

## MEDI-CAL

Source:

*“Medi-Cal Service Rights and Entitlement Programs affecting Californians with Disabilities”*

PAI’s Revised Edition 1997,

and

*“Medi-Cal - What It Means to You”,*

State of California Department of Health Services - June 1994

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### ADVOCACY SKILLS

To receive the services and benefits you believe you are entitled to, you may need some advocacy skills. This Section will give you some general strategies, excerpted from PAI's manual on Medi-Cal, that may help you get the services you need.

1. "Do agencies that provide services to persons with disabilities have to follow any laws?"

All programs that serve children and adults with disabilities operate under statutes and regulations. Statutes are laws passed by the Legislature. Regulations are rules adopted by the agency responsible for enforcing the statute. Copies of a program's regulations usually are available for you to read at the agency local office. Ask where to go to look at the regulations. You do not need to give a reason to look at the regulations.

Agencies must obey the laws governing specific programs. Agencies that receive funds from the federal government also must comply with Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of handicap. They also must comply with Title VI of the Civil Rights Act, which prohibits discrimination on the basis of race or ethnic background.

2. What steps can I take to protect my rights?
  1. **Be assertive.** You have a right to receive services; agency staff is there to help you receive services.
  2. **If you don't understand, ask questions.** You have a right to get information from every agency in a form you understand. Ask the agency to give you information in your native language. If you don't understand what someone tells you, ask for a further explanation. Ask as many questions as you need to in order to understand.
  3. **Share information.** Your opinions are valuable. You know your needs as well as the professionals who conducted the

evaluations. Don't be afraid to voice your opinion.

4. **Be prepared.** Before going to a meeting, review your case file. Be sure you know what you want, and the reasons you want it. Make a list of questions you want answered.
  5. **Be willing to listen.** After you request a service or ask a question, listen to the agency's response. As you listen, ask yourself if the response answers your question. If you are unsure of the response, ask more questions.
  6. **Keep records.** Keep all the papers concerning your case together in a file. Keep a diary or log of verbal contacts. Write down the name of each person you talked to and when you talked to that person.
  7. **Get help.** If you feel uncomfortable about going to a meeting alone-don't. Take a friend, a relative or a representative from an advocacy organization. You always have the right to take someone with you. That person can often keep you focused on the problem, take notes about what was decided, and give you support.
3. ***I want to apply for benefits, but I cannot go to an office to apply because of my disability. What can I do?***

If you cannot go to an agency's office to apply for benefits because of your disability, Section 504 of the Rehabilitation Act may require that the agency visit your home to take your application.

4. ***I believe I am entitled to benefits, but the agency has denied my application. What can I do?***

Any time you disagree with an agency's decision, you can challenge that decision. To challenge an agency's decision, you should:

1. Have someone from the agency put the decision and the reasons for it in writing. The decision must:
  - (1) give the facts upon which the agency based its decision;

- (2) list the statutes and regulations that apply to the decision;
  - (3) explain how the law (the statutes and regulations) applies to the facts in your case;
  - (4) give the specifics of any change or reduction.
2. Ask for a written copy of the agency's appeal procedure. The agency should provide the appeal procedure as part of its decision.
3. Ask the agency to explain its decision in your native language. You may also ask the agency to explain its appeal procedure in your native language if you are unsure about reading and understanding English. You have this right under Title VI of the Civil Rights .
4. Ask the agency for names of organizations that can help you file an appeal. Even if the organizations cannot represent you, they can give you advice about what to do.
5. ***Do I have a right to examine the agency's file concerning my case?***

Generally, all agencies must give you, your parents if you are a minor, and your representative, access to agency's files concerning you. The agency also must provide you with copies of documents in the file upon request. An agency may charge the actual cost of reproducing the records if you can pay. If you cannot pay, the agency must provide the records without charge."

## WHAT IS MEDI-CAL?

MEDI-CAL , California's version of the Medicaid program, is a state and federal funded program to pay for the medically necessary treatment services, medicines and devices needed by people with disabilities and certain low-income persons. Recipients of Supplemental Security Income (SSI), Aid To Family With Dependent Children (AFDC) and In-Home

Supportive Services (IHSS) automatically receive Medi-Cal. Others receive Medi-Cal under the Medically Needy and Medically Indigent Child Medi-Cal programs, though often they must pay a monthly share of cost (SOC).

For low-income elderly, Medi-Cal operates in addition to Medicare to cover some of the costs not paid for by Medicare. Medicare is available to seniors 65 years and over who are eligible for Social Security benefits, regardless of financial need.

This manual tells about who can get MEDI-CAL, the services available to those determined eligible for full or restricted benefits, the choices for getting services, how to use the permanent plastic California Benefits Identification Card (BIC), and your appeal rights if you feel you are treated unfairly or do not get what you are entitled to get by law.

You can get MEDI-CAL benefits regardless of sex, race, religion, color, national origin, sexual orientation, marital status, age, disability, or veteran status.

Your local County Welfare Department (CWD) manages MEDI-CAL eligibility determinations. If you have questions, you can find the addresses and telephone numbers of the welfare departments in the Telephone Directory.

If you do not know some of the MEDI-CAL terms or words, you can turn to the back pages of this booklet for the meanings of those words.

## ELIGIBILITY AND MEDI-CAL PROGRAMS

Even if you are working, own a house, or are married, you may be eligible for MEDI-CAL. To get MEDI-CAL, you must fall into one of the MEDI-CAL program categories.

### ABOUT THE MEDI-CAL PROGRAMS.

To qualify for Medi-Cal, you must meet the eligibility criteria of one of the Medi-Cal programs. If you do not fit the requirements for one of the Medi-Cal programs or qualify for California Children Services (CCS), then - with limited exceptions<sup>1</sup> - the only public health care coverage is that

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<sup>1</sup>*The limited exceptions include:*

(a) *Treatment services through county administered Child Health and Disability Prevention (CHDP) programs - Health & Saf. Code §§320 et seq. for low-income children who are not eligible for Medi-Cal and whose treatment needs were identified in a CHDP screen. The treatment services are funded with Proposition 99 Tobacco Tax money allocated by the state to the counties.*

(b) *The program that pays for HIV medication for persons who do not qualify for Medi-Cal. Program participants with adjusted gross incomes of \$50,000 a year or less contribute an amount equal to twice their state income tax liability. [Health & Saf. Code §§188 et seq.]*

(c) *The Genetically Handicapped Persons Programs (GHPP) which covers persons with such disabilities as cystic fibrosis, hemophilia, sickle cell disease. Huntington's disease, Friedreich's Ataxia, Joseph's disease, Von Hippel-Landau syndrome and metabolic disorders such as Wilson's disease, disorders of lactate and pyruvate metabolism, etc. Children (under age 21) with qualifying conditions receive services through CCS. CCS financial eligibility and contribution rules apply here as well. {Health & Saf. Code §§ 340 et seq.}*

(d) *California Major Risk Medical Insurance Program - "MEMIP" or "Mr. MIP" - an assigned risk type of program for persons who cannot get adequate health benefit coverage elsewhere. You are not eligible if you have not exhausted COBRA benefits. Assigned risk slots are limited, so there is a waiting list for Mr. MIP. For more information contact Mr. MIP, 744 P. Street, Room 1077, Sacramento, CA 95814, (916) 324-4695.*

(e) *Persons whose Medi-Cal benefits fund their case in a nursing facility may be able to return home with Medi-Cal-funded services, without being disqualified because of their parents' income and resources (if they are under age 18) or their spouse's income and resources (if married).*

which may be available through the county for low income persons such as that available through the county hospital.

#### **A. CATEGORICALLY OR MANDATORY ELIGIBLE PROGRAMS**

You receive Medi-Cal benefits automatically if you receive SSI, AFDC or IHSS benefits. Your SSI, AFDC or IHSS “*categorically links*” you to the Medi-Cal program. SSI includes regular SSI as well as SSI under the 1619 programs for persons who work even though still disabled: 1619(a) special cash benefits and 1619(b) when your income is too high for cash benefits but below the income level which would suspend your SSI status. Under 1619(b) you are considered an SSI beneficiary and receive the benefit - such as Medi-Cal - you would receive if you were receiving regular SSI.

You are eligible for *categorically needy* Medi-Cal if you receive Cuban or Indo-Chinese refugee assistance.

You may be eligible to receive Medi-Cal as *categorically needy* if you are ineligible for SSI or AFDC for reasons that do not apply to the Medi-Cal program. For instance, both SSI and AFDC deems a child’s income to his siblings and parents. Medi-Cal counts only the income of a parent or a spouse.

You may be eligible for categorically needy Medi-Cal with no share of cost under the “Pickle” program if:

- you receive SSI (Title XVI) in addition to Social Security benefits at any time after April 1997;
- you are not now eligible to receive SSI because the intervening cost-of-living allowance (COLA) increase in your Social Security benefits were greater than the increases in your SSI, so that your Social Security benefit is now too high for you to qualify for SSI; and
- You meet other SSI eligibility requirements except for income from your Social Security increases.<sup>2</sup>

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<sup>2</sup> *Earned income should not disqualify you as a “Pickle” unless it was substantial because, without the intervening Title II cost-of-living allowance (COLA) increases, you would qualify for continued SSI beneficiary status and Medi-Cal under Social Security’s 1619(b) program, {42 U.S.C. § 1382H.}*

To see whether you are eligible now for “Pickle” Medi-Cal, go back to the last time you qualified for both SSI and Title II. Usually you lose SSI in January when you have a cost-of-living increase in your Title II. If you lost SSI because of a rollback in state funding SSI, then you have to wait until the next Title II cost- of-living increase to see if you would qualify as a “Pickle.” In most cases you compare your Title II grant level from the time you last received both SSI and Title II Social Security with the current SSI grant level. You are a “Pickle” if you would now be eligible for SSI if you were now receiving the same Title II Social Security benefits as you were receiving before when you qualified for both SSI and Title II.<sup>3</sup> The Title II grant level from the last time you qualified, or could have qualified, for both SSI and Title II continues indefinitely as your “Pickle” measure.

You may be eligible to receive Medi-Cal with no share of cost under a special program (*Medi-Cal DACs* or “*pseudo-Pickle DACs*”) for people who receive Social Security Disabled Adult Child (DAC) benefits if:

- you receive SSI in July 1987 or later;
- you initially qualified for Title II DAC benefits, or an increase in

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<sup>3</sup>*“Pickle” example If John were receiving \$624 in Title II benefits in 1992, his SSI countable income would be \$604: \$624 less \$20 any income disregard = \$604. In January through September, when the SSI grant level for an individual was \$645, John would receive \$41 in SSI. In November, the state reduce its supplement so that, for November and December, the SSI grant level for an individual was \$608. That means John receives an SSI grant of \$4. In January 1993, there was a Title II COLA, so John’s Title II grant went from \$624 to \$642. Also in January 1993, the SSI COLA was passed through so that the individual SSI grant level was \$620. John was no longer eligible for SSI because the Title II countable unearned income was \$622 - \$642 less \$20 = \$622.*

*John would, however, be eligible as a “Pickle.” If he receives the same amount of Title II in 1993 that he had been receiving in 1992, he would be eligible for SSI in 1993. If he received \$624 in Title II benefits in 1993, he would receive \$16 in SSI: \$624 LESS \$20 = \$604. SSI grant level \$620 less \$604 = \$16.*

*However, in September 1993 the SSI grant level was again rolled back to \$603.40. That is less than John’s countable “Pickle” income of \$604 a month. To help people like John, California enacted a state “Pickle” program so that John still qualifies for Medi-Cal with no share of cost. John would qualify again as a true “Pickle” if the SSI grant level for an individual was ever more than \$604 a month.*

DAC benefits, on or after June 1, 1987;

- you should be eligible for SSI now but for (a) the Title II DAC benefits you first started receiving in July 1987 or later, or (b) the increases in your Title II DAC benefits received in July 1987 or later.

If you receive Title II DAC before July 1987, and you want to see if you qualify as a “pseudo-Pickle DAC,” compare your Title II grant level in 1987 with the current SSI grant level. You would qualify for SSI now if your Title II Social Security DAC benefits were at the same level as they were in 1987, then you qualify for no share-of-cost Medi-Cal as a “pseudo-Pickle DAC” or “Medi-Cal DAC.” You should also qualify for no share-of-cost Medi-Cal if you did not begin to receive Title II DAC benefits until July 1987 or later.

Whether determining your eligibility for no share-of-cost Medi-Cal as a true “Pickle” or as a “pseudo-Pickle DAC,” count your Title II benefits *before* any deduction for Medicare premiums.

**Note:** *If you lost your SSI and are now paying a share-of-cost for your IHSS benefits, you may be eligible for IHSS with no share-of-cost if you qualify as a “pseudo Pickle DAC.” IHSS beneficiaries with a share-of-cost will receive notices in July to identify those who may be eligible for no share-of-cost personal care services as a “Pickle” or “pseudo-Pickle DAC.”*

## **B. MEDICALLY NEEDY (MN) AND MEDICALLY INDIGENT (MI) PROGRAMS**

You are eligible to receive Medically Needy (MN) Medi-Cal if you would be eligible to receive SSI or AFDC, but your income is too high.<sup>4</sup> For example, you may receive Social Security Disability Income (SSDI) check each month which is more than the SSI grant level plus \$20.

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<sup>4</sup> *Appendix B includes work sheets showing how you determine share of cost for the MN and MI Medi-Cal programs. You can also ask PAI to send you a memo entitled: SSI-linked Medi-Cal Eligibility - “Establishing your child’s eligibility under the ABD Medically Needy Program when family income is too high for your child to qualify for SSI; determining your monthly share of cost”*

Families with children may qualify for AFDC-linked MN Medi-Cal if they meet the AFDC “dependency” requirements. “Dependency” means that either (a) one parent is absent or “incapacitated” or (b) both parents are in the home but unemployed.<sup>5</sup> The AFDC “incapacity” standard is easier to meet than the SSI disability standard. If you have children and you are disabled, but you are waiting for SSA to approve your SSI or SSDI application, you may qualify for AFDC and/or AFDC-linked Medi-Cal. Parents or caretaker relatives may also qualify for AFDC and/or MN Medi-Cal.

Even if their parents don’t qualify for MN Medi-Cal, there are several ways children may qualify on their own.

Children are eligible for disability-linked or ABD (for “aged, blind, disabled”) MN Medi-Cal if they meet SSI disability standards and family resource limitations, but the family income is too high to qualify for an SSI cash grant. Children who do not meet SSI disability standards may qualify for AFDC-linked MN Medi-Cal if they meet AFDC dependency or other AFDC requirements.

A single parent may qualify for AFDC-linked MN Medi-Cal. Both parents in a two-parent family may qualify if one is unable to work because of a health or disability problem or, in certain circumstances, if one of them is unemployed. A single parent with a child who receives SSI may qualify for MN Medi-Cal.

Children over age 18 and under age 21 - and in certain circumstances the parent - may qualify for AFDC-linked MN Medi-Cal. AFDC cash benefits end for both parent and child when (a) the child turns 18 (if she will not graduate before her 19<sup>th</sup> birthday) or (b) the child graduates from high school (if she graduates before her 19<sup>th</sup> birthday).

Children under age 21 are eligible for Medically Indigent (MI) Medi-Cal

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<sup>5</sup> *The parental deprivation requirements are set out in 22 Cal. Code Regs. §§50205, 50209, 50211, 50213, and 50215. They require a deceased, absent, incapacitated, unemployed, or underemployed parent. AFDC requires that the child be living with a parent or relative.*

even if they do not receive public assistance (SSI or AFDC), and even if they would not be eligible for MN Medi-Cal because they do not meet SSI disability standards, AFDC dependency requirements, or other AFDC requirements.

Children may also qualify for MI Medi-Cal if they are eligible for assistance under Aid for Adoption of Children [Title 22 California Code of Regulations (22 Cal. Code Regs.), § 5025(a)(4)], or they are court dependents, or they are otherwise under the jurisdiction of the county welfare department. [22 Cal. Code Regs §5025(a)(3).] Children who qualify under these two categories do not need to meet the property, income, citizenship, residence, or institutional status requirements that otherwise apply to Medi-Cal applicants and beneficiaries. [22 Cal. Code Regs. § 5025(d).]

Adults are covered under the MI Medi-Cal program if they are in Medi-Cal -funded long-term care (a nursing home or intermediate care facility) or if they are pregnant. [22 Cal. Code Regs. §5025(b).]

If there is a share-of-cost under the MN or MI Medi-Cal program, your eligibility worker will check to see if any family members qualify under one of the zero-share-of-cost FPL program. There will no share-of-cost for members of the family who do qualify.

### ***C. MEDI-CAL FOR CHILDREN: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)***

#### *WHAT IS EPSDT?*

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) refers to a federal Medicaid obligation imposed on the states as a condition of receiving federal Medicaid money. There are two parts to the program - the screening part, and the diagnosis and treatment part. Screening services include both periodic screens (like scheduled “well-baby” examinations) and inter-periodic screens (defined as any encounter with a health professional who identifies a need for follow-up diagnosis services or treatment services). [42 U.S.C. § 1396(r)(1)(A).] Medi-Cal often provides periodic screens for Medi-Cal children under the CHDP program.<sup>6</sup>

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<sup>6</sup>*The State has used Proposition 99 Tobacco Tax funds to*

Screening services trigger a broad treatment mandate under EPSDT. Ordinarily, states have the option of not covering certain services in their state plan. Under EPSDT, California and other states must cover any optional service - that is, anything California could have opted to include in its Medi-Cal program - if the EPSDT medical necessity definition is met. However, the state has a broad discretion in determining how to meet a child's diagnostic and treatment needs.

*WHAT IS THE EPSDT MEDICAL NECESSITY STANDARD?*

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*expand the EPSDT program for low-income children (up to 200% of FPL) who do not qualify for Medi-Cal. The State CHDP program provides evaluation, assessment, and follow-up care for undocumented children and children over one year old who do not meet the resource or income standards for the 100% and 133% FPL program, as long as the family income is still less than 200% of FPL [Health & Saf. Code § 241653.3.]*

Children eligible for Medi-Cal are entitled to “necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered<sup>7</sup> by the screening services, whether or not such services are covered under the state plan.” [42 U.S.C. § 1396d(r)(5); 22 Cal. Code Regs. § 51184(b).]

*KIND OF SERVICES OUTSIDE THE SCOPE OF REGULAR MEDI-CAL SERVICES, BUT AVAILABLE UNDER EPSDT.*

Services available under EPDST, but not under the regular Medi-Cal program include services beyond Medi-Cal’s visit or treatment limits. Although the Medi-Cal program allows only two psychologist visits a month for adults, that limitation need not apply for children. Although the Medi-Cal program covers only short visits under its home health services, shift nursing and other services are available to children because the state could provide shift nursing, if it elected to do so, under the Medi-Cal home health care service. Services such as in-home behavior management, behavior aides, private duty nursing, are also available to children - even if the services are not available to adults under the regular Medi-Cal program. EPSDT may require that services the state will provide only in an institutional setting be provided in less restrictive and more natural environments when the treating physician believes a noninstitutional setting is medically necessary under the EPSDT medical necessity standard.

*HOW TO GET MEDI-CAL AUTHORIZATION FOR EPSDT DIAGNOSIS OR TREATMENT SERVICES?*

The procedures are set out in emergency regulations issued March 25, 1994. According to the regulations at 22 Cal. Code Regs. § 51340(d), the doctor must submit a TAR which states that it is submitted under EPSDT. The TAR must include the following:

- principal diagnosis and significant associated diagnoses.
- prognosis

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<sup>7</sup>*Under EPSDT, children are entitled to treatment for conditions that existed prior to eligibility for Medicaid. In addition, an “inter-periodic screen” can include an encounter with a provider prior to Medicaid eligibility, or a provider that otherwise does not participate in Medi-Cal.*

- date of onset of the illness or condition, and etiology if known.
- clinical significance or functional impairment caused by the illness or condition.
- specific types of services to be rendered by each discipline with physician's prescription where applicable.
- the therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals.
- the extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care.
- any other documents necessary to justify the medical necessity of the requested service.

We recommend that any TAR documentation include headings that track what the state EPSDT regulations require for medical necessity justification.

*WHAT ADDITIONAL SERVICES ARE AVAILABLE TO PERSONS UNDER THE EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) PROGRAM?*

The Federal Government and the State provide funding for services over and above those listed in Section XVIII to persons under 21 if they are medically necessary to correct or ameliorate physical and mental health problems or conditions discovered during a visit to a licensed health care professional.

For example, if you or your child needs more than two speech or hearing services during the month, your provider can ask MEDI-CAL for authorization to provide them, and MEDI-CAL will pay for them if they are determined medically necessary. Also, if you need help in finding the services you need, MEDI-CAL may be able to help.

If you or you doctor think that health services which are not usually covered by MEDI-CAL may be needed, you should talk to:

- your local county Child Health and Disability Prevention Program
- The Managed Care Plan you are enrolles in

Or ask your doctor to contact:

- Your local MEDI-CAL Field Office, or
- The California Children's Services Program.

*D. FEDERAL POVERTY LEVEL (FPL) PROGRAMS WITH A ZERO SHARE-OF-COST*

There are three Federal Poverty Level (FPL) program with a zero share-of-cost for a child or pregnant woman. If one family member qualifies under an FPL program, this does not make the whole family eligible. However, other family members may be eligible for other MN Medi-Cal programs based on AFDC or SSI linkage, even though they may have a share-of-cost.

Under the 200% of FPL program, low income pregnant women qualify for all pregnancy related care during and after pregnancy (for 60 days after the end of the pregnancy, and to the end of the calendar month in which the 60<sup>th</sup> day falls). You do not have to pay a share-of-cost if your family income after allowable deductions does not exceed 200% of the FPL for your family size (in 1994, \$2,467 per month for a family of four)<sup>8</sup>. In all of the FPL programs, a pregnant woman counts as two people. The 200% FPL zero share-of-cost program also covers infants under one year old for medically necessary care.<sup>9</sup>

The 133% of FPL program covers children who are at least one year old, but who have not yet reach their sixth birthday. For the child to qualify for Medi-Cal, family income may not exceed 133% of the FPL for the family size (in 1994, \$1,641 per month for a family of four).

The 100% of FPL covers children over six years of age, born **after**

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<sup>8</sup>*At the end of this manual is the 1994 Federal Poverty Level (FPL) chart showing the cut-off point for the percentage programs.*

<sup>9</sup> *[22 Cal. Code Regs. § 50262.] California has had two programs for pregnant women and infants: a 185% program mandated by federal law and a 200% program funded by state-only funds. State law was recently amended to allow the state to get federal funds for women and infants with family incomes up to 200% of poverty. Thus, in effect, there is no longer a 185% program. However, you may still see old references to the 185% program in state statutes, state regulations, and the DHS ACWDLs.*

September 30, 1983. (This means that in 1994 children up to age 11 will qualify if their 11<sup>th</sup> birthday was on or after October 1, 1994. Children who turned 11 before October 1 would not be eligible.) These qualify for Medi-Cal if the family income does not exceed 100% of the FPL (in 1994, \$1,234 for a family of four).

To determine whether the monthly family income is at or below the applicable FPL income level, Medi-Cal adds unearned income plus earned income,<sup>10</sup> then deducts child care expenses<sup>11</sup> and a \$90 work allowance. You cannot “spend down” to qualify for the zero-share-of-cost FPL programs. Thus, a four-year-old child in a family of four with income of \$1,650 a month after allowable deductions would not qualify for the 133% zero-share-of-cost Medi-Cal. The family is \$9 over the FPL income level of \$1,641 for a family of four. The child likely would qualify under another program, but probably with a share-of-cost unless the child qualifies for ABD Medi-Cal.

For a child to qualify under the 100% and 133% of FPL programs, the family must meet the Medi-Cal resource standards. Under the 200% of FPL programs, there is no resource standard. Medi-Cal waives all assets for pregnancy-related care, and for services for a child up to age one.

Undocumented children and pregnant women may qualify for Medi-Cal without a share-of-cost under one of the FPL programs, but will receive only “restricted” benefits to cover emergency and pregnancy-related care.

#### **E. TRANSITIONAL MEDI-CAL FOR FORMER AFDC BENEFICIARIES**

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<sup>10</sup> *Gross earned income means your wages and salary before any deductions. It does not mean your take-home pay. If you are self-employed, your gross earned income is your adjusted gross income - that is, your gross receipts less IRS allowable deductions. Everything else, including unemployment insurance and social security benefits, is unearned income.*

<sup>11</sup> *Child care allowance- up to \$200 a month for a child under age two, \$175 for a child aged two or older.*

If the caretaker relative or principal wage earner's earned income makes the AFDC family ineligible for AFDC, the family probably will be eligible for two six-month periods of transitional Medi-Cal. The family is eligible for the first six-month period regardless of income if the family receive AFDC benefits in three out of the last six months. For the second six-month period, the family is eligible if the family income, after allowable deductions for child care, is at or below 185% of the FPL. Twelve months of transitional Medi-Cal also would be available if the family lost AFDC because of the lost of AFDC earned income disregards which used to end after three months. However, the AFDC earned income incentives continue indefinitely because of a federal waiver that continues until 1996.

If the family loses AFDC because of an increase in child or spousal support collected, the family is eligible for four months of transitional Medi-Cal without regard to family income.

Per Section 17 of Chapter 148, Statutes of 1994, California added Welfare & Institutions Code (Welf. & Inst. Code) § 14995.85 to ask the federal government for a waiver so that the state could provide twelve months of transitional Medi-Cal when a family loses AFDC eligibility because of marriage or because separated spouses reunite.

#### ***F. MINOR CONSENT PROGRAM***

Under certain circumstances a minor (a person under age 21) may be eligible for limited benefits - "minor consent services" - without regard to family income. You may apply for minor consent services without parental contact. [Welf. & Inst. Code § 14010.22 Cal. Code Regs. § 50147.1(a).] Minor consent services include services related to sexual assault, family planning, and pregnancy. If you are age 12 or older, services include those related to substance abuse and sexually transmitted diseases. They also include out-patient mental health care if you are over age 12 and can participate in treatment services where: (a) you need those services to prevent harm to yourself or others, or (b) there is alleged incest or other child abuse. [22 Cal. Code Regs. § 50063.5] Minor consent services do not include in-patient mental health services. [DHS ACWDL No 94-63. (8/8/94), COMMERCE CLEARING HOUSE (CCH) MEDI-CAL GUIDE New Dev. ¶ 7582.]

How you apply depends on whether you are asking for mental health services or other services. For mental health services, you go to the welfare

department with a letter from a health care professional indicating that you need minor consent services because: (a) you are at risk of causing physical or mental harm to yourself or others, or (b) you are the alleged victim of incest or child abuse. [ 22 Cal. Code Regs. § 50147.1(c).] The letter from your health care professional should estimate the length of time you will need services because that determines how long your minor's consent services card will be valid. If you need only other services, you do not need to submit a letter as part of the application process. The application process involves completing the form "Request for Eligibility for Limited Services".

While other Medi-Cal beneficiaries receive a plastic card, Medi-Cal beneficiaries eligible for only minor consent services receive a paper card. Like those who have plastic card, holders of the minor consent services card will have to be verified to determine eligibility. The card contains code reference to the categories of minor consent services authorized.<sup>12</sup>

#### **G. MEDI-CAL'S SPECIAL PROGRAMS**

California in 1994 opted to cover tuberculosis treatment for persons who do not qualify for Medi-Cal on another basis and whose income and resources do not exceed the maximum amount for disabled persons under Medi-Cal. We believe that includes persons who would qualify without a share-of-cost and persons who would have a share-of-cost based on their income. [Welf. & Inst. Code § 14005.20; § 13,603 of OBRA 1993 (Public Law 103-66), amending Title 42 United States Code (42 U.S.C.) §§ 1396a(a)(10)(A), 1396a(z), 1396n(g).]

Medi-Cal also has special programs for persons who need dialysis or parenteral hyperalimentation but who otherwise do not qualify for Medi-Cal.[Welf. & Inst. Code §§ 14140 through 14144; 22 Cal. Code Regs. §§ 50801-50831.] Both programs require payment of an amount equal to 2%

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<sup>12</sup> *Per § 19B-2-b of the Procedures sections of the MEDI-CAL ELIGIBILITY MANUAL, minor consent services codes on the card or part of the verification process include: L-4, sexually transmitted diseases; L-5, mental health services; L-6, services related to sexual assault (and we assume child abuse/incest); L-7, drug and alcohol abuse services; L-8, services related to pregnancy or family planning; L-9, services related to venereal diseases.*

of your nonexempt annual worth or 1% of your nonexempt annual worth if you are

working. The dialysis program requires that you meet the MN linkage requirements except for income and resources; the parenteral hyperalimentation programs does not.

If you are working even though still disabled and, as a result of working, lost SSI<sup>13</sup> benefits, but you do not qualify for SSI's 1619 program, then you may qualify for Medi-Cal and IHSS under a special state program. [Welf. & Inst. Code § 14005.3; 22 Cal. Code Regs. § 50245(a)(5); Welf. & Inst. Code § 12305.5; Department of Social Services (DSS) Manual § 30-755-114.]

There also is a special Medi-Cal program for persons with multiple sclerosis who do not qualify for regular Medi-Cal because of income and/or resources. This program would bridge the gap between initially qualifying for SSDI benefits and the two years you have to wait before Medicare starts. Under this program, you would receive services related to multiple sclerosis until you qualify for other health care coverage, or for two years, whichever comes first. [Welf. & Inst. Code § 14005.75.] It does not appear, however, that California has implemented this program.

#### **H. MEDICARE-RELATED PROGRAMS**

There are three Medi-Cal programs for persons who qualified for Medicare:

- **“Qualified Medicare Beneficiaries”** (or QMB or Quimby”) program: This group may include persons who already receive Medi-Cal and persons who do not. Under this program Medi-Cal will pay Part A premiums (for the few who have to pay), Part B premiums, and Medicare-required deductibles and coinsurance. You qualify as a

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<sup>13</sup> We believe Welf. & Inst. Code § 14003.3 also covers persons who lost Title II Social Security benefits because of work.

QMB if your resources are \$4,000 or below for an individual, \$6,000 or below for a couple, and your countable family income is not above 100% of the FPL. (See *Appendix A, the 1995 FPL chart.*) To determine countable income to see whether you qualify for QMB, you deduct for children and an ineligible spouse as you would under SSI. If you already qualify for MN Meci-Cal, you may benefit because, under QMB, Medi-Cal would pay the Part B premium. Thus, your Part B premium would not be deducted from your monthly Title II check. In addition, Medi-Cal may have to pay for all of the coinsurance, not just up to the amount Medi-Cal would pay if it were the only payer.

- **“Qualified Disabled Working Individual”** (or QDWI) program. If you lost Medicare because of work but-
  - you are still disabled, and
  - you are still eligible for Medicare under a work incentive program, and
  - you are under age 65, and
  - you are not eligible for any other Medi-Cal program, and
  - you have resources within the level provided for QMBs, and
  - you have countable earned income under 200% of the FPL -Medi-Cal will pay the Part A premiums. You would have to pay your own Part B premiums, but not Part A premiums or other required deductibles or coinsurance. This program makes sense for people who are just over income for QMB program or for no share-of-cost Medi-Cal. “Countable income” is calculate like “countable income” under SSI program. That means QDWI may deduct Impairment Related Work Expenses (IRWE) and the \$65 and 50% disregards for earned income. Thus, if you have IRWE deductions and no unearned income, and you are a single person, you would qualify if your gross earned income were \$2,539 a month or less, based on a 200% 1994 montly FPL of \$1,237.
- **“Specified Low Income Medicare Beneficiaries”** (or SLMB) program. If you receive Medicare, and your income is at or below 110% of the FPL in 1994 (120% in 1995), and you meet the same resource limitations listed for the QMB program , then the Medi-Cal will pay your Part B premiums. This program only makes sense for those few people who do not otherwise qualify for the QMB program or for no share-of-cost Medi-Cal. To determine income you deduct

for an ineligible spouse as you would under SSI.

***I. STATE "PICKLE" MEDI-CAL PROGRAM FOR PERSON WHO LOST SSI IN 1993 OR 1994 BECAUSE OF THE SEPTEMBER 1993 AND SEPTEMBER 1994 ROLLBACKS IN SSI.***

California's 1993 and 1994 Budget Act cut back again the amount by which the state supplements the federal part of the SSI grant. Because of what happened with the 1992 cutback in the state supplementation of the federal SSI grant, the California State Legislature said that if you were eligible for SSI-linked Medi-Cal before September 1993 or September 1994 you will still be eligible after the SSI rollbacks. In addition, if you qualified as a "Pickle" before September 1993 or before September 1994 the rollbacks will not affect your Medi-Cal. Unfortunately, the 1993 and 1994 protections are not available if you still have a problem qualifying for Medi-Cal because of the 1992 SSI cutback., including if you were de-Pickle" in September of 1992.

***J. "RESTRICTED" MEDI-CAL***

Depending on your immigration status, you may qualify for regular "full-scope" Medi-Cal, or for "restricted" Medi-Cal. Immigrants who meet all the other qualifications for Medi-Cal,<sup>14</sup> but who do not have "satisfactory immigration status" (SIS) can only get "restricted" Medi-Cal. Persons who have SIS and are eligible full-scope Medi-Cal benefits include:

- lawfully admitted permanent residents, or people with "Green Card";
- persons who have formal asylum status;
- refugees with recognized status, including those granted conditional entry (refugees admitted prior to 1980, refugees from Cube and Haiti);
- persons granted parole status for humanitarian reasons;
- aliens who have an "indefinite voluntary departure" or a stay of deportation to process a petition for immigrant status visa;

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<sup>14</sup> *Even though the scope of services is limited, to qualify for "restricted" Medi-Cal you must still meet all the other requirements for one of the regular Medi-Cal programs, such as the AFDC - or SSI-linked Medically Needy program, one of the FPL programs, etc.*

- registry aliens who have lived in the United States continually since 1972.

If you are undocumented, or if you have applied for political asylum but have not yet been approved, you **do not** have SIS and you can only qualify for “restricted” Medi-Cal.<sup>15</sup> When you apply for “restricted” Medi-Cal, (a) you do not have to provide a social security number, (b) all information about your immigration status is confidential, and (c) Medi-Cal will not turn the information over to the Immigration and Naturalization Service (INS).

If you believe you have SIS, but you have lost your immigration documents or never received them, you are “presumptively eligible.” You can receive full-scope Medi-Cal during the verification process while you request your documents from INS. If INS later says you do not have permission to be here, Medi-Cal will transfer you to the restricted Medi-Cal program.

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<sup>15</sup>*Some undocumented immigrants may qualify for full-scope Medi-Cal because they are “permanently residing under color of law” - known as PRUCOL status. You have PRUCOL status if the INS knows you are living in the United States and does not intend to deport you. Most immigrants on kidney dialysis or in long-term care have PRUCOL. Other people may also apply. If you claim PRUCOL status, your county welfare department must submit a form G-845 to INS and grant you full-scope Medi-Cal while waiting for verification from INS [DHS ACWDL No 92-48 (8/7/92).]*

Restricted Medi-Cal covers emergency services. It does not cover follow-up services and continued care after the emergency is over.<sup>16</sup> Restricted Medi-Cal also covers kidney dialysis and long-term care<sup>17</sup> For pregnant women, restricted Medi-Cal covers medically necessary pregnancy-related services - including prenatal care, and labor and delivery services. If you are pregnant, virtually every health care problem could affect your pregnancy or the child you are carrying. Therefore, almost any health care problem would be related to your pregnancy.

You may have a share-of-cost for restricted Medi-Cal services, depending on (a) the rules for the MN Medi-Cal program to which you are linked and (b) your income. You may qualify for pregnancy-related services without a share-of-cost if you qualify under the 185/200% FPL program. Undocumented children may qualify for emergency services without a share-of-cost under one of the other FPL programs.

Children without SIS, but who are California residents and have a physically handicapping condition, may receive services related to their qualifying condition under the CCS program.

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<sup>16</sup>See 22 Cal. Code Regs. § 51056(b). Before April 1993, restricted Medi-Cal **did** cover follow-up services and continuation care after an emergency, but the Legislature stopped these services.

<sup>17</sup>For restricted Medi-Cal to cover kidney dialysis or long-term care, you must apply for full-scope Medi-Cal as PRUCOL-eligible. If INS denies you PRUCOL status, restricted Medi-Cal will still cover your care [DHS ASWDL No 89-84, revised 8/7/92 in DHS ACWDL No 92-84 (re: Crespin v. Kizer).]

Children eligible to receive adoption assistance benefits, or who are in out-of-home placement through the dependency court, are eligible for full-scope Medi-Cal benefits without regard to their immigration status.<sup>18</sup>

### **K. PREGNANT WOMEN**

If you are pregnant and cannot afford to pay for health care, MEDI-CAL can help pay for medical expenses for you and you baby. Many times you can get MEDI-CAL at no cost to you, even if you have income. Once you get MEDI-CAL, increases in your family's will not be counted:

- during your pregnancy, and
- \* for your baby first year of life.

Participating perinatal providers throughout California can offer the pregnant patient immediate, temporary MEDI-CAL coverage pending the formal MEDI-CAL application under a new program called Presumptive Eligibility for pregnant women. If you are pregnant and interested in this service, ask if your provider participate in this program.

### **L. MEDICAL SUPPORT ENFORCEMENT**

All children have the right to be supported by both parents. If you are applying for MEDI-CAL benefits, you must cooperate in establishing paternity for a child(ren) born out of wedlock and obtaining medical support services

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<sup>18</sup>[22 Cal. Code Regs. §§ 5025(a)(4), (c), (f) adoption assistance; 22 Cal. Code Regs. §§ 50251(a)(3), (c), (e).] The regulations provide that MI Medi-Cal is available to "[a] child who is not living with a parent or relative and for whom a public agency is assuming financial responsibility in whole or in part." [22 Cal. Code Regs. § 50251 (a)(3).] That would on its face include children in out-of-home placement funded by a regional center, and/or children such as those on probation from the juvenile justice system. However, Welf. & Inst. Code § 14007.4 seems to limit coverage to children under the jurisdiction of the county welfare department. A recent General Accounting Office (GAO) report expressly provides that the children on probation are not entitled to full-scope benefits despite the above regulation. [GAO Letter B-256248, GAO/HHS-94-116r (3/18/94); CCH MEDI-CAL GUIDE New Dev.¶ 7558.]

for a child(ren) who has an absent parent. You will be provided all child support services unless you notify the FSD/DA that you do not want to receive those services that are unrelated to obtaining medical support and establishing paternity. Some of the available services are as follows:

- locate the parent(s) for support enforcement purposes;
- Establishing paternity;
- Establishing a child and/or medical support (health insurance) order;
- Enforcing a child and/or medical support order;
- Modifying an existing court order for child and/or medical support;
- Enforcing a spousal support order in conjunction with a child support order;
- Collecting and distributing support payments.

***Custody and visitation services are not provided.***

*M. AMNESTY ALIENS:*

Congress passed a law in 1986 which granted amnesty to aliens who previously did not have the right to remain in the U.S. If you are an amnesty alien and also blind, disabled, under age 18, or age 65 or older, you may get full MEDI-CAL benefits. If you are not blind, disabled, under age 18 or 65 or older, you may only get restricted MEDI-CAL benefits during the first five years of your legalization, if otherwise eligible.

## WHAT DOES IT MEAN TO BE “DISABLED” FOR MEDI-CAL?

To get MEDI-CAL as a disabled person, you must have severe physical and/or mental problem(s) which will:

- last at least 12 months in a row and,
- stop you from working during those 12 months, **or**
- probably result in death.

You must prove your disabling physical and/or mental problem(s) with medical records, tests, and other medical findings. The medical problem must be the main reason why you do not work.

To get MEDI-CAL for a disabled child, the child must have severe medical and/or mental problem(s) which:

- are on a list of disabling childhood conditions, **or**
- are so severe that he/she would not be able to do daily activities which a healthy child would be able to do.

If you have a severe and/or mental problem that is on a list of disabling conditions, you may be able to get MEDI-CAL based on disability prior to the final determination of disability. (This also applies to children.) Ask your eligibility worker for more information about Presumptive Disability.

## INCOME, RESOURCES AND MEDI-CAL ELIGIBILITY

Resources are cash or anything you can convert to cash for your maintenance and support. The following resources are exempt (do not count):

- \* the home you live in;
- Proceeds from the sale of a home and/or other real estate property used to purchase a home (for six months);
- other income-producing real property or a trust deed from sale of your property not exceeding \$6,000 in assessed value (not the same as face value);
- one motor vehicle;
- clothing and household goods;
- musical instruments;
- wedding and engagement rings, heirlooms, and any other item of jewelry with a market value of \$100 or less;
- work tools, items needed for self-employment;
- burial funds<sup>19</sup>
- retirement accounts (IRA, Keogh, tax-sheltered annuity) that belong to your spouse or parent if you are eligible for Medi-Cal because of age, blindness or disability are exempt (but the cash in value of any retirement accounts that belong to you when you apply for or receive Medi-Cal count against your resource limitation)<sup>20</sup>

Resources are not counted in the 200% FPL program for pregnant women and infants up to one. The regular resource limits apply for other FPL programs.

If your resources are greater than the Medi-Cal limits when you first submit your Medi-Cal application, you have until the end of the month to

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<sup>19</sup> *The burial fund may be a separate bank account you have designated for that purpose. You may not commingle it with other funds. For instance, you cannot say that \$1,500 of a 43,000 bank account is a burial fund, but you can move \$1,500 of that account into a separate account for burial expenses.*

<sup>20</sup> {20 CFR. § 416.1202.} We believe the rule applies even though the Medi-Cal program has not adopted a rule to implement the change in the SSI regulations into the Medi-Cal program.

reduce them to resource limits. If you do, and you are otherwise eligible, you will get Medi-Cal for the whole month. When you submit your application, an eligibility worker must tell you about your right to reduce your resources to qualify in the month of application. If no one explains this rule to you in person (either because your interview is delayed to the next month or because the worker forgets) then the county may not apply the resource limits to you.

*WHAT HAPPENS IF I HAVE A TRUST ACCOUNT? DOES THAT COUNT AS A RESOURCE?*

Medi-Cal rules about trusts are different from the rules SSI and AFDC programs use. Under SSI and AFDC, if you are beneficiary of a trust, but the trustee does not have to make payments to you or on your behalf, then the trust generally is not “available” to you and does not count as an asset. Medi-Cal works in reverse. Most of the time, if a trust is revocable, or if the trust terms do not prohibit the trustee from making payment to you or on your behalf, the trust is considered “available” for Medi-Cal purposes. There are some important exceptions.

**First**, if you actually receive AFDC or SSI, you should get Medi-Cal no matter what Medi-Cal might think about the trust.

**Second**, if you are disabled, under age 65, and your trust meets certain conditions - it was established by a parent, grandparent, legal guardian, or court, and the state has a claim against the assets remaining in the trust when you die - then the special Medi-Cal rules do not apply.

**Third**, the special Medi-Cal rules do not apply to your trust if you are disabled, no matter what your age, if (a) the trust is run by a non-profit association, (b) the association pools the accounts of various beneficiaries, (c) the accounts were established by a parent, grandparent, legal guardian, or court, and (d) the state has a claim against the assets that are not retained by the trust when you die.

**Fourth**, if it would be an “undue hardship” for Medi-Cal to disqualify you because of problems with your trust, you should receive Medi-Cal.

**Fifth**, even if your trust does disqualify you from Medi-Cal, other people in the family - who are not your spouse or children - should get Medi-Cal if they are otherwise eligible.

**Note:** If your trust is accountable for Medi-Cal, and the trustee makes it irrevocable so it will not count anymore, that change might lead to a penalty disqualifying you from Medi-Cal-financed nursing home care. [42 U.S.C. §§ 1396p(d)(3)(B)(ii) and 1396p(c); 22 Cal. Code Regs. § 50409.]

This is a very complicated area of the law. Congress passes a law in 1993 that makes it even more complicated. Neither federal nor state regulations to implement the 1993 law are complete. If you need help getting current information on the law, you can contact the National Senior Citizens Law Center or the National Health Law Program in Los Angeles.

## MUST I LIVE IN CALIFORNIA TO GET MEDI-CAL?

Yes. You must be a resident of California in order to get MEDI-CAL.

You must also give evidence that you are a resident of California before your MEDI-CAL can be approved. You must give one of the following listed items to the eligibility worker:

1. A recent California rent or mortgage receipt or utility bill in your name, or
2. A current and valid California motor vehicle driver's license or identification Card issued by the California Department of Motor Vehicles in your name, or
3. A current and valid California motor vehicle registration in your name, or
4. A document showing you are employed in California, or
5. A document showing you are registered with a public or private employment service in California, or
6. Evidence that you or your children are enrolled in school in California, or
7. Evidence that you are receiving public assistance, other than MEDI-CAL in California, or
8. Evidence that you are registered to vote in California, or
9. Other acceptable evidence of your California residence, if you declare, under penalty of perjury, that you do not have any of the documents or evidence listed in Section 1 through 8.

However, you do **not** have to give this evidence if:

1. You are applying for Minor Consent services, or
2. You are the child of a parent who has also applied for MEDI-CAL and given evidence of California residence, or
3. Your wife or husband has applied for MEDI-CAL and given evidence of California residence, if she or he lives at your same address.

## WHERE DO I APPLY FOR MEDI-CAL?

You should apply for MEDI-CAL at your local County Welfare Department office nearest you. You can find the addresses and phone numbers of the welfare departments in Telephone Directory. MEDI-CAL eligibility workers may be located at some health clinics or hospitals where you get health care services. Ask your local county welfare department to tell you where you can apply in your area.

If you get an SSI/SSP grant, MEDI-CAL eligibility is automatically set up by your Social Security district office.

## HOW DO I APPLY FOR MEDI-CAL?

If you are pregnant or in immediate need of medical care, ask the eligibility worker who interviews you for “expedited service.” The county welfare department will process your application as fast as possible. Pregnancy is considered an immediate medical need. Be sure to tell your eligibility worker right away when you apply if you have a medical appointment soon.

Please read the booklet section called “What Do I Need To Bring for Verification?” so that you know what to bring to the office when you apply for MEDI-CAL. You can speed up the process by bringing in the necessary information and paperwork quickly. The usual application procedure is:

1. **Get a MEDI-CAL application** from the county welfare department in your area.
2. **Fill out the form(s)** as completely as you can.
3. **You should apply for MEDI-CAL “retroactive benefits”** if you had medical services in the three months before the month you apply for MEDI-CAL, and you think you will need help from MEDI-CAL to pay the bills. If you were eligible for MEDI-CAL during the three months before the month you apply, even if you have paid the bills, MEDI-CAL may pay these bills. You can apply for “retroactive” MEDI-CAL at the same time you apply for MEDI-CAL. If you don’t ask for retroactive MEDI-CAL until **after** you start getting MEDI-CAL, you have up to one year to ask for MEDI-CAL for that retroactive month.

4. When you apply for MEDI-CAL, ***your eligibility worker will explain your rights and responsibilities. You must give any changes*** in address, property, income, family composition, other circumstances, and private insurance coverage to your eligibility worker ***within ten days.***
5. ***Return the application form and wait to be seen by or given an appointment with an eligibility worker. You will receive additional forms to fill out. Bring all the necessary paperwork, including proof of all information, with you to the interview.***

**NOTE:** *In some counties, when you are a MEDI-CAL “beneficiary” (that’s what you are called when you get MEDI- CAL) you may be required to sign up for a MEDI-CAL medical plan and/or dental plan. If you are required to sign up for a medical or dental plan, you may choose a personal doctor and/or dental from a list given to you by the medical and dental plans.*

*If you live in one of those counties where there are MEDI-CAL medical and dental plans, you will receive additional information about the choices you have available for getting your MEDI-CAL benefits, and the plans offered to you. You will receive this information at the time you apply for benefits, or when the county redetermines your benefits.*

*In some cases, you will receive information about the medical and dental plans available, and information about how to enroll in the plans, through mail.*

6. ***It may takes up to 45 days for you MEDI-CAL application to be processed.*** If you are applying for MEDI-CAL based on disability, your application process may take 90 days. If you think you have an immediate medical need, tell your eligibility worker and your application may be processed faster. You can speed up the process by bringing in the necessary information and paperwork quickly.
7. ***You will get a letter in the mail telling you if your MEDI- CAL application is approved or denied.*** If you choose to sign up for MEDI-CAL health care plan, you will get a health care plan identification in addition to the State-issued BIC.
8. ***If you do not get an answer to your MEDI-CAL application within a month after you apply, call your eligibility worker.***

## *WHAT DO I NEED TO BRING FOR VERIFICATION (PROOF)*

You must give certain information **before** your MEDI-CAL can be approved. Your eligibility worker will tell you what this proof is.

You may apply without the proof, but you will have to give it within a few days. If you cannot get the proof yourself, ask your eligibility worker to help you.

### ***ITEMS REQUIRED for full MEDI-CAL benefits (if applicable):***

1. Social Security Card(s).
2. Medicare card(s).
3. Naturalization document(s).
4. Alien registration card(s).
5. Pregnancy verification.
6. Income verification:
  5. Employee pay stubs or a statement from employer showing gross earnings and deductions.
  - {SEQ a,\_b,\_c, \\* alphabetic \n}. Award letter or checks showing amount of pension or benefits, including Social Security and V.A.
  6. State Unemployment or Disability award letter.
  7. Student Loan grant award letter(s) or loan grant papers.
  8. Statement from providers or other income (contributions, refunds, child support, etc. )
  9. Self-employment information: Last year's tax return or current ledgers, current inventory, including business equipment and supplies.
  10. Care costs for child/incapacitated person(s).
7. Property Tax statements for all property.
8. Vehicle Registration(s) for automobiles, boats, campers and trailers.
9. All checking and savings account statements and trust account documents.
10. All stocks (brokerage statements), bonds (including U.S. Savings bonds) and mutual funds.
11. All deeds of trust, mortgages, other promissory notes and contracts of sale.
12. All life insurance policies, including cash surrender value.

13. All annuity policies.
14. All burial trusts/prepaid burial contracts/information on burial plots.
15. Documentation regarding the current value of all trusts.
16. Payment book(s) for all encumbered property.
17. All policies/cards for health insurance you currently have or which are available to you.
18. Application(s) for possible available income (i.e. unemployment benefits, state disability benefits).
19. Court orders relating to income and property.
20. Lease agreements.
21. Life estate agreements.
22. Copies of patient trust account ledgers.
23. Rent receipts, current utility bills, or housing statement.
24. Copies of child support orders or divorce decree.
25. Social Security disability or SSI denial or discontinuance notice (if applying for disability-based MEDI-CAL).
26. Evidence of California residence.

## SHARE OF COST (SOC)

### *WILL I HAVE A SHARE OF COST AND HOW MUCH WILL IT BE?*

Depending on your monthly income, MEDI-CAL may determine that you have to meet a share of cost (SOC) before MEDI-CAL will pay for you, or your family's medical expenses for the month. The next section explain "meeting a share of cost".

Whether you will have a share of cost (SOC) for a month, and the size of your SOC, depends on how much money or income you and your family get for the month. MEDI-CAL allows you to keep a certain amount of your family's income for your living expenses (this portion is called your Maintenance Need). MEDI-CAL may also allow you to keep additional amounts of your family's income. Any income for the month which is more than the amount you are allowed to keep becomes your SOC for the month.

In some families, the income of one person cannot be used to decide if another person has a SOC. For example, income of a child cannot be used to decide whether a brother or sister, parent, stepparent or caretaker relative has a SOC. Income of a stepparent cannot be used to see if a stepchild has a SOC.

If you don't have any medical expenses during a month, you do not need to show that you met your SOC for that month. However, keep your BIC in case you need medical services in upcoming months.

### *HOW DO I MEET MY SHARE OF COST?*

You may meet your SOC for the current month by showing MEDI-CAL that you have paid, or have promised to pay, for your medical expenses an amount of money the same as your SOC. There are two ways to show MEDI-CAL that you have paid or promised to pay your SOC for a certain month. These two methods are:

1. In every month that you have a SOC, your county will notify the State of the amount of SOC you must pay. When you go to the medical provider and give the provider your BIC, your provider will be able to obtain information from a computer system about your SOC. After the

provider accepts your promise to pay for the medical services, or you pay those services, the provider will forward the amount of SOC paid, or promised to be paid, through the computer system to the State. The State will immediately update the SOC system so that future providers will know the amount of SOC that remains, if any. When you have met your SOC for the month, all future providers will receive information that you have met your SOC for the month and whether or not you are eligible for covered MEDI-CAL services.

2. Another way to show you have paid or promised to pay your SOC is to take your medical bills directly to your county eligibility worker. You may take your bills for medical services you got during the current month to your county eligibility to apply toward your SOC. You **must** take all medical bills from previous months (for which you still own money and which you want to apply toward your SOC) to your eligibility worker. Your provider cannot use the SOC computer system for your old medical bills.

Medical bills brought to your eligibility worker must contain certain kinds of information before your eligibility worker can apply these bills toward your SOC. Your medical bills must show this information:

1. Provider's name and address.
2. Name of person who got the medical service.
3. Description of the medical service received.
4. Procedure Code (a medical/dental reference number) for medical/dental services received - your provider will know what this number is.
5. Provider's MEDI-CAL provider number, or if not a MEDI-CAL provider, the provider license number, or federal tax identification number.
6. Date(s) medical services received.
7. Date on which bill was issued. For old medical bills, this date must be within 90 days of the date you give the old medical bills to your county worker.
8. Amount billed to person getting service.

If any of this information is missing from a medical bill, you must try to get it from your provider. If you are unable to get it, your eligibility worker will try to help you. Billing statements from collection agencies and credit card statements sometimes may be used as evidence of medical expenses. Under certain conditions, you may give the missing information by making a

sworn statement.

If your eligibility worker is unable to accept a medical bill, you will get a letter giving the reason for the disapproval of the bill. You will have ten days to fix the problem and bring/send the bill again. If you do not do this, you will receive a denial letter within the next 30 days which will give the reason for the denial and tell you what you must do before you may bring/send your medical bill again. You will get a separate letter for medical bills which have been accepted and applied toward your SOC.

*WHAT IF I HAVE PRIVATE INSURANCE HEALTH INSURANCE COVERAGE?*

You can have MEDI-CAL even though you have private health coverage. If you are a MEDI-CAL beneficiary and have individual or group private health insurance coverage, you are required by federal and state law to report it. This information must be given to your county welfare department, to your health care provider, and/or to the Family Support Division/District Attorney (FSD/DA), when there is an absent parent who may be responsible for your child(ren)'s medical care, or in a paternity establishment when a child is born out of wedlock. If you fail to report any private health insurance coverage that you have, you are committing a misdemeanor.

Under Federal law, health insurance belonging to MEDI-CAL recipient in a child or medical support enforcement case is used as follows:

The provider of service will bill MEDI-CAL. MEDI-CAL will pay the provider of service. Then MEDI-CAL will seek repayment from other health coverage. You will not be liable for any insurance cost-sharing amount (coinsurance or deductible) unless a MEDI-CAL share of cost must be met. If your other health insurance is a Prepaid Health Plan (PHP) or a Health Maintenance Organization (HMO), you must use the plan facilities for regular medical care. Out of area services or emergency care should also be billed to the PHP/HMO.

Therefore, you must tell your eligibility worker (EW) and/or the FSD/DA:

if you, your child(ren), or the other parent of your child(ren) has a private health insurance coverage.

- when the private health insurance coverage is through your employer, your union, or group organization.
- within ten days, when your private health insurance coverage changes or stops.
- about any court order (such as divorce judgement or temporary support order) which makes the other parent responsible for providing health insurance.

You must:

- give your medical provider any information needed to bill your private health insurance coverage.
- send to the Department of Health Services' Third Party Liability Branch any payment you get directly from an insurance carrier for services paid by MEDI-CAL. The address is:

***Department of Health Services  
Third Party Liability Branch  
Health Insurance Section  
P.O.Box 671  
Sacramento, CA 95812-6710***

You must:

- send to the Department of Health Services' Third Party Liability Branch any medical support payment you get from the absent parent. The address is:

***Department of Health Services  
Third Party Liability Branch  
Recovery Section  
P.O. Box 2946  
Sacramento, CA 95812-2946***

- use your health maintenance organization (HMO), and/or prepaid health plan (PHP) such as Kaiser Health Plan, CHAMPUS, or military coverage, for regular care. Out of area services for emergency care should also be billed to the HMO/PHP.
- use your BIC only for MEDI-CAL covered services that your prepaid or health maintenance plan or military **does not** cover.

If you have other health insurance coverage, the computer system will

be coded to show other health insurance.

A provider (doctor or pharmacy) may not refuse to provide service or fill your prescription solely because you have other health insurance coverage (in addition to MEDI-CAL.) If you do **not** have other health insurance coverage and the computer system is coded that you **do**, ask your eligibility worker to correct the coding on the computer system. If you have SSI/SSP and the computer system is incorrectly coded to show other health insurance coverage, and you do not have it, please call the Department of Health Services' Health Insurance Section at 1-800- 952-5294 (toll free) to correct the coding on the computer system.

If you are having a claims payment problem with a provider, you may call the Electronic Data Systems Beneficiary Inquiry Unit at (916) 636 1980.

*WILL MEDI-CAL PAY MY PRIVATE HEALTH INSURANCE PREMIUMS IF I CAN NO LONGER AFFORD TO MAKE PAYMENTS?*

If you are a MEDI-CAL beneficiary and you have a very high-cost medical condition which requires a physician's care, the Department of Health Services may pay your private health insurance premiums, if it is cost effective, under the Health Insurance Premium Payment (HIPP) program. There are specific requirements to qualify for the program and not all applicants are approved for HIPP. For more information on HIPP:

- ask your eligibility worker to refer you, or
- call the Department of Health Services' HIPP Program at 1-800-952-5294.

A HIPP representative in Sacramento will explain the process and requirements for the program. If it appears that you may meet the eligibility requirements, an application will be sent to you.

*MY SSI STOPPED AND I RECEIVE A MEDI-CAL TERMINATION NOTICE. WHAT SHOULD I DO TO MAKE THAT THERE IS NO BREAK IN MY MEDI-CAL?*

Under federal law and the *Ramos v. Myers* case, when you lose your SSI, Medi-Cal cannot cut off your benefits until the county has determined whether you qualify for Medi-Cal on another basis. First, the State Medi-Cal program will send you (a) a notice that your SSI-linked Medi-Cal is

terminated and (b) a new Medi-Cal application form.

It is very important that you fill out and return the application to the county by the date indicated - usually the 20<sup>th</sup> of the month. We recommend that you send in the application by return receipt requested so that you have proof of when the county received your application. Because the county often makes mistakes, we also recommend that you appeal this first notice of action - to make sure that your Medi-Cal continues while the county process your new Medi-Cal application.

If your (or your child's) SSI stopped because your income increased, your Medi-Cal will continue, but you will have a share-of-cost. If SSI stopped because

of excess resources, or because Social Security decided your child was no longer disabled, then Medi-Cal will continue with a zero share-of-cost.

If you lose SSI because you enter a nursing home, Medi-Cal will continue with no share-of-cost, but the county must contact you within 30 days and help you complete a Medi-Cal application. Although you do not have to send a Medi-Cal application to the county, and the county is supposed to make sure that your Medi-Cal continues without interruption, it is still good idea to appeal the first notice of action - in case the county makes a mistake.

If you do not return the new MN Medi-Cal application, or if the county decides you don't qualify, you will receive a second notice of action from the county terminating your extended Medi-Cal benefits under *Ramos*. If you appeal this county termination notice before the end of the month, your Medi-Cal will continue as "aid paid pending" until your fair hearing. If you forgot to send your new Medi-Cal application in on time, this should give you time to straighten out the problem.

MY AFDC STOPPED AND I RECEIVED A MEDI-CAL TERMINATION NOTICE. WHAT SHOULD I DO?

Just as with SSI, when you lose your AFDC benefits, the state must continue Medi-Cal benefits with no share-of-cost. Under the *Edwards v. Myers* case Medi-Cal must continue until the county decides whether you

qualify on another basis - such as the MN Medi-Cal program (if your income or resources have increased) or one of the FPL programs. (if you no longer meet the AFDC-linkage requirements but you still have a low income.

Under *Edwards*, when AFDC is terminate, if there is enough information in the case file to permit continued Medi-Cal eligibility on some other basis (such as through the MN Medi-Cal program), the family should be transferred automatically without the need for a new application. If the county needs more information, the AFDC termination notice should tell what information you need to provide to establish Medi-Cal eligibility for a new program. The county must then continue Medi-Cal benefits with no share-of-cost for one , month while you provide this information.<sup>21</sup>

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<sup>21</sup>If the county needs more information, you will have 20 days to complete a form and return it to the county. If you turn the form in late, or it is incomplete, the county will send you a notice terminating extended Medi-Cal under *Edwards*. If you appeal this notice and/or turn in the form before the date your benefits terminate, your Medi-Cal will continue and the county may find that you had good cause for missing the deadline.

You will not have one month of extended Medi-Cal eligibility under *Edwards* if AFDC is terminate because: (a) an absent parent returns so that deprivation no longer exists; (b) you move out of California; (c) loss contact; or (d) non-cooperation. The county **must** reevaluate your eligibility and provide one month of extended Medi-Cal if you lose AFDC for any other reason (including lump-sum income) which is not an eligibility requirement for Medi-Cal.<sup>22</sup>

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<sup>22</sup>Families that have received transitional Medi-Cal or four-month continuing Medi-Cal with no share-of-cost must also receive extended Medi-Cal with no share-of-cost for an extra month if their Medi-Cal reevaluation is not completed before the end of their eligibility period.

## MEDI-CAL CARDS

### *IS THERE A NEW MEDI-CAL CARD FOR 1994?*

Starting in early 1994, and over a period of months, a new permanent plastic California Benefits Identification Card (BIC) will be sent to MEDI-CAL beneficiaries throughout California, on a county by county basis. In this booklet, the new MEDI-CAL card will be called BIC. The “old” MEDI-CAL card will be called the paper MEDI-CAL card. When you get the BIC, ***do not throw it away. You will not get a new plastic ID card (BIC) every month.***

***NOTE: The Benefits Identification Card (BIC) does not guarantee MEDI-CAL eligibility.*** Take this card to your doctor, pharmacy, hospital or other medical provider. The provider will use this card to obtain information to determine if you are eligible for MEDI-CAL.

### *WILL I STILL GET A PAPER MEDI-CAL CARD?*

After beneficiaries in all counties get the BIC, only MEDI-CAL beneficiaries who get Confidential Medical Services (as described on page 2) and those beneficiaries in “immediate need” will get a paper MEDI-CAL card.

***NOTE: If you are a beneficiary 18 years of age or older who is not in long-term care, and not getting emergency services, you must sign and date your paper MEDI-CAL card or BIC when you get it and before you give the paper MEDI-CAL card or BIC to a provider for any care.***

### *HOW DO I USE THE BENEFITS IDENTIFICATION CARD?*

You should always carry your BIC with you.

***Remember: Find out if the provider takes MEDI-CAL patients before you go to treatment. The provider has a right to refuse to take MEDI-CAL. If you forgot to tell the provider that you have MEDI-CAL, you may have to pay your bill.***

Ask your local medical society for providers who take MEDI-CAL patients. Call the Delta Dental Office for dental referrals at (800) 322 6384.

For each service you get, give the provider your BIC so MEDI-CAL can pay the provider (if you are eligible for MEDI-CAL.)

Some services must be approved by MEDI-CAL before you may get them. The provider will know when you need prior approval.

***MEDI SERVICES:***

MEDI labels will be phased out as BIC's are distributed. Some services are restricted to two per month. There are a few exceptions, but generally you can get a total of two of the following services:

- \* Acupuncture services
- \* Audiology services
- \* Chiropractic services
- \* Occupational Therapy
- \* Podiatry services (some)
- \* Psychology services
- \* Speech Therapy

If you need any of the above services, discuss your treatment plan and appointments with your doctor. Your doctor must "reserve" MEDI services in advance. A reservation can be canceled by your doctor if you don't need the service after all or if you need a different service instead.

***POE SERVICES:***

POE labels will be phased out as BICs are distributed.

1. The following services are not automatically limited but your doctor may need to get prior approval from MEDI-CAL. Your doctor will decide which services you need and will ask for approval when it is needed. Some of the services which require prior approval are:

- \* Hemodialysis services (kidney treatment)
- Medical transportation
- Nursing home care
- Hospice care
- Some dental services
- Artificial limbs, braces, and eyes

- Hearing aids
- Inpatient hospital care (see MEDI-CAL terms)
- Physical Therapy
- Crutches, wheelchairs, and other durable medical equipment
- Prescribed drugs not on the MEDI-CAL drug list
- Medical supplies not on the MEDI-CAL medical supplies list
- Home health - Home and Community-based services as a possible alternative to hospital or nursing home care.

2. The following services are not automatically limited and do not need prior approval:

- Most doctor's services and most clinic visits
- Eyes glasses and eye appliances
- Laboratory, X-ray, and radiation treatment
- Blood and blood derivatives
- Medical screenings for person under 21 are available to identify medical problems.

*You are encouraged to take advantage of this service because regular physical check-ups will help keep your children healthy. Ask your eligibility worker about the Child Health and Disability Prevention Program. If you are pregnant, you can get prenatal care guidance to help you get the care you need to have a healthy baby.*

- Prescribed drugs on the MEDI-CAL drugs list if prescribed for the conditions specified on the list.
- Medical supplies on the MEDI-CAL medical supplies list if prescribed for the conditions specified on the list.

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services do not require prior approval. However, these services may be limited.

#### **WHAT ARE SHORT-DOYLE MEDI-CAL SERVICES?**

Short-Doyle Medi-Cal services include a range of mental health

services delivered through county mental health program. [Welf. & Inst. Code § 14021.] In 1992, the California Legislature recognized or “realigned” funding for mental health services, including Medi-Cal mental health services. As part of the “realignment,” the counties received block grants for mental health services, including services for persons who qualified for Medi-Cal, plus the authority to draw down the federal match for services delivered to Medi-Cal beneficiaries. The Bronzan-McCorquodale Act [Welf. & Inst. Code §§ 5600 and sections following] set out the standards and procedures for locally administered and controlled community mental health programs. The target populations include severely emotionally disturbed (SED) children and adolescents, adults and older adults with a serious mental disorder, adults at risk of inpatient psychiatric care, residential treatment or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence, persons needing brief treatment because of a natural disaster or severe local emergency. [Welf. & Inst. Code § 500.3.] The minimum services for eligible children include pre-crisis and crisis services, assessment, medication education and management, case management, 24-hour treatment services, rehabilitation, and support services designed to alleviate symptoms and foster development of age-appropriate cognitive, emotional, and behavioral skills necessary for maturation. [Welf. & Inst. Code § 5600.5.]

## PRIOR AUTHORIZATION

### *HOW CAN I GET PRIOR AUTHORIZATION FOR A MEDICAL SERVICE?*

The provider will submit a treatment authorization request (TAR) form with documentation on your need for the requested services, medicine, or device. In most cases the provider will submit the TAR by fax. However, the provider also may mail the TAR or may telephone in the request and, if approved, follow up with a written confirmation. [Welf. & Inst. Code §§ 14133.3, 14133.37, 14133.6, 14133.65, 14133.9, 14136.1, 14136.3, 14136.4; 22 Cal. Code Regs. § 51003.] The documentation must explain why you need the service to protect your life, to prevent significant illness or disability, or to alleviate severe pain.<sup>23</sup> The provider must submit complete medical justification with the TAR form because that is the only thing Medi-Cal analyst reviews except in the case of medical transportation. Medi-Cal will return the TAR form to the provider with its approval or denial with (a) an explanation of why the authorization was denied and (b) information about your appeal right. [22 Cal. Code Regs. § 51014.1(a).]

### *HOW LONG DOES MEDI-CAL HAVE TO APPROVE OR DENY A TAR?*

The California Legislature said that the Medi-Cal program is to act on a TAR in a timely manner. A timely manner is an average of five working days following receipt of the TAR. If the Medi-Cal program does not act on TAR within 30 days of receiving it, the TAR is approved by operation of law. The Medi-Cal program may approve, deny, notify, or ask for additional information. If you submit additional information, the Medi-Cal program processes the TAR as a new TAR in terms of timelines. Sometimes the Medi-Cal program “defers” a TAR and sends it back to the provider for more information. If Medi-Cal does not defer the TAR within 30 days of receipt, the TAR is deemed approved.

### *CAN MEDI-CAL MAKE THE PHARMACY SUBMIT TARs?*

Medi-Cal says no. Submitting TARs when necessary is not a condition of doing business under the Medi-Cal program.

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<sup>23</sup>If the Medi-Cal beneficiary is under the age 21, the EPSDT medical necessity definition may apply.

*WHAT IF THE PHARMACY SAYS THAT, SINCE MEDI-CAL DOES NOT COVER A PARTICULAR MEDICATION, I WILL HAVE TO PAY FOR IT IF I NEED IT?*

That statement may constitute fraud because, in fact, Medi-Cal will pay for the drug if approved following the submission of a TAR<sup>24</sup>. There would be no fraud if the pharmacist simply said she would not submit the TAR. The fraud is in suggesting that there is no way Medi-Cal would cover the medication, so the only way to get the medication is to pay for it.

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<sup>24</sup>*You may report Medi-Cal fraud to the two offices processing prescription TARs for forwarding to the appropriate person: Inyo County, Kern County, San Luis Obispo south - State Medi-Cal Drug Unit, Attn. Dr. Craig Mizuno, State Building, Room 9103, 107 South Broadway, Los Angeles, CA 90012; Northern California - State Medi-Cal Drug Unit, Attn. Dr. Joyce Rutan, P.O. BOX 201007. Stockton, CA 95201.*

## BIC LOST, STOLEN OR NEVER RECEIVED

### *WHAT IF I LOSE MY BIC LOST, STOLEN, OR I DO NOT GET IT WHEN I SHOULD?*

You may ask for a BIC from your CWD when you are eligible for MEDI-CAL but you have not gotten the card, you lost your card, your card was stolen, or the card you got in the mail has wrong information in it.

If your BIC is stolen, you must tell your local police and your CWD. You should give as much information about the theft as possible.

If you get SSI/SSP or AFDC each month, you should automatically get a BIC in the mail. If you do not get the card, you should contact your CWD. Even though the county does not make SSI/SSP eligibility determination or send SSI/SSP checks, they help with BIC problems for people who get SSI/SSP. The county can order a replacement BIC for you. The CWD will tell you also if you need to contact a Social Security office to correct the problem with your BIC.

## HOW DO I GET SERVICES WITH MEDI-CAL?

There are two ways to get your MEDI-CAL services. How you get your MEDI-CAL services will depend on the area you live in. In some areas, you may choose your providers from those who accept MEDI-CAL, or you may choose to sign up for a MEDI-CAL health plan if there are any in your area. In other areas, some MEDI-CAL beneficiaries must sign up for a health care plan. In the areas where you must sign up for a health care plan, there are exceptions. The exceptions will be explained to you at the same time your choices for getting MEDI-CAL services are explained to you.

You will get more information about health care plans at the time you apply or reapply for benefits. You may be required to go to a presentation at the county welfare department where they tell you about the health care plans you can sign up for. You may also get information in the mail about the health care plans in your area.

1. In those areas where you can choose your own providers, you should know how to use the BIC before you see a doctor or other provider of health services. Please read the sections called "How Do I Use the BIC?" and "What Does the Information on the Paper MEDI-CAL Card Mean?" (Look at the Table of Contents at the front of this booklet to

find the right page.)

2. If you are not enrolling in a health care plan and choosing your own providers, *you must tell the health care provider that you have MEDI-CAL before you first get care.* If you do not tell the provider that you have MEDI-CAL, *the provider may legally bill you for all services you get.* Providers of health care do not have to take MEDI-CAL patients or may only take a few MEDI-CAL patients. ***If you do not use your BIC correctly, you may have to pay for the services you get.***
3. If you sign up for a MEDI-CAL *health care plan*, you may choose a provider from a provider list the plan gives you. As a plan member, you can get all of the services covered by MEDI-CAL. Some plans offer extra services which you cannot get with your MEDI-CAL card. In addition, you do not have to pay a “co-payment” when you are a plan member.

#### WILL MEDI-CAL PAY FOR ALL MY MEDICAL EXPENSES?

Your BIC will pay for many kinds of medical expenses. When your provider uses your BIC to verify your MEDI-CAL eligibility, your provider will know if MEDI-CAL will pay for a medical treatment or if you need to make a “co-payment” for any treatment. You may have to pay \$1.00 each time you get a medical service or prescribed drug and \$ 5.00 if you go to a hospital emergency service. You do not have to pay if you are enrolled in a MEDI-CAL health care plan.

#### HOW CAN I GET HELP FROM MEDI-CAL IF I AM OUT OF STATE?

Take your BIC or proof of enrollment in a MEDI-CAL health plan with you when you travel outside California. MEDI-CAL can help in limited situations; for example, in an emergency due to accident, injury, or severe illness, or when your health would be endangered by postponing treatment until you return to California. MEDI-CAL must first approve any out-of-state in-patient medical services before you get the service. You will be responsible for medical costs for services you got out-of-state if the medical provider is not a MEDI-CAL provider or does not wish to become a MEDI-CAL provider.

The provider should first verify eligibility by contacting the fiscal intermediary at (961) 636 1000. The provider may get information on coverage, authorization and billing procedures by contacting the following:

**Medical Services**

Department of Health Services  
MEDI-CAL Field Office  
P.O.BOX 193704  
San Francisco, CA 94119-3704  
Tel: (425) 904 9600

**Dental Services**

Delta Dental  
Denti-Cal  
7667 Folsom Blvd.  
Sacramento, CA 95826  
Tel: (916) 386 1620, Ext. 3950

If you live near the California state line and use doctors or other providers of medical service in the other state, some of these restrictions do not apply. (However, medical services in Mexico or Canada are not covered except for emergency hospitalization.)

You will not get MEDI-CAL if you move out of California. You may apply for Medicaid in the state in which you live.

## MEDI-CAL MANAGED CARE

### *IS MEDI-CAL MANAGED CARE THE SAME AS A HEALTH CARE PLAN?*

Yes. MEDI-CAL Managed Care is a program whereby the State contracts with various medical providers to provide services to you in an organized and coordinated manner. The managed care plan must directly give, or arrange for, all MEDI-CAL services to you.

### *CAN I GO TO ANY PROVIDER IF I ENROLL IN A HEALTH CARE PLAN?*

If you enroll in a health care plan, you must use the plan providers and clinics unless emergency care is needed.

### *HOW DO I JOIN A MANAGED CARE PLAN?*

You can ask your eligibility worker if managed care is available and how to contact either the health care plan or the local health care options worker.

### *HOW DO I GET OUT OF A MANAGED CARE PLAN?*

In some areas, if you are in a health care plan, either through voluntary enrollment or through being assigned to a health plan, you will have to stay in the health plan for a period of six months. If you join or are assigned to one of these plans, you may disenroll (cancel) for any reason any time within the first 30 days you are in the plan, or after you have been in the plan six months.

If you are in the area where you have to stay in a health care plan for six months before disenrolling, you will get more information about this when you sign up for the health plan.

If you live in an area where the option to join a health care plan is voluntary, you may disenroll (cancel) at any time. (You contact the plan membership staff at the phone number provided in the papers you got when you signed up.) It usually takes 45 days to be canceled. If membership is mandatory in your area, then you contact the local health care options worker for help and to learn all your choices. If you are not disenrolled in 45 days, contact your eligibility worker for help.

## APPEALS AND FAIR HEARINGS

You get a Notice of Action (NOA) form in the mail from CWD whenever

your MEDI-CAL eligibility changes. If you disagree with a decision about your right to get MEDI-CAL benefits, you should talk to your county eligibility worker. If you are still dissatisfied, you may ask for a State hearing through the CWD or the State Department of Social Services. On the back of the NOA, you will find out how you can request a State hearing and where to send your request. If you disagree with the denial of a health benefit, you can also ask for a State hearing. You can also ask for a State hearing by writing, calling, or going to:

***Public Inquiry and Response Unit State Department of Social Services***

**744 P Street, Room 1616  
Sacramento, CA 95814  
1-800-952-5253 (toll-free), or  
For the deaf only  
TDD: 1-800-952-8349 (toll-free)**

You must ask a State hearing within 90 days from the date on which you believe the wrong action took place. If you ask for a hearing before the effective date of the action which stopped or lowered your MEDI-CAL benefits, you may continue to get the same MEDI-CAL benefits until the hearing.

You or your representative can read the regulations about the MEDI-CAL program and most of the facts in your case. Help is also available in some languages other than English, including Spanish.

At the hearing, an Administrative Law Judge will review the CWD's actions to see if someone made a mistake. You must either go to the hearing or give written notice for someone to go in your place. You may bring others to represent you or as witnesses. You may ask questions of the county representative or any County or State witnesses.

***MEDI-CAL DENIED COVERAGE FOR THE SERVICES MY DOCTOR PRESCRIBED.  
WHAT CAN I DO?***

Medi-Cal often refuses to pay for services or denies a prior treatment authorization request (TAR), even when your doctor prescribes the services. Medi-Cal will claim that the services are not medically necessary, or are not

covered under the state Medi-Cal plan.

When Medi-Cal denies services or denies a TAR, it must send a “notice of action” to you and to your provider explaining the reason for the denial and the regulation on which it is based, and telling you how to appeal.

Medi-Cal must also send you a notice when it modifies a TAR, or “defers” it by delaying approval until your doctor submits additional information. If you are receiving ongoing services and Medi-Cal decides to terminate or reduce those services, it must send you and your provider a notice at least ten days in advance. If you appeal during this ten-day period, Medi-Cal must continue services until your hearing. This is known as “aid paid pending”.

You have 90 days from the date of your notice of action to appeal the decision.<sup>25</sup> If you do not appeal within 90 days but decide to do so later, make a new request for the service and then appeal the second denial.

In deciding whether to appeal, review the request or TAR that your provider sent to Medi-Cal. If it did not include a letter from your treating doctor explaining in detail why you need the service, or other documents about why the service is medically necessary, it might be faster to start over again by filing a new request with adequate letters and documentation to support your need for the service.

If there **was** good documentation of medical necessity, request a fair hearing right away. As soon as you receive an acknowledgment of your fair hearing request (which will contain your hearing number), write to the Medi-Cal office that denied the TAR (the address is on the TAR denial notice). Your letter might follow this example:

### Sample Letter

Date

Medi-Cal Field Address

City, State, Zip Code

Ref: State Hearing No \_\_\_\_\_

Medi-Cal No. \_\_\_\_\_

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<sup>25</sup> *[Welf. & Inst. Code § 10951.] However, if you don't receive a notice, or the notice didn't explain why Medi-Cal denied your request and cite a regulation, then the 90-day limit does not apply. [Morales v. McMahon, 223 Cal. App. 3d 184 (1990).]*

Your name, Address, Phone Number

Prior to the hearing, I will want to review my Medi-Cal case file. At the same time, I will want to review the following:

1. The specific regulations (including the applicable Manual of Criteria section) which related to the requested services/device; and
2. Any Field Instruction Notices (FINs) and Policy Statements which address: (a) when or whether services/devices of the type requested are covered under the Medi-Cal program; and/or (b) the medical necessity and documentation requirements that have to be met or considered in connection with the field office review of the TAR.

After reviewing this information, I may want to photocopy some or all of these documents in order to submit them to the Administrative Law Judge who will hear the case. I consider the rules and policies which are relevant to your decision to be as much a part of my file as the TAR documents.

I will call to set up an appointment to review the file and applicable policies and rules. If you are unable or unwilling to make the requested information available to me, please let me know so that I can ask the Chief Administrative Law Judge to issue subpoena.

I assume there is no charge for copies I make to submit as part of the hearing record.

Sincerely.

Send a copy of your letter to the Chief Administrative Law Judge at the address indicated in the booklet you receive with the hearing request acknowledgment.

The MANUAL OF CRITERIA is in a book separate from the other Medi-Cal regulations but is a part of the regulations. It covers many services (for example, hospital care, long-term care) and sets out the criteria the field office will use in deciding whether to authorize services in a particular case.

The Field Instruction Notices (FINs) and Policy Statement are important because they explain how the Medi-Cal program defines medical necessity when they approve or deny devices or services to the type you requested. For instance, there are FINs that cover durable medical

equipment and electric wheelchairs. The FINs and Policy Statement are not regulations but guidelines. They are not binding on you or on the Administrative Law Judge who will hear the case. However, if you can show you fit within the Medi-Cal guidelines, Medi-Cal should not be able to deny your eligibility for the service or device requested.

If you get copies of the relevant materials, show them to your treating doctor to see if the document submitted with the TAR need to be explained. Doctors sometimes write for other health professionals. You may need to ask the doctor to translate what she said into the non-medical language. If the Medi-Cal field office does not give you the relevant information, call the 800 number on the hearing request acknowledgment and ask them to explain what you have to do to get a subpoena duces tecum (pronounced sah-PEE-na due-ses TEE-kum) issued.

It is also useful to get other fair hearing decisions approving services similar to those you have requested. Although the hearing judge does not have to follow other hearing decisions, she or he will find them persuasive. You can find other decisions by looking at the "Digest of Hearing Decisions."

#### *IF I DISAGREE WITH MEDI-CAL, WHAT CAN I DO?*

You have the right to challenge anything Medi-Cal does - or does not do - which you believe to be wrong and which hurts you. You challenge Medi-Cal by requesting a fair hearing. You do not need a notice of action from the county or state in order to request a fair hearing.

#### *WHAT IF I DISAGREE WITH MY MEDI-CAL HMO or MANEGED CARE PLAN?*

You have the right to challenge what the HMO does - or does not do - to the same extent you can challenge what Medi-Cal does if you are outside a managed care plan. The fair hearing procedure is the same. The managed care plan is really acting as the Medi-Cal field office.

#### *WHAT IF I DISAGREE WITH A COUNTY MENTAL HEALTH PROGRAM?*

You have the right to challenge, through the Medi-Cal fair hearing procedure, what county mental health does or does not do. You also have

the right to challenge what a county contract program does or does not do. Some of the things you may wish to challenge include:

- Termination from a program before you are ready;
- Putting you on a waiting list for a program you think you need now;
- Disagreement about your treatment plan or refusal to develop a treatment plan;
- Denying you a service or an evaluation you believe you need;
- Refusal to provide a case manager, or disagreement about what sorts of things the case manager should help you with.

#### *WHAT ACTIONS CAN I CHALLENGE IN A FAIR HEARING?*

In a fair hearing, you can challenge Medi-Cal's actions in any or all of the following areas:

- Refusal to process, or delay in processing, your Medi-Cal application;
- Determination that you are not eligible for Medi-Cal, or that you are no longer eligible for Medi-Cal;
- The amount of your monthly share-of-cost;
- Denial of a prior authorization request or TAR (be sure to check the packet that was sent into Medi-Cal to see if, instead of appealing, you want to submit it with more complete documentation) or a managed care or county mental health denial of authorization for a service or referral;
- Termination of a service such as medical transportation to receive dialysis, nursing or home- and community-based waiver services, long-term care (including facility ICF);
- Refusal to reauthorize a service such as physical therapy when the treatment goals of the original authorization have not been made.

#### *HOW DO I FILE A FAIR HEARING? WHEN DO I HAVE TO FILE?*

You file for a fair hearing by filling out and mailing the reverse side of

the Medi-Cal notice-of-action form you want to challenge, or by sending a letter to:

*Office of the Chief Administrative Law Judge  
Administrative Adjudications Division  
Department of Social Services  
744 P Street  
Sacramento, CA 95814*

*RE: Medi-Cal Fair Hearing  
Your name  
Your state Medi-Cal number or your Social Security  
number*

Your letter should include a general statement about why you are asking for a fair hearing. For example:

- The county is taking too long to process my Medi-Cal application.
- I believe I am eligible for Medi-Cal.
- I need an electric wheelchair because I am too disabled to use a manual wheelchair.
- I need physical therapy so that I can progress to getting around with a walker.

You have 90 days from the date of the Medi-Cal action you are challenging to ask for a fair hearing.

#### *WHAT HAPPENS TO MY MEDI-CAL BENEFITS WHILE I AM APPEALING?*

If you request a fair hearing within 10 days of the date of the notice which says you are no longer eligible for Medi-Cal, or before your Medi-Cal eligibility ends, your Medi-Cal benefits will continue until the Administrative Law Judge issues a hearing decision. Similarly, if you receive a notice terminating kidney dialysis, chemotherapy or radiation treatments, transportation, in-home medical care services, or any stay in an SNF or ICF, your benefits will continue until the hearing decision if you request a fair hearing within 10 days of the notice date or before the benefits end.

In certain circumstances, Medi-Cal services can continue pending a

hearing decision when Medi-Cal refuses to reauthorize the services. Some non-acute hospital services can continue pending a hearing decision (or pending completion of the request reauthorization if earlier) provided that: (a) the reauthorization TAR is received by the Medi-Cal field office before (or within 10 days after) expiration of a prior authorization; and (b) your request for hearing is submitted within 10 days of mailing the denial notice to you, or before the expiration of the prior TAR, whichever is later. The following services are included:

- Long-term care (nursing facilities including subacute, ICF);
- Chronic hemodialysis (including all related services such as transportation);
- In-home medical care services ( and all related services);
- Skilled Nursing Facility Waiver services (and all related services);
- Model Community-Based Waiver services (and all related services);
- All other non-acute services when your treating doctor substantiates on or with the TAR that services should continue because the treatment goal on the original TAR has not been met.

If Medi-Cal denies your request to reauthorize acute care, and you had been approved for at least five days, and your treating doctor determines that you cannot be discharged from the hospital because you still need care in an acute facility. Medi-Cal funding at the acute care rate continue pending a hearing. Medi-Cal will have the notice of denial delivered to you personally by the first working day following the denial - unless your treating doctor says the notice should be delivered by other means for health reasons. Medi-Cal coverage of the acute care will continue pending the hearing if you request a fair hearing within 10 days of the notice denying reauthorization.

*DISCRIMINATION:*

If you believe a decision about your right to get MEDI-CAL benefits was unfairly made because of your sex, race, religion, color, national origin, sexual

orientation, marital status, age, disability or veteran status, you may file a written or telephone complaint with the California State Department of Health Services, Civil Rights Office, 714 "P" Street, Sacramento, CA 95814, tel: (916) 657 1411. Your complaint of discrimination will be investigated.

WHAT IF I HAVE BEEN HURT BY  
ANOTHER PERSON OR HURT AT WORK?

If you are hurt by another person or hurt at work, you may use your BIC to get services. You must report the accident or injury to your eligibility worker so that the MEDI-CAL program can be paid back by the responsible party.

Also be sure to send the following information to:

**Department of Health Services  
P. O. Box 2471  
Sacramento, CA 95811-9990**

1. Your name, address and phone number.
2. Your MEDI-CAL number, and Social Security number.
3. The date you were hurt, and what happened.
4. The name, address, and phone number of your attorney, if you hire one.
5. The name, address, and phone number of the person who hurt you.
6. The name, address, and phone number of the liable insurance company; also add policy number.
7. If you were hurt at work, the name, address and phone number of your employer.

Instead of writing, you may call the following offices:

If your last name begins with:

**A - F** ..... (916) 324 1715

**G - P** ..... (916) 327 0970

**Q - Z** ..... (916) 323 0157

## WILL MEDI-CAL BILL A DECEASED MEDI-CAL BENEFICIARY'S ESTATE?

MEDI-CAL may claim against the estate of a MEDI-CAL beneficiary who has died after October 1, 1993, only if:

- MEDI-CAL pay for certain medical services after the beneficiary's 65<sup>th</sup> birthday, and the deceased MEDI-CAL beneficiary had no surviving spouse, minor, or totally disabled child(ren), and
- the MEDI-CAL claim against the estate does not create a substantial hardship on the heirs of the deceased MEDI-CAL beneficiary.

MEDI-CAL shall impose a lien upon the equity interest in the home or other property of the institutionalized MEDI-CAL beneficiary if certain conditions are met. Such claims and liens may be reduced if it can be demonstrated that a substantial hardship is created on the survivors or heirs of the deceased MEDI-CAL beneficiary.

If the surviving spouse of a deceased MEDI-CAL beneficiary dies, MEDI-CAL may bill the estate of the surviving spouse for either the amount paid by MEDI-CAL for medical assistance, or the value of the estate received by the surviving spouse, whichever is less.

The estate of individuals of any age may also be billed if that individual had been a resident of a nursing facility.

## WHAT IS MEDI-CAL FRAUD?

If you are getting treatment from more than one doctor, you should tell each doctor about the other doctor(s) giving care to you. It is your responsibility not to abuse or improperly use your MEDI-CAL benefits. It is a crime to:

- allow others to use your MEDI-CAL benefits, and
- get drugs through false statements.

It is a crime for you to sell or lend your BIC to any person or furnish your BIC to anyone other than your provider of services as required under MEDI-CAL guidelines. Misuse of a BIC/MEDI-CAL benefits is a crime that could result in administrative action or criminal prosecution. If you suspect someone of misusing MEDI-CAL benefits, you may make a confidential report to one of the following toll-free numbers:

**Northern California: 1- 800-822-6223**

***Southern California:* 1-800-822-6222**

## RIGHTS AND RESPONSIBILITIES

### *RIGHTS:*

There are a number of rights that you have regarding your MEDI-CAL applications and benefits. These are:

1. ***The right to an interpreter*** to help you in applying for MEDI-CAL if you have difficulties in speaking or understanding English language.
2. ***The right to a fair and equal treatment***, regardless of your race, color, religion, national origin, sex or political beliefs.
3. ***The right to apply for*** MEDI-CAL and the right to a written notice stating whether or not you qualify. The written notice must be provided even if you have been told that it appears that you are ineligible. It must be timely and state the reasons why you are not eligible.
4. ***The right to review the manuals*** containing the rules and regulations of the MEDI-CAL program if you want to question the basis on which your eligibility is approved or denied.
5. ***The right to a strict confidentiality*** of all information given in connection with MEDI-CAL.
6. ***The right to be told about social service resources***, the family planning program, and the child health disability prevention program available to you.
7. ***The right to a fair hearing*** if you are dissatisfied with any action taken by CWD or the State Department of Health Services.

### *RESPONSIBILITIES:*

If you receive MEDI-CAL, you have the following responsibilities:

1. ***The responsibility to notify your eligibility worker*** within 10 days of

any changes in income, property, other health coverage, or any changes in family circumstances. Specifically, you must notify CWD whenever:

1. Income received by you or any member of your family increases, decreases, or stop. This includes Social Security payments, loans, settlements, or income from other sources.
- {SEQ a,\_b,\_c, \\* alphabetic \n}. You plan to visit or move outside the County, State, or United States.
2. You change your residence.
3. A person, related or not to you or your family, moves in or out of your home.
4. You receive, transfer, give away, or sell any item or real or personal property, and whenever someone gives you or a member of your family such things as car, house, insurance payments, etc.
5. You have any expenses which are paid for by someone other than yourself.
6. You or a member of your family becomes employed, changes employment, or is no longer employed.
7. You have a change in expenses related to employment or education (i.e., child care, transportation, etc.)
8. One of your children drops out of school or returns to school.

***Warning:***

*You may be responsible to repay MEDI-CAL for any overpayment of benefits due to your failure to report changes promptly.*

2. ***The responsibility to apply for and provide a Social Security Number*** for you and any member of your family who wants MEDI-CAL. The Social Security Number may be used for case identification and/or to verify income or property.
3. ***The responsibility to apply for MEDI-CAL benefits*** if you are blind, disabled, or 64 years and 9 months of age or older and eligible for these benefits. If you do not apply, you will no longer be eligible to receive MEDI-CAL benefits.
4. ***The responsibility to report to CWD*** any health care coverage (insurance) you carry or are entitled to use. ***Warning: Failure to tell***

*CWD about other health care coverage or failure to use other coverage available to you is a misdemeanor.*

5. ***The responsibility to report to CWD*** when MEDI-CAL will be billed for health care services received as a result of an accident or injury caused by other person's action or failure to act.
6. ***The responsibility to cooperate with the State of California*** if your case is selected for review by the Quality Control review team. If you refuse to cooperate, your MEDI-CAL will be discontinued.

## WHAT DO THE WORDS MEANS?

**Beneficiary:** a person who has been determined eligible for MEDI-CAL.

**Buy-in:** If you are aged, blind, disabled, getting the Title II Social Security payments or Railroad Retirement disability benefits, or dialysis-related health care services, you must apply for Medicare at the Social Security office in order to qualify for MEDI-CAL. If you qualify for both Medicare and MEDI-CAL, MEDI-CAL will pay your monthly Medicare Part B insurance premiums and MEDI-CAL may pay your monthly Part A insurance premiums. Please tell your doctor you have both Medicare and MEDI-CAL so you will not be billed for Medicare co-insurance.

**(MEDI-CAL) Health Care Plan:** The Department of Health Services contracts with prepaid health plans, health maintenance organizations, and primary care case management systems to give covered MEDI-CAL services to MEDI-CAL beneficiaries. MEDI-CAL beneficiaries who enroll in a plan are guaranteed access to a full range of quality health care, including preventive medical services.

**Home and Community Based Care Services:** Health care services that can sometimes be given to persons who usually would need to stay in a hospital or nursing home. These services are only available to certain people getting MEDI-CAL who meet special requirements. Ask your doctor or hospital discharge planner to contact the local MEDI-CAL Field Office if you think you might need these services.

**Inpatient Hospital Care:** Care you get when you are admitted to a hospital. In some area of the State, you can only get inpatient care at hospitals contracting with the State. If you need care, you should contact your doctor, and if necessary, your doctor will make arrangements for hospitalization. In a life-threatening emergency, or if you are a pregnant woman in active labor, any hospital can give you care.

**Linkage:** Persons who meet the federal definition of age (65 or older), blindness, or disability, or parents and their children who are deprived of parental support or care are considered "linked" (or connected) to one of these categories.

**Maintenance Need:** The amount of monthly income MEDI-CAL has

determined that a person or family needs for food, clothing, housing, etc. The amount will change with the number of people in the family.

**Medi-Cal:** California's name for Medicaid, the federal and state program of medical assistance for needy and low-income persons.

**Medicare:** A federal health insurance program administered by the Social Security Administration which is available regardless of income. Most persons 65 years of age or older and certain disabled or blind persons, regardless of age, are covered. Medicare Part A covers hospitalization. Medicare Part B covers doctor bills. A Medicare card is red, white, and blue.

**Medicaid:** A federal program to provide medical care for eligible low-income people. "Medi-Cal" is the name California gives its Medicaid program. The federal government and most other states use "Medicaid"/

**Medi-Medi:** Medi-Medi - a person who is covered by both Medi-Cal and Medicare benefits,

**Model Waiver:** a category of home- and community-based waiver where the state may request the waiver of the deeming of parental or spouse income and resources for persons who are receiving Medi-Cal funded out-of-home care.

**Nursing Facilities :** medical institutions that (a) meet certain federal Medicaid requirements and (b) are not intermediate care facilities for developmentally disabled persons.

**Other Health Care Coverage:** Any private health benefit plan or health insurance coverage (whether individual or through a union, group, employer, or organization) under which payment can be made for health care services provided to the persons covered by that policy or plan.

**Personal Property:** All liquid and non-liquid assets (other than real property) such as cash, savings accounts, stocks, bonds, jewelry, boats, life insurance policies, recreational vehicles, etc.

**Pickle:** persons who used to receive SSI and Social Security benefits and who no longer receive such benefits because the Social Security cost of living benefits went up faster than SSI cost of living. Such persons are eligible for

Medi-Cal as if they were still receiving SSI — i.e., with no share-of-cost . “Pickle” comes from the name of Texas Congressman J.J. Pickle who sponsored the 1977 legislation which created the Medi-Cal right.

**Presumptive Eligibility:** a procedure that allows certain disabled or blind persons and mothers to be to qualify for Medi-Cal on an expedited basis.

**Property Reserve:** The total net market value of countable property assets of those persons applying for MEDI-CAL.

**Pseudo-Pickle:** Pseudo-Pickle DAC - person who receive Social Security Disabled Adult Child Benefits based on the earnings record of a disabled, retired or deceased parent, who used to receive both SSI and DAC benefits, and who is not eligible now for DAC benefits because of an increase in DAC benefits received in July of 1987 or later.

**Public Institution:** a government facility of more than 17 beds which is not a medical institution.

**Real Property:** Land and improvements which generally include any immovable property attached to the land and any oil, mineral or other rights related to the land.

**Share of Cost (SOC):** The amount you must pay or promise to pay each month toward the cost of your health care before MEDI-CAL will pay. Your share of cost may change when your monthly income changes. You only pay a share of cost in a month when you get health care services. A SOC is not a monthly charge that you must pay whether or not you have medical bills.

**Verification:** Acceptable evidence (documents) which gives proof of statements made by an applicant/beneficiary.

## GLOSSARY OF ABBREVIATIONS AND ACRONYMS

- 1619** the special SSI program for people who work even though still disabled.
- ABD** Aged, Blind, Disabled - a category of Medically Needy Medi-Cal who meet the requirements for SSI except for income. *See Appendix C.*
- ACWDL** All County Welfare Directors Letter.
- AFDC** Aid to Families with Dependent Children.
- AIDS** Acquired Immunodeficiency Syndrome.
- BIC** Beneficiary Identification Card - the plastic card issued to Medi-Cal beneficiaries and used by Medi-Cal providers to verify eligibility.
- Cal. Code Regs.** California Code of Regulations
- CCS:** California Children Services - a program for low and limited income children with physical disability program.
- C.F.R.** Code of Federal Regulations.
- CHDP:** Child Health and Disability Prevention - a program that screens and provides diagnosis and treatment services for low income children. Children who are Medi-Cal eligible receive diagnostic and treatment services through Medi-Cal and EPSDT; low-income children not covered by Medi-Cal are covered through Proposition 99 money.
- COBRA:** the blanket term for the right to continuation of private health benefit plan coverage after termination of employment.
- COLA:** Cost of Living Allowance - an increase in benefits based on the cost of living.

**CPSP:** Comprehensive Perinatal Services Program.

**DAC:** Disabled Adult Child - a category of Social Security benefits for persons who have been disabled since before age 22 and who receive Social Security benefits drawn against the earnings record of a disabled, retired or deceased parent.

**DDS:** Department of Developmental Services (California).

**DED:** Disability Evaluation Division - a division within the Department of Social Services (DSS) that makes the disability/blindness determination as part of the ABD Medically Needy application process.

**GAO:** General Accounting Office.

**GHPP:** Genetically Handicapped persons Program.

**HIPP:** Health Insurance Premium Payment - a program whereby Medi-Cal pays health benefit plan premiums, including COBRA premiums, when it is cost effective to do so.

**HIV:** Human Immunodeficiency Virus.

**HMO:** Health Maintenance Organization.

**ICF:** Intermediate Care Facility.

**ICF/DD:** Intermediate Care Facility for persons who are Developmentally Disabled.

**IMD:** Institution for Mental Disease - a facility, usually a nursing facility, where more than 50% of the residents have mental diseases requiring in-facility treatment.

**IQ:** Intelligence Quotient.

- IRA:** Individual Retirement Account.
- IRWE:** Impairment Related Work Expenses - deductions from earned income available to persons who qualify for QDWI benefits.
- MNIL:** Maintenance Need Income Level - after allowable deductions from income, the applicable MNIL based on family size is deducted from the balance to determine the share-of-cost, if any.
- MRMIP** Major Risk Medical Insurance Program - an assigned risk program  
**Mr. MIP** with limited slots for people who cannot get regular health benefit coverage.
- OBRA:** Omnibus Budget reconciliation Act.
- QDWI:** Qualified Disabled Working Individual - a special program for certain individuals who lost Medicare because of work, are still disabled, and have income below certain levels.

**APPENDIX A**  
**1998 Federal Poverty Level Chart - Effective 4/1/1998**

Persons	MMNL* (\$)	% of FPL (\$)	100% (\$)	Annual (\$)	120% (\$)	Annual s (\$)	133% (\$)	Annual s (\$)	185% (\$)	Annual s (\$)	200% (\$)	Annual s (\$)
1	600	90%	671	8,050	805	9,660	893	10,707	1,242	14,893	1,342	16,100
2	750	80%	905	10,850	1085	13,020	1,203	14,431	1,673	20,073	1,809	21,700
2 adults	934	104%	905	10,850	1,085	13,020	1,203	14,431	1,673	20,073	1,809	21,700
3	934	83%	1,138	13,650	1,365	16,380	1,513	18,155	2,105	25,253	2,275	27,300
4	1,100	81%	1,371	16,450	1,645	19,740	1,824	21,879	2,537	30,433	2,742	32,900
5	1,259	79%	1,605	19,250	1,925	23,100	2,134	25,603	2,968	35,613	3,209	38,500
6	1,417	78%	1,838	22,050	2,205	26,460	2,444	29,237	3,400	40,793	3,675	44,100
7	1,550	75%	2,071	24,850	2,485	29,820	2,755	33,051	3,852	45,973	4,142	49,700
8	1,692	74%	2,305	27,650	2,765	33,180	3,065	36,775	4,263	51,153	4,609	55,300
9	1,825	72%	2,538	30,450	3,045	36,540	3,375	40,499	4,695	56,333	5,075	60,900
10	1,959	71%	2,771	33,250	3,325	39,900	3,686	44,223	5,127	61,513	5,542	66,500
For each additional member add	\$14		234	2,800	280	3,360	311	3,724	432	5,180	467	5,600

- MMNL is the Medi-Cal Medically Needy Level
  - Children age 1 up to age 6 = 133%
  - Medi-Cal Maintenance need limit for person in LTC = \$35
  - Pregnant women and infants up to age 1 = 200%
- Qualified Medicare Beneficiary (QMB) = 100%
  - Qualified Disabled Working Individuals = 200%
  - Transitional Medi-Cal (TMC) = 185%
- Specified Low Income Beneficiaries = 120%
  - Decimals are rounded up to nearest dollar.
- Children born after 9/30/83, age 6 and up = 100%

## APPENDIX B

### **How to determine share-of-cost under one of the Federal Poverty Level Medi-Cal programs for children and pregnant women.**

For more information about this program, refer to pages “Federal Poverty Level (FPL) Program With a Zero Share-of-Cost” above. At the end of this Appendix section is a blank worksheet. The applicable FPL standard you enter to see if a pregnant woman or child qualifies is set out in Appendix A. The Appendix A chart is valid until April of 1997 when a new chart will come out. To show you how the calculations are done in an individual case, we give you the example and then show you how the worksheet could be filled out.

#### *Steps for determining FPL Medi-Cal eligibility*

1. Enter total unearned income [22 CCR § 50507.]
2. Enter gross earned income. [22 CCR § 50503.] If you are self-employed enter your adjusted gross income - that is, your gross receipt less IRS allowable deductions. [22 CCR § 50505.]
3. Deduct a \$90 work allowance deduction. [22 CCR § 50262(a)(3). 50262.(a)(2), 50533.5.]
4. Deduct the cost of child care - up to \$200 a month for a child under age two, \$175 for a child age two or older.
5. Enter the total countable income after the work allowance and childcare deductions, if any.
6. Add together the total unearned (Step 1) and earned income (Step 5) for your total countable income.

#### ***Appendix B - Page 1***

7. Is there a pregnant woman and/or a child under the age of one year in the family? If so, from Appendix A (or the current FPL chart) enter the

200%<sup>26</sup> FPL amount for the family size, counting the pregnant woman as two. If the entry in Step 6 is the same or less than the entry in Step 7, the pregnant woman and/or child qualifies for no share-of-cost Medi-Cal.

8. Is there a child between the ages of one and six in the family? If so, from Appendix A enter the 133% FPL amount for the family size. If the entry in Step 6 is the same or less than the amount in Step 8, the child or children between the ages of 1 and 6 qualify for no share-of-cost Medi-Cal.
9. Is there a child age six or older, but born before September 30, 1983? If so, from Appendix A enter the 100% FPL for the family size. If the entry in Step 6 is the same or less than the amount in Step 9, the child or children who are age six or older, but born before September 30, 1983, qualify for no share-of-cost Medi-Cal.

### ***Appendix B - Page 2***

#### *Example*

Our example case is a mother alone with two children, an 18-month-old

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<sup>26</sup>Technically there are two FPL programs. The 185% and 200% FPL programs for mothers to be and infants under age one. In addition there is a special program called "Transitional Medi-Cal" for certain families who used to receive cash grant AFDC but who no longer do so because of an increase in child support or because of earned income.

child and an eight-year-old child. Neither child meet the Social Security disability standard. The mother works and earns \$1,700 a month before any deductions. She pays \$300 a month to care for the two children. (Her employer deducts \$80 a month as her share of the health benefit plan payment premium, but she cannot deduct this premium under the FPL programs, although she can deduct it under the medically needy and medically indigent programs. [22 CCR §§ 50262(a)(3), 50262(a)(2).] She has no unearned income.

Step 1	Since there is no unearned income, enter 0	\$0,00	
Step 2	Gross earned income	\$1,700,00	
Step 3	Deduct the \$90 work incentive deductio	(\$90,00)	
Step 4	Deduct the child care costs	(\$300,00)	
Step 5	Total countable earned income		\$1,310,00
Step 6	Total countable earned and unearned income		\$1,310,00
Step 7	Family member pregnant or child under the age of one year?	<b>No</b>	
Step 8	A child between the ages of 1 year and 6 years? 133% of poverty level in 1994 for a family of 3 Since the amount in Step 6 is less than the amount in Step 8, the 18-month-old child qualifies for no share-of-	<b>Yes</b>	\$1,478,00
Step 9	A child 6 years or older and born after 9. 30,1983? 100% of the poverty level in 1994 for a family of three: Since the amount in Step 6 is more than the amount in Step 9, the 8-year-old child does not qualify for FPL Medi-Cal at so share-of-cost.	<b>Yes</b>	\$1,111,00

Because the mother and the 8-year-old child do not qualify under the FPL program, they would be covered with a share-of-cost under the AFDC linked medically needy Medi-Cal program. (See Appendix D). In doing the medically calculations, those eligible for no-share-of-cost Medi-Cal under one of the FPL programs are included as ineligible members of the family budget unit for purposes of determining the amount of the family maintenance allowance. Child care costs are not deductible from the earned income under either the FPL programs or the ABD Medically Needy program, but are deductible under the AFDC Medically Needy or Medically Indigent Medi-Cal programs. Health benefit plan premiums are not deductible under the FPL program but are deductible under the medically needy and medically indigent programs

***Appendix B - Page 4***

*FPL Medi-Cal Worksheet*

Step 1	Total earned income		

Step 2	Earned income before any deductions		
Step 3	Less \$90 work incentive deduction	(\$90)	
Step 4	Less child care costs (up t \$200 a month for achild under age two; \$175 per month for older children)	( )	
Step 5	Total countable earned income		
Step 6	Total countable earned and unearned income		
Step 7	If there is a mother-to-be (counts as two people) or a child under the age of one year in the family, enter 200% FPL for the family size: The mother-to-be or the child is eligible if the entry in Step 6 is not more than the entry in Step 7.		
Step 8	If there is a child (or children) between the ages of one year and six years in the family, enter 133% FPL for the family size: A child between age one and age six is eligible if the entry in Step 6 is not more than the entry in Step 8.		
Step 9	If there is a child six years or older, and born before 9/30//1983, enter the 100% of FPL for the family size: A child over 6 years old, and born before 9/30/83, is eligible if the entry in Step 6 is not more than the entry in Step 9.		

**Family Allowance Schedule since July 1, 1989**

Family Size	Allowance	Family Size	Allowance
1	\$600,00	6	\$1,417,00
2	\$750,00	7	\$1,550,00
2 adults	\$934,00	8	\$1,692,00
3	\$934,00	9	\$1,825,00
4	\$1,100	10	\$1,959,00
5	\$1,259,00		

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APPENDIX C

**How to determine share-of-cost when a family member qualifies for ABD Medi-Cal, the Medically Needy program for people who meet the SSI disability or**

**blindness standard.**

If the Medi-Cal is for a child, look first to Appendix B to see whether the child would be qualify for no-share-of-cost Medi-Cal under one of the FPL programs.

At the end of this appendix section is blank worksheet. The steps you take to calculate share-of-cost are explained below. The step numbers below correspond to the number in the blank worksheet. At the bottom of the blank worksheet is the maintenance need allowance chart based on family size. After all allowable deductions from earned and unearned income, the maintenance need allowance is deducted from the income to determine share-of-cost if any. There have been no cost-of-living adjustment since July 1, 1989. To show you how the calculations are done in an individual case, we give you the example and then show you how the worksheet would be filled out.

*Steps for determining ABD Medi-Cal Share-of- Cost*

- Step 1 Enter the total unearned income. [22 CCR § 50506.]
  - Step 2 Deduct the \$20 “any income” deduction. [22 CCR §50549.2(a).
  - Step 3 Enter the balance, if any. The balance is your total countable unearned income.
  - Step 4 Enter the total gross earned income. If you are self-employed, that means your adjusted gross income - that is, your gross receipt less IRS allowable deductions.
  - Step 5 Deduct the balance of the \$20 any-income deduction. [22 CCR §§50549.2(b), 50551.2.]
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- Step 6 Deduct the \$65 earned income work incentive deduction. [22 CCR § 50551.3.]
  - Step 7 After deducting the \$65 earned income deduction, deduct 50% of the subtotal balance as a further work incentive deduction. [22 CCR § 50551.3.]

- Step 8 Enter the balance which is your total countable earned income.
- Step 9 Add together the subtotals of your countable unearned income (Step 3) and your countable earned income (Step 8) for your total countable income.
- Step 10 Deduct any health benefit plan premiums whether you pay for them directly yourself or they are deducted from your paycheck. [22 CCR § 50555.2.]
- Step 11 Deduct the Medi-Cal Family Maintenance Allowance based on the size of the family. Children under age 21 count. [22 CCR § 50603.]
- Step 12 The balance is the monthly share-of-cost for the child with disability - and for other children in the family plus the single parent or both parents if one is unable to work because of a health problem or in certain circumstances unemployed.

Example

Our example case is a family with two parents who work and who have one child with a disability which meets the Social Security standard plus two other children. They get \$10 a month in interest on their savings and checking account. Their combined gross income is \$3,100 a month. Part of the cost (\$180 a month) of the health benefit premium is deducted from one parent's paycheck, (The

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family pays \$150 for child care for each child, but this expense is not deductible under the ABD Medically Needy Medi-Cal program.) The monthly share-of-cost for the three children together would be \$73.50. The parents would not qualify for Medi-Cal because they do not meet the AFDC deprivation standard.

Step 1	Unearned income	\$10,00	
Step 2	Less any-income deduction	(\$20,00)	
Step 3	Countable unearned income		\$0,00

Step 4	Earned income	\$3,100,00	
Step 5	Unused balance of \$20 any-income deduction	\$10,00	
Step 6	Less \$65 work incentive deduction	(\$65,00)	
	Subtotal	<u>\$3,025,00</u>	
Step 7	Less 50% for additional work incentive deduction	(\$1,512,50)	
Step 8	Countable earned income		<u>\$1,512,50</u>
Step 9	Total earned and unearned income		\$1,512,50
Step 10	Health benefit plan payment deduction	(\$180,00)	
Step 11	Less allowance for family of five	(\$1,259,00)	
Step 12	Total monthly share-of-cost		\$73.50

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**ABD Medi-Cal Share-of-Cost Worksheet**

Step 1	Unearned income		
Step 2	Less any-income deduction	(\$20,00)	
Step 3	Countable unearned income		
Step 4	Earned income		
Step 5	Unused balance of \$20 any-income deduction	(\$ )	

Step 6	Less \$65 work incentive deduction	<u>(\$65.00)</u>	
	Subtotal		
Step 7	Less 50% for additional work incentive deduction	<u>(\$ _____)</u>	
Step 8	Countable earned income		_____
			-
Step 9	Total earned and unearned income		
Step 10	Health benefit plan payment deduction	<u>(\$ _____)</u>	
Step 11	Less family maintenance need deduction	<u>(\$ _____)</u>	
Step 12	Total monthly share-of-cost		

*Family Allowance Schedule since July 1, 1989*

Family Size	Allowance	Family Size	Allowance
1	\$600,00	6	\$1,417,00
2	\$750,00	7	\$1,550,00
2 adults	\$934,00	8	\$1,692,00
3	\$934,00	9	\$1,825,00
4	\$1,100,00	10	\$1,959,00
5	\$1,259		

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*Appendix D*

**How to determine share-of-cost when family members qualify for AFDC-linked Medically Needy Medi-Cal or when children qualify for Medically Indigent Medi-Cal.**

If there are any children in the family, look first to Appendix B to see whether the child would qualify for no share-of-cost Medi-Cal under on of the

FPL programs.

At the end of this Appendix section is a blank worksheet. The steps you take correspond to the entries on the completed example worksheet. At the bottom of the blank worksheet is the maintenance need allowance based on family size. After all allowable deductions from earned and unearned income, the maintenance need allowance need is deducted from income to determine share-of-cost, if any. There have been no cost living adjustments since July 1, 1989. After an explanation of the steps but before the blank worksheet is an example to show you how share-of-cost is determined.

*Steps to determine AFDC Medically Needy and Medically Indigent share-of-cost.*

- Step 1 Enter total unearned income. [22 CCR § 50507.] (Deduct \$50 a month from spousal/ child support received. [22 CCR § 50554.]
- Step 2 Enter total gross earned income. [22 CCR § 50503.] If you are self-employed, enter your adjusted gross income - that is, your gross receipts less IRS allowable deductions. [ 22 CCR § 50505.]
- Step 3 Deduct from earned income a \$90 work incentive allowance. [ 22 CCR § 50553.1.]
- Step 4 Deduct from earned income cost of child care (\$200 a month for a child under age two, \$175 for a child age two or older) or deduct the cost of dependent adult care (\$175 a month). [22 CCR § 50553.5.]

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- Step 5 Enter the total earned income after allowable deductions
- Step 6 Add together the total countable unearned income (Step 1) and the total countable earned income (Step 5).
- Step 7 Deduct the cost of any health benefit plan premiums whether you pay for them directly yourself or they are deducted from your paycheck. [ 22 CCR § 5055.2.]

- Step 8 Deduct the Medi-Cal family Maintenance Allowance based on the size of the family. Children age 18 but below age 21 count. [22 CCR § 50603.]
- Step 9 The balance is the monthly share-of-cost for eligible members of the family. Eligible members include the children, a single parent, both parents if one is unemployed or unable to work because of the health or disability problem.

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*Example*

Our example case is from the example in Appendix B: A mother alone with two children, one 18 months and the other eight years of age. The mother works and earns \$1,700 a month before any deductions. She pays \$300 a month for child care for her two children. The mother's employer deduct \$80 a month as her share of the health benefit plan premiums.

Step 1	There is no unearned income	\$0,00	
Step 2	Gross earned income	\$1,700,00	
Step 3	Work incentive deduction of \$90	(\$90,00)	
Step 4	Deduction for allowable child care costs	(\$300,00)	

Step 5	Countable earned income		\$1,310,00
Step 6	Total earned and unearned income		\$1,310,00
Step 7	Deduction for health benefit plan premium	(\$80,00	
Step 8	Family Maintenance Allowance for a family of 3	(\$934,00)	
Step 9	Share of cost		(\$296,00)

In this example, the 18-month-old child qualifies for Medi-Cal with no share-of-cost under the FPL programs. (See Appendix B above.) However, the 18-month-old child is included in the family unit as an ineligible member for purposes of determining the share-of-cost. The share-of-cost is applicable to the mother and the eight-year-old child.

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*AFDC linked Medically Needy and Medically Indigent Worksheet*

Step 1	Total unearned income		
Step 2	Gross (before deductions) earned income		
Step 3	Less work incentive deduction of \$90	(\$90,00 )	
Step 4	Less allowable deductions for child care costs and care of dependent adults in the family	(\$ )	
Step 5	Total countable earned income		
Step	Total countable earned and unearned income		

6			
Step 7	Deductible for health benefit plan premium	(\$ )	
Step 8	Family Maintenance Allowance for a family size (see below)		
Step 9	Share of cost		

*Family Allowance Schedule since July 1, 1989*

Family Size	Allowance	Family Size	Allowance
1	\$600,00	6	\$1,417,00
2	\$750,00	7	\$1,550,00
2 adults	\$934,00	8	\$1,692,00
3	\$934,00	9	\$1,825,00
4	\$ 1,100,00	10	\$1,959,00
5	\$1,259,00		