

**ACTIVITY CODE (4)
MEDI-CAL OUTREACH**

Claiming Unit:	Submittal Date:
Local Governmental Agency:	Amended Date:

For *each* campaign, program, or ongoing outreach activity, provide the following information:

1. Provide a clear description of the type of Outreach activity performed:

2. Provide a clear description of how each Outreach activity will be performed to achieve the objective:

3. Identify the target population(s):

4. Provide the length of time of the Outreach, i.e. days and/or hours:

5. Provide the location(s) where the Outreach will be conducted:

6. Provide the number of times Outreach will be conducted during the fiscal year or indicate if Outreach is an ongoing activity:

7. If using a method other than time survey, describe how the costs of Outreach will be developed and documented:

8. Provide Names of Subcontractors, if applicable:

Documents Required:

1. Flyers, announcements, or any materials that describe the Outreach campaigns. If materials are unavailable when the claiming plan is submitted to the DHCS, provide a statement that gives the location of where materials will be maintained for future DHCS and CMS review.
2. A list of subcontractors, if direct-charge invoices will be submitted for those subcontractors.
3. Copies of those sections of contracts that clearly describe the Outreach A to be performed, how the time spent performing Outreach will be documented, and that show the effective date of the contract. If direct charging, the contract must clearly show the method used for determining direct-charge claiming (including application of the Medi-Cal percentage discount) and the dollar amount to be paid to the contractor.

**ACTIVITY CODE (6)
REFERRAL, COORDINATION, AND MONITORING OF MEDI-CAL SERVICES**

Claiming Unit:	Submittal Date:
Local Governmental Agency:	Amended Date:

For *each* type of Referral, Coordination, and Monitoring activity, provide the following information:

1. Provide a clear description of the type of Referral, Coordination, and Monitoring activity performed and each activity's purpose:

2. Provide a clear description of how each Referral, Coordination, and Monitoring activity will be performed to achieve the objective:

3. Identify the target population(s):

4. Provide the location(s) where the Referral, Coordination, and Monitoring will be conducted:

5. If using a method other than time survey, describe how the costs of Referral, Coordination, and Monitoring will be developed and documented:

6. Provide Names of Subcontractors, if applicable:

7. Provide in detail the method that will be used to calculate the Medi-Cal discount methodology and the sources that will provide the client data:

Documents Required:

A list of subcontractors, if direct-charge invoices will be submitted for those subcontractors.
If additional space is required, use the next page.

**ACTIVITY CODE (6)
REFERRAL, COORDINATION, AND MONITORING OF MEDI-CAL SERVICES**

Claiming Unit:

Submittal Date:

Local Governmental Agency:

Amended Date:

Use the space below to provide additional information:

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**ACTIVITY CODE (8)
FACILITATING MEDI-CAL APPLICATION**

Claiming Unit:	Submittal Date:
Local Governmental Agency:	Amended Date:

Provide the information listed below:

1. Identify the Eligibility Intake objective and provide a detailed description of the Medi-Cal application facilitation process performed:

2. Provide a detailed description of how the Eligibility Intake activity will be performed to achieve the objective. For example, identify the staff performing the activity, describe what is performed, indicate when and where it is performed:

3. Indicate whether the Eligibility Intake is performed by the LGA's subcontractors or by claiming unit staff:

A. Provide the name(s) and address(s) of the subcontractor(s), if applicable:

4. If using a method other than time survey, describe how the costs of the Eligibility Intake will be developed and documented:

Documents Required:

1. Copies of any documents unique to or designed by the claiming unit for use in conjunction with this activity.
2. A list of subcontractors, if direct-charge invoices will be submitted for those subcontractors.
3. Copies of those sections of contracts that clearly describe the Eligibility Intake to be performed, how the time spent performing the Eligibility Intake will be performed, and that show the effective date of the contract. If direct charging, the contract must clearly show the method used for determining direct-charge claiming (including application of the Medi-cal percentage discount) and the dollar amount to be paid to the contractor.

ACTIVITY CODE (10)
**ARRANGING and/or PROVIDING NON-EMERGENCY, NON-MEDICAL TRANSPORTATION
 TO A MEDI-CAL COVERED SERVICE**

Claiming Unit:	Submittal Date:
Local Governmental Agency:	Amended Date:

For each type of transportation performed, provide the following information:

1. **Individually list** and clearly describe each allowable type of transportation activity and its purpose:

2. Provide a clear and specific description of how each type of transportation activity will be performed to achieve the objective:

3. Provide the names of the subcontractors performing the transportation, if applicable:

4. Provide the method used to determine time and costs when the activity is performed by claiming unit staff or by subcontractors, and how the cost is calculated:

5. Provide in detail the method that will be used to calculate the Medi-Cal discount methodology and the sources that will provide the client data:

Documents Required:

1. Copies of those sections of contracts that clearly describe the transportation to be performed: how the time spent performing the transportation will be documented; how the transportation will be charged, e.g., per mile, per trip, etc.: how the rate is calculated; and that show the effective date of the contract.
2. Documents that support the calculation of transportation costs. For example: sales receipts for vans, salary schedules for drivers, etc.

If additional space is required, use the next page.

**ACTIVITY CODE (10)
ARRANGING and/or PROVIDING NON-EMERGENCY, NON-MEDICAL TRANSPORTATION
TO A MEDI-CAL COVERED SERVICE**

Claiming Unit:

Submittal Date:

Local Governmental Agency:

Amended Date:

Use the space below to provide additional information:

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ACTIVITY CODES (12) (13)
CONTRACT ADMINISTRATION for MEDI-CAL SERVICES
SPECIFIC TO MEDI-CAL and/or NON MEDI-CAL POPULATIONS

Claiming Unit:

Submittal Date:

Local Governmental Agency:

Amended Date:

Provide the following information:

1. Individually list each type of contract administered by the unit. Describe how staff perform contract administration for each contract listed:
2. For each contract, indicate whether the contract is for Medi-Cal populations only (12) or for a combination of Medi-Cal and non-Medi-Cal populations (13):
3. For those contracts that combine both Medi-Cal and non-Medi-Cal populations, indicate the Medi-Cal population served by each contract and the methodology used for determining the Medi-Cal percentage:
4. For each contract, explain the method for allocating time spent by employees between Medi-Cal and non-Medi-Cal contract functions:
5. Provide in detail how the responses to questions 3 and 4 are used to create a final Medi-Cal discount percentage and the sources that will provide the client data:

Documents required:

1. Copies of a sample of the contracts being administered to include the scope of work, contract page with the start and end dates and signed and dated executed contract page.

If additional space is required, use the next page.

ACTIVITY CODES (12) (13)
CONTRACT ADMINISTRATION for MEDI-CAL SERVICES
SPECIFIC TO MEDI-CAL and/or NON MEDI-CAL POPULATIONS

Claiming Unit:

Submittal Date:

Local Governmental Agency:

Amended Date:

Use the space below to provide additional information:

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**ACTIVITY CODES (15) (16) (17) (18)
PROGRAM PLANNING AND POLICY DEVELOPMENT
FOR MEDI-CAL SERVICES FOR MEDI-CAL and/or NON MEDI-CAL CLIENTS**

Claiming Unit:	Submittal Date:
Local Governmental Agency:	Amended Date:

Provide the following information:

1. The names of the units and/or classifications being claimed and whether or not they are skilled professional medical personnel (SPMP):
2. Individually list each type of allowable PP&PD tasks performed by staff:
3. If the activity is performed in the LGA's health department, identify the health programs involved:
4. Provide the location(s) where the activity(s) is performed:
5. Indicate whether staff performs PP&PD activities full-time or part-time. For part-time, indicate whether staff deliver direct services part-time in a billable setting and identify the setting:
6. Provide in detail the method that will be used to calculate the Medi-Cal discount methodology and the sources that will provide the client data:
7. Describe the method that will be used for claiming, i.e., direct-charge or time-studies, and explain the method for determining time and costs:
8. Indicate whether and which PP&PD activities are being performed by contractors or consultants:

Documents Required:

1. List of subcontractors, if applicable.
2. Copies of any contracts entered into the for performance of PP&PD that:
 - a) Clearly describe the PP&PD to be performed;
 - b) Describe how the time spent performing PP&PD will be documented;
 - c) The effective date of the contract;
 - d) The method used for determining the direct-charge claiming (include application of the Medi-Cal percentage discount); and
 - e) The dollar amount to be paid to the contractor.
3. Resource directories, if available.
4. A listing of staff employed in service provider settings who are involved with the four allowable MAA tasks above which are: developing strategies, interagency coordination, developing resource directories, and contracted support services. As noted above, PP&PD is not allowable if staff performing this function are employed by LGA service providers, such as clinics.

If additional space is required, use the next page.

**ACTIVITY CODES (15) (16) (17) (18)
PROGRAM PLANNING AND POLICY DEVELOPMENT
FOR MEDI-CAL SERVICES FOR MEDI-CAL and/or NON MEDI-CAL CLIENTS**

Claiming Unit:

Submittal Date:

Local Governmental Agency:

Amended Date:

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ACTIVITY CODE (19)
MAA/TCM COORDINATION AND CLAIMS ADMINISTRATION

Claiming Unit:	Submittal Date:
Local Governmental Agency:	Amended Date:

For each type of MAA/TCM Coordination and Claims Administration performed, provide the following information:

1. **Individually list** each type of allowable MAA/TCM coordination and claims administration activity performed and describe how staff perform this activity (if adding the LGA Participation Fee, list that here):

2. Indicate whether staff perform this activity part-time in addition to other duties:

3. Describe the method that will be used for claiming, i.e. direct charge or time survey:

4. If applicable, indicate whether contractors or consultants will provide claims preparation activities. Then provide the names of those contractors/consultant:

Documents Required:

1. Attach copies of any contracts entered into for the performance of LGA claims administration.

ACTIVITY CODE (20)
CMAA/TCM IMPLEMENTATION TRAINING

Claiming Unit:	Submittal Date:
Local Governmental Agency:	Amended Date:

Provide the following information:

1. List the type(s) of training to be provided and/or attended:

2. If applicable, provide the location(s) the training will be provided and/or attended:

3. Indicate whether the training is or will be CMAA/TCM Program specific or integrated with other training information and who will provide the training:

Documents Required:

1. Attach copies of any training brochures, materials, or itineraries.