

DEPARTMENT OF HEALTH SERVICES

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(916) 657-2941



June 10, 1996

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

Letter No.: 96-31

TINOCO POLICY AND PROCEDURES: IMPLEMENTATION, PHASE 2

Ref.: All County Welfare Directors Letter (ACWDL) No. 96-09 and 96-16

SECTION I. INTRODUCTION

History of the Tinoco Litigation: Since the inception of the Medi-Cal program, the Department of Health Services (DHS) has interpreted federal Medicaid law as requiring State Disability Insurance payments (SDI) to be counted as unearned income. In 1994, the Tinoco lawsuit was initiated to change DHS policy to one of counting SDI payments as earned income for the purpose of lowering the case's share of cost (SOC) through the application of the AFDC-MN and MI earned income deductions. The Tinoco court has decreed that the Medi-Cal program shall treat the SDI of AFDC MN or MI persons as earned income.

SECTION II. OVERVIEW

Overview of The Tinoco Second Phase Implementation: This ACWDL implements Phase II of Tinoco. The purpose of this ACWDL is to provide procedures for reimbursing qualified cases which were not previously reimbursed under the previous (Phase I) Tinoco ACWDL 96-09. Under this ACWDL, counties will evaluate identified cases to determine whether they qualify for a reimbursement for certain past months. Counties will follow the same procedures described in ACWDL 96-09, and reiterated in this ACWDL, for recalculating SOC and determining the appropriate reimbursement for these cases. Cases will be identified from Tinoco Reimbursement Applications submitted by current or former Medi-Cal beneficiaries responding to posted Tinoco Notices (Poster Notices) or to Individual Notices distributed by DHS to certain former or current beneficiaries.

Summary of Previously Issued Tinoco Policy: ACWDL 96-09, dated February 14, 1996, implemented the first phase of the Tinoco procedures. Under ACWDL 96-09, new cases, cases flagged per ACWDL 95-79, and cases identified using the Quarterly Status Report (QR.) and redetermination documents, had their SOC recalculated, and were reimbursed as appropriate.

SECTION III. DEFINITIONS

Qualifying State Disability Insurance Payments: Under the terms of the settlement agreement, SDI qualifies as earned income when verified SDI is received by a AFDC MN or MI person in a Qualified Case.

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Qualified Case: For purposes of determining eligibility for the reimbursement described in this ACWDL, a case is a qualified case for any month from January, 1991 through September, 1995 in which (1) an eligible or ineligible AFDC MN or MI person in the case Medi-Cal Family Budget Unit (MFBU) received verified SDI, (2) the case had a SOC, and (3) the case was not previously identified and evaluated for reimbursement under ACWDL 96-09. The case must first be an identified case: a case for which the county has received a properly completed Tinoco claim application from an eligible or ineligible member of the MFBU.

Individuals receiving SDI who are on Medi-Cal as ABD-MN persons do not have their SDI counted as earned income, and a case containing such a person and no AFDC-MN or MI person with SDI is not a qualified case. Qualified cases must be evaluated under this ACWDL to determine whether they are eligible for a reimbursement.

Reimbursable Case: A reimbursable case is a qualified case for which an applicable earned income deduction(s) results in a decreased SOC (the post-Tinoco SOC) and which has verified medical expenses which exceed the case's post-Tinoco SOC.

Reimbursement Period (Reimbursement Period): This period begins January 1991 and ends September 1995. Reimbursement under this ACWDL is limited to months within this period except as provided in the next paragraph.

This ACWDL provides for reimbursement of cases which were not reimbursed under ACWDL 96-09. Cases not reimbursed under ACWDL 96-09 are cases which could not have been previously identified under the former Tinoco ACWDL. These are cases which were discontinued previous to October 1995, the month in which counties began flagging cases with SDI or, although continuing cases through this month, were not flagged because they only received SDI in months previous to October 1995. Any continuing qualified cases receiving SDI in October 1995 or a later month will have been previously reimbursed. However, if in the course of determining eligibility for reimbursement under this ACWDL, the county becomes aware that a case is eligible for reimbursement for month(s) later than the September, 1995 cut-off, and was not previously reimbursed, the case must be reimbursed for those months under this ACWDL.

Case Conversion And Calculation of Post-Tinoco SOC: Case conversion means recalculating the qualified case's SOC to reflect that the case's qualifying SDI payment(s) is earned income by applying the applicable Medi-Cal AFDC MN/MI earned income disregards (per the instructions in this ACWDL) to the case's qualifying SDI payments. The recalculated SOC is the case's Post-Tinoco SOC.

Applicant: Former or current beneficiaries who, after responding to the Individual Notice distributed by DHS, or to a Poster Notice, submit a properly completed Tinoco Reimbursement Application form (Exhibit A), part of the combined Tinoco Notice and Application form, to the appropriate county welfare office.

SECTION IV. POSTER NOTICES AND APPLICATIONS

Tinoco Poster Notices: Pursuant to the settlement agreement, beginning August 1, 1996 through October 31, 1996, counties must display Tinoco Poster Notices (Exhibit B) in visible locations at their county welfare department (CWD) locations serving Medi-Cal applicants and beneficiaries. The purpose of these posters is to provide notice regarding the availability of Tinoco reimbursement benefits to persons in cases which were discontinued previous to October 1995, or, in cases continuing through October 1995, which did not receive SDI after this date. Such cases could not have been reimbursed under ACWDL 96-09 because they were not flagged under the instructions provided in ACWDL 94-49, nor were they identifiable through the Quarterly Status Report process described in ACWDL 96-09.

The Poster Notices will advise persons that, if they met certain requirements during the Tinoco Reimbursement Period, they may contact their county welfare office for a Tinoco Reimbursement Application. Counties will issue the Tinoco Reimbursement Application to persons who request one on or before October 31, 1996. The Tinoco Reimbursement Application is a part of the combined Tinoco Notice and Application (Exhibit A) that DHS is mailing to DHS-identified persons. See the "Individual Mailings" sub-heading, below.

Duplication of Poster Notice And Reimbursement Application: This ACWDL transmits "camera-ready" originals of the Tinoco Poster Notice (Exhibit B) and the Tinoco Reimbursement Application (Exhibit A). Counties will use the Tinoco Poster Notices to make copies. The Poster Notice will be on 11" by 17" paper. Exhibit B contains this notice on a 11" by 17" sheet, and on two 8½" by 11" sheets. The latter configuration may facilitate the duplication process in those counties which are not able to easily duplicate a 11" by 17" sheet.

Counties may use the Tinoco Reimbursement Application in Exhibit A to make duplicates as needed. In addition, DHS will print an additional 20,000 copies of this Application and make them available for county order from the DHS Warehouse. The address for the DHS Warehouse is provided in Section X.

Other Public Notices: Pursuant to the settlement agreement, county welfare directors are requested to have the Tinoco Poster Notice posted at food stamp outlets visited by the public. Please follow the duplication instructions provided in the sub-heading above. Pursuant to the settlement agreement, DHS will also request the Employment Development Department to display these posters at their public offices.

Mailing The Individual Tinoco Poster Notice: On July 31, 1996, DHS will mail the combined Tinoco Individual Notice and Reimbursement Application form (Exhibit A) to aid codes which include AFDC-MN and MI persons who have been on Medi-Cal with SOC in one or more months from January, 1991 through September, 1995. Counties may expect beneficiaries to complete and submit to the county welfare office the Application part of these forms beginning August 1, 1996. This form will also serve as the Tinoco Reimbursement Application which counties will provide to beneficiaries who request one in response to the Poster Notice.

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SECTION V. TINOCO APPLICATIONS AND IDENTIFICATION OF CASES FOR REIMBURSEMENT

Beginning August 1, 1996 counties may expect to receive requests for Tinoco Reimbursement Application forms from persons responding to the mailed or posted Tinoco notices. For properly completed application forms received by the county no later than October 31, 1996, the county must review case files and any other pertinent records to determine whether the application corresponds to a qualified case within the Tinoco Reimbursement Period (see definition) which was not previously identified and reimbursed pursuant to ACWDL 96-09.

SECTION VI. CONVERTING THE CASE BUDGET FOR QUALIFIED CASES; ADJUSTING SOC

Converting The Continuing Case Budget And Adjusting SOC: Beginning August 1, 1996, after (i) receiving a timely properly completed Tinoco application for a Medi-Cal case, (ii) determining that the case was not previously reimbursed under Phase I of Tinoco (ACWDL 96-09), (iii) identifying the months within the Tinoco Reimbursement Period, if any, in which the case is a qualified case (see definition of qualified case in Section III), (iv) and obtaining the necessary verification (see Section IX), the county will recalculate and adjust the case's SOC for those months in which the case may have medical expenses in excess of the post-Tinoco SOC. It is not necessary to convert the case budget for any periods for which there are no verified medical expenses.

In the event the county requests verification from the applicant, he/she has 30 days to provide such verification. In addition, beneficiaries have another 15 days to provide this verification if there is good cause for the beneficiary being unable to provide the verification within 30 days. The items requiring verification are discussed in Section IX. Once the county has fulfilled its obligations to obtain verification, and 45 days have elapsed since the county has requested verification from the applicant, the county must commence recalculation of the case's SOC with the verification the county has in its possession.

Conversion Note: Although the conversion of the case budget under Tinoco means treating the qualified case's SDI as earned income and applying the four AFDC-MN/MI earned income deductions as appropriate to that SDI, if a qualified case has already received all available deductions based on other earned income, the conversion of the case budget under Tinoco may not have any impact on the case's SOC. Some of the earned income deductions, for example the \$90 work deduction, allow only a limited amount to be disregarded and this limited deduction may have already been fully applied to other earned income of the individual receiving the SDI payments. Other earned income deductions may not apply.

SECTION VII. DETERMINING THE REIMBURSEMENT FOR QUALIFYING CASES

Calculating The Reimbursement: After recalculating the case's SOC to determine the case's post-Tinoco SOC, counties will calculate the case's total reimbursement by totaling the monthly reimbursement amounts for the months within the Tinoco Reimbursement Period. The monthly reimbursement amounts are the amounts by which the case's verified medical expenses (see Section IX on "Verification") exceed the case's post-Tinoco SOC. Counties will enter the total of these monthly reimbursement amounts on the Tinoco Reimbursement Request form (see Exhibit C), and then send this completed form to DHS. This Reimbursement Request form is discussed below.

SECTION VIII. COMPLETING AND TRANSMITTING THE TINOCO REIMBURSEMENT REQUESTS

The "Tinoco Reimbursement Request" (Exhibit C) is the vehicle which DHS will use to issue Tinoco reimbursement checks. Counties will complete a "Tinoco Reimbursement Request" form for each case which the county has determined will receive a Tinoco reimbursement. Counties must transmit the completed Reimbursement Requests to DHS within 30 days of calculating the reimbursement for the case. Mail the Tinoco Reimbursement Requests to the DHS address shown at the top left-hand corner of this form.

SECTION IX. VERIFICATION

SDI Verification: Before recalculating the SOC under the case's budget conversion, counties must verify (1) that the payments in question are qualifying SDI payments, and (2) the months and monthly amount(s) of such SDI payments. SDI is paid for disability arising from a non-work-related injury or illness. It is paid at 55 percent of wages received during a certain base period, up to a certain ceiling. The SDI benefit is generally paid semi-monthly for up to a year.

Counties may verify SDI by reviewing the case file or, at the counties' option, by completing and submitting a DE 8720 form to the headquarters office of the Employment Development Department (EDD). Counties will then receive an EDD report (SDI-verification report) showing the SDI payment history for the requested months for each case identified on the DE 8720. If the appropriate documents pertinent to verifying SDI in the case file do not cover the entire Reimbursement Period, the county must use the DE 8720 form (not the DE 8720A form) to request SDI information for any such "uncovered" months. A sample copy of this form is provided in Exhibit D. Instructions for completing this form are provided in Section X.

If, despite the case file and EDD-supplied documentation, the county is unable to ascertain whether SDI was received during the Reimbursement Period, counties must phone or otherwise contact the applicant and advise the applicant that he/she has responsibility to contact his/her local EDD Disability Insurance office to obtain the necessary documentation for the county. Counties must also advise the applicant that, if after contacting the EDD office, the applicant is

unable to obtain the necessary documentation within a reasonable period of time, he/she may visit the county welfare department which will, in the presence of the applicant, place a phone call on his/her behalf to the EDD headquarters in Sacramento at (916) 654-8198. The timelines for the beneficiary's submission of requested verification are set forth in Section VI.

Nothing in this section affects the usual county procedures for verifying SDI for new cases, for cases not subject to, or no longer eligible for, the Tinoco reimbursement, and, for cases eligible for the Tinoco Reimbursement, for those months after the month in which these cases' SOC was recalculated under this ACWDL.

Applicable Earned Income Deduction Verification: The \$90 Work Expense Deduction (Title 22, California Code of Regulations (CCR), Section 50553.1) is always applicable to SDI, to the extent it has not been applied to other earned income of the SDI recipient. The other three earned income deductions (Dependent Care Deduction, Section 50553.5, Student Exemption, Section 50543, and the Thirty Dollars Plus One-Third deduction, Section 50553.3) are not applicable unless the requirements of each have been satisfied. If the county is not able to ascertain the applicability of these three deductions from information in its case file when converting the case's budget for any month in which it is a qualified case, the county must issue a written request to the qualified case at its last known address requesting the submission of the appropriate verification for any of these three deductions which the beneficiary alleges is applicable. A sample form for requesting this verification is in Exhibit E. The timelines for the beneficiary's submission of requested verification are set forth in Section VI.

Normally, a person receiving SDI is not working and is therefore available to care for the children. The Dependent Care Deduction is not applicable to SDI unless either the SDI recipient is still working, or he/she is so incapacitated from his/her illness or injury that he/she is unable to care for the children, and there is no one else in the family who is able to care for the children. The other requirements of this deduction still apply.

Medical Expense Verification: In order to obtain a Tinoco reimbursement for any month, the qualified case's verified medical expenses must exceed the case's post-Tinoco SOC. For purposes of this ACWDL, incurred medical expenses for identified qualified cases will be verified as follows:

1. For counties in which the Benefits Identification Card (BIC) has replaced the paper card (called BIC counties), medical expenses incurred by a case will be verified by inspecting the MEDS screens or "SOCCR" screens. If MEDS shows that the case has been certified as meeting its (pre-Tinoco) SOC, the case's incurred medical expenses equal this SOC. If MEDS does not show the case as certified, the case's medical expenses, if any, will be the case's SOC less the remaining SOC balance shown on the "SOCCR" screen.
2. For all counties, for months in which the MC 177 "Record of Health Care Costs" was in use, this form may be used to ascertain what the case's medical expenses were for a month. The case's medical expenses are equal to the total of the medical expenses incurred by the case as shown on the MC 177.

3. For all counties, for months previous to the 15-month limit applicable to the MEDS or SOCR screens continuing back through January 1, 1991, the Data Systems Branch (DSB) of DHS will provide SOC-verification reports for cases for which counties have requested this information (see ACWDL 96-16). For cases for which a SOC-verification report shows a certified SOC for the month, the case's medical expenses for that month will be equal to the case's SOC. If the report does not show a certified SOC, counties will not be able to use these reports to verify SOC for that month. Counties will use their TAO systems to transmit the identity of cases for which they want SOC-verification data to DSB. Counties may request this list on a "flow or batch basis." DSB will make available a TAO screen which counties will use to submit these requests. DSB will transmit the SOC-verification data for the case requested by a county to the address(es) submitted by the county to DHS on the Sawyer/Tinoco Questionnaire which was distributed to counties via ACWDL 96-16, or a back-up address, that of the counties' MEDS Coordinators, if the county did not provide an address. See ACWDL 96-16 for more information regarding this process.
4. For months for which the medical expenses incurred by the case cannot be determined through the methods described in numbered-paragraphs 1-3 above, for example the SOC-verification report shows that the case did not meet is pre-Tinoco SOC, the county must issue a written request to the case at its last known address for the household to verify medical expenses provided by a health care provider which were incurred by the household. The case's verified medical expenses for such a month are the documented medical expenses, but not exceeding the case's pre-Tinoco SOC. The timelines for the beneficiary's submission of requested verification are set forth in Section VI. Acceptable verification will consist of medical bills or statements from medical providers which identify the following:
 - a) the nature of the medical service,
 - b) the date the medical service was provided,
 - c) the recipient of the medical service,
 - d) the bill's or statement's issuance date,
 - e) the cost of the medical service,
 - f) the name, address and provider number of the medical provider for a medical bill (a receipt for a pharmaceutical purchased at a pharmacy need not contain the address of the provider), and
 - g) applicable only to provider's statements (and not to medical bills), the provider's signature and phone number.

The prescription label from a pharmaceutical container may be submitted by the beneficiary to meet the requirements listed in a), b) and c) above. A provider's statement or medical bill

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providing the rest of the necessary information must be submitted in conjunction with this prescription label. In such a case, the bill or provider statement must correspond to the pharmacy label.

SECTION X. INSTRUCTIONS FOR COMPLETING AND TRANSMITTING THE SDI VERIFICATION FORM DE 8720A

As of the publication date of this ACWDL, DHS is negotiating with EDD to provide SDI verification reports to counties. Not all details have been finalized. Counties will receive an update to the information provide below as soon as it becomes available.

To obtain a report from EDD verifying SDI for a particular case or cases, counties will submit a DE 8720 form identifying such case(s). Take care that your county is completing the DE 8720 form (Exhibit D) and not the DE 8720A. The procedure for completing the form is mostly self-explanatory. Instructions are included on the reverse side of the form. EDD will not process these forms without the "customer code" number which counties must include in the top left-hand part of the form. The customer code for the verification of SDI for Tinoco purposes is not yet available. It will be transmitted by a separate letter as soon as it becomes available.

The first two digits of the four digit "preparer code" entered on the top right-hand part of the form must be the county I.D. number. The last two digits of the "preparer code" should be used by those counties have multiple sites which will be requesting and utilizing EDD's SDI verification reports so that SDI reports can be sent directly to such sites. Counties with only one such site should leave these last two digits blank. DHS intends to deliver these reports to the same county addresses to which the SOC-verification reports are currently sent.

Generally counties will request SDI verification by marking the appropriate box, or combination of "DI Claim History" boxes, "5d" through "5f," on this form which will provide for SDI verification for the SSN for the Medi-Cal case needing SDI verification for period farthest back in time. For example, if the county has entered multiple SSNs for a group of Medi-Cal cases on this form, and any one of them, or any set of them, needs SDI verification records for the entire period spanned by "5d" - "5f," make sure each box, "5d," "5e," and "5f" are marked, even though the other cases on this form don't need this entire set of records. However, as a labor and cost savings device, to the extent it does not impede county evaluation of cases for reimbursement benefits, DHS requests counties to group SSNs for cases which require SDI verification for more than four years in the past on a separate DE 8720 form so that all the cases which need only SDI verification records for up to four years are grouped together on another form.

The DE 8720 may be photocopied from the "camera-ready original" provided in Exhibit D. DHS will also make available 10,000 of these forms at the DHS Warehouse. Please keep your counties order proportional to your county size. The DHS Warehouse address is:

DHS Warehouse
1037 North Market Boulevard, Suite 9
Sacramento, CA 95834

SECTION XI. MEDI-CAL EXPENSES FROM TINOCO-REIMBURSED CASES
NOT APPLICABLE TO SOC UNDER HUNT

A medical expense may not be applied both toward SOC in the month of eligibility and in a later month under Hunt v. Kizer. It follows that once medical expenses are counted in determining a Tinoco reimbursement such expenses may not be applied toward SOC in any later month under the Hunt v. Kizer old medical bill remedy. Such bills either have already been reimbursed under the Tinoco remedy or were used to certify SOC for purposes of providing such reimbursement. Similarly, if medical expenses incurred in the month of eligibility have already been applied toward SOC in a later month under Hunt v. Kizer, they cannot be re-applied in any other month for purposes of obtaining a Tinoco reimbursement.

SECTION XII. REVIEW OF THE EARNED INCOME DISREGARDS POTENTIALLY
APPLICABLE TO SDI PAYMENTS

The four AFDC MN and MI earned-income deductions, and instructions for their application, are summarized below. Instructions regarding which of these deductions may be applied to a qualified case are provided elsewhere in this ACWDL.

1. \$90 Work Expense Deduction (Title 22, CCR, Section 50553.1). This deduction may be applied to qualifying SDI payments only to the extent not previously applied to the other earned income of the SDI recipient.
2. Student Exemption (Title 22, CCR, Section 50543). Apply to qualifying SDI only when warranted by the facts in the case record or provided to the county.
3. \$30 and 1/3 deduction. Apply to qualifying SDI payments only to the extent warranted by the information in the case record or provided to the county.
4. The Dependent Care Deduction at Title 22, CCR, Section 50543 will generally not be applicable (because the SDI recipient will generally be available to care for the children), except when there is no other family member able to care for the dependent children and the SDI recipient is so disabled as to be unable to care for the children. Apply to qualifying SDI payments only to the extent warranted by the information in the case record or provided to the county.

SECTION XIII. IDENTIFICATION OF THE TINOCO REIMBURSEMENT RECIPIENT

The Tinoco reimbursee is the applicant provided he/she was an eligible or ineligible member of the MFBU of a qualified case during the Tinoco reimbursement period whose income was counted for purposes of determining the MFBU's SOC. The reimbursee's address will be that stated on the claim form. When completing the "Tinoco Reimbursement Request," counties will include the name and address of the reimbursee. DHS will issue the Tinoco reimbursement in

the name of the reimbursee to the reported address. Occasionally DHS may issue the reimbursement to another person in the MFBU, if appropriate. DHS reimbursement to any person in the case MFBU fulfills DHS' liability for Tinoco reimbursement for the case.

SECTION XIV. MAINTAINING RECORDS OF CASES WHICH QUALIFIED FOR TINOCO REIMBURSEMENT

For the purpose of settling potential disputes regarding Tinoco benefits, counties must maintain records for one year of the calculations used to determine the post-Tinoco SOC and reimbursement amount for all cases which were evaluated for a Tinoco reimbursement. Counties must keep copies of all Tinoco-related documents issued to, or received from, the beneficiary. Counties must keep Tinoco-related documents received from any source used for verification purposes. Counties must also compile and maintain a log of cases which will receive a Tinoco Reimbursement or keep copies of the completed Tinoco Reimbursement Request form for the case. A sample log form is provided in Exhibit F.

SECTION XV. PROVISION OF NOTICE OF ACTION REGARDING APPROVAL/DENIAL

Counties will issue Tinoco NOA's (enclosed as Exhibit G) to all persons submitting a Tinoco Reimbursement Application. For applications for which the county has determined that there is either no Medi-Cal case, or no qualified Medi-Cal case, the "denial" NOA will be issued within 30 days of the county's making that determination. For applications for which the county has determined that there is qualified case, the appropriate NOA, a "denial," or an "approval," will be issued within 30 days of the county's making the determination whether the qualified case will receive a reimbursement. The Tinoco NOA 2.1 will be issued to cases which will not receive any reimbursement. The Tinoco NOA 2.2 will be issued to cases which will receive a reimbursement. These NOAs will not be available on SAWS. This ACWDL does not alter the standard NOA notification issued to new cases.

Counties may make copies of these NOAs for manual distribution from the "camera-ready" originals provided in Exhibit G, or counties may use these originals as templates for the issuance of county-automated NOAs.

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If you have questions regarding the subject matter of this ACWDL, please contact
Dave Rappolee of my staff at (916) 657-0163.

Sincerely,

ORIGINAL SIGNED BY
GLENDA ARELLANO for

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

EXHIBIT A

TINOCO NOTICE

Were you on Medi-Cal from January 1991 through September 1995 in a family which had a Medi-Cal share-of-cost and at least one child, or in which someone in the household was pregnant? If so, did you or any person in your Medi-Cal family budget unit receive State Disability Insurance (SDI) payments during this time? State Disability payments are insurance payments paid due to an off-the-job illness or injury. If you can answer yes to these questions, you may be eligible for money if your share-of-cost was too high because the Medi-Cal program did not treat your SDI as earned income. If you feel that you meet these requirements and wish to be considered for this benefit, complete the application below and send it to your county welfare department. You cannot get benefits under this program for Worker's Compensation payments for on-the-job illness or injuries or for federal disability payments. Complete and return this application to the county welfare office by October 31, 1996.

TINOCO REIMBURSEMENT APPLICATION

Name	Social Security number	Telephone number	Age	Date of birth
Current address (number, street)		City	State	ZIP code
Name of person who received SDI (if other than yourself)		Social Security number		Date of birth
Indicate the period of time SDI was received :		Beginning month/year	Ending month/year	
Indicate the period of time you were on Medi-Cal with a SOC:		Beginning month/year	Ending month/year	
During this period, did you have children, were you pregnant, or were you a minor (less than 21)?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
During this period, was the person getting SDI 65 or older, blind, or disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
During the period that you were on Medi-Cal and receiving SDI, what county were you living in?				Name of county

EXHIBIT B

TINOCO POSTER NOTICES

Due to the automated reproduction and mailing process, the Department of Health Services was unable to include the oversize (11" by 17") single-sheet version of the Tinoco Poster Notice in this Exhibit. This single-sheet oversize version of the Poster Notice will be sent to counties via a separate mailing

(Post August 1, 1996 through October 31, 1996)

WELFARE MAY OWE YOU MONEY

Were you on Medi-Cal from January, 1991 through September, 1995 in a family which had a Medi-Cal share of cost and at least one child, or in which someone in the household was pregnant? If so, did you or any person in your Medi-Cal family budget unit receive State Disability Insurance payments (SDI) during this time? State Disability payments are insurance payments paid due to an off-the-job illness or injury. If you can answer yes to these questions, you may be eligible for money if your share of cost was too high because the Medi-Cal program did not treat your SDI as earned income. If you feel that you meet these requirements and wish to be considered for this benefit, obtain a Tinoco Reimbursement Application from the county welfare office. You must complete and return the Reimbursement Application to the county welfare office by October 31, 1996. You cannot get benefits under this program for Worker's Compensation payments for on the job illness or injuries or for federal disability payments.

ES POSIBLE QUE EL DEPARTAMENTO DE BIENESTAR LE DEBA DINERO

¿Forma usted parte de una familia que recibió beneficios de Medi-Cal desde enero de 1991 hasta septiembre de 1995, una familia que pagaba una Parte del Costo de Medi-Cal (Medi-Cal Share-of-Cost) y que constaba por lo menos de un niño o de una mujer embarazada? ¿Si tal es el caso, recibió usted o alguna persona en su familia recibiendo beneficios de Medi-Cal, pagos de Seguro del Estado contra Incapacidad (State Disability Insurance; SDI) durante esta temporada? Los pagos del Estado contra Incapacidad son pagos de seguro otorgados debido a una enfermedad o accidente sufridos fuera del trabajo. Si usted puede contestar "sí," a estas preguntas, es posible que sea elegible para dinero si su parte del costo fue demasiado elevado porque el programa de Medi-Cal no consideró sus beneficios de SDI (Seguro del Estado contra Incapacidad) como ingresos ganados. Si usted piensa que reúne los requisitos y quisiera que evalúen su caso para determinar si es elegible para estos beneficios, obtenga en la oficina de Bienestar del condado un formulario de Solicitud de Reembolso bajo el programa Tinoco (Tinoco Reimbursement Application). Usted debe completar y devolver la Solicitud de Reembolso a la oficina de Bienestar del condado antes del 31 de octubre de 1996. Bajo este programa, no puede obtener beneficios para pagos de incapacidad federal ("federal disability") o para pagos del programa de Compensación por lesiones de trabajo (Worker's Compensation) para enfermedades o accidentes sufridos en el trabajo.

SỞ XÃ-HỘI CÓ THỂ NỢ TIỀN CỦA QUÍ VỊ

Có phải quý vị là người thụ hưởng Medi-Cal từ tháng 1 năm 1991 đến tháng 9 năm 1995 mà trong gia đình có ít nhất là một đứa con và phải trả một phần tiền phụ với Medi-Cal gọi là (*share-of-cost*) hoặc có người trong gia đình mang thai? Nếu phải, có người nào trong gia đình nhận được tiền bảo hiểm tàn phế của Tiểu Bang (SDI) trong thời gian này không? Tiền tàn phế của Tiểu Bang là tiền bảo hiểm trả cho những người nghỉ việc vì đau yếu hoặc bị thương tích. Nếu quý vị trả lời có với các câu hỏi kể trên, quý vị có thể sẽ nhận lại được một số tiền bồi hoàn nếu tiền *share-of-cost* của quý vị lúc đó quá cao, vì chương trình Medi-Cal không phép được tính tiền tàn phế SDI như một lợi tức. Nếu quý vị nghĩ rằng quý vị hội đủ điều kiện và muốn nhận lại số tiền này, hãy lấy mẫu đơn xin bồi hoàn Tinoco Reimbursement tại phòng xã-hội của county. Quý vị phải điền đơn và nộp cho phòng xã-hội của county hạn chót là ngày 31 tháng 10, 1996. Quý vị không được hưởng chương trình này nếu quý vị có nhận tiền tai nạn lao động được gọi là (*Worker's Compensation*) hoặc tiền tàn phế của Liên Bang (*Federal Disability*).

社會福利部可能欠你的錢

在一九九一年一月至一九九五年九月期間，在你家庭要看病時，你是否需要付一部分醫療費 (share of cost) 呢？當時家中至少有一小孩子以上或家裏有人懷孕。如果是的話，同時在家裏有沒有人那時候有領取 State Disability Insurance payments (SDI) 殘廢金呢？SDI 殘廢金是州政府付予因病或因傷不能工作的人。如果你對上述答案是肯定的話。這次有可能符合資格取回金錢，如果過去的 share of cost 要是付得太高的話，因為社會福利部不能將 SDI 當作你的入息計算。如果你考慮有這樣需求，想要取回上述那些金錢的話，請你馬上在你所居住地方福利部門辦公室領取 Tinoco Reimbursement 申請表格。你必須在一九九六年十月三十一日前，填妥 Reimbursement 表格，郵寄回社會福利部辦公室。你不能享用這種優惠，如果你擁有 Worker's Compensation 殘廢金的話。Worker's Compensation 殘廢金是聯邦政府付予因工作致病或受傷不能工作的人。

ក្រសួងវិជ្ជាជីវៈប្រហែលជំពាក់ប្រាក់លោកអ្នក

តើលោកអ្នកស្ថិតនៅលើ Medi-Cal ចាប់តាំងពីថ្ងៃមករាឆ្នាំ 1991 រហូតដល់ថ្ងៃកញ្ញាឆ្នាំ 1995 ក្នុងគ្រួសារមួយដែលបានទទួល Medi-Cal ចូលរួម-នៃ-ការចេញថ្លៃ យ៉ាងហោចណាស់កូនមួយ ឬក៏ក្នុងលក្ខណៈដែលអ្នកណាម្នាក់ក្នុងគ្រួសារមានផ្ទៃពោះ? បើដូច្នោះតើលោកអ្នកឬក៏អ្នកណាម្នាក់នៅក្នុងក្រុមវិជ្ជាជីវៈការគ្រួសារ Medi-Cal របស់លោកអ្នកទទួល State Disability Insurance (SDI) ការបង់ថ្លៃនៅក្នុងពេលនេះ? State Disability ការចេញថ្លៃគឺជាការរ៉ាប់រងការចេញថ្លៃដល់ថ្លៃចង់ដល់ជម្ងឺឬក៏ការត្រូវរបួស ក្រៅ-ពី-ការងារ។ បើសិនជាលោកអ្នកអាចធ្វើយុទ្ធសាស្ត្រទៅសំណួរទាំងនេះ លោកអ្នកប្រហែលមានសិទ្ធិទទួលបានប្រាក់ បើសិនជាការចូលរួមនៃការចេញថ្លៃរបស់លោកអ្នកគឺសំរេចដោយព្រះតែកម្មវិធី Medi-Cal ឥតប្រព្រឹត្ត SDI របស់លោកអ្នកដូចជាប្រាក់ដែលលោកអ្នករកបាន។ បើសិនជាលោកអ្នកមានអារម្មណ៍ថាលោកអ្នកជួបប្រទះការតម្រូវទាំងនេះ ហើយមានគោលបំណងយកមកពិនិត្យសម្រាប់ការជំនួយនេះ សូមមេត្តាទាក់ទង Tinoco Reimbursement Application ទៅការិយាល័យវិលវិញរត់ចំឡើងថ្ងៃ 31 ខែតុលាឆ្នាំ 1996។ លោកអ្នកមិនអាចទទួលបានការជំនួយក្រោមកម្មវិធីនេះសម្រាប់ការចេញថ្លៃ Worker's Compensation មានជម្ងឺឬក៏ការត្រូវរបួស នៅពេល-ធ្វើ-ការងារ ឬក៏ការចេញថ្លៃដល់អ្នកគ្មានសមត្ថភាពធ្វើការមួយរយៈមកពីការិយាល័យជំទេ។

EXHIBIT C

DHS Address: Attn: Tinoco Reimbursement, Phase 2
Dept. of Health Services
M.E.B. Clerical Unit, Rm 1719
714 P Street
Sacramento, CA 95814

Issuing County (Address)

TINOCO REIMBURSEMENT REQUEST, PHASE 2

To: Carol O'Bryant
DHS Accounting
8/1080

From: Medi-Cal Eligibility Branch
8/1650

This is to advise you that the following individual qualifies for a reimbursement under the Tinoco v. Belshe, et. al. court order, U.S. District Court, Northern District of California, case #C 94 0947 WHO. Please prepare and issue a reimbursement check for the amount shown below to the address provided.

TO BE COMPLETED BY THE COUNTY - PLEASE PRINT

Reimbursee (MFBU/Household Head) Name: _____ SSN _____

Address: _____

SDI Recipient's Name and SSN _____
(Name) (SSN)

Reimbursement Total: _____

Number of Months In Which Case's Verified
Medical Expenses Exceed The Post-Tinoco SOC _____;

Reimbursement Months, From _____ To _____; Other reimbursement months _____

Case ID Number _____

Signature of County Preparer: _____ Ident. No. _____ Date: _____

Phone Number: _____ Title: _____

FOR STATE USE ONLY

Certified by: _____ Date: _____
Authorized M.E.B reviewer

Phone Number: _____

EXHIBIT D



REQUEST FOR WAGE, CLAIM AND ADDRESS INFORMATION

1. SEND REQUEST TO: STATE OF CALIFORNIA EMPLOYMENT DEVELOPMENT DEPARTMENT P.O. BOX 826880 SACRAMENTO, CA 94280-0001 ATTN: INVENTORY CONTROL UNIT II, MIC 23-A	2. NAME & ADDRESS OF REQUESTING ORGANIZATION
---	---

3a. PREPARED BY:	3b. PREPARER'S TELEPHONE NUMBER: () - -	3c. DATE: / /
-------------------------	---	----------------------------

4a. CUSTOMER CODE	4b. PREPARER CODE
---	---

5. REQUESTED PRODUCTS (See instructions on back)	6. S S A N U M B E R S		S S A N U M B E R S (Cont.)		
5a. <input type="checkbox"/> WAGE & CLAIM INFO (DE 507)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5b. <input type="checkbox"/> EMPLOYER ADDRESS (DE 4989)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5c. <input type="checkbox"/> CLIENT ADDRESS	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5d. <input type="checkbox"/> DI CLAIM HISTORY (Up to 2 years old)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5e. <input type="checkbox"/> DI CLAIM HISTORY (2 to 4 years old)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5f. <input type="checkbox"/> DI CLAIM HISTORY (Over 4 years old)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5g. <input type="checkbox"/> UI CLAIM HISTORY (Up to 2 years old)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5h. <input type="checkbox"/> UI CLAIM HISTORY (2 to 4 years old)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5i. <input type="checkbox"/> UI CLAIM HISTORY (Over 4 years old)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

COMPLETION INSTRUCTIONS

GENERAL INFORMATION

You may duplicate this form, or order additional copies by writing to:

EDD FORMS & SUPPLY WAREHOUSE
805 "R" STREET
SACRAMENTO, CA 95814

The DE 8720 is a key entry document used to request information from the Employment Development Department (EDD). Please abide by the following when preparing your requests:

Please complete the form carefully, completely, and legibly.

Complete items 2 through 4a. in order for EDD to track your request. Items 5 and 6 must be completed according to the instructions below.

INSTRUCTIONS FOR COMPLETING; REQUEST FOR WAGE, CLAIM AND ADDRESS INFORMATION, DE 8720 Rev. 4 (6-95)
BY ITEM NUMBER:

1. **SEND REQUEST TO:** This preprinted item requires no customer action.
2. **NAME & ADDRESS OF REQUESTING ORGANIZATION:** Enter the complete name of your organization, followed by the street address (or P.O. Box), city, state, and ZIP code.
- 3a. **PREPARED BY:** Print your name.
- 3b. **PREPARER'S TELEPHONE NUMBER:** Enter your telephone number.
- 3c. **DATE:** Enter the date you are preparing this request.
- 4a. **CUSTOMER CODE:** This item contains the six character code that was contractually assigned to your organization by EDD. This code is used by EDD to track and distribute requested products.
- 4b. **PREPARER CODE:** This item is optional and for your internal use. The four boxes may contain any combination of numeric and/or alphabetic characters to assist in distributing products throughout your organization (back to the "PREPARER").
5. **REQUESTED PRODUCTS:** (Items 5a. thru 5i.):
 - One or more products may be selected by entering an in the box next to the associated product.
 - At least one product must be requested.
 - If a product is not wanted, leave its associated box blank.
 - All requested products will be produced, for all corresponding Social Security Account (SSA) numbers entered in item 6:
 - When the customer has contracted to receive the requested product.
 - If the requested product is available.
6. **SSA NUMBERS:** Enter one or more SSA numbers. For each SSA number entered, all available and authorized products will be produced.

EXHIBIT E

INTRODUCTION TO THE TINOCO EARNED INCOME DEDUCTIONS VERIFICATION FORM

The Tinoco Earned Income Deductions Verification Form in this Exhibit may be used in those instances where the ACWDL requires the county to seek verification of any of the earned income deductions from the Tinoco Reimbursement applicant. The county may use copies of this form, or the county may use this form as a template for purposes of designing a county form. This form need be distributed to the applicant only if the county is unable to determine from information in the case file whether the earned income deductions are applicable during the months in which the case is a qualified case.

From: County Return Address

Addressees Name: _____

Reimbursement Period _____
under evaluation: _____

TINOCO EARNED INCOME DEDUCTIONS VERIFICATION FORM

You have submitted an application to the county Medi-Cal office for a Tinoco reimbursement for your Medi-Cal case. The county Medi-Cal office needs more information to evaluate which Medi-Cal income deductions may be applicable to you. This information may be used to recalculate your Medi-Cal share-of-cost.

Which of the following earned income disregards do you believe were applicable to your family during the Reimbursement Period written above?

1. The \$90 Work Expense Deduction will automatically be evaluated by the county. You do not need to check anything. You need not submit any verification. The county will evaluate the applicability of this deduction to your family during the Reimbursement Period.

2. Yes ___ No ___. Did you have child care expenses during the reimbursement period shown at the top of this form? (Child care expenses are amounts you had to pay to someone living outside of your household for the care of your child(ren))?

If you marked yes, and if you want the county to evaluate whether the child care deduction may be applied when recalculating your SOC, answer the following questions and provide documentation as requested (if you do not, the county will still evaluate the applicability of this income exemption based on the information in its case files):

a. Names and age of children during the beginning of this period:

Child 1; Name _____ Age (yrs) _____ (mos) _____

Child 2; Name _____ Age(yrs) _____ (mos) _____

Child 3; Name _____ Age(yrs) _____ (mos) _____

Child 4; Name _____ Age(yrs) _____ (mos) _____

b. Were you or any other member of your household present to take care of the children in your family? Yes ___ No ___. If no one was present in your household to take care of the children, please explain why on a separate sheet of paper. This explanation

should tell why the person who was receiving the SDI was not able to take care of the children.

c. What were your monthly child care expenses? You may submit bills for each month in which you want this deduction, or a statement from your child care provider, which show the following information:

- i. The provider's name and address (and license number if the provider has one.)
- ii. The date the bill was issued
- iii. The period of service covered by the bill.
- iv. The provider's phone number
- v. The amount of the bill.
- vi. If the bill is not on the provider's letterhead, the provider's signature.

For each bill, you may provide the provider's address and phone number if this information is missing from the bill.

3. Yes ___ No ___ Was a member of your household a child who was in school during the Reimbursement Period shown above? If yes, answer the following questions and present the requested documentation (if you do not, the county will still evaluate the applicability of this income exemption based on the information in its case files)

- i. How old was the child attending school at the time of attendance: _____.
- ii. When did the child begin school: beginning date _____; ending date _____.
- iii. What kind of school was attended (high school, college, other): _____
- iv. What was the name and address of the school

v. Was your child a full time ___ or part time ___ student?

4. ___ Note to the applicant: if the blank at the beginning of this sentence has a check mark, DO NOT complete this section. You are not eligible for this deduction because you were in a no-share-of-cost Transitional Medi-Cal Program for the period of time for which the deduction would have been applicable.

Read the above sentence before filling in the blanks below. Did you ever receive a cash payment from the AFDC welfare program? Yes ___ No _____. If yes, fill in the following blanks:

When did you receive your last AFDC payment: (month and year) _____ ?
Did you receive the 30% deduction while on AFDC: Yes ___ No ____; if yes, what was the last date you received this deduction: month and year _____ ?
After your last AFDC cash payment, when did you begin Medi-Cal: month and year _____ ?

Were you receiving an AFDC cash grant in any of the last four months: Yes____; No____.
If you marked yes, answer the following questions and present the requested documentation (if you do not, the county will still evaluate the applicability of this income exemption based on the information in its case files):

Did you receive the AFDC \$30 and 1/3 deduction for four months in the last 12 months:
Yes____; No _____.

EXHIBIT F

EXHIBIT G

PLEASE READ BEFORE USING THESE NOTICES OF ACTIONS

The English language NOAs in this Exhibit are ready for use. DHS was unable to translate these NOAs into Spanish in time to include it with this ACWDL. DHS will transmit the Spanish language versions via a separate All County Information Letter as soon as they become available. DHS apologizes for the inconvenience.

NOTICE OF ACTION

County name and address:

County of:

Notice Date:
Case Name:
Case Number:
Worker Name:
Telephone:
Address:

Addressee:

You do not qualify for a reimbursement under Tinoco. This is because:

- 1. No Medi-Cal case could be identified from your application.
- 2. No AFDC MN or MI person in your case received State Disability Insurance (SDI) during the January 1991 through September 1995 Reimbursement Period.
- 3. Your case did not have a share of cost (SOC) in any month in which your case received SDI during the Reimbursement Period.
- 4. Your case has already received a Tinoco Reimbursement.
- 5. Your case did not have enough medical expenses to meet your case's recalculated SOC (see recalculated SOC, top right).
- 6. The \$90 deduction was fully applied to your other earned income and you qualified for no other AFDC MN/MI deduction.
- 7. Your application was submitted after the October 31, 1996 due date.
- 8. Other; explanation:

Questions? Ask your worker.

If you do not understand English, ask your worker.

បើសិនជាមិនយល់នូវភាសាអង់គ្លេស សូមទាក់ទងវគ្គធុរកិច្ច

ຖ້າຫາກ ຫາມບໍ່ເຂົ້າໃຈພາສາອັງກິດ, ເຊີນຫ້າມຖາມ ເຈົ້າເກີ ຂອງທ່ານ.

如你不懂英語, 請問你的資格審查員 (WORKER)

Si no entiende el inglés, hable con su trabajador(a)

Nếu quý vị không hiểu tiếng Anh, xin hỏi nhân viên xã-hội

To be completed by the county if number five is checked:

Your SOC has been changed to \$ _____ from \$ _____ for _____.

Your new SOC was determined as follows:

Gross income:	\$ _____
Net nonexempt income:	\$ _____
Maintenance need:	\$ _____
Excess income:	\$ _____
Share of cost:	\$ _____

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

Rules: These rules apply; you may review them at your welfare office: 50781, 50782, 50783.

NOTICE OF ACTION

County of:

County name and address:

Notice Date:
Case Name:
Case Number:
Worker Name:
Telephone:
Address:

Addressee:

The county has determined that your share of cost (SOC) has decreased as a result of the fact that Medi-Cal now counts your case's state disability insurance (SDI) as earned income.

Questions? Ask your worker.

If you do not understand English, ask your worker.

Your SOC has been changed to \$ _____ from \$ _____ for _____

បើសិនជាមិនយល់នូវភាសាអង់គ្លេស សូមទាក់ទងវត្តមាន

ក្រុមការណ៍ ធានាបំណែងការងារសាមីស្រី, ដើម្បីការពារ ជីវិត របស់អ្នក.

Your new SOC was determined as follows:

如你不懂英語, 請問你的資格審查員 (WORKER)

Gross income: \$ _____
Net nonexempt income: \$ _____
Maintenance need: \$ _____
Excess income: \$ _____
Share of cost: \$ _____

Si no entiende el inglés, hable con su trabajador(a)

Nếu quý vị không hiểu tiếng Anh, xin hỏi nhân viên xã-hội

Your will receive a reimbursement of \$ _____

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

Rules: These rules apply; you may review them at your welfare office: 50653.5(B), 50781, 50782, 50783.