SECTION 10 – REFERENCES

Federal Financial Participation Form and Excel File Instructions 3

Time Study Forms 3

Monthly Form 3

Weekly Form 4

FFP Calculations 4

Staffing Standards for California Children's Services (Historical Document) 11

Figure 2: County Estimates of FTEs Required (Type and Number of Staff) 18

Figure 3: County Staffing Profiles (Number of Staff by Personnel Class and Active Cases) 19

The Staffing Matrix and Funding of the Child Health and Disability Prevention Program (Historical Document) 20

Legislation, Regulations, and Guidelines for CCS 23

Selected State Laws Relating to CCS 24

Health and Safety Code Section 24

Government Code Sections (Re: School Therapy Services) 37

Insurance Code (Re: Healthy Families) 41

Welfare and Institutions Code (Re: Medi-Cal Managed Care Contract Laws) 42

Legislation, Regulations, and Guidelines for the CHDP Program 47

Selected State Laws Relating to the CHDP Program 49

Health and Safety Code Section 49

Insurance Code (Re: CHDP Gateway) 60

Welfare and Institutions Code (Re: CHDP Gateway) 61

Legislation, Regulations, and Guidelines for the HCPCFC 65

Selected State Laws Relating to the HCPCFC 67

Welfare and Institutions Code Section 67

Annual Review for Cash Aid and Food Stamps (TEMP CA 600) 73

CHDP Pre-Enrollment Application (DHS 4073) 74

CHDP Referral (PM 357) 75

CHDP Referral for SAWS Automated Template 78

CHDP Referral for Welfare Case Data System Counties 79

Confidential Referral/Follow Up Report (PM 161) 80

Confidential Screening/Billing Report - Standard (PM 160) 82

Confidential Screening/Billing Report – Information Only (PM 160 INFO ONLY) 84

Important Information for Persons Requesting Medi-Cal (MC 219) 86

Medical and Dental Exams for Children and Youth and Family Planning Services (TEMP 602 B) 90

Medi-Cal/Healthy Families Mail-In Application (MC 321 HFP) 91

Quarterly Report of Medi-Cal Recipients Requesting CHDP Services 103

Statement of Citizenship, Alienage, and Immigration Status (MC 13) 104

Statement of Facts for Cash Aid, Food Stamps, and Medi-Cal/State-Run County Medical Services Program (SAWS 2) 106

Medi-Cal New Mail-In Application and Instructions (MC 210) 120

Federal Financial Participation Form and Excel File Instructions

There are two parts to calculating FFP for use in quarterly program invoices:

1. Time study activity recording (through the use of forms)

2. Entering time study data into the FFP calculation file worksheets.

After these steps have been taken the resultant information on the FFP Table from the file can be entered on the quarterly invoice.

Time Study Forms

Two sample forms are included in the FFP file. One captures an entire time study period of one. The other is for use on a weekly basis so each time study period would require 4-5 weekly forms. These specific forms are optional. However, regardless of the time study form that is used, it must contain the following information:

1. Name of staff,

2. Time Study Period,

3. All time the staff is reimbursed for,

4. Clearly identified function codes in 30 minute increments,

5. Each function code identified with a Program code, and

6. Each time study signed by a supervisor-verifying accuracy of the time study.

The following instructions relate to the two sample forms.

Monthly Form

This option utilizes the form entitled **Time Study Survey for FFP Program Claiming**. The Centers for Medicare and Medicaid Services (CMS) has given the states the option of documenting the activities done during a time study month by grouping the functions in one-hour increments and summarizing them on a monthly form. Instructions are as follows:

Step 1 Complete the header information, time study period (Month/Year), employee name, position/employee number, personnel classification, agency name, unit name, and location of employee.

Step 2 Identify the program to be assigned to each letter in the Program Coding Scheme.

Step 3 Enter all the work dates included in the time study month.

Step 4 At the end of each day, summarize the number of hours worked by function and program code (across). Total the time at the bottom of the column and verify that the total documented equals the time actually worked.

Step 5 If using the FFP Calculation file furnished by the Children's Medical Services Branch, go to Option 2, Step 5. If not using the FFP Calculation file, transfer rows totals by program to Summary Information at bottom and group by enhanced, non-enhanced, non-claimable, and allocated costs. Perform necessary calculations and prepare invoice.

Step 6 The supervisor of each staff must sign the time study document, attesting to the accuracy and validity of the time study.

Weekly Form

This option utilizes the form entitled **Weekly Time Study for Federal Financial Participation** and provides a format for each employee to document their program time in 30 minute increments. Employees complete one of these forms for each week in the time study period.

Step 1 Complete the header information; time study period (Month/Year), employee name, job title, and location of employee and time base.

Step 2 Identify the program to be assigned to each letter in the Program Code Scheme and dates.

Step 3 Enter all dates in the time study week.

Step 4 Indicate the time worked identified by function and program code (see example). At the end of the week, total the daily information by program and function code in the Summary Information box. The totals of the Summary Information and daily computations are joined by an arrow and should match.

Step 5 The supervisor of each staff must sign the time study document, attesting to the accuracy and validity of the time study.

FFP Calculations

While the forms to record FFP are optional, the calculations of the appropriate amounts of FFP to require the use of the CMS-FFP Excel file. In order to perform the necessary calculations use the following instructions:

Step 6 Pull up the file named **FFP_CALC** in Microsoft Excel format.

Step 7 The spreadsheet is divided into three worksheets. They are: **Employee Info**, **Enter Data**, and **Report**. Click the tab labeled **Employee Info**.

Line 1 Enter the time study period.

Line 2 Enter the name of the employee name.

Line 3 Enter the employee's job classification.

Line 4 Indicate if this person is a Skilled Medical Professional by erasing either the **Yes** or **No**.

Line 5 Enter the name of each program according to the designation on the staff time study (this may vary person to person).

Line 6 Enter the FFP factor for each program claiming Title XIX matching dollars (for information on determining the Medi-Cal factor, contact your Administrative Consultant).

Step 8 Click on the tab labeled **Enter Data**. If you use the weekly time studies, transfer the information from the Summary Information to the appropriate column in each table. (If you use some other form [such as the monthly form], enter information into the column headed **Manual Entry of Totals**). Note that the allocated functions (10 and 12) are listed on the first table and are not associated with any specific program.

Step 9 Click on the tab labeled **Report**. All information for completing the quarterly invoice is shown on this worksheet. This report should be printed and kept with the time study and supporting documentation in the FFP audit file.

Step 10 The percentages identified on the report are the ones to use for each individual listed on the budget when invoicing.

1	Time Study Period:	
2	Name of Employee:	
3	Classification:	
4	SPMP?:	

5 Enter Salary and Benefit Information Below if you **do not** identify Program hours on daily Time-Cards.

Quarter's Total Salary:	
Quarter's Total Benefits:	

OR

6 Enter Salary and Benefit Information below if you identify Program hours on daily Time-Cards for the entire invoice period.

Program A Salary:	
Program A Benefits:	
Program B Salary:	
Program B Benefits:	
Program C Salary:	
Program C Benefits:	
Program D Salary:	
Program D Benefits:	
Program E Salary:	
Program E Benefits:	
Program F Salary:	
Program F Benefits:	

7 For purposes of claiming federal match, indicate the **average** percentage of clients in the target population for each program who are Medi-Cal eligibles.

Program A:		**Program D:**	
Program B:		**Program E:**	
Program C:		**Program F:**	

Monthly Summary of FFP Time Study Information

This information is entered from the weekly or monthly time study document.

Allocated Functions

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
10							
12							

Program A

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

Program B

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

Program C

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

Program D

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

Program E

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

Program F

Function Code	Week 1	Week 2	Week 3	Week 4	Week 5	Manual Entry of Mo. Totals	Total
1							
2							
3							
4							
5							
6							
7							
8							
9							
11							

FFP Time-Study Calculations

Monthly Summary of Hours by Program

	Program A	Program B	Program C	Program D	Program E	Program F	Allocated Functions	Total Hours By Function
1	0.0	0.0	0.0	0.0	0.0	0.0		0.0
2	0.0	0.0	0.0	0.0	0.0	0.0		0.0
3	0.0	0.0	0.0	0.0	0.0	0.0		0.0
4	0.0	0.0	0.0	0.0	0.0	0.0		0.0
5	0.0	0.0	0.0	0.0	0.0	0.0		0.0
6	0.0	0.0	0.0	0.0	0.0	0.0		0.0
7	0.0	0.0	0.0	0.0	0.0	0.0		0.0
8	0.0	0.0	0.0	0.0	0.0	0.0		0.0
9	0.0	0.0	0.0	0.0	0.0	0.0		0.0
10							0.0	0.0
11	0.0	0.0	0.0	0.0	0.0	0.0		0.0
12							0.0	0.0
Totals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

	I. TOTAL HOURS from above table	II. PERCENT OF HOURS Col. I / total dist Col. I	III. ALLOCATE PAID TIME OFF HOURS Col. II x Pd time off	IV. TOTAL HOURS Col. I + Col. III	V. PERCENT OF TOTAL IV. Col. IV/ total of Col. IV	VI. PERCENT OF GEN ADMIN	VII. ALLOCATE GEN ADMIN HRS	VIII. TOTAL DIR AND ALLOC HOURS Col. IV+VII	IX. PERCENT TO DISTRIBUTE COSTS Col. VIII/total Col. VIII	X. DISTRIBUTE SALARY Col. IX x Salary	XI. DISTRIBUTE BENEFITS Col. IX x Benefits	XI. DISTRIBUTE SALARY (TS info only)	XI. DISTRIBUTE BENEFITS (TS info only)	IX. PERCENT TO DISTRIBUTE COSTS Col. VIII/total Col. VIII
ENHANCED														
Program A	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program B	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program C	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program D	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program E	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program F	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
NON-ENHANCED				0.0		Enh+Non-Enh from Col. V	Col. VI x New Gen admin hrs.							
Program A	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program B	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program C	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program D	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program E	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program F	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
NON-CLAIMABLE				0.0		non-claimable from Col. V								
Program A	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program B	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program C	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program D	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program E	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program F	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
GENERAL ADMIN	0.0	#DIV/0!	#DIV/0!				#DIV/0!							
TOTAL FOR DISTRIBUTION	0.0	#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	New Gen Admin total hrs Col. I + Col. III	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
PAID TIME OFF	0.0		#DIV/0!											
TOTAL HOURS FOR MONTH	0.0													

Time Study Period: January-00
Name of Employee: 0
Classification: 0

The following percentages have been generated for each program:
(For use by agencies **with** daily record of program time for the entire invoice period)

	Enhanced	Non-Enhanced	Not Claimable	Total	Salary	Benefits
Program A	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00
Program B	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00
Program C	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00
Program D	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00
Program E	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00
Program F	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$0.00	$0.00
Total					$0.00	$0.00

Total time spent in each program:
(For use by agencies **without** daily record of program time for entire invoice period)

	Percentage of time worked in Program	Salary	Benefits
Program A	0.0%	$0.00	$0.00
Program B	0.0%	$0.00	$0.00
Program C	0.0%	$0.00	$0.00
Program D	0.0%	$0.00	$0.00
Program E	0.0%	$0.00	$0.00
Program F	0.0%	$0.00	$0.00
	0.0%	$0.00	$0.00

Staffing Standards for California Children's Services (Historical Document)

I. Background

In 1992 a mandate to develop staffing standards for county CCS programs was given to a committee of independent CCS county representatives to comply with AB 948, Chapter in 1991 in the Health and Safety Code, Section 123955. The staffing standards and the rationale for their development is contained in the document below. The staffing standards developed by the committee in 1992 have been modified for FY 2000-01 by incorporating the CCS Enhanced Budget staffing requirement into the basis staffing standards.

II. Introduction

A mandate was given to a committee of independent county representatives in order to comply with AB 948, specifically the changes in Section 123955 of the Health and Safety Code. The following apply to the committee's mandate:

123955. (a) The state and the counties shall share in the cost of administration of the California Children's Services program at the local level.

(b)(1) The director shall adopt regulations establishing minimum standards for administration, staffing and local implementation of this article subject to reimbursement by the state.

(b)(2) The standards shall allow necessary flexibility in the administration of county programs, taking into account the variability of county needs and resources, and shall be developed and revised jointly with state and county representatives.

The diversity of independent CCS programs in California made this task extremely difficult. There are presently 26 independent county CCS programs with an active caseload ranging from 300 to 68,000 per county. The counties also vary in their organization structure, staff classifications and the duties and responsibilities assigned to a particular classification. This, in turn, is due to the variation in caseload, availability of personnel, and county policy. Finally, recent program changes, such as the legislatively mandated Due Process, will require an as yet undetermined increase in staff. The development of "standards" in the face of such diversity and uncertainty was problematic.

III. A Theoretical Model as Guide

The deliberations of the committee and the rationale for an approach to the mandate can best be illustrated by applying an "open system" model to the CCS program. A system is a set of interdependent parts designed to achieve a goal. An organization, such as a CCS program, is a system. The characteristic features of an open system are inability to always control the influence of the external environment and an incomplete knowledge of the cause/effect relationships of components within the system. Such a system strives to achieve its goal and to remain viable by self-stabilization or homeostasis. This requires the capability to identify dysfunction within the system and the capability to self-correct. The features of this model and components of the CCS system as they relate to

staffing are illustrated in Figure 1, below. The list of activities under process and outcome measures under output is intended for the purpose of illustration only.

The assumption in the model is that there is relationship between staffing (type, numbers), the activities staff perform, and the outcome (actual or desired). Therefore, the monitoring of outcomes and the review of activities needed to achieve the desired outcome is essential for re-defining the type of staffing and the numbers needed. The open-system model requires that this be a continuous process rather than a one-time formulation of standards. It is a process that continuously monitors its outcome (selected outcome measures are suggested above) and adjusts its staffing and/or activities to achieve the desired outcome in the most efficient manner. Thus, "minimal" standards in this model are those demonstrated to be most cost-effective for goal realization.

IV. Methodology

The subcommittee approached its task by first reviewing the program's rapidly changing environment and the effect of these changes on staffing needs. Examples of major changes considered included: the increasing complexity of medical technology and the fiscal and regulatory changes affecting program operations. The subcommittee also considered the market variation from county to county in a number of areas: caseload; local availability of funds and personnel; and the duties and responsibilities of personnel within a given category.

After considering these constraints, the subcommittee developed a two-pronged approach. The first was to define certain general principles that were to be uniformly applicable. The second was to develop numerical staffing profiles, which incorporated provisions for flexibility. The development of staffing profiles was more difficult and complicated and the methodology/rationale is presented here in more detail.

The Southern California independent counties had begun, several years earlier, to identify staffing needs for optimum case management. By correlating selected outcome measure with number/type of staff required to achieve these measures, staffing ratios (prorated per 1000 active cases) were developed. It was assumed that these ratios could be applied to most counties except those fewer than 1000 and over 10,000. The initial focus of this committee was to revise these ratios and they were revised upward, more on belief than documented fact, to the point that questions were being raised about their being realistic. A survey was, therefore, undertaken to compare current FTEs with FTEs generated by the Southern California and the committee ratios. A fourth category was added - the county estimate of its staffing needs.

V. Results of the Survey

The timeline for a response was short and 20 counties completed the survey forms (11 from Northern California and 9 from Southern California). The data are tabulated in Figure 2 (see page 10-16).

A. Total FTEs in the four categories (current staffing, county estimate of need, FTEs generated by Southern California and the committee ratios) were compared:

1. County estimates were higher than current staffing, but reasonably so.

2. County estimates of FTEs needed correlated most closely with FTEs generated by the Southern California ratios; the correlation was best in counties with an active caseload of 1355-2100; it was less for counties with smaller and larger caseloads. This appears to invalidate the assumption about the broader applicability of the Southern California ratio.

3. FTEs based on committee ratios were higher than FTEs in the other categories. There was a 40 - 400 percent increase over current FTEs.

4. These findings, crude as they were, led to the conclusion that county **estimates of staffing needs** would be the most logical basis for this initial iteration of numerical standards.

B. Caseload

The committee had agreed earlier that **active cases** did not reflect true workload and recommended the use of caseload (or workload) figures, to be defined as follows: "an unduplicated count of the clients and applicants with at least one contact or service during the fiscal year." Because counties were not counting cases in this manner, an interim measure of workload was agreed upon: "open caseload at the beginning of a fiscal year plus all referrals during the same fiscal year."

The survey requested numbers on active cases as well as referrals. However, the figures on the latter were unreliable because many were estimates only or included duplicate counts. Thirteen of the 20 responses were considered to have accurate referral counts and the ratio or referrals to active cases was found to be as follows: range - 0.49 to 1.23; mean - 0.58; median - 0.61; and mode - 0.50, 0.71. These figures suggest that, when the extremes are excluded, the ratio is fairly consistent for most of the counties and active cases can be used in this iteration of the standards as proxy for the caseload. However, in subsequent iterations, caseload, as defined above, is to be used in developing staffing profiles.

C. Staffing Profiles

The committee then focused on identifying patterns in the "county estimates" of FTEs needed. This was done by comparing the following data - range, mean, median, and mode for the various personnel classes. Initially, three profiles or staffing patterns were developed, based on three groupings of counties by caseload.

However, this did not provide sufficient discrimination, particularly for counties with active caseloads over 2600. The committee finally defined the following groups by active caseload:

Group 1:	350-550	**Group 5:**	3,215-3,306
Group 2:	874-951	**Group 6:**	5,926-6,882

Group 3:	1,355-1,792	**Group 7:**	55,000
Group 4:	2,100-2,600		

Again, the range, mean, median and mode were calculated for each group and "profiles" were developed for all but Groups 2, 4, and 7. Groups 2 and 4 were Intermediate and group 7 was in a class by itself.

The profiles are presented in Figure 3 (see page 10-17). The committee recognizes the limitation of this study - the very small sample size, particularly when further divided into groups, hence lack of statistical significance. However, there was a pattern to the profiles, and the figures showed considerable consistency and incremental change with the increase in caseload. The only exception was the lack of a pattern for the technical and clerical staff in groups 5 and 6. The larger counties, represented by groups 5 and 6, have a more highly specialized staff with more classification levels within each category. It is believed that, as a result, there is less distinction between the technical and clerical staff and the functions they perform, hence the lack of the pattern that was seen in the smaller counties. For this reason, these two categories are, for groups 6 and 7, combined. In spite of all the inherent drawbacks noted, it is believed that these figures are a logical and reasonable starting point for "standards" for the administration of an open-system program.

VI. Staffing Standards

A. Composition of Staff

The diversity of personnel essential for CCS case management and program operations today is reflected in the requirements specified below. In the application of these qualitative standards, it is essential to keep in mind that, particularly in small counties, an individual may function in several staff categories while in larger counties a more highly specialized staffing is to be expected.

The type of staff shall include, at minimum, the following:

1. A person who has overall responsibility for the direction and operation of the program.

2. A person who has overall responsibility for the day-to-day operation of the program (e.g., budgeting, personnel management, fiscal and claims management, etc.).

3. A physician who has experience and/or interest in health care services to children with complex disabilities shall be available to provide the following services: determine medical eligibility and medical benefits, participate as team member in the case management of complex cases; assist with the preparation of Notices of Action and responses to appeals and Fair Hearing requests; assist with by-report fee determinations;

estimate the cost of care for selected cases; and to assist with other program activities requiring medical input, as needed The physician may delegate certain functions to a nurse or other health professional, however, direct and on-site consultations well as availability by telephone must be maintained.

4. A nurse (RN or PHN) to provide the following services: determine medical eligibility and/or medical benefits under the overall direction of the physician; determine nursing benefits and related medical supplies; participate in the management of complex cases; and assist, as needed, with other program activities requiring medical input.

5. A physical therapist from the MTU staff to provide services for patients in the general CCS program (i.e., outside the MTU program) such as: determine, under the overall direction of the physician, medical eligibility for the MTU and for inpatient/outpatient rehabilitation; determine DME benefits; participate in the case management of complex cases; and provide consultation to case management staff, as needed.

6. The potential contribution of the MSW professional with a medical background to the case management of CCS clients is well recognized. Due to the selectivity of cases requiring their services, there shall be an MSW in counties with a caseload of 2000 or greater (1300 active cases or more) to perform the following functions: provide direct social work intervention to selected cases; participate in the case management of complex cases; identify community resources; serve as liaison to and provide coordination with referring hospitals, centers, and community agencies; provide consultation to CCS staff as needed.

7. The desirability of a Nutritionist as a member of the health professional team was recognized and such a position may be added (subject to the staffing profile appropriate for the county) but is not required.

8. Account clerks to process claims and determine appropriate payment, as needed.

9. Technical staff to perform non-medical case management functions such as: serve as initial contact with client/family; interpret program to client/family or the provider relative to a specific case; determine financial eligibility/residence; request reports; triage charts to the appropriate health professional, as needed; maintain date files and monitor follow-up; maintain timelines, etc.

10. Clerical staff to provide support to all other program staff. Examples of functions are answering telephone, opening/routing mail, typing, transcribing, photocopying, filing, etc.

B. Staffing Standards (Figure 3)

Staffing profiles, developed as described in IV,C, are the first iteration of the staffing standards, representing the patterns of staffing in county programs

believed to be necessary to carry out the program goals. They are numerical figures for the requisite staff identified in A, above, and are presented in Figure 3 (see page 10-17). The ordering of survey respondents by active caseload produced seven categories. Profiles were developed for four of the groups, with two in intermediate categories and one a special situation due to the extremely large active caseload. These profiles or standards eliminate the extremes in county estimates of staffing needs, specifically inadequate staffing and over staffing. Again, it is worth noting that these profiles or standards are simply the first iteration of a process that requires revision and redesign, as warranted by experience.

VII. Use of "Standards" in FY 1992-93 and Beyond

The need for flexibility and the need to redesign the system on the basis of experience have been stressed throughout this report. To assure that these standards do not violate these basic principles, the following procedures for the use of these standards are outlined.

A. Each county shall submit a budget that is based on the county's estimate of the staff needed to achieve program goals.

B. The state CCS program shall review with each county its proposed county budget and determine the amount of state reimbursement as well as Medi-Cal reimbursement. The review shall include compliance with required staff composition, as outlined in VI, A, as well as the numbers of staff in each category (Figure 3).

C. In determining compliance with the appropriate profile (Figure 3), the following unique circumstances of the county need to be considered:

1. The availability of personnel in the county and other unique circumstances.

2. The allocation of tasks among personnel (these may vary, for good reason, from the profile or standard).

3. Counties that, by virtue of an active caseload, fall into the Intermediate groups, (Groups 2 and 4), may have their budgets evaluated on the basis of the standards for the preceding or succeeding group, as indicated. For example, the midpoint of the active caseload of Group 2 is 912. Counties with an active caseload of 912 or less may be assessed on the staffing standards of Group 1; those with an active caseload higher than 912, may be assessed on the standards of Group 3. However, in keeping with flexibility criterion, judgment and local circumstances are to take precedence in borderline situations, particularly during this initial, learning stage of implementation of the standards.

4. In **all groups** the budget review is to take into consideration the findings of the latest program review with necessary adjustments to be made, as indicated.

D. The committee strongly urges that the State Medicaid plan include a provision for CCS reimbursement under the Federal Funding Participation program. The reimbursement is to be based on the number of Medi-Cal beneficiaries served by CCS and also on county staffing in accordance with these standards. The reimbursement for case management requires an accurate count of Medi-Cal beneficiaries, hence state CCS needs to implement, as quickly as possible, the proposal submitted by another county committee for such a count. Eligibility of a county for FFP on the basis of these staffing standards will also be assessed in the budget review process.

E. These standards are to be reassessed within the next two (2) years. For the next iteration, it is essential that the following procedures be in place:

1. Reporting to the state by counties include caseload, (as defined in IV, B) and subsequent staffing profiles be based on caseload rather than active cases.

2. The reassessment and redesign of the program requires that staffing be considered not in isolation but in relationship to all three components of the system. The next staffing profiles are to be based on such a redesign. This requires the identification of key outcome measure and use of these outcome measures to modify staffing and/or activities.

Figure 2: County Estimates of FTEs Required (Type and Number of Staff)

County	Active Cases	Referrals	MD	Nurse	Other Health Prof	Admin	Admin Sec	Asst Admin	Assoc/ Tech Support	Account Staff	Clerks *	Total	Comments
1	340	220	0.1	0.5	0	1.0	0	0	0	1.0	1.0	3.6	
2	340	240	0.15	0.5	0.06	0.75	0	0	1.0	0.6	1.0	4.06	
3	529	264	0.25	0.5	0	0.40	0.1	0	3.0	1.0	1.0	5.6	
4	550	275+	0.05	1.0	0	1.0	0	0	1.0	0.5	0.5	4.05	
5	874	471	0.1	0.1	0	1.0	0	0	2.0	1.0	1.0	5.2	Automated
6	951	996	0.4	1.5	0.4	1.0	0	0	3.5	1.0	3.0	11.0	Partly Automated
7	1,355	1020	0.4	1.0	0.6	1.0	0.25	0	4.0	2.0	2.0	11.0	
8	1,377	1698	0.3	3.0	0	1.0	0	0	3.0	2.0	5.5	15.05	Nurse count includes traditional PHN services to CCS patients
9	1,586	914	0.25	2.0	0.75	0.25	0	0	4.0	3.0	2.0	12.25	
10	1,591	1400	0.75	1.0	1.0	1.0	0	0	3.0	2.0	2.0	10.75	
11	1,792	892	0.30	2.0	0.37	0.6	0	1.0	4.0	2.0	1.0	11.27	Automated
12	2,100	1128	0.50	1.0	2.0	1.0	0	0	6.0	1.5	3.5	15.50	
13	2,600	2100	0.80	1.0	1.0	1.0	0	0	5.0	2.5	5.0	16.30	
14	3,215	1977	0.50	2.0	0.3	1.0	0	0	8.0	3.0	1.0	15.8	Partly Automated
15	3,277	2623	1.0	4.0	1.5	1.0	0	0	10.0	2.0	9.0	28.5	
16	3,306	2394	1.0	3.6	1.15	1.0	1.0	1.0	8.0	3.0	4.0	23.75	
17	5,926	5898	1.0	7.0	2.0	1.0	1.0	1.4	14.0	15.0	19.4	61.80	
18	6,118	3014	1.0	4.0	1.5	1.0	1.0	0.5	4.5	3.0	18.0	34.50	
19	6,882	6032	1.0	6.0	2.25	1.0	1.0	1.0	16.0	4.3	3.0	32.25	Automated
20	68,061	46005	5.0	29.0	25	1.0	1.0	1.0	38.5	9.5	143.0	253.00	Automated

* Please Note: MTU clerical staff have been excluded from these figures.

Prepared 1992

Figure 3: County Staffing Profiles (Number of Staff by Personnel Class and Active Cases)

	Personnel [A]									
Active Cases	**MD**	**Nurse**	**Other Health Prof [B]**	**Adm**	**Asst Admin**	**Admin Sec**	**Account Clerks**	**Tech Staff**	**Clerks [C]**	**Total**
Group 1: 340-550 (N=4)	0.1-0.15	0.5	0	1.0	0	0	1	1	1	4.6-4.65
Group 2: 874-951 (N=2)	**Intermediate**									
Group 3: 1,335-1,792 (N=5)	0.3	1.0-2.0	0.5	1.0	0	0	2	4	2	10.8-11.8
Group 4: 2,100-2,000 (N=2)	**Intermediate**									
Group 5: 3,215-3,306 (N=3)	1.0	3.5	1.5	1.0	0.	0	3	8	4	22
Group 6: 5,926-6,882 (N=3)	1.0	6.0	2.0	1.0	1.0	1.0	4	32 [D]		48
Group 7: 55,000 (N=1) [C]	3.0	26.0	11.0	**Special Situation** 1.0	3.0	2.0	9	117.4		172.4

a. Numbers are derived primarily from median, mode data.

b. RPT, MSW, Nutritionist (please refer to V/A, staff composition).

c. Figures do not include clerical staff for the MTU program.

d. No meaningful pattern.

e. Figures were developed specifically for this county by making additions, based on needs identified in a program review, to existing staff.

The Staffing Matrix and Funding of the Child Health and Disability Prevention Program (Historical Document)

I. Background

With the transition of the CHDP program to the CHDP Gateway in FY 2002-03, the funding of the local CHDP administrative programs needed to shift correspondingly from expenditures of State-only general funds to those matched through federal participation.

The State convened a workgroup of local CHDP program and State staff in December 2002 to develop a methodology for funding that would be caseload driven and responsive to the fluctuations in target populations and administrative responsibilities. The workgroup analyzed the basic required activities of the CHDP program to assure that Medi-Cal eligible children and youth have an effective access to healthcare resources. Critical functions include seeking out and informing eligible populations about the benefits of prevention and the health care resources available for early and periodic assessments and assuring diagnosis and treatment for any health conditions found as a result of a health assessment through a qualified provider network. Staffing guidelines evolved for these basic program activities using target population, health assessments, and provider data. A statewide survey portrayed the extensive coordination and collaboration among public health department programs and community agencies such as the Women, Infants, and Children (WIC) programs, the Maternal and Child Health programs, Childhood Lead Poisoning Prevention programs, public and private schools, and Head Start and State preschools.

II. Program Activities- Staffing Factors and Methodology

Program activities became the foundational factors in the development of a staffing methodology in which program management and program support were configured.

Staffing methodologies are summarized for Program Activities, Program Management, and Program Support in the following sections.

Informing/Linking — Children and their families and caregivers need information about the kind and location of services available to them and the processes for navigating successfully in the health care delivery system, including that of the CHDP Gateway. This information is provided through a variety of methods and locations with individuals and groups and with an expected outcome that eligible populations are provided periodic health assessments.

There are two broad classifications of staff involved in these activities. One is ancillary staff who are paraprofessionals possessing higher levels of knowledge and problem solving capabilities and the other is health professional staff such as dental staff, health educators, nutritionists, physicians, and public health nurses. - Ancillary staff is designated as the index level of staff for the completion of Informing and Linking activities. The determination of the FTE for informing and linking requires knowledge of the estimated total CHDP target population.

Care Coordination — Care coordination activities assure that children with the identified conditions are provided the necessary diagnosis and treatment. These conditions may vary from simple and routine areas of follow-up for vision and dental

problems to those that require specialty medical and mental health services. The expected outcome is that children's health needs are addressed in a timely way so that potentially disabling and chronic conditions are prevented. This outcome is obtained through the use of qualified available resources for referral, assisting with scheduling and arranging transportation to appointments. The PHN is designated the index classification for Care Coordination. Other staff, namely ancillary and health professional staff is also active in care coordination activities.

The determination of the FTE for the PHN, Ancillary and Health Professional staff requires knowledge of the total number of health assessments or health screens completed for the designated fiscal year, the number of health assessments completed for Medi-Cal Managed Care Plan members and the percent of health assessments or screens that require follow up.

Provider Orientation And Training — CHDP providers are the critical element in California's ability to meet early and periodic screening requirements for Medi-Cal eligible children and youth. Local CHDP program staff assure that participating providers understand the screening and reporting requirements of the CHDP program including the components of a comprehensive health assessment, the importance of comprehensive care and the role of the CHDP program in assisting with care coordination and complex billing problems. A qualified provider network is achieved and maintained through ongoing communication and training found at the local program level.

The PHN is designated the index classification for Provider Orientation and Training. The PHN possesses professional education and training qualifications that allow for the PHN to follow up with the health care provider along with the array of other health professionals such as dental staff, health educator, nutritionist, and physician, when they are available. The determination of the FTE for the PHN and Health Professional staff requires knowledge of the total number of active CHDP providers in the local program area.

Liaison — As required by EPSDT, local CHDP programs have cooperative and collaborative agreements with multiple agencies and organizations that share an interest in healthy children and youth. These agreements outline basic areas of responsibility and reinforce consistent messages about the importance of comprehensive coordinated services. Duplicative services are avoided. Through leadership and coordination, local CHDP programs maintain an infrastructure for preventative health care services for children and youth. The health professional inclusive of the PHN is the designated classification for Liaison. The health professional possesses professional education and training qualifications that allow for the purpose of the program to be interpreted and shared with multiple agencies.

The determination of the FTE for the health professional staff as Liaison requires knowledge of the type of Medi-Cal managed care in the local program area, the local public health department programs and the other community and school programs.

III. Program Management - Staffing Factors and Methodology

The Program Activities and staff of Informing/Linking, Care Coordination, Provider Orientation and Training, and Liaison are under the leadership and supervision of Program Management. Program Management involves staff that has overall responsibility for the direction and operation of the program in a leadership role. Program Management staff includes Information Technology staff who are responsible for developing and maintaining management information.

The determination of the FTE for the Program Management staff requires knowledge of the total FTEs in the areas of Program Activity.

IV. Program Support -Staffing Factors and Methodology

The Program Management staff and Program Activities staff clerical support in the performance of their responsibilities. The determination of the FTE for clerical staff requires knowledge of the total FTEs in Program Activity and Program Management.

V. Use of Staffing Factors and Methodology in 2003-04 and Beyond

The staffing factors and methodology were designed to be dynamic with caseload growth in mind. Beginning in FY 2003-04, County/City Local Programs prepared their CHDP No County/City Match budgets using the staffing factors and staffing methodology as outlined.

The CMS Branch has recognized that this methodology will require monitoring and evaluation to assure that the methodology meets the expectations for a dynamic program responsive to shifts in population caseload and available resources.

Legislation, Regulations, and Guidelines for CCS

A. Federal enabling legislation establishing the provisions and funding related to children with special health care needs.

Reference: Title V, Part II of the Social Security Act.

B. State enabling legislation of the CCS program.

Reference: Health and Safety Code, Sections 123800 through 123995.

C. CCS program regulations that implement, interpret, or make specific the enabling legislation.

Reference: California Code of Regulations (CCR), Title 22, Sections 41508 through 42801.

D. Medi-Cal laws pertaining to managed care plan contracts and prior authorization of services by the director as it related to children with conditions eligible under the CCS program.

Reference: Welfare and Institutions Code, Sections 14093, 14093.05, 14094, 14094.1, 14094.2, 14094.3, 14093.05, and 14103.8.

E. Medi-Cal regulations pertaining to the referral of beneficiaries with a medical or surgical condition which would qualify for services under CCS.

Reference: CCR, Title 22, Section 51013.

F. Department of Education laws pertaining to School Therapy Services as it relates to children with conditions eligible under the CCS program.

Reference: Government Code, Sections 7570, 7571, 7572, 7572.5, 7573, 7575, and 7582.

G. Other state laws which impact many CCS families that may be helpful in the CCS case management process:

1. Immunization reactions

Reference: Health and Safety Code, Section 120455.

2. Ventilator-dependent children in foster family homes

Reference: Health and Safety Code, Section 1507.5.

H. Current interpretative releases by State Department of Health Services, CCS program.

1. Numbered Letters for communicating policies and procedures.

2. Non-numbered letters for transmitting information.

Selected State Laws Relating to CCS

The following are selected sections of California laws relating to CCS. These sections have been extracted from California's Health and Safety Code, Government Code, Insurance Code, and Welfare and Institutions Code. For more current and complete information on State laws, please visit the Legislative Counsel of California's website at www.leginfo.ca.gov/calaw.html.

This section is not all-inclusive. Not included are other State laws, federal laws, State and federal regulations, or provisions of the CCS Manual of Procedures or CCS Numbered Letters.

Health and Safety Code Section

120455. Immunization Reactions; liability for act or omission in administration of immunizing agent to minor

No person shall be liable for any injury caused by an act or omission in the administration of a vaccine or other immunizing agent to a minor, including the residual effects of the vaccine or immunizing agent, if the immunization is either required by state law, or given as part of an outreach program pursuant to Article 2 (commencing with Section 3395) of Chapter 7 of Division 4, and the act or omission does not constitute willful misconduct or gross negligence.

123800. Title of act

This article shall be known and may be cited as the Robert W. Crown California Children's Services Act.

123805. Services for physically defective or handicapped minors; powers and duties of department

The department shall establish and administer a program of services for physically defective or handicapped persons under the age of 21 years, in cooperation with the federal government through its appropriate agency or instrumentality, for the purpose of developing, extending and improving the services. The department shall receive all funds made available to it by the federal government, the state, and its political subdivisions or from other sources. The department shall have power to supervise those services included in the state plan that are not directly administered by the state. The department shall cooperate with the medical, health, nursing and welfare groups and organizations concerned with the program, and any agency of the state charged with the administration of laws providing for vocational rehabilitation of physically handicapped children.

The reference to "the age of 21 years" in this section is unaffected by Section 1 of Chapter 1748 of the Statutes of 1971 or any other provision of that chapter.

123810. Transfer of duties, purposes, responsibilities and jurisdiction

The department succeeds to and is vested with the duties, purposes, responsibilities, and jurisdiction heretofore exercised by the State Department of Benefit Payments with respect to moneys, funds, and appropriations available to the department for the purposes of processing, audit, and payment of claims received for the purposes of this article.

123815. Possession and control of records, equipment and supplies

The department shall have possession and control of all records, papers, equipment, and supplies held for the benefit or use of the Director of Benefit Payments in the performance of his duties, powers, purposes, responsibilities, and jurisdiction that are vested in the department by Section 123810.

123820. Transfer of officers and employees

All officers and employees of the Director of Benefit Payments who on July 1, 1978 are serving in the state civil service, other than as temporary employees, and engaged in the performance of a function vested in the department by Section 123810 shall be transferred to the department. The status, positions, and rights of these persons shall not be affected by the transfer and shall be retained by them as officers and employees of the department pursuant to the State Civil Service Act, except as to positions exempt from civil service.

123822. Claims for services; submission to fiscal intermediary; centralized billing system

All claims for services provided under this article shall be submitted to the state fiscal intermediary for payment no later than January 1, 1999. The State Department of Health Services shall work in cooperation with the counties to develop a timeline for implementing the centralized billing system. If a department review of those counties participating in the centralized billing system demonstrates that as of January 1, 2000, any county has incurred increased costs as a result of submitting claims for services to the state fiscal intermediary, that county may be exempt from this section.

123825. Intent

It is the intent of the Legislature through this article to provide, to the extent practicable, for the necessary medical services required by physically handicapped children whose parents are unable to pay for these services, wholly or in part. This article shall also include the necessary services rendered by the program to physically handicapped children treated in public schools that provide services for physically handicapped children.

123830. Handicapped child

"Handicapped child," as used in this article, means a physically defective or handicapped person under the age of 21 years who is in need of services. The director shall establish those conditions coming within a definition of "handicapped child" except as the Legislature may otherwise include in the definition. Phenylketonuria, hyaline membrane disease, cystic fibrosis, and hemophilia shall be among these conditions.

The reference to "the age of 21 years" in this section is unaffected by Section 1 of Chapter 1748 of the Statutes of 1971 or any other provision of that chapter.

123835. Keeping program abreast of advances in medical science; pilot studies

The department shall keep the program abreast of advances in medical science, leading to the inclusion of other handicapping conditions and services within the limits of and consistent with the most beneficial use of funds appropriated for this purpose. With the approval of the agency administrator the department may carry out pilot studies to determine the need for, or the

feasibility of, including other handicapping conditions and services in the program within the limits of available funds appropriated for the program.

123840. Services

"Services," as used in this article, means any or all of the following:

(a) Expert diagnosis

(b) Medical treatment

(c) Surgical treatment

(d) Hospital care

(e) Physical therapy

(f) Occupational therapy

(g) Special treatment

(h) Materials

(i) Appliances and their upkeep, maintenance, care and transportation

(j) Maintenance, transportation, or care incidental to any other form of "services"

123845. California Children's Services program

"California Children's Services program," as used in this article, means the program of services established and operated pursuant to this article.

123850. Designation of agency to administer California Children's Services program; standards of local administration

The board of supervisors of each county shall designate the county department of public health or the county department of social welfare as the designated agency to administer the California Children's Services program. Counties with total population under 200,000 persons may administer the county program independently or jointly with the department. Counties with a total population in excess of 200,000 persons shall administer the county program independently. Except as otherwise provided in this article, the director shall establish standards relating to the local administration and minimum services to be offered by counties in the conduct of the California Children's Services program.

123855. Case finding; consent of parent or guardian

The department or designated county agency shall cooperate with, or arrange through, local public or private agencies and providers of medical care to seek out handicapped children, bringing them expert diagnosis near their homes. Case finding shall include, but not be limited to, children with impaired sense of hearing. This section does not give the department or designated agency power to require medical or other form of physical examination without consent of parent or guardian.

123860. Diagnosis for handicapped children

In accordance with applicable regulations of the United States Children's Bureau, the department and designated county agencies shall provide a diagnosis for handicapped children. Within the limits of available funds, the department and designated local agencies may accept for diagnosis a handicapped child believed to have a severe chronic disease or severe physical handicap, as determined by the director, irrespective of whether the child actually has an eligible medical condition specified in Section 123830. The department shall cause a record to be kept listing all conditions diagnosed by the program and shall publish the information annually, including data on the number and kinds of diagnosed medical conditions that do not come within the definition of "handicapped child" as specified in Section 123830.

123865. Application for services

Whenever the parents or estate of a handicapped child is wholly or partly unable to furnish for the child necessary services, the parents or guardian may apply to the agency of the county that has been designated by the board of supervisors of the county of residence under the terms of Section 123850 to administer the provisions for handicapped children. Residence shall be determined in accordance with the provisions of Section 243 and 244 of the Government Code.[1]

123870. Standards of financial eligibility; exception for services under the medical therapy program in public schools; fees

(a) The department shall establish uniform standards of financial eligibility for treatment services under the California Children's Services (CCS) program.

(1) Financial eligibility for treatment services under this program shall be limited to persons in families with an adjusted gross income of forty thousand dollars ($40,000) or less in the most recent tax year, as calculated for California State income tax purposes. If a person is enrolled in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), the financial documentation

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[1]**Government Code, Section 243 and 244:**

243. "Every person has, in law, a residence."

244. "In determining the place of residence the following rules shall be observed:

(a) It is the place where one remains when not called elsewhere for labor or other special or temporary purpose, and to which he or she returns in seasons of repose.

(b) There can only be one residence.

(c) A residence cannot be lost until another is gained.

(d) The residence of the parent with whom an unmarried minor child maintains his or her place of abode is the residence of such unmarried minor child.

(e) The residence of an unmarried minor who has a parent living cannot be changed by his or her own act.

(f) The residence can be changed only by the union of act and intent. A married person shall have the right to retain his or her legal residence in the state of California notwithstanding the legal residence or domicile of his or her spouse."

required for that program in Section 2699.6600 of Title 10 of the California Code of Regulations may be used instead of the person's California State income tax return. However, the director may authorize treatment services for persons in families with higher incomes if the estimated cost of care to the family in one year is expected to exceed 20 percent of the family's adjusted gross income.

(2) Children enrolled in the Healthy Families Program who have a CCS program eligible medical condition under Section 123830, and whose families do not meet the financial eligibility requirement of paragraph (1), shall be deemed financially eligible for CCS program benefits.

(b) Necessary medical therapy treatment services under the California Children's Services program rendered in the public schools shall be exempt from financial eligibility standards and enrollment fee requirements for the services when rendered to any handicapped child whose educational or physical development would be impeded without the services.

(c) All counties shall use the uniform standards for financial eligibility and enrollment fees established by the department. All enrollment fees shall be used in support of the California Children's Services program.

(d) Annually, every family with a child eligible to receive services under this article shall pay a fee of twenty dollars ($20), that shall be in addition to any other program fees for which the family is liable. This assessment shall not apply to any child who is eligible for full scope Medi-Cal benefits without a share of cost, for children receiving therapy through the California Children's Services program as a related service in their individualized education plans, for children from families having incomes of less than 100 percent of the federal poverty level, or for children covered under the Healthy Families Program.

123872. Repayment agreement for treatment services

In addition to the other eligibility requirements set forth in this article, prior to being determined financially eligible for services under this article, the applicant family shall agree to repay the California Children's Services program for any treatment services authorized by the program in an amount not to exceed the proceeds of any judgment, award, or settlement for damages as a result of a lawsuit or pursuant to an agreement relating to a California Children's Services medically eligible condition.

123875. Determination that handicapped child is eligible for therapy by California Children's Services medical therapy unit conference team; disagreement; further justification

When the California Children's Service medical therapy unit conference team, based on a medical referral recommending medically necessary occupational or physical therapy in accordance with subdivision (b) of Section 7575 of the Government Code,[2] finds that a

[2]**Government Code, Section 7575(b):**

handicapped child, as defined in Section 123830, needs medically necessary occupational or physical therapy, that child shall be determined to be eligible for therapy services. If the California Children's Services medical consultant disagrees with the determination of eligibility by the California Children's Services medical therapy unit conference team, the medical consultant shall communicate with the conference team to ask for further justification of its determination, and shall weigh the conference team's arguments in support of its decision in reaching his or her own determination.

This section shall not change eligibility criteria for the California Children's Services programs as described in Sections 123830 and 123860.

This section shall not apply to children diagnosed as specific learning disabled, unless they otherwise meet the eligibility criteria of the California Children's Services.

123880. Continued eligibility; receipt of treatment services under teaching program

The department and designated agencies shall not deny eligibility or aid under the California Children's Services program because an otherwise eligible person is receiving treatment services under a teaching program at an accredited medical school facility or accredited school or college of pediatric medicine, whether or not all or part of the treatment services are performed by the staff at the facility, school, or college, provided that treatment services at the facility, school or college are under the general supervision of a California Children's Services program panel physician and surgeon, including a family physician, and podiatrist.

123885. Panel members; qualifications

Panel members, as set forth in Section 123880, shall be board-certified and have expertise in the care of children.

(b) The department shall determine whether a California Children's Services eligible pupil, or a pupil with a private medical referral needs medically necessary occupational therapy or physical therapy. A medical referral shall be based on a written report from a licensed physician and surgeon who has examined the pupil. The written report shall include the following:

(1) The diagnosed neuromuscular, musculoskeletal, or physical handicapping condition prompting the referral.

(2) The referring physician's treatment goals and objectives.

(3) The basis for determining the recommended treatment goals and objectives, including how these will ameliorate or improve the pupil's diagnosed condition.

(4) The relationship of the medical disability to the pupil's need for special education and related services.

(5) Relevant medical records.

123890. Burn victims; treatment in hospital without separate facilities for children

(a) The state department shall not deny a hospital's request to provide treatment to burn victims who are eligible under the California Children's Services program solely on the basis that the hospital does not have separate facilities for child and adult burn victims, provided that the hospital has approval from the department to operate a burn center pursuant to Section 1255.

(b) Subdivision (a) shall only be applied to burn units located in hospitals where there are no regional burn centers, or any other existing burn center, within an 85-mile radius of the hospital.

(c) Subdivision (a) shall only apply if the hospital seeking the exemption has a state-approved burn center in operation as of January 1, 1982, and if there is no hospital specializing in children's services within an 85-mile radius of the hospital seeking the subdivision (a) exemption.

(d) Hospitals having qualified and received a subdivision (a) exemption, shall demonstrate, at the request of the department, that the nursing staff providing burn care to children victims have satisfactorily completed post-graduate training in pediatrics.

123895. Determination of eligibility; certification for care

The designated agency shall determine the financial eligibility of the family according to standards established by the department. The agency will also determine if the parents are residents of the county, if the guardian of the child is a resident of the county, or if the emancipated minor is a resident of the county where application for services is made. If the agency finds that the family, guardian, or emancipated minor is a resident of the county and financially eligible for services, it shall make a record of the facts and shall certify this child for care under the program.

123900. Annual enrollment fee; exemptions; one time start up fee; accounting

(a) Beginning September 1, 1991, in addition to any other standards of eligibility pursuant to this article, each family with a child otherwise eligible to receive services under this article shall pay an annual enrollment fee as a requirement for eligibility for services, except as specified in subdivision (f).

(b) The department shall determine the annual enrollment fee, that shall be a sliding fee scale based upon family size and income, and shall be adjusted by the department to reflect changes in the federal poverty level.

(c) "Family size" shall include the child, his or her natural or adoptive parents, siblings, and other family members who live together and whose expenses are dependent upon the family income.

(d) "Family income" for purposes of this article, shall include the total gross income, or their equivalents, of the child and his or her natural or adoptive parents.

(e) Payment of the enrollment fee is a condition of program participation. The enrollment fee is independent of any other financial obligation to the program.

(f) The enrollment fee shall not be charged in any of the following cases:

(1) The only services required are for diagnosis to determine eligibility for services, or are for medically necessary therapy pursuant to Section 123875.

(2) The child is otherwise eligible to receive services and is eligible for full Medi-Cal benefits at the time of application or reapplication.

(3) The family of the child otherwise eligible to receive services under this article has a gross annual income of less than 200 percent of the federal poverty level.

(4) The family of a child otherwise eligible to receive services under this article who is enrolled in the Healthy Families Program (Part 6.2 [commencing with Section 12693] of Division 2 of the Insurance Code).

(g) Failure to pay or to arrange for payment of the enrollment fee within 60 days of the due date shall result in disenrollment and ineligibility for coverage of treatment services 60 days after the due date of the required payment.

(h) The county shall apply the enrollment fee scale established by the department and shall collect the enrollment fee. The county may arrange with the family for periodic payment during the year if a lump-sum payment will be a hardship for the family. The agency director of California Children's Services may, on a case-by-case basis, waive or reduce the amount of a family's enrollment fee if, in the director's judgment, payment of the fee will result in undue hardship.

(i) By thirty days after the effective date of this section or August 1, 1991, whichever is later, the department shall advance to each county, as a one-time startup amount, five dollars and fifty cents ($5.50) for each county child who was receiving services under this article on June 30, 1990, and who was not a Medi-Cal beneficiary. This one-time payment shall be in addition to the 4.1 percent of the gross total expenditures for diagnoses, treatment, and therapy by counties allowed under subdivision (c) of Section 123955.

(j) Each county shall submit to the state, as part of its quarterly claim reimbursement, an accounting of all revenues due and revenues collected as enrollment fees.

123905. Certification of eligibility; authorization and payment for services; reimbursement

A county of under 200,000 population, administering its county program jointly with the department, shall forward to the department a statement certifying the family of the handicapped child as financially eligible for treatment services. The department shall authorize necessary services within the limits of available funds. The department shall make payment for services, with reimbursement from the county for its proportionate share as specified in this article.

123910. Payment for services without certification; furnishing services; gifts and legacies

The department may, without the possession of a county certification, pay the expenses for services required by any physically handicapped child out of any funds received by it through gift, devise, or bequest or from private, state, federal, or other grant or source.

The department may authorize or contract with any person or institution properly qualified to furnish services to handicapped children. It may pay for services out of any funds appropriated for the purpose or from funds it may receive by gift, devise, or bequest.

The department may receive gifts, legacies, and bequests and expend them for the purpose of this article, but not for administrative expense.

123915. Direct arrangement for services; agreements with parents for payment of enrollment fee

When the department provides, or arranges for the provision of, services to physically handicapped children directly, as in the case of nonresident physically handicapped children, it shall enter into an agreement with parents, guardians or persons responsible for the care of handicapped children for payment of the enrollment fee.

123920. Payment of services for non-resident children; special grants or allotments for costs

Upon the request of another state or of a federal agency, the department may pay the expenses of services required by any physically handicapped child who is not a resident of the state; provided, that the cost the such services is fully covered by special grants or allotments received from the state or federal agency for that purpose.

123925. Supervision over services; records

The department and designated agencies shall maintain surveillance and supervision over the services provided handicapped children under authorization by the program to assure a high quality of service and shall cause a record to be kept showing the condition and improvement of these handicapped children.

123930. Consent of parent or guardian; exception

This article does not authorize any treatment service without the written consent of a parent or guardian except as a person under 18 years of age is an emancipated minor.

123935. Effect of mental retardation

A handicapped child shall not be denied services pursuant to this article because he or she is mentally retarded.

123940. County appropriations and expenditures; state matching

(a)

(1) Annually, the board of supervisors shall appropriate a sum of money for services for handicapped children of the county, including diagnosis, treatment, and therapy services for physically handicapped children in public schools, equal to 25 percent of the actual expenditures for the

county program under this article for the 1990-1991 fiscal year, except as specified in paragraph (2).

(2) If the state certifies that a smaller amount is needed in order for the county to pay 25 percent of costs of the county's program from this source. The smaller amount certified by the state shall be the amount that the county shall appropriate.

(b) In addition to the amount required by subdivision (a), the county shall allocate an amount equal to the amount determined pursuant to subdivision (a) for purposes of this article from revenues allocated to the county pursuant to Chapter 6 (commencing with Section 17600) of Division 9 of the Welfare and Institutions Code.

(c)

(1) The state shall match county expenditures for this article from funding provided pursuant to subdivisions (a) and (b).

(2) County expenditures shall be waived for payment of services for children who are eligible pursuant to paragraph (2) of subdivision (a) of Section 123870.

(d) The county may appropriate and expend moneys in addition to those set forth in subdivisions (a) and (b) and the state shall match the expenditures, on a dollar-for-dollar basis, to the extent that state funds are available for this article.

(e) Nothing in this section shall require the county to expend more than the amount set forth in subdivision (a) plus the amount set forth in subdivision (b) nor shall it require the state to expend more than the amount of the match set forth in subdivision (c).

123945. State emergency aid

For those counties with a total appropriation of county funds not exceeding one hundred and twenty-five thousand dollars ($125,000) and upon the expenditure of the county funds equivalent to a county appropriation pursuant to Section 123940, the department may, to the extent funds are available from state appropriated funds for the California Children's Services program and upon certification of the county that there are insufficient revenues from the account established pursuant to Chapter 6 (commencing with Section 17600) of Division 9 of the Welfare and Institutions Code, pay for services for cases deemed by the department to represent emergencies or cases where medical care cannot be delayed without great harm to the child.

123950. Administration of medical-therapy program; cost; standards; regulations

The designated county agency shall administer the medical-therapy program in local public schools for physically handicapped children. As provided in Section 123940, the state and counties will share in the cost of support of therapist salaries in these schools in the ratio of one dollar ($1) of state or federal funds reimbursed quarterly to one dollar ($1) of county funds. The director shall establish standards for the maximum number of therapists employed in the schools eligible for state financial support in this program, the services to be provided, and the county administrative services subject to reimbursement by the state.

The department may adopt regulations to implement this section as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act, the adoption of the regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, and general welfare. Not withstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, these emergency regulations shall not be subject to the review and approval of the Office of Administrative Law.

Notwithstanding any other provision of law, if the department determines that emergency regulations are necessary to implement any part of this article, there shall be deemed to be good cause for the regulations to take effect prior to public notice and hearing.

Notwithstanding subdivision (h) of Section 11346.1 and Section 11349.6 of the Government Code, the department shall transmit these regulations directly to the Secretary of State for filing. The regulations shall become effective immediately upon filing by the Secretary of State.

The Office of Administrative Law shall provide for the printing and publication of these regulations in the California Code of Regulations. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, these regulations shall not be repealed by the Office of Administrative Law and shall remain in effect until revised or repealed by the department.

123955. California Children's Services program; sharing costs; standards

(a) The state and the counties shall share in the cost of administration of the California Children's Services program at the local level.

(b)

(1) The director shall adopt regulations establishing minimum standards for the administration, staffing, and local implementation of this article subject to reimbursement by the state.

(2) The standards shall allow necessary flexibility in the administration of county programs, taking into account the variability of county needs and resources, and shall be developed and revised jointly with state and county representatives.

(c) The director shall establish minimum standards for administration, staffing and local operation of the program subject to reimbursement by the state.

(d) Until July 1, 1992, reimbursable administrative costs, to be paid by the state to counties, shall not exceed 4.1 percent of the gross total expenditures for diagnosis, treatment and therapy by counties as specified in Section 123940.

(e) Beginning July 1, 1992, this subdivision shall apply with respect to all of the following:

(1) Counties shall be reimbursed by the state for 50 percent of the amount required to meet state administrative standards for that portion of the county caseload under this article that is ineligible for Medi-Cal to the

extent funds are available in the state budget for the California Children's Services program.

(2) On or before September 15 of each year, each county program implementing this article shall submit an application for the subsequent fiscal year that provides information as required by the state to determine if the county administrative staff and budget meet state standards.

(3) The state shall determine the maximum amount of state funds available for each county from state funds appropriated for CCS county administration. If the amount appropriated for any fiscal year in the Budget Act for county administration under this article differs from the amounts approved by the department, each county shall submit a revised application in a form and at the time specified by the department.

(f) The department and counties shall maximize the use of federal funds for administration, of the programs implemented pursuant to this article, including using state and county funds to match funds claimable under Title 19 of the Social Security Act.

123960. Program data; purposes

The department shall require of participating local governments the provision of program data including, but not limited to, the number of children treated, the kinds of disabilities, and the costs of treatment, to enable the department, the Department of Finance, and the Legislature to evaluate in a timely fashion and to adequately fund the California Children's Services program.

123965. Placement of handicapped children for adoption; entitlement to services

A handicapped child placed for adoption, determined to be financially eligible for care at the time of placement, shall not be denied services pursuant to this article based upon the income of the adopting parents, nor shall the adopting parents be required to enter into any agreement to pay toward the costs of services authorized for the care. This section shall only apply to physical handicaps present, and diagnosed, at the time of adoption. Residence, for the purposes of this section, shall be that of the adopting parents.

123970. Notification of prospective adopting parents; termination of program funds

The department and the placing adoption agency at the time of placement shall notify all prospective adopting parents in writing, that funds received under the California Children's Services program shall terminate if the adopting parents move out of the state. However, the department and the placing adoption agency shall advise the prospective adopting parents that they may be eligible for the funds in the new state, subject to any applicable qualifications.

123975. Screening newborn infants for deafness; follow up and assessment

(a) The department, in consultation with selected representatives of participating neonatal intensive care units, shall establish a system to screen newborn infants at high risk for deafness and create and maintain a system of follow up and assessment for infants identified by such screening in neonatal intensive care units participating in the California Children's Services program.

This section shall not be applicable to a newborn child whose parent or guardian objects to the tests on the ground that the tests conflict with his or her religious beliefs or practices.

(b) It is the intent of the Legislature, in enacting this section, to ensure the establishment and maintenance of protocols and quality of standards.

(c) The department shall implement this section for infants in neonatal intensive care units participating in the California Children's Services program.

123980. Actions against third persons liable for injury; notice

If the recipient of services provided by the California Children's Services program, his or her guardian, conservator, personal representative, estate, or survivors, or any of them brings an action against a third person who may be liable for the injury, notice of institution of legal proceedings, notice of settlement, and all other notices required by this code shall be given to the State Director of Health Services in Sacramento and to the county-managed California Children's Services program. The director may provide notice to the Attorney General. All of these notices shall be given by the attorney retained to assert the beneficiary's claim, or by the injured party beneficiary, his or her guardian, conservator, personal representative, estate, or survivors, if no attorney is retained.

123982. Treatment provided under children's services program; claim against judgment, award or settlement received against third-party; liens

Except as otherwise provided by law, the amount of any judgment, award, or settlement relating to a medical condition for which treatment services have been provided under the California Children's Services program shall be subject to a claim by the state department and the designated county agency for reimbursement of the costs of the benefits provided, and to any lien filed against that judgment, award, or settlement. The department or the county designated agency, through its civil legal adviser, may, to enforce this right, institute and prosecute legal proceedings against the person who has received benefits under this article, his or her guardian, conservator, or other personal representative, or his or her estate. In the event of a judgment, award, or settlement in a suit or claim against a third person who is liable for the medical condition for which treatment services have been provided under the California Children's Services program, the court or other agency shall first order paid from the judgment, award, or settlement the actual costs of the care and treatment furnished, or to be furnished, under the California Children's Services program.

123985. Bone marrow transplant; reimbursement; conditions

(a) A bone marrow transplant for the treatment of cancer shall be reimbursable under this article, when all of the following conditions are met:

(1) The bone marrow transplant is recommended by the recipient's attending physician.

(2) The bone marrow transplant is performed in a hospital that is approved for participation in the California Children's Services program.

(3) The bone marrow transplant is a reasonable course of treatment and is approved by the appropriate hospital medical policy committee.

(4) The bone marrow transplant has been deemed appropriate for the recipient by the program's medical consultant. The medical consultant shall not disapprove the bone marrow transplant solely on the basis that it is classified as experimental or investigational.

(b) The program shall provide reimbursement for both donor and recipient surgery.

(c) Any county that has a population of not more than 600,000, as determined by the most recent decennial census conducted by the United States Bureau of the Census, shall be exempt from complying with the 25-percent matching requirement provided for under this article, for any bone marrow transplant reimbursable under this section.

123990. Adoption of regulations; authority of department

The department shall adopt regulations to implement the amendments of this article in 1991. The adoption of the regulations shall be deemed to be an emergency, and necessary for the immediate preservation of the public peace, health, safety, and general welfare.

123995. Medi-Cal application requirements

(a) The department shall require all applicants to the program who may be eligible for cash grant assistance or for Medi-Cal benefits to apply for Medi-Cal.

(b) This section shall not be interpreted to prohibit the coverage of services in emergency cases.

Government Code Sections (Re: School Therapy Services)

7570. Maximum utilization of resources

Ensuring maximum utilization of all state and federal resources available to provide children and youth disabilities, as defined in subsection (1) of the Section 1401 of Title 20 of the United States Code, with a free appropriate public education, the provision of related services, as defined in Subsection (17) of Section 1401 of Title 20 of the United States Code and designated instruction and services, as defined in Section 56363 of the Education Code, to children and youth with disabilities, shall be the joint responsibility of the Superintendent of Public Instruction and the Secretary of Health and Welfare. The Superintendent of Public Instruction shall ensure that this chapter is carried out through monitoring and supervision.

7571. Assumption of responsibilities; department and county agencies to be designated

The Secretary of Health and Welfare may designate a department of state government to assume the responsibilities described in Section 7570. The secretary, or his or her designee, shall also designate a single agency in each county to coordinate the service responsibilities described in Section 7572.

7572. Assessments; provision of related services or designated instruction and services

(a) A child shall be assessed in all areas related to the suspected disability by those qualified to make a determination of the child's need for the service before any action is taken with respect to the provision of related services or designated instruction and services to a child, including, but not limited to, services in the areas of, occupational therapy, physical therapy, psychotherapy, and other mental health assessments. All assessments required or conducted pursuant to this section shall be governed by the assessment procedures contained in Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of the Education Code.

(b) Occupational therapy and physical therapy assessments shall be conducted by qualified medical personnel as specified in regulations developed by the State Department of Health Services in consultation with the State Department of Education.

(c) Psychotherapy and other mental health assessments shall be conducted by qualified mental health professionals as specified in regulations developed by the State Department of Mental Health, in consultation with the State Department of Education, pursuant to this chapter.

(d) A related service or designated instruction and service shall only be added to the child's individualized education program by the individualized education program team, as described in Part 30 (commencing with Section 56000) of the Education Code, if a formal assessment has been conducted pursuant to this section, and a qualified person conducting the assessment recommended the service in order for the child to benefit from special education. In no case shall the inclusion of necessary related services in a pupil's individualized education plan be contingent upon identifying the funding source. Nothing in this section shall prevent a parent from obtaining an independent assessment in accordance with subdivision (b) of Section 56329 of the Education Code, which shall be considered by the individualized education program team.

(1) Whenever an assessment has been conducted pursuant to subdivision (b) or (c), the recommendation of the person who conducted the assessment shall be reviewed and discussed with the parent and with appropriate members of the individualized education program team prior to the meeting of the individualized education program team. When the proposed recommendation of the person has been discussed with the parent and there is disagreement on the recommendation pertaining to the related service, the parent shall be notified in writing and may require the person who conducted the assessment to attend the individualized education program team meeting to discuss the recommendation. The person who conducted the assessment shall attend the individualized education program team meeting if requested. Following this discussion

and review, the recommendation of the individualized education program team members who are attending on behalf of the local educational agency.

(2) If an independent assessment for the provision of related services or designated instruction and services is submitted to the individualized education program team, review of that assessment shall be conducted by the person specified in subdivisions (b) and (c). The recommendation of the person who reviewed the independent assessment shall be reviewed and discussed with the parent and with appropriate members of the individualized education program team prior to the meeting of the individualized education program team. The parent shall be notified in writing and may request the person who reviewed the independent assessment to attend the individualized education program team meeting to discuss the recommendation. The person who reviewed the independent assessment shall attend the individualized education program team meeting if requested. Following this review and discussion, the recommendation of the person who reviewed the independent assessment shall be the recommendation of the individualized education program team members who are attending on behalf of the local agency.

(3) Any disputes between the parent and team members representing the public agencies regarding a recommendation made in accordance with paragraphs (1) and (2) shall be resolved pursuant to Chapter 5 (commencing with Section 56500) of Part 30 of the Education Code.

(e) Whenever a related service of designated instruction and service specified in subdivision (b) or (c) is to be considered for inclusion in the child's individualized education program, the local education agency shall invite the responsible public agency representative to meet the individualized education program team to determine the need for the service and participate in developing the individualized education program. If the responsible public agency representative cannot meet the individualized education program team, then the representative shall provide written information concerning the need for the service pursuant to subdivision (d). Conference calls, together with written recommendations, are acceptable forms of participation. If the responsible public agency representative will not be available to participate in the individualized education program meeting, the local educational agency shall ensure that a qualified substitute is available to explain and interpret the evaluation pursuant to subdivision (d) of Section 56341 of the Education Code. A copy of the information shall be provided by the responsible public agency to the parents or any adult pupil for whom no guardian or conservator has been appointed.

7573. Special education and related services

The Superintendent of Public Instruction shall ensure that local education agencies provide special education and those related services and designated instruction and services contained in a child's individualized education program that are necessary for the child to benefit educationally from his or her instructional program. Local education agencies shall be responsible only for the provision of those services which are provided by qualified personnel whose employment standards are covered by the Education Code and implementing regulations.

7575. Occupational therapy and physical therapy

(a)

(1) Notwithstanding any other provision of law, the State Department of Health Services, or any designated local agency administering the California Children's Services, shall be responsible for the provision of medically necessary occupational therapy and physical therapy, as specified by Article 2 (commencing with Section 248) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code, by reason of medical diagnosis and when contained in the child's individualized education program.

(2) Related services or designated instruction and services not deemed to be medically necessary by the State Department of Health Services, which the individualized education program team determines are necessary in order to assist a child to benefit from special education, shall be provided by the local education agency by qualified personnel whose employment standards are covered by the Education Code and implementing regulations.

(b) The department shall determine whether a California Children's Services eligible pupil, or a pupil with a private medical referral needs medically necessary occupational therapy or physical therapy. A medical referral shall be based on a written report from a licensed physician and surgeon who has examined the pupil. The written report shall include the following:

(1) The diagnosed neuromuscular, musculoskeletal, or physical disabling condition prompting the referral.

(2) The referring physician's treatment goals and objectives.

(3) The basis for determining the recommended treatment goals and objectives, including how these will ameliorate or improve the pupil's diagnosed condition.

(4) The relationship of the medical disability to the pupil's need for special education and related services.

(5) Relevant medical records.

(c) The department shall provide the service directly or by contracting with another public agency, qualified individual, or a state-certified nonpublic nonsectarian school or agency.

(d) Local education agencies shall provide necessary space and equipment for the provision of occupational therapy and physical therapy in the most efficient and effective manner.

(e) The department shall also be responsible for providing the services of a home health aide when the local education agency considers a less restrictive placement from home to school for a pupil for whom both of the following conditions exist:

(1) The California Medical Assistance Program provides a life-supporting medical service via a home health agency during the time in which the pupil would be in school or traveling between school and home.

(2) The medical service provided requires that the pupil receive the personal assistance or attention of a nurse, home health aide, parent or guardian, or some other specially trained adult in order to be effectively delivered.

7582. Assessment and therapy treatment services; exemption from financial eligibility standards

Assessment and therapy treatment services provided under programs of the State Department of Health Services or the State Department of Mental Health, or their designated local agencies, rendered to a child referred by a local education agency for an assessment or a handicapped child with an individualized education program, shall be exempt from financial eligibility standards and family repayment requirements for these services when rendered pursuant to this chapter.

Insurance Code (Re: Healthy Families)

"CCS Carve-out related to HF Health Benefits"

12693.62. California Children's Services program; plan responsibility for services to eligible subscribers; referral of children; case management

Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services program for the particular subscriber for the treatment of a California Children's Services program eligible medical condition. Participating plans shall refer a child who they reasonably suspect of having a medical condition that is eligible for services under the California Children's Services program to the California Children's Services program. The California Children's Services program shall provide case management and authorization of services if the child is found to be medically eligible for the California Children's Services program. Diagnosis and treatment services that are authorized by the California Children's Services program shall be performed by paneled providers for that program and approved special care centers of that program in accordance with treatment plans approved by the California Children's Services program. All other services provided under the participating plan shall be available to the subscriber.

"CCS Carve-out related to HF Dental Benefits"

12693.64. California Children's Services program; plan responsibility for services to eligible subscribers

Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services program for the particular subscriber for the treatment of a California Children's Services program eligible medical

condition. All other services provided under the participating plan shall be available to the subscriber.

"CCS Carve-out related to HF Vision Benefits"

12693.66. California Children's Services program; plan responsibility for services to eligible subscribers

Notwithstanding any other provision of law, for a subscriber who is determined by the California Children's Services program to be eligible for benefits under the program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, a participating plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services program for the particular subscriber for the treatment of a California Children's Services program eligible medical condition. All other services provided under the participating plan shall be available to the subscriber.

"CCS County Expenditure Exemption"

12693.69. Child enrolled in Health Families Program; eligibility for services under California Children's Services program

A child enrolled in the Healthy Families Program who has a medical condition that is eligible for services pursuant to the California Children's Services program, and whose family is not financially eligible for the California Children's Services program, shall have the medically necessary treatment services for their California Children's Services program eligible medical condition authorized and paid for by the California Children's Services program. County expenditures for the payment of services for the child shall be waived and these expenditures shall be paid for by the state from Title XXI funds that are applicable and state general funds.

Welfare and Institutions Code (Re: Medi-Cal Managed Care Contract Laws)

14093. Purpose

The purpose of this article is to ensure quality of care and to provide increased access to health care services in the most cost-effective and efficient manner possible, to persons who are eligible to receive medical benefits under publicly supported programs other than Medi-Cal.

14093.05. Establishment of contract; amendment of existing Medi-Cal managed care contracts; agreement to hold beneficiaries of publicly supported programs harmless; managed care contractors serving children; standards of care; report of expenditures and savings; reduction in benefits

(a) The director shall enter into contracts with managed care plans under this chapter and Chapter 8 (commencing with Section 14200), including, but not limited to, health maintenance organizations, prepaid health plans, and primary care case management plans; counties, primary care providers, independent practice associations, private foundations, children's hospitals, community health centers, rural health centers, community clinics, and university medical center systems, or other entities for the provision of medical benefits to all persons who are eligible to receive medical benefits under publicly supported programs. The director may also amend existing Medi-Cal managed care contracts to include

the provision of medical benefits to persons who are eligible to receive medical benefits under publicly supported programs. Contracts may be on an exclusive or nonexclusive basis.

(b) Contractors pursuant to this article and participating providers acting pursuant to subcontracts with those contractors, shall agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the contractor does not ensure sufficient funding to cover program benefits.

(c) Any managed care contractor serving children with conditions eligible under the California Children's Services (CCS) program shall maintain and follow standards of care established by the program, including use of paneled providers and CCS-approved special care centers and shall follow treatment plans approved by the program, including specified services and providers of services. If there are insufficient paneled providers willing to enter into contracts with the managed care contractor, the program shall seek to establish new paneled providers willing to contract. If a paneled provider cannot be found, the managed care contractor shall seek program approval to use a specific non-paneled provider with appropriate qualifications.

(d)

(1) Any managed care contractor serving children with conditions eligible under the CCS program shall report expenditures and savings separately for CCS covered services and CCS eligible children.

(2) If the managed care contractor is paid according to a capitated or risk-based payment methodology, there shall be a separate actuarially sound rates for CCS eligible children.

(3) Notwithstanding paragraph (2), a managed care pilot project may, if approval is obtained from the State CCS program director, utilize an alternative rate structure for CCS eligible children.

(e) This article is not intended to and shall not be interpreted to permit any reduction in benefits or eligibility levels under the CCS program. Any medically necessary service not available under the managed care contracts authorized under this article shall remain the responsibility of the state and county.

(f) To assure CCS benefits are provided to enrollees with a CCS eligible condition according to CCS program standards, there shall be oversight by the state and local CCS program agencies for both services covered and not covered by the manage care contract.

(g) Any managed care contract which will effect the delivery of care to CCS eligible children shall be approved by the state CCS program director prior to execution. The state CCS program shall continue to be responsible for selection of CCS paneled providers and monitoring of contractors to see that CCS state standards are maintained.

Article 2.98. California Children's Services program and Medi-Cal Managed Care Contracts

14094. CCS

For purposes of this article "CCS" means California Children's Services.

14904.1. Managed care contractors; Standards of care; use of panel providers; report of expenditures and savings; payment according to capitated payment methodology

(a) The director shall investigate and to the extent feasible require any managed care contractor serving children with conditions eligible under the CCS program, to maintain and follow standards of care established by the program, including use of paneled providers and CCS approved special care centers and to follow treatment plans approved by the program, including specified services and providers of services. If there are insufficient paneled providers willing to enter into contracts with the managed care contractor, the program shall seek to establish new paneled providers willing to contract. If a paneled provider cannot be found, the managed care contractor shall seek program approval to use a specific nonpaneled provider with appropriate qualifications.

(b) The director shall investigate and to the extent feasible require any managed care contractor serving children with conditions eligible under the CCS program, to report expenditures and savings separately for CCS covered services and CCS eligible children.

(c)

(1) If the managed care contractor is paid according to a capitated or risk-based payment methodology, there shall be a separate actuarially sound rate for CCS eligible children.

(2) Notwithstanding paragraph (1), a managed care pilot project may, if approval is obtained from the state CCS program director, utilize an alternative rate structure for CCS eligible children.

14094.2. Medically necessary services not available under managed care contracts; state and county responsibility

(a) This article is not intended, and shall not be interpreted, to permit any reduction in benefits or eligibility levels under the CCS program. Any medically necessary service not available under the managed care contracts authorized under this article shall remain the responsibility of the state and county.

(b) In order to ensure that CCS benefits are provided to enrollees with a CCS eligible condition according to CCS program standards, there shall be oversight by the state and local CCS program agencies for both services covered and not covered by the managed care contract.

14094.3. Incorporation of CCS covered services into Medi-Cal managed care contracts; time; fee-for-service billing prior to incorporation; pilot projects

(a) Notwithstanding this article or Section 14093.05 or 14094.1, CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994, pursuant to Article 2.7(commencing with

Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), Article 2.95 (commencing with Section 14092); or either Article 2 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8, until three years after the effective date of the contract.

(b) Notwithstanding any other provision of this chapter, providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but who are not enrolled in a pilot project pursuant to subdivision (c) shall continue to submit billing for CCS covered services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed care contracts described in subdivision (a).

(c)

(1) The department may authorize a pilot project in Solano County in which reimbursement for conditions eligible under the CCS program may be reimbursed on a capitated basis pursuant to Section 14093.05, and provided all CCS program's guidelines, standards, and regulations are adhered to, and CCS program's case management is utilized.

(2) During the three-year time period described in subdivision (a), the department may approve, implement, and evaluate limited pilot projects under the CCS program to test alternative managed care models tailored to the special health care needs of children under the CCS program. The pilot projects may include, but need not be limited to, coverage of different geographic areas, focusing on certain subpopulations, and the employment of different payment and incentive models. Pilot project proposals from CCS program-approved providers shall be given preference. All pilot projects shall utilize CCS program-approved standards and providers pursuant to Section 14094.1.

(d)

(1) The department shall submit to the appropriate committees of the Legislature an evaluation of pilot projects established pursuant to subdivision (c) based on at least one full year of operation.

(2) The evaluation required by paragraph (1) shall address the impact of the pilot projects on outcomes as set forth in paragraph (4) and, in addition, shall do both of the following:

(A) Examine the barriers, if any, to incorporating CCS covered services into the Medi-Cal managed care contracts described in subdivision (a).

(B) Compare different pilot project models with the fee-for-service system. The evaluation shall identify, to the extent possible, those factors that make pilot projects most effective in meeting the special needs of children with CCS eligible conditions.

(3) CCS covered services shall not be incorporated into the Medi-Cal managed care contracts described in subdivision (a) before the evaluation process has been completed.

(4) The pilot projects shall be evaluated to determine if:

(A) All children enrolled with a Medi-Cal managed care contractor described in subdivision (a) identified as having a CCS eligible condition are referred in a timely fashion for appropriate health care.

(B) All children in the CCS program have access to coordinated care that includes primary care services in their own community.

(C) CCS program standards are adhered to.

(e) For purposes of this section, CCS covered services include all program benefits administered by the program specified in Section 251 of the Health and Safety Code regardless of the funding source.

(f) Nothing in this section shall be construed to exclude or restrict CCS eligible children from enrollment with a managed care contractor or from receiving from the managed care contractor with which they are enrolled primary and other health care unrelated to the treatment of the CCS eligible condition.

Legislation, Regulations, and Guidelines for the CHDP Program

a. Enabling legislation of the CHDP program

Reference: Health and Safety Code, Sections 104395, 105300, 105305, 120475, and 124025 through 124110.

b. CHDP program regulations that implement, interpret, or make specific the enabling legislation.

Reference: California Code of Regulations (CCR), Title 17, Sections 6800 through 6874.

c. Medi-Cal regulations pertaining to the availability and reimbursement of EPSDT services through the CHDP program.

Reference: CCR, Title 22, Sections 51340 and 51532.

d. Regulations defining county Social Services Department responsibilities for meeting CHDP/EPSDT Program requirements.

1. Social Services Regulations

   a. Staff Development and Training Standards - Manual of Policies and Procedures (MPP) Section 14-530 and 14-610.

   b. Civil Rights - MPP Sections 21-101, 21-107, and 21-115.

   c. Eligibility and Assistance Standards - MPP Sections 40-107.61, 40-131.3(k), 40-181.211, and 45-201.5.

   d. Child Welfare Services Program Standards: MPP Sections 31-002(c)(8), 31-075.3(h)(1), 31-075.3(h)(2), 31-205.18, 31-206.35, 31-206.351, 31-206.352, 31-206.36, 31-206.361, 31-206.362, 31-206.42, 31-206.421, 31-206.422, 31-330.111, 31-401.4, 31-401.41, 31-401.412, 31-401.413, 31-405.1(f), 31-405.1(g), and 31-405.1(g)(1).

   e. Intra and Interagency relations and agreements Chapters 29-405 and 29-410.

2. Medi-Cal Regulations

   Reference: CCR, Title 22, Sections 50031; 50157(a), (d), (e), and (f) and 50184(b).

e. Current Interpretive release by State Health Services and Social Services Departments:

1. State CHDP Program Letters and Information Notices - Health Services

2. All County Letters - Social Services

3. Joint Letters - Health Services and Social Services

4. CHDP Program Health Assessment Guidelines - Health Services

f. Statutes requiring review of new program standards by State Advisory Groups.

New program standards affecting local programs to be reviewed by the California Conference of Local Health Officers.

Reference: Health and Safety Code Section 1110.111.

g. Federal regulations governing States' provision of EPSDT:

Reference: Title 42, Code of Federal Regulations (CFR), Section 440.40 and Part 441, Subpart B.

h. Federal statutes applying to the EPSDT program:

Reference: Social Security Act (42 USC Section 139(a) Sections 1902(a) (43), 1905(a)(4)(B), and 1905(r).

Reference: OBRA89 - Public Law 101-239, Section 6403.

Selected State Laws Relating to the CHDP Program

The following are selected sections of California laws relating to the CHDP program. These sections have been extracted from California's Health and Safety Code, Insurance Code, and Welfare and Institutions Code. For more current and complete information on State laws, please visit the Legislative Counsel of California's website at www.leginfo.ca.gov/calaw.html.

This section is not all-inclusive. Not included are other State laws, federal laws, State and federal regulations, or provisions of the CHDP Provider Manual, CHDP Program Guidance Manual, CHDP Program Letters, or CHDP Provider Information Notices.

Health and Safety Code Section

104395. Child Health and Disability Prevention (CHDP) Program Expansion

The department shall expand the CHDP program contained in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 as follows:

(a) Any child between birth and 90 days after entrance into first grade, all persons under 21 years of age who are eligible for the California Medical Assistance Program, and any person under 19 years of age whose family income is not more than 200 percent of the federal poverty level shall be eligible for services under the program in the county of which they are a resident. The department shall adopt regulations specifying which age groups shall be given certain types of screening tests and recommendations for referral.

(b) The first source of referral under the program shall be the child's usual source of health care. If referral is required and no regular source of health care can be identified, the facility or provider providing health screening and evaluation services shall provide a list of three qualified sources of care, without prejudice for or against any specific source.

(c) The department shall issue protocols for an anti-tobacco education component of the child health and disability prevention medical examination. The protocols shall include the following: dissuading children from beginning to smoke, encouraging smoking cessation, and providing information on the health effects of tobacco use on the user, children, and nonsmokers. The protocols shall also include a focus on health promotion, disease prevention, and risk reduction, utilizing a "wellness" perspective that encourages self-esteem and positive decision making techniques, and referral to an appropriate community smoking cessation program.

(d) Notwithstanding any other provision of law, the department shall ensure that a portion of the funds in the Child Health Disability Prevention Program budget is used to facilitate the integration of the medical and dental components of all aspects of that program.

(e) The department shall expand its support and monitoring of county child health and disability prevention program efforts to provide all of the following:

(1) Review of a representative, statistically valid, randomly selected sample of child health and disability prevention health assessments, including,

but not limited to, dental assessments, which result in the discovery of conditions which require follow-up diagnosis and treatment, including but not limited to dental treatment, and which qualify for services under this section. The purpose of the survey and follow-up reviews of local programs is to determine whether necessary diagnosis and treatment services are being provided, and the degree to which those services comply with the intent of the act that added this subdivision. These survey reviews shall include all counties and shall be conducted at least three times a year.

(2) At least once a year, as part of regular visits to county child and health and disability prevention programs to provide technical assistance, support services and monitoring and evaluation of program performance, department staff shall review the effectiveness of the mandated treatment program. The purpose of this review is to assure that the county is providing appropriate follow-up services for conditions discovered during child health and disability prevention health assessments. This review shall be done in conjunction with the ongoing survey activity of the Child Health and Disability Prevention Branch of the department and shall utilize data resulting from that activity.

(3) If the department establishes that a county has failed to provide treatment services mandated by the act that added this subdivision, the department shall require the county to submit a plan of correction within 90 days. If the department finds that substantial correction has not occurred within 90 days following receipt of the correction plan, it may require the county to enter into a contract pursuant to Section 16934.5 of the Welfare and Institutions Code for the remainder of the fiscal year and the following fiscal year, and for this purpose shall withhold the same percentage of funds as are withheld from other counties participating in the program pursuant to Section 16934.5 of the Welfare and Institutions Code.

105300. CHDP program Statutory Relationship to the Childhood Lead Poisoning Prevention Program; Regulatory Authority

Notwithstanding Section 124130, the department shall have broad regulatory authority to fully implement and effectuate the purposes of this chapter. The authority shall include, but is not limited to, the following:

(a) The development of protocols to be utilized in screening and the procedures for changing those protocols when more accurate or efficient technologies become available.

(b) The designation of laboratories which are qualified to analyze whole blood specimens for concentrations of lead and the monitoring of those laboratories for accuracy.

(c) The development of reporting procedures by laboratories.

(d) Reimbursement for state-sponsored services related to screening and appropriate case management.

(e) Establishment of lower concentrations of lead in whole blood than specified by the United States Center for Disease Control for the purpose of determining the existence of lead poisoning.

(f) Establishment of lower acceptable levels of the concentration of lead in whole blood than those specified by the United States Center for Disease Control for the purpose of determining the need to provide appropriate case management for lead poisoning.

(g) Development of appropriate case management protocols.

(h) Notification to the child's parent or guardian of the results of blood lead testing and environmental assessment.

(i) The establishment of a periodicity schedule for evaluation for childhood lead poisoning.

105305. Program funding

The program implemented pursuant to this chapter shall be fully supported from the fees collected pursuant to Section 105310. Notwithstanding the scope of activity mandated by this chapter, in no event shall this chapter be interpreted to require services necessitating expenditures in any fiscal year in excess of the fees, and earnings therefrom, collected pursuant to Section 105310. This chapter shall be implemented only to the extent fee revenues pursuant to Section 105310 are available for expenditure for purposes of this chapter.

120475. Immunization of children; CHDP program statutory requirement to report to legislature

On or before March 15, 1991, and on or before March 15 of each year thereafter, the department shall submit a report to the Legislature on all of the following issues:

(a) The immunization status of young children in the state, based on available data.

(b) The steps taken to strengthen immunization efforts, particularly efforts through the Child Health and Disability Prevention Program.

(c) The steps taken to improve immunization levels among currently underserved minority children, young children in family day care and other child care settings, and children with no health insurance coverage.

(d) The improvements made in ongoing methods of immunization outreach and education in communities where immunization levels are disproportionately low.

(e) Its recommendations for a comprehensive strategy for fully immunizing all California children and its analysis of the funding necessary to implement the strategy.

124025. Legislative finding and declaration

The Legislature finds and declares that many physical and mental disabilities can be prevented, or their impact on an individual lessened, when they are identified and treated before they become chronic and irreversible damage occurs. The Legislature finds and declares that a

community-based program of early identification and referral for treatment of potential handicapping conditions will be effective in reducing the incidence of the conditions and will benefit the health and welfare of the citizens of this state.

It is the intent of the Legislature in enacting this article and Section 120475 to establish child health and disability prevention programs, which shall be financed and have standards established at the state level and that shall be operated at the local level, for the purpose of providing early and periodic assessments of the health status of children. It is further intended that child health and disability prevention programs shall make maximum use of existing health care resources and shall utilize, as the first source of screening, the child's usual source of health care so that health screening programs are fully integrated with existing health services, that health care professionals be appropriately represented and utilized in these programs, that outreach programs be developed to stimulate the use of preventive health services, and that services offered pursuant to this article be efficiently provided and be of the highest quality.

124030. Definitions

As used in this article and Section 120475:

(a) "State Board" means the State Maternal, Child, and Adolescent Health Board.

(b) "Department" means the department.

(c) "Director" means the director.

(d) "Governing Body" means the county board of supervisors or boards of supervisors in the case of counties acting jointly.

(e) "Local Board" means local maternal, child, and adolescent health board.

(f) "Local health jurisdiction" means county health department or combined health department in the case of counties acting jointly or city health department within the meaning of Section 101185.

(g) "Child Health and Disability Prevention provider" or "CHDP provider" means any of the following, if approved for participation in the Child Health and Disability Prevention program by the community Child Health and Disability program director in accordance with program standards to practice medicine in California.

(1) A physician licensed to practice medicine in California.

(2) A family nurse practitioner certified pursuant to Sections 2834 and 2836 of the Business and Professions Code.

(3) A pediatric nurse practitioner certified pursuant to Sections 2834 and 2836 of the Business and Professions Code.

(4) A primary care center, clinic, or other public or private agency or organization that provides outpatient health care services.

(5) A physician's group.

(6) A licensed clinical laboratory.

124033.

(a) Commencing July 1, 2003, all applications for services under the Child Health and Disability Prevention program shall be filed electronically in accordance with subdivision (b) of Section 14011.7 of the Welfare and Institutions Code.

(b) To implement the program described in subdivisions (b) to (e), inclusive, of Section 14011.7 of the Welfare and Institutions Code for the use of an electronic application for the Child Health and Disability Prevention program and for preenrollment into the Medi-Cal program or the Healthy Families Program, the following shall apply:

(1) The department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement.

(2) Contracts, including the Medi-Cal program fiscal intermediary contract for the Child Health and Disability Prevention Program, including any contract amendment, any system change pursuant to a change order, and any project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

124035. Administration; minimum standards for approval; rules and regulations; state plan

The department shall administer this article and Section 120475 and shall adopt minimum standards for the approval of community child health and disability prevention programs and regulations as necessary. The standards shall allow necessary flexibility in the administration of county programs, taking into account the variability of county needs and resources. However, the standards, rules, and regulations may be adopted only with the advice and written recommendations of the board. Standards shall be adopted for:

(a) Education and experience requirements for directors of community child health and disability prevention programs.

(b) Health screening, evaluation, and diagnostic procedures for child health and disability prevention programs.

(c) Public and private facilities and providers that may participate in community child health and disability prevention programs.

The department shall adopt a five-year state plan for child health and disability prevention services by October 1,1977. The plan shall include a method for allocating child health and disability prevention funds to counties. The plan shall be reviewed and revised as necessary to provide a basis for allocating state child health and disability prevention program funds throughout the state.

Nothing in this section shall be construed as prohibiting programs provided pursuant to this article from being conducted in public and private school facilities; provided that, with respect to private school facilities, no services provided thereon pursuant to this article and financed by public funds shall result in any material benefit to, or be conducted in a manner that furthers any educational or other mission of, such a school or any person or entity maintaining the school.

124040. Establishment of programs; plan requirements; standards for procedures; record system

(a) The governing body of each county or counties shall establish a community child health and disability prevention program for the purpose of providing early and periodic assessments of the health status of children in the county or counties by July 1,1974. However, this shall be the responsibility of the department for all counties that contract with the state for health services. Contract counties, at the option of the board of supervisors, may provide services pursuant to this article in the same manner as other county programs, provided the option is exercised prior to the beginning of each fiscal year. Each plan shall include, but is not limited to, the following requirements:

(1) Outreach and educational services.

(2) Agreements with public and private facilities and practitioners to carry out the programs.

(3) Health screening and evaluation services for all children including a physical examination, immunizations appropriate for the child's age and health history, and laboratory procedures appropriate for the child's age and population group performed by, or under the supervision or responsibility of, a physician licensed to practice medicine in California or by a certified family nurse practitioner or a certified pediatric nurse practitioner.

(4) Referral for diagnosis or treatment when needed, including, for all children eligible for Medi-Cal, referral for treatment by a provider participating in the Medi-Cal program of the conditions detected, and methods for assuring referral is carried out.

(5) Record keeping and program evaluations.

(6) The health screening and evaluation part of each community child health and disability prevention program plan shall include, but is not limited to, the following for each child:

1. A health and developmental history.

2. An assessment of immunization status.

3. An examination for obvious physical defects.

4. Ear, nose, mouth, and throat inspections, including inspection of teeth and gums, and for all children three years of age and older who are eligible for Medi-Cal, referral to a dentist participating in the Medi-Cal program.

5. Screening tests for vision, hearing, anemia, tuberculosis, diabetes, and urinary tract conditions.

(7) An assessment of nutritional status.

(8) An assessment of immunization status.

(9) Where appropriate, testing for sickle cell trait, lead poisoning, and other tests that may be necessary to the identification of children with potential disabilities requiring diagnosis and possibly treatment.

(10) For all children eligible for Medi-Cal, necessary assistance with scheduling appointments for services and with transportation.

(b) Dentists receiving referrals of children eligible for Medi-Cal under this section shall employ procedures to advise the child's parent or parents of the need for and scheduling of annual appointments.

(c) Standards for procedures to carry out health screening and evaluation services and to establish the age at which particular tests should be carried out shall be established by the director. At the discretion of the department, these health screening and evaluation services may be provided at the frequency provider under the Healthy Families Program and permitted in managed care plans providing services under the Medi-Cal program, and shall be contingent upon appropriation in the annual Budget Act. Immunizations may be provided at the frequency recommended by the Committee on Infectious Disease of the American Academy of Pediatrics and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

(d) Each community child health and disability prevention program shall, pursuant to standards set by the director, establish a record system that contains a health case history for each child so that costly and unnecessary repetition of screening, immunization and referral will not occur and appropriate health treatment will be facilitated as specified in Section 124085.

124045. Services by city; election; powers

A city that operates an independent health agency may elect to provide the services described in this article with the approval of the department. In this instance, the powers granted a governing body of a county shall be vested in the governing body of the city.

124050. Directors of community programs

Each community child health and disability program shall have a director meeting qualification standards by the department, appointed by the governing body, except for counties contracting with the state for health services.

124055. Intercounty service contracts

Any community child health and disability prevention program may contract to furnish services to any other county if the contract is approved by the director.

124060. Budget update; community child health and disability prevention plan; requirements; multi-year base plan

(a) On or before September 15 of each year, each county program director shall submit a budget update for the subsequent fiscal year that provides the following information:

(1) A summary of the previous year's activity, including the number of children screened, the number of children referred for diagnosis and treatment, by condition, and the cost of screening services.

(2) A summary description of the results of cases in that a treatable disability was identified and referral made.

(3) A projection and cost estimates of the number of children to be screened for the fiscal year for which the budget is being submitted.

(b) The multi-year base community child health and disability prevention plan shall include the following:

(1) An assessment of the adequacy and availability of the facilities and providers to provide health screening diagnostic and treatment services.

(2) A description of the child health and disability prevention program to be offered, including expected participating providers and outreach mechanisms to be utilized.

(3) A summary description of the current year's activity, including the number of children screened, the number of children referred for diagnosis and treatment, by condition, and the cost of screening services.

(4) A description of how existing school health resources, including school health personnel, are to be utilized for outreach and other services.

(5) Budget estimates, including all sources of revenue, for the budget.

(c) On or before September 15 of each year each governing board shall submit an update to the multi-year base community child health and disability prevention plan.

The director shall determine the amount of state funds available for each county for specified services under an approved multi-year base community child health and disability prevention plan, as updated, from state funds appropriated for child health and disability prevention services.

If the amount appropriated in the Budget Act for the fiscal year as enacted into law differs from the amount in the budget submitted by the Governor for the fiscal year, each governing board shall submit an additional revised update in the form and at the time specified by the department.

Notwithstanding any other provision of this article, no new community child health and disability prevention plan shall be submitted by a county until September 15, 1983. Each county plan and budget approved for the 1981-82 fiscal year shall be updated on or before September 15 by the

governing body of each county for the 1982-83 and 1983-84 fiscal years pursuant to regulations adopted by the department. On or before September 15, 1983, the governing body of each county shall prepare and submit to the department a multi-year base plan and budget for the 1984-85 fiscal year that shall be annually updated on or before September 15 of each subsequent year pursuant to regulations adopted by the department.

The department shall develop and implement the format and procedures for the preparation and submission of a multi-year base plan update in order for the counties to have sufficient time prior to September 15, 1983, to prepare and submit their multi-year base plan by September 15, 1983.

For the purposes of simplifying and reducing plan requirements, the Legislature intends that the annual update shall not duplicate any of the material in the multi-year base plan, but serve as a progress report both evaluating what has been accomplished over the past year and describing in more detail what will be accomplished in relation to each of the elements in the base plan during the coming year.

124065. State reimbursement

Counties shall be reimbursed for the amount required by the county to carry out its community child health and disability prevention program in accordance with the approved community child health and disability prevention plan. Claims for state reimbursement shall be made in the manner as the director shall provide. Each claim for state reimbursement shall be payable form the appropriation made for the fiscal year when the expenses upon which the claim is based are incurred.

There shall be no reimbursement for expenditures for the treatment of disabilities identified as a result of the program or for capital improvements or the purchase or construction of buildings, except for the equipment items and remodeling expenses as may be allowed by regulations adopted by the director.

124070. State reimbursement

Counties shall be reimbursed for the amount required by the county to carry out its community child health and disability prevention program in accordance with the approved community child health and disability prevention plan. Claims for state reimbursement shall be made in a manner as the director shall provide. Each claim for state reimbursement shall be payable from the appropriation made for the fiscal year in which the expenses upon which the claim is based are incurred.

There shall be no reimbursement for expenditures for the treatment of disabilities identified as a result to the program, except for the costs of immunizations necessary to bring the child current in his or her immunization status as provided for by regulations of the department, or for capital improvements or the purchase or construction of buildings, except for the equipment items and remodeling expenses as may be allowed by regulations adopted by the director.

124075. Schedule and method of reimbursement; use of federal funds

(a) In order to ensure the maximum utilization of the California Medical Assistance Program and other potential reimbursement sources, the department shall develop a schedule and method of reimbursement at reasonable rates for services rendered pursuant to this article. The reimbursement schedule shall include provision for well child examinations as well as for administrative

expenses incurred by providers pursuant to meeting this article. Inquiry shall be made of all recipients of services under this article as to their entitlement for third-party reimbursement for medical services. Where an entitlement exists it shall be billed. Notwithstanding subdivision (c) of Section 14000 of the Welfare and Institutions Code and Section 14005 of that code, the California Medical Assistance Program shall be billed for services rendered pursuant to this article for every Medi-Cal eligible beneficiary.

(b) The department and counties shall maximize the use of federal funds for carrying out of this article, including using state or county funds to match funds claimable under Title 19 of the Social Security Act. Services and administrative support costs claimable under federal law shall include, but not be limited to, outreach, health education, case management, resource development, and training at state and local levels. Any federal funds received shall augment and not replace funds appropriated from the General Fund for carrying out the purposes of this chapter.

124080. Contracts for claims processing

The department may contract with a private entity for the performance of processing claims for state reimbursement, so long as the cost of the contract is no more than 85 percent of the cost of the service if performed in state service and there is compliance with other applicable provisions of the Government Code including, but not limited to, Sections 19130 to 19132, inclusive.

124085. Certificate of receipt; health screening and evaluation services; waiver by parent or guardian

On and after July 1, 1976, each child eligible for services under this article shall, within 90 days after entrance into the first grade, provide a certificate approved by the department to the school where the child is to enroll documenting that within the prior 18 months the child has received the appropriate health screening and evaluation services specified in Section 124040. A waiver signed by the child's parents or guardian indicating that they do not want or are unable to obtain the health screening and evaluation services for their children shall be accepted by the school in lieu of the certificate. If the waiver indicates that the parent or guardian was unable to obtain the services for the child, then the reasons why should be included in the waiver.

124090. Eligibility for services; rules and regulations specifying age groups for screening tests and recommendations for referral; sources of referral

Any child between birth and 90 days after entrance into the first grade and all persons under 21 years of age who are eligible for the California Medical Assistance Program shall be eligible for services from the child health and disabilities prevention program in the county where they are a resident. The department, with review and recommendation by the board, shall adopt regulations specifying age groups that shall be given certain types of screening tests and recommendations for referral.

The first source of referral shall be the child's usual source of health care. If referral is required and no regular source of health care can be identified, the facility or provider providing health screening and evaluation services shall provide a list of three qualified sources of care, without prejudice for or against any specific source.

124095. Copy of results of screening and evaluation; reference for further diagnosis and treatment

Each community child health and disability prevention program shall provide the child or his or her parent or guardian with a copy of the results of the health screening and evaluation, as well as an explanation of the meaning of the results, and shall, where the need indicates, refer the child for further diagnosis and treatment.

124100. School districts and private schools; information to parents or guardians of kindergarten children; withholding of average daily-attendance funds

(a) In cooperation with the county child health and disability prevention program, the governing body of every school district or private school that has children enrolled in kindergarten shall provide information to the parents or guardians of all children enrolled in kindergarten of this article and Section 120475. Every school district or private school that has children enrolled in the first grade shall report by January 15 of each year to the county child health and disability prevention program, the department, and the Department of Education the following information:

(1) The total number of children enrolled in first grade.

(2) The number of children who have had a health screening examination, as evidenced by the certificate required by Section 124085.

(3) The number of children whose parents or guardian have given written waiver pursuant to Section 124085 that they do not want their child to receive a health screening examination.

(b) Each county child health and disability prevention program shall reimburse school districts for information provided pursuant to this section. The Superintendent of Public Instruction may withhold state average daily attendance funds to any school district for any child for whom a certification or parental waiver is not obtained.

124105. Health screening; school districts; exclusion of enrolled pupils from school; short title; legislative intent

(a) This section shall be known and may be cited as the "Hughes Children's Health Enforcement Act."

(b) The Legislature recognizes the importance of health to learning and to a successful academic career. The Legislature also recognizes the important role of schools in ensuring the health of pupils through health education and the maintenance of minimal health standards among the pupil population. Therefore, it is the intent of the Legislature that schools ensure that pupils receive a health screening before the end of the first grade.

(c) The department shall compile district information, using the information reported pursuant to Section 124100, and report to the Legislature the percentage levels of compliance with Section 124085 on an annual basis commencing January 1, 1994, utilizing data from the prior school year.

(d) The governing board of each school district shall exclude from school, for not more than five days, any first grade pupil who has not provided either a certificate or a waiver, as specified in Section 124085, on or before the 90th day after the pupil's entrance into the first grade. The exclusion shall commence with the 91st calendar day after the pupil's entrance into the first grade, unless school is not in session that day, then the exclusion shall commence on the next succeeding school day. A child shall not be excluded under this section if the pupil's parent or guardian provides to the district either a certificate or a waiver as specified in Section 124085.

(e) The governing board of a school district may exempt any pupil from the exclusion described in subdivision (d) if, at least twice between the first day and the 90th day after the pupil's entrance into the first grade, the district has contacted the pupil's parent or guardian and the parent or guardian refuses to provide either a certificate or a waiver as specified in Section 124085. The number of exemptions from exclusion granted by a school district pursuant to this subdivision may not exceed 5 percent of a school district's first grade enrollment. It is the intent of the Legislature that exemptions from exclusion are used in extraordinary circumstances, including, but not limited to, family situations of great dysfunction or disruption, such as substance abuse by parents or guardians, child abuse, or child neglect.

(f) It is the intent of the Legislature that, upon a pupil's enrollment in kindergarten or first grade, the governing board of the school district notify the pupil's parent or guardian of the obligation to comply with Section 124085 and the availability for low-income children of free health screening for up to 18 months prior to entry into first grade through the Child Health Disabilities Prevention Program.

(g) It is the intent of the Legislature that school districts provide information to parents regarding the requirements of Section 124085 within the notification of immunization requirements. Moreover, the Legislature intends that the information sent to parents encourage parents to obtain health screens simultaneously with immunizations.

124110. Confidentiality of information and results; health screening and evaluation; release; professional interpretation of results

All information and results of the health screening and evaluation of each child shall be confidential and shall not be released without the informed consent of a parent or guardian of the child.

The results of the health screening and evaluation shall not be released to any public or private agency, even with the consent of a parent or guardian unless accompanied by a professional interpretation of what the results mean.

Insurance Code (Re: CHDP Gateway)

12693.41.

(a) The board shall consult and coordinate with the State Department of Health Services in implementing a preenrollment program into the Healthy Families Program or the Medi-Cal program pursuant to subdivision (b) of Section 14011.7

of the Welfare and Institutions Code. The board shall accept the follow-up application provided for in Section 14011.7 of the Welfare and Institutions Code as an application for the Healthy Families Program. Preenrollment shall be administered by the State Department of Health Services to provide full-scope benefits pursuant to Medi-Cal program requirements, at no cost to the applicant.

(b) The board may use the state fiscal intermediary for Medicaid to process the eligibility determinations and payments required pursuant to Section 14011.7 of the Welfare and Institutions Code.

(c) The board shall be exempt from the requirements of Chapter 7 (commencing with Section 11700) of Division 3 of Title 2 of the Government Code and Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code as those requirements apply to the use of processing services by the state fiscal intermediary.

The board may adopt emergency regulations to implement preenrollment into the Healthy Families Program or the Medi-Cal program pursuant to Section 14011.7 of the Welfare and Institutions Code. The emergency regulations shall include, but not be limited to, regulations that implement any changes in rules relating to eligibility, enrollment, and disenrollment in the programs pursuant to Sections 12693.45 and 12693.70. The initial adoption of emergency regulations and one readoption of the initial regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. Initial emergency regulations and the first readoption of those regulations shall be exempt from review by the Office of Administrative Law. The initial emergency regulations and one readoption of those regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations and each shall remain in effect for no more than 180 days.

This section shall become operative on April 1, 2003.

Welfare and Institutions Code (Re: CHDP Gateway)

14011.7.

(a) To the extent allowed under federal law and only if federal financial participation is available, the department shall exercise the option provided in Section 1396r-1a of Title 42 of the United States Code and the Managed Risk Medical Insurance Board shall exercise the option provided in Section 1397gg(e)(1)(D) of Title 42 of the United States Code to implement a program for preenrollment of children into the Medi-Cal program or the Healthy Families Program. Upon the exercise of both of the federal options described in this subdivision, the department shall implement and administer a program of preenrollment of children into the Medi-Cal program or the Healthy Families Program.

(b) Before July 1, 2003, the department shall develop an electronic application to serve as the application for preenrollment into the Medi-Cal program or the Healthy Families Program and to also serve as an application for the Child Health and Disability Prevention (CHDP) program, to the extent allowed under federal law.

(c)

(1) The department may designate, as necessary, those CHDP program providers described in paragraphs (1) to (5), inclusive, of subdivision (g) of Section 124030 of the Health and Safety Code as qualified entities who are authorized to determine eligibility for the CHDP program and for preenrollment into either the Medi-Cal program or the Healthy Families Program as authorized under this section.

(2) The CHDP provider shall assist the parent or guardian of the child seeking eligibility for the CHDP program and for preenrollment into the Medi-Cal program or the Healthy Families Program in completing the electronic application.

(d) The electronic application developed pursuant to subdivision (b) may only be filed through the CHDP program when the child is in need of CHDP program services in accordance with the periodicity schedule used by the CHDP program.

(e)

(1) The electronic application developed pursuant to subdivision (b) shall request all information necessary for a CHDP provider to make an immediate determination as to whether a child meets the eligibility requirements for CHDP and for preenrollment into either the Medi-Cal program or the Healthy Families Program pursuant to the federal options described in Section 1396r-1a or 1397gg(e)(1)(D) of Title 42 of the United States Code.

(2)

(A) If the electronic application indicates that the child is seeking eligibility for either no cost full-scope Medi-Cal benefits or enrollment in the Healthy Families Program, the department shall mail to the child's parent or guardian a follow-up application for Medi-Cal program eligibility or enrollment in the Healthy Families Program. The parent or guardian of the child shall be advised to complete and submit to the appropriate entity the follow-up application.

(B) The follow-up application, at a minimum, shall include all notices and forms necessary for both a Medi-Cal program and a Healthy Families Program eligibility determination under state and federal law, including, but not limited to, any information and documentation that is required for the joint application package described in Section 14011.1.

(C) The date of application for the Medi-Cal program or the Healthy Families Program is the date the completed follow-up application is submitted with the appropriate entity by the parent or guardian.

(3) Upon making a determination pursuant to paragraph (1) that a child is eligible, the CHDP provider shall inform the child's parent or guardian of both of the following:

(A) That the child has been determined to be eligible for services under the CHDP program and, if applicable, eligible for preenrollment into either the Medi-Cal program or the Healthy Families Program.

(B) That if the child has been determined to be eligible for preenrollment into either the Medi-Cal program or the Healthy Families Program, the period of preenrollment eligibility will end on the last day of the month following the month in which the determination of preenrollment eligibility is made, unless the parent or guardian completes and returns to the appropriate entity the follow-up application described in paragraph (2) on or before that date.

(4) If the follow-up application described in paragraph (2) is submitted on or before the last day of the month following the month in which a determination is made that the child is eligible for preenrollment into either the Medi-Cal program or the Healthy Families Program, the period of preenrollment eligibility shall continue until the completion of the determination process for the applicable program or programs.

(f) The scope and delivery of benefits provided to a child who is preenrolled for the Healthy Families Program pursuant to this section shall be identical to the scope and delivery of benefits received by a child who is preenrolled for the Medi-Cal program pursuant to this section.

(g) The department and the Managed Risk Medical Insurance Board shall seek approval of any amendments to the state plan, necessary to implement this section, for purposes of funding under Title XIX (42 USC 1396 et seq.) and Title XXI (42 USC 1397aa et seq.) of the Social Security Act. Notwithstanding any other provision of law and only when all necessary federal approvals have been obtained, this section shall be implemented only to the extent federal financial participation is available.

(h) Upon the implementation of this section, this section shall control in the event of a conflict with any provision of Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code governing the Child Health and Disability Prevention Program.

(i) To implement this section, the department may contract with public or private entities, or utilize existing health care service provider enrollment and payment mechanisms, including the Medi-Cal program's fiscal intermediary, only if services provided under the program are specifically identified and reimbursed in a manner that appropriately claims federal financial reimbursement. Contracts, including the Medi-Cal fiscal intermediary contract for the Child Health and Disability Prevention Program, including any contract amendment, any system change pursuant to a change order, and any project or systems development notice shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Chapter 7 (commencing with Section 11700) of Part 1 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and any policies, procedures, or regulations authorized by these laws.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement this section by means of all-county letters or similar instructions, without taking any further regulatory action. Thereafter, the department shall adopt regulations, as necessary, to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(k) Notwithstanding subdivision (g), in no event shall this section be implemented before April 1, 2003.

Legislation, Regulations, and Guidelines for the HCPCFC

a. Enabling legislation of the HCPCFC.

Reference: Welfare and Institutions Code; Section 16501.3.

1. Medi-Cal regulations pertaining to the availability and reimbursement of EPSDT services through the CHDP program.

Reference: CCR, Title 22, Sections 51340 and 51532.

2. Statutes and regulations defining county Social Services Department responsibilities for meeting HCPCFC requirements.

b. Social Services Statutes

Reference: Welfare and Institutions Code Section 16010, 358.1, 361.5, 366.1, 366.22(b) or 366.22(d).

c. Social Services Regulations

Reference: Child Welfare Services Program Standards: MPP Sections 31-002(10), 31-075 (l 1-2), 31-205 (h), 31-206.35, 31-206.351, 31-206.352, 31-206.36, 31-206.361, 31-206.362, 31-335 .1, 31-401.4, 31-401.41, 31-401.412, 31-401.413, 31-405.1(j), 31-405.1(k, l, l1), and 31-420.1(.7).

d. Medi-Cal Regulations

Reference: CCR, Title 22, Sections 50031; 50157(a), (d), (e), and (f) and 50184(b).

Current interpretive releases by California Departments of Health Services and Social Services.

1. State CHDP Program Letters and Information Notices - Health Services. Specifically CHDP Program Letter 99-6 and CMS Information Notice 99-E.

2. All County Letters - Social Services. Specifically, All County Information Notice No I-55-99 and All County Letter No. 99-108.

3. Joint Letters - Health Services and Social Services

4. CHDP Program Health Assessment Guidelines - Health Services

e. New program standards affecting local programs to be reviewed by the California Conference of Local Health Officers.

Reference: Health and Safety Code, Section 100925

f. New regulations shall be adopted only after consultation and approval by the California Conference of Local Health Officers.

Reference: Health and Safety Code, Section 100950.

g. Federal regulations governing States' provision of EPSDT:

Reference: Title 42, Code of Federal Regulations (CFR), Section 440.40 and Part 441, Subpart B.

h. Federal statutes applying to the EPSDT program:

Reference: Social Security Act (42 USC Section 139(a) Sections 1902(a) (43), 1905(a)(4)(B), and 1905(r).

Reference: OBRA89 - Public Law 101-239, Section 6403.

Selected State Laws Relating to the HCPCFC

The following are selected sections of California laws relating to the HCPCFC. These sections have been extracted from California's Welfare and Institutions Code. For more current and complete information on State laws, please visit the Legislative Counsel of California's website at www.leginfo.ca.gov/calaw.html.

This section is not all-inclusive. Not included are other State laws, federal laws, State and federal regulations, or provisions of the CHDP Provider Manual, CHDP Program Guidance Manual, CHDP Program Letters, or CHDP Provider Information Notices.

Welfare and Institutions Code Section

16501.

(a) As used in this chapter, "child welfare services" means public social services which are directed toward the accomplishment of any or all the following purposes: protecting and promoting the welfare of all children, including handicapped, homeless, dependent, or neglected children; preventing or remedying, or assisting in the solution of problems which may result in, the neglect, abuse, exploitation, or delinquency of children; preventing the unnecessary separation of children from their families by identifying family problems, assisting families in resolving their problems, and preventing breakup of the family where the prevention of child removal is desirable and possible; restoring to their families children who have been removed, by the provision of services to the child and the families; identifying children to be placed in suitable adoptive homes, in cases where restoration to the biological family is not possible or appropriate; and assuring adequate care of children away from their homes, in cases where the child cannot be returned home or cannot be placed for adoption. "Child welfare services" also means services provided on behalf of children alleged to be the victims of child abuse, neglect, or exploitation. The child welfare services provided on behalf of each child represent a continuum of services, including emergency response services, family preservation services, family maintenance services, family reunification services, and permanent placement services. The individual child's case plan is the guiding principle in the provision of these services. The case plan shall be developed within 30 days of the initial removal of the child or of the in-person response required under subdivision (f) of Section 16501 if the child has not been removed from his or her home, or by the date of the jurisdictional hearing pursuant to Section 356, whichever comes first.

(1) Child welfare services may include, but are not limited to, a range of service-funded activities, including case management, counseling, emergency shelter care, emergency in-home caretakers, temporary in-home caretakers, respite care, therapeutic day services, teaching and demonstrating homemakers, parenting training, substance abuse testing, and transportation. These service-funded activities shall be available to children and their families in all phases of the child welfare program in accordance with the child's case plan and departmental regulations. Funding for services is limited to the amount appropriated in the annual Budget Act and other available county funds.

(2) Service-funded activities to be provided may be determined by each county, based upon individual child and family needs as reflected in the service plan.

(3) As used in this chapter, "emergency shelter care" means emergency shelter provided to children who have been removed pursuant to Section 300 from their parent or parents or their guardian or guardians. The department may establish, by regulation, the time periods for which emergency shelter care shall be funded. For the purposes of this paragraph, "emergency shelter care" may include "transitional shelter care facilities" as defined in paragraph (11) of subdivision

(a) of Section 1502 of the Health and Safety Code.

(b) As used in this chapter, "respite care" means temporary care for periods not to exceed 72 hours. This care may be provided to the child's parents or guardians. This care shall not be limited by regulation to care over 24 hours. These services shall not be provided for the purpose of routine, ongoing child care.

(c) The county shall provide child welfare services as needed pursuant to an approved service plan and in accordance with regulations promulgated, in consultation with the counties, by the department. Counties may contract for service-funded activities as defined in paragraph (1) of subdivision (a). Each county shall use available private child welfare resources prior to developing new county-operated resources when the private child welfare resources are of at least equal quality and lesser or equal cost as compared with county-operated resources. Counties shall not contract for needs assessment, client eligibility determination, or any other activity as specified by regulations of the State Department of Social Services, except as specifically authorized in Section 16100.

(d) Nothing in this chapter shall be construed to affect duties which are delegated to probation officers pursuant to Sections 601and 654.

(e) Any county may utilize volunteer individuals to supplement professional child welfare services by providing ancillary support services in accordance with regulations adopted by the State Department of Social Services.

(f) As used in this chapter, emergency response services consist of a response system providing in-person response, 24 hours a day, seven days a week, to reports of abuse, neglect, or exploitation, as required by Article 2.5 (commencing with Section 11164) of Chapter 2 of Title 1 of Part 4 of the Penal Code for the purpose of investigation pursuant to Section 11166 of the Penal Code and to determine the necessity for providing initial intake services and crisis intervention to maintain the child safely in his or her own home or to protect the safety of the child. County welfare

departments shall respond to any report of imminent danger to a child immediately and all other reports within 10 calendar days. An in-person response is not required when the county welfare department, based upon an evaluation of risk, determines that an in-person response is not appropriate. This evaluation includes collateral, contacts, a review of previous referrals, and other relevant information, as indicated.

(g) As used in this chapter, family maintenance services are activities designed to provide in-home protective services to prevent or remedy neglect, abuse, or exploitation, for the purposes of preventing separation of children from their families.

(h) As used in this chapter, family reunification services are activities designed to provide time-limited foster care services to prevent or remedy neglect, abuse, or exploitation, when the child cannot safely remain at home, and needs temporary foster care, while services are provided to reunite the family.

(i) As used in this chapter, permanent placement services are activities designed to provide an alternate permanent family structure for children who because of abuse, neglect, or exploitation cannot safely remain at home and who are unlikely to ever return home. These services shall be provided on behalf of children for whom there has been a judicial determination of a permanent plan for adoption, legal guardianship, or long-term foster care.

(j) As used in this chapter, family preservation services include those services specified in Section 16500.5 to avoid or limit out-of-home placement of children, and may include those services specified in that section to place children in the least restrictive environment possible.

(k)

(1)

(A) In any county electing to implement this subdivision, all county welfare department employees who have frequent and routine contact with children shall, by February 1, 1997, and all welfare department employees who are expected to have frequent and routine contact with children and who are hired on or after January 1, 1996,and all such employees whose duties change after January 1, 1996, to include frequent and routine contact with children, shall, if the employees provide services to children who are alleged victims of abuse, neglect, or exploitation, sign a declaration under penalty of perjury regarding any prior criminal

conviction, and shall provide a set of fingerprints to the county welfare director.

(B) The county welfare director shall secure from the Department of Justice a criminal record to determine whether the employee has ever been convicted of a crime other than a minor traffic violation. The Department of Justice shall deliver the criminal record to the county welfare director.

(C) If it is found that the employee has been convicted of a crime, other than a minor traffic violation, the county welfare director shall determine whether there is substantial and convincing evidence to support a reasonable belief that the employee is of good character so as to justify frequent and routine contact with children.

(D) No exemption shall be granted pursuant to subparagraph (C) if the person has been convicted of a sex offense against a minor, or has been convicted of an offense specified in Section 220, 243.4,264.1, 273d, 288, or 289 of the Penal Code, or in paragraph (1) of Section 273a of, or subdivision (a) or (b) of Section 368 of, the Penal Code, or has been convicted of an offense specified in subdivision (c) of Section 667.5 of the Penal Code. The county welfare director shall suspend such a person from any duties involving frequent and routine contact with children.

(E) Notwithstanding subparagraph (D), the county welfare director may grant an exemption if the employee or prospective employee, who was convicted of a crime against an individual specified in paragraph (1) or (7) of subdivision (c) of Section 667.5 of the Penal Code, has been rehabilitated as provided in Section 4852.03 of the Penal Code and has maintained the conduct required in Section 4852.05 of the Penal Code for at least 10 years and has the recommendation of the district attorney representing the employee's or prospective employee's county of residence, or if the employee or prospective employee has received a certificate of rehabilitation pursuant to Chapter 3.5 (commencing with Section 4852.01) of Title 6 of Part 3 of the Penal Code. In that case, the county welfare director may give the employee or prospective employee an opportunity to explain the conviction and shall consider that explanation in the evaluation of the criminal conviction record. If no criminal record information has been recorded, the

county welfare director shall cause a statement of that fact to be included in that person's personnel file. (2) For purposes of this subdivision, a conviction means a plea or verdict of guilty or a conviction following a plea of no lo contendere. Any action which the county welfare director is permitted to take following the establishment of a conviction may betaken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, notwithstanding a subsequent order pursuant to Sections 1203.4 and1203.4a of the Penal Code permitting the person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment. For purposes of this subdivision, the record of a conviction, or a copy thereof certified by the clerk of the court or by a judge of the court in which the conviction occurred, shall be conclusive evidence of the conviction.

16501.3.

(a) The Department of Social Services shall establish a program of public health nursing in the child welfare services program. The purpose of the public health nursing program shall be to enhance the physical, mental, dental, and developmental well being of children in the child welfare system.

(b) As a condition of receiving funds under this section, counties shall use the services of a foster care public health nurse. The foster care public health nurse shall work with the appropriate child welfare services workers to coordinate health care services and serve as a liaison with health care professionals and other providers of health-related services. This shall include coordination with county mental health plans and local health jurisdictions, as appropriate.

(c) The duties of a foster care public health nurse may include, but need not be limited to, the following:

(1) Collecting health information and other relevant data on each foster child as available, receiving all collected information to determine appropriate referral and services, and expediting referrals to providers in the community for early intervention services, specialty services, dental care, mental health services, and other health-related services required by the child.

(2) Participating in medical care planning and coordinating for the child. This may include, but is not limited to, assisting caseworkers in arranging for comprehensive health and mental health assessments, interpreting the results of health assessments or evaluations for the purpose of case planning and coordination, facilitating the acquisition of any necessary

court authorizations for procedures or medications, advocating for the health care needs of the child and ensuring the creation of linkage among various providers of care.

(3) Providing follow-up contact to assess the child's progress in meeting treatment goals.

(d) The services provided by foster care public health nurses under this section shall be limited to those for which reimbursement may be claimed under Title XIX at an enhanced rate for services delivered by skilled professional medical personnel. Not withstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation, as provided under Title XIX of the federal Social Security Act (42 USC Sec. 1396 et seq.), is available.

Notwithstanding Section 10101 of the Welfare and Institutions Code, there shall be no required county match of the nonfederal cost of this program.

Annual Review for Cash Aid and Food Stamps (TEMP CA 600)

Online Version: www.dss.cahwnet.gov/pdf/TEMPCA600.pdf

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

ANNUAL REVIEW

FOR CASH AID AND FOOD STAMPS

A redetermination of your continued eligibility for cash aid and/or recertification for food stamps is now due. You do not need to come to the office for an interview unless you want to.

If you get food stamps, your certification period ends on the last day of next month. If you want to keep getting food stamps, you must fill out the TEMP DFA 377.2B ESP, Shelter Information, and return it with your next Monthly Report.

The TEMP DFA 377.2B ESP, Shelter Information:

- ☐ is enclosed
- ☐ will be mailed under separate cover with the Notice of Expiration of Certification, TEMP DFA 377.2A ESP

You need to read and save the enclosed important informing documents. They give you facts about cash aid, food stamps, the Cash Aid Lump Sum Rule, Greater Avenues to Independence (GAIN), Food Stamp Employment and Training Rules, the Child Health and Prevention Disability Prevention Program, Family Planning Services, etc.

If you have any questions or want an interview, call your worker.

Please submit the following items:

_____

_____

_____

_____

_____

_____

_____

_____

TEMP CA 600 (4/99) ESP COVERLETTER - RECOMMENDED FORM

CHDP Pre-Enrollment Application (DHS 4073)

Online Version: www.ca.gov/pcfh/cms/chdp/publications.htm#dhs4073

State of California—Health and Human Services Agency

Department of Health Services
Children's Medical Services Branch

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
PRE-ENROLLMENT APPLICATION

Instructions to the Parent or Patient:

- In order to receive a health examination today at no charge, you must provide the information required on this form. The information you give is confidential. This is a voluntary program.

  Is the patient less than 19 years of age? ☐ Yes ☐ No

  How many people are in your family? _____

  How much money does your family make before taxes? $ _____ (Monthly) Or $ _____ (Yearly)

- You or your child may be eligible for continued health care coverage through Medi-Cal or Healthy Families.

  I want to apply for continuing coverage through Medi-Cal or Healthy Families. ☐ Yes ☐ No

  If you answered *yes* to this question, an application will be mailed to you in a few days. Please return it promptly. If you answered *no* to this question (or if you answered *yes* but do not return the application), the patient's coverage for health, dental, and vision benefits will stop at the end of next month unless the county Department of Social Services notifies you otherwise.

Patient Information

Does the patient have a State of California Benefits Identification Card (BIC) or Medi-Cal card? ☐ Yes ☐ No

If yes, what is the identification number on the BIC card (if available)? _____

Patient's name—Last	First	Middle initial

Date of birth (month/day/year)	Gender ☐ Male ☐ Female	Patient's social security number (SSN) ***(optional)***

☐ If you are homeless, check here. Enter the general location in the "Home address" section and complete the "Mailing address" section.

Home address	Apartment number	City	State	ZIP code

County of residence

Mailing address (if different from home address)	Apartment number	City	State	ZIP code

Mother's name—Last	First	Middle initial

For patients under one year of age, please complete this section.

If less than one year of age, did the infant live with the mother in the month of birth? ☐ Yes ☐ No

Mother's date of birth (month/day/year)	Mother's BIC or Medi-Cal card number or social security number

Parent/Legal Guardian Information

Name of parent/legal guardian or emancipated minor patient—Last	First	Middle initial

Home telephone number	Work telephone number	Message telephone number
( )	( )	( )

What language do you speak at home?	What language do you read best?

Certification

I am requesting a CHDP health examination today. I certify that I have read and understand this form. I declare that the information I have provided is true, correct, and complete.

Signature of parent/guardian or emancipated minor	Relationship to patient	Date

An individual has a right to review records containing his/her personal information. The official entity responsible for keeping the information is the Department of Health Services, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413. A copy of this information may be shared with the county Department of Social Services in the county in which you reside and will be kept with your child's medical record by your child's CHDP provider.

DHS 4073 (English) (6/04)

CHDP Referral (PM 357)

State of California—Health and Human Services Agency | Department of Health Services

CHDP REFERRAL

All Medi-Cal eligible persons under 21 years of age can receive a health and dental check-up.
Client: Fill in unshaded areas only.

PART A: Completed by county Department of Social Services (DSS)/welfare staff for all cases requesting services or additional information

1. Case name (last) (first) (middle)	2. County code	3. Aid code	4. Case number

5. ☐ Requested additional information, but no services.

Requested Medical Services (Health Assessment)

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

Requested Dental Services

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

12. ☐ New application
13. ☐ Redetermination
14. ☐ Self-referral
15. ☐ CALWORKs
16. ☐ Foster care
17. ☐ Medi-Cal only
18. ☐ Share-of-cost

19. Primary language, if other than English _____
20. Other circumstances _____

	Person Number	Client(s) Name (Last, First, Middle)	Birth Date Month	Day	Year	Age	If health care plan member, give plan name
21.		Parent or caretaker name					
22.		Other parent in home					
23.		Child's name					
24.		Child's name					
25.		Child's name					
26.		Child's name					
27.		Child's name					
28.		Other person in home					

29. Residence address (number, street)	City	State	ZIP code	32. Home phone
		CA		( )
31. Mailing address (if different) (number, street; P.O. Box)	City	State	ZIP code	32. Message phone
				( )

33. Family or child's doctor (optional)	34. Family or child's dentist (optional)

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

Comments:

35. DSS worker signature	36. DSS worker number	37. DSS worker telephone	38. Date eligibility determined

Copy 1—County CHDP *Copy 2—County CHDP* *Copy 3—Client Case Report (Welfare Department)*
CHDP Referral and Case Management Form

12-1204.34

PM 357 (6/99) Required Form

State of California—Health and Human Services Agency | Department of Health Services

PART B: Completed by EPSDT staff to document assistance with requested health assessment and/or dental services.

Case name (last) (first) (middle)

Contact attempt with responsible person:

Type of Contact	Date	Result	Who Contacted	Date	Result	Who Contacted	FINAL RESULT:
☐ Face-to-face							
☐ Telephone							☐ Contact made
☐ Mail							☐ No contact made

Comments:

Client Name		Type T	Type S	Assistance Given	Date	Provider Name and Telephone	Appt. Date	Appt. Kept Yes	Appt. Kept No	Further Dx/ Rx Needed Yes	Further Dx/ Rx Needed No	Source of Info.	Date PM 160 Received
	M												
	D												
	M												
	D												
	M												
	D												
	M												
	D												

(If more space is needed, attach additional sheets.)

Comments:

EPSDT worker signature | Date

Part C: Completed by CHDP program staff to document follow-up to diagnosis and treatment.

Contact attempt with responsible person:

Type of Contact	Date	Result	Who Contacted	Date	Result	Who Contacted	FINAL RESULT:
☐ Face-to-face							
☐ Telephone							☐ Contact made
☐ Mail							☐ No contact made

Comments:

Client Name	Type of Condition	Response to Offer Trans.	Response to Offer Sched.	Assistance Given	Date	Provider Name and Telephone	Appt. Date	Appt. Kept Yes	Appt. Kept No	Source of Info.

Comments:

CHDP Health Professional Signature | Date

PM 357 (6/99) Required Form

INSTRUCTIONS FOR COMPLETING PART A

ITEM

1–4 Self-explanatory.

5 Check the box if no services are requested but the client wants additional information about the program.

6 Check yes or no as appropriate.

7–8 If item 6 is checked no, skip these items. If item 6 is checked yes, check the boxes in both items 7 and 8 indicating the response to the offer of transportation and scheduling assistance.

9 Check yes or no as appropriate.

10–11 If item 9 is checked no, skip these items. If item 9 is checked yes, check the boxes in both items 10 and 11 indicating the response to the offer of transportation and scheduling assistance.

12–13 When the referral is being made by a CalWORKS, Medi–Cal, or placement worker, check item 12 if the request for services is from a new application or restoration or item 13 if the request is made at the annual redetermination.

14 When services have been requested directly from the local EPSDT Unit or CHDP Program, check item 14.

15–17 Check the one applicable box.

18 Check the box when a Medi–Cal only beneficiary has to pay a share of the costs.

19–20 Complete if applicable. Indicate special communications needs such as deaf, blind, or illiterate—for other circumstances, item 20.

21–28 Fill in the state person number (Example: 01-father, 02-mother, 11-child, etc.), and the name of the health care plan, if applicable. A person number need not be entered on self-referrals. The unshaded portion must be completed in full by the county welfare department, local EPSDT Unit, or CHDP Program staff for self-referrals, or may be completed by the client.

29–32 Record the caretaker's address and telephone number.

33–34 Optional—not required. Enter the name of the doctor or dentist who currently provides care the eligible children.

Comments: Use this section to record any comments which will help recipients receive requested services, such as the best time for them to be contacted.

35–37 Self-explanatory.

38 "Date eligibility determined"—Enter the date the application is determined eligible, not the date the application was made. For redetermination, the date eligibility determined is the date that the county verifies and certifies that eligibility continues. For "self-referrals" the date of request for services should be entered.

12.1204.35.a

PM 357 (6/99) Required Form

CHDP Referral for SAWS Automated Template

SOME COUNTY
DEPARTMENT OF SOCIAL SERVICES
760 Madison Avenue
P.O. Box 4650
Anywhere, CA 95973

SAWS CHDP REFERRAL

Date:

CASE INFORMATION

CASE LAST NAME FIRST M APP CO AID CODE CASE NUMBER

29 84

RESIDENCE ADDRESS HOME TELEPHONE:
MESSAGE PHONE:

MAILING ADDRESS:

CASE STATUS PRIMARY LANGUAGE

DATE ELIGIBILITY DETERMINED:

☐ NEW APPLICATION ☐ REDETERMINATION ☐ SELF-REFERRAL
☐ CALWORKS ☐ FOSTER CARE ☐ MEDI-CAL ONLY ☐ SHARE OF COST

OTHER CIRCUMSTANCES: _____

PARENT/CARETAKER

PERS LAST NAME FIRST M BIRTH AGE IF HEALTH PLAN MEMBER, GIVE PLAN NAME

PERS CHILD'S LAST NAME FIRST M BIRTH AGE IF HEALTH PLAN MEMBER, GIVE PLAN NAME

OTHER PERSON IN HOME:

REQUESTED MEDICAL SERVICES: SERVICES? Y/N TRANSPORTATION? Y/N SCHEDULING? Y/N

REQUESTED DENTAL SERVICES: SERVICES? Y/N TRANSPORTATION? Y/N SCHEDULING? Y/N

REQUESTED ADDITIONAL INFORMATION BUT NO SERVICES? Y/N

FAMILY DOCTOR:

FAMILY DENTIST:

FORM PM 357 Revision Date: March, 1999

CHDP Referral for Welfare Case Data System Counties

PM 357
DEL 4/87

BD50120--5Z

COUNTY OF ALAMEDA
WELFARE CASE DATA SYSTEM
CHDP REFERRAL FORM

CDS286

CODE 4 SW EH WH6H

CASE NAME LAST FIRST AID-T MS-X CASE NUMBER ELIG. DET. DATE 4-14-00

PAYEE -

PHONE NUMBER-

LANGUAGE-

OAKLAND CA 94603-1602

CASE REFERRED FOR- MEDICAL AND DENTAL WITH SCHEDULING/TRANSPORTATION

ELIGIBLE PERSONS IN CASE REFERRED

PERS NBR	FIRST	LAST	SEX	BIRTHDATE	HC
11	YAS		F	8-13-92	N
12	AD'		M	9-28-97	N
13	UNBORN			9-25-00	N

PART B: FOLLOW-UP TO HEALTH ASSESSMENT AND/OR DENTAL SERVICES
CONTACT ATTEMPT WITH RESPONSIBLE PERSON:

TYPE OF CONTACT	DATE	RESULT	WHO CONTACTED	DATE	RESULT	WHO CONTACTED
☐ FACE - TO - FACE						
☐ TELEPHONE						
☐ MAIL						

COMMENTS:

FINAL RESULT:
☐ CONTACT MADE
☐ NO CONTACT MADE

PART B CONTINUED ON REVERSE SIDE

Confidential Referral/Follow Up Report (PM 161)

Online Version: www.ca.gov/pcfh/cms/chdp/publications.htm#pm161

State of California—Health and Human Services Agency

Department of Health Services
Child Health and Disability Prevention Program

CHDP CONFIDENTIAL REFERRAL/FOLLOW-UP REPORT

CHDP Health Assessment Provider:

- Retain original form in patient's medical record.
- Send photocopy to diagnosis/treatment provider.

Diagnosis/Treatment Provider:

- Complete and sign form. Retain the signed form in patient's medical record.
- If patient consent is given, send photocopy of completed and signed form to the CHDP Health Assessment Provider.
- If patient consent is given, send photocopy of completed and signed form to the local CHDP program. To find the mailing address for the local CHDP Program, go to www.dhs.ca.gov/chdp

CHDP HEALTH ASSESSMENT PROVIDER COMPLETES THIS SECTION:

Patient name (Last) (First) (Initial) BIC number

Date of birth Month Day Year | Sex ☐ Female ☐ Male | Patient's county of residence | Code | Telephone number

Responsible person (Name) (Street) (City) (ZIP code)

Dear _____:
(Diagnosis/Treatment Provider)

The above named patient received a CHDP health assessment on _____. The following suspected condition(s) was identified as needing further evaluation:
(Date)

1. _____

2. _____

3. _____

After you have seen and examined the patient, please note your findings below. If appropriate consent has been obtained below, please send a photocopy to me and/or the local CHDP program. Thank you,

Printed name of CHDP Health Assessment Provider | Signature | Date

Mailing Address (street, number) | City | ZIP code | ( ) Telephone number

PARENT COMPLETES THIS SECTION:

CONSENT: I have read the release of information disclosure on page 2 and I hereby authorize release of information to:

☐ Local CHDP Program ☐ CHDP Health Assessment Provider

Signature of Responsible Person | Date

DIAGNOSIS/TREATMENT PROVIDER COMPLETES THIS SECTION:

A. What was your diagnosis (ICD terminology) of **suspected condition 1**?	What was your diagnosis (ICD terminology) of **suspected condition 2**?	What was your diagnosis (ICD terminology) of **suspected condition 3**?
ICD Code *(optional)*	ICD Code *(optional)*	ICD Code *(optional)*
B. **Result of diagnosis:** *(Check appropriate line.)*	**Result of diagnosis:** *(Check appropriate line.)*	**Result of diagnosis:** *(Check appropriate line.)*
☐ Abnormality not confirmed	☐ Abnormality not confirmed	☐ Abnormality not confirmed
☐ Abnormality confirmed:	☐ Abnormality confirmed:	☐ Abnormality confirmed:
☐ No treatment indicated	☐ No treatment indicated	☐ No treatment indicated
☐ Treatment indicated—given	☐ Treatment indicated—given	☐ Treatment indicated—given
☐ Treatment indicated—referred	☐ Treatment indicated—referred	☐ Treatment indicated—referred
☐ Treatment indicated—not given nor referred	☐ Treatment indicated—not given nor referred	☐ Treatment indicated—not given nor referred
Reason:	**Reason:**	**Reason:**

Diagnosis/Treatment Provider signature ➤ | Date examined Month Day Year | Diagnosis/Treatment Provider's telephone number ( )

PM 161 (4/03) Page 1 of 2

RELEASE OF INFORMATION DISCLOSURE

To the responsible person:

When your child or you are referred for diagnosis and/or treatment as a result of a CHDP health assessment, this form will be used to assist in the referral. Certain information regarding the reason for referral will be written on this form.

The original will be kept in your child's or your confidential patient file by the CHDP health assessment provider, and a copy will be sent to the health care provider or agency providing diagnostic and/or treatment services.

The results of the diagnostic and/or treatment services will be recorded on the copy. It will be kept by the diagnostic and/or treatment provider in your child's or your confidential patient file. With your permission, copies will be distributed as follows:

- A copy will be sent to your local CHDP program to let them know that your child or you received the recommended services. The director or the deputy director of the local CHDP program at your local health department has the responsibility to maintain this copy as a confidential record.

- A copy will be sent to the CHDP health assessment provider to let this provider know that your child or you received the recommended services. This copy will be kept by the health assessment provider in your child's or your confidential patient file.

Confidential Screening/Billing Report - Standard (PM 160)

State of California—Health and Human Services Agency

Department of Health Services

[redacted]

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

7

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NUMBER | L.A. CODE

BIRTH DATE Month Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Month Day Year | Ethnic Code: 1—American Indian, 2—Asian, 3—Black, 4—Filipino, 5—Mexican American Hispanic, 6—White, 7—Other, 8—Pacific Islander

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE NUMBER) (CITY) (ZIP CODE)

S

CHDP ASSESSMENT Indicate outcome for each Screening procedure	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Followup Code in Appropriate Column: NEW C	KNOWN D	DATE OF SERVICE Month Day Year / FEES
01 HISTORY AND PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION					
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					12

A

M

CODE	OTHER TESTS—PLEASE REFER TO THE CHDP LIST OF TEST CODES				CODE	OTHER TESTS

P

FOLLOW-UP CODES
1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED.
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED.

REFERRED TO | TELEPHONE NUMBER

REFERRED TO | TELEPHONE NUMBER

COMMENTS/PROBLEMS
IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA.

HEIGHT IN INCHES 0 4 | WEIGHT Pounds Ounces | BLOOD PRESSURE

HEMOGLOBIN . | HEMATOCRIT .0% | BIRTH WEIGHT Pounds Ounces

ROUTINE REFERRAL(S) (✓): ☐ BLOOD LEAD ☐ DENTAL | PATIENT IS A FOSTER CHILD (✓) ☐

ICD 9 CODES 1 2 3

IMMUNIZATIONS
PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	REFUSED OR CONTRA-INDICATED D

I

THE QUESTIONS BELOW MUST BE ANSWERED.

	Yes	No
1. Is patient exposed to passive (second-hand) tobacco smoke?	☐	☐
2. Is tobacco used by patient?	☐	☐
3. Is patient counseled about/referred for tobacco use prevention/cessation?	☐	☐

E

PATIENT VISIT (✓): 1 ☐ New Patient or Extended Visit 2 ☐ Routine Visit

TYPE OF SCREEN (✓): 1 ☐ Initial 2 ☐ Periodic

TOTAL FEES

PROVIDER OF SERVICE: Name, address, telephone number (please include area code)

PROVIDER NUMBER

1 ☐ Enrolled in WIC 2 ☐ Referred to WIC
NOTE: WIC requires Ht., Wt., and Hemoglobin/Hematocrit

1 ☐ PARTIAL SCREEN 2 ☐ SCREENING PROCEDURE RECHECK
ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY: COUNTY | AID | IDENTIFICATION NUMBER

1 ☐ If covered by Medi-Cal or preenrolled in CHDP Gateway, enter BIC number above.
2 ☐ Patient eligible for CHDP benefits only.

SITE OF SERVICE IF OTHER THAN ABOVE:

This is to certify that the screening information is true and complete, and the results explained to the child or his/her parent or guardian. I understand that payment and satisfaction of this claim may be from federal or state funds, and that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable federal or state law. I also certify that none of the services billed on this form have been or will be billed to Medi-Cal, the patient, or other insurance providers.

SIGNATURE OF PROVIDER | DATE

STATE OF CALIFORNIA—CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

COPY 1—MAIL TO MEDI-CAL CHDP

Medi-Cal/CHDP
P. O. Box 15300
Sacramento, CA 95851-1300

CONFIDENTIAL SCREENING/BILLING REPORT

PM 160 (7/03)

RELEASE OF INFORMATION NOTICE TO THE RESPONSIBLE PERSON:

The information provided on this form is voluntary and is used by the California Child Health and Disability Prevention (CHDP) program in accordance with Article 7, Subchapter 13, Title 17, of the California Administrative Code to monitor program quality, to reimburse providers of health assessments for their services, and to facilitate diagnosis and treatment at the local level for children found to have health problems. Information provided may be transferred to local health departments for follow-ups. Refusal to supply the information requested will hamper efforts to monitor this program, may delay reimbursement procedures, and may delay diagnosis and treatment of health conditions affecting your child. For access to records containing this information, you may contact the individual listed below. You may also request the location of this information and the categories of persons who use it.

Chief, Children's Medical Services Branch
Primary Care and Family Health Division
Department of Health Services
P.O. Box 942732
Sacramento, CA 94234-7320

(916) 327-1400

PM 160 (7/03)

Confidential Screening/Billing Report – Information Only (PM 160 INFO ONLY)

State of California—Health and Human Services Agency

Department of Health Services

[redacted]

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

7

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NUMBER | LA CODE

BIRTH DATE Month Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Month Day Year | Ethnic Code 1—American Indian 2—Asian 3—Black 4—Filipino 5—Mexican American Hispanic 6—White 7—Other 8—Pacific Islander

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE NUMBER) (CITY) (ZIP CODE)

S

CHDP ASSESSMENT Indicate outcome for each Screening procedure	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Follow-up Code in Appropriate Column: NEW C	KNOWN D	DATE OF SERVICE Month Day Year / FEES
01 HISTORY AND PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION					
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					12
CODE — OTHER TESTS—PLEASE REFER TO THE CHDP LIST OF TEST CODES					CODE / OTHER TESTS

A

M

FOLLOW-UP CODES
1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED.
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED.

REFERRED TO | TELEPHONE NUMBER

REFERRED TO | TELEPHONE NUMBER

COMMENTS/PROBLEMS
IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA.

HEIGHT IN INCHES 0 4 | WEIGHT Pounds Ounces | BLOOD PRESSURE

HEMOGLOBIN | HEMATOCRIT .0% | BIRTH WEIGHT Pounds Ounces

INFORMATION ONLY REPORTING

P

ROUTINE REFERRAL(S) (✓) BLOOD LEAD DENTAL | PATIENT IS A FOSTER CHILD (✓)

ICD 9 CODES 1 2 3

IMMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES	GIVEN TODAY: NOW UP TO DATE FOR AGE A	STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	REFUSED OR CONTRA-INDICATED D

THE QUESTIONS BELOW MUST BE ANSWERED.

L

	Yes	No
1. Is patient exposed to passive (second-hand) tobacco smoke?	☐	☐
2. Is tobacco used by patient?	☐	☐
3. Is patient counseled about/referred for tobacco use prevention/cessation?	☐	☐

PATIENT VISIT (✓) 1 ☐ New Patient or Extended Visit 2 ☐ Routine Visit

TYPE OF SCREEN (✓) 1 ☐ Initial 2 ☐ Periodic

TOTAL FEES

PROVIDER OF SERVICE: Name, address, telephone number (please include area code)

HEALTH PLAN CODE/PROVIDER NUMBER

1 ☐ Enrolled in WIC 2 ☐ Referred to WIC

NOTE: WIC requires Ht., Wt., and Hemoglobin/Hematocrit

E

1 ☐ PARTIAL SCREEN 2 ☐ SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY COUNTY AID IDENTIFICATION NUMBER

RENDERING PROVIDER (PRINT NAME):

SIGNATURE OF PROVIDER | DATE

STATE OF CALIFORNIA—CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

COPY 1—MAIL TO MEDI-CAL CHDP → Medi-Cal/CHDP P.O. Box 15300 Sacramento, CA 95851-1300

CONFIDENTIAL SCREENING/BILLING REPORT

PM 160 INFORMATION ONLY (7/03)

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Chief, Children's Medical Services Branch
Primary Care and Family Health Division
Department of Health Services
P.O. Box 942732
Sacramento, CA 94234-7320

(916) 327-1400

PM 160 INFORMATION ONLY (7/03)

Important Information for Persons Requesting Medi-Cal (MC 219)

Online Version: www.dhs.ca.gov/publications/forms/pdf/mc219.pdf

State of California—Health and Human Services Agency | Department of Health Services

ENGLISH

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits. The information will be used:

1. By the county welfare department to establish first-time and ongoing Medi-Cal eligibility.
2. By Administrative Vendor (AV) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy-In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Immigration and Naturalization Service (INS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S. Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the INS receives can only be used to determine Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

MEDI-CAL APPLICANT/BENEFICIARY RIGHTS, RESPONSIBILITIES, AND UNDERSTANDINGS

I HAVE THE RIGHT TO:

1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
2. Request a face-to-face interview with a county representative.
3. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
4. Apply as a disabled person if I think I am disabled.
5. Receive information about the rules for retroactive Medi-Cal eligibility.
6. Apply for Medi-Cal and to be told in writing whether I qualify for any Medi-Cal program.
7. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
8. Have all facts that I give to the county welfare department kept in the strictest confidence and to look at those facts during regularly scheduled office hours.
9. Receive an immediate need card, **when possible and eligible**, if I have a medical emergency or I am pregnant.
10. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. **Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens with a valid and current I-688 card are in a satisfactory immigration status.**
11. Receive information about the Child Health and Disability Prevention Program (CHDP) and the Special Supplemental Food Program for Women, Infants, and Children (WIC), and to ask for help in receiving those services.
12. Receive information about the Personal Care Service Program (PCSP), and to ask for help in receiving those services.
13. Receive information about the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT).
14. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.

MC 219 (2/02) On-line | Page 1 of 4

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

15. Speak to a social worker about other public or private services or resources that I can get.
16. Receive information about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.
17. Lower my share of cost by providing past unpaid medical bills (that I still owe).
18. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal, including the month I apply, and to be told how I may spend my excess property.
19. Divide countable (nonexempt) community (MY SPOUSE's AND MY) property by written agreement into equal shares of separate property if ether of us entered a long-term care (LTC) facility before September 30, 1989.
20. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.
21. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within **90 days** of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within **90 days** from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest county welfare department.

I HAVE THE RESPONSIBILITY TO TELL MY COUNTY REPRESENTATIVE WITHIN TEN DAYS WHENEVER:

1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money), or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. I have any expenses that are paid for by someone other than myself.
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired (this would include a child in the family).
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change in the citizenship/immigration status of any family member applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

I HAVE THE RESPONSIBILITY TO:

1. Complete and return a status report by the date required when requested.
2. Give proof that I am a resident of California.

MC 219 (2/02) On-line

Page 2 of 4

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

3. Make a declaration about my citizenship/immigration status.
4. Provide an SSN for myself and/or for any member of my family who has an SSN and wants Medi-Cal benefits. If I am a U.S. citizen, a U.S. national, or an alien in a satisfactory immigration status, I must apply for an SSN and provide it to the county if I do not already have one. If I need to apply for an SSN, I can get help from my eligibility worker, but I must work with the SSA to clear up any questions or my Medi-Cal will be denied or stopped. (Aliens who are not in a satisfactory immigration status and do not have an SSN can get **restricted Medi-Cal** without applying for an SSN if they meet all the rules.)
5. Apply for any income that may be available to me or any member of my family.
6. Apply for Medicare benefits if I am blind, disabled, have End Stage Renal Disease, or am 64 years and 9 months of age or older and eligible. I am responsible for telling my providers that I have both Medi-Cal and Medicare coverage.
7. Apply for and enroll in any health insurance if that is available to me and my family at no cost. I have the responsibility to remain enrolled in the health plan when Medi-Cal approves payment of plan premiums by the State of California.
8. Report to the county department, and to the health care provider, any health care coverage/insurance I carry or am entitled to use, including Medicare. If I willfully fail to give this fact, I may be guilty of a criminal offense, or may be billed by my provider.
9. Go to my health care plan (such as Kaiser, CHAMPUS, or a Medicare HMO) for medical care. (Medi-Cal will not pay for any services covered by the plan.)
10. Give any insurance payments I receive to the State if Medi-Cal has already paid for my care.
11. Go to a presentation, if presentations are given, and make a written choice, **or** answer if received by mail, about how I want to get my Medi-Cal benefits. If I do not go and make a choice, **or** choose by mail, my eligible family members and I may be signed up in a Medi-Cal Health Care Plan near my home.
12. Sign and date my BIC when I get it and ensure it is used only to get necessary health care for myself or eligible family members.
13. Take my BIC to my medical provider when I am sick or have an appointment. In emergencies when the BIC is not in hand, I must get the BIC to the medical provider when possible.
14. Report to the county department when I receive health care services because of an accident or injury caused by another person's action or failure to act, for which Medi-Cal has been, or may be billed.
15. Cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to through an absent parent.
16. Cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be stopped.

I UNDERSTAND THAT:

1. Failure to give necessary facts or deliberately giving false facts can result in Medi-Cal benefits being denied or stopped. My case may also be investigated for suspected fraud.
2. The facts I give will be checked by computer with facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong.
3. Aliens who are not in a satisfactory immigration status and do not have an SSN can get **restricted** Medi-Cal without applying for an SSN if they meet all the rules.
4. Immigration status data given as part of the Medi-Cal application is confidential.
5. Based on my income, I will have to pay or be billed for part of my medical expenses before I can get Medi-Cal.
6. If I do not report changes promptly, and because of this, receive Medi-Cal benefits that I am not eligible for, I may have to repay the State Department of Health Services.

MC 219 (2/02) On-line

Page 3 of 4 4

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Continued)

7. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the **SSA, and the SSA** denies my disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA allows my claim, then my Medi-Cal benefits will continue. If the SSA does not allow my claim, then my Medi-Cal benefits will stop.
8. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.
9. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.
10. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.
11. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.
12. If I ask a Medi-Cal provider for any services not covered by my **non-Medi-Cal** health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal-covered services.
13. Medi-Cal providers cannot collect insurance copayment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share-of-cost and/or copayment.
14. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.
15. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse (during his or her lifetime), minor children, blind or permanently and totally disabled children, or it would create a hardship for my heirs.
16. After the death of my surviving spouse, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

Sign and keep for your records.

I hereby state that I have reviewed the information on this form with the county representative and that I fully understand my RIGHTS AND RESPONSIBILITIES to have my eligibility determined for Medi-Cal and to maintain that eligibility.

➤ _____ _____

Applicant/Representative Signature *(optional)* Date

Flex your POWER

COUNTY USE SECTION

I have provided (check one) ❒ In person ❒ By mail to the applicant the rights, responsibilities, and other information listed on this form.

➤ _____ _____ _____

Eligibility Worker's Signature Worker Number Date

MC 219 (2/02) On-line Page 4 of 4

State of California – Health and Human Services Agency Department of Health Services

NOTE: The Temp 602 B CHDP/FP Questionnaire form is no longer in use since the end of the option for CalWORKs Redetermination by mail. However, this form may be useful when considering strategies for informing those persons who apply to Medi-Cal Only by mail.

Medical and Dental Exams for Children and Youth and Family Planning Services (TEMP 602 B)

Please read the enclosed booklets. If you have any questions about the Child Health and Disability Prevention (CHDP) Program, please call the number listed on the back of the CHDP booklet. If you have any questions about Family Planning, please call toll-free 1-800-942-1052.

Your answers to the following questions will not affect your eligibility for cash aid.

1. Members of your family who are under age 21 and on Medi-Cal are eligible for free medical and dental exams. The medical exam includes a complete physical, immunizations (shots), eye and hearing tests, and information about growth and development. Regular medical and dental exams help protect your family's health and are available upon request through the CHDP program.

   Please check box if you want:

   - More information about CHDP services. ☐ Yes
   - More information about immunization services. ☐ Yes
   - A medical exam for your children. ☐ Yes
   - A dental exam for your children. ☐ Yes
   - Help making an appointment or getting to the doctor or dentist. ☐ Yes

2. Do you or any family members want free or low-cost family planning services to help plan how to prevent unplanned pregnancies and/or have the next child? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.

✉ Please print your name, address, telephone and social security numbers in the space below. Return this form with your next Monthly Income Eligibility form.

Name:	_____	Telephone Number:	( ) _____
Address:	_____	Social Security Number:	_____
City:	_____	Zip Code:	_____

Temp 602B CHDP/FP Questionnaire Revision Date March 1999