP and continue to receive a no-cost Medi-Cal card in accordance with Title 22, Section 50564.

ABD/LTC-----For an aged, blind, or disabled person or the spouse of
or
ABD/B&C an aged, blind, or disabled person who is in LTC or board and care who will be in a separate MFBU from his/her spouse and/or children listed on this MC 176-M.

7. Under name, enter the names of all family members living in the home in accordance with Title 22, Section 50071, and any aged, blind, or disabled person or spouse of an aged, blind, or disabled person in LTC. Enter an unborn child by listing as the name "unborn" and expected month of birth after "unborn".
8. Enter the birth date of each person listed. Under sex, enter "M" for male and "F" for female for each person listed.
9. Enter the Social Security number after (1) for each person applying as MN or MI. If a person does not have a Social Security number, he/she must apply for one. If application has been made for the Social Security number, enter "applied". If a person refuses to apply for a Social Security number, the person would not be eligible for Medi-Cal and would be an ineligible member of the MFBU in accordance with Title 22, Section 50379. Enter the Medicare or Railroad Retirement claim number, if any, after (2). See Title 22, Section 50187.
10. Other Coverage Code. Determine the other coverage code in accordance with Section 15A of the procedural portion of the Medi-Cal Eligibility Manual.

Column I -- Income of MFBU Members Applying as Aged, Blind, or Disabled Plus Income of Spouse or Parent

In this column enter all the nonexempt unearned and earned income of all the family members who are applying as aged, blind, or disabled in (a), and the nonexempt unearned and earned income of their spouse or parent(s) in (b). Do not consider the income of family members who are PA or Other PA (except Four Month Continuing). Do not consider income of family members who are not considered living in the home in accordance with Title 22, Section 50071. Do not list income which is exempt in accordance with Title 22, Sections 50523 through 50544.

Nonexempt Unearned Income

If the countable unearned income is the same for all of the months within the share-of-cost period, itemize the income in month one only (lines 1 through 8). Enter the amount from month 1, line 10 on line(s) 10 for the remaining month(s). If the countable unearned income is not the same for all of the months, complete lines 1 through 8 for each month within the period. (see note ~~below~~ on next page).

1. Enter the Social Security income.
2. Enter the net income received from property.
- 3-4. Enter the amount of all other unearned income. If applicable, include SSI/SSP recipient's available income and stepparent contribution from MC 176-W, Part III and Part V.
5. Add the amounts in Column I, Part A, lines 1a, 2a, 3a, and 4a. This is the total unearned income of the aged, blind, or disabled family members. Add the amounts in Column I, Part A, lines 1b, 2b, 3b, and 4b. This is the total unearned income of the spouse or parent(s) of the aged, blind, or disabled family members.
6. Enter the total deductions specified in Title 22, Sections 50547 and 50549.1. Enter the deductions applicable to the separate income of the aged, blind, or disabled family members in 6a. Enter the deductions applicable to the separate income of the spouse or parent(s) in 6b.
7. Subtract line 6a from line 5a. Subtract line 6b from line 5b.
8. Add lines 7a and 7b. This is the combined unearned income of the aged, blind, or disabled family members and their spouse or parent(s).
9. No entry. This line shows the \$20 any income deduction.
10. Subtract line 9 from line 8. This is the countable unearned income. If the countable unearned income is a minus figure, enter zero on line 10 and enter the minus figure which is the unused portion of the \$20 any income deduction in the blank provided on line 15.

Nonexempt Earned Income

If the countable earned income is the same for all of the months within the share-of-cost period, itemize the income in month one only (lines 11 through 16). Enter the amount from month 1, line 17 on line(s) 17 for the remaining month(s). If the countable earned income is not the same for all of the months, complete lines 11 through 16 for each month within the period. (see note ~~below~~ on next page).

Note: If both the unearned and earned income is the same for all months within the share-of-cost period, complete lines 1 through 17 for month one only. Enter the amount from month 1, line 18 on line(s) 18 for the remaining month(s).

11. Enter the gross earned income.
12. Enter the total deductions specified in Title 22, Sections 50551 and 50551.1. Enter the deductions applicable to the separate income of the aged, blind, or disabled family members in 12a. Enter the deductions applicable to the separate income of the spouse or parent(s) in 12b. Include the \$30 plus 1/3 deduction if appropriate.
13. Subtract line 12a from line 11a. Subtract line 12b from line 11b.
14. Add lines 13a and 13b. This is the combined earned income of the aged, blind, or disabled family members and their spouse or parent(s).
15. Enter the \$65 of the \$65 and 1/2 deduction plus any unused portion of the \$20 any income deduction here.
16. Subtract line 15 from line 14. If line 15 is greater than line 14, enter zero.
17. Divide line 16 by 2. This figure equals the countable earned income.
18. Add lines 16 and 17. This is the total countable income of the aged, blind, or disabled members of the MFBU plus their spouse or parent(s). Enter this amount here and in Column III, line 1 for each month in the share-of-cost period.

Column II -- Income of MFBU Members or Persons Responsible for the MFBU Not Listed in I

In this column enter the nonexempt income of all other members of the MFBU or persons responsible for members of the MFBU whose income was not considered in Column I. Do not list the income of family members who are PA or Other PA (except Four Month Continuing). (Do not include the income of excluded children.) Do not list income which is exempt in accordance with Title 22, Sections 50523 through 50544.

Nonexempt Unearned Income

If the countable unearned income is the same for all of the months within the share-of-cost period, itemize the income in month one only (line 1 through 6). Enter the amount from month 1, line 7 on line(s) 7 for the remaining month(s). If the countable unearned income is not the same for all of the months, complete lines 1 through 6 for each month within the period. (see note below) ON

next page

1. Enter the Social Security income.
2. Enter the net income received from property.
- 3-4. Enter the amount of all other unearned income. Include SSI/SSP recipient's available income and stepparent contribution from the MC 176-W, Part III and Part V.
5. Add the amounts in Column II, Part A, lines 1, 2, 3, and 4. This is the total unearned income.
6. Enter the total deductions applicable to the unearned income. See Title 22, Section 50547.
7. Subtract line 6 from line 5. This is the countable unearned income.

Nonexempt Earned Income

If the countable earned income is the same for all of the months within the share-of-cost period, itemize the income in month one only (lines 8 through 12). Enter the amount from month 1, line 13 on line(s) 13 for the remaining month(s). If the countable earned income is not the same for all of the months, complete lines 8 through 12 for each month within the period. (see note below)

Note: If both the unearned and earned income is the same for all months in the period, complete lines 1 through 13 for month one only. Enter the amount from month 1, line 14 on line(s) 14 for the remaining month(s).

8. Enter the combined gross earned income.
9. a. Enter the \$30, if the 30 and 1/3 deduction is appropriate. The 30 and 1/3 deduction is appropriate if the persons who earned the income were receiving an AFDC cash grant in any one of the 4 months immediately prior to the month in which the deduction will be applied and the \$30 was not applied to income listed in Column I. See Title 22, Section 50553.1.

b. If the 30 and 1/3 deduction is appropriate, enter 1/3 of the remainder of the earned income after subtracting the \$30. This is determined by dividing the remainder by three. If the \$30 was applied to income in Column I, divide the gross earnings by 3.
10. Enter the mandatory deductions that apply to the nonexempt earned income.
11. Enter the work-related expenses, including mileage, that apply to the nonexempt earned income.

12. Add lines 9a and b, 10, and 11. This is the total of the earned income deductions.
13. Subtract line 12 from line 8. This is the countable earned income.
14. Add lines 7 and 13. This is the subtotal of the countable income of the family members who are not applying as aged, blind, or disabled or their spouse or parent(s).
15. Enter any amount paid for court ordered child support or alimony or child support paid under an agreement with the district attorney.
16. Subtract line 15 from line 14 for each month in the share-of-cost period. This is the total countable income. Enter in Column III, line 2 for each month in the share-of-cost period.

Column III -- Share of Cost Computation

1. Enter the total countable income from Column I, line 18 for each month in the share-of-cost period.
2. Enter the total countable income from Column II, line 16 for each month in the share-of-cost period.
3. Enter the income allocated from the LTC or board and care person to the family members at home for each month in the share-of-cost period. This amount is computed in Part IV of the MC 176-W and is entered here when doing the share-of-cost determination for the spouse and/or children of the LTC or board and care person who are at home.
4. Add lines 1 through 3 for each month in the share-of-cost period. This is the total countable income of the MFBU.

Allocations and Deductions

If the allocations and deductions are the same for all months within the share-of-cost period, itemize the amounts in month one only (lines 5 through 8). Enter the amount from month 1, line 11 on line(s) 11 for the remaining month(s).

5. List the allocation to the children with income or property of their own who are excluded. This amount is determined in Part I of the MC 176-W.
6. List the Special Deduction for all aged, blind, and disabled members of the MFBU. This amount is computed in part II of the MC 176-W.
7. List the amount of income of the MFBU which is used to determine the eligibility of any family member who is a PA or Other PA recipient. If a family member is receiving SSI/SSP, complete Part III of the MC 176-W. If a member of the family is receiving AFDC, contact the current month's grant.

8. List any health insurance premiums paid by, and purchased for, any person in the family. This includes Medicare Buy-In premiums when actually paid by a family member.

9&10. Lines 9 and 10 are reserved for future use.

11. Add lines 5 through 8. This is the total of the final deductions and allocations for each month in the share-of-cost period.

12. Subtract line 11 from line 4 for each month in the share-of-cost period. This is the total net nonexempt income.

13. Round line 12 to the nearest dollar for each month in the share-of-cost period. This is the total net nonexempt income to be used in the share-of-cost computation.

14. Enter the maintenance need for the MFBU for each month in the share-of-cost period.

Note: The maintenance need should total the family members (including Four Month Continuing Eligibles and Title II Disregard Members) listed at the top of the MC 176-M. Do not include any person who is PA, Other PA, excluded, part of a stepparent unit, or a person in LTC or board and care who will be in a separate MFBU.

Share of Cost

13.a Add lines 13 for all months in the share-of-cost period. This is the total net nonexempt income for the period.

14.a Add lines 14 for all months in the share-of-cost period. This is the total maintenance needs for the period.

15. Subtract line 14a from line 13a. This is the share of cost.

16. Enter any underpayment adjustment determined in accordance with Title 22, Section 50567.

17. Subtract line 16 from line 15. This is the adjusted share of cost.

IV. Exempt Income

In this section list separately any income which is exempt. The income exemptions are specified in Title 22, Sections 50523 through 50544.

Explanation of Changes Within SOC Period

Briefly describe changes within SOC period.

Eligibility Worker Signature

The worker enters his/her signature.

54

Worker Number

If the eligibility worker has a county number, enter here.

Date of Computation

The eligibility worker completes this box with the date the form was completed.

County Use

Optional -- to be used in accordance with county policy.

Processing

1. The form is prepared in duplicate.
2. If there is a share of cost, attach the original MC 176-M to the MC 177 when it is completed and the share of cost has been met if it is the first time the share of cost has been met or there has been a change in the share of cost since the last time it was met. The MC 176-M and the MC 177 are then processed in accordance with departmental procedures specified in Section 124 of the procedural portion of the Medi-Cal Eligibility Manual.
3. A copy of the MC 176-M is retained in the case file.

Special Note: If form 176-M is being completed for a change occurring within a share of cost period, rather than for a change in the ongoing share of cost, only the change must be itemized. Carry over as many totals from the previous MC 176-M as possible. For the 176-M for the ongoing share of cost; itemize in accordance with the instructions above.

SHARE OF COST DETERMINATION - MN AND MI PERSONS - LTC

						County District	County Use		
<input type="checkbox"/> New Application <input type="checkbox"/> Redetermination <input type="checkbox"/> Change <input type="checkbox"/> Retroactive Elig. <input type="checkbox"/> Correction						Effective Eligibility Date for this Budget			
						Mo.	Yr.		
State Number				Name - First, Middle, Last	Birthdate		Sex	(1) Social Security No. and (2) Health Insurance Claim No. or Railroad Retirement No.	Other Coverage
No.	Aid	7 Digit Serial No.	MFBU No.		Mo.	Day			
								(1)	
								(2)	
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I. Income of MFBU members applying as aged, blind, or disabled plus income of spouse or parent (except PA or other PA)	II. Income of MFBU members not listed in I. (except PA or other PA)	III. Share of cost computation																																																															
A. NONEXEMPT UNEARNED INCOME	A. NONEXEMPT UNEARNED INCOME	1. Countable income from I 18																																																															
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			11. Income to determine PA Eligibility																																																														
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Eligibility Worker Signature/Computation Date	Worker Number	County Use
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MEDI-CAL ELIGIBILITY MANUAL

INSTRUCTIONS
SHARE OF COST DETERMINATION MFBU'S WHICH INCLUDE
A PERSON IN LONG-TERM CARE (LTC)
FORM MC 176-M-LTC

Form MC 176-M-LTC, Share of Cost Determination, is used to complete the share of cost for all Medi-Cal Family Budget Units (MFBU's) which include a person in LTC. This form is completed at the time of a new application, restoration, reapplication, change in income affecting the share of cost, or correction in the share of cost, and to determine the share of cost for any month in the three-month retroactive period.

Instructions for Completion

Identification Section

1. Enter Case Name.
2. County District. If the county has districts, identify the district.
3. County Use. Make any entries the county department has designated it wants, such as caseload numbers for automatic sorting and return. Coding for this space is worked out with the Center for Health Statistics, Department of Health Services.
4. Check the appropriate box which gives information concerning the reason for the computation. The box "new application" includes restorations and reapplications.
5. Effective Eligibility Date for this Budget. Enter the month in which eligibility will begin with this budget computation.
6. State Number. For family members who are applying as MN or MI, and included in the Medi-Cal Family Budget Unit (MFBU), enter the county code, appropriate aid code, seven-digit number, MFBU number, and the persons number. If the county does not use a seven-digit serial number, enter zeros in front of the serial number until there are seven digits. For the family members who are not included in the MFBU, enter their status under state number, in accordance with the following:

PA-----For Public Assistance Recipients.

Other PA-----For Other Public Assistance Recipients except Four Month Continuing.

Four Mo. Cont.-For family members eligible for Four Month Continuing Eligibility.

Excluded-----For children with income or property of their own excluded from the MFBU.

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I.E.-----For members of the MFBU who are ineligible to receive a Medi-Cal card.

S/P-----For family members in the stepparent unit when only the parent and the parent's children are included in the MFBU.

Title II Disregard Member---For aged, blind, or disabled family members who were discontinued from SSI/SSP and continue to receive a no-cost Medi-Cal card in accordance with Title 22, Section 50564.

ABD/LTC-----For an aged, blind, or disabled person or the spouse of
or
ABD/B&C an aged, blind, or disabled person who is in LTC or board and care who will be in a separate MFBU from his/her spouse and/or children listed on this MC 176-M-LTC.

7. Under name, enter the names of all family members living in the home in accordance with Title 22, Section 50071, and any aged, blind, or disabled person or spouse of an aged, blind, or disabled person in LTC. Enter an unborn child by listing as the name "unborn" and expected month of birth after "unborn".
8. Enter the birth date of each person listed. Under sex, enter "M" for male and "F" for female for each person listed.
9. Enter the Social Security number after (1) for each person applying as MN or MI. If a person does not have a Social Security number, he/she must apply for one. If application has been made for the Social Security number, enter "applied". If a person refuses to apply for a Social Security number, the person would not be eligible for Medi-Cal and would be an ineligible member of the MFBU in accordance with Title 22, Section 50379. Enter the Medicare or Railroad Retirement claim number, if any, after (2). See Title 22, Section 50187.
10. Other Coverage Code. Determine the other coverage code in accordance with Section 15A of the procedural portion of the Medi-Cal Eligibility Manual.

Column I -- Income of MFBU Members Applying as Aged, Blind, or Disabled Plus Income of Spouse or Parent

In this column enter all the nonexempt unearned and earned income of all the family members who are applying as aged, blind, or disabled in (a), and the nonexempt unearned and earned income of their spouse or parent(s) in (b). Do not consider the income of family members who are PA or Other PA (except Four Month Continuing). Do not consider income of family members who are not considered living in the home in accordance with Title 22, Section 50071. Do not list income which is exempt in accordance with Title 22, Sections 50523 through 50544.

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Nonexempt Unearned Income

1. Enter the Social Security income.
2. Enter the net income received from property.
- 3-4. Enter the amount of all other unearned income. If applicable, include SSI/SSP recipient's available income and stepparent contribution from MC 176-W, Part III and Part V.
5. Add the amounts in Column I, Part A, lines 1a, 2a, 3a, and 4a. This is the total unearned income of the aged, blind, or disabled family members. Add the amounts in Column I, Part A, lines 1b, 2b, 3b, and 4b. This is the total unearned income of the spouse or parent(s) of the aged, blind, or disabled family members.
6. Enter the total deductions specified in Title 22, Sections 50547 and 50549.1. Enter the deductions applicable to the separate income of the aged, blind, or disabled family members in 6a. Enter the deductions applicable to the separate income of the spouse or parent(s) in 6b.
7. Subtract line 6a from line 5a. Subtract line 6b from line 5b.
8. Add lines 7a and 7b. This is the combined unearned income of the aged, blind, or disabled family members and their spouse or parent(s).
9. No entry. This line shows the \$20 any income deduction.
10. Subtract line 9 from line 8. This is the countable unearned income. If the countable unearned income is a minus figure, enter zero on line 10 and enter the minus figure which is the unused portion of the \$20 any income deduction in the blank provided on line 15.

Nonexempt Earned Income

11. Enter the gross earned income.
12. Enter the total deductions specified in Title 22, Sections 50551 and 50551.1. Enter the deductions applicable to the separate income of the aged, blind, or disabled family members in 12a. Enter the deductions applicable to the separate income of the spouse or parent(s) in 12b. Include the \$30 plus 1/3 deduction if appropriate.
13. Subtract line 12a from line 11a. Subtract line 12b from line 11b.
14. Add lines 13a and 13b. This is the combined earned income of the aged, blind, or disabled family members and their spouse or parent(s).

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15. Enter the \$65 of the \$65 and 1/2 deduction plus any unused portion of the \$20 any income deduction here.
16. Subtract line 15 from line 14. If line 15 is greater than line 14, enter zero.
17. Divide line 16 by 2. This figure equals the countable earned income.
18. Add lines 16 and 17. ~~This is the total countable income of the aged, blind, or disabled members of the MFBU plus their spouse or parent(s).~~ Enter this amount here and in Column III, line 1.

Column II -- Income of MFBU Members or Persons Responsible for the MFBU Not Listed in I

In this column enter the nonexempt income of all other members of the MFBU or persons responsible for members of the MFBU whose income was not considered in Column I. Do not list the income of family members who are PA or Other PA (except Four Month Continuing). (Do not include the income of excluded children.) Do not list income which is exempt in accordance with Title 22, Sections 50523 through 50544.

Nonexempt Unearned Income

1. Enter the Social Security income.
2. Enter the net income received from property.
- 3-4. Enter the amount of all other unearned income. Include SSI/SSP recipient's available income and stepparent contribution from the MC 176-W, Part III and Part V.
5. Add the amounts in Column II, Part A, lines 1, 2, 3, and 4. This is the total unearned income.
6. Enter the total deductions applicable to the unearned income. See Title 22, Section 50547.
7. Subtract line 6 from line 5. This is the countable unearned income.

Nonexempt Earned Income

8. Enter the combined gross earned income.
9. a. Enter the \$30, if the 30 and 1/3 deduction is appropriate. The 30 and 1/3 deduction is appropriate if the persons who earned the income were receiving an AFDC cash grant in any one of the 4 months immediately prior to the month in which the deduction will be applied and the \$30 was not applied to income listed in Column I. See Title 22, Section 50553.1.

MEDI-CAL ELIGIBILITY MANUAL

- b. If the 30 and 1/3 deduction is appropriate, enter 1/3 of the remainder of the earned income after subtracting the \$30. This is determined by dividing the remainder by three. If the \$30 was applied to income in Column I, divide the gross earnings by 3.
10. Enter the mandatory deductions that apply to the nonexempt earned income.
 11. Enter the work-related expenses, including mileage, that apply to the nonexempt earned income.
 12. Add lines 9a and b, 10, and 11. This is the total of the earned income deductions.
 13. Subtract line 12 from line 8. This is the countable earned income.
 14. Add lines 7 and 13. This is the subtotal of the countable income of the family members who are not applying as aged, blind, or disabled or their spouse or parent(s).
 15. Enter any amount paid for court ordered child support or alimony or child support paid under an agreement with the district attorney.
 16. Subtract line 15 from line 14. This is the total countable income. Enter in Column III, line 2.

Column III -- Share of Cost Computation

1. Enter the total countable income from Column I, line 18.
2. Enter the total countable income from Column II, line 16.
3. Add line 1 and line 2. This is the total countable eligibility income of the MFBU.

Eligibility Deductions Available for Share of Cost

4. Enter the total income deductions from Column I, lines 6, 9, 12, 15, and 17.
5. Enter the total income deductions from Column II, lines 6, 12, and 15.
6. Add lines 4 and 5. These are the amounts which must be considered available in share-of-cost determinations for persons in LTC.
7. Add lines 3 and 6. This is the total countable income available to the MFBU.

MEDI-CAL ELIGIBILITY MANUAL

Allocations and Deductions

- 8. Enter the allocation made from an aged, blind, or disabled spouse or parent in LTC or board and care to the spouse and/or children at home when the spouse and the LTC or board and care person are separated in accordance with Title 22, Section 50377, or there is no spouse. This amount is computed in Part IV of the MC 176-W and is entered here when doing the share-of-cost determination for the aged, blind, or disabled spouse or parent in LTC or board and care. This allocation also applies when the spouse of an aged, blind, or disabled person is in LTC or board and care.
- 9. List the allocation to the family members who are excluded. This amount is determined in Part I of the MC 176-W.
- 10. List the Special Deduction for all aged, blind, and disabled members of the MFBU. This amount is computed in Part II of the MC 176-W.
- 11. List the amount of income of the MFBU which is used to determine the eligibility of any family member who is a PA or Other PA recipient. If a family member is receiving SSI/SSP, complete Part III of the MC 176-W. If a member of the family is receiving AFDC, contact the AFDC worker to obtain the amount of income being used to determine the current month's grant.
- 12. List any health insurance premiums paid by, and purchased for, any person in the family. This includes Medicare Buy-In premiums when actually paid by a family member.
- 13. Add lines 8 through 12. This is the total of the deductions and allocations.
- 14. Subtract line 13 from line 7. This is the total net nonexempt income.
- 15. Round line 14 to the nearest dollar. This is the total net nonexempt income to be used in the share-of-cost computation.

16. Maintenance Need

- a. Enter the maintenance need for the members of the MFBU who are not in LTC. Specify the number of persons to be included.
- b. Enter the maintenance need for the members of the MFBU who are in LTC. This would be:

\$25 for personal and incidental needs for each MFBU member in LTC.

An amount for upkeep of the home. This amount is only allowed if the conditions of Title 22, Section 50605 (b), are met. The amount allowed is determined in accordance with Title 22, Section 50605 (c).

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An amount to meet the needs of any disabled relatives, other than a spouse or child, or the LTC person. This amount is determined in accordance with Title 22, Section 50605 (d) and (e).

c. Add a and b. This is the total maintenance need for the MFBU.

Note: The maintenance need should total the family members (including Four Month Continuing Eligibles and Title II Disregard Members) listed at the top of the MC 176-M-LTC. Do not include any person who is PA, Other PA, excluded, part of a stepparent unit, or a person in LTC or board and care who will be in a separate MFBU.

17. Subtract line 16c from line 15. This is the share of cost.
18. Enter any underpayment adjustment determined in accordance with Title 22, Section 50567.
19. Subtract line 18 from line 17. This is the adjusted share of cost.

Column IV -- Exempt Income

In this section list separately any income which is exempt. The income exemptions are specified in Title 22, Sections 50523 through 50544.

Eligibility Worker Signature

The worker enters his/her signature.

Worker Number

If the eligibility worker has a county number, enter here.

Date of Computation

The eligibility worker completes this box with the date the form was completed.

County Use

Optional -- to be used in accordance with county policy.

(County Stamp)

**MEDI-CAL
NOTICE OF ACTION
APPROVAL FOR BENEFITS**

State No.: _____
District: _____
Approval for: _____
(Name)

Your application for Medi-Cal benefits has been approved.

You are entitled to receive Medi-Cal benefits beginning the first day of _____ (Month). You will receive a Medi-Cal card soon.

Always present this card to your doctor or any other Medi-Cal provider when you are requesting medical services.

Since your income exceeds the amount allowed for living expenses, you have a share of cost to pay or obligate toward your medical care. Your share of cost is \$ _____ beginning _____. Your share of cost was computed as follows:

	Month 1	Month 2	Month 3
Gross Income	\$ _____	\$ _____	\$ _____
Net nonexempt income	\$ _____	\$ _____	\$ _____
Maintenance need	\$ _____	\$ _____	\$ _____
Excess income	\$ _____	\$ _____	\$ _____

Share of cost \$ _____

Enclosed is a RECORD OF HEALTH CARE COSTS FOR _____ (Month Through Month). Please follow the instructions on the

reverse side of that form. If your medical expenses exceed your share of cost for any period, a Medi-Cal card will be issued to you after the form has been completed and approved.

A Medi-Cal card showing the share of cost will be mailed to you at the long-term care facility each month. The share of cost is to be paid or obligated to the facility each month.

You must bring or mail verification of the following items by _____ (Date) or eligibility for Medi-Cal benefits will be discontinued effective the last day of _____ (Month).

The regulations that require this action are California Administrative Code, Title 22, Section(s):

Your application has been approved for _____ (Month) only because _____

The regulations which require this action are California Administrative Code, Title 22, Section(s):

(Eligibility Worker)

(Phone)

(Date)

(County Stamp)

**MEDI-CAL
NOTICE OF ACTION
INCREASE IN SHARE OF COST**

State No.: _____
District: _____
Increase in Share of Cost for: _____
(Names)

Your share of cost has been increased to \$ _____ per period beginning _____ because:

Enclosed is an additional RECORD OF HEALTH CARE COSTS for the period _____ (Month Through Month). It shows your new share of cost for the period. Attach this form to the form you have already received for the period. Take both forms to any medical provider you see. If your medical expenses exceed this new amount, a Medi-Cal card will be issued to you after the form has been completed and approved.

You have been assigned a supplemental share of cost of \$ _____ for the months _____ (Month Through Month) in your current share of cost period, because:

Enclosed is a supplemental RECORD OF HEALTH CARE COSTS for _____ (Month Through Month). It shows your supplemental share of costs for these months. If your medical expenses in these months exceed that share of cost, a Medi-Cal card will be issued to you after the form has been completed and approved.

The regulations which require this action are California Administrative Code, Title 22, Section(s):

Your new share of cost was determined as follows:

	Month 1	Month 2	Month 3
Monthly gross income	\$ _____	\$ _____	\$ _____
Monthly net nonexempt income	\$ _____	\$ _____	\$ _____
Maintenance need	-\$ _____	\$ _____	\$ _____
Excess income	\$ _____	+\$ _____	+\$ _____
Share of cost	\$ _____		

(Eligibility Worker)

(Phone Number)

(Date)

PLEASE READ THE REVERSE SIDE OF THIS NOTICE

**MEDI-CAL
NOTICE OF ACTION
REDUCTION IN SHARE OF COST**

State No.: _____

District: _____

Reduction in Share of Cost for: _____

(Names)

Your share of cost for the period _____ has been reduced to \$ _____ because:
Month Through Month

- You will receive a Medi-Cal card soon. Always present this card to your doctor or any other Medi-Cal provider when you are requesting medical services.
- Attach this notice to your RECORD OF HEALTH CARE COSTS for this period. Take both forms to any medical providers you see during the period. If your medical expenses are already greater than the amount shown above, take both forms to your county welfare department.

The regulations which require this action are California Administrative Code, Title 22, Section(s):

Your new share of cost was determined as follows:

	Month 1	Month 2	Month 3
{ Monthly gross income	\$ _____	\$ _____	\$ _____ }
Monthly net nonexempt income	\$ _____	\$ _____	\$ _____
Maintenance need	-\$ _____	\$ _____	\$ _____
Excess Income	\$ _____	+ \$ _____	+ \$ _____
Share of cost	\$ _____		

(Eligibility Worker)

(Phone Number)

(Date)

OF HEALTH CARE COSTS - SHARE OF COST

D INSTRUCTIONS ON BACK BEFORE COMPLETING

Only Medical expenses in the following months may be listed below.						Share of Cost The amount that you must pay or obligate is: \$ _____	Page Retro. E (Yes/No)
Month A	Month B	Month C					
Mo. Yr.	Mo. Yr.	Mo. Yr.					
<i>m/d/y m/d/y m/d/y</i> Certification date							

me
 address
 City/State/Zip
 County Code

Medical expenses of family members listed below may be used to meet Share of Cost

Aid	State Number			Name - Last, First	Eligible in			Birthdate			Sex	Other Gov. Code	Social Security No.	MHC or RR No.
	7 Digit Serial No.	FBU	Pers.		A	B	C	Mo.	Day	Yr.				

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I will not seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program for that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient. This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	Provider No.	Date of Service			SERVICE	Proc. Code/ Proc. No.	Total Bill	Billed Patient	Billed Medi-Cal
		Mo.	Day	Yr.			\$	\$	\$
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									
PROVIDER NAME	Provider No.								
PATIENT NAME									
PROVIDER SIGNATURE (See Declaration Above)									

STATE USE ONLY

I have read the instructions on the back of this form. I agree to assume full legal responsibility for the amounts listed above in the "Billed Patient" column.

Print Name: _____
 Signature: _____

**INSTRUCTIONS FOR
RECORD OF HEALTH CARE COSTS –
SHARE OF COST**

Instructions to Patient

At the top of the other side of this form is a box labeled "Share of Cost." The amount shown in this box is your share of medical expenses for the months indicated. You must pay or agree to pay this amount of your medical bills before Medi-Cal will pay. Medical expenses for any family member shown on the other side of this form can be used to meet the share of cost. **IMPORTANT:** If you get another notice that says your share of cost has changed for these months, attach that notice to this form.

Give this form to anyone who has given or will give you medical services (e.g., doctor, pharmacist, hospital, etc.) in the month specified. The provider will fill in the amount of the total bill and the amount you have paid or have agreed to pay; you should not pay or agree to pay more than the amount shown in the "Share of Cost" box. If the total amount in the "Billed Patient" column is more than your share of cost, you will be responsible for the entire amount shown in this column.

When the total amount in the "Billed Patient" column equals exactly your share of cost, you should then sign the bottom of the form and return it to your eligibility worker. Keep the last copy for your records. If the form has been completed correctly, you will receive your Medi-Cal card shortly.

When you receive the card, it is your responsibility to take the card to the providers who have signed the front of the form; they can then bill Medi-Cal for the part of your medical bills which you did not have to pay or agree to pay in meeting your share of cost.

If all four of the provider boxes on the front of the form have been used and you have not met your share of cost, contact your eligibility worker for issuance of an additional form.

If you have any questions about this form, call your eligibility worker.

Instructions to Provider

DECLARATION — To Avoid Delay in Processing the Record of Health Care Costs, Complete All Items (3) Through (13).

Only Medical expenses in the following months may be listed below.			Share of Cost	Page <u> </u> of <u> </u>
Month A	Month B	Month C	The amount that you must pay or obligate is:	Retro. Elig?
	2		\$ <u> 1 </u>	
Mo. Yr.	Mo. Yr.	Mo. Yr.		(Yes/No)

Name — Last, First	Eligible in	Birthdate
	A B C E	Mo. Day Yr.
	13	

PATIENT NAME	Provider No.	Date of Service	SERVICE	Proc. Code/Presc. No.	Total Bill	Billed Patient	Billed Medi-Cal
4	5	Mo. Day Yr.	8	9	\$ 10	\$ 11	\$ 12
PATIENT NAME							
6		7					
DEAR SIGNATURE (See Declaration Above)							
13							

- SHARE OF COST** This is the amount which must be paid or obligated by the patient.
- MONTHS OF EXPENSE** These are the months for which services received may be applied toward the share of cost.
- MONTHS OF ELIGIBILITY** These are the months for which the patient is eligible for Medi-Cal coverage.
- PROVIDER NAME** Enter physician, facility, or other provider's name.
- PROVIDER NUMBER** Enter provider's license number/if not a California provider, enter "out-of-state."
- PATIENT NAME** Enter name of patient to whom service has been provided.
- DATE OF SERVICE** Enter exact date (month, day, year) each service was performed. Do not list dates such as April 2 through April 10, but list each separate day, month, and year on which services were provided. The services must have been performed in the month listed in Item 2. Do not list any services not yet rendered. Continuous service (such as hospitalization) should be shown as month, day, year THROUGH month, day, year.
- SERVICE** Enter specific Medi-Cal covered service rendered.
- PROC. CODE/PRESC. NO.** Enter the procedure code number or prescription number.
- TOTAL BILL** Enter total charge for service. Do not enter in this space any amount billed to Medicare or other third party payers.
- BILLED PATIENT** Enter the amount billed to patient. If more than one provider lists services, the totals of Item 10 must not exceed amount listed in Item 1, or the amount listed in any notice of revised share of cost attached to this form.
- BILLED MEDICAL**