

TABLE OF CONTENTS

SECTION 1 – CHILDREN’S MEDICAL SERVICES BRANCH AND PROGRAM DESCRIPTIONS	1
CHILDREN'S MEDICAL SERVICES BRANCH OVERVIEW.....	3
<i>Information Technology Section</i>	3
<i>Program Support Section</i>	3
<i>Regional Operations Sections</i>	4
<i>Statewide Programs Section</i>	4
<i>Program Development Section</i>	5
CALIFORNIA CHILDREN'S SERVICES OVERVIEW.....	6
<i>Program Description</i>	6
<i>Legislative Authority</i>	7
<i>Funding Description</i>	8
CHILD HEALTH AND DISABILITY PREVENTION PROGRAM OVERVIEW	10
<i>Program Description</i>	10
<i>Legislative Authority</i>	11
<i>Funding Description</i>	12
GENETICALLY HANDICAPPED PERSONS PROGRAM OVERVIEW.....	13
<i>Program Description</i>	13
<i>Legislative Authority</i>	14
<i>Funding Description</i>	15
HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE OVERVIEW	16
<i>Program Description</i>	16
<i>Legislative Authority</i>	16
<i>Funding Description</i>	17
<i>References</i>	17
NEWBORN HEARING SCREENING PROGRAM OVERVIEW	18
<i>Program Description</i>	18
<i>Legislative Authority</i>	18
<i>Funding Description</i>	18
SECTION 2 – PLAN AND BUDGET SUBMISSION	1
GENERAL INSTRUCTIONS.....	2
PLAN AND BUDGET REQUIRED DOCUMENTS CHECKLIST.....	6
AGENCY INFORMATION SHEET.....	8
CERTIFICATION STATEMENT - CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM.....	9
CERTIFICATION STATEMENT - CALIFORNIA CHILDREN’S SERVICES (CCS)	10
INCUMBENT LIST - CALIFORNIA CHILDREN’S SERVICES	11
INCUMBENT LIST - CHILD HEALTH AND DISABILITY PREVENTION PROGRAM	12
INCUMBENT LIST - HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE.....	13
MEMORANDA OF UNDERSTANDING/INTERAGENCY AGREEMENT LIST.....	14
SECTION 3 – SCOPE OF WORK AND PERFORMANCE MEASURES	1
CMS GOALS.....	3

CMS PROGRAM COMPONENTS – SCOPE OF WORK.....	4
USING AND REPORTING PERFORMANCE MEASURES IN CMS PROGRAMS.....	11
DIRECTIONS FOR COMPLETING THE REPORT OF PERFORMANCE MEASURES.....	12
CHDP PERFORMANCE MEASURE - CARE COORDINATION	13
REPORTING FORM:	13
CHDP PERFORMANCE MEASURE - NEW PROVIDER ORIENTATION.....	14
REPORTING FORM:	14
CHDP PERFORMANCE MEASURE - PROVIDER RECERTIFICATION	15
REPORTING FORM:	15
CHDP PERFORMANCE MEASURE - DESKTOP REVIEW.....	16
REPORTING FORM:	16
CHDP PERFORMANCE MEASURE - CHILDHOOD OVERWEIGHT.....	17
REPORTING FORM*:.....OVERWEIGHT PREVALENCE RATE BY CRITICAL AGE GROUP	17
HCPCFC PERFORMANCE MEASURE - CARE COORDINATION.....	20
REPORTING FORM:	20
HCPCFC PERFORMANCE MEASURE - HEALTH AND DENTAL EXAMS FOR CHILDREN IN OUT-OF-HOME PLACEMENT	21
REPORTING FORM:	21
CHDP PERFORMANCE MEASURE - SCHOOL ENTRY EXAMS - OPTIONAL -	22
<i>CHDP Optional Performance Measures</i>	23
CCS PERFORMANCE MEASURES.....	24
CCS PERFORMANCE MEASURE – MEDICAL HOME	25
CCS PERFORMANCE MEASURE – DETERMINATION OF CCS PROGRAM ELIGIBILITY.....	26
CCS PERFORMANCE MEASURE – SPECIAL CARE CENTER	27
CCS PERFORMANCE MEASURE – SPECIAL CARE CENTER	28
CCS PERFORMANCE MEASURE – TRANSITION PLANNING	29
CCS - TRANSITION PLANNING CHECKLIST	30
CCS PERFORMANCE MEASURE – FAMILY PARTICIPATION	31
REPORTING FORM:.....	32
SECTION 4 – DATA FORMS	1
GENERAL OVERVIEW	2
CALIFORNIA CHILDREN’S SERVICES CASELOAD SUMMARY INSTRUCTIONS	4
<i>Caseload Determination (for each fiscal year requested)</i>	5
CALIFORNIA CHILDREN’S SERVICES CASELOAD SUMMARY FORM	7
CHDP PROGRAM REFERRAL DATA	11
SECTION 5 – MEMORANDA OF UNDERSTANDING AND INTER/INTRA-AGENCY AGREEMENTS.....	1
GENERAL INSTRUCTIONS.....	2
CALIFORNIA CHILDREN’S SERVICES (CCS)	2
<i>Healthy Families Program:</i>	2
<i>Medi-Cal Managed Care Plans:</i>	2
<i>Special Education/Local Education Agency:</i>	2
<i>Other Programs:</i>	2
CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (CHDP).....	3
<i>Department of Social Services:</i>	3
<i>Health Care Program for Children in Foster Care (HCPCFC):</i>	3
<i>Medi-Cal Managed Care Plans:</i>	3

Other Programs:..... 3
 MEMORANDUM OF UNDERSTANDING CALIFORNIA CHILDREN’S SERVICES
 PROGRAM/HEALTHY FAMILIES PROGRAM PLAN4
 DELINEATION OF RESPONSIBILITIES FOR CHILDREN’S MEDICAL SERVICES BRANCH,
 REGIONAL OFFICES, AND DEPENDENT COUNTIES AS THEY RELATE TO THE HEALTHY
 FAMILIES MEMORANDUM OF UNDERSTANDING7
 COUNTY/CITY CHDP PROGRAM MODEL INTERAGENCY AGREEMENT 10
 MODEL HCPCFC MEMORANDUM OF UNDERSTANDING25

SECTION 6 - BUDGET INSTRUCTIONS..... 1

CMS BUDGET INSTRUCTIONS GENERAL INFORMATION AND DESCRIPTIONS FOR ALL CMS
 BUDGETS..... 3
 BUDGET TIPS.....6
 DEFINITIONS AND GUIDELINES7
 SAMPLE BUDGET JUSTIFICATION NARRATIVE 12
 COUNTY/CITY CAPITAL EXPENSES JUSTIFICATION FORM..... 15
 COUNTY/CITY OTHER EXPENSES JUSTIFICATION FORM 16
 CHDP BUDGET INFORMATION AND STAFFING GUIDELINES 17
 CHDP STAFFING MATRIX PROFILE GUIDELINES.....35
 SUMMARY CHDP STAFFING PROFILE 36
 CHDP ADMINISTRATIVE BUDGET WORKSHEET INSTRUCTIONS (NO COUNTY/CITY MATCH)
 37
 CHDP State General Funds and Medi-Cal State/Federal Funds 37
 CHDP NO COUNTY/CITY MATCH ADMINISTRATIVE BUDGET SUMMARY INSTRUCTIONS... 46
 CHDP ADMINISTRATIVE BUDGET WORKSHEET INSTRUCTIONS (COUNTY/CITY MATCH) ... 50
 CHDP COUNTY/CITY MATCH ADMINISTRATIVE BUDGET SUMMARY INSTRUCTIONS 58
 FOSTER CARE ADMINISTRATIVE (COUNTY/CITY MATCH) BUDGET WORKSHEET
 INSTRUCTIONS 61
 FOSTER CARE ADMINISTRATIVE (COUNTY/CITY MATCH) BUDGET SUMMARY INSTRUCTIONS
 67
 HCPCFC BUDGET INFORMATION AND STAFFING GUIDELINES 70
 HCPCFC BUDGET WORKSHEET INSTRUCTIONS (STATE/FEDERAL MATCH) 73
 HCPCFC ADMINISTRATIVE BUDGET SUMMARY INSTRUCTIONS 78
 CCS ADMINISTRATIVE BUDGET INFORMATION, STAFFING STANDARDS, AND CASELOAD
 INSTRUCTIONS 81
 CCS COUNTY STAFFING STANDARDS PROFILE 93
 CCS ADMINISTRATIVE BUDGET WORKSHEET INSTRUCTIONS..... 94
 CCS ADMINISTRATIVE BUDGET SUMMARY INSTRUCTIONS..... 101
 CMS BUDGET REVISION GENERAL INFORMATION 108
 CHDP ADMINISTRATIVE BUDGET REVISION INSTRUCTIONS (NO COUNTY/CITY MATCH) 110
 CHDP ADMINISTRATIVE BUDGET REVISION SUMMARY 110
 CHDP ADMINISTRATIVE BUDGET REVISION INSTRUCTIONS (COUNTY/CITY MATCH) 114
 FOSTER CARE ADMINISTRATIVE COUNTY/CITY MATCH BUDGET REVISION INSTRUCTIONS
 118
 HCPCFC BUDGET REVISION INSTRUCTIONS 122
 CCS ADMINISTRATIVE BUDGET REVISION INSTRUCTIONS..... 125
 Budget Revision Worksheet..... 125
 SAMPLE BUDGET REVISION JUSTIFICATION NARRATIVE 134

SECTION 7 – CHDP SPECIAL PROJECTS..... 1

SUBMITTING A SPECIAL PROJECT REQUEST	2
CHDP SPECIAL PROJECT REQUEST FORM	3
CHDP SPECIAL PROJECT SCOPE OF WORK	4
LETTERS OF SUPPORT	5
CHDP SPECIAL PROJECT BUDGETS	5
<i>Special Project Budget Instructions</i>	5
<i>Special Project Invoice Instructions</i>	5
CHDP SPECIAL PROJECT BUDGET	6
CHDP QUARTERLY SPECIAL PROJECT EXPENDITURE INVOICE	7
TIPS ON WRITING MEASURABLE OBJECTIVES.....	8
<i>Definition of Objectives</i>	8
<i>Guidelines for Stating Objectives</i>	8
<i>Examples of Objectives</i>	9
SECTION 8 – EXPENDITURE CLAIMS AND PROPERTY MANAGEMENT	1
GENERAL INFORMATION AND REQUIREMENTS FOR CHILDREN’S MEDICAL SERVICES (CMS) QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICES.....	2
GENERAL INFORMATION AND REQUIREMENTS FOR CHILDREN’S MEDICAL SERVICES (CMS) QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICES.....	2
CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS	5
HPCFC QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS.....	14
INSTRUCTIONS FOR PREPARATION OF CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM FOSTER CARE QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE	18
CCS QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS .	22
CCS ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS (SUPPLEMENTAL A).....	37
CCS ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS (SUPPLEMENTAL B).....	52
CCS DIAGNOSTIC, TREATMENT, AND THERAPY EXPENDITURE REPORTING ..	67
<i>PART I. SUMMARY REPORT OF DIAGNOSTIC AND TREATMENT EXPENDITURES</i>	67
<i>PART II. SUMMARY REPORT OF THERAPY EXPENDITURES</i>	70
CCS INSTRUCTIONS FOR CCS CLAIM FOR REIMBURSEMENT	85
CCS INSTRUCTIONS FOR CCS HEALTHY FAMILIES (HF)	87
QUARTERLY REPORT OF EXPENDITURES	87
MANAGEMENT OF EQUIPMENT PURCHASED WITH STATE FUNDS.....	90
EQUIPMENT IDENTIFICATION TAG TRANSMITTAL LETTER.....	95
SECTION 9 – FEDERAL FINANCIAL PARTICIPATION	1
TIME STUDY INSTRUCTIONS FOR ENHANCED/NONENHANCED TITLE XIX MEDICAID FUNDING	4
SKILLED PROFESSIONAL MEDICAL PERSONNEL QUIZ	13
TIME STUDY FUNCTION CODE DESCRIPTIONS AND GENERAL ACTIVITIES	15
FUNCTION 1 – OUTREACH	15
FUNCTION 2 – SPMP ADMINISTRATIVE MEDICAL CASE MANAGEMENT	15
FUNCTION 3 – SPMP INTRA/INTERAGENCY COORDINATION, COLLABORATION, AND ADMINISTRATION.....	16
FUNCTION 4 – NON-SPMP INTRA/INTERAGENCY COORDINATION, COLLABORATION, AND ADMINISTRATION.....	16
FUNCTION 5 – PROGRAM SPECIFIC ADMINISTRATION	17
FUNCTION 6 – SPMP TRAINING.....	17

FUNCTION 7 – NON-SPMP TRAINING	18
FUNCTION 8 – SPMP PROGRAM PLANNING AND POLICY DEVELOPMENT.....	18
FUNCTION 9 – QUALITY MANAGEMENT BY SKILLED PROFESSIONAL MEDICAL PERSONNEL	19
FUNCTION 10 – NON-PROGRAM SPECIFIC GENERAL ADMINISTRATION.....	19
FUNCTION 11 – OTHER ACTIVITIES	20
FUNCTION 12 – PAID TIME OFF	21
FEDERAL FINANCIAL PARTICIPATION EXAMPLES OF ACTIVITIES FOR CMS PROGRAMS	22
FUNCTION 1 – OUTREACH	22
<i>California Children's Services</i>	22
<i>Child Health and Disability Prevention Program</i>	22
<i>Health Care Program for Children in Foster Care</i>	23
FUNCTION 2 – SPMP ADMINISTRATIVE MEDICAL CASE MANAGEMENT	23
<i>California Children's Services</i>	23
<i>Child Health and Disability Prevention Program</i>	24
<i>Health Care Program for Children in Foster Care</i>	25
FUNCTION 3 – SPMP INTRA/INTERAGENCY COORDINATION, COLLABORATION, AND ADMINISTRATION.....	26
<i>California Children's Services</i>	26
<i>Child Health and Disability Prevention Program</i>	26
<i>Health Care Program for Children in Foster Care</i>	27
FUNCTION 4 – NON-SPMP INTRA/INTERAGENCY COORDINATION, COLLABORATION, AND ADMINISTRATION.....	28
<i>California Children's Services</i>	28
<i>Child Health and Disability Prevention Program</i>	28
FUNCTION 5 – PROGRAM SPECIFIC ADMINISTRATION	28
<i>California Children's Services</i>	28
<i>Child Health and Disability Prevention Program</i>	29
<i>Health Care Program for Children in Foster Care</i>	30
FUNCTION 6 – SPMP TRAINING.....	31
<i>California Children's Services</i>	31
<i>Child Health and Disability Prevention Program</i>	31
<i>Health Care Program for Children in Foster Care</i>	31
FUNCTION 7 – NON-SPMP TRAINING	32
<i>California Children's Services</i>	32
<i>Child Health and Disability Prevention Program</i>	32
<i>Health Care Program for Children in Foster Care</i>	33
FUNCTION 8 – SPMP PROGRAM PLANNING AND POLICY DEVELOPMENT.....	33
<i>California Children's Services</i>	33
<i>Child Health and Disability Prevention Program</i>	33
<i>Health Care Program for Children in Foster Care</i>	34
FUNCTION 9 – QUALITY MANAGEMENT BY SKILLED PROFESSIONAL MEDICAL PERSONNEL	34
<i>California Children's Services</i>	34
<i>Child Health and Disability Prevention Program</i>	35
<i>Health Care Program for Children in Foster Care</i>	36
FUNCTION 10 – NON-PROGRAM SPECIFIC GENERAL ADMINISTRATION.....	36
<i>California Children's Services, Child Health and Disability Prevention Program, and Health Care Program for Children in Foster Care</i>	36
FUNCTION 11 – OTHER ACTIVITIES	37

California Children's Services, Child Health and Disability Prevention Program, and Health Care Program for Children in Foster Care..... 37

FUNCTION 12 – PAID TIME OFF 37

FEDERAL FINANCIAL PARTICIPATION FORM AND EXCEL FILE INSTRUCTIONS..... 38

Time Study Forms..... 38

Monthly Form 38

Weekly Form..... 39

FFP Calculations..... 39

SECTION 10 – REFERENCES 1

STAFFING STANDARDS FOR CALIFORNIA CHILDREN'S SERVICES (HISTORICAL DOCUMENT)3

Figure 2: County Estimates of FTEs Required (Type and Number of Staff) 10

Figure 3: County Staffing Profiles (Number of Staff by Personnel Class and Active Cases)..... 11

THE STAFFING MATRIX AND FUNDING OF THE CHILD HEALTH AND DISABILITY PREVENTION PROGRAM (HISTORICAL DOCUMENT) 12

LEGISLATION, REGULATIONS, AND GUIDELINES FOR CCS..... 15

SELECTED STATE LAWS RELATING TO CCS..... 16

Health and Safety Code Section 16

Government Code Sections (Re: School Therapy Services) 29

Insurance Code (Re: Healthy Families) 33

Welfare and Institutions Code (Re: Medi-Cal Managed Care Contract Laws)..... 34

LEGISLATION, REGULATIONS, AND GUIDELINES FOR THE CHDP PROGRAM..... 39

SELECTED STATE LAWS RELATING TO THE CHDP PROGRAM 41

Health and Safety Code Section 41

Insurance Code (Re: CHDP Gateway)..... 52

Welfare and Institutions Code (Re: CHDP Gateway)..... 53

LEGISLATION, REGULATIONS, AND GUIDELINES FOR THE HCPCFC 57

SELECTED STATE LAWS RELATING TO THE HCPCFC..... 59

Welfare and Institutions Code Section 59

ANNUAL REVIEW FOR CASH AID AND FOOD STAMPS (TEMP CA 600) 65

CHDP PRE-ENROLLMENT APPLICATION (DHS 4073)..... 66

CHDP REFERRAL (PM 357)..... 67

CHDP REFERRAL FOR SAWS AUTOMATED TEMPLATE 70

CHDP REFERRAL FOR WELFARE CASE DATA SYSTEM COUNTIES 71

CONFIDENTIAL REFERRAL/FOLLOW UP REPORT (PM 161) 72

CONFIDENTIAL SCREENING/BILLING REPORT - STANDARD (PM 160) 73

CONFIDENTIAL SCREENING/BILLING REPORT – INFORMATION ONLY (PM 160 INFO ONLY) 75

MEDICAL AND DENTAL EXAMS FOR CHILDREN AND YOUTH AND FAMILY PLANNING SERVICES (TEMP 602 B)..... 77

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (MC 219) 78

MEDI-CAL/HEALTHY FAMILIES MAIL-IN APPLICATION (MC 321 HFP) 79

STATEMENT OF CITIZENSHIP, ALIENAGE, AND IMMIGRATION STATUS (MC 13) 80

STATEMENT OF FACTS FOR CASH AID, FOOD STAMPS, AND MEDI-CAL/STATE-RUN COUNTY MEDICAL SERVICES PROGRAM (SAWS 2)..... 81

MEDI-CAL NEW MAIL-IN APPLICATION AND INSTRUCTIONS (MC 210)..... 82

SECTION 11 – APPENDIX..... 1

THE ESSENTIAL SERVICES OF PUBLIC HEALTH AND TEN ESSENTIAL PUBLIC HEALTH SERVICES TO PROMOTE CHILD HEALTH IN AMERICA 2

DATA AND RESEARCH RESOURCE GUIDE..... 4

Child Care 4

Demographics 4

Education 4

Health..... 5

Social Services..... 7

ABBREVIATIONS AND ACRONYMS 8

REPORT OF HEALTH EXAMINATIONS -- ANNUAL SCHOOL REPORT (OPTIONAL) 12

..... 12

SECTION 12 – INDEX 1

**SECTION 1 – CHILDREN’S MEDICAL SERVICES BRANCH AND
PROGRAM DESCRIPTIONS**

Children's Medical Services Branch Overview3
 Information Technology Section3
 Program Support Section3
 Regional Operations Sections4
 Statewide Programs Section4
 Program Development Section5
California Children's Services Overview6
 Program Description6
 Legislative Authority7
 Funding Description8
Child Health and Disability Prevention Program Overview10
 Program Description10
 Legislative Authority11
 Funding Description12
Genetically Handicapped Persons Program Overview13
 Program Description13
 Legislative Authority14
 Funding Description15
Health Care Program for Children in Foster Care Overview16
 Program Description16
 Legislative Authority16
 Funding Description17
 References17
Newborn Hearing Screening Program Overview18

Program Description 18

Legislative Authority..... 18

Funding Description..... 18

Children's Medical Services Branch Overview

Website: www.dhs.ca.gov/cms

The Children's Medical Services (CMS) is a branch of the Primary Care and Family Health Division (PCFH) of the California Department of Health Care Services (CDHCS). The CMS Branch is responsible for the administration of three major statewide programs: the Child Health and Disability Prevention (CHDP) program, which includes the Health Care Program for Children in Foster Care (HCPCFC); the California Children's Services (CCS), which includes the Medical Therapy Program (MTP); and the Genetically Handicapped Persons Program (GHPP). The CMS Branch is also responsible for implementation, monitoring, and oversight of the Newborn Hearing Screening Program (NHSP) and special grants to serve special needs children such as the High Risk Infant Follow-Up (HRIF) Program and the Caring for California's Children Project. The mission of CMS is to assure the health of California's children.

The Branch is organized as follows:

Information Technology Section

The Information Technology Section is responsible for all aspects of information technology support for the CMS Branch and CMS Net, the Branch's automated case management system. This includes CMS Branch office products, CMS Net network support, CMS Net operations, CMS Net Help Desk operation. The section provides consultation to the Department of Technology Services regarding county LAN/WAN connectivity and is responsible for corrections and modifications to CMS Net application.

Program Support Section

The Program Support Section is composed of three units and has responsibility for a variety of activities in support of Branch operations. The units and functions are as follows:

- Administration Unit – responsible for fiscal, personnel, contracting, purchasing, and business services for the Branch. Staff in the unit review, approve, and monitor CCS county programs and CHDP county/city budgets and expenditures; resolve county budgeting/invoicing issues; develop and implement administrative and fiscal procedures for new programs administered by the Branch; develop and manage contracts and interagency agreements; process contract and county expenditure invoices; and maintain personnel and business services transactions for all CMS Branch staff. Unit staff also develop and participate in training programs for State and county program staff relating to the above areas of responsibility.
- Provider Services Unit – responsible for enrolling providers for the CCS, CHDP, and GHPP programs and acts as a liaison between CMS Branch programs, their providers, the Fiscal Intermediary and Contracts Oversight Division (formerly Medi-Cal Payment Systems Division), and the State fiscal intermediary, Electronic Data Systems (EDS). The PSU works with individual providers, hospitals, and CCS/GHPP Special Care Centers to resolve provider reimbursement issues. Staff in this unit also develop and conduct provider training to individual and group health care providers, hospitals, special care centers, clinics, etc. in statewide formal training seminars.

- Clerical Support Unit – provides general clerical support services to CMS Branch management and staff. The unit is responsible for completion of complex typing assignments, formatting of proposals, regulations, program standards, reports, research papers, etc. The Clerical Unit also assists in organizing and filing all program documents; responds to telephone calls, faxes, and e-mails; disseminates program information to State staff, local agencies, the general public, and various other organizations; coordinates meetings; and makes travel arrangements for Branch staff.

Regional Operations Sections

The Regional Operations Section (ROS) is composed of three CMS regional offices located in Sacramento, San Francisco, and Los Angeles. The section provides case management services for CCS-eligible clients residing in dependent counties (those with populations of less than 200,000). Case management services include, but are not limited to, determination of medical eligibility and authorizations for services, resolution of financial appeals, determination of eligibility for Medical Therapy Unit services, and program consultation/technical assistance.

Regional office professional staff also have oversight responsibilities for local CCS and CHDP programs, including evaluating and monitoring county CCS and local CHDP programs for compliance with federal and State regulations and local policies and procedures. Oversight responsibilities include, but are not limited to, program development, review and approval of annual budgets and work plans, provision of technical assistance and program consultation. The majority of Early and Periodic Screening, Diagnosis, and Treatment-Supplemental Services (EPSDT-SS) requests have been transitioned to the local counties for review and approval, however, the ROS consultant staff will continue to provide technical assistance, consultation, and will be responsible for review and approval of specific and unique EPSDT-SS requests that may be received statewide.

Staff in the regional offices are responsible for coordinating and facilitating on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures and for certifying outpatient rehabilitation centers located within CCS medical therapy units.

Statewide Programs Section

The Statewide Programs Section is responsible for administration of specialty programs with statewide responsibilities. There are three units within the section: Specialty Programs, Hearing and Audiology Services, and the Genetically Handicapped Persons Program.

- Specialty Programs Unit – responsible for implementation and monitoring of specialty programs under the purview of the CMS Branch such as the Caring for California's Children Project and the Health Care Program for Children in Foster Care. Staff in the unit are responsible for collaboration efforts with local programs in implementation activities and to ensure that providers, hospitals, Special Care Centers, other State programs, local agencies, community-based organizations, and

the general public are informed and assisted in the process of providing services to eligible populations.

- Hearing and Audiology Services Unit –Responsible for implementation and administration of the Newborn Hearing Screening Program (NHSP) and for the review and approval of outpatient infant screening providers and CCS audiology providers and facilities. The Unit provides technical assistance and consultation to providers and local CCS programs regarding NHSP and CCS Program policies and procedures relating to hearing services and assists in the resolution of unpaid provider claims for services. The Unit Staff compile and report NHSP data and monitor contracts with NHSP Hearing Coordination Centers which provide infant tracking and monitoring to ensure infants with suspected hearing loss receive needed services. The Unit supports the training of CHDP providers in the audiometric testing of hearing and fulfills the CDHCS component of the mandated statewide school hearing testing program. The latter includes the compilation, review and reporting of school testing data and the review and certification of school audiometrists.
- Genetically Handicapped Persons Program – provides all medical and administrative case management services for approximately 1550 clients statewide with serious, often life threatening, genetic conditions (i.e., hemophilia, cystic fibrosis, sickle cell anemia).

Program Development Section

The Program Development Section is responsible for the development and implementation of program policy, regulations, and procedures for the programs administered by the Branch and for provision of statewide consultation in a variety of professional health disciplines. The section consists of two units: Program Policy and Analysis Unit and Statewide Consultation Unit.

- Program Policy and Analysis Unit – responsible for development and implementation of program policy, regulations, and procedures for all programs administered by the Branch. Unit staff develop provider standards for CCS; develop policies and procedures to assist in the implementation of Medi-Cal Managed Care and the Healthy Families program; review and approve/deny all requests for organ transplants for children covered by CCS and Medi-Cal, and provide pediatric consultation to Medi-Cal and other CDHCS programs. The unit is also responsible for research and program analysis functions and development and implementation of a pharmaceutical rebate program for CCS and GHPP.
- Statewide Consultation Unit – staff provide expertise in the disciplines of medicine, nursing, social work, nutrition, dentistry, dental hygiene, health education, occupational therapy, and physical therapy and participate in the evaluation and monitoring of county CCS and local CHDP programs for compliance with federal and state regulations and local policies and procedures. Staff in the unit are also responsible for ensuring that all providers who deliver services to children are qualified and in good standing with the appropriate board under the Department of Consumer Affairs and for assisting with on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures.

California Children's Services Overview

Website: www.dhs.ca.gov/ccs

Program Description

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

The CCS program is administered as a partnership between county health departments and the California Department of Health Care Services (CDHCS). Currently, approximately 70 percent of CCS-eligible children are also Medi-Cal eligible. The Medi-Cal program reimburses their care. The cost of care for the other 30 percent of children served by the program is funded equally between the State and counties.

In counties with populations greater than 200,000 (independent counties), county staff perform all case management activities for eligible children residing within their county. This includes determining all phases of program eligibility, evaluating needs for specific services, determining the appropriate provider(s), and authorizing for medically necessary care. For counties with populations under 200,000 (dependent counties), the CMS Branch provides medical case management and eligibility and benefits determination through its regional offices located in Sacramento, San Francisco, and Los Angeles. Dependent counties interact directly with families and make decisions on financial and residential eligibility. Some dependent counties have opted to participate in the Case Management Improvement Project (CMIP) to partner with regional offices in determining medical eligibility and service authorization. The regional offices also provide consultation, technical assistance, and oversight to independent counties, individual CCS paneled providers, hospitals, and the Special Care Centers within their region.

Children eligible for CCS must be residents of California, have CCS eligible conditions, and have family adjusted gross income of forty thousand dollars or less in the most recent tax year. Children in families with higher incomes may still be eligible for CCS 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. In addition, the CCS program is responsible for authorization of medically necessary services and medical case management of Medi-Cal beneficiaries with no share of cost who meet CCS medical and age criteria.

Services authorized by the CCS program to treat a Healthy Families (HF)-enrolled child's CCS-eligible medical condition are excluded from the plan's responsibilities. The HF health plan remains responsible for providing primary care and prevention services not related to the CCS-eligible medical condition to the plan subscriber as long as they are within the HF program scope of benefits. The health plan is also responsible for children who are referred to but not determined to be eligible for the CCS program.

CCS currently provides services to approximately 175,000 children through a network of CCS paneled specialty and subspecialty providers and Special Care Centers.

The CCS Medical Therapy Program (MTP) provides physical therapy, occupational therapy, and Medical Therapy Conference (MTC) services to children who meet specific medical eligibility criteria. These services are provided in an outpatient clinic setting known as a Medical Therapy Unit (MTU) that is located on a public school site. Licensed physical therapists and occupational therapists provide evaluation, treatment, consultation services and case management to children with conditions such as cerebral palsy and other neurologic and musculoskeletal disorders. Services in the MTP require:

- A prescription for the physical and occupational therapy services to be delivered at an MTU and provided under the supervision of physicians (MTC, Special Care Centers, or private medical doctors).
- Coordination of services in the MTU under the medical management of a physician/therapy team. This is done through the MTC which is conducted at an MTU to plan for an individual child's need for, and level of, therapy services or through the prescription of a private medical provider.
- Participation from the child's family, school personnel, and other health care professional staff.

A child who is medically eligible for the MTP does not have to meet the CCS financial requirement to receive therapy or conference services through the MTP. However, if the MTC team recommends a service that is not provided by the MTP, the child must meet CCS financial eligibility, be a full scope Medi-Cal beneficiary with no share of cost, or be a Healthy Families subscriber. Services must be prescribed by a CCS paneled physician who has seen and examined the child for the CCS eligible condition.

The CMS Branch maintains procedures to meet the regulatory requirements to certify eligible MTUs as Outpatient Rehabilitation Centers (OPRCs). In a Memorandum of Understanding (MOU) with CDHS Licensing and Certification Division, the CMS Branch was given the responsibility for certifying MTUs. Certified MTUs can receive Medi-Cal provider numbers and bill for physical therapy and occupational therapy services provided to Medi-Cal eligible beneficiaries in the MTUs.

Legislative Authority

Health and Safety Code, 123800 et seq. is the enabling statute for the CCS program. The explicit legislative intent of the CCS program is to provide necessary medical services for children with CCS medically eligible conditions whose parents are unable to pay for these services, wholly or in part. The statute also requires the CDHCS and the county CCS program to seek handicapped children by cooperating with local public or private agencies and providers of medical care to bring eligible children to sources of expert diagnosis and treatment.

The CCS program is mandated by the Welfare and Institutions Code and the California Code of Regulations (Title 22, Section 51013) to act as an "agent of Medi-Cal" for Medi-Cal beneficiaries with CCS medically eligible conditions. Medi-Cal is to refer all CCS-eligible clients to CCS for case management services and prior authorization for

treatment. The statute also requires all CCS applicants who may be eligible for the Medi-Cal program to apply for that program.

Funding Description

The funding source for a county CCS program is a combination of monies appropriated by the county, State General Funds, and the federal government. AB 948, the realignment legislation passed in 1992, mandated that the State and county CCS programs share in the cost of providing specialized medical care and rehabilitation to physically handicapped children through allocations of State General Fund and county monies. The amount of State money available for the CCS program is determined annually through the Budget Act.

CCS program funds are categorized in two parts:

- A. Funding for payment for diagnostic and treatment services provided to eligible children with physically handicapping conditions, and physical/ occupational therapy services and medical therapy conference services provided at public school sites. Funding for these medical services in current fiscal years must be at least equivalent to the actual CCS expenditures claimed by the county during FY 1990-91. The county Boards of Supervisors annually must appropriate 25 percent of this amount and allocate an additional 25 percent from the County Social Services Trust Account. The State is mandated to match these funds within available State General Funds. Funding for children who are Medi-Cal beneficiaries and are case managed by the CCS program is covered by the Medi-Cal program. Federal Financial Participation (FFP) under Title XXI of the Social Security Act may be claimed for CCS-eligible children enrolled in the HF program. Funding for services for children who are HF subscribers is covered by federal funds (65 percent), with the remaining cost shared by the county (17.5 percent) and the State (17.5 percent).
- B. Reimbursement for administrative and operational costs of county CCS programs is shared between the State and county programs (Health and Safety Code, Section 123955 [a]). The 1991-92 realignment legislation developed the system of allocating administrative funds, including FFP for CCS Medi-Cal eligible children. Funding for administrative costs is based on CCS staffing standards and the caseload mix of CCS clients. County CCS programs are responsible for 50 percent of the administrative cost for the straight CCS non-Medi-Cal and 17.5 percent of administrative costs for the Healthy Families caseload with the State sharing an equal amount and 65 percent federal Title XXI funds; the State matches the costs to the extent funds are available in the State budget. Administrative costs incurred for the Medi-Cal portion of the CCS caseload are shared by the State and federal government by claiming Medi-Cal administrative reimbursement.

The funding process for the cost of medical care for diagnosis, treatment, and MTP services is based on an allocation to each county and is accomplished as follows:

- A. Each fiscal year the county CCS program must allocate a sum equal to 25 percent of the actual county CCS expenditures claimed during Fiscal Year 1990-91 (known as a maintenance of effort [MOE]).

- B. The CDHCS matches the MOE with State funds on a dollar-for-dollar basis to the extent that State funds are available.
- C. To secure the funds for CCS costs of care, a county must submit, on an annual basis, a letter of certification stating the amount of county funds that DHS will be asked to match.
- D. Counties that submit authorized medical service claims for individual CCS clients to the state CDHCS fiscal intermediary for payment prepare a "Report of Expenditure Invoice" and reimburse the CMS Branch for the county's share of diagnosis, treatment, and therapy services expenditures.
- E. Counties must process claims for authorized medical services through a county payment process and prepare an "Expenditure Invoice" to request payment of the State's 50 percent share of diagnosis, treatment, and therapy services expenditures.

Funding for county CCS administrative and operational costs is based on budgets prepared by the county CCS programs and approved by the CMS Branch. The following budgets are used to fund the administrative and operational costs of county CCS programs:

- A. The CCS Administrative Budget is based on CCS staffing standards and a caseload mix of CCS clients whose services are funded by a mix of county, state, Healthy Families Title XXI federal funds, and Medi-Cal Title XIX federal funds.
 - 1. County CCS programs are responsible for 50 percent of administrative costs incurred for the straight CCS non Medi-Cal caseload and 17.5 percent of administrative costs for the Healthy Families caseload with the State sharing an equal amount and 65 percent federal Title XXI funds.
 - 2. Administrative costs incurred by counties to pay for services for Medi-Cal beneficiaries are shared by the State and federal government. These funds are identified in specific sections of the CCS Administrative Budget.
 - 3. County programs must submit, by September 15 of each year for the subsequent fiscal year, an application known as an Administrative Budget Request for the county administrative cost of administration of the CCS program. Directions for budget completion are found in Section 6 – Budget Instructions.

Child Health and Disability Prevention Program Overview

Website: www.dhs.ca.gov/chdp

Program Description

The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities in children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment. The eligible population for the CHDP program includes all Medi-Cal eligible children/youth under age 21 and low-income non-Medi-Cal eligible children/youth under age 19 with family incomes at or below 200 percent of the federal income guidelines.

The CHDP Program is financed and has standards established at the State level. The Program is operated at the local level by local health departments for each county and three cities. The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth. The CHDP Program also provides preventive health assessments for non-Medi-Cal eligible children/youth. In the past, the program was responsible for monitoring the first grade entry program, which requires that all children entering the first grade or kindergarten have either a certificate of health examination or a waiver on file at their school. Due to legislative changes, AB 2855, Chapter 895, Statutes of 2004 included amendments to the Health and Safety (H&S) Code Section 124100. This amended H&S Code no longer requires every public school district and private school in California to report data on the number of children receiving health screening examinations at school entry. Therefore, public school districts and private schools are NOT required to submit the CHDP Annual School Report (PM 272) to the CHDP Program within the local health department. Private schools and public school districts may continue to gather and share this information at their discretion. (CHDP Program Letter No: 05-01).

The CHDP Program is responsible for resource and provider development to ensure that high quality services are delivered and available to eligible children/youth. In addition, the program informs the target populations to increase their participation; and community agencies and residents to increase the knowledge and acceptance of preventive services.

Local CHDP programs are also responsible for carrying out community activities which include planning, evaluation and monitoring, case management, informing, providing health education materials, provider recruitment, quality assurance, and client support services such as assistance with transportation and medical, dental, and mental health appointment scheduling and encouraging the completion of an application for ongoing health care coverage. Local CHDP programs are also responsible for oversight of the Health Care Program for Children in Foster Care (HCPCFC). For more information, see page 16.

In July 2003, the CHDP program began the CHDP Gateway using an automated pre-enrollment process for non Medi-Cal, uninsured children, serving as the entry point for

these children to enroll in ongoing health care coverage through Medi-Cal or the Healthy Families program. The CHDP Gateway is based on federal law found in Titles XIX and XXI of the Social Security Act that allows states to establish presumptive eligibility programs for children/youth.

When a child/youth seeks CHDP services at a provider's office, CHDP providers enter the client's information through the Internet or a Point of Service (POS) Device using the CHDP Pre-Enrollment Application (DHS 4073) (see sample in Section 10, Page 66). In accordance with the CHDP periodicity schedule and age and income requirements, the CHDP program pre-enrolls the child/youth into full scope, no-cost temporary Medi-Cal for the month of their CHDP health assessment and the following month. Children/youth who are not eligible for either program continue to receive CHDP services in accordance with the CHDP periodicity schedule. Parents or legal guardians may indicate on the DHS 4073 that they want to receive an application for continuing health care coverage for their child beyond the pre-enrollment period. For more information, refer to the CHDP Provider Manual located at http://files.medi-cal.ca.gov/pubsdoco/pubsframe.asp?hURL=/pubsdoco/CHDP_search.asp

Legislative Authority

The CHDP program enabling statute provides the following authority:

- A. "...[C]hild 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." (Health and Safety Code, Section 124025).
- B. The DHS is given the authority to develop and implement the format and procedures that local CHDP programs utilize to prepare and submit a multi-year base plan on or before September 15 of each year. Each county program director submits an update to the multi-year base community CHDP plan as well as a budget update for the subsequent fiscal year (Health and Safety Code, Section 124060).
- C. Local CHDP programs are reimbursed from the appropriation made for the fiscal year when the expenses on which the claim is based are incurred (Health and Safety Code, Section 124070).
- D. The DHS is given the statutory authority to develop a schedule and method of reimbursement at reasonable rates for services rendered. The reimbursement schedule shall include provisions for well child examinations as well as for administrative expenses incurred by providers (Health and Safety Code, Section 124075).
- E. State and local CHDP programs maximize the use of federal funds and use state and/or county/city funds to match funds claimable under Title XIX of the Social Security Act. Services and administrative support costs claimable under federal

law may include but are not limited to outreach, health education, case management, resource development, and training at state and local levels. Any federal funds received are used to augment, not replace, funds appropriated from State General Funds (Health and Safety Code, Section 124075).

Funding Description

- A. Target population, health assessments, and active CHDP providers form the basis for each CHDP local program's fiscal year funding from the annual state appropriation for CHDP (see Section 4 - Data Forms).
- B. Funding for county/city CHDP administrative and operational costs is based on budgets prepared by the CHDP local program and approved by the CMS Branch (see Section 6 - Budget Instructions).
- C. Medi-Cal children/youth under age 21 receive services under the Federal Title XIX program known as the EPSDT program. The EPSDT program is part of the Medi-Cal program and is funded by state general and federal funds.
- D. Low-income children/youth under age 19 with family incomes up to 200 percent of the federal income guidelines, and without preventive health care coverage are temporarily enrolled through the CHDP Gateway process into full scope, no-cost temporary Medi-Cal for the month of their CHDP health assessment and the following month. These services are funded by state general and federal funds under the EPSDT and Healthy Families (Title XXI) program.
- E. Low-income children/youth not eligible through the CHDP Gateway pre-enrollment process for the Medi-Cal or Healthy Families program receive CHDP services paid for by state general funds.

Genetically Handicapped Persons Program Overview

Website: www.dhs.ca.gov/pcf/cms/ghpp

Program Description

The GHPP provides medical and administrative case management and funds medically necessary services for California residents over the age of 21 with GHPP-eligible medical conditions. Persons under age 21 with GHPP eligible conditions may also be eligible for GHPP if they have first been determined financially ineligible to receive services from the CCS program. Examples of GHPP-eligible conditions include, but are not limited to, genetic conditions such as:

- Charcot-Marie-Tooth Syndrome
- Cystic Fibrosis
- Disorders of carbohydrate transport and metabolism, i.e., Galactosemia
- Disorders of copper metabolism, i.e., Wilson's Disease
- Friedreich's Ataxia
- Hemophilia and other specific genetic coagulation defects
- Hereditary Spastic Paraplegia
- Huntington's Disease
- Inborn errors of metabolism including disorders of amino-acid transport and metabolism, such as Phenylketonuria (PKU)
- Joseph's Disease
- Refsum's Disease
- Rousy-Levy Syndrome
- Sickle Cell Disease including Thalassemia
- von Hippel-Lindau Syndrome

Referrals to the GHPP come from a variety of sources including hospital staff, physicians' offices, community health care providers, school nurses, public health departments, family members, and self-referrals. The GHPP is responsible for authorization of medically necessary services and medical case management of Medi-Cal beneficiaries not in managed care plans. Currently there are approximately 1,550 clients enrolled in GHPP.

Program service benefits require prior authorization by GHPP. These benefits include services such as:

- Blood transfusions and blood derivatives
- Durable medical equipment
- Expert diagnosis
- Genetic and psychological counseling
- Home health care
- Hospital care
- Initial intake and diagnostic evaluation
- Inpatient/outpatient medical and surgical treatment
- Maintenance and transportation
- Medical and surgical treatment
- Physical therapy, occupational therapy, speech therapy
- Rehabilitation services, including reconstructive surgery
- Respite care
- Specified prescription drugs
- Treatment services

The GHPP has a system of Special Care Centers (SCC) that provide comprehensive, coordinated health care to clients with specific genetic GHPP medically eligible conditions. The GHPP SCCs are multi-disciplinary, multi-specialty teams that evaluate the GHPP client's medical condition and develop a comprehensive, family-centered plan of healthcare that facilitates the provision of timely, coordinated treatment.

Legislative Authority

The Holden-Moscone-Garamendi Genetically Handicapped Persons Program (SB 2265 1975, 1976, 1977, 1980, 1982) was the enabling legislation for GHPP. In 1975, the Program was enacted to pay for medical care and to provide medical case management for persons with Hemophilia. In 1976, Cystic Fibrosis was added by legislation. In 1977, Sickle Cell Disease was added to the GHPP. In subsequent years, conditions such as Huntington's Disease, Joseph's Disease, Friedreich's Ataxia, von Hippel-Lindau Syndrome, PKU, and other metabolic conditions were included. The legal authority for GHPP is the Health and Safety Code, Chapter 2, Section 125125 et. seq.

Funding Description

The GHPP is a State-funded program which receives funds through the State General Fund. The GHPP also generates funds from enrollment fees that some clients, depending on their financial resources, are required to pay. Medi-Cal funds are utilized for GHPP clients who are Medi-Cal beneficiaries, but who are not in a Medi-Cal Managed Care Plan. The GHPP clients who have other healthcare insurance must utilize their other healthcare insurance first before funding is available from the State General Fund. The GHPP is the payer of last resort.

Health Care Program for Children in Foster Care Overview

Website: www.dhs.ca.gov/hcpcf

Program Description

The Health Care Program for Children in Foster Care (HCPCFC) is a public health nursing program administered by local public health department Child Health and Disability Prevention (CHDP) programs to provide public health nursing expertise in meeting the medical, dental, mental and developmental health needs of children and youth in out-of-home placement or foster care. The public health nurses (PHNs) work with the child's social worker or probation officer as a team member to ensure that children in foster care receive needed health services. PHNs provide health care oversight of the medical, dental, behavioral, and development needs and services, including those placed "out-of-county" and "out-of-state". The PHNs assist the social worker and probation officer in the entry and update of the child's medical and health information in the required record known as the Health and Education Passport (HEP). The PHNs collaborate with the foster care team in the provision of training programs for foster parents, health care providers, and child welfare, probation, and juvenile court staff.

In their role as consultants to child welfare workers and probation officers, PHNs assist in meeting the challenges of delivering health care to children and youth in foster care by coordinating services with multiple caregivers, health care providers, agencies, and organizations. The PHNs participate in interdisciplinary team conferences and they assist with the transition from foster care by linking the child to community resources to meet the health care services needs upon termination of foster care.

Since the HCPCFC is a program within the local CHDP program, the required administrative activities of budget preparation and management, nursing supervision, and implementation of the HCPCFC Memorandum of Understanding (MOU) are the responsibility of the CHDP program. Collaboration among the local health, welfare, and probation departments in the development and implementation of the MOU is recognized as being fundamental to the success of the HCPCFC.

To assist and monitor local program implementation of the HCPCFC, the California Department of Health Services (CDHS) through a Letter of Agreement with the California Department of Social Services (CDSS) develops budget methodology, provides guidance on required program activities and performance measures, and recommends content of the local interdepartmental HCPCFC MOU.

Legislative Authority

The State Budget Act of 1999 appropriated State General Funds to the CDSS for the purpose of increasing the use of PHNs in meeting the health care needs of children in foster care. These funds were transferred to CDHCS for distribution through the local CHDP program as an augmentation to operate the HCPCFC. The legal authority for the HCPCFC is the Welfare and Institutions Code, Section 16501.3 (a) through (e).

Funding Description

Caseload data for children and probation youth in foster care from the Child Welfare System/Case Management System (CWS/CMS), maintained by the CDSS form the basis for each CHDP local program's fiscal year funding from the annual state appropriation for HCPCFC (see Section 6 – Budget Instructions). The source of funds for the HCPCFC Administrative Budget is State General Funds matchable with up to 75 percent Federal Funds (XIX). The source of funds for the optional CHDP Foster Care Administrative Budget County/City Match is county/city funds matchable with up to 75 percent Federal Funds (XIX).

Funding for county/city HCPCFC administrative and operational costs is based on budgets prepared by the local CHDP program and approved by the CMS Branch (see Section 6 – Budget Instructions). PHN and Supervising PHN Personnel, Operating and Internal Indirect costs are the budget categories.

References

- [CHDP Program Letter 99-06](#) (October 21, 1999) regarding “Health Care Program for Children in Foster Care”
- CMS Branch Correspondence and Attachments (October 25, 1999) regarding “Health Care Program for Children in Foster Care”
- [All County Letter 99-108](#) (December 21, 1999) regarding “Instructions Regarding Local Memorandum of Understanding for Health Care Program for Children in Foster Care”
- [All County Information Notice I-55-99](#) (September 2, 1999) regarding “New Foster Care Public Health Nurse Program in County Welfare Departments”
- [CHDP Program Letter 03-15](#) (July 25, 2003) regarding “Revisions to the HCPCFC Administrative Funding Methodology and Budget Format
- [CHDP Program Letter 06-05](#) (May 12, 2006) regarding “Revisions to the Health Care Program For Children in Foster Care (HCPCFC) Administrative Funding Methodology”

Newborn Hearing Screening Program Overview

Website: www.dhs.ca.gov/nhsp

Program Description

The NHSP has established a comprehensive coordinated system of early identification and provision of appropriate services for infants with hearing loss. The program offers the parents of all infants born in CCS-approved hospitals the opportunity to have their babies screened for hearing loss in the hospital at the time of birth; tracks and monitors all infants who need follow-up testing and diagnostic evaluations; and provides access to medical treatment and other appropriate educational and support services.

The NHSP has contracted with four organizations to serve as Hearing Coordination Centers (HCC): Miller Children's Hospital, Loma Linda University, Sutter Memorial Hospital, and John Muir/Mt. Diablo Health System. These HCCs are responsible for certifying CCS approved hospitals to participate in the program, assuring the quality of the hospital hearing screening services, and tracking of infants needing follow-up testing.

The program has available educational and outreach materials in multiple languages for parents and providers.

Legislative Authority

The enabling legislation for the NHSP was Assembly Bill 2780, Chapter 310, Statutes of 1998. This legislation defined the components of the program, amended Health and Safety Code Section 123975, and added Sections 124115-124120.5 to the Health and Safety Code.

Funding Description

The NHSP is funded through the State General Fund with matching funds from the Medi-Cal program. Reimbursement for inpatient and outpatient screenings is available to certified providers for infants whose care is paid for by the Medi-Cal program and those infants who have no expectation or evidence of a third party payer. Medi-Cal reimbursement is paid on a fee-for-service basis outside of the hospital per diem rate, regardless of whether the child is enrolled in a Medi-Cal Managed Care plan or has fee-for-service Medi-Cal. Reimbursement for uninsured children is available through the State CCS program using State General Funds.

SECTION 2 – PLAN AND BUDGET SUBMISSION

General Instructions	2
Plan and Budget Required Documents Checklist	6
Agency Information Sheet	8
Certification Statement - Child Health and Disability Prevention (CHDP) Program	9
Certification Statement - California Children's Services (CCS)	10
Incumbent List - California Children's Services	11
Incumbent List - Child Health and Disability Prevention Program	12
Incumbent List - Health Care Program for Children in Foster Care.....	13
Memoranda of Understanding/Interagency Agreement List	14

General Instructions

Submit one original and three copies of the CMS plan and budget package to your CMS Regional Administrative Consultant. The plan is composed of the documents that are required for submission.

Individual CCS, CHDP, and HCPCFC budgets will be approved only when all required documents have been submitted and reviewed by the appropriate regional office staff. Unless specified, counties should submit one package for all three CMS programs. Beginning with Fiscal Year (FY) 2006-07, the CMS Branch requires counties to submit two separately signed Certification Statements, one for CHDP and another for CCS. The Certification Statements and Interagency Agreement, however, may be sent under separate cover after other documents have been submitted. **All pages must be numbered and dated.** After assembling the plan and budget package, complete the Checklist and include the Checklist in the plan and budget package.

The following are required documents of the CMS plan and budget package for Fiscal Year (FY) 2007-08:

I. Checklist (see page 6)

The CMS Plan and Budget Required Documents Checklist assists in identifying the contents and sequence of the documents for submission in the plan package. The contents of the package must be submitted in the sequence reflected on the checklist.

II. Agency Information Sheet (see page 8)

Complete the Agency Information Sheet with **all of the following**:

- A. Official name and address of the county/city agency in which the CCS, CHDP, and HCPCFC programs are organizationally located
- B. Name and contact information of the CMS Director, if any
- C. Name and contact information of the CCS Administrator
- D. Name and contact information of the CHDP Director (must be a physician)
- E. Name and contact information of the CHDP Deputy Director
- F. Name and contact information of the Clerk of the County Board of Supervisors or City Council
- G. Name and contact information of the Director of the Social Services Agency for the HCPCFC Program
- H. Name and contact information of the Chief Probation Officer for the HCPCFC Program

III. Certification Statements (see pages 9 and 10)

- A. For the CHDP Certification Statement, obtain current signatures, including the dates signed, of the CHDP Director, Director/Health Officer, and the chairperson of the local governing body, as required.
- B. For the CCS Certification Statement, obtain current signatures, including the dates signed, of the CCS Administrator, Director/Health Officer, and the chairperson of the local governing body, as required.
- C. Submit the CHDP and CCS original Certification Statements (with signatures) and one photocopy to the Regional Office. The Certification Statements are valid for one year.
- D. The citations of current federal and state legislation and regulations for the CCS, CHDP, and HCPCFC programs are listed in Section 10 - References.
- E. An additional line for the signature of any other person with fiscal or programmatic responsibility is included for optional use.

IV. Agency Description

- A. Describe in brief narrative:
 - 1. The structure of the agencies in which CCS, CHDP, and HCPCFC programs are located;
 - 2. The current organizational structures of the CCS, CHDP, and HCPCFC programs within the local agencies (Health and/or Social Services);
 - 3. The affiliation and integration of the CCS, CHDP, and HCPCFC programs within the agency and county structure; and
 - 4. Anticipated changes that will take place before the next fiscal year.
- B. Submit current organizational charts for CHDP, HCPCFC and CCS with names of incumbent staff using the **same job titles** as listed on the budget worksheets.
- C. Submit a copy of the CCS Staffing Standards Profile (Section 6, page 93) and highlight the caseload category for your county/city. For counties with total caseloads below 500, write the words "Below 500" at the top of the CCS Staffing Standards Profile and highlight those words only.
- D. Complete Incumbent List (see pages 11 through 13) for CCS, CHDP, and HCPCFC programs.
- E. Submit civil service classification statements for newly established, proposed, or revised classifications.
- F. Submit duty statements for all staff budgeted to the programs **if there are changes from the previous year** (see pages 11 through 13).
 - 1. Changes are defined as:

- a. Changes in job duties or activities, or
 - b. Changes in percentage of time allotted for each activity.
 - c. Changes in percentages of time allotted for enhanced and non-enhanced activities.
2. Include in the duty statement **all of the following**:
 - a. Position title,
 - b. Civil service classification,
 - c. Percent FTE in CCS, CHDP, and/or HCPCFC program(s) and percent FTE in other program(s) if applicable, and
 - d. Actual job duties appropriate and specific to the CCS, CHDP, and/or HCPCFC program **with an estimated percentage of time allocated to each activity** (see Documentation of Staff and Time for more information (see Section 9, page 8).
 3. If staff work in multiple programs, submit separate job duty statements for each program.

V. Implementation of Performance Measures (see Section 3 – Scope of Work and Performance Measures)

- A. CCS, CHDP, and HCPCFC programs under joint administrations should submit joint Performance Measures when reporting to the CMS Branch.
- B. CCS, CHDP, and HCPCFC programs under separate administrations should collaborate to ensure coordination of services and resources and cooperatively submit one package when reporting Performance Measures to the CMS Branch.
- C. Performance Measures should be reported in the appropriate reporting format, except for those Performance Measures that specifically require a county tracking system.
- D. Data collection for these Performance Measures began with Fiscal Year 2002-03. **Reporting on these Performance Measures is due November 30, 2007 for Fiscal Year (FY) 2006-07.**

VI. Data Forms

- A. CCS Caseload Summary (see Section 4, pages 4-7).
- B. CHDP Program Management Data (see Section 4, page 8)

VII. Memoranda of Understanding (MOU) and Interagency Agreements (IAA) List (see page 14)

- A. List all current MOUs and IAAs
- B. Submit all MOUs and IAAs that are new, renewed, or have been revised since the prior fiscal year.
 - 1. Submit CHDP IAA with DSS biennially.
 - 2. Submit Interdepartmental MOU for HCPCFC biennially.

VIII. Budgets

- A. CHDP Administrative Budget (No County/City Match)
 - Budget Summary
 - Budget Worksheet
 - Budget Justification Narrative
- B. CHDP Administrative Budget (County/City Match) – **Optional**
 - Budget Summary
 - Budget Worksheet
 - Budget Justification Narrative
- C. Foster Care Administrative Budget (County/City Match) – **Optional**
 - Budget Summary
 - Budget Worksheet
 - Budget Justification Narrative
- D. HCPCFC Administrative Budget
 - Budget Summary
 - Budget Worksheet
 - Budget Justification Narrative
- E. CCS Administrative Budget
 - Budget Summary
 - Budget Worksheet
 - Budget Justification Narrative
 - Worksheet to Determine Healthy Families Funding Sources

Plan and Budget Required Documents Checklist

County/City: _____

Fiscal Year: 2007-08

Document	Page Number
1. Checklist	_____
2. Agency Information Sheet	_____
3. Certification Statements	_____
A. Certification Statement (CHDP) – Original and one photocopy	_____
B. Certification Statement (CCS) – Original and one photocopy	_____
4. Agency Description	_____
A. Brief Narrative	_____
B. Organizational Charts for CCS, CHDP, and HCPCFC	_____
C. CCS Staffing Standards Profile	_____
D. Incumbent Lists for CCS, CHDP, and HCPCFC	_____
E. Civil Service Classification Statements – Include if newly established, proposed, or revised	_____
F. Duty Statements – Include if newly established, proposed, or revised	_____
5. Implementation of Performance Measures – Performance Measures for FY 2006-07 are due November 30, 2007.	N/A
6. Data Forms	_____
A. CCS Caseload Summary	_____
B. CHDP Case Management Data	_____
7. Memoranda of Understanding and Interagency Agreements List	_____
A. MOU/IAA List	_____
B. New, Renewed, or Revised MOUs or IAAs	_____
C. CHDP IAA with DSS biennially	_____
D. Interdepartmental MOU for HCPCFC biennially	_____
8. Budgets	_____
A. CHDP Administrative Budget (No County/City Match)	_____
1. Budget Summary	_____
2. Budget Worksheet	_____

County/City: _____

Fiscal Year: 2007-08

Document	Page Number
3. Budget Justification Narrative	_____
B. CHDP Administrative Budget (County/City Match) - Optional	_____
1. Budget Worksheet	_____
2. Budget Justification Narrative	_____
3. Budget Justification Narrative	_____
C. Foster Care Administrative Budget (County/City Match) - Optional	_____
1. Budget Summary	_____
2. Budget Worksheet	_____
3. Budget Justification Narrative	_____
D. HCPCFC Administrative Budget	_____
1. Budget Summary	_____
2. Budget Worksheet	_____
3. Budget Justification Narrative	_____
E. CCS Administrative Budget	_____
1. Budget Summary	_____
2. Budget Worksheet	_____
3. Budget Justification Narrative	_____
4. Worksheet to Determine Healthy Families Funding Source	_____
F. Other Forms	_____
1. County/City Capital Expenses Justification Form	_____
2. County/City Other Expenses Justification Form	_____

Agency Information Sheet

County/City: _____

Fiscal Year: 2007-08

Official Agency

Name: _____	Address: _____
Title: _____	_____
_____	_____

CMS Director (if applicable)

Name: _____	Address: _____
Phone: _____	_____
Fax: _____	E-Mail: _____

CCS Administrator

Name: _____	Address: _____
Phone: _____	_____
Fax: _____	E-Mail: _____

CHDP Director

Name: _____	Address: _____
Phone: _____	_____
Fax: _____	E-Mail: _____

CHDP Deputy Director

Name: _____	Address: _____
Phone: _____	_____
Fax: _____	E-Mail: _____

Clerk of the Board of Supervisors or City Council

Name: _____	Address: _____
Phone: _____	_____
Fax: _____	E-Mail: _____

Director of Social Services Agency

Name: _____	Address: _____
Phone: _____	_____
Fax: _____	E-Mail: _____

Chief Probation Officer

Name: _____	Address: _____
Phone: _____	_____
Fax: _____	E-Mail: _____

Certification Statement - Child Health and Disability Prevention (CHDP) Program

County/City: _____

Fiscal Year: 2007-08

I certify that the CHDP Program will comply with all applicable provisions of Health and Safety Code, Division 106, Part 2, Chapter 3, Article 6 (commencing with Section 124025), Welfare and Institutions Code, Division 9, Part 3, Chapters 7 and 8 (commencing with Section 14000 and 14200), Welfare and Institutions Code Section 16970, and any applicable rules or regulations promulgated by DHS pursuant to that Article, those Chapters, and that section. I further certify that this CHDP Program will comply with the Children's Medical Services Plan and Fiscal Guidelines Manual, including but not limited to, Section 9 Federal Financial Participation. I further certify that this CHDP Program will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.). I further agree that this CHDP Program may be subject to all sanctions or other remedies applicable if this CHDP Program violates any of the above laws, regulations and policies with which it has certified it will comply.

Signature of CHDP Director

Date Signed

Signature of Director or Health Officer

Date Signed

Signature and Title of Other – Optional

Date Signed

I certify that this plan has been approved by the local governing body.

Signature of Local Governing Body Chairperson

Date

Certification Statement - California Children's Services (CCS)

County/City: _____

Fiscal Year: 2007-08

I certify that the CCS Program will comply with all applicable provisions of Health and Safety Code, Division 106, Part 2, Chapter 3, Article 5, (commencing with Section 123800) and Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000-14200), and any applicable rules or regulations promulgated by DHS pursuant to this article and these Chapters. I further certify that this CCS Program will comply with the Children's Medical Services Plan and Fiscal Guidelines Manual, including but not limited to, Section 9 Federal Financial Participation. I further certify that this CCS Program will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.) and recipients of funds allotted to states for the Maternal and Child Health Services Block Grant pursuant to Title V of the Social Security Act (42 U.S.C. Section 701 et seq.). I further agree that this CCS Program may be subject to all sanctions or other remedies applicable if this CCS Program violates any of the above laws, regulations and policies with which it has certified it will comply.

Signature of CCS Administrator

Date Signed

Signature of Director or Health Officer

Date Signed

Signature and Title of Other – Optional

Date Signed

I certify that this plan has been approved by the local governing body.

Signature of Local Governing Body Chairperson

Date

State of California - Health and Human Services Agency Department of Health Services - Children's Medical Services Branch

Incumbent List - California Children's Services

For FY 2007-08, complete the table below for all personnel listed in the CCS budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. Only submit job duty statements and civil service classification statements that are new or have been revised. This includes (1) changes in job duties or activities, (2) changes in percentage of time spent for each activity, and (3) changes in percentage of time spent for enhanced and non-enhanced job duties or activities.

Identify Nurse Liaison positions using: **MCMC** for Medi-Cal Managed Care; **HF** for Healthy Families; **IHO** for In-Home Operations, and; **RC** for Regional Center.

County/City: _____

Fiscal Year: 2007-08

Job Title	Incumbent Name	FTE % on CCS Admin Budget	FTE % in Other Programs (Specify)	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)

State of California - Health and Human Services Agency Department of Health Services - Children's Medical Services Branch

Incumbent List - Child Health and Disability Prevention Program

For FY 2007-08, complete the table below for all personnel listed in the CHDP budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. Only submit job duty statements and civil service classification statements that are new or have been revised. This includes (1) changes in job duties or activities, (2) changes in percentage of time spent for each activity, and (3) changes in percentage of time spent for enhanced and non-enhanced job duties or activities.

County/City: _____

Fiscal Year: 2007-08

Job Title	Incumbent Name	FTE % on CHDP No County/ City Match Budget	FTE % on CHDP County/City Match Budget	FTE % in Other Programs (Specify)	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)

State of California - Health and Human Services Agency Department of Health Services - Children's Medical Services Branch

Incumbent List - Health Care Program for Children in Foster Care

For FY 2007-08, complete the table below for all personnel listed in the HCPCFC and Foster Care Administrative (County/City) budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. Only submit job duty statements and civil service classification statements that are new or have been revised. This includes (1) changes in job duties or activities, (2) changes in percentage of time spent for each activity, and (3) changes in percentage of time spent for enhanced and non-enhanced job duties or activities.

County/City: _____

Fiscal Year: 2007-08

Job Title	Incumbent Name	FTE % on HCPCFC Budget	FTE % on FC Admin County/City Match Budget	FTE % in Other Programs (Specify)	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)

State of California - Health and Human Services Agency Department of Health Services - Children's Medical Services Branch

Memoranda of Understanding/Interagency Agreement List

List all current Memoranda of Understanding (MOUs) or Interagency Agreements (IAAs) in California Children's Services, Child Health and Disability Prevention Program, and Health Care Program for Children in Foster Care. Specify whether the MOU or IAA has changed. Submit only those MOUs and IAAs that are new, have been renewed, or have been revised. For audit purposes, counties or cities should maintain current MOUs and IAAs on file.

County/City: _____

Fiscal Year: 2007-08

Title or Name of MOU/IAA	Is this a MOU or an IAA?	Effective Dates From/To	Date Last Reviewed by County/ City	Name of Person Responsible for this MOU/IAA?	Did this MOU/IAA Change? (Yes or No)

SECTION 3 – SCOPE OF WORK AND PERFORMANCE MEASURES

CMS Goals	3
CMS Program Components – Scope of Work.....	4
Using and Reporting Performance Measures in CMS Programs	11
Directions for Completing the Report of Performance Measures	12
CHDP Performance Measure - Care Coordination	13
Reporting Form:	13
CHDP Performance Measure - New Provider Orientation	14
Reporting Form:	14
CHDP Performance Measure - Provider Recertification	15
Reporting Form:	15
CHDP Performance Measure - Desktop Review	16
Reporting Form:	16
CHDP Performance Measure - Childhood Overweight	17
Reporting Form*: Overweight Prevalence Rate by Critical Age Group	17
HCPCFC Performance Measure - Care Coordination	20
Reporting Form:	20
HCPCFC Performance Measure - Health and Dental Exams for Children in Out-of-Home Placement	21
Reporting Form:	21
CHDP Performance Measure - School Entry Exams - OPTIONAL -	22
CHDP Optional Performance Measures	23
CCS Performance Measures	24
CCS Performance Measure – Medical Home	25
CCS Performance Measure – Determination of CCS Program Eligibility.....	26
CCS Performance Measure – Special Care Center.....	27
CCS Performance Measure – Special Care Center.....	28

CCS Performance Measure – Transition Planning29

CCS - Transition Planning Checklist 30

CCS Performance Measure – Family Participation31

Reporting form:32

Children's Medical Services (CMS) Branch used Fiscal Year 2002-03 to transition from an annual individualized reporting format to a continuous quality improvement format to evaluate and improve the performance of both local CMS programs and the CMS Branch. The guiding principles used to complete this transition were the CMS Branch Mission and Vision Statements.

Mission: Assuring the health of California's children.

Vision Statement: Children's Medical Services is the leader in assuring the health of California's children through access to services for all children, in an environment committed to excellence, in partnership with families and communities, as supported by information and communication.

During Fiscal Year 2002-03, a statewide workgroup assembled to review and revise the CMS Scope of Work and to incorporate performance measures in the context of our mission and vision statement. The five CMS broad goals, used over the past several years as a way of providing focus for local programs, were condensed into four. The workgroup considered the former CMS goal 1 "Children will receive quality medical, dental, and support services across all provider settings" duplicated concepts in the other goal statements.

Four goal statements continue to provide the foundation for program components and activities that move local California Children's Services (CCS), Child Health and Disability Prevention (CHDP), Health Care Program for Children in Foster Care (HCPFC) programs toward meeting the CMS Mission and Vision Statement.

CMS Goals

Goal 1: Families, children, and providers will be assisted in how to use new and ongoing CMS program services, and access and navigate changing health care systems to assure effective, continuous care delivery.

Goal 2: Health and support services for children with special physical, emotional and social health needs will be addressed efficiently and effectively by qualified CMS providers, private and public offices and clinics, special care centers, regional centers, medical therapy programs and through home health agencies.

Goal 3: Clinical preventive services will be provided to children eligible for CMS programs.

Goal 4: CMS outreach activities will be conducted to assure that all eligible children and their families are informed of program services in a manner that is culturally and linguistically competent.

CMS Program Components – Scope of Work

The day-to-day operations of the CCS, CHDP, and HCPCFC programs have been outlined in Program Components with associated activities. These Program Components are the basic required activities that must be performed to meet Federal and State requirements. The Program Components and activities are the CMS Branch Scope of Work.

I. Program Planning and Administration

- A. Develop CMS plans and updates reflective of CCS, CHDP, and HCPCFC programs according to guidelines distributed by the CMS Branch. Submit these plans according to the date specified in the Plan Guidelines. Review and update quarterly for their application locally.
 - 1. CCS, CHDP, and HCPCFC staff meet a minimum of two times a year to develop a CMS plan, identify priorities, and evaluate resources for a multi-year scope of work.
 - a. Identify and prioritize health department and community programs with whom CMS staff will meet, e.g., Tuberculosis, Immunizations, WIC, Dental, Maternal and Child Health, Public Health Nursing, Lead, Injury Prevention, HIV Program, Perinatal Services Program, Family Planning, Rural Health, Migrant and Indian Health, Mental Health, Head Start, Child Care Facilities, Regional Centers, Special Care Centers, Paneled Hospitals, and Providers.
 - b. Identify and evaluate mutual activities and areas of implementation. Participate as CMS Administrators in arranging for the development of special services as necessary, e.g., orthodontic screening, Medical Therapy Conferences at the MTU, primary care, foster care resources, dental care.
 - c. Identify and implement program activities to maintain services as necessary.
 - 2. Meet at least once each year with the staff of other health department and community programs working on behalf of children to discuss goals and activities for/with these populations.
 - 3. Collaborate with the CMS Branch on standards, guidelines, and policies through participation in statewide and regional meetings. Include reporting mechanism to local program so that State information flows back to the local level.
 - 4. Evaluate program outcome data to plan more effective use of program resources.
- B. Develop and monitor the CCS, CHDP, and HCPCFC yearly budgets and invoices according to the format and time frames established by the CMS Branch.
 - 1. Expend funds according to approved budgets.
 - 2. Develop budget revisions as necessary.

3. Prepare and submit quarterly invoices to the State *no later than 60 days after the end of each quarter*. Track timeliness of, and invoiced payments for CCS services.
 4. Prepare and submit expenditure reports reallocating or requesting additional funds as appropriate and as requested by the CMS Branch.
 5. Use all equipment purchased with designated State program funds for the specified program purposes only.
 6. Complete and retain daily time studies a minimum of one month each quarter according to State provided guidelines.
 7. Maintain an audit trail for all expenditures for three years after the current fiscal year unless an audit has been announced or is in process.
- C. Assure a competent public health workforce for CMS Programs (CCS, CHDP, and HCPCFC).
1. Recruit, orient, supervise, provide ongoing training, and evaluate personnel responsible for implementing the Plan/Program.
 2. Assure sufficient adequately trained staff for performing the required activities in accordance with CMS standards.
 3. Develop and review with personnel their duty statements and their performance of allowable enhanced/nonenhanced functions pertinent to their classification.
 4. Provide comprehensive orientation and updates that should include information on all three programs.
 5. Provide **annual** update to **all local CMS staff** on the Plan (i.e., the budget, scope of work, performance measures) and its progress.
- D. Develop and obtain signed Intra/Interagency Agreements (IAA) and Memoranda of Understanding (MOU) with agencies/organizations serving California's children.
- E. Develop, implement, and monitor working relationships with Medi-Cal Managed Care Plans and between Health Families and the CCS program. Reflect these working relationships in an MOU between local CHDP and CCS programs and Managed Care Plan(s). Reflect the scope and responsibilities of both parties in the MOU, including but not limited to outreach, provider training, referral tracking and follow-up, health education, data management, and quality assurance and problem resolution.
- F. Develop an IAA between the Department of Social Services (DSS), Juvenile Probation Department, and the HCPCFC program according to the model IAA provided by the CMS Branch.
- G. Develop an MOU, for implementing responsibilities in the HCPCFC program, among the local CHDP program, local Child Welfare Agency of the County

Department of Social Services, and the Juvenile Probation Department according to the outline provided by the CMS Branch.

- H. Develop and maintain an IAA between:
 - 1. CMS and the local Head Start program,
 - 2. The MTP and the Local Educational Agency (LEA), and
 - 3. CMS and the Early Start program.
- I. Discuss with other departments, agencies, and organizations ways and means to inform and empower families about obtaining and utilizing quality health care services.
 - 1. Make available current, comprehensive listings and resources of agencies and organizations providing services to children related to CHDP and Prevention Services, Foster Care, and/or CCS. Listing would include official and voluntary agencies, serving health, social, and related issues to assist families in understanding services available and how to obtain them.
 - 2. Develop and maintain a collaborative working relationship among health department programs serving children, e.g., Lead; Maternal and Child Health; Black Infant Health; Public Health Nursing; Comprehensive Perinatal Services; Immunizations; Women, Infants, Children (WIC), Children and Families Commission. Prepare a written agreement with WIC and other programs, as needed.
 - 3. Maintain a liaison with public and private schools and Head Start/State Preschools to ensure:
 - a. Dissemination of CMS information.
 - b. Participation in CMS services among eligible children.
 - c. Coordination of applicable health care and related services to support school readiness.
 - d. Provision of in-services for school personnel on CHDP standards and services according to the provisions in the California Health and Safety Code, 124025-124110 and the applicable sections in the California Code of Regulations, Title 17.
 - e. Implementation of school reporting requirements.

CHDP Program Letter No.: 05-01 documents changes brought about by AB2855, Chapter 895, Statutes of 2004 included amendments to the Health and Safety (H & S) Code Section 124100. The amended H & S Code no longer require every public school district and private school in California to report data on the number of children receiving health screening examinations at school entry. Therefore, public school districts and private schools are NOT required to submit the CHDP Annual School Report (PM 272) to the CHDP Program within the local

health department and there will be no reimbursement provided. Private schools and public school districts may continue to gather and share this information at their discretion.

Local CHDP programs continue to have the responsibility to work collaboratively with schools to inform and empower families about obtaining and utilizing quality health care services. The activities involved in maintaining a liaison with public and private schools will help to support school readiness and ensure healthy children ready to learn.

For those private schools and public school districts that will continue to report:

- 1) Review the local school compliance statistics. Develop specific activities to increase the compliance rate of any school falling below the statewide average.
 - 2) Analyze the proportion of waivers and certificates for complete health examinations. Identify causative factors for the schools with a high incidence of waivers and develop strategies to increase the number of complete health examinations among school entrants when the factors are not based on personal/religious beliefs.
- f. Provision of lists of CHDP providers biannually to Head Start/State Preschool programs.
 - g. Provide an overview of eligibility requirements to school personnel regarding the CCS Program.
- J. Develop and maintain a collaborative relationship with the Medi-Cal Program: (i.e., Field Offices, In-Home Operations, and Medi-Cal Managed Care Plans).
 - K. Develop and maintain collaborative relationships with the regional Hearing Coordination Center to facilitate the process of newborn referral and testing for hearing loss; and the diagnostic testing and follow-up care for infants identified with suspected hearing loss through the Newborn Hearing Screening Program (NHSP).
 - L. Establish a process in counties/cities for CMS programs to participate in the MCH Title V planning process.
- II. Resource Development - Provider Relations, Recruitment, Maintenance, and Quality Assurance**
- A. Recruit, orient, and maintain a collaborative relationship with CMS providers serving all eligible children.
 1. Facilitate CMS provider application process.
 2. Train/orient all CMS providers to program responsibilities.

3. Provide on-going information, assistance, resources, and support necessary to ensure quality program implementation including, but not limited, to Provider Notices sent by CMS Branch and returning Reports of Distribution (DHS 4504) to the CMS Branch.
- B. Develop and implement a quality assurance plan to ensure CMS children receive quality care.
1. Conduct periodic formal and informal review of CMS providers' compliance with program standards.
 2. Support providers in development and implementation of corrective action plans when indicated.

III. Case Coordination/Case Management, Tracking, and Quality Improvement in Public Health Services

- A. Implement care coordination/case management to assure children known to CMS programs use available services.
1. Receive or initiate referrals among:
 - a. CCS,
 - b. CHDP,
 - c. HCPCFC/Child Welfare Services (CWS),
 - d. Outside agencies/individuals,
 - e. Managed care plans, and
 - f. Health care providers.
 2. Inform the family about health care/services in their community and how to access these services.
 3. Determine eligibility and link all eligible members of a household to health services by inquiring of each child's health status, health care coverage, and need for health care services.
 4. Facilitate all necessary services within program standards and guidelines.
 5. Document and report the results of care coordination/case management in accordance with program standards and guidelines.
- B. Implement and maintain a data/file tracking system(s) to assure data retrieval and recovery in accordance with program standards and guidelines for a period no less than three years or until the completion of any federal audit in progress, including but not limited to:
1. Referrals,

2. Health status,
 3. Care coordination/case management activities,
 4. Services utilization,
 5. Informing activities,
 6. Documentation, and
 7. Reports.
- C. Develop, implement, and maintain a quality improvement system to assure CMS programs assist children receive quality medical, dental, and support services across all provider settings.
1. Develop measures to gauge quality of care coordination/case management including:
 - a. Timely services delivery,
 - b. Completeness and accuracy of documentation,
 - c. Effective interdisciplinary/interagency collaboration,
 - d. Culturally and linguistically competent care,
 - e. Family centered care,
 - f. Service delivery outcomes, and
 - g. Access to a medical home.

IV. Outreach and Education

- A. Employ a multifaceted approach working with community agencies; informal networks; residents; health, education, human service, and legal systems; providers; and policy makers to increase value and understanding of, access to, and participation in, primary and specialty health services in accordance with CMS standards, for all children, including children with special health care needs (CSHCN), across the continuum of care.
1. Address those population groups known to have low utilization or high incidence patterns of conditions that are of local concern.
 2. Determine ways and means to inform and encourage families about obtaining health care coverage and utilizing quality health care services.
 3. Establish contacts and inform the community where CMS services are not known, understood, and/or not utilized.
 4. Review, coordinate distribution, and promote the utilization of health education and CMS program materials.

5. Develop, arrange, and/or conduct educational programs regarding health care needs of children.

Using and Reporting Performance Measures in CMS Programs

The use of performance measures to evaluate the effectiveness and success of public health program interventions and activities is part of public health practice. With time, effective program activities enable the attainment of CMS goals and outcomes.

Reporting on the CMS performance measures is a Scope of Work requirement that started in Fiscal Year (FY) 2002-03. CMS local programs have been using tracking systems and other data collection methods for five years to measure their work with communities, provider networks, and target populations.

Accountability is determined in three ways:

1. by having budget and expenditure figures;
2. by measuring the progress towards successful implementation and achievement of individual performance measures; and ultimately,
3. by having a positive impact on the desired outcomes of the program. These outcome measures are the CMS goals. If program activities are effective and successful, the CMS goals/outcomes will be accomplished.

While improvement in outcome measures is the long-term aim, more immediate success may be demonstrated through performance measures that are shorter term, incremental, intermediate, and/or precursors for the outcome measures. To that end, in Fiscal Year (FY) 2007-08 the performance measures have been revised to reflect program specific measures which are to be reported separately.

The following performance measures were selected by state staff with local program input to represent the focus of CMS programs. Data are to be reported annually for each performance measure.

Directions for Completing the Report of Performance Measures

Reporting on the CMS performance measures is a Scope of Work requirement.

The following outlines the requirements for reporting annually **by November 30th**. One original and three copies of the CMS Report of Performance Measures are to be sent to the local program's CMS Regional Administrative Consultant.

- I. CCS, CHDP, and HCPCFC programs under **joint** administrations are to submit a **single joint** performance report when submitting to the CMS Branch.
- II. Performance measures should be reported in the appropriate format identified for each performance measure. Include a narrative description of the process used to define a percentage for the performance measure or to achieve the score presented.
- III. Performance and monitoring of the performance measures will be evaluated on an annual basis.
- IV. The Annual Report of the Performance Measures of the following elements.
 - A. Report the Results of the Performance Measures using the report forms provided.
 - B. Include a narrative **not to exceed one page**. The narrative should outline the ways that each program approached the task of data collection, and any unique issues related to the measure, e.g. sampling methodology, information used to validate the data to ensure measures were being tracked correctly.
 - C. Describe plans to enhance or change interventions or monitoring activities based on review of this data.

CHDP Performance Measure - Care Coordination

The degree to which the local CHDP program provides effective care coordination to CHDP eligible children.

Definition: This measure demonstrates effective care coordination in the CHDP program.

Numerator: Number of CHDP health assessments (PM-160) coded 4 or 5 where the follow-up appointment was within 120 days of receipt of the PM 160.

Denominator: Number of CHDP health assessments (PM-160), coded 4 or 5, indicating a need for further diagnosis and treatment.

Data Source/Issue: Local program tracking system.

Reporting Form:

Element	Number of Children with Code 4 or 5	Number who received follow-up care	Percent who received follow-up care
Fee-for-service Medi-Cal children whose CHDP screening exams reveal a condition requiring follow-up care (Code 4 or 5 on the PM-160), actually received follow-up within 120 days of receipt of the PM 160.			
Non-Medi-Cal children (Aid code 8Y) whose CHDP screening exams reveal a condition requiring follow-up care (Code 4 or 5 on the PM-160), actually received follow-up within 120 days of the receipt of the PM 160.			

CHDP Performance Measure - New Provider Orientation

The percentage of new CHDP providers with evidence of quality improvement monitoring by the local CHDP program through a **New Provider Orientation**.

Definition: The number of *new* CHDP providers for whom the local program staff has done an orientation within the past fiscal year.

Numerator: The number of *new* CHDP Providers who completed an orientation within the past fiscal year.

Denominator: The number of *new* CHDP providers in the county or city enrolled within the past fiscal year.

Data Source/Issue: Local program/area tracking report system.

Reporting Form:

Provider Name	Provider Number	Date of Orientation	# of Provider staff in attendance

Number of New Providers	
Number of New Providers Receiving Orientation	
Percent of New Providers Oriented	

CHDP Performance Measure - Provider Recertification

The percentage of CHDP providers who have **completed** the re-certification within the past fiscal year. The purpose of this performance measure is to ensure that at least 1/3 of providers are recertified every year. The goal is that all providers in each county/city will be recertified every 3 years. This performance measure is a benchmark to ensure that all providers are recertified.

Definition: An office visit which includes a medical record review and a facility review or Critical Element Review with a Managed Care Plan.

Numerator: The number of CHDP providers who have completed the Re-certification within the past fiscal year using the facility review tool and medical record review tool.

Denominator: The number of active CHDP provider sites in the county/city.

Data Source: Local program tracking report system.

Reporting Form:

Number of Completed Re-certifications	
Number of Active CHDP Providers	
Percent of Completed Re-certifications (33 1/3% is the desired goal)	

CHDP Performance Measure - Desktop Review

The percentage of PM-160's reviewed for compliance with the CHDP Periodicity Schedule as evidenced by documentation when utilizing the desktop review.

Definition: A targeted desktop review for the three highest volume county/city active providers by determining the per cent of PM-160's that documentation is present for:

- A. BMI Percentile for all ages over 2 years
- B. The number of children referred to a dentist (1yr of age and older)
- C. The number of children referred for a lead test (minimum of 1 referral for age 2 and under)

Numerator: The number of PM-160's elements recorded correctly per provider

Denominator: The number of PM-160's reviewed per provider

Data Source: Local program tracking system

Reporting Form:

	BMI		Dental		Lead	
	Number of PM-160s reviewed (ages 2yrs and over)	Percent compliance	Number of PM- 160s reviewed (age 1 year)	Percent Compliance	Number of PM 160s reviewed (1 referral for age 2 and under)	Percent Compliance
Provider						
A						
B						
C						

CHDP Performance Measure - Childhood Overweight

Identification of the prevalence rate of overweight children in a “critical group” according to Pediatric Nutrition Surveillance System (PedNSS) Annual Report and description of local program use of PedNSS reports in healthcare and community venues.

Definition: “Critical group” is the age and/or race/ethnic group with the highest prevalence rate of overweight as indicated by Body Mass Index (BMI)-for-Age \geq 95th % in County/City PedNSS reports. PedNSS is the national surveillance system which tracks population nutrition status trends of children 1-19 years of age and by various race/ethnic groups. It supports Goal 4 of the California Obesity Prevention Plan (2005), “Create and implement a statewide tracking and evaluation system”.

Local CHDP program use of County/City PedNSS reports with other agencies and organizations for the purposes of informing and promoting appropriate community and healthcare responses to the prevalence of childhood overweight.

Data Source: Most current Centers for Disease Control and Prevention, PedNSS Annual Report, County/City Specific Data, Table 16B, Growth Indicators by Race/Ethnicity and Age. Values are obtained by referring to the right-hand column % \geq 95th of Table 16B. Please attach your county/city Table 16B to your submission.

Reporting Form*: Overweight Prevalence Rate by Critical Age Group

For _____ County/City

Critical Group	Overweight (BMI-for-Age \geq 95 th %) Prevalence Rate

*When the number of children for any age category is less than 100, CDC does not provide a prevalence rate. It is “optional” for counties to report prevalence rates when they have less than 100 children. A hand count (manual) will be accepted, if available.

Childhood Overweight

County/City Use of PedNSS Prevalence Rates

1. PedNSS Shared with CHDP Providers to:	YES	NO
Inform about overweight prevalence rates		
Conduct office staff BMI training or other training <i>Please specify:</i>		
Provide office resource materials related to healthy weight		
Conduct Desktop Reviews specific for _____		
2. PedNSS Shared to support Local Assistance grants and implementation of multi-sector policy strategies to create healthy eating and active living community environments (Goal 3, California Obesity Prevention Plan 2005): (check yes for each category that is applicable and circle all that apply)		
<u>Academic:</u> University, Academic Institutions, Educators and Researchers <i>Other (Please specify):</i>		
<u>Community Coalitions/Committees:</u> Health Advisory Committee, Health Collaboratives/Coalitions <i>Other (Please specify):</i>		
<u>Community Planning:</u> City Planners, County Land Use Staff, Built Environment Groups		
<u>Community Programs:</u> Faith-based Groups, YMCA/YWCA, After School programs, Parks and Recreation programs, Child Care, University Cooperative Extension <i>Other (Please specify):</i>		
<u>Healthcare:</u> Managed Care Health Plans and Insurers, Hospitals, CCS Program/Special Care Centers, Medical Provider Groups, Medical Societies, Health Associations <i>Other (Please specify):</i>		
<u>Policy Makers:</u> County Board of Supervisors, City Council, Community Planners, Legislators <i>Other (Please specify):</i>		
<u>Projects or Funding Entities:</u> First Five Commission, Public and Private Foundations/Endowments/Grants <i>Other (Please specify):</i>		

<p><u>Public Health:</u> Programs-WIC, Foster Care, MCAH, Nutrition Network Funded Projects</p> <p>Key Personnel- Health Officer, Epidemiologists, Program Directors</p> <p>Other (<i>Please specify</i>):</p>		
<p><u>Schools:</u> School Health Nurses, School Health Coordinators, County Office of Education, Elementary, Junior High and High School, Head Start, other preschool programs, student groups and parent groups.</p> <p>Other (<i>Please specify</i>):</p>		

HPCFC Performance Measure - Care Coordination

The degree to which the local HPCFC program provides effective care coordination to eligible children.

Definition: This measure demonstrates effective care coordination in the HPCFC program. Please indicate the score based on the level of implementation.

Numerator: Number of CHDP health assessments (PM-160) coded 4 or 5 where the follow-up appointment was kept within 120 days of receipt of the PM 160.

Denominator: Number of CHDP health assessments (PM-160) indicating a need for follow-up (coded 4 or 5).

Data Source/Issue: Local program tracking system.

Reporting Form:

Number of Children in out-of-home placement whose CHDP health assessments reveal a condition requiring follow-up care (Code 4 or 5 on the PM-160).	
Number of those children who received follow-up care within 120 days of receipt of the PM 160.	
Percent of those children who received follow-up care within 120 days of receipt of the PM 160.	

HCPCFC Performance Measure - Health and Dental Exams for Children in Out-of-Home Placement

The degree to which the local HCPCFC program ensures access to health and dental care services for eligible children according to the CHDP periodicity schedule.

Definition: This measure is based on characteristics that demonstrate the degree to which the PHN in the HCPCFC facilitates access to health and dental services as evidenced by documentation of a health and dental exam in the health education passport.

Numerator 1: Number of children in out-of-home placement with a preventive health exam, according to the CHDP periodicity schedule documented in the Health and Education Passport, and

Numerator 2: Number of children in out-of-home placement with a preventive dental exam, according to the CHDP dental periodicity schedule documented in the Health and Education Passport.

Denominator: Number of children in out of home placement during the previous fiscal year supervised by Child Welfare Services or Probation Department.

Data Source/Issue: Child Welfare Services Case Management System (CWS/CMS), and county specific data for Probation Department.

Reporting Form:

Element	Number of Children	Number of Children with Exams	Percent of Children with Exams
Children in out-of-home placement supervised by Child Welfare Services or Probation Department have a preventive <u>health exam</u> according to the CHDP periodicity schedule documented in the Health and Education Passport.			
Children in out-of-home placement supervised by Child Welfare Services or Probation Department have a preventive <u>dental exam</u> according to the CHDP dental periodicity schedule documented in the Health and Education Passport.			

CHDP Performance Measure - School Entry Exams - OPTIONAL -

The percent of children entering first grade in public and private school by school district reporting a "Report of Health Examination for School Entry" (PM 171 A) or "Waiver of Health Examination for School Entry" (PM 171 B).

- Definition:** The percent of children entering first grade with a health exam certificate or waiver.
- Numerator:** Among those private and public school districts continuing to report: The total number of children entering first grade with a:
- a. Certificate and
 - b. Waiver.
- Denominator:** Among those private and public school districts continuing to report: The total number of children enrolled in first grade in public and private school.
- Data Source/Issue:** Public school districts and private schools serving first grade students.
- Reporting Form:** Local program/area tracking report form.

CHDP Optional Performance Measures

Clinical preventive services for CHDP eligible children and youth are expected in accordance with the CMS/CHDP Health Assessment Guidelines. The delivery of those services is documented on the Confidential Screening/Billing Report (PM 160). Examples of evidence-based performance of these services includes focused monitoring for presence of completed fields on the PM 160 for:

- Number and percent of children 2-years old fully immunized,
- Number and percent of age appropriate children given a WIC referral,
- Number and percent of age appropriate children screened for asthma, and
- Number and percent of children and youth with health needs being detected and addressed through clinical preventive services in the CHDP program.
- Number and percent of CHDP health assessments (PM-160) coded 4 or 5 for dental where the follow-up appointment was kept
- Number of providers returning PM 160's within 30 days.

CCS Performance Measures

The purpose of the CCS Performance Measures is to determine the degree to which county CCS programs provide or monitor effective case management and care coordination to eligible children. County programs will evaluate and rate **each** of the five components as individual indicators of program effectiveness.

The five components for review are:

1. Medical Home

Purpose: To identify children in the CCS program who do not have an identified Primary Care Provide (PCP) or Medical Home. The continued monitoring of this performance measure is to ensure all children in the CCS Program have a PCP or medical home identified.

2. Determination of CCS Eligibility

Purpose: To examine whether CCS Program Eligibility Guidelines are being met in the local program.

3. Special Care Center (SCC)

Purpose: To determine if the children that are authorized to a special care center are seen annually and to ensure that visit is documented by an interdisciplinary team report. In addition, the CMS Branch wishes to evaluate the number of children with a medical condition that warrant SCC service to measure the CMS Program's compliance with the requirement for appropriate referral follow-up with a special care center authorization.

4. Transition Planning

Purpose: To evaluate the status of transition planning that is currently taking place for CCS and MTP Children by CCS partners who provide CCS services. The current activity will focus on the documentation received in the local CCS program from a variety of sources such as center report, IEP report, etc. This Performance Measure is to begin evaluation of CCS partner transition services planning, not CCS County program's performance.

5. Family Participation

Purpose: To evaluate the level of family participation and the integration of Family Centered Care in the CCS programs.

CCS Performance Measure – Medical Home

Children enrolled in the CCS Program will have documented Medical homes/primary care providers. The goal is to have 100% compliance.

Definition: Children in the CCS program will have a designated primary care physician and/or physician who provides a medical home.

Numerator: The total number of open cases, excluding pending and orthodontic cases with a completed field in the CMS Net Registration Sheet indicating medical home.

Denominator: The total number of children in the local CCS county program.

Data Source: Medical Home field in CMSNet on the Registration Face Sheet for all counties on CMSNet. *

Reporting Form:

*Counties not yet on CMS Net, a data source and tracking system will need to be established to measure this criterion.

#of children with a primary care physician/ Medical Home	# of children in the local CCS program	% compliance

CCS Performance Measure – Determination of CCS Program Eligibility

Children referred to CCS have their program eligibility determined within the prescribed guidelines per Title 22, California Code of Regulations, Section 42000, and according to CMS Branch policy. Counties will measure the following:

Numerators:

- a. Medical eligibility within five working days of receipt of all medical documentation necessary to determine whether a CCS-eligible condition exists.
- b. Residential and financial eligibility within 30 days of receipt of documentation needed to make the determination.

Denominator: Number of CCS unduplicated new referrals to the CCS program assigned a pending status in the last fiscal year.

Data Source: Conduct a random sample of 10% of cases from CMS Net (not to exceed 100 or be less than 10).

Reporting Form:

	Number of Clients	Percentage %:
New unduplicated referrals		
Medical eligibility determined within 5 days		
Residential and financial eligibility determined within 30 days		

CCS Performance Measure – Special Care Center

This Performance Measure will be evaluated in two parts:

PART A

Definition: This measure is based on the CCS requirement for an annual team report for each child enrolled in CCS whose condition requires CCS Special Care Center services and has received an authorization to a Special Care Center. County CCS programs will evaluate by the presence of an annual team conference report in the file.

Numerator: Number of children that received a Special Care Center authorization and were seen at least annually at appropriate Special Care Center as evidenced by documentation and completion of the interdisciplinary team report.

Denominator: Number of children enrolled in CCS whose condition require CCS Special Care Center services and has received an authorization to a Special Care Center.

Data source: 10% of the cases from local Cystic Fibrosis/Pulmonary and Craniofacial Centers. Counties have an option of reviewing additional Special Centers if there is an identified county need. If a county is located in area without local SCC, use the two specific SCC where local children are referred.

Reporting Form for PART A:

# Children with team services authorization in a Craniofacial Center	# Children with annual team report	%
# Children with team services authorizations in CF/Pulmonary Center	# Children with annual team report	%
# Children with team services authorization in Optional Center	# Children with annual team report	%

CCS Performance Measure – Special Care Center

PART B:

- Definition:** This measure is based on the CCS requirement that certain CCS eligible medical conditions require referral to a CCS Special Care Center for ongoing coordination of services.
- Numerator:** Number of children enrolled in CCS, with medical conditions requiring Special Care Center Authorization, who receive an authorization for services.
- Denominator:** Number of children enrolled in CCS, with medical conditions, requiring Special Care Center Authorizations.
- Date Source:** Conduct a random sample of 10% of cases from CMS Net (not to exceed 100 or be less than 10). This number would accommodate both small and large counties.

Reporting Form for PART B

# Children with eligible medical conditions that require referral to a Special Care Center.	# Children with authorization to a Special Care Center	%
---	--	---

CCS Performance Measure – Transition Planning

Definition: Children, 14 years and older will have documentation of transition planning for preparation to into adult services on an annual basis.

Numerator: Number of CCS charts containing documentation of at least one element in the Transition Check List for children aged 14 years and over.

Denominators:

- a. Number of CCS charts reviewed in 10% of a sample of children aged 14 and over.
- b. Number of MTP charts reviewed in 10% of a sample of children aged 14 and over.

Data Source: Chart Audit, Completion of Transition Check List.

* Due to caseload numbers in Los Angeles County, LA County should work with Regional Office to select an appropriate number of clients to be included in their sample size.

CCS - Transition Planning Checklist

Transition Documentation	YES	NO	Comments
1. Transition planning noted in child's medical record			
2. Transition planning noted in SCC reports			
3. Vocational Rehab noted in child's reports			
4. Adult provider discussed or identified.			
5. Transition planning noted in IEP.			

Reporting Form:

# of CCS charts reviewed	# with transition planning	%
# of MTP charts reviewed	#with transition planning	%

CCS Performance Measure – Family Participation

The degree to which the CCS program demonstrates family participation.

Definition: This measure will be evaluated based on **each** of the following three specific criteria that documents family participation in the CCS program. Counties need to indicate the score based on the level of implementation.

Checklist documenting family participation in the CCS program.	Yes	No	Please submit explanation with your response.
1. Family members are offered an opportunity to provide feedback regarding their satisfaction with the services received through the CCS program by participation in such things as surveys, group discussions, or individual consultation.			
2. Family members participate on advisory committees or task forces and are offered training, mentoring and reimbursement when appropriate.			
3. Family advocates, either as private individuals or as part of an agency advocating family centered care, which have experience with children with special health care needs, are contracted or consultants to the CCS program for their expertise.			

Reporting form:

Criteria	Performing (33.33% for each criteria)	Not Performing
1.		
2.		
3.		
Total	<hr/> %	

SECTION 4 – DATA FORMS

General Overview.....	2
California Children's Services Caseload Summary Instructions.....	4
Caseload Determination (for each fiscal year requested).....	5
California Children's Services Caseload Summary Form.....	7
CHDP Program Referral Data	11

General Overview

With the Data Forms found in this section, each local program is able to evaluate its program needs, performance, and trends. The number of children eligible for CMS services (CCS Caseload, CHDP Target Population, and Health Care Program for Children in Foster Care (HCPCFC Caseload), the level of CHDP referrals assist local program to reflect on the impact of their program on children's health and the trends of program participation.

I. CCS Caseload Summary

The data collected on this form are used to report the actual CCS caseload and demonstrate trends in the caseload over time. (See page 4)

Additional Data

Additional data are used to evaluate the staffing requirements for the CHDP and HCPCFC programs.

- The following CHDP Reports are available online through the **Business Objects Reporting System** (<http://www.bi.ext.dhs.ca.gov/wijsp>). For information on accessing the system, contact CMS Branch Information Technology Services Section and request Business Objects support.
 - *CHDP Annual Summary of Screens by Funding Source For Fiscal Year*
 - *CHDP Monthly Summary of Screens by Funding Source For Month o XX-200X*
 - *CHDP Provider Claims and Amounts Paid by County and Funding Source*
 - *Active CHDP Providers by County and Provider Name*
- The CHDP Target Population estimate is from the CMS Branch.
 - *CHDP Target Population Estimate for Fiscal Years 2005-06, 2006-07, and 2007-08.*
- Data regarding children in out of home placement are from the California Department of Social Services, Research and Development Division:
 - Monthly reports available online at <http://www.dss.cahwnet.gov/research/children's 405.htm>

CWS/CMS1 – Child Welfare Services/Case Management System-Foster Care Children by Placement

This report includes information by placement in-county, out-of-county, and out-of-state.

CWS/CMS2 – Child Welfare Services/Case Management System – Characteristics of Children in Out-of-Home Care

This report provides information on the characteristics of the children in out-of-home placement, including age, gender, ethnicity, type of placement home, funding source, agency responsible, number of cases that were terminated and reason for termination.

- Out of Home Placement Caseload Data (see page 19).

California Children's Services Caseload Summary Instructions

The purpose of submission of the CCS Caseload Summary is to demonstrate the caseload count changes in the county CCS program during the three previous fiscal years. The CCS Caseload Summary demonstrates CCS county workload activity on all cases, whether determined CCS eligible or not. The CCS Caseload Summary shows program participation (Medi-Cal and Non Medi-Cal; Non Medi-Cal caseload includes Healthy Families and all other CCS cases) and is defined as the number of all open (active) CCS cases plus the number of potential CCS cases.

Calculation of Eligible Months and Reporting as Caseload

Beginning in Fiscal Year (FY) 2006-07, the terminology for caseload changed to "eligible months". However, the word "caseload" will be seen throughout the PF&G manual as this is the terminology that is most familiar to the previous users of this manual.

Caseload in FY 2007-08 will be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS)/Medi-Cal client.
- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

There are two reports that can be accessed to calculate "eligible months" for caseload. There is one report in CMS Net Legacy titled "Monthly Caseload Count Report" (for Medi-Cal and Non Medi-Cal counts), and the second report is in Business Objects (BO) titled "Healthy Families Caseload Count Report". In the CMS Net Legacy report, the non-Medi-Cal count is both HF and CCS together. Counties need to subtract FH from the total to get the CCS population.

The CMS Net Legacy report has a history so the report "Monthly Caseload Count Report" (Medi-Cal and non-Medi-Cal) can be processed whenever a county needs the information. However, the HF count in the Business Objects report "Healthy Families Caseload County" only contains information as of the prior day so it is critical for counties to run the report every month to get the HF totals if they want to use BO to retrieve the caseload counts.

This Computes Information Bulletin #167 provides more details regarding these reports. This Bulletin can be found at:

<http://www.dhs.ca.gov/PCFH/cms/ccs/cmsnet/pdf/thiscomputes/thiscomputes167.pdf>

The eligible month information should be retrieved for each type of case for which a child would be counted, e.g. CCS/Medi-Cal, CCS/HF, and CCS-only. At the end of the three month period, the total number of "eligible months" from the three combined reports would need to be divided by three to achieve the "average caseload" number for the quarter.

An example would be:

Month One = 150 eligible months

Month Two = 148 eligible months

Month Three = 167 eligible months

TOTAL 465 Eligible Months

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter.

Beginning FY 2003-04, the CCS Caseload format (Page 7) added Healthy Families cases along with Medi-Cal and Non Medi-Cal CCS to appropriately reflect program participation in the caseload. To assist counties in determining caseload using this format, the rows on the CCS Caseload Summary have been labeled using numbers 1 to 11, and the columns have been labeled using letters A to B.

To complete this report, caseload data are collected from the CCS Quarterly Administrative Invoices for each fiscal year to be reported. The four quarters of the fiscal year are totaled and divided by four to gain the yearly average CCS Caseload.

Caseload Determination (for each fiscal year requested)

1. Add the average open (active) caseload number for all quarterly invoices from the previous fiscal year and divide by four.
2. Determine the number of potential cases by:
 - a. An actual count of potential cases assigned a temporary number if the county CCS program is using CMS Net, or
 - b. An actual count of potential cases if the county CCS program has a method for assigning a temporary number when the county is not on CMS Net, or
 - c. An estimate of potential cases may be used based on the county's experience.

3. Medi-Cal

Add the average total open (average) caseload (row 1, column A) to the potential cases (row 2, column A) to get the Total Medi-Cal caseload (row 3, column A).

4. Non Medi-Cal

- a. Add the average total open (active) caseload (row 4, column A) to the potential cases (row 5, column A) to get the Total Healthy Families caseload (row 6,

column A). **NOTE:** Healthy Families data may not be available for some counties for one or more of the requested fiscal years, in which case use zeros.

- b. Add the average total open (active) caseload (row 7, column A) to the potential cases (row 8, column A) to get the Total Straight CCS (row 9, column A).
- c. Add Total Healthy Families (row 6, column A) to the Straight CCS caseload (row 9, column A) to get the Total Non Medi-Cal caseload (row 10, column A).

5. Grand Total

Add Total Medi-Cal (row 3, column A), to Total Non Medi-Cal (row 10, column A), and place the result in row 11, column A.

6. Determine the total Medi-Cal and Non Medi-Cal percentage split:

- a. Medi-Cal: Divide row 3, column A, by the Grand Total in row 11, column A. The resulting percentage is placed in row 3, column B.
- b. Non Medi-Cal: Divide row 10, column A by the Grand Total in row 11, column A. The resulting percentage is placed in row 10, column B.
- c. Add the percentages in row 3, column B added to row 10, column B and place the result in row 11, column B (will equal 100 percent).

California Children's Services Caseload Summary Form

County: _____

Fiscal Year: _____

CCS Caseload 0 to 21 Years		A		B			
		04-05 Actual Caseload	% of Grand Total	05-06 Actual Caseload	% of Grand Total	06-07 Estimated Caseload based on first three quarters	% of Grand Total
MEDI-CAL							
1	Average of Total Open (Active) Medi-Cal Children						
2	Potential Case Medi-Cal						
3	TOTAL MEDI-CAL (Row 1 + Row 2)						
NON MEDI-CAL							
Healthy Families							
4	Average of Total Open (Active) Healthy Families						
5	Potential Cases Healthy Families						
6	Total Healthy Families (Row 4 + Row 5)						
Straight CCS							
7	Average of Total Open (Active) Straight CCS Children						
8	Potential Cases Straight CCS Children						
9	Total Straight CCS (Row 7 + Row 8)						
10	TOTAL NON MEDI-CAL (Row 6 + Row 9)						
GRAND TOTAL							
11	(Row 3 + Row 10)						

Child Health and Disability Prevention (CHDP) Program Referral Data Instructions

The purpose of submission of the CHDP Program Referral Data is to report the results of referrals for information, medical/dental resources, scheduling appointments and arranging transportation to appointments and care coordination for children eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/CHDP services. Informing children and their families about the benefits of prevention and the health services and assistance available to them, helping children and their families use health resources and assuring that health problems found during screenings are diagnosed and treated early are critical activities in the CHDP Program.

California local departments of social services provide basic information about EPSDT to recipients of Medi-Cal benefits. The information includes the importance of preventive health services and the assistance available to children and families through the CHDP Program. Departments of Social Services convey children and families' responses to this basic information and the need for more information and/or assistance. When children and families request more information about CHDP services, or help with making a medical and/or dental appointment and/or for assistance with scheduling the appointment and transportation to reach the appointment, the local department of social services sends a referral to the local CHDP program in the jurisdiction of the child's residence.

Data are reported on this form annually. Trends observed over the course of three Fiscal years (FY) can be used to enhance collaboration with the Department of Social Services eligibility workers in the assurance of CHDP referrals, provide feedback to Managed Care Plan Liaisons, quantify the number of children getting follow-up care, and as an indicator of workload.

Data to Complete the Form

Complete this form using data that are currently available. Where data are not available, please attach an explanation. If your program collects any other data regarding the numbers and types of contacts made or attempted, or other measures of your workload and related outcome data, please attach this information in whatever format you currently gather it.

The most recent FY on the form is the FY prior to the FY of the Plan and Fiscal Guidelines (PFG). For example, when the PFG has been released with instructions and forms for FY 07-08, the most recent year on the CHDP Program Referral Data is FY 06-07. The reason for this is that the results of care coordination for a child with a date of service in a prior FY are often not reportable until after another FY has started.

1. Total number of CalWORKs/Medi-Cal cases informed and determined eligible by the Department of Social Services.

Request this number from the Department of Social Services on a monthly basis and compile annually. The CHDP – Social Services Interagency Agreement, found in Section 5, describes in IX. A. the level and type of management information that will be compiled and shared between the departments.

The data are to reflect the total number of cases with eligible individuals less than 21 years of age, including a child not born but with an expected date for delivery. This number becomes a reference/denominator for the number of cases that are referred to the local

CHDP Program reported in 2.

2. Total number of cases and recipients requesting CHDP services. Requests for CHDP services include referrals to CHDP for medical and/or dental services; and medical and/or dental services with scheduling and/or transportation assistance.
 - a. CalWORKs cases/recipients
 - b. Foster care cases/recipients
 - c. Medi-Cal only cases/recipients

This section shows how many cases and recipients resulted in a referral to CHDP by class of eligibility as a result of the basic information provided by Department of Social Services. Known as CalWORKs since 1996, the cases/recipients in CalWORKs have been referred to as "categorically needy" and part of the Aid for Families with Dependent Children. The Medi-Cal only cases/recipients have been referred to as "medically needy".

Complete the total number of cases and recipients requesting CHDP services from the CHDP Referral, Form PM 357. The Department of Social Services may have this information in their data reports also which would be identified in the CHDP – Social Services Interagency Agreement with the level and type of management information that will be compiled and shared between the departments.

Tracking the number of cases referred and by eligibility type provides information about the level of need for health care services information and referrals and the proportion of cases that are requesting CHDP services.

3. Total number of EPSDT eligible recipients and unborn, referred by Department of Social Services' workers requesting
 - a. Medical and/or dental services
 - b. Medical and/or dental services with scheduling and/or transportation
 - c. Information only (optional)

This section shows what kind of CHDP services have been requested by the eligible recipients.

Complete the total number of cases and recipients requesting CHDP services from the CHDP Referral, Form PM 357. The Department of Social Services may have this information in their data reports also which would be identified in the CHDP – Social Services Interagency Agreement with the level and type of management information that will be compiled and shared between the departments.

Tracking the number of recipients referred by type of request provides information about the level of need for health care services information and referrals and the proportion of cases that are requesting CHDP services with scheduling and/or transportation assistance.

4. Number of persons contacted by telephone, home visit, face-to-face, office visit, or written response to outreach letter.

Complete the total number of recipients contacted by telephone, home visit, face-to-face, office visit, or written response to outreach letter. A successful contact is defined as a response that is received "face-to-face, ear-to-ear, or pen-to-pen" from the recipient.

If you gather other data such as the number of attempts before a successful contact is made, include that data as an addendum.

5. Total number of recipients actually provided scheduling and/or transportation assistance by program staff.

Include the information you record locally that shows the number of recipients provided scheduling and/or transportation assistance. This reflects the assistance you are able to provide that enables a recipient to have an appointment and the necessary transportation to make that appointment.

Note: A good faith effort has to be documented. A good faith effort as referenced in the model Interagency Agreement, Section VIII, includes at least one documented attempt to trace the person through local welfare departments by obtaining a current address and telephone number and to contact the family at their current address/telephone number.

6. Total recipients provided assistance with scheduling and/or transportation who actually received medical and/or dental services

Of those recipients in "5", include the total number who received medical services as confirmed by a Confidential Screening/Billing Report (PM 160) on file or provider certification of provision of service; and/or for dental services, family, provider, or child verification.

CHDP Program Referral Data

Complete this form using the Instructions found on page 4-8 through 4-10.

County/City:	FY 04-05		FY 05-06		FY 06-07	
Basic Informing and CHDP Referrals						
1. Total number of CalWORKs/Medi-Cal cases informed and determined eligible by Department of Social Services						
2. Total number of cases and recipients in "1" requesting CHDP services	Cases	Recipients	Cases	Recipients	Cases	Recipients
a. Number of CalWORKs cases/recipients						
b. Number of Foster Care cases/recipients						
c. Number of Medi-Cal only cases/recipients						
3. Total number of EPSDT eligible recipients and unborn, referred by Department of Social Services' workers who requested the following:						
a. Medical and/or dental services						
b. Medical and/or dental services with scheduling and/or transportation						
c. Information only (optional)						

4. Number of persons who were contacted by telephone, home visit, face-to-face, office visit, or written response to outreach letter			
Results of Assistance			
5. Number of recipients actually provided scheduling and/or transportation assistance by program staff			
6. Number of recipients in "5" who actually received medical and/or dental services			

CALIFORNIA DEPARTMENT OF HEALTH SERVICES
 CHILDREN MEDICAL SERVICES
 CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
 TABLE 2-2
 FY 2005-2006 TARGET POPULATION ESTIMATE

County	Medi-Cal Under 21	Medi-Cal Percent	CHDP Gateway Under 19	CHDP Gateway Percent	Total Children
ALAMEDA	88,741	69.8%	38,407	30.2%	127,148
ALPINE	130	74.3%	45	25.7%	175
AMADOR	1,508	60.3%	994	39.7%	2,502
BUTTE	22,944	71.0%	9,371	29.0%	32,315
CALAVERAS	2,535	61.7%	1,572	38.3%	4,107
COLUSA	2,300	60.0%	1,532	40.0%	3,832
CONTRA COSTA	48,984	65.1%	26,303	34.9%	75,287
DEL NORTE	3,698	72.5%	1,399	27.5%	5,097
EL DORADO	6,496	55.2%	5,271	44.8%	11,767
FRESNO	142,831	71.1%	57,939	28.9%	200,770
GLENN	3,384	61.0%	2,164	39.0%	5,548
HUMBOLDT	11,537	65.8%	5,991	34.2%	17,528
IMPERIAL	22,089	63.5%	12,701	36.5%	34,790
INYO	1,282	64.2%	715	35.8%	1,997
KERN	100,827	67.3%	49,020	32.7%	149,847
KINGS	16,469	61.8%	10,166	38.2%	26,635
LAKE	6,414	64.1%	3,595	35.9%	10,009
LASSEN	2,326	64.4%	1,284	35.6%	3,610
LOS ANGELES	1,231,212	70.9%	504,751	29.1%	1,735,963
MADERA	19,368	69.0%	8,709	31.0%	28,077
MARIN	6,253	60.3%	4,120	39.7%	10,373
MARIPOSA	1,192	61.7%	739	38.3%	1,931
MENDOCINO	9,988	70.1%	4,269	29.9%	14,257
MERCED	40,686	68.7%	18,578	31.3%	59,264
MODOC	1,041	68.8%	473	31.2%	1,514
MONO	562	49.0%	584	51.0%	1,146
MONTEREY	39,342	62.6%	23,518	37.4%	62,860
NAPA	5,922	58.0%	4,289	42.0%	10,211
NEVADA	3,555	53.6%	3,076	46.4%	6,631
ORANGE	187,902	61.4%	118,372	38.6%	306,274
PLACER	9,364	54.8%	7,726	45.2%	17,090
PLUMAS	1,096	60.7%	710	39.3%	1,806
RIVERSIDE	151,788	60.0%	101,200	40.0%	252,988
SACRAMENTO	138,655	70.1%	59,008	29.9%	197,663
SAN BENITO	3,786	57.1%	2,841	42.9%	6,627
SAN BERNARDINO	201,701	64.0%	113,280	36.0%	314,981
SAN DIEGO	179,141	60.0%	119,221	40.0%	298,362
SAN FRANCISCO	38,919	71.6%	15,466	28.4%	54,385
SAN JOAQUIN	71,302	66.5%	35,912	33.5%	107,214
SAN LUIS OBISPO	13,164	61.4%	8,291	38.6%	21,455
SAN MATEO	27,282	65.2%	14,538	34.8%	41,820
SANTA BARBARA	32,930	65.8%	17,119	34.2%	50,049

**CALIFORNIA DEPARTMENT OF HEALTH SERVICES
CHILDREN MEDICAL SERVICES
CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
TABLE 2-2
FY 2005-2006 TARGET POPULATION ESTIMATE**

County	Medi-Cal Under 21	Medi-Cal Percent	CHDP Gateway Under 19	CHDP Gateway Percent	Total Children
SANTA CLARA	93,243	70.4%	39,221	29.6%	132,464
SANTA CRUZ	16,139	64.9%	8,718	35.1%	24,857
SHASTA	16,157	66.7%	8,068	33.3%	24,225
SIERRA	212	62.8%	125	37.2%	337
SISKIYOU	4,402	67.9%	2,078	32.1%	6,480
SOLANO	26,269	64.4%	14,548	35.6%	40,817
SONOMA	22,277	61.2%	14,110	38.8%	36,387
STANISLAUS	58,523	65.9%	30,275	34.1%	88,798
SUTTER	8,741	64.0%	4,913	36.0%	13,654
TEHAMA	6,618	68.0%	3,118	32.0%	9,736
TRINITY	1,067	63.4%	617	36.6%	1,684
TULARE	71,949	69.7%	31,262	30.3%	103,211
TUOLUMNE	3,175	63.1%	1,854	36.9%	5,029
VENTURA	50,886	63.7%	29,058	36.3%	79,944
YOLO	13,718	61.3%	8,665	38.7%	22,383
YUBA	9,256	64.2%	5,158	35.8%	14,414
CITY OF BERKELEY	6,641	69.8%	2,874	30.2%	9,515
CITY OF LONG BEACH	63,316	70.9%	25,957	29.1%	89,273
CITY OF PASADENA	18,718	70.9%	7,674	29.1%	26,392
TOTAL	3,391,953	67.2%	1,653,552	32.8%	5,045,505

Definitions and Data Sources: Columns 1 and 2: Number and percent of Medi-Cal certified eligible children under 21 years
Data Source: Medi-Cal target population derived from Medical Care Statistics, Department of Health Calender year 2003; Table 17: Medi-Cal Program Persons Certified Eligible by County, Sex, and A

Medi-Cal Funded Births by Beneficiary County:
Data Source: Medi-Cal target population derived from Medical Care Statistics, Department of Health Table 10: Deliveries to Medi-Cal Beneficiaries by Beneficiary County and Category, Calender Year

Data Source and Notes for CHDP Gateway Target Population: CHDP Gateway Target Population:
Finance Dept., Demographic information, data file 2005 age under 19, updated May 2004.
Poverty level between 100-200 percent values from the Census 2000.

The Number Derived from population estimates for cities of Berkeley, Pasadena and Long Beach are from Department of Finance, California Statistical Abstract 2004, Table B-4: Total Population of California Cities, January 1, 2004.

Prepared by Helen Zheng 4/5/2005

**CALIFORNIA DEPARTMENT OF HEALTH SERVICE
CHILDREN MEDICAL SERVICES
CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
TABLE 2-2
FY 2006-2007 TARGET POPULATION ESTIMATE**

County/City	Medi-Cal Under 21	Medi-Cal Percent	CHDP Gateway Under 19	CHDP Gateway Percent	Total Children
ALAMEDA	88,741	71.2%	35,908	28.8%	124,649
ALPINE	130	74.7%	44	25.3%	174
AMADOR	1,508	61.5%	945	38.5%	2,453
BUTTE	22,944	72.3%	8,812	27.7%	31,756
CALAVERAS	2,535	62.5%	1,520	37.5%	4,055
COLUSA	2,300	60.8%	1,483	39.2%	3,783
CONTRA COSTA	48,984	66.1%	25,154	33.9%	74,138
DEL NORTE	3,698	75.1%	1,229	24.9%	4,927
EL DORADO	6,496	56.3%	5,051	43.7%	11,547
FRESNO	142,831	71.8%	56,171	28.2%	199,002
GLENN	3,384	61.7%	2,099	38.3%	5,483
HUMBOLDT	11,537	67.7%	5,509	32.3%	17,046
IMPERIAL	22,089	63.5%	12,695	36.5%	34,784
INYO	1,282	66.3%	652	33.7%	1,934
KERN	100,827	67.7%	48,023	32.3%	148,850
KINGS	16,469	62.2%	9,988	37.8%	26,457
LAKE	6,414	65.0%	3,456	35.0%	9,870
LASSEN	2,326	65.8%	1,208	34.2%	3,534
LOS ANGELES	1,231,212	71.4%	494,222	28.6%	1,725,434
MADERA	19,368	69.3%	8,580	30.7%	27,948
MARIN	6,253	62.2%	3,794	37.8%	10,047
MARIPOSA	1,192	63.0%	700	37.0%	1,892
MENDOCINO	9,988	71.5%	3,975	28.5%	13,963
MERCED	40,686	68.9%	18,330	31.1%	59,016
MODOC	1,041	72.4%	397	27.6%	1,438
MONO	562	50.3%	556	49.7%	1,118
MONTEREY	39,342	64.3%	21,873	35.7%	61,215
NAPA	5,922	59.2%	4,082	40.8%	10,004
NEVADA	3,555	54.5%	2,966	45.5%	6,521
ORANGE	187,902	62.3%	113,767	37.7%	301,669
PLACER	9,364	55.4%	7,529	44.6%	16,893
PLUMAS	1,096	62.4%	660	37.6%	1,756
RIVERSIDE	151,788	60.3%	100,060	39.7%	251,848
SACRAMENTO	138,655	71.1%	56,335	28.9%	194,990
SAN BENITO	3,786	57.4%	2,815	42.6%	6,601
SAN BERNARDINO	201,701	64.9%	108,956	35.1%	310,657
SAN DIEGO	179,141	61.3%	113,055	38.7%	292,196
SAN FRANCISCO	38,919	72.4%	14,811	27.6%	53,730
SAN JOAQUIN	71,302	67.2%	34,837	32.8%	106,139
SAN LUIS OBISPO	13,164	62.3%	7,977	37.7%	21,141
SAN MATEO	27,282	67.1%	13,368	32.9%	40,650

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

SANTA BARBARA	32,930	66.9%	16,287	33.1%	49,217
SANTA CLARA	93,243	71.4%	37,261	28.6%	130,504
SANTA CRUZ	16,139	66.3%	8,211	33.7%	24,350
SHASTA	16,157	67.8%	7,664	32.2%	23,821
SIERRA	212	64.8%	115	35.2%	327
SISKIYOU	4,402	70.6%	1,830	29.4%	6,232
SOLANO	26,269	66.4%	13,277	33.6%	39,546
SONOMA	22,277	62.4%	13,399	37.6%	35,676
STANISLAUS	58,523	66.6%	29,414	33.4%	87,937
SUTTER	8,741	64.7%	4,777	35.3%	13,518
TEHAMA	6,618	69.1%	2,963	30.9%	9,581
TRINITY	1,067	66.3%	541	33.7%	1,608
TULARE	71,949	69.8%	31,094	30.2%	103,043
TUOLUMNE	3,175	64.0%	1,790	36.0%	4,965
VENTURA	50,886	64.8%	27,636	35.2%	78,522
YOLO	13,718	61.3%	8,666	38.7%	22,384
YUBA	9,256	65.4%	4,899	34.6%	14,155
CITY OF BERKELEY	6,641	71.2%	2,687	28.8%	9,328
CITY OF LONG BEACH	63,316	89.4%	7,514	10.6%	70,830
CITY OF PASADENA	18,718	42.4%	25,416	57.6%	44,134
TOTAL	3,391,953	68.0%	1,599,033	32.0%	4,990,986

Definitions and
Data Sources:

Columns 1 and 2: Number and percent of Medi-Cal certified eligible children under 21 years
Data Source: Medi-Cal target population derived from Medi-Cal Care Statistics, Department of Health Services. Calendar Year 2003: Table 17: Medi-Cal Program Persons Certified Eligible by County, Sex, and Age

Medi-cal Funded Births by Beneficiary County:

Data Source: Medi-Cal target population derived from Medi-Cal Care Statistics, Department of Health Services. Table 10: Deliveries To Medi-Cal Beneficiaries by Beneficiary County and Category, Calendar Year 2003

Data Source and note
for CHDP Gateway

State funded target population: Finance Dept., Demographic information, data file (www.dof.ca.gov/HTML/DEMOGRAP/data.htm), 2006.txt and select age under 19 years

Target Population

Poverty level between 100-200 percent values from the Census 2000.

The number derived from population estimates for cities of Berkeley, Pasadena and Long Beach are from Department of Finance, California Statistical Abstract 2004, Table B-4: Total Population of California Cities, January 1, 2003 and 2004 (this table used 2004).

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
TABLE 2-2
FY 2007-2008 TARGET POPULATION ESTIMATE

County	Medi-Cal Under 21	Medi-Cal Percent	CHDP Gateway Under 19	CHDP Gateway Percent	Total Children
ALAMEDA	95,232	71.2%	38,558	28.8%	133,789
ALPINE	114	72.6%	43	27.4%	157
AMADOR	1,454	59.6%	986	40.4%	2,440
BUTTE	22,626	71.1%	9,205	28.9%	31,831
CALAVERAS	2,441	60.9%	1,566	39.1%	4,007
COLUSA	2,424	61.6%	1,512	38.4%	3,936
CONTRA COSTA	52,483	66.4%	26,502	33.6%	78,985
DEL NORTE	3,650	73.3%	1,333	26.7%	4,983
EL DORADO	6,735	56.7%	5,149	43.3%	11,884
FRESNO	148,331	72.1%	57,408	27.9%	205,739
GLENN	3,512	62.0%	2,149	38.0%	5,661
HUMBOLDT	11,606	66.5%	5,835	33.5%	17,441
IMPERIAL	22,965	64.1%	12,869	35.9%	35,834
INYO	1,340	66.9%	664	33.1%	2,004
KERN	108,105	68.6%	49,432	31.4%	157,537
KINGS	17,119	62.3%	10,348	37.7%	27,467
LAKE	6,628	64.6%	3,625	35.4%	10,253
LASSEN	2,424	66.2%	1,235	33.8%	3,659
LOS ANGELES	1,167,170	69.6%	509,456	30.4%	1,676,626
MADERA	20,110	69.5%	8,825	30.5%	28,935
MARIN	6,678	62.5%	4,000	37.5%	10,678
MARIPOSA	1,083	60.4%	710	39.6%	1,793
MENDOCINO	9,964	70.8%	4,115	29.2%	14,079
MERCED	40,438	67.8%	19,201	32.2%	59,639
MODOC	1,076	71.9%	420	28.1%	1,496
MONO	650	54.5%	542	45.5%	1,192
MONTEREY	40,015	63.4%	23,076	36.6%	63,091
NAPA	5,862	57.8%	4,273	42.2%	10,135
NEVADA	3,656	54.8%	3,015	45.2%	6,671
ORANGE	199,354	62.9%	117,763	37.1%	317,117
PLACER	10,841	58.0%	7,840	42.0%	18,681
PLUMAS	1,144	62.5%	688	37.5%	1,832
RIVERSIDE	161,729	60.6%	105,052	39.4%	266,781
SACRAMENTO	142,383	70.0%	61,118	30.0%	203,501
SAN BENITO	4,299	60.6%	2,795	39.4%	7,094
SAN BERNARDINO	211,056	65.2%	112,857	34.8%	323,913
SAN DIEGO	184,569	60.6%	120,071	39.4%	304,640
SAN FRANCISCO	40,724	71.8%	16,031	28.2%	56,755
SAN JOAQUIN	75,674	67.4%	36,597	32.6%	112,271
SAN LUIS OBISPO	13,725	62.8%	8,132	37.2%	21,857
SAN MATEO	28,980	67.0%	14,249	33.0%	43,229

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

SANTA BARBARA	35,763	68.2%	16,687	31.8%	52,450
SANTA CLARA	104,159	72.6%	39,341	27.4%	143,500
SANTA CRUZ	17,393	67.1%	8,519	32.9%	25,912
SHASTA	16,625	67.2%	8,123	32.8%	24,748
SIERRA	190	61.1%	121	38.9%	311
SISKIYOU	4,521	70.5%	1,896	29.5%	6,417
SOLANO	27,916	65.9%	14,457	34.1%	42,373
SONOMA	22,954	62.3%	13,906	37.7%	36,860
STANISLAUS	62,005	66.9%	30,729	33.1%	92,734
SUTTER	9,177	64.7%	4,999	35.3%	14,176
TEHAMA	6,864	68.8%	3,111	31.2%	9,975
TRINITY	1,066	65.1%	572	34.9%	1,638
TULARE	76,250	70.6%	31,807	29.4%	108,057
TUOLUMNE	3,331	64.4%	1,839	35.6%	5,170
VENTURA	54,070	65.5%	28,427	34.5%	82,497
YOLO	14,224	60.8%	9,187	39.2%	23,411
YUBA	9,500	64.3%	5,270	35.7%	14,770
CITY OF BERKELEY	7,143	71.2%	2,892	28.8%	10,036
CITY OF LONG BEACH	59,537	69.6%	25,987	30.4%	85,524
CITY OF PASADENA	17,750	69.6%	7,748	30.4%	25,498
TOTAL	3,430,807	67.3%	1,664,862	32.7%	5,095,669

Note:

Estimates are derived from Department of Health Services, Department of Finance and Census Bureau data.

HCPCFC AVERAGE ANNUAL CASELOAD*

FISCAL YEAR 2006 - 2007

County/City Program	July 31, 2006 Caseload (See Notes)	County/City Program	July 31, 2006 Caseload (See Notes)
Alameda	2,911	Pasadena	468
Alpine	1	Placer	356
Amador	33	Plumas	51
Berkeley	80	Riverside	5,648
Butte	728	Sacramento	4,837
Calaveras	91	San Benito	77
Colusa	51	San Bernardino	5,062
Contra Costa	1,728	San Diego	5,968
Del Norte	117	San Francisco	1,848
El Dorado	225	San Joaquin	1,757
Fresno	2,582	San Luis Obispo	438
Glenn	97	San Mateo	538
Humboldt	333	Santa Barbara	0
Imperial	0	Santa Clara	2,130
Inyo	18	Santa Cruz	342
Kern	2,580	Shasta	577
Kings	334	Sierra	0
Lake	225	Siskiyou	162
Lassen	91	Solano	565
Long Beach	1,185	Sonoma	616
Los Angeles	29,396	Stanislaus	579
Madera	322	Sutter	177
Marin	97	Tehama	264
Mariposa	58	Trinity	37
Mendocino	308	Tulare	1,208
Merced	637	Tuolumne	151
Modoc	19	Ventura	732
Mono	9	Yolo	448
Monterey	510	Yuba	228
Napa	146		
Nevada	97	Totals	83,431
Orange	3,158		

Notes on Caseload Data Sources:

The Annual Average Out-of-Home Placement Caseload Data for the HCPCFC are from Child Welfare Services/Case Management System (CWS/CMS) reports prepared by the California Department of Social Services, Research and

Development Division.

*Total Children in Supervised Out-of-Home Placements by Placement, July 31, 2006.
http://www.dss.cahwnet.gov/research/CWS-CMS2-C_412.htm

SECTION 5 – MEMORANDA OF UNDERSTANDING AND INTER/INTRA-AGENCY AGREEMENTS

General Instructions	2
California Children's Services (CCS).....	2
Healthy Families Program:	2
Medi-Cal Managed Care Plans:.....	2
Special Education/Local Education Agency:	2
Other Programs:	2
Child Health and Disability Prevention Program (CHDP).....	3
Department of Social Services:	3
Health Care Program for Children in Foster Care (HCPCFC):.....	3
Medi-Cal Managed Care Plans:.....	3
Other Programs:	3
Memorandum of Understanding California Children's Services Program/Healthy Families Program Plan	4
Delineation of Responsibilities for Children's Medical Services Branch, Regional Offices, and Dependent Counties as They Relate to the Healthy Families Memorandum of Understanding	7
County/City CHDP Program Model Interagency Agreement.....	10
Model HCPCFC Memorandum of Understanding	25

General Instructions

Please complete the Memoranda of Understanding (MOU)/Inter/Intra-Agency Agreements (IAA) listing to summarize all the MOUs and IAAs in your county/city program (see Section 2, page 15). MOUs and IAAs that are new, have been renewed, or have been changed should be submitted. If you are unsure, please check with your Regional Nurse Consultant.

California Children's Services (CCS)

Healthy Families Program:

Independent County Responsibilities: MOUs and procedures for implementation of MOUs between the county CCS program and the Healthy Families plan(s) must be on file at the county CCS office. Anytime a HF plan initially enters or re-enters a county, a signed MOU is required and procedures must be developed with the HF plan for implementing the MOU. **MOUs that have already been signed with the existing plans should remain the same.** It is appropriate that all staff who coordinate with the plans are aware of this document and periodically review it.

Dependent County Responsibilities: MOUs and procedures for implementation of MOUs between the county CCS program, the CMS Branch and Regional Offices, and the HF plan(s) must be on file at the county CCS office. Anytime a HF plan initially enters or re-enters a county, a signed MOU is required and the procedures that were developed by the CMS Branch must be shared with the HF plan(s) for implementing the MOU. MOUs that have already been signed with the existing plans should remain the same. It is appropriate that all staff who coordinate with the plans are aware of this document and periodically review it.

Counties that use one MOU for both Medi-Cal and Healthy Families may revise the MOUs as necessary.

Medi-Cal Managed Care Plans:

MOUs between the plans in the 12 two-plan model and the Geographic Managed Care (GMC) counties must have an approved MOU on file. The approval comes from the Medi-Cal Managed Care Division. If the MOU is not yet approved, the county should develop and submit a workplan to complete the MOU.

Counties with County Organized Health Systems (COHS) are strongly encouraged to negotiate a MOU with the Medi-Cal Managed Care Plan(s) in their jurisdiction.

Special Education/Local Education Agency:

An IAA is required between the county CCS Medical Therapy Program and the Local Education Agency (LEA) or Special Education Local Planning Area (SELPA). The IAA delineates responsibilities such as, but not limited to, appointment of liaison positions, referral and exchange of information, participation in Individual Education Planning Meetings, and Medical Therapy Unit requirements for space, operations, and supplies.

Other Programs:

Include other agreements such as Regional Centers, Early Start, etc.

Child Health and Disability Prevention Program (CHDP)

Department of Social Services:

An IAA between the local Child Health and Disability Prevention (CHDP) program and the Department of Social Services (DSS) is required every two fiscal years. A model format is provided in this section that reflects the minimum requirements (see page 10). *Please describe local needs and policies where words appear in Italics.*

Sample forms referenced in the IAA specific to the CHDP Program and used by the DSS, such as the CHDP Referral Form (PM 357), can be found in Section 10 - References. The name of the local health jurisdiction and the effective dates of agreement are to be listed on each page of the IAA and must correspond to the signature page.

Health Care Program for Children in Foster Care (HCPCFC):

A MOU among health, welfare, and probation departments in each county is required for the continued operation of the HCPCFC at least biennially. The MOU delineates the roles and responsibilities of the PHN, Social Worker, and Probation Officer in the HCPCFC.

The HCPCFC MOU may be referred to in the IAA between the CHDP Program and the DSS. A model MOU for the HCPCFC is located in this section beginning on Page 25. The name of the local health jurisdiction and the effective dates of agreement are to be listed on each page of the MOU and must correspond to the signature page.

Medi-Cal Managed Care Plans:

Local CHDP programs in the 12 Managed Care Expansion Counties must have in place a **current** negotiated MOU with each of the Medi-Cal Managed Care Plans in their jurisdiction.

Local CHDP programs in other counties implementing Medi-Cal Managed Care are strongly encouraged to have in place a negotiated MOU with the Medi-Cal Managed Care Plan(s) in their jurisdiction.

Other Programs:

Any revised interagency/interprogram agreements with the Women, Infants, and Children (WIC) Supplemental Nutrition Program, the Childhood Lead Poisoning Prevention Program (CLPPP), the Adolescent Family Life Program (AFLP), Head Start, and any other program, should also be attached to the Plan.

Memorandum of Understanding California Children's Services Program/Healthy Families Program Plan

County/City:

Effective Dates:

Service	Health Plan Responsibilities	CCS Program Responsibilities
Liaison	<ul style="list-style-type: none"> • Designate a liaison to CCS and/or require plan networks to designate a liaison to coordinate and track referrals. • Meet, at a minimum, quarterly to ensure ongoing communication; resolve operational and administrative problems; and identify policy issues needing resolution at the management level. 	<ul style="list-style-type: none"> • Designate a liaison to the plan who will be the program's point of contact for the health plan and its networks to coordinate all related activities. • Meet, at a minimum, quarterly, to ensure ongoing communication; resolve operational and administrative problems; and identify policy issues needing resolution at the management level.
Provider Training	<ul style="list-style-type: none"> • Develop policies and procedures that will ensure that providers are informed of CCS eligibility requirements and the need to identify potentially eligible children and refer to the CCS program. • Provide multiple initial training opportunities, in conjunction with the local CCS program, for primary care providers, including organized provider groups and support staff, in order to ensure awareness and understanding of the CCS program and eligibility requirements. • Collaborate with CCS to develop training materials that will assure that primary care providers, specialty providers, and hospitals understand the respective responsibilities of the health plan and the CCS program in authorizing services for subscribers with CCS-eligible conditions. • Maintain training opportunities on, at least, an annual basis. 	<ul style="list-style-type: none"> • Collaborate with plan to assist with the development of CCS related policies and procedures, as needed by health plan and CCS. • Collaborate with health plan to provide multiple initial training opportunities that will give providers an understanding of the CCS program and eligibility requirements. • Provide availability of local program medical consultant or designee to consult with primary care providers and/or specialty providers on a case-by-case basis. • Support ongoing training opportunities as needed.
CCS Provider Network	<ul style="list-style-type: none"> • Develop a process to review plan providers for qualifications for CCS provider panel participation and encourage those qualified to become paneled. • Identify in training to providers and in the provider manual those facilities that are CCS approved, including hospitals and Special Care Centers. • Ensure access for diagnostic services to appropriate specialty care within the network or medical group. When appropriate specialist not available within network or medical group, ensure access to appropriate plan specialist. 	<ul style="list-style-type: none"> • Provide plans with CCS provider applications to expedite the paneling or approval of specialty and primary care network providers. • Coordinate with the CMS Branch to assure identification of local CCS provider network to health plan. • Coordinate with plan to refer to an appropriate CCS paneled specialty provider to complete diagnostic services and treatment as needed.

County/City:

Effective Dates:

Service	Health Plan Responsibilities	CCS Program Responsibilities
Case Identification and Referral	<ul style="list-style-type: none"> • Develop procedures, in conjunction with the local CCS program, for plan or provider to submit the necessary documentation to determine medical eligibility at the time of referral. • Develop procedures to specify that providers are to refer a subscriber to the CCS program within two days of a suspicion of the presence of a CCS eligible condition. (Referral date will identify the earliest possible date from which medically necessary services may be approved.) • Inform families of subscribers of referral to the CCS program and the need to have care under the direction of an appropriate CCS paneled physician once program eligibility has been determined. • Arrange for medically necessary care during the period after referral and prior to the CCS eligibility determination. (Medically necessary services provided by a CCS paneled provider during the interim may be authorized by the CCS program for a condition determined to be CCS eligible.) • Develop with network designees, where applicable, a monthly tracking list to include: name of referred subscriber; address and telephone number; birth date; social security number (if known); plan eligibility status; primary care provider name, address, and telephone number; and plan number and enrollment /disenrollment dates to be used for coordination and follow-up with the local CCS program. 	<ul style="list-style-type: none"> • Provide technical assistance to plans for the development of plan policies, procedures, and protocols for making referrals to the program, including necessary medical documentation. • Determine medical eligibility within five working days of receiving adequate medical documentation of the suspicion of a CCS eligible condition. • Ensure that provider, designated plan personnel, and subscriber family are informed of either program eligibility or denial upon eligibility determination. Provide medical consultation as appropriate during the time period from referral to medical eligibility determination. • Authorize from referral date medically necessary CCS benefits required to treat a subscriber's CCS eligible condition and be responsible for the reimbursement of care to authorized providers when CCS eligibility is established. • Coordinate with plan liaison and network designees to share a tracking list of CCS eligibles who are known to the plans. The list will include name, CCS case number, birth date, social security number (if known), CCS eligible diagnoses, date of eligibility and status; in case of denial or closure, reason for ineligibility and date closed; referral source and primary care provider on file, if known.
Case Management/Tracking and Follow-Up	<ul style="list-style-type: none"> • Utilize tracking system to coordinate health care services for members receiving services authorized by the CCS program. • Develop policies and procedures that specify providers' responsibility for coordination of specialty and primary care services and ensure that CCS eligible children receive all medically necessary pediatric preventive services, including immunizations. • Develop policies and procedures that specify coordination activities among primary care providers, specialty providers, and hospitals and communication with CCS program case managers. 	<ul style="list-style-type: none"> • Assist plan in assessing, and alleviating barriers to accessing primary and specialty care related to the CCS eligible condition. Assist subscriber/subscriber family to complete enrollment into the CCS program. • Provide case management services in order to coordinate the delivery of health care services to subscribers with CCS eligible conditions, including services provided by other agencies and programs, such as Local Education Agencies and Regional Centers. • Develop systems that result in transmission of medical reports of services provided by CCS authorized providers to the appropriate plan primary care providers.

County/City:

Effective Dates:

Service	Health Plan Responsibilities	CCS Program Responsibilities
Quality Assurance and Monitoring	<ul style="list-style-type: none"> • Conduct jointly with the CCS program, regular reviews of policies and procedures related to this agreement. • Participate, at a minimum, in quarterly meetings with the CCS program to update policies and procedures as appropriate. • Review and update protocols annually in conjunction with the CCS program. • Develop work plan, in conjunction with CCS, that will monitor the effectiveness of the MOU and the plan/CCS interface. 	<ul style="list-style-type: none"> • Conduct jointly with the plans, regular reviews of policies and procedures related to this agreement. • Participate, at a minimum, in quarterly meetings with the plan to update policies and procedures as appropriate. • Review and update protocol on an annual basis in conjunction with the health plan. • Develop work plan, in conjunction with the plan, to monitor the effectiveness of the MOU and the plan/CCS interface.
Problem Resolution	<ul style="list-style-type: none"> • Assign appropriate health plan management/liaison staff to participate with the local CCS program management and professional staff in the resolution of individual subscriber issues as they are identified. • Assign appropriate health plan management/liaison staff to participate in, at a minimum, quarterly meetings to identify and resolve operational and administrative issues, including coordination, communication, referral, training, billing, provision of appropriate services, and authorization of services. • Refer issue to the appropriate CMS Regional Office if problem cannot be resolved locally. 	<ul style="list-style-type: none"> • Assign appropriate CCS program management and professional/liaison staff to participate with health plan management staff in the resolution of individual subscriber issues as they are identified. • Assign appropriate CCS program/liaison staff to participate in, at a minimum, quarterly meetings with health plan management/liaison staff to identify and resolve operational and administrative issues, including coordination, communication, referral, training, billing, provision of appropriate services, and authorization of services. • Refer issue to CMS Regional Office if problem cannot be resolved locally.

Signatures of the undersigned indicate intent to develop policies and procedures that will successfully develop the local CCS and Healthy Families Program interface.

County CCS Administrator

Date

Plan Designee

Date

Marian Dalsey, M.D., Acting
Children's Medical Services Branch Chief

Date

Delineation of Responsibilities for Children's Medical Services Branch, Regional Offices, and Dependent Counties as They Relate to the Healthy Families Memorandum of Understanding

County/City:

Effective Dates:

Service	CCS Program Responsibilities	CMS Branch, Regional Offices, and Dependent County CCS Program Responsibilities
Liaison	<ul style="list-style-type: none"> Designate a liaison to the plan, who will be the program's point of contact for the health plan and its networks to coordinate all related activities. 	<ul style="list-style-type: none"> Regional Office will designate a liaison as lead for their responsibilities as identified in the CCS case management procedure manual. Each dependent county will also designate a liaison to work with the plan.
	<ul style="list-style-type: none"> Meet, at a minimum, quarterly, to ensure ongoing communication; to resolve operational and administrative problems; and identify policy issues needing resolution at the management level. 	<ul style="list-style-type: none"> CMS Branch staff, one representative from Regional Office and designated dependent county representative(s).
Provider Training	<ul style="list-style-type: none"> Collaborate with plan to assist in the development of CCS related policies and procedures as needed by health plan and CCS. 	<ul style="list-style-type: none"> Regional Office and dependent county CCS program (joint)
	<ul style="list-style-type: none"> Collaborate with health plan to provide multiple initial training opportunities that will give providers an understanding of the CCS program and eligibility requirements. 	<ul style="list-style-type: none"> Regional Office and dependent county CCS program (joint)
	<ul style="list-style-type: none"> Provide availability of local program medical consultant or designee to consult with primary care providers and/or specialty providers on a case-by-case basis. 	<ul style="list-style-type: none"> Regional Office
	<ul style="list-style-type: none"> Support ongoing training opportunities as needed. 	<ul style="list-style-type: none"> Regional Office and dependent county CCS program (joint)
CCS Provider Network	<ul style="list-style-type: none"> Provide plans with CCS provider applications to expedite the paneling or approval of specialty and primary care network providers. 	<ul style="list-style-type: none"> Dependent county CCS program
	<ul style="list-style-type: none"> Coordinate with the State office to assure identification of local CCS provider network to health plan. 	<ul style="list-style-type: none"> Dependent county CCS program
	<ul style="list-style-type: none"> Coordinate with plan to refer to an appropriate CCS-paneled specialty provider to complete diagnostic services and treatment as needed. 	<ul style="list-style-type: none"> Regional Office and dependent county CCS program (joint)

County/City:

Effective Dates:

Service	CCS Program Responsibilities	CMS Branch, Regional Offices, and Dependent County CCS Program Responsibilities
Case Identification and Referral	<ul style="list-style-type: none"> • Provide technical assistance to plans for the development of plan policies, procedures, and protocols for making referrals to the program including necessary medical documentation. 	<ul style="list-style-type: none"> • Regional Office
	<ul style="list-style-type: none"> • Determine medical eligibility within five working days of receiving adequate medical documentation of the suspicion of a CCS-eligible condition. 	<ul style="list-style-type: none"> • Regional Office
	<ul style="list-style-type: none"> • Ensure that provider, designated plan personnel, and subscriber family are informed of either program eligibility or denial upon eligibility determination. 	<ul style="list-style-type: none"> • Regional Office and dependent county CCS program (joint), as per CCS Case Management Procedure manual
	<ul style="list-style-type: none"> • Provide medical consultation as appropriate during the time period from referral to medical eligibility determination. 	<ul style="list-style-type: none"> • Regional Office
	<ul style="list-style-type: none"> • Authorize, from referral date, medically necessary CCS benefits required to treat a subscriber's CCS-eligible condition and be responsible for the reimbursement of care to authorized providers when CCS eligibility is established. 	<ul style="list-style-type: none"> • Regional Office
	<ul style="list-style-type: none"> • Coordinate with plan liaison and network designees to share a tracking list of CCS eligibles who are known to the plans. The list will include name, CCS case number, DOB, SSN (if known), CCS eligible diagnoses, date of eligibility, and status; in case of denial or closure, reason for ineligibility and date closed; referral source and primary care provider on file, if known. 	<ul style="list-style-type: none"> • CMS Branch
Case Management/Tracking and Follow-Up	<ul style="list-style-type: none"> • Assist plan in assessing and alleviating barriers to accessing primary and specialty care related to the CCS-eligible condition. Assist subscriber/subscriber family to complete enrollment into the CCS program. 	<ul style="list-style-type: none"> • Regional Office and dependent county CCS program (joint)
	<ul style="list-style-type: none"> • Provide case management services in order to coordinate the delivery of health care services to subscribers with CCS-eligible conditions, including services provided by other agencies and programs, such as Local Education Agencies and Regional Centers. 	<ul style="list-style-type: none"> • Regional Office and dependent county CCS program (joint)
	<ul style="list-style-type: none"> • Develop systems that will result in transmission of medical reports of services provided by CCS-authorized providers to the appropriate plan primary care providers. 	<ul style="list-style-type: none"> • Regional Office

County/City:

Effective Dates:

Service	CCS Program Responsibilities	CMS Branch, Regional Offices, and Dependent County CCS Program Responsibilities
Quality Assurance and Monitoring	<ul style="list-style-type: none"> • Conduct, jointly with the plans, regular reviews of policies and procedures related to this agreement. 	<ul style="list-style-type: none"> • CMS Branch and designated dependent county representative (joint) with CMS Branch as lead
	<ul style="list-style-type: none"> • Participate, at a minimum, in quarterly meetings with the plans to update policies and procedures as appropriate 	<ul style="list-style-type: none"> • CMS Branch and designated dependent county representative (joint) with CMS Branch as lead.
	<ul style="list-style-type: none"> • Review and update protocol on an annual basis in conjunction with the health plan. 	<ul style="list-style-type: none"> • CMS Branch and designated dependent county representative (joint) with CMS Branch as lead.
	<ul style="list-style-type: none"> • Develop work plan in conjunction with the plans that will monitor the effectiveness of the MOU and the plan/CCS interface. 	<ul style="list-style-type: none"> • CMS Branch and designated dependent county representative (joint) with CMS Branch as lead.
Problem Resolution	<ul style="list-style-type: none"> • Assign appropriate CCS program management and professional/liaison staff to participate with health plan management staff in the resolution of individual subscriber issues, as they are identified. 	<ul style="list-style-type: none"> • Regional Office
	<ul style="list-style-type: none"> • Assign appropriate CCS program/liaison staff to participate in, at a minimum, quarterly meetings with health plan management/liaison staff to identify and resolve operational and administrative issues, including coordination, communication, referral, training, billing, provision of appropriate services and authorization of services. 	<ul style="list-style-type: none"> • Regional Office will refer to CMS Branch, Program Standards, and Quality Assurance Section if issue cannot be resolved.
	<ul style="list-style-type: none"> • Refer issue to CMS Regional Office if problem cannot be resolved locally. 	<ul style="list-style-type: none"> • Regional Office will refer to CMS Branch, Program Standards, and Quality Assurance Section if issue cannot be resolved.

Signatures of the undersigned indicate intent to develop policies and procedures that will successfully develop the local CCS and Healthy Families Program interface.

County CCS Administrator

Date

Plan Designee

Date

Marian Dalsey, M.D., Acting
Children's Medical Services Branch Chief

Date

County/City CHDP Program Model Interagency Agreement

Fiscal Years ____ to ____

(Please describe local needs and procedures where words appear in *Italics*.)

I. Statement of Agreement

This statement of agreement is entered into between (*Name of Health Department*) and (*Name of Social Services Department*) to assure compliance with Federal and State regulations and the appropriate expenditure of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) funds in the implementation of the Child Health and Disability Prevention (CHDP) Program.

II. Statement of Need

The following specific needs in (*County/City*) have been identified by the Health and Social Services departments as a focus for FY ____ - ____.

Specify, for example:

- A. *Need for increasing the number of referrals for CHDP services using a variety of modalities including continuing staff education for the purposes of increasing referrals and identifying children's health conditions for which to seek consultation and coordination by trained health professionals.*
- B. *Need for increasing the number of children ages 0 to 21 years receiving health assessments.*
- C. *Need for increasing coordinated, comprehensive, and culturally competent services for children living in foster care (relative/kinship, foster family homes, group homes, etc.) including CHDP health assessment services and necessary diagnostic and treatment services.*
- D. *Gaps in existing program.*
- E. *Objectives for the year(s) of the agreement that represent joint activities of the health and social services departments.*
- F. *Need for consultation and information about CHDP resources and general public health services in child care settings.*
- G. *Need for involvement of other community organizations in the program, e.g., advocacy groups.*
- H. *Need for evaluation of reporting systems in health and social services departments.*
- I. *Need for coordination with local Medi-Cal Managed Care Plans, where appropriate.*

County/City: _____

Effective Dates: _____ to _____

J. *Other, such as changes in State or Federal regulations.*

III. Organizational and Functional Relationships

A. The exchange of information about persons applying for or receiving Medi-Cal, with or without linkages to other social services programs as outlined in this document, is permitted by State and Federal law and regulations, and is to be maintained in a confidential manner.

B. *Attach organizational charts to display important points of interface between CHDP and Social Services programs and personnel.*

1. *The relationship between administrative staff of the CHDP Program and the DSS.*

2. *Health system interrelationships.*

3. *Social services system interrelationships.*

4. *Social services system relationship to probation departments, licensed adoption agencies, and placement agencies.*

5. *Relation of EPSDT unit(s) to departments named in number "4".*

6. *Reporting relationship of EPSDT unit to CHDP Director.*

7. *Designation, by name, title, and location (address) of liaison personnel from Departments of Social Services and Health Services.*

8. *Health Care Program for Children in Foster Care.*

C. *Attach flow charts to depict the CHDP process of informing from availability of health care, preventive care, through diagnosis and treatment for the following:*

1. California Work Opportunity and Responsibility to Kids (CalWORKs) Families, In-person Application/Annual Re-determination.

2. Medi-Cal

a. In-person Application/Annual Re-determination (if requested)

b. Mail-in Application/Re-determination

3. Children Placed in Foster Care

Indicate departmental responsibility for each step.

IV. Social Services Department Responsibilities and Activities

A. Basic Informing and Documentation of Informing for CalWORKs or Medi-Cal.

County/City: _____

Effective Dates: _____ to _____

Following are the requirements for Basic Informing and Documentation of Informing by Eligibility Determination staff for persons applying for, or receiving, CalWORKs or Medi-Cal.

Describe procedures for informing the responsible adult who is blind, deaf, illiterate, or does not understand the English language. Include one or more specific methods for informing each identified group with special communication needs.

1. In-person Application/Annual Re-determination
 - a. In the requested face-to-face eligibility intake interview or at the time of the annual re-determination, the appropriate adult(s) responsible for Medi-Cal eligible persons, including unborn, and persons under 21 years of age will be:
 - 1) Given a State-approved brochure about the CHDP Program.
 - 2) Given an oral explanation about CHDP including:
 - a) The value of preventive health services and the differences between episodic and wellness care;
 - b) Availability of health assessments;
 - c) Availability of dental services;
 - d) The need for prompt diagnosis and treatment of suspected conditions to prevent disabilities and that all medically necessary diagnosis and treatment services will be paid for by Medi-Cal; and
 - e) The nature, scope, and benefits of the CHDP Program.
 - 3) Asked questions to determine whether:
 - a) More information about CHDP Program services is wanted;
 - b) CHDP Program services - medical and/or dental - are wanted; and
 - c) If appointment scheduling and/or transportation assistance are needed to obtain requested CHDP medical and/or dental services.
 - b. The Eligibility Determination staff will document on the *designated form and/or the case narrative, as appropriate, (please specify,*

County/City: _____

Effective Dates: _____ to _____

e.g., JA2, SAWS2, MC 210, MC 210 RV) using automated or non-automated systems (please specify) that **face-to-face** informing occurred:

- 1) Explanation and brochure given;
- 2) Date of the explanation and giving of the brochure; and,
- 3) The individual responses to the CHDP service questions.

NOTE: The JA2 form is obsolete but if still in use by the county the requirements in this section still apply.

2. Mail-in Application/Annual Re-determination - Medi-Cal

a. Responsible adult(s) for Medi-Cal eligible persons under 21 years of age who apply by mail will do so through completion of a State-approved Medi-Cal Application/Annual Re-determination form. The Application/Annual Re-determination process includes the mailing of a State-approved brochure about the CHDP Program to the applicant. The State-approved brochure about the CHDP Program, entitled "Medical and Dental Health Check-Ups," informs the family of where to call or write if:

- 1) More information about CHDP Program services is wanted; or
- 2) Help with getting an appointment and transportation to medical care is needed.

b. Eligibility Determination staff will document on the *designated form and/or the case narrative, as appropriate, (please specify, e.g., MC 321 HFP or Healthy Families Annual Eligibility Review (AER) Form; MC 210 RV or in the case record if any follow-up action is required).*

NOTE: Any "Yes" response to the CHDP questions or offer of services through face-to-face encounters or mail-in applications requires a referral on the CHDP Referral Form (PM 357), or State-approved alternate referral form. *If using an alternate referral form, indicate name and number and date of approval.* See CHDP Program Letter No. 81-5/DSS All County Letter No. 81-43. *Cite the form title and number of your county's State-approved, alternate form.*

B. Basic Informing and Documentation of Informing for Children in Foster Care Program Placement

Following are the requirements for Basic Informing and Documentation of Informing by staff responsible for placement of children in foster care, including

County/City: _____

Effective Dates: _____ to _____

placements controlled by the Probation Department, Licensed Adoption Agency, and/or Placement Agencies.

1. Within 30 days of placement, the staff responsible for placing the child (i.e., social worker, probation officer) will document the need for any known health, medical, or dental care and ensure that information is given to the payee, hereafter referred to as the substitute care provider, about the needs of the eligible person and the availability of CHDP services through the CHDP Program. In the case of an out-of-state placement, the social worker shall ensure information is given to the substitute care provider about the Federal EPSDT services. The substitute care provider and/or child will be:
 - a. Given a State-approved brochure about CHDP services and information about the child's need of preventive health care; and
 - b. Given a face-to-face oral explanation about CHDP, including:
 - 1) The value of preventive health services and the differences between episodic and wellness care;
 - 2) The availability of health assessments according to the CHDP periodicity schedule, and how to obtain health assessments at more frequent intervals if no health assessment history is documented or the child has entered a new foster care placement;
 - 3) The availability of annual dental exams for children one year of age and older;
 - 4) The need for prompt diagnosis and treatment of suspected conditions to prevent disabilities and that all medically necessary diagnosis and treatment services will be paid for by Medi-Cal; and
 - 5) The nature, scope, and benefits of the CHDP Program.
 - c. Asked questions to determine whether:
 - 1) More information about the CHDP Program is wanted;
 - 2) CHDP Program services - medical and/or dental - are wanted; and
 - 3) If appointment scheduling and/or transportation assistance is needed to obtain CHDP medical and/or dental services.
2. The Child Welfare Services staff responsible for placement will document the substitute care provider's response to the questions in the CHDP Program area of the Identification Page in the Placement Notebook in the

County/City: _____

Effective Dates: _____ to _____

Placement Management Section in the Client Services Application on the Child Welfare Services/Case Management System (CWS/CMS):

- a. Date care provider was informed of the CHDP Program and brochure given; and
 - b. Care provider's request for CHDP services.
3. The Probation Department, Licensed Adoption Agency, or other Placement Agency staff responsible for placement will document the substitute care provider and/or child's response to the CHDP questions on the CHDP Referral Form (PM 357) and maintain a copy in the case record.

NOTE: Any "Yes" response to the CHDP questions or offer of services requires a referral on the CHDP Referral Form (PM 357). See CHDP Program Letter No. 81-5/DSS All County Letter No. 81-43. A copy of the Referral Form is to be maintained in the child's case record.

4. A "payee," referred to as the "out-of-home care provider" or "substitute care provider," is defined as the foster parent(s) in a foster home, the officially designated representative of the payee when the child is in the foster care program, or a Medi-Cal eligible child residing in a group home, residential treatment center, or other out-of-home care facility.
5. Child Welfare Services staff responsible for the child in a foster care placement will complete annual informing of the care provider/child. They will include information about CHDP preventive health services, unmet health care needs requiring follow up, and a review of the child's access to a primary care provider according to the process outlined for initial informing in B.1. a – B.1.c; and will document the results of informing in the case plan update.
6. The Probation Department, Licensed Adoption Agency, or other Placement Agency staff responsible for placement will complete annual informing and the documentation of that informing according to the outline in B.1 and B.3.
7. Describe the procedures used by the DSS for ensuring satisfactory initial and annual informing on behalf of children in the Foster Care program or Medi-Cal eligible children when the placement responsibility is controlled by the probation department or any other social agency such as licensed adoption agencies, and/or placement agencies. Include any interagency agreements developed for this assurance if they are available.
8. Describe procedures for ensuring that informing about the need for a CHDP exam and the health status of children in the Foster Care program and/or Medi-Cal eligible children is provided at the time of out-of-home placement with a relative, *or upon return of the child to the parent(s)*.

County/City: _____

Effective Dates: _____ to _____

9. Describe procedures for assuring that substitute care providers/payees responsible for children placed in foster care out-of-county are properly informed about CHDP services.

C. Referral to the EPSDT Unit of the CHDP Program

1. All "Yes" responses to the offers of more information about CHDP, CHDP medical/dental services, and appointment scheduling/ transportation assistance will be documented on a CHDP Referral Form (PM 357), or a State-approved alternate referral form. The Referral Form will be sent to the *EPSDT Unit of the CHDP Program*. This action is required to ensure these services are received and that any necessary diagnostic and/or treatment services are initiated within 120 days of the date of eligibility determination for persons receiving assistance through CalWORKs or Medi-Cal, and within 120 days of the date of request for children in foster care placement.
2. *Describe the process for referrals indicated by "Yes" responses from persons, children, or care providers to the offers of more information about CHDP, CHDP medical/dental services and appointment scheduling/ transportation assistance when the child is a member of a Medi-Cal Managed Care Plan.*
3. *Describe procedures for assuring that children in foster care placed out-of-county are properly referred for CHDP services.*
4. Referral requirements described in C.1 and C.2 above also apply to children in foster care placement controlled by the probation department, licensed adoption agency, and/or a placement agency. *Describe the procedures used by the DSS to assure that proper referrals are made by the probation department, licensed adoption agencies, and/or placement agencies. Include any interagency agreements developed for this assurance if they are available.*

D. Information Provided by Social Services Staff on the CHDP Referral Form (PM 357) or State-Approved Alternate Referral Form

The following will be included on the referral form when any "Yes" response is given, written or verbal, to the offer of services:

1. Case Name and Medi-Cal Identification Number.
2. Type of services requested:
 - a. Additional information
 - b. Medical services
 - c. Dental services

County/City: _____

Effective Dates: _____ to _____

- d. Transportation assistance
 - e. Appointment scheduling assistance
 - 3. Source of referral:
 - a. New application
 - b. Re-determination
 - c. Self-referral
 - 4. Case type:
 - a. CalWORKs (on existing form as AFDC)
 - b. Foster Care
 - c. Medi-Cal Only (Full Scope, Limited Scope with or without a Share-of-Cost)
 - 5. Complete listing of members in case with birth dates including unborn and the expected date of confinement (EDC)
 - 6. Listing of the payee/substitute care provider and child in foster care
 - 7. Residence address and telephone number
 - 8. Eligibility Worker signature
 - 9. Date of eligibility determination for CalWORKs and Medi-Cal only cases or date of request for children in Foster Care and self-referrals
- E. Care Coordination for Children in Foster Care
- 1. The staff responsible for placement of the child will ensure that the child receives medical and dental care that places attention on preventive health services through the CHDP Program, or equivalent health services in accordance with the CHDP Program's schedule for periodic health and dental assessments. More frequent health assessments may be obtained for a child when the child enters a new placement. Another health assessment may be claimed through CHDP by entering "New Foster Care Placement" in the Comments/Problems area of the Confidential Screening/Billing Report (PM 160). (For example: if there is no record documenting a health assessment during the child's previous placement, if the child is not performing age-expected developmental skills, or if he/she has been moved to an area with a new provider.)
 - 2. The staff responsible for placement of the child will ensure that arrangements are made for necessary diagnosis and treatment of health conditions suspected or identified.

County/City: _____

Effective Dates: _____ to _____

3. Medical records including, but not limited to, copies of the CHDP Confidential Screening/Billing Reports (PM 160) or results of an equivalent preventive health screen for any child in foster care will be kept in the child's case record. Case records for children age one and over must also contain the result(s) of dental visit(s).
4. The case record will contain a plan which ensures that the child receives medical and dental care which places attention on preventive health services through CHDP or equivalent preventive health services in accordance with the CHDP Program's schedule for periodic health and dental assessments.

V. EPSDT Unit of the CHDP Program Responsibilities and Activities for Referrals

- A. *Describe where the EPDST unit is administratively located and physically stationed (i.e., Health and/or Social Services Department(s)).*
- B. *Attach duty statements of unit personnel.*
- C. *Describe provision for (1) overall medical supervision, (2) administrative supervision, and (3) day-to-day supervision.*
- D. The EPSDT Unit will accept and take appropriate action on all referrals of Medi-Cal eligible persons under 21 years of age, including unborn, and will:
 1. Intensively inform those requesting more information, and offer scheduling and transportation assistance to those who request CHDP medical and/or dental services.
 2. Provide all requested scheduling and/or transportation assistance so that medical and/or dental services can be received from a managed care plan or provider of the requester's choice. These services will be provided and diagnosis and treatment initiated within 120 days of the child's date of eligibility determination or re-determination, and within 120 days of a request if by self referral or for children in foster care unless:
 - a. Eligibility is lost; or,
 - b. Child is lost to contact and a good faith effort was made to locate the child as defined in Section VII; or,
 - c. Failure to receive services was due to an action or decision of the family or child.

Describe the procedure for new and established members in Medi-Cal managed care plans.

3. Assure that families asking for health assessment procedures not furnished by their provider are referred to another provider for those

County/City: _____

Effective Dates: _____ to _____

procedures so that all requested CHDP services are received within 120 days of the initial request.

Describe the procedure for new and established members in Medi-Cal Managed Care Plans.

4. Follow up on families requesting appointment scheduling and transportation assistance to:
 - a. Re-offer scheduling and transportation assistance to those persons whose failure to keep appointments was not due to an action or decision of the family or child.
 - b. Offer and provide requested assistance to those for whom further diagnosis and treatment is indicated.

Describe the procedure for new and established members in Medi-Cal Managed Care Plans.

- E. Health Assessment reminder cards with current addresses will be generated and mailed by the State CHDP Program for all children twenty-seven months of age and younger who are receiving Medi-Cal through the Fee-for-Service system.
- F. The following will be documented on the CHDP Referral Form (PM 357) or an alternate, State-approved referral form for each eligible person listed:
 1. Type of transportation assistance and date given
 2. Appointment scheduling assistance and date given
 3. Date(s) of appointment(s) and name(s) of provider(s)
 4. Confirmation of CHDP services:
 - a. Health assessment requires a PM 160 on file or provider certification of provision of service.
 - b. Dental services require family, provider, or child verification.
 5. Follow up to needed diagnosis and treatment:
 - a. Response to offer of appointment scheduling and transportation assistance
 - b. Type of transportation assistance and date given
 - c. Date(s) of appointment(s) and name(s) of provider(s)
 - d. Confirmation of care - PM 161 or similar form of certification by provider

County/City: _____

Effective Dates: _____ to _____

6. Date appointment scheduling and/or transportation assistance was declined and by whom.
 7. Disposition of case: appointment kept or not kept, eligibility lost, family declined further services, or family/person lost to contact and Good Faith Effort was made to locate the person as defined in Section VII.
- G. A quarterly report will be prepared by the 15th day following the end of each quarter showing the number of CalWORKs and Medi-Cal Only persons requesting CHDP services. This report will be used to verify information submitted annually on the Case Management Data Flow sheet as part of the county's Plan and Budget for the following fiscal year.

VI. CHDP Program Responsibilities and Activities

- A. An adequate number of medical providers will be available to meet county needs and Federal regulations in regard to allowable time frames.
- B. The county CHDP Program will make all possible attempts to assure an adequate number of dental providers are available to meet county needs and Federal regulations.
- C. An adequate supply of the following materials will be available to meet Social Services Department and other county needs:
 1. State-approved informing brochure with the address and phone number of the local CHDP Program
 2. Current list of CHDP medical and dental providers
 3. Other informational material, e.g., CHDP poster
- D. When eligible persons still needing CHDP services move to another county, the new county will be notified and appropriate information sent. *Describe this process.*
- E. Copies of Screening/Billing Reports (PM 160) for services given to children in foster care will be sent to the responsible DSS. *Describe this process.*
- F. All persons eligible for Title V services (California's women of reproductive age, infants, children, adolescents, and their families) will be informed of availability of these services and referred as requested.
- G. Referrals for Public Health Nursing services for intensive informing and follow up to health assessment and diagnosis and treatment will be accepted, and such services will be provided.

NOTE: Item G is required only when EPSDT funds are requested for Public Health Nursing through a county/federal match.

County/City: _____

Effective Dates: _____ to _____

VII. Joint Social Services/CHDP Responsibilities

A Good Faith Effort will be made to locate all persons lost to contact. The EPSDT Unit/CHDP Program will query the DSS for current addresses, telephone numbers, and Medi-Cal status of these persons. Upon request, the DSS will share this information. The exchange of this confidential information is based on Federal and State regulations.

VIII. Staff Education

- A. Within 90 days of employment by the DSS, all new staff with responsibility for placement or eligibility determination will have completed orientation regarding the CHDP Program and their role and responsibilities for informing persons about CHDP and referring for services. *Identify staff person(s) from the Health Department CHDP Program responsible for conducting this training.*
- B. Within 90 days of employment by the Probation Department or licensed adoption agency, staff responsible for placement will have completed orientation regarding the CHDP Program and their roles and responsibilities for informing persons about CHDP and referring for services. *Identify staff person(s) responsible for conducting this training.*
- C. Upon licensure and at renewal, foster parent(s) and group care home, residential treatment center, and other out-of-home care facility staff will complete orientation regarding nature, scope, benefits, and availability of CHDP Program services. *Identify staff person(s) responsible for conducting this training.*
- D. All appropriate health department staff will receive orientation and an annual update regarding the CHDP Program.
- E. The local CHDP Program will provide an annual update to all placement and eligibility determination staff regarding the CHDP Program.
- F. *Describe how additional staff in-service education needs will be identified. Specify, for example:*
 - 1. *Need due to regulatory changes.*
 - 2. *Need revealed through program evaluation/reports.*
 - 3. *Need revealed through task force/problem solving meetings.*
 - 4. *Use of formalized education needs assessment tools.*

IX. Management Information and Program Evaluation

- A. The following information will be compiled and shared between departments. *Describe mechanism of reporting this information to management and program staff, e.g., eligibility and placement workers. Specify, for example:*
 - 1. *Numbers of:*

County/City: _____

Effective Dates: _____ to _____

- a. *Eligibles - intake/re-determination. Break out number of children in foster care placement.*
 - b. *Requests for CHDP services.*
 - c. *Requests for more information.*
 - d. *Requests for scheduling and/or transportation assistance.*
 - e. *Medical assessment services requested and received.*
 - f. *Dental services requested and received.*
 - g. *Referrals to diagnosis and treatment.*
2. *Examples of children helped.*
 3. *At a minimum, quarterly newsletter focusing on the aforementioned information from "1" and "2" to be sent to program/agency staff.*
- B. Conduct and describe methods of program evaluation. *Specify, for example:*
1. *Description of internal process for monitoring, improving, and evaluating compliance with the program as outlined in the agreement.*
 2. *Review in the DSS and EPSDT units in the Departments of Health and/or Social Services.*
 3. *Review of program procedures - e.g., periodic notification.*
 4. *Special studies in each department.*
 5. *Care coordination reviews of CHDP process/system within each department.*
 6. *Review of status of plan/interagency agreement objectives on a systematic basis.*

County/City: _____

Effective Dates: _____ to _____

X. Compliance Certification

In signing this agreement, we hereby certify that the CHDP Program in our community will meet the compliance requirements and standards pertaining to our respective departments contained in the following:

A. Enabling legislation of the CHDP Program

Reference: Health and Safety Code Sections 124025 through 124110 and Section 104395.

B. CHDP Program regulations that implement, interpret, or make specific the enabling legislation.

Reference: California Code of Regulations, Title 17, Section 6800 through 6874.

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

Reference: California Code of Regulations, Title 22, Sections 51340(c), 51340 and 51532.

D. Regulations defining county DSS responsibilities for meeting CHDP/EPSDT Program requirements.

1. Social Services Regulations

Reference:

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

b. Civil Rights - MPP Section 21-101, 21-107, 21.115.

c. Eligibility and Assistance Standards - MPP Sections: 40-107.61, 40-131.3(k), 40-181.211, 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), 31-205.1(h), 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), 31-405.1(g)(1).

e. Intra and interagency relations and agreements Chapter 29-405 and Chapter 29-410.

County/City: _____

Effective Dates: _____ to _____

2. Medi-Cal Regulations

Reference:

- a. California Code of Regulations, Title 22, Sections: 50031; 50157(a), (d), (e), (f), and 50184(b).
- b. Other Title 22 regulations governing DSS programs regarding adoptions and referring parents to community services, including CHDP Pre-placement Advisement, California Code of Regulations, Title 22, Section 35094.2 and Advisement of Parents Whose Child has not been Removed from Parent's Care, Section 35129.1

E. Current interpretive releases by State Departments of Health Services and Social Services.

- 1. Children's Medical Services (CMS) Branch /CHDP Program Letters and Information Notices - Health Services.
- 2. All County Letters - Social Services.
- 3. Joint Letters - Health Services and Social Services
- 4. CMS Branch/CCS Numbered Letters pertaining to the CHDP Program - Health Services.

This interagency agreement is in effect from *July 1, 20__ through June 30, 20__* unless revised by mutual agreement.

NOTE: In the event that changes in Federal or State legislation impact the current Interagency Agreement, the Health Department and Social Services Department agree to renegotiate the pertinent section within 90 days of receiving new language or instructions from the State.

Child Health and Disability Prevention Program Director

Date

County Social Services Department Director

Date

County Probation Department

Date

County/City: _____

Effective Dates: _____ to _____

Model HCPCFC Memorandum of Understanding

Suggested Areas of Responsibility for Child Health and Disability Prevention (CHDP) Public Health Nurses (PHNs) and Child Welfare Service (CWS) Agency Social Workers and Probation Officers in the Health Care Program For Children In Foster Care (HCPCFC)

County/City:

Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Location	<ul style="list-style-type: none"> • PHN will be located in the CWS agency with accessibility to all team members 	<ul style="list-style-type: none"> • PHN will be located in the CWS agency with accessibility to all team members servicing children in foster care, including any PHNs currently working in CWS.
Supervision	<ul style="list-style-type: none"> • PHN will be supervised by supervising PHN in the local CHDP Program with input from CWS agency staff. 	<ul style="list-style-type: none"> • CWS agency/Supervising Probation Officer will provide input to the supervising PHN.
Accessing Resources	<ul style="list-style-type: none"> • PHN will identify health care providers in the community. • PHN will evaluate the adequacy, accessibility and availability of the referral network for health care services and collaborate with CHDP staff to identify and recruit additional qualified providers. • PHN will serve as a resource to facilitate (e.g., assist in scheduling appointments, arranging transportation, etc.) referrals to early intervention providers, specialty providers, dentists, mental health providers, CCS and other community programs. • PHN will assist PHNs in the child's county of residence to identify and access resources to address the health care needs of children placed out of county. 	<ul style="list-style-type: none"> • CWS agency Social Worker/Probation Officer will work with PHN to ensure that all children in foster care are referred for health services appropriate to age and health status on a timely basis. • CWS agency Social Worker/Probation Officer will work with the substitute care provider (Foster Parent) and the PHN to identify an appropriate health care provider for the child. • CWS agency Social Worker/Probation Officer will work with the PHN to ensure that children placed out of county have access to health services appropriate to age and health status.

County/City:

Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Health Care Planning and Coordination	<ul style="list-style-type: none"> • PHN will interpret health care reports for social worker/probation officers and others as needed. • PHN will develop a health plan for each child expected to remain in foster care. • PHN will work with substitute care provider to ensure that the child's Health and Education Passport or its equivalent is updated. • PHN will assist substitute care provider s in obtaining timely comprehensive assessments. • PHN will expedite timely referrals for medical, dental, developmental, and mental health services. • PHN will assist social worker/probation officer in obtaining additional services necessary to educate and/or support the foster caregiver in providing for the special health care needs, including but not limited to Early and Periodic Screening, Diagnosis, and Treatment Supplemental Services (EPSDT-SS). • PHN will obtain and provide health care documentation when necessary to support the request for health care services. • PHN will collaborate with social worker/probation officer, biological parent when possible and substitute care provider to ensure that necessary medical/health care information is available to those persons responsible for providing healthcare for the child, including a copy of the Health Education Passport (HEP) to the substitute care provider. • PHN will assist social worker/probation officer to assess the suitability of the foster care placement in light of the health care needs of the child. • PHN will collaborate with the social worker/probation officer and substitute care provider to develop a system of tracking and follow-up on changes in the health care status of the child, service needs, effectiveness of services provided, etc. • PHN will review child's health plan with social worker/probation officer as needed and at least every six months. 	<ul style="list-style-type: none"> • Child's Social Worker/Probation Officer will collaborate with PHN to develop a health plan which identifies the health care needs and service priorities for each child expected to remain in foster care for 6 months or longer. • Social Worker/Probation Officer or designee will incorporate health plan into child's case record. • Social Worker/Probation Officer will assemble and provide health care documentation to the court when necessary to support the request for health care services. • Social Worker/Probation Officer will collaborate to complete and keep current the child's Health and Education Passport or its equivalent and provide a copy of the HEP to the substitute care provider. • Social Worker/Probation Officer will consult with the PHN to assess the suitability of the foster care placement in light of the health care needs of the child. • Social Worker/Probation Officer will collaborate with the PHN and substitute care provider to develop a system of tracking and follow-up on changes in the health care status of the child, service needs, effectiveness of services provided, etc. • Social Worker/Probation Officer will review child's health plan with PHN at least every six months and before every court hearing relevant information will be incorporated into the HEP and court report.

County/City:

Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Training/Orientation	<ul style="list-style-type: none"> • PHN will participate in developing and providing educational programs for health care providers to increase community awareness of and interest in the special health care needs of children in foster care. • PHN will educate social workers, juvenile court staff, substitute care providers, school nurses and others about the health care needs of children in foster care. 	<ul style="list-style-type: none"> • CWS agency staff/Probation Officers will provide input to PHN in developing curriculum for training others about health care needs of children in foster care. • CWS agency staff/Probation Officers will collaborate with PHNs in educating juvenile court staff, substitute care providers, and others about the health care needs of children in foster care. • CWS agency personnel will arrange for PHN access to the Child Welfare Services/Case Management System (CWS /CMS) system and provide training in its use.
Policy/Procedure Development	<ul style="list-style-type: none"> • PHN will provide program consultation to CDSS/ Probation Departments in the development and implementation of the EPSDT/CHDP Program policies related to the Health Care Program for Children in Foster Care. • PHN will participate in multi-disciplinary meetings for review of health-related issues. 	<ul style="list-style-type: none"> • CWS agency staff/Probation Officers will include the PHN in team meetings and provide orientation to social services and consultation on CWS/CMS.
Transition from Foster Care	<ul style="list-style-type: none"> • PHN will provide assistance to the Social Worker/Probation Officer and youths leaving foster care on the availability of options of health care coverage as well as community resources to meet the health care needs upon emancipation. 	<ul style="list-style-type: none"> • CWS agency staff/Probation Officers will collaborate with PHN to assure youths leaving foster care supervision are aware and connected to resources for independent living.

County/City:

Effective Dates:

Service Provided	Local CHDP Responsibilities Foster Care PHN	Local Child Welfare Service Agency Responsibilities Social Worker/Probation Officer
Quality Improvement	<ul style="list-style-type: none"> • PHN will conduct joint reviews of case records for documentation of health care services with CWS agency/Probation Department. • PHN will work with CWS agency/Probation Department to develop a plan for evaluating the process and impact of the addition of the PHN component to the foster care team. • PHN will establish baseline data for evaluating health care services provided to children in foster care. 	<ul style="list-style-type: none"> • CWS agency staff/Probation Officers will conduct joint reviews of case records for documentation of health care services • CWS agency/Probation Department will work with PHN to develop a plan for evaluating the process and impact of the addition of the PHN component to the foster care team. • CWS agency/Probation Officers will collaborate and assist PHN in gathering data.

This Memorandum of Understanding in effect from July 1, 20__ through June 30, 20__ unless revised by mutual agreement. In the event that changes in Federal or State requirements impact the current Memorandum of Understanding, the local health department, social services department, and probation department agree to renegotiate the pertinent section within 90 days of receiving new instructions from the State.

Public Health Director or Child Health and Disability
Prevention Program Director

Date

County Social Services Director or County Child Welfare
Service Agency Director

Date

Chief Probation Officer

Date

SECTION 6 - BUDGET INSTRUCTIONS

CMS Budget Instructions General Information and Descriptions for all CMS Budgets	3
Budget Tips	6
Definitions and Guidelines.....	7
Sample Budget Justification Narrative.....	12
County/City Capital Expenses Justification Form.....	15
County/City Other Expenses Justification Form.....	16
CHDP Budget Information and Staffing Guidelines.....	17
CHDP Staffing Matrix Profile Guidelines	35
Summary CHDP Staffing Profile	36
CHDP Administrative Budget Worksheet Instructions (No County/City Match)	37
CHDP State General Funds and Medi-Cal State/Federal Funds	37
CHDP No County/City Match Administrative Budget Summary Instructions.....	46
CHDP Administrative Budget Worksheet Instructions (County/City Match)	50
CHDP County/City Match Administrative Budget Summary Instructions	58
Foster Care Administrative (County/City Match) Budget Worksheet Instructions	61
Foster Care Administrative (County/City Match) Budget Summary Instructions	67
HCPCFC Budget Information and Staffing Guidelines.....	70
HCPCFC Budget Worksheet Instructions (State/Federal Match).....	73
HCPCFC Administrative Budget Summary Instructions.....	78
CCS Administrative Budget Information, Staffing Standards, and Caseload Instructions.....	81
CCS County Staffing Standards Profile.....	93
CCS Administrative Budget Worksheet Instructions	94
CCS Administrative Budget Summary Instructions	101
CMS Budget Revision General Information.....	108
CHDP Administrative Budget Revision Instructions (No County/City Match).....	110
CHDP Administrative Budget Revision Summary	110
CHDP Administrative Budget Revision Instructions (County/City Match)	114
Foster Care Administrative County/City Match Budget Revision Instructions	118
HCPCFC Budget Revision Instructions	122
CCS Administrative Budget Revision Instructions.....	125
Budget Revision Worksheet	125

Sample Budget Revision Justification Narrative..... 134

CMS Budget Instructions General Information and Descriptions for all CMS Budgets

I. General Information

- A. All CMS administrative budgets are composed of the following five major line items:
1. Personnel Expenses,
 2. Operating Expenses,
 3. Capital Expenses,
 4. Indirect Expenses, and
 5. Other Expenses

(See Definitions and Guidelines on page 7.)

- B. **All CMS budget submissions must include a budget worksheet, budget summary, budget justification narrative, and if applicable, County/City Capital Expenses Justification Form or County/City Other Expenses Justification Form.**
- C. List specific line items for individual staffing positions, services, supplies, and other operating expenses on the budget worksheet.
- D. Round all amounts, **except totals**, to the nearest dollar.

If the calculation results in **50 cents or more**, then **round up to the next whole number**, e.g., \$3,009.52 is rounded up to \$3,010.

If the calculation results in **less than 50 cents**, then **round down to the next whole number**, e.g., \$5,110.43 is rounded down to \$5,110.

- E. **Do not round totals.** The amounts used to calculate the totals have already been rounded up or down. When calculating total amounts, add the amounts in the column down or in the line across.

Using the examples from 1.D. above, the total is \$8,120.

Calculation X	\$ 3,010	
Calculation Y	<u>5,110</u>	
	\$ 8,120	Total

- F. Staff for whom enhanced Title XIX (Medicaid) funding is budgeted must be county/city employees.
- G. Use an acceptable accounting distribution method (e.g., square footage for rent or historic charges for telephone numbers assigned to the program) to determine rent, utilities, and communications costs. Allocate these costs to each budget

based on full time equivalent (FTE) ratios when the same staff is included on more than one budget, when staff work for more than one program, and when direct charges cannot be otherwise determined.

- H. Local programs charging Indirect Expenses must include such costs in all budgets.
- I. The Budget Worksheet and Budget Summary must be signed by the department fiscal officer and a county/city official with authority to sign on behalf of the local jurisdiction (for the CHDP Program, the CHDP Director has regulatory authority to sign program documents). An original signature is required. Signature stamps are not acceptable.
- J. Highest rate of pay in salary range is to be used. If a lower rate is used, please explain in budget justification narrative.
- K. All requests for budget revisions must be submitted to the Regional Office Administrative Consultant/Analyst *no later than six months (December 31) after the end of the fiscal year, e.g.* budget revision requests for FY 2006-07 received after December 31, 2007 will not be accepted.
- L. A budget justification narrative must accompany each budget worksheet and budget summary, and must justify budget line items, e.g.:
 - 1. The basis of formula used to determine travel costs, rent, etc.,
 - 2. Increases/decreases in FTE and enhanced/nonenhanced time,
 - 3. Significant increases/decreases in line item amounts,
 - 4. Identify all new, changed, or eliminated positions or changes in duties, and
 - 5. Staff benefits and indirect cost plan

II. CMS Budget Description

- A. CHDP Administrative Budgets
 - 1. **CHDP Administrative Budget (No County/City Match)** – represents the local program's estimate of administrative expenditures for CHDP and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program for the fiscal year given the available State funding.

The CHDP Administrative Budget is comprised of five major line items: Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses. This budget is funded through the State General Fund and Medi-Cal State/Title XIX Federal Funds.
 - 2. **CHDP Administrative Local Match Budget (County/City Match)** – a CHDP Program may request additional funding through submission of a

CHDP Administrative Local Match Budget (County/City Match) when the program is requesting federal matching funds to augment local program funds. The additional funds enable the local program to perform activities dedicated to Medi-Cal beneficiaries meeting the federal EPSDT Program mandates over and above those funded through the CHDP Administrative Budget (No County/City Match) allocation.

The CHDP Administrative Local Match Budget (County/City Match) is comprised of five major line items: Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses. This budget is funded through county/city and Title XIX Federal Funds.

3. **Foster Care Administrative Local Match Budget (County/City Match)-** A CHDP Program may request additional funding for SPHN(s) and PHN(s) staff working in support of children and youth in out-of-home placement or foster care through the use of the Foster Care Administrative Budget (County/City Match). Local county/city funds, specified on the budget category summary sheet, are matched with federal funds to augment local program activities. The three major line items of this optional budget are: Personnel Expenses, Operating Expenses, and Indirect Expenses. This budget is funded through county/city and Title XIX Federal Funds.

B. HCPCFC Administrative Budget

Health Care Program for Children in Foster Care (HCPCFC) Budget – represents the local program's estimate of administrative expenditures for the HCPCFC for the fiscal year given the available state funding. It is comprised of three major line items: Personnel Expenses, Operating Expenses, and Indirect Expenses. State General Funds matched with federal Medicaid, Title XIX, funds are the source of funds for this program.

C. CCS Administrative Budget

1. **CCS Administrative Budget –** represents a county request for CCS program funding for case management and administrative costs. The CCS Administrative Budget is based on a county's caseload applied to a staffing standard. The CCS Administrative Budget is comprised of five major line items: Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses. CCS Administrative Budgets are funded with a mix of County, State, Healthy Families Title XXI federal funds, and Medi-Cal Title XIX federal funds. Fund Source amounts are distributed based on types of caseload served.

Included in the Personnel category is a county's request for funding administrative Skilled Professional Medical Personnel (SPMP) costs in accordance with the Federal Financial Participation guidelines. Funding is based on the requested number of SPMP to serve the CCS Medi-Cal caseload in the following specific areas: concurrent hospital review, intensive medical case management, liaison activities with Medi-Cal managed care systems, and early childhood coordination.

Budget Tips

The items listed below will assist in the preparation of budgets. This list represents common mistakes that CMS staff have noted in the review of local program budgets.

- I. All budgets must be submitted on the current budget worksheet forms.
- II. Double-Check the math. The figures for both percentages and calculated amounts must add down and across.
- III. Annual salaries must match when the same personnel are listed on multiple budgets.
- IV. Professional License Renewals are to be budgeted within the Benefits line item,
- V. FTEs on the duty statement must match FTEs on the budget worksheet and incumbent listing.
- VI. No staff total time can exceed 100 percent.
- VII. No full-time FTE in a single program can be 100 percent enhanced.
- VIII. Line item amounts on the budget worksheets and budget justification narrative must match.
- IX. A "Capital Expenses Justification Form" must be submitted for items of equipment purchased with CMS Program funds that exceed \$5,000 per item (see page 15).
- X. Staff must be appropriately classified under enhanced and nonenhanced in accordance with Federal Financial Participation (FFP) Guidelines (See Section 9).
- XI. Staff listed on the budget worksheet must correspond with the incumbent listing and organizational chart.
- XII. Enhanced clerical staff must be under direct supervision of an SPMP.
- XIII. A CHDP Director who is also the County Health Officer cannot be included on the CHDP budget.
- XIV. Any other operating expenses not noted in Section 6, page 7 and are not included in the Indirect Expenses with overhead costs may be listed as an expense line item (e.g. liability & malpractice insurance, equipment/connectivity charges).
- XV. The Budget Worksheet and Budget Summary must be signed by the department fiscal officer and a county/city official with authority to sign on behalf of the local jurisdiction;
 - a. For the CHDP Program, the CHDP Director has regulatory authority to sign program documents.
 - b. An original signature is required. Signature stamps are not acceptable.

Definitions and Guidelines

The five major line items for each budget are identified and defined below:

- I. Personnel Expenses – Includes county/city staff salaries, wages, and benefits.**
- A. Local program staff assigned to work on any of the CMS programs and for whom salary, wages, benefits, and bilingual or any other differential expenses are claimed through the appropriate CMS budgets. Detailed information, including specific classifications, percentages of time, and incumbents' names, are included on the budget worksheet.
 - B. Time base and personnel expenses are calculated using total full-time annual salary per position. For a position allocated to more than one budget, the same annual salary must be used on each budget.
 - C. Percentages of time for positions allocated to multiple budgets cannot exceed 100 percent of the time base for those positions, e.g., one full-time position cannot be shown as 50 percent on a CHDP budget, 50 percent on a CCS budget, and 20 percent on a HCPCFC budget.
 - D. Percentages or estimates for staff benefits may be budgeted based on actual dollar amounts. A change of more than 5 percent in staff benefits from the prior fiscal year must be explained in the budget justification narrative.
 - E. Professional License Renewals is a benefit handled in employee bargaining agreements and should be budgeted as part of the Benefits line item.
- II. Operating Expenses – Includes, but not limited to, expenses such as travel, training, space rental, office supplies, and furniture.**
- A. Personnel Travel (includes per diem, commercial auto rental, motor pool, air travel and private vehicle mileage, etc.).
NOTE: All training costs (e.g., registration fees and tuition) must be included under "Training".
 - 1. Allowable in-state travel expenses are those necessary to administer CMS programs, provide case management services, attend State-required meetings, and participate in training workshops.
 - 2. No travel outside the State of California shall be reimbursed unless prior written authorization is obtained from the State.
 - 3. The following documentation must be maintained at the local level to support travel expenditures:
 - a. Purpose of travel,
 - b. Travel expense documents, and

- c. Total cost.
- 4. Travel costs incurred by county/city program staff are reimbursed at the county/city designated rate.
- B. Personnel Training

NOTE: All travel costs (e.g., per diem, mileage, etc.) related to training must be included under "Travel."

 - 1. Training/conference registration and tuition fees are specifically for events relevant to CMS programs.
 - 2. The following documentation must be maintained at the local level to support training expenditures:
 - a. Description of training course or conference,
 - b. The required training log for SPMP claiming Title XIX funds,
 - c. Justification for attendance,
 - d. Total cost, and
 - e. Confirmation of attendance.
- C. Space Rental
 - 1. Direct costs for rental of space needed to conduct CMS programs may be budgeted as either "Operating Expenses" or "Indirect Expenses."
 - 2. Space rental costs are determined by total square feet and cost per square foot or other calculation methodology. Common and shared space costs are prorated among program users.
- D. Office Supplies
 - 1. Personal computers, printers, cabling, surge protectors, etc., and commercially available software of less than \$5,000 per unit cost (See III D and E on Page 9).
 - 2. Miscellaneous office supplies such as pens, pencils, paper, staplers, etc.
- E. Furniture
 - 3. Costs of small office furniture and small office machines which do not meet the definitions of "capital expenses" equipment below.
 - 4. Costs of modular office furniture work stations.

- 5. Costs of individual replacement parts (for a unit of equipment) having a base unit cost of less than \$5,000 (excluding tax, delivery, and installation charges).
- F. Any other operating expenses not noted above and not included in the Indirect Expenses with overhead costs may be listed as an expense line item (e.g. liability & malpractice insurance, equipment/connectivity charges).

III. Capital Expenses – Includes tangible property (equipment).

- A. Equipment with a unit cost of \$5,000 or more (excluding tax, delivery, and installation charges) and a useful life of four years or more.
- B. Automated Data Processing (ADP) hardware with a unit cost of \$5,000 or more.
- C. A unit of equipment and ADP hardware shall be defined as all connecting parts, modifications, attachments, or auxiliary apparatus necessary to make it usable.
- D. Miscellaneous equipment such as personal computers, printers, cabling, surge protectors, etc., and commercially available software of less than \$5,000 per unit cost is not defined as equipment and shall **not** be budgeted in the "Capital Expenses" line item. These items shall be budgeted as office supplies and detailed on a budget worksheet under "Operating Expenses."
- E. Considerations for Approval of Request for Computers in CHDP and CCS Budgets:
 - 1. Does the number of computers correspond to program FTEs?
 - 2. Is the county on, or transitioning to, CMS Net?
 - 3. When was the last request for computers?
 - 4. What is the intended use of the equipment? (Is it appropriate for classification(s) and duties?)
- F. Written justification for capital expenses must be submitted with the CMS Plan and Budget package and approved by CMS prior to expenditure of State funds. See County/City Capital Expenses Justification Form, page 15.
- G. A county/city with an established procurement system may use its system to make equipment purchases of up to \$50,000 as allowed in Health and Safety Code, Subsection 1033, Section 38078.5 (Statutes of 1993). However, the system must be described when requesting State approval of the purchase and State authorization must be received in writing by the local agency prior to the purchase(s).
- H. If the entire line item totals \$50,000 or more, all items of equipment included in the line item are subject to procurement for the local agency by the State. Contact your CMS Regional Office for guidance before purchasing.

- I. All equipment requested for purchase with State funds shall be the property of the State and shall be subject to the provisions listed below.
 - 1. State property shall be used only to conduct business related to programs funded by CMS.
 - 2. The county/city is required to maintain and administer, in accordance with sound business practice, a program for the utilization, maintenance, repair, protection, and preservation of State property to assure its full availability and usefulness.
 - 3. The county/city is required to submit, upon request, an annual inventory of equipment purchased with State funds.
 - 4. Specific instructions on managing and invoicing equipment purchased with State funds are found in Section 8 – Expenditure Claims and Property Management.
 - J. Other expenses associated with relocation may be Capital Expenses. Consult your regional office for guidance.
- IV. Indirect Expenses – Includes all internal and external administrative overhead costs including county/city and departmental overhead costs. External administrative overhead allocations must have an approved plan on file with the State Controller's Office. Internal administrative overhead costs must be developed with a cost allocation plan (CAP) prepared in accordance with federal guidelines, "Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government, Implementation Guide for Office of Management and Budget, Circular A-87".**
- A. County/city agencies must maintain internal records supporting indirect costs. The county/city must maintain documentation of methods for claiming internal and external overhead. This information shall be readily available for review by the CMS Branch.
 - B. Indirect cost rates may be applied to Total Salaries and Wages or Total Personnel Expense, depending upon the base used by the county/city to develop the approved rate.
- V. Other Expenses – Other expenses not defined above include:**
- A. Subcontractors/consultants shall be used only for activities directly related to CMS program(s). The use of subcontractors/consultants must be clearly described. Complete the County/City Other Expenses Justification Form (see page 16) for subcontract/consultant services. Local programs shall notify CMS staff at the CMS Regional Office of any proposed use of subcontractors/consultants to ensure that appropriate State and federal requirements regarding such agreements are met. All employees with paid benefits including bilingual or other differentials shall be included under Personnel Expense. Paid benefits are vacation, sick leave, health/medical insurance, worker's compensation, social security, etc.

- B. Maintenance and transportation is a line item that was first included during FY 2000-01. Inclusion of this line item changed the reimbursement of the CCS Maintenance & Transportation benefits to an administrative cost. County CCS programs that include an anticipated expenditure on the CCS Administrative Budget may claim actual expenditures incurred by CCS clients to provide the maintenance and transportation benefit allowed in federal Medi-Cal regulations and defined in CCS Numbered Letter 01-0104. (See Section 8 of this manual for claiming instructions.)

Sample Budget Justification Narrative

**Children's Medical Services
Gold County
Budget Narrative
Fiscal Year 2007-08**

I. PERSONNEL EXPENSES

Identify and explain any changes in Personnel including FTE percentage changes.

Total Salaries: \$1,528,586

Total Benefits: \$ 489,148

Changes in staff benefits and whether benefits are actual or estimated must be stated. A change of more than 5 percent in benefits from the prior fiscal year must be explained.

Total Personnel Expenses: \$2,017,734

Supervising PHN (2)

Two Supervising PHN positions have been added. These positions have been upgraded from Senior PHN to Supervising PHN.

Public Health Nurse

An increase of .10 FTE for Program Administration and a decrease of .10 FTE for Medical Case Mgmt functions. Additional time is being allocated to program administration to oversee continued quality assurance and MTU implementation activities for the MTP and or continued development of family participation services for performance measurement.

PHN II

One new PHN II has been added to meet State staffing standards.

PHN I

Two new PHN I positions requested to meet State staffing standards.

Office Assistant III (2)

Two new positions added to meet State staffing standards.

Office Assistant II (1)

One new position added.

Office Assistant I

OA I moved from extra help (Other Expense) to full time.

II. OPERATING EXPENSES

List all Operating Expense line items. Identify and explain any increase, decrease, or newly listed line item.

Travel \$ 7,500

Includes per diem, private vehicle mileage, commercial auto rental, air travel, etc. Example: mileage reimbursement @\$.445 per mile for CCS staff travel to regional and State meetings,

		conferences and trainings, and other program related travel.
Training	\$ 6,500	Includes registration and/or tuition fees for CCS trainings, seminars, conferences, etc. This is a 25% decrease based on prior fiscal year expenditures.
Office Supplies and Services	\$ 14,636	Increase by 7% due to additional personnel needing office supplies and increased cost of office supplies over late year. Includes printer supplies, on-going chart supplies; copy, print and reproduction costs.
Postage & Shipping	\$ 13,600	Cost of postage for anticipated volume of mailing CMSNet correspondence and other miscellaneous mailing based on history.
Space Rental	\$130,500	Increase of 63%. Present building location can not accommodate increase in personnel, telephone lines, and computer lines. Building relocation is necessary. This figure is based upon 8,700 square feet @ \$15 per square foot.
Telephone	\$ 21,434	Increased by 17% from last year. To accommodate new position requests.
Computer upgrade/maintenance	\$ 5,700	Increase 100%. Upgrade of CCS computers to Windows 2000.
Office Equipment	\$ 78,194	Increase 100%. Modular furniture needed for re-location of division to another building.
Hook-up computers to Hub	\$ 3,000	Increase 100%. For re-location of division.
Computer and Monitor (6)	\$ 12,000	Increase 100%. Computer access for additional staff requested. For 6 computers and 6 monitors for new positions @ \$2,000 each.
Total Operating Expenses:	<u>\$311,064</u>	

III. CAPITAL EXPENSES

List all Capital Expense line items. Identify and explain any newly listed Capital Expense. Include County/City Capital Expenses Justification Form.

Total Capital Expenses:	<u>0</u>	None
--------------------------------	----------	------

IV. INDIRECT EXPENSES

A. Internal @ 15.79%	\$241,364	According to Cost Allocation Plan on file.
B. External @ 1.20%	\$ 18,343	County-Wide Cost Allocation Plan (COWCAP) allocates audited expenses by County Budget Unit. The rate for the Children's Medical Services Programs is 1.20% applied to total net salaries.
Total Indirect Expenses:	<u>\$259,707</u>	

V. OTHER EXPENSES

List all Other Expense line items. Identify and explain increased, decreased, or newly listed line items. Include County/City Other Expenses Justification Form.

Maintenance and Transportation	\$ 40,241	Increase of 7%. Reimbursements and payments to families for travel, lodging and meals incurred while obtaining CCS authorized services allowing for special circumstances and other contingencies. This is based on last years expenditures.
Student Internship	\$ 12,480	Increase 100%. Cost per student is \$3.00 per hour. Colleges place students interested in Public Service to gain working knowledge of CMS. There is a contract per each student outlining goals and objectives to be accomplished by the student. CMS benefits from the assistance students provide the program. Students are sometimes hired as PHN, office support staff, etc.
Total Other Expenses:	<u>\$ 52,721</u>	
BUDGET GRAND TOTAL	\$2,641,226	

California Department of Health Care
Services

Children's Medical Services Branch

County/City Capital Expenses Justification Form

County/City: _____

Contact Person: _____

Date: _____

Telephone Number: _____

A. List all equipment and each item's price.

B. How is the equipment going to benefit the CMS program(s)?

C. Describe what functions will be performed on the equipment and why the current process can no longer be used.

D. Specify if the new equipment must have enhanced capabilities and why.

NOTE: If additional space is required, please include the information on a separate sheet of paper and attach it to this form.

CHDP Budget Information and Staffing Guidelines

I. Budget Information

- A. Each CHDP local program is provided an annual allocation of Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) State funds based on the EPSDT State appropriation for the Fiscal Year. The allocation is comprised of a base allocation and a proportion applied to the remaining funds beyond those distributed through the base allocation.
- B. The base allocation is the sum of the allocations in three Program Activities areas. One portion of the base allocation is related to size of target population (Informing/Linking). A second portion of the base allocation is related to the number of health screens (Care Coordination); and a third portion is related to the number of active CHDP provider numbers (Provider Orientation and Training). The CHDP local program falls within a range specific to one of seven groups in each program activity area.
- C. Assigning a proportion of the remaining allocation to each local program extends the base allocation. The proportion of the remaining allocation is distributed according to the average proportion of the local program of the statewide totals. As a result, each CHDP local program receives a unique allocation of EPSDT State funds for their administrative activities. (See CHDP EPSDT Base Allocation Table, page 34)
- D. The EPSDT State funds allocation is matched through the federal Medicaid (Title XIX) program for administrative activities in support of the Medicaid program (Medi-Cal in California).
- E. Each CHDP local program is also provided an annual allocation of State General or State-only funds based on the non Medi-Cal State appropriation for the Fiscal Year. The allocation is distributed according to the average proportion of the local program in the statewide totals. The State-only funds may not be matched with Federal Title XIX funds.
- F. If a local program determines it is necessary to request additional funds for staff who perform administration program activities in support of the Medicaid (Medi-Cal) program, an optional CHDP Administrative Budget, County/City Match may be submitted (see Page 4).

II. Staffing Guidelines

- A. The CHDP Staffing Matrix Profile Guidelines and the Guidelines Summary and the CHDP Guidelines Worksheet for Full-time Equivalent Calculations are provided to assist programs in the evaluation and preparation of their staffing patterns for the local administration of the CHDP Program. Program administrative activities are in three broad areas:

- Program Activities which includes Informing/Linking, Care Coordination, Provider Orientation and Training, and Liaison;
 - Program Management which includes Supervision and Administration and Information Technology; and
 - Program Support which includes Clerical Support.
- B. With the EPSDT State allocation, the CHDP local program is expected to carry out the basic administrative activities of the program. The foundation of these activities with staffing guidelines is outlined below and is followed by a worksheet to assist with planning. The CHDP Staffing Matrix Profile Guidelines (page 35) shows a range of total FTEs by program area.

PROGRAM ACTIVITIES

INFORMING/LINKING

Ancillary (ANC) Informing/Linking

Basis of Formula

- designated staff = non skilled professional medical personnel (non SPMP) paraprofessionals who possess higher levels of knowledge, problem-solving capabilities, and follow-up skills
- total annual target population estimate for CHDP program
 - varies by county/city
 - source of data is:
 - Budget Year CHDP Target Population Estimate column entitled Total Children
 - location of source of data is:
 - Plan and Fiscal Guidelines, Section 4
- total number of children within a group to whom an ANC would address = 25 children per group
- total hours that ANC spends addressing each group = 1 hour per group
- total annual work hours per full-time equivalent (FTE) = 2080 hours per year (40 hours per week x 52 weeks per year = 2080 hours per year); for counties/cities whose official work week may be less than 40 hours per week, make the appropriate adjustment and explain the reasons for the lower hours per week

Health Professional (HP) Informing/Linking

Basis of Formula

- designated staff = e.g., dental staff, health educators, nutritionists, physicians, public health nurses who meet skilled professional medical personnel (SPMP) qualifications in accordance with Title 42, Code of Federal Regulations (CFR), Chapter IV
- total annual target population estimate for CHDP program.
 - varies by county/city.
 - source of data is:

Budget Year CHDP Target Population Estimate column entitled Total Children

➤ location of source of data is:

Plan and Fiscal Guidelines, Section 4

- total number of children within a group to whom HP would address = 25 children per group
- total hours that HP spends addressing each group = 0.5 hour or 30 minutes per group
- total annual work hours per full-time equivalent (FTE) = 2080 hours per year (40 hours per week x 52 weeks per year = 2080 hours per year); for counties/cities whose official work week may be less than 40 hours per week, make the appropriate adjustment and explain the reasons for the lower hours per week

Public Health Nurse Informing/Linking

To be determined by each county/city's needs as calculated in the Health Professional category.

CARE COORDINATION

Public Health Nurse (PHN) Care Coordination

Basis of Formula

- designated staff = public health nurse
 - total annual number of screens or health assessments performed
 - varies by county/city
 - source of data is:

CHDP Annual Summary of Screens by Funding Source for Fiscal Year 07-01-2003 – 06-30-2004, CHDP Data Reporting System, Business Objects
 - total number of screens through Medi-Cal Managed Care Plans (M-C MCPs)
 - varies by county/city
 - source of data is:

Medi-Cal Managed Care Plan Provider Numbers and reported Health Assessments found in “CHDP Provider Claims and Amount Paid by County and Funding Source” (prompted report for Fiscal Year 07-01-2003 – 06-30-2004), CHDP Data Reporting System, Business Objects
 - count the number of health assessments completed by M-C MCPs in your county/city
 - percentage of screens that require follow-up or acuity rate
 - acuity rate = use 16.5 percent (%); includes 1.5% for required follow-up with newborn hearing, elevated blood lead levels, California Children's Services (CCS), and self-referrals among others
 - total hours that PHN spends performing care coordination activities per counted health assessment = 1 hour
 - total annual work hours per full-time equivalent (FTE) = 2080 hours per year (40 hours per week x 52 weeks per year = 2080 hours per year); for counties/cities whose official work week may be less than 40 hours per week, make the appropriate adjustment and explain the reasons for the lower hours per week
- * For counties/cities with M-C MCPs, reduce the total annual number of screens by the number of screens provided through Medi-Cal plans. If you need help in calculating this proportion or no data are available, contact your Regional Consultant.

Health Professional (HP) Care Coordination

Basis of Formula

- designated staff = e.g., dental staff, health educators, nutritionists, physicians, public health nurses who meet skilled professional medical personnel (SPMP) qualifications in accordance with Title 42, Code of Federal Regulations (CFR), Chapter IV
- total annual number of screens or health assessments performed
 - varies by county/city
 - source of data is:

CHDP Annual Summary of Screens by Funding Source for Fiscal Year 07-01-2003 – 06-30-2004, CHDP Data Reporting System, Business Objects
- total number of screens through Medi-Cal Managed Care Plans (M-C MCPs)
 - varies by county/city
 - source of data is:

Medi-Cal Managed Care Plan Provider Numbers and reported Health Assessments found in "CHDP Provider Claims and Amount Paid by County and Funding Source" (prompted report for Fiscal Year 07-01-2003 – 06-30-2004), CHDP Data Reporting System, Business Objects
- count the number of health assessments completed by M-C MCPs in your county/city
- percentage of screens that require follow-up or acuity rate
 - acuity rate = use 16.5 percent (%); includes 1.5% for required follow-up with newborn hearing, elevated blood lead levels, California Children's Services (CCS), and self-referrals among others
- total hours that HP spends performing care coordination activities per counted health assessment = 0.25 hour or 15 minutes per screen
- total annual work hours per full-time equivalent (FTE) = 2080 hours per year (40 hours per week x 52 weeks per year = 2080 hours per year); for counties/cities whose official work week may be less than 40 hours per week, make the appropriate adjustment and explain the reasons for the lower hours per week

Ancillary (ANC) Care Coordination

Basis of Formula

- designated staff = non skilled professional medical personnel (non SPMP) paraprofessionals who possess higher levels of knowledge, problem-solving capabilities, and follow-up skills
- total annual number of screens or health assessments performed
 - varies by county/city
 - source of data is:

CHDP Annual Summary of Screens by Funding Source for Fiscal Year 07-01-2003 – 06-30-2004, CHDP Data Reporting System, Business Objects
- total number of screens through Medi-Cal Managed Care Plans (M-C MCPs)
 - varies by county/city
 - source of data is:

Medi-Cal Managed Care Plan Provider Numbers and reported Health Assessments found in “CHDP Provider Claims and Amount Paid by County and Funding Source” (prompted report for Fiscal Year 07-01-2003 – 06-30-2004), CHDP Data Reporting System, Business Objects
- count the number of health assessments completed by M-C MCPs in your county/city
- percentage of screens that require follow-up or acuity rate
 - acuity rate = use 16.5 percent (%); includes 1.5% for required follow-up with newborn hearing, elevated blood lead levels, California Children's Services (CCS), and self-referrals among others
- total hours that ANC spends performing care coordination = 45 minutes per screen or 0.75 hour per screen
- total annual work hours per full-time equivalent (FTE) = 2080 hours per year (40 hours per week . 52 weeks per year = 2080 hours per year); for counties/cities whose official work week may be less than 40 hours per week, make the appropriate adjustment and explain the reasons for the lower hours per week

*For counties/cities with M-C MCPs, reduce the total annual number of screens by the number of screens provided through Medi-Cal plans. If you need help in calculating this proportion or no data are available, contact your Regional Consultant.

PROVIDER ORIENTATION AND TRAINING

Public Health Nurse (PHN) Provider Orientation and Training

Basis of Formula

- designated staff = public health nurse
- total CHDP provider numbers, hereafter referred to as enrolled providers
 - varies by county/city
 - source of data is:

“Active CHDP Providers by County/City and Provider Name”, CHDP Data Reporting System, Business Objects
- total annual hours that PHN spends with each enrolled provider = 18 hours per year
- total annual work hours per full-time equivalent (FTE) = 2080 hours per year (40 hours per week x 52 weeks per year = 2080 hours per year); for counties/cities whose official work week may be less than 40 hours per week, make the appropriate adjustment and explain the reasons for the lower hours per week

Health Professional (HP) Provider Orientation and Training

Basis of Formula

- designated staff = e.g., nutritionists, dental staff, physicians, public health nurses, and health educators who meet skilled professional medical personnel (SPMP) qualifications in accordance with Title 42, Code of Federal Regulations (CFR), Chapter IV
- total number of providers, hereafter referred to as enrolled providers
 - varies by county/city
 - source of data is:

“Active CHDP Providers by County/City and Provider Name”, CHDP Data Reporting System, Business Objects
- total annual hours that HP spends with each enrolled provider = 9 hours per year
- total annual work hours per full-time equivalent (FTE) = 2080 hours per year (40 hours per week x 52 weeks per year = 2080 hours per year); for counties/cities whose official work week may be less than 40 hours per week, make the appropriate adjustment and explain the reasons for the lower hours per week

Ancillary (ANC) Provider Orientation and Training

Basis of Formula

- total FTEs of PHNs for Provider Orientation and Training
- total FTEs of HPs for Provider Orientation and Training
- established ratio
 - 1:5
 - one (1) ANC to every five (5) FTEs of PHNs and HPs

Liaison

Basis of Formula

- designated staff = e.g., dental staff, health educators, nutritionists, physicians, public health nurses who meet skilled professional medical personnel (SPMP) qualifications in accordance with Title 42, Code of Federal Regulations (CFR), Chapter IV
- county/city has an established Medi-Cal Managed Care program (M-C MCP)
 - County/City has a two-plan or geographic managed care model of M-C MCP;
 - County/City has an established county-organized health system (COHS)
- coordination with other county/city public health department (PHD) programs such as the following:
 - California Children's Services (CCS)
 - Immunization (IZ)
 - Childhood Lead Poisoning Prevention
 - Maternal and Child Health (MCH)
 - Women's, Infants, and Children (WIC)
- coordination with other community and school programs
- counties/cities are entitled to a range (0.01 to 0.5) of HP FTEs for liaison for established M-C MCP, COHS, and coordination efforts with other county/city PHD programs and with other community and school programs

PROGRAM MANAGEMENT

Supervision (SUPV)

Basis of Formula

- total FTEs of PHN for Care Coordination and Provider Orientation and Training
- total FTEs of HP for Informing/Linking, Care Coordination, Provider Orientation and Training, and Liaison.
- total FTEs of ANC for Informing/Linking, Care Coordination, and Provider Orientation and Training
- established ratio
 - 1:10
 - one (1) SUPV FTE to every ten (10) FTEs of PHN, HP, and ANC

Administration and Information Technology (AIT)

Basis of Formula

- total FTEs of PHN for Care Coordination and Provider Orientation and Training
- total FTEs of HP for Informing/Linking, Care Coordination, Provider Orientation and Training, and Liaison
- total FTEs of ANC for Informing/Linking, Care Coordination, and Provider Orientation and Training
- percentage of AIT staff oversight, guidance, direction, and technical support of all other staff excluding SUPV = 10 percent (%)
- budget sufficient Information Technology (IT) support not only for software and hardware maintenance but also for development of reports, LAN administration, technical support, desktop assistance, statistical extrapolation, etc.

PROGRAM SUPPORT

Clerical Support (CS)

Basis of Formula

- total FTEs of PHN for Care Coordination and Provider Orientation and Training
- total FTEs of HP for Informing/Linking, Care Coordination, Provider Orientation and Training, and Liaison

- total FTEs of ANC for Informing/Linking, Care Coordination, and Provider Orientation and Training
- total FTEs of Supervision (SUPV)
- total FTEs of Administration and Information Technology (AIT)
- established ratio
 - 1:6
 - one (1) Clerical Support (CS) FTE to every six (6) FTEs of PHN, HP, ANC, SUPV, and AIT
- defined as clerical support to CHDP program activity and management personnel
- duties include tracking providers, maintaining and updating files, scheduling appointments, finalizing correspondence for release, etc.

**CHDP GUIDELINES
STAFFING FACTORS
FISCAL YEAR 2006 – 2007
WORKSHEET FOR FULL-TIME EQUIVALENT (FTE) CALCULATIONS**

Based on the experience of CHDP local program staff in their preparation of the Staffing Matrix for Fiscal Year 2003 – 2004, this worksheet is redesigned for use as a framework in staffing CHDP local programs. The formulas for Provider Orientation and Training, and Liaison have been adjusted. With these formulas and the use of the allocation, the FTEs should be attainable within the range shown in the Staffing Matrix Profile Guidelines that follow the worksheet.

As an electronic document, the areas for numerical entries are highlighted by marching red ants. As a paper document, the areas for numerical entries are not highlighted and left blank. Whether this worksheet is used as an electronic or paper document, the individual completing the worksheet is still required to compute the full-time equivalent calculations by hand.

PROGRAM ACTIVITIES

INFORMING/LINKING

Ancillary (ANC)

Total annual target population estimate for CHDP program		children
÷ Total children within a group to whom ANC would address		÷ 25 children/group
= Number of groups that ANC addresses each year	=	groups
× Total hours that ANC spends addressing each group		× 1 hr/group
= Total annual hours spent on addressing groups	=	hours
÷ Total annual work hours per FTE		÷ 2,080 hrs/FTE
= Annual FTEs of ANC	=	FTEs of ANC

Health Professional (HP)

Total annual target population estimate for CHDP program		children
÷ Total children within a group to whom HP would address		÷ 25 children/group
= Number of groups that HP addresses each year	=	groups
× Total hours that HP spends addressing each group		× 0.5 hr/group
= Total annual hours spent on addressing groups	=	hours
÷ Total annual work hours per FTE		÷ 2,080 hrs/FTE
= Annual FTEs of HP	=	FTEs of HP

Public Health Nurse (PHN)

To be determined by each county/city's needs as calculated in the Health Professional category.

PROGRAM ACTIVITIES

CARE COORDINATION

Public Health Nurse (PHN)

Total annual number of screens performed	screens
- Total screens reported through Medi-Cal Managed Care Plans (M-C MCPs)	screens via M-C MCPs
= Net total of annual screens performed	screens
× Percentage 16.5% of screens that require follow-up	× 16.5%
= Total of screens requiring follow-up	screens
× Total hours PHN spends performing care coordination	× 1 hr/screen
= Total annual hours spent on care coordination	hours
÷ Total annual work hours per FTE	÷ 2080 hrs/FTE
= Annual FTEs of PHN	FTEs of PHN

Health Professional (HP)

Total annual number of screens performed	screens
- Total screens reported through M-C MCPs	screens via M-C MCPs
= Net total of annual screens performed	screens
× Percentage 16.5% of screens that require follow-up	× 16.5%
= Total of screens requiring follow-up	screens
× Total hours HP spends performing care coordination	× 0.25 hr/screen
= Total annual hours spent on care coordination	hours
÷ Total annual work hours per FTE	÷ 2080 hrs/FTE
= Annual FTEs of HP	FTEs of HP

Ancillary (ANC)

Total annual number of screens performed	screens
- Total screens reported through M-C MCPs	screens via M-C MCPs
= Net total of annual screens performed	screens
× Percentage 16.5% of screens that require follow-up	× 16.5%
= Total of screens requiring follow-up	screens
× Total hours ANC spends performing care coordination	× 0.75 creen
= Total annual hours spent on care coordination	hours
÷ Total annual work hours per FTE	÷ 2080 hrs/FTE
= Annual FTEs of ANC	FTEs of ANC

PROGRAM ACTIVITIES

PROVIDER ORIENTATION AND TRAINING

Public Health Nurse (PHN)

Total number of enrolled providers	=	Providers
× Total annual time PHN spends with each enrolled provider		× 18 hrs/yr
= Total annual work hours		= hrs/yr
÷ Total annual work hours per FTE		÷ 2,080 hrs/FTE
= Annual FTEs of PHN		= FTEs of PHN

Health Professional (HP)

Total number of enrolled providers	=	Providers
× Total annual time HP spends with each enrolled provider		× 9 hrs/yr
= Total annual work hours		= hrs/yr
÷ Total annual work hours per FTE		÷ 2,080 hrs/FTE
= Annual FTEs of HP		= FTEs of HP

Ancillary (ANC)

Total FTEs of PHNs		FTEs of PHNs
+ Total FTEs of HPs		+ FTEs of HPs
= Total FTEs of PHNs and HPs		= FTEs of PHNs and HPs
÷ Established ratio of ANC to PHNs and HPs		÷ 5
= Annual FTEs of ANC		= FTEs of ANC

PROGRAM ACTIVITIES

Liaison

The Health Professional (HP) full-time equivalents (FTE) for the program activity entitled Liaison (L) is determined by the target population for each county/city. Please locate the target population range in which your local program's target population falls. The target population range indicates a predetermined FTE of HP-L.

FTEs Target Population Range

0.50 180,000 to 1,500,000

0.25 100,000 to 179,999

0.15 30,000 to 99,999

0.10 8,000 to 29,999

0.05 3,000 to 7,999

0.01 under 3,000

Minimum Liaison FTE = FTEs of HP

PROGRAM MANAGEMENT

Supervision (SUPV)

$$\begin{array}{r}
 \text{Total FTEs of PHN} \\
 + \text{ Total FTEs of HP} \\
 + \text{ Total FTEs of ANC} \\
 \hline
 = \text{ Total FTEs of PHN, HP, and ANC} \\
 \div \text{ Established ratio of SUPV to PHN, HP, and ANC} \\
 \hline
 = \text{ Annual FTEs of SUPV}
 \end{array}$$

$$\begin{array}{r}
 \text{FTEs of PHN} \\
 + \text{ FTEs of HP} \\
 + \text{ FTEs of ANC} \\
 \hline
 = \text{ FTEs of PHN, HP, and ANC} \\
 \hline
 \div 10 \\
 \hline
 = \text{ FTEs of SUPV}
 \end{array}$$

Administration and Information Technology (AIT)

$$\begin{array}{r}
 \text{Total FTEs of PHN} \\
 + \text{ Total FTEs of HP} \\
 + \text{ Total FTEs of ANC} \\
 \hline
 = \text{ Total FTEs of PHN, HP, and ANC} \\
 \times \text{ Percentage of AIT for oversight, guidance,} \\
 \text{direction, and technical support of all other staff,} \\
 \text{excluding SUPV} \\
 \hline
 = \text{ Annual FTEs of AIT}
 \end{array}$$

$$\begin{array}{r}
 \text{FTEs of PHN} \\
 + \text{ FTEs of HP} \\
 + \text{ FTEs of ANC} \\
 \hline
 = \text{ FTEs of PHN, HP, and ANC} \\
 \hline
 \times 10\% \\
 \hline
 = \text{ FTEs of AIT}
 \end{array}$$

PROGRAM SUPPORT

Clerical Support (CS)

	Total FTEs of PHN		FTEs of PHN
+	Total FTEs of HP	+	FTEs of HP
+	Total FTEs of ANC	+	FTEs of ANC
+	Total FTEs of SUPV	+	FTEs of SUPV
+	Total FTEs of AIT	+	FTEs of AIT
	<hr/>		<hr/>
=	Total FTEs of PHN, HP, ANC, SUPV and AIT	=	FTEs
÷	<u>Established ratio of CS to PHN, HP, ANC, SUPV, and AIT</u>		<u>÷ 6</u>
=	Annual FTEs of CS	=	FTEs of CS

**CHDP EPSDT
FISCAL YEAR 2006 - 2007
BASE ALLOCATION TABLE**

Group	1	2	3	4	5	6	7
-------	---	---	---	---	---	---	---

Target Population	1 - 4,999	5,000 - 14,999	15,000 - 29,999	30,000 - 49,999	50,000 - 99,999	100,000 - 350,000	> 350,000
Base Allocation	\$ 10,000	\$ 30,000	\$ 45,000	\$ 60,000	\$ 105,000	\$ 150,000	\$ 300,000

Screens	1 - 4,999	5,000 - 14,999	15,000 - 29,999	30,000 - 49,999	50,000 - 99,999	100,000 - 350,000	> 350,000
Base Allocation	\$ 10,000	\$ 30,000	\$ 45,000	\$ 60,000	\$ 105,000	\$ 150,000	\$ 300,000

Providers	1 - 6	7 - 15	16 - 40	41 - 80	81 - 140	141 - 220	> 220
Base Allocation	\$ 10,000	\$ 30,000	\$ 45,000	\$ 60,000	\$ 105,000	\$ 150,000	\$ 300,000

The Total EPSDT State Allocation is the sum of the base allocation for each area of program activity plus a portion of the unallocated base funds. The unallocated base funds are distributed by the CHDP Local Program's statewide proportion in each of the Program Activity Areas.

CHDP Staffing Matrix Profile Guidelines

	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Target Population (Informing and Linking)	1 - 4,999	5,000 - 14,999	15,000 - 29,999	30,000 - 49,999	50,000 - 99,999	100,000 - 350,000	> 350,000
Screens (Care Coordination)	1 - 4,999	5,000 - 14,999	15,000 - 29,999	30,000 - 49,999	50,000 - 99,999	100,000 - 350,000	> 350,000
Active Providers (Provider Orientation and Training)	1 - 6	7 - 15	16 - 40	41 - 80	81 - 140	141 - 220	> 220
FTEs Program Activities*							
Informing and Linking	0.01 - 0.14	0.14 - 0.43	0.43 - 0.89	0.87 - 1.4	1.44 - 2.9	2.9 - 10.1	
Care Coordination	0.01 - 0.8	0.8 - 2.4	2.4 - 4.8	4.8 - 8.0	8.0 - 15.9	15.9 - 47.6	
Provider Orientation and Training	0.03 - 0.09	0.1 - 0.2	0.2 - 0.6	0.6 - 1.2	1.2 - 2.2	2.2 - 3.4	
Liaison	0.01 - 0.05	0.05 - 0.1	0.1	0.15	0.15	0.25 - 0.50	0.5
Subtotal	0.06 - 1.08	0.4 - 3.1	3.1 - 6.4	6.4 - 10.8	10.8 - 21.2	21.3 - 61.6	
FTEs Program Management*							
Supervision	0.01 - 0.04	0.04 - 0.3	0.3 - 0.6	0.6 - 1.1	1.1 - 2.1	2.1 - 6.2	
Administration and Information Technology Support	0.01 - 0.04	0.04 - 0.3	0.3 - 0.6	0.6 - 1.1	1.1 - 2.1	2.1 - 6.2	
Subtotal	0.02 - 0.08	0.08 - 0.6	0.6 - 1.2	1.2 - 2.2	2.2 - 4.2	4.2 - 12.4	
FTEs Program Support							
Clerical	0.01 - 0.08	0.08 - 0.6	0.6 - 1.3	1.5 - 2.2	2.2 - 4.2	4.2 - 12.3	
Total FTEs	0.1 - 0.6	0.6 - 4.4	4.3 - 8.9	9.1 - 15.2	14.8 - 29.6	29.7 - 86.3	

* Additional Liaison activities are incorporated into these functions.

** Staffing for Program Activities include Ancillary non skilled professional medical personnel (non SPMP) paraprofessionals and Health Professionals (SPMP) including but not limited to dental staff, health educators, nutritionists, physicians, and public health nurses (PHNs) who meet skilled professional medical personnel qualifications.

Summary CHDP Staffing Profile

	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6	Group 7
Target Population (Informing and Linking)	1 - 4,999	5,000 - 14,999	15,000 - 29,999	30,000 - 49,999	50,000 - 99,999	100,000 - 350,000	> 350,000
Screens (Care Coordination)	1 - 4,999	5,000 - 14,999	15,000 - 29,999	30,000 - 49,999	50,000 - 99,999	100,000 - 350,000	> 350,000
Active Providers (Provider Orientation and Training)	1 - 6	7 - 15	16 - 40	41 - 80	81 - 140	141 - 220	> 220
FTEs Program Activities*							
Informing and Linking, Care Coordination, Provider Orientation and Training, and Liaison**	0.06 - 0.4	0.4 - 3.1	3.1 - 6.4	6.4 - 10.8	10.8 - 21.2	21.3 - 61.6	
FTEs Program Management*							
Supervision (1:10) and Administration and Information Technology Support (1:10)	0.02 – 0.08	0.08 - 0.6	0.6 - 1.2	1.2 - 2.2	2.2 - 4.2	4.2 - 12.4	
FTEs Program Support							
Clerical	0.01 – 0.08	0.08 - 0.6	0.6 - 1.3	1.5 - 2.2	2.2 - 4.2	4.2 - 12.3	
Total FTEs	0.1 - 0.6	0.6 - 4.4	4.3 - 8.9	9.1 - 15.2	14.8 - 29.6	29.7 - 86.3	

* Additional Liaison activities are incorporated into these functions.

** Staffing for Program Activities include Ancillary non skilled professional medical personnel (non SPMP) paraprofessionals and Health Professionals (SPMP) including but not limited to dental staff, health educators, nutritionists, physicians, and public health nurses (PHNs) who meet skilled professional medical personnel qualifications.

CHDP Administrative Budget Worksheet Instructions (No County/City Match)

CHDP State General Funds and Medi-Cal State/Federal Funds

The CHDP Administrative Budget Worksheet for FY 2007-08 (No County/City Match) shows percentages and dollar amounts in both the State-funded CHDP budget and the Medi-Cal funded CHDP budget. These dollar amounts are not to exceed the amounts allocated in the annual CHDP allocation letter.

Complete the County/City Name/Budget Fiscal Year. See sample on pages 44 and 45.

I. Personnel Expenses

In this section, list each funded position by classification and incumbent name as a separate line item and complete the following Columns:

- 1A. Percentage or FTE:** Enter the portion of the FTE in Column 1A for the percentage of time spent on program activities during the budget fiscal year for each position listed in the "Personnel Expenses" section.

Formula: Time base multiplied by twelve months.

Example: Employee works one day per week (1/5 time) $1/5 = 0.2$ or 20%

- 1B. Annual Salary:** Enter in Column 1B the annual salary for the full-time position listed in the "Personnel Expenses" section.

1. Total Budget

- Multiply each entry in Column 1A "% FTE" by the corresponding entry in Column 1B "Annual Salary"
- Enter the amount in Column 1, "Total Budget." The amount in Column 1 is also the sum of Columns 2 and 3.

2/2A. Percentage or FTE/Total CHDP Budget

- The percentages of Columns 2A (State-funded CHDP budget) and 3A (Medi-Cal Budget) must total 100%. In Column 2A enter the portion of the FTE for program activities directed to non-Medi-Cal children and youth for each position listed.
- Multiply the FTE in Column 2A by the Total Budget in Column 1 and enter this amount in Column 2, entitled "Total CHDP Budget."

3/3A. Percentage of FTE/Total Medi-Cal Budget

- Subtract the % FTE in Column 2A from 100% and enter the percentage in Column 3A. Percentage of time in the Medi-Cal budget shall be spent on program activities directed to Medi-Cal children and youth for each position listed.
- Multiply the FTE in Column 3A by the Total Budget in Column 1 and enter this amount in Column 3, entitled, "Total Medi-Cal Budget."
- The sum of Column 2 and Column 3 is equal to the Total Budget Column.

4/4A. Percentage of FTE/Enhanced State/Federal (25/75)

- Columns 4A plus 5A must equal 100% in order to accurately show percentages of enhanced and non-enhanced Medi-Cal-funded activities.
- For each line item in Personnel Expenses, enter in Column 4A the percentage of the FTE in Column 3A for program activities eligible for enhanced Medi-Cal funding. See FFP Information in Section 9 for qualifying position descriptions.
- Multiply the amount in Column 3 "Total Medi-Cal Budget" by the FTE entered in Column 4A for each position, and
- Enter this amount in Column 4 "Enhanced."

NOTE: If your local program uses one cost center for time studies in the CHDP program, and the time studies are used to invoice expenditures for the No County/City Match and the County/City Match Budgets, the proportions of enhanced and nonenhanced time for personnel claimed in the two budgets must be the same.

5/5A. Percentage of FTE/Nonenhanced State/Federal (50/50)

- For each line item in Personnel Expenses, enter in Column 5A the percentage of the FTE in Column 3A for program activities eligible for nonenhanced Medi-Cal funding for each position. See FFP Information in Section 9.
- Multiply the amount in Column 3 "Total Medi-Cal Budget" by the FTE entered in Column 5A for each position, and
- Enter this amount in Column 5 "Nonenhanced."
- The sum of Columns 4A and 5A equals 100 percent.

Total Salaries and Wages

- Add the amounts itemized in Columns 1, 2, 3, 4, and 5, and
- Enter the total for each column on the "Total Salaries and Wages" line item.

Less Salary Savings

- Complete the "Less Salary Savings" line item only if the county/city government mandates salary savings.
- Multiply the county/city salary savings percentage by the amount of "Total Salaries and Wages" in each column, and
- Enter the negative amount on the "Salary Savings" line for each column.

Net Salaries and Wages

- Subtract the "Salary Savings" amount from the "Total Salaries and Wages" amount in Columns 1, 2, 3, 4, and 5 and
- Enter the balance of each column on the line entitled, "Net Salaries and Wages."

Staff Benefits

The Staff Benefits line item shall include the county/city share of expenses for (a) employee benefits, e.g., employee group insurance (health, dental, life, accident, and unemployment insurance) and (b) worker's compensation insurance.

- Multiply the approved county/city staff benefits percentage by the "Net Salaries and Wages" for Columns 1, 2, 3, 4, and 5, and enter the amount on this line, or
- Enter the actual staff benefits amount as determined by the county/city on this line.
- If a percentage is used, the county/city must enter this percentage next to the words "Staff Benefits" on the form.

Total Personnel Expenses

- Add the "Staff Benefits" amount to the "Net Salaries and Wages" amount in Columns 1, 2, 3, 4, and 5, and
- Enter the total for each column on the "Total Personnel Expenses" line item.

II. Operating Expenses

Personnel Travel – Includes per diem, commercial automobile rental, motor pool, air travel, and private vehicle mileage, etc.

Personnel Training – Includes registration fees and tuition costs for training of program staff.

NOTE: All travel costs related to training must be included under "Travel."

- Enter the amounts budgeted for each item in CHDP in Column 2, Medi-Cal Enhanced in Column 4, and Medi-Cal Nonenhanced in Column 5.
- Add Column 4 and Column 5 for each line and enter in the sum Column 3.

- Add Column 3 and Column 2 for each line and enter in the sum Column 1.

Additional Operating Expenses

- List all other line items separately, e.g., rent, supplies.
- Enter the amounts budgeted for each line item of additional operating expenses in CHDP in Column 2 and Medi-Cal Nonenhanced in Column 5.
- Enter each amount in Column 5 and in Column 3.
- Add Column 2 and Column 3 and enter the sum in Column 1 for each line.

NOTE: The only "Operating Expenses" line items that are eligible for enhanced costs are travel and training.

Total Operating Expenses

- Add the "Operating Expenses" amounts itemized in Columns 1, 2, 3, 4, and 5 and
- Enter the total for each column on the "Total Operating Expenses" line item.

III. Capital Expenses – Includes all equipment and Automated Data Processing (ADP) hardware.

- Enter the approved "CHDP Budget" amount in Column 2 for each item.
- Enter the approved "Medi-Cal Budget" amounts in Column 5 and Column 3 for each item.
- Add Columns 2 and 3 for each line and enter the sum in Column 1.

Total Capital Expenses

- Add the "Capital Expenses" amounts itemized in Columns 1, 2, 3, and 5, and
- Enter the totals for each column on the "Total Capital Expenses" line item.

VI. Indirect Expenses

External – Any countywide overhead costs must have an approved plan on file with the State Controller's Office (A-87 plan).

Internal – Any departmental overhead costs must be developed with a cost allocation plan (CAP) prepared in accordance with federal guidelines, "Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government, Implementation Guide for Office of Management and Budget, Circular A-87".

The amount of "External Indirect Expenses" and "Internal Indirect Expenses" will be calculated by multiplying the percentages (assigned by the county fiscal staff for each

type of indirect expenses) by the budgeted amounts for "Total Salaries, Wages and Benefits," depending upon the base amount used to develop the percentage. Some counties/cities may have a flat dollar amount versus a percentage to distribute. This may be accomplished by developing ratios from total FTEs or from the budgeted amounts as described above.

- Enter calculated amounts for all "External Indirect Expenses" and "Internal Indirect Expenses" on the appropriate lines in Columns 2 and 5.
- For each line, enter the amounts from Column 5 in Column 3.
- Add the amounts for each line in Columns 2 and 3, and enter the sum in Column 1.

Total Indirect Expenses

- All "Indirect Expenses" are nonenhanced.
- Add all "Indirect Expenses" amounts itemized in Columns 1, 2, 3, and 5, and
- Enter the totals for each column on the "Total Indirect Expenses" line item.

V. Other Expenses – Includes any expenses not directly attributable to one of the above "Operating Expenses" line items.

List each "Other Expenses" item individually under this section.

- Enter the budgeted amount in CHDP, Column 2 and Medi-Cal Nonenhanced, Column 5 for each line.
- Enter the amount from Column 5 in Column 3 for each line.
- Add Columns 2 and 3 for each line and enter the sum in Column 1.

Total Other Expenses

- Add all "Other Expenses" amounts itemized in Columns 1, 2, 3, and 5, and
- Enter the total for each column on the "Total Other Expenses" line item.

Budget Grand Total

- Add the "Total Personnel Expenses," "Total Operating Expenses," "Total Capital Expenses," "Total Indirect Expenses," and "Total Other Expenses" lines for Columns 1, 2, 3, 4, and 5, and
- Enter the grand total of each column on the "Budget Grand Total" line item.

**CHDP Administrative Budget Worksheet for FY 2007-08
No County/City Match
State and State/Federal**

County/City Name: _____

Column	1A	1B	1	2A	2	3A	3	4A	4	5A	5
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	CHDP % or FTE	Total CHDP Budget	Total Medi-Cal %	Total Medi-Cal Budget (4 + 5)	% or FTE	Enhanced State/Federal (25/75)	% or FTE	Nonenhanced State/Federal (50/50)
I. Personnel Expenses											
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
Total Salaries and Wages											
Less Salary Savings											
Net Salaries and Wages											
Staff Benefits (Specify %)	%										
I. Total Personnel Expenses											
II. Operating Expenses											
1. Travel											
2. Training											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
II. Total Operating Expenses											

**CHDP Administrative Budget Worksheet for FY 2007-08
No County/City Match
State and State/Federal**

County/City Name: _____

Column	1A	1B	1	2A	2	3A	3	4A	4	5A	5
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	CHDP % or FTE	Total CHDP Budget	Total Medi-Cal %	Total Medi-Cal Budget (4 + 5)	% or FTE	Enhanced State/Federal (25/75)	% or FTE	Nonenhanced State/Federal (50/50)
III. Capital Expenses											
1.											
2.											
3.											
4.											
5.											
II. Total Capital Expenses											
IV. Indirect Expenses											
1. Internal (Specify %)	%										
2. External (Specify %)	%										
IV. Total Indirect Expenses											
V. Other Expenses											
1.											
2.											
3.											
4.											
5.											
V. Total Other Expenses											
Budget Grand Total											

Prepared By

Date Prepared

Phone Number

CHDP Director or
Deputy
Director (Signature)

Date

Phone Number

SAMPLE

**CHDP Administrative Budget Worksheet for FY 2007-08
No County/City Match
State and State/Federal**

County/City Name: Golden

Column	1A	1B	1	2A	2	3A	3	4A	4	5A	5
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	CHDP % or FTE	Total CHDP Budget	Total Medi-Cal %	Total Medi-Cal Budget (4 + 5)	% or FTE	Enhanced State/Federal (25/75)	% or FTE	Nonenhanced State/Federal (50/50)
Personnel Expenses											
1. Deputy Director – James	50%	\$61,000	\$30,500	20%	\$6,100	80%	\$24,400	60%	\$14,640	40%	\$9,760
2. Public Health Nurse – Wade	80%	\$55,423	\$44,338	30%	\$13,301	70%	\$31,037	75%	\$23,278	25%	\$7,759
3. PH Education Assistant – Smith	75%	\$40,000	\$30,000	30%	\$9,000	70%	\$21,000			100%	\$21,000
4. Account Technical – Roe	15%	\$25,650	\$3,848	15%	\$577	85%	\$3,271			100%	\$3,271
5.											
6.											
7.											
8.											
9.											
10.											
Total Salaries and Wages			\$108,686		\$28,978		\$79,708		\$37,918		\$41,790
Less Salary Savings											
Net Salaries and Wages			\$108,686		\$28,978		\$79,708		\$37,918		\$41,790
Staff Benefits (Specify %)	25%		\$27,172		\$7,245		\$19,927		\$11,580		\$8,347
I. Total Personnel Expenses			\$135,858		\$36,223		\$99,635		\$49,498		\$50,137
II. Operating Expenses											
1. Travel			\$1,500		\$900		\$600		\$300		\$300
2. Training			\$3,500		\$1,601		\$1,899		\$1,000		\$899
3. Office Expenses			\$4,427		\$3,500		\$927				\$927
4. Communication			\$1,000		\$500		\$500				\$500
5.											
6.											
7.											
8.											
9.											
10.											
II. Total Operating Expenses			\$10,427		\$6,501		\$3,926		\$1,300		\$2,626

**CHDP Administrative Budget Worksheet for FY 2007-08
No County/City Match
State and State/Federal**

County/City Name: Golden

Column	1A	1B	1	2A	2	3A	3	4A	4	5A	5
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	CHDP % or FTE	Total CHDP Budget	Total Medi-Cal %	Total Medi-Cal Budget (4 + 5)	% or FTE	Enhanced State/Federal (25/75)	% or FTE	Nonenhanced State/Federal (50/50)
III. Capital Expenses											
1.											
2.											
3.											
4.											
5.											
II. Total Capital Expenses											
IV. Indirect Expenses											
1. Internal (Specify %)	.07%		\$951		\$254		\$697				\$697
2. External (Specify %)	.09%		\$13,586		\$3,622		\$9,964				\$9,964
IV. Total Indirect Expenses			\$14,537		\$3,876		\$10,661				\$10,661
V. Other Expenses											
1.											
2.											
3.											
4.											
5.											
V. Total Other Expenses											
Budget Grand Total			\$160,822		\$46,600		\$114,222		\$50,798		\$63,424

John Smith
Prepared By

5/1/07
Date Prepared

916-555-1212
Phone Number

Dr. Jane Doe
CHDP Director or Deputy
Director (Signature)

5/1/07
Date

916-555-1212
Phone Number

CHDP No County/City Match Administrative Budget Summary Instructions

I. Budget Summary Instructions

- Transfer the dollar amount from each Total Line item in each column of the CHDP No County/City Match Budget to the CHDP Administrative Budget Summary Form (see sample, page 49).
- Compute the amounts in the "Source of Funds" section of the budget as described below.

II. Source of Funds (No County/City Match)

A. State General Funds

Total CHDP Budget

Enter the "Budget Grand Total" amount from Column 2 "Total CHDP Budget" in the "Source of Funds" section, "Total CHDP" column, on the State General Funds line. The total CHDP funds may not exceed the funds allocated annually in the CHDP allocation letter sent by the CMS Branch.

B. Medi-Cal Funds

1. Enhanced Funds

- Multiply the Enhanced, Column 4 "Budget Grand Total" amount by 25 percent, and enter the amount in the "Source of Funds" section, Enhanced column, on the State Funds line.
- Multiply the Enhanced, Column 4 "Budget Grand Total" amount by 75 percent, and enter the amount in the "Source of Funds" section, Enhanced column, on the Federal Funds line.

2. Nonenhanced Funds

- Multiply the Nonenhanced, Column 5, "Budget Grand Total" amount by 50 percent, and enter the amount in the "Source of Funds" section, Nonenhanced column, on the State Funds line.
- Multiply the Nonenhanced, Column 5, "Budget Grand Total" amount by 50 percent, and enter the amount in the "Source of Funds" section, Nonenhanced column, on the Federal Funds line.

3. Total Medi-Cal Funds

- Add Columns 4 and 5 and enter the sum in Column 3 "Source of Funds."

- The total Medi-Cal State Funds for the CHDP No County/City Match Budget may not exceed the funds allocated annually in the CHDP Allocation letter sent by the CMS Branch.

4. Total Funds

- Enter the State General Funds amount from Column 2, Total CHDP Budget, in Column 1.
- For both State and Federal, enter the amounts from Column 3, Total Medi-Cal Budget, in Column 1, Total Funds

State of California – Health and Human Services Agency

California Department of Health Care Services – Children's Medical Services Branch

CHDP Administrative Budget Summary for FY 2007-08
No County/City Match
 County/City Name: _____

Column Category/Line Item	1 Total Budget (2 + 3)	2 Total CHDP Budget	3 Total Medi-Cal Budget (4 + 5)	4 Enhanced State/Federal (25/75)	5 Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses					
II. Total Operating Expenses					
III. Total Capital Expenses					
IV. Total Indirect Expenses					
V. Total Other Expenses					
Budget Grand Total					

Column Source of Funds	1 Total Funds	2 Total CHDP Budget	3 Total Medi-Cal Budget	4 Enhanced State/Federal	5 Nonenhanced State/Federal
State General Funds					
Medi-Cal Funds:					
State					
Federal (Title XIX)					

Prepared By _____ Date Prepared _____ Phone Number _____ Email Address _____

CHDP Director or Deputy Director
(Signature) _____ Date _____ Phone Number _____ Email Address _____

State of California – Health and Human Services Agency

California Department of Health Care Services – Children's Medical Services Branch

SAMPLE

CHDP Administrative Budget Summary for FY 2007-08
No County/City Match
County/City Name: Golden

Column	1	2	3	4	5
Category/Line Item	Total Budget (2 + 3)	Total CHDP Budget	Total Medi-Cal Budget (4 + 5)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses	\$135,858	\$36,223	\$99,635	\$49,498	\$50,137
II. Total Operating Expenses	\$10,427	\$6,501	\$3,926	\$1,300	\$2,626
III. Total Capital Expenses	\$0	\$0	\$0		\$0
IV. Total Indirect Expenses	\$14,537	\$3,876	\$10,661		\$10,661
V. Total Other Expenses	\$0	\$0	\$0		\$0
Budget Grand Total	\$160,822	\$46,600	\$114,222	\$50,798	\$63,424

Column	1	2	3	4	5
Source of Funds	Total Funds	Total CHDP Budget	Total Medi-Cal Budget	Enhanced State/Federal	Nonenhanced State/Federal
State General Funds	\$46,600	\$46,600			
Medi-Cal Funds:	\$114,222		\$114,222		
State	\$44,412		\$44,412	\$12,700	\$31,712
Federal (Title XIX)	\$69,810		\$69,810	\$38,098	\$31,712

<u>John Smith</u> Prepared By	<u>05/01/07</u> Date Prepared	<u>916-555-1212</u> Phone Number	<u>jsmith@golden.ca.us</u> Email Address
<u>Dr. Jane Doe</u> CHDP Director or Deputy Director (Signature)	<u>5/01/07</u> Date	<u>916-555-1122</u> Phone Number	<u>jdoe@golden.ca.us</u> Email Address

CHDP Administrative Budget Worksheet Instructions (County/City Match)

County/City Funds and Title XIX Federal Funds

I. Personnel Expenses

In this section, list each funded position as a separate line item by incumbent name and classification and complete the following columns (see sample on pages 56 and 57).

1A. Percentage or FTE: Enter the portion of the FTE in Column 1A for the percentage of time spent on program activities during the budget fiscal year for each position listed in "Personnel Expenses" section.

Formula: Time base multiplied by twelve months.

Example: Employee works one day per week (1/5 time) $1/5 = 0.2$ or 20 percent

1B. Annual Salary: Enter in Column 1B the salary for each full-time position listed in the "Personnel Expenses" section.

Total Budget

- Multiply each entry in Column 1A "% FTE" by the corresponding entry Column 1B "Annual Salary" and
- Enter the amount in Column 1 "Total Budget" (Columns 2 plus 3 must equal this amount.)

2/2A. Percentage of FTE/Enhanced (25/75)

- Enter in Column 2A, the percentage of the FTE in Column 1A for eligible enhanced program activities for each position listed.
- Multiply the FTE in Column 2A by the "Total Budget" in Column 1, and
- Enter the amount in Column 2, Enhanced.

NOTE: If your local program uses one cost center for time studies in the CHDP program, and the time studies are used to invoice expenditures for the No County/City Match and the County/City Match Budgets the proportions of enhanced and nonenhanced time for personnel claimed in the two budgets must be the same.

3/3A. Percentage of FTE/Nonenhanced

- Enter in Column 3A, the percentage of the FTE in Column 1A for eligible nonenhanced program activities for each position listed.
- Multiply the FTE in Column 3A by the Total Budget in Column 1 and
- Enter the amount in Column 3, Nonenhanced.

Total Salaries and Wages

- Add the "Salaries and Wages" amounts itemized in Columns 1, 2, and 3, and
- Enter the total for each column on the "Total Salaries and Wages" line item.

Less Salary Savings

NOTE: Complete only if the county/city government mandates salary savings.

- Multiply the county/city salary savings percentage by the "Total Salaries and Wages" line for each column, and
- Enter the negative amount on the "Salary Savings" line for each column.

Net Salaries and Wages

- Subtract the "Salary Savings" amount from the "Total Salaries and Wages" in Columns 1, 2, and 3, and
- Enter the balance of each column on the line entitled "Net Salaries and Wages."

Staff Benefits

- Multiply the approved county/city staff benefits percentages by the "Net Salaries and Wages" in Columns 1, 2, and 3, and enter the amounts on this line, or
- Enter the actual staff benefits amount as determined by the county/city on this line.

Total Personnel Expenses

- Add the "Staff Benefits" amounts to the "Net Salaries and Wages" amounts in Columns 1, 2, and 3, and
- Enter the total for each column on the "Total Personnel Expenses" line item.

II. Operating Expenses

Personnel Travel – Includes per diem, commercial automobile rental, motor pool, air travel, and private vehicle mileage, etc.

Personnel Training – Includes registration fees and tuition costs for training of program staff.

NOTE: All travel costs related to training must be included under "Travel."

- Enter the amounts budgeted for each item in Medi-Cal Enhanced in Column 2 and Medi-Cal Nonenhanced in Column 3.
- Add Columns 2 and 3 for each line and enter the sum in Column 1.

Additional Operating Expenses

List all other operating expenses line items separately, e.g., rent, supplies.

- Enter the amounts budgeted for each line item of additional operating expenses in Medi-Cal Nonenhanced (Column 3).
- Enter amount of Column 3 in Column 1 for each line.

NOTE: The only "Operating Expenses" line items that are eligible for enhanced costs are travel and training.

Total Operating Expenses

- Add the "Operating Expenses" amounts itemized in Columns 1, 2, and 3, and
- Enter the total for each column on the "Total Operating Expenses" line.

III. Capital Expenses

- Enter the approved budget amounts in Column 3.
- Enter the same amount in Column 1.

Total Capital Expenses

- Add the "Capital Expenses" amounts itemized, and
- Enter the total for each column on the "Total Capital Expenses" line item.

IV. Indirect Expenses

External – Any countywide overhead costs must have an approved plan on file with the State Controller's Office (A-87 plan)

Internal – Any departmental overhead costs must be developed with a cost allocation plan (CAP) prepared in accordance with federal guidelines, "Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government, Implementation Guide for Office of Management and Budget, Circular A-87".

The amount of External and Internal Indirect Expenses will be calculated by multiplying the percentages (assigned by the county/city fiscal staff for each type of Indirect Expenses) by the budgeted amounts for "Total Salaries, Wages and Benefits," depending on the base amount used to develop the percentage. Some counties/cities may have a flat dollar amount versus a percentage to distribute. This may be accomplished by developing ratios from total FTEs or from the budgeted amounts as described above.

- Enter the calculated amounts of External and Internal Indirect expenses on the appropriate lines in Column 3.

- Enter the amounts from Column 3 for each line in Column 1.

Total Indirect Expenses

- All indirect expenses are nonenhanced.
- Add all "Indirect Expenses" amounts itemized, and
- Enter the total for Columns 1 and 3 on the "Total Indirect Expenses" line item.

V. Other Expenses

This Section includes any expenses not directly attributable to one of the above "Operating Expenses" line items.

List each "Other Expenses" item individually under this section.

- Enter the budgeted amount in Medi-Cal Nonenhanced, Column 3.
- Enter the amount from Column 3 in Column 1.

Total Other Expenses

- Add all "Other Expenses" amounts itemized, and
- Enter the totals for each column on the "Total Other Expenses" line item.

Budget Grand Total

- Add the "Total Personnel Expenses," "Total Operating Expenses," "Total Capital Expenses," "Total Indirect Expenses," and "Total Other Expenses" lines in Columns 1, 2, and 3, and
- Enter the grand total for each column on the "Budget Grand Total" line item.

CHDP Administrative Budget Worksheet for FY 2007-08
County/City Match
 County/City Name: _____

Column	1A	1B	1	2A	2	3A	3
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	% or FTE	Enhanced County/Federal (25/75)	% or FTE	Nonenhanced County/Federal (50/50)
I. Personnel Expenses							
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Total Salaries and Wages							
Less Salary Savings							
Net Salaries and Wages							
Staff Benefits (Specify %) %							
I. Total Personnel Expenses							
II. Operating Expenses							
1. Travel							
2. Training							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
II. Total Operating Expenses							

CHDP Administrative Budget Worksheet for FY 2007-08

County/City Match

County/City Name: _____

Column	1A	1B	1	2A	2	3A	3
III. Capital Expenses							
1.							
2.							
3.							
4.							
5.							
II. Total Capital Expenses							
IV. Indirect Expenses							
1. Internal (Specify %) %							
2. External (Specify %) %							
IV. Total Indirect Expenses							
V. Other Expenses							
1.							
2.							
3.							
4.							
5.							
V. Total Other Expenses							
Budget Grand Total							

Prepared By _____

Date Prepared _____

Phone Number _____

CHPD Director or Deputy Director (Signature) _____

Date _____

Phone Number _____

SAMPLE

CHDP Administrative Budget Worksheet for FY 2007-08

County/City Match

County/City Name: Golden

Column	1A	1B	1	2A	2	3A	3
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	% or FTE	Enhanced County/Federal (25/75)	% or FTE	Nonenhanced County/Federal (50/50)
I. Personnel Expenses							
1. Deputy Director - James	50%	\$61,000	\$30,500	60%	\$18,300	40%	\$12,200
2. Public Health Nurse - Smith	20%	\$55,423	\$11,085	75%	\$8,314	25%	\$2,771
3. PH Education Asst - Jones	25%	\$40,000	\$10,000	0%		100%	\$10,000
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Total Salaries and Wages			\$51,585		\$26,614		\$24,971
Less Salary Savings							
Net Salaries and Wages			\$51,585		\$26,614		\$24,971
Staff Benefits (Specify %)	25%		\$12,897		\$6,654		\$6,243
I. Total Personnel Expenses			\$64,482		\$33,268		\$31,214
II. Operating Expenses							
1. Travel			\$500		\$350		\$150
2. Training			\$700		\$500		\$200
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
II. Total Operating Expenses			\$1,200		\$850		\$350

CHDP Administrative Budget Worksheet for FY 2007-08

County/City Match

County/City Name: Golden

Column	1A	1B	1	2A	2	3A	3
III. Capital Expenses							
1.							
2.							
3.							
4.							
5.							
II. Total Capital Expenses							
IV. Indirect Expenses							
1. Internal (Specify %)	0.00%						
2. External (Specify %)	0.00%						
IV. Total Indirect Expenses							
V. Other Expenses							
1.							
2.							
3.							
4.							
5.							
V. Total Other Expenses							
Budget Grand Total			\$65,682		\$34,118		\$31,564

John Smith

 Prepared By

May 1, 2007

 Date Prepared

916-555-1212

 Phone Number

 Email Address

Dr. Jane Doe

 CHPD Director or Deputy Director (Signature)

May 1, 2007

 Date

916-555-1122

 Phone Number

 Email Address

CHDP County/City Match Administrative Budget Summary Instructions

I. CHDP County/City Administrative Budget Summary

- Transfer the dollar amount from the total amount of each line item and column of the CHDP Budget Worksheet to the CHDP Administrative Budget Summary Form (see sample on page 60). Compute the amounts in the "Source of Funds" section of the budget as described below.

II. Source of Funds (County/City Match)

A. Enhanced Funds

- Multiply the Enhanced "Budget Grand Total" amount in Column 2 by 25 percent. Enter the amount on the County/City Funds line, Enhanced column, in the "Source of Funds" section.
- Multiply the Enhanced, Column 3, "Budget Grand Total" amount by 75 percent, and enter the amount in the "Source of Funds" section, Enhanced column, on the Federal Funds line.

B. Nonenhanced Funds

- Multiply the Nonenhanced "Budget Grand Total" amount in Column 3 by 50 percent. Enter this amount on the County/City Funds line, Nonenhanced column, in "Source of Funds" section.
- Multiply the Nonenhanced, Column 3, "Budget Grand Total" amount by 50 percent, and enter the amount in the "Source of Funds" section, Nonenhanced column, on the Federal Funds line.

C. Total Funds

- Total Funds will equal the Enhanced plus the Nonenhanced County/City Funds for the County/City Funds line and the Enhanced plus the Nonenhanced Funds for the Federal Funds line.

NOTE: The total of funding amounts entered under each column in the Source of Funds section must agree with the totals for the same column entered on the Budget Grand Total line.

State of California – Health and Human Services Agency

California Department of Health Care Services – Children's Medical Services Branch

CHDP Administrative Budget Summary for FY 2007-08
County/City Match
County/City Name: _____

Column	1	2	3
Category/Line Item	Total Budget (2 + 3)	Enhanced County/City /Federal (25/75)	Nonenhanced County/City/Federal (50/50)
I. Total Personnel Expenses			
II. Total Operating Expenses			
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
Budget Grand Total			

Column	1	2	3
Source of Funds	Total Funds	Enhanced County/City /Federal (25/75)	Nonenhanced County/Federal (50/50)
County Funds			
Federal Funds (Title XIX)			

Prepared By	Date	Phone Number	Email Address
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CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address
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State of California – Health and Human Services Agency

California Department of Health Care Services – Children's Medical Services Branch

CHDP Administrative Budget Summary for FY 2007-08

County/City Match

County/City Name: Golden

SAMPLE

Column	1	2	3
Category/Line Item	Total Budget (2 + 3)	Enhanced County/City /Federal (25/75)	Nonenhanced County/City/Federal (50/50)
I. Total Personnel Expenses	\$64,482	\$33,268	\$31,214
II. Total Operating Expenses	\$1,200	\$850	\$350
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
Budget Grand Total	\$65,682	\$34,118	\$31,564

Column	1	2	3
Source of Funds	Total Funds	Enhanced County/Federal (25/75)	Nonenhanced County/Federal (50/50)
County Funds	\$24,312	\$8,530	\$15,782
Federal Funds (Title XIX)	\$41,370	\$25,588	\$15,782

John Smith	05/01/2007	916-555-1212	jsmith@golden.ca.us
Prepared By	Date	Phone Number	Email Address
<i>Dr. Jane Doe</i>	05/01/2007	916-555-1122	jdoe@golden.ca.us
CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address

Foster Care Administrative (County/City Match) Budget Worksheet Instructions

The budget has three line items, Personnel, Operating and Indirect Expenses

I. Personnel Expenses

Personnel Expenses are limited to PHNs and SPHNs who meet the federal definition of Skilled Professional Medical Personnel (SPMP). (see Section 9).

In this section, list each funded position as a separate line item by incumbent name and classification and complete the following columns (see sample, page 66):

1A. Percentage of FTE: Enter the portion of the FTE in Column 1A for the percentage of time spent on program activities during the budget fiscal year for each position listed in "Personnel Expense" section.

Formula: Time base multiplied by twelve months.

Example: Employee works one day per week (1/5 time) $1/5 = 0.2$ or 20 percent

1B. Annual Salary: Enter in Column 1B the salary for each full-time position listed in the "Personnel Expense" section.

Total Budget

- Multiply each entry in Column 1A "% FTE" by the corresponding entry Column 1B "Annual Salary" and
- Enter the amount in Column 1 "Total Budget" (Columns 2 plus 3 must equal this amount.)

2/2A. Percentage of FTE/Enhanced (25/75)

- Enter in Column 2A, "% FTE" the portion of the annualized FTE to be spent on eligible enhanced program activities for each position listed. The sum of Column 2A and 3A must equal 100 percent.
- Multiply the FTE in Column 2A by the "Total Budget" in Column 1, and
- Enter the amount in Column 2, Enhanced.

NOTE: If your local program uses one cost center for time studies in the CHDP program, and the time studies are used to invoice expenditures for the HCPCFC Administrative Budget and the Foster Care County/City Match Budget the proportions of enhanced and nonenhanced time for personnel claimed in the two budgets must be the same.

3/3A. Percentage of FTE/Nonenhanced

- Enter in Column 3A, the percentage of the FTE in Column 1A for eligible nonenhanced program activities for each position listed.

- Multiply the FTE in Column 3A by the Total Budget in Column 1 and
- Enter the amount in Column 3, Nonenhanced.

Total Salaries and Wages

- Add the "Salaries and Wages" amounts itemized in Columns 1, 2 and 3, and
- Enter the total for each column on the "Total Salaries and Wages" line item.

Less Salary Savings

NOTE: Complete only if the county/city government mandates salary savings.

- Multiply the county/city salary savings percentage by the "Total Salaries and Wages" line for each column, and
- Enter the negative amount on the "Salary Savings" line for each column.

Net Salaries and Wages

- Subtract the "Salary Savings" amount from the "Total Salaries and Wages" in Columns 1, 2, and 3, and
- Enter the balance of each column on the line entitled "Net Salaries and Wages."

Staff Benefits

- Multiply the approved county/city staff benefits percentages by the "Net Salaries and Wages" in Column 1, 2, and 3, and enter the amounts this line, or
- Enter the actual staff benefits amount as determined by the county/city on this line.

Total Personnel Expenses

- Add the "Staff Benefits" amounts to the "Net Salaries and Wages" amounts in Columns 1, 2, and 3, and
- Enter the total for each column on the "Total Personnel Expenses" line item.

II. Operating Expenses

Operating Expenses to support the PHNs and SPHNs are limited to travel and training. Space and computer access are provided by the child welfare agency.

Personnel Travel – Includes per diem, commercial automobile rental, motor pool, air travel, and private vehicle mileage, etc.

Personnel Training – Includes registration fees and tuition costs for training of program staff.

NOTE: All travel costs related to training must be included under "Travel."

- Enter the amounts budgeted for each item in Medi-Cal Enhanced in Column 2 and Medi-Cal Nonenhanced in Column 3.
- Add Columns 2 and 3 for each line and enter the sum in Column 1.

NOTE: The only "Operating Expenses" line items that are eligible for enhanced costs are travel and training.

Total Operating Expenses

- Add the "Operating Expenses" amounts itemized in Columns 1, 2, and 3, and
- Enter the total for each column on the "Total Operating Expenses" line.

III. Capital Expenses

- "Capital Expenses" cannot be claimed on this budget.

IV. Indirect Expenses

Internal Indirect Expenses are capped at 10 percent of the total cost of the budgeted personnel expenses.

External Indirect Expenses cannot be claimed on this budget.

Internal – Internal Indirect Expenses are limited to 10 percent of the Total Personnel Expenses for this budget. Any departmental overhead costs that are allocated must be developed with a cost allocation plan (CAP) prepared in accordance with federal guidelines, "Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal, Implementation Guide for Office of Management and Budget, Circular A-87".

- Enter the calculated amounts of External and Internal Indirect expenses on the appropriate lines in Column 3.
- Enter the amounts from Column 3 for each line in Column 1.

Total Indirect Expenses

- All indirect expenses are nonenhanced.
- Add all "Indirect Expenses" amounts itemized, and
- Enter the totals for Columns 1 and 3 on the "Total Indirect Expenses" line item.

V. Other Expenses

"Other Expenses" cannot be included on this budget.

Budget Grand Total

- Enter the sum of the "Total Personnel Expenses," "Total Operating Expenses," and "Total Indirect Expenses," and lines in Columns 1, 2, and 3, and
- Enter the grand total for each column on the "Budget Grand Total" line item.

Foster Care Administrative Budget Fiscal Year 2007-08
 County-City/Federal Match
 County/Title XIX Federal Funds
 County/City Name: _____

Column	1A	1B	1	2A	2	3A	3
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	% or FTE	Enhanced County-City/Federal (25/75)	% or FTE	Nonenhanced County-City/Federal (50/50)
I. Personnel Expenses							
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Total Salaries and Wages							
Less Salary Savings							
Net Salaries and Wages							
Staff Benefits (Specify %) 0.00%							
I. Total Personnel Expenses							
II. Operating Expenses							
1. Travel							
2. Training							
II. Total Operating Expenses							
III. Capital Expenses							
1.							
2.							
III. Total Capital Expenses							
IV. Indirect Expenses (10% cap)							
1. Internal (Specify %) 0.00%							
2. External							
IV. Total Indirect Expenses							
V. Other Expenses							
1.							
2.							
V. Total Other Expenses							
Budget Grand Total							

Prepared By _____

Date _____

Phone Number _____

CHDP Director or Deputy Director (Signature) _____

Date _____

Phone Number _____

Foster Care Administrative Budget Fiscal Year 2007-08
 County-City/Federal Match
 County/Title XIX Federal Funds
 County/City Name: Golden

SAMPLE

Column	1A	1B	1	2A	2	3A	3
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	% or FTE	Enhanced County-City/Federal (25/75)	% or FTE	Nonenhanced County-City/Federal (50/50)
I. Personnel Expenses							
1. SPHN Jones	5%	\$61,000	\$3,050	60%	\$1,830	40%	\$1,220
2. PHN II Adams	25%	\$55,420	\$13,855	85%	\$11,777	15%	\$2,078
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Total Salaries and Wages			\$16,905		\$13,607		\$3,298
Less Salary Savings							
Net Salaries and Wages			\$16,905		\$13,607		\$3,298
Staff Benefits (Specify %) 15.00%			\$2,536		\$2,041		\$495
I. Total Personnel Expenses			\$19,441		\$15,648		\$3,793
II. Operating Expenses							
1. Travel			\$500		\$200		\$300
2. Training			\$200		\$100		\$100
II. Total Operating Expenses			\$700		\$300		\$400
III. Capital Expenses							
1.							
2.							
II. Total Capital Expenses							
IV. Indirect Expenses (10% Cap)							
1. Internal (Specify %) 10.00%			\$1,944				\$1,944
2. External							
IV. Total Indirect Expenses			\$1,944				\$1,944
V. Other Expenses							
1.							
2.							
V. Total Other Expenses							
Budget Grand Total			\$22,085		\$15,948		\$6,137

 John Smith
 Prepared By

 May 1, 2007
 Date

 916-555-1122
 Phone Number

 Dr. Jane Doe
 CHDP Director or Deputy Director (Signature)

 May 1, 2007
 Date

 915-555-1122
 Phone Number

Foster Care Administrative (County/City Match) Budget Summary Instructions

I. Foster Care County/City Administrative Budget Summary

- Transfer the dollar amount from the total amount of each line item and column of the Foster Care Administrative Budget County/City Match Worksheet to the Foster Care Administrative Budget County/City Match Summary form. Compute the amounts in the "Source of Funds" section of the budget as described below (see sample, page 69).

II. Source of Funds (County/City Match)

The source of local funds for the county/city match must be identified on the budget summary and included in the budget justification narrative.

A. Enhanced Funds

- Multiply the Enhanced Budget Grand Total amount in Column 2 by 25 percent. Enter the amount on the County/City Funds line, Enhanced column, in the Source of Funds section.
- Subtract the County/City Funds amount from the Budget Grand Total in Column 2, and enter this amount on the Federal Funds line, Enhanced Column, in the Source of Funds section.

B. Nonenhanced Funds

- Multiply the Nonenhanced Budget Grand Total amount in Column 3 by 50 percent. Enter this amount on the County/City Funds line, Nonenhanced column, in Source of Funds section.
- Subtract the County/City Funds amount from the Budget Grand Total in Column 3, and enter this amount on the Federal Funds line, Nonenhanced column, of the Source of Funds section.

C. Total Funds and Grand Total

- Add the amount of State Funds in Column 1 in the Source of Funds section to the Federal Funds (Title XIX) in Column 1 in the Source of Funds section to arrive at a Grand Total.

NOTE: The Total Funds will equal the Enhanced plus the Nonenhanced State Funds for the State Funds line and the Enhanced plus the Nonenhanced Funds for the Federal Funds line.

The total of funding amounts entered under each column in the Source of Funds section must agree with the totals for the same column entered on the Budget Grand Total line.

**Foster Care Administrative Budget Summary Fiscal Year 2007-08
County-City Match
County/Title XIX Federal Funds
County/City Name: Golden**

Column	1	2	3
Category/Line Item	Total Budget (2 + 3)	Enhanced County-City/Federal (25/75)	Nonenhanced County-City/Federal (50/50)
I. Total Personnel Expenses			
II. Total Operating Expenses			
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
Budget Grand Total			

Column	1	2	3
Source of Funds	Total Funds	Enhanced County-City/Federal (25/75)	Nonenhanced County-City/Federal (50/50)
County-City Funds			
Federal Funds (Title XIX)			
Budget Grand Total			

Source County-City Funds: _____ (Specify source of funds, e.g. county child welfare, probation, grant, etc.)

Prepared By _____ Date _____ Phone Number _____ Email Address _____

CHDP Director or Deputy Director (Signature) _____ Date _____ Phone Number _____ Email Address _____

SAMPLE

**Foster Care Administrative Budget Summary Fiscal Year 2007-08
County-City Match
County/Title XIX Federal Funds
County/City Name: Golden**

Column	1	2	3
Category/Line Item	Total Budget (2 + 3)	Enhanced County-City/Federal (25/75)	Nonenhanced County-City/Federal (50/50)
I. Total Personnel Expenses	\$19,441	\$15,648	\$3,793
II. Total Operating Expenses	\$700	\$300	\$400
III. Total Capital Expenses			
IV. Total Indirect Expenses	\$1,944		\$1,944
V. Total Other Expenses			
Budget Grand Total	\$22,085	\$15,948	\$6,137

Column	1	2	3
Source of Funds	Total Funds	Enhanced County-City/Federal (25/75)	Nonenhanced County-City/Federal (50/50)
County-City Funds	\$7,056	\$3,987	\$3,069
Federal Funds (Title XIX)	\$15,029	\$11,961	\$3,068
Budget Grand Total	\$22,085		

Source County-City Funds: _____ (Specify source of funds, e.g. county child welfare, probation, grant, etc.)

John Smith	05/01/07	916-555-1212	jsmith@golden.ca.us
Prepared By	Date	Phone Number	Email Address

<i>Dr. Jane Doe</i>	05/01/07	916-555-1122	idoeg@golden.ca.us
CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address

HPCFC Budget Information and Staffing Guidelines

I. Budget Information

The State Budget Act of 1999 appropriated State General Funds to the California Department of Social Services for the purpose of increasing the use of public health nurses in meeting the health care needs of children in foster care. These funds were transferred to the State California Department of Health Care Services for distribution through the CHDP program in the form of a fiscal augmentation to operate the HPCFC.

- A. State General funds are matched through the federal Medicaid (XIX) program for administrative activities in support of the Medicaid program (Medi-Cal in California) and therefore must be used for activities that are administrative case management functions.
- B. Funds for this program are not to supplant public health nurse (PHN) positions in local programs that provide administrative case management services to children in foster care unless the PHN to child ratio is less than 1:200.
- C. The required annual administrative budget and quarterly expenditure invoices are prepared and submitted by local CHDP programs in accordance with CMS Budget instructions and guidelines (see Section 8).
- D. Program administrative oversight for the HPCFC PHNs is provided by the local CHDP program. PHNs funded by the HPCFC are hired by the local health department and physically located at local child welfare agency and probation department offices.
- E. State General Funds are distributed to local programs based on caseload data from the Child Welfare System/Case Management System (CWS/CMS), maintained by the California Department of Social Services (CDSS).
- F. The caseload data reflect the annual monthly average of children and probation youth in out of home placement, or foster care, supervised by the County and placed in the County from other counties.
- G. The local HPCFC Administrative budgets should reflect the total Public Health Nurse (PHN) and Supervising PHN (SPHN) FTE staffing obtainable with the allocation of State General funds as matched through Federal Financial Participation.
- H. The budget has three line items, Personnel, Operating and Indirect Expenses.
 - 1. Personnel Expenses are limited to PHNs and SPHNs who meet the federal definition of Skilled Professional Medical Personnel (SPMP). (see Section 9).
 - 2. Operating Expenses to support the PHNs and SPHNs are limited to travel and training. Space and computer access are provided by the child welfare agency.

3. Internal Indirect Expenses are capped at 10 percent of the total cost of the budgeted personnel. External Indirect Expenses are not allowed on the HCPCFC Budget. (see page 75).
 4. Total expenses are not to exceed the amount of State General funds allocated to the CHDP program for implementation and operation of the HCPCFC.
- I. A local program that determines it is necessary to request additional funds for staff who perform administrative case management activities in support of children in out-of-home placement, may submit an optional Foster Care Administrative Budget (see page-68). A statement identifying the source of local funds is required (e.g. county child welfare, probation, grant, etc).

II. Staffing Guidelines

- A. PHNs implementing the Health Care Program for Children in Foster Care are to be located on site at the child welfare services agency and probation department. PHNs funded by the HCPCFC are dedicated personnel and participate with the social worker/probation officer in the development of health care plan located in the child's case record. In collaboration with the child's social worker/probation officer, PHNs plan and coordinate health care services for children in out-of-home placement in accordance with the PHN responsibilities and program activities outlined in the model interdepartmental HCPCFC MOU (see Section 5) and Scope of Work (see Section 3).
- B. The administrative activities of the PHN include Informing and Linking; Care Coordination; Orientation and Training with Caseworkers, Probation Officers, Foster Care Providers, Health Care Providers, Officers Of The Court and Others; and Liaison Functions.
 1. Informing and Linking activities focus on promoting knowledge of the need for preventive health services; how to access services; and the need to maintain a link to health care services provided through the Child Health and Disability Prevention (CHDP) and Medi-Cal programs. The PHN collaborates with a multi-disciplinary team of health care professionals, community providers and agencies, and understands the principles of child health promotion and nursing care of children with special needs.
 2. Care Coordination activities focus on ensuring appropriate health services are accessed; assisting with the health plan as a part of the case plan; providing follow up to maintain continuity of care; providing consultation to the foster care team members, and assisting with the maintenance of the child's Health and Education Passport. PHNs need knowledge and experience in primary and secondary care in order to assure children in out-of-home placement obtain necessary health care services.
 3. Orientation and Training activities focus on the provision of health and medical information to the foster care team as it relates to the special health needs of the child in foster care. The PHN serves as a consultant

to social workers; probation officers; biological and substitute care providers, and health care providers.

4. Liaison activities focus on coordinating and problem solving with CHDP program staff, health care providers, community agencies, and transitional programs to ensure the continued effective and appropriate use of the Medi-Cal program; coordinating with county/city social services programs, Independent Living Skills Program; coordinating with other county/city public health department (PHD) programs and social services programs such as the following:
 - California Children's Services (CCS)
 - Schools
 - Regional Center
 - Mental and Behavioral Health programs
 - Immunization (IZ)
 - Childhood Lead Poisoning Prevention
 - Maternal and Child Health (MCH)
 - Women's, Infants, and Children (WIC)
 - Child Health and Disability Prevention (CHDP)
- C. For children in foster care placed out of the supervising county of residence, the PHN will work with the Foster Care PHN in the county of placement to locate and arrange for needed health care services.
- D. PHNs working in the HCPCFC require professional nursing supervision. The HCPCFC established ratio is one (1) SPHN FTE to every ten (10) FTEs of PHN, 1:10.

HPCFC Budget Worksheet Instructions (State/Federal Match)

I. Personnel Expenses

List as a separate line item each funded position by incumbent name and classification. For each line item complete the following columns (see sample, page 77):

1A. Percentage or Full Time Equivalent (FTE): Enter the annualized FTE in Column 1A, i.e., percentage of time to be spent on program activities during the budget fiscal year for each position listed under "Personnel Expenses."

Formula: Time base multiplied by number of months to be worked in fiscal year divided by number of months in year equals FTE.

Example: Employee works one day per week (1/5 time) for six months out of 12 months (6/12); Formula: $1/5 \times 6/12 = 6/60 = 1/10$ FTE or .10.

NOTE: The totals of Columns 2A plus 3A must equal 100%. The totals of Column 2 plus 3 must equal the total of Column 1.

1B. Annual Salary: Enter in Column 1B, the annual full time salary for each position listed under "Personnel Expenses."

1. Total Budget

- Multiply each entry in Column 1A, "% FTE", by the corresponding entry in Column 1B, "Annual Salary", and
- Enter the amount in Column 1 "Total Budget." (Column 2 plus Column 3 must equal this amount.)

2/2A. Percentage of FTE/Enhanced (25/75)

- Enter in Column 2A, "% FTE", the portion of annualized FTE to be spent on eligible enhanced program activities for each position listed.
- Multiply the amount in Column 1, "Total Budget" by the percent of FTE in Column 2A, "% FTE", and
- Enter the amount in Column 2, Enhanced.

3/3A. Percentage of FTE/Nonenhanced (50/50)

- Enter in Column 3A, the portion of annualized FTE to be spent on eligible nonenhanced program activities for each position listed.
- Multiply the amount in Column 1, "Total Budget" by the FTE in Column 3A, and
- Enter the amount in Column 3, Nonenhanced.

Total Salaries and Wages

- Add the "Salaries and Wages" amounts itemized in Columns 1, 2, and 3, and
- Enter the total for each column on the "Total Salary and Wages" line item.

Less Salary Savings

- "Salary Savings" cannot be included on this budget.

Net Salaries and Wages

- Re-enter the balance of each column on the line entitled "Net Salaries and Wages."

Staff Benefits

- Multiply the approved county/city staff benefits percentages by the "Net Salaries and Wages" in Columns 1,2, and 3, and enter the amount on this line, or
- Enter the actual staff benefits amount as determined by the county/city on this line.

Total Personnel Expenses

- Add the "Staff Benefits" amounts in each column (1,2, and 3) to the "Net Salaries and Wages" in each column, and
- Enter the total of each column on the "Total Personnel Expenses" line item.

III. Operating Expenses

- Travel. (includes per diem, commercial auto rental, motor pool, air travel and private vehicle mileage, etc.), and
- Training.
- Documents related to these expenses are to be maintained on file by the local program in accordance with the FFP Guidelines, Section 9.

IV. Capital Expenses

- "Capital Expenses" cannot be included on this budget.

V. Indirect Expenses

Indirect expenses are limited to a maximum of 10 percent of Personnel Expenses.

External – "External Indirect Expenses" cannot be included on this budget.

NOTE: Public Health Nurses working in the HCPCFC are located in the local offices of child welfare services or departments of probation. External Indirect Expenses are not incurred by local health departments.

Internal – Internal Indirect Expenses are limited to 10 percent of the Total Personnel Expenses for this budget. Any departmental overhead costs, which are allocated, must be developed with a cost allocation plan (CAP) prepared in accordance with federal guidelines, “Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government, Implementation Guide for Office of Management and Budget, Circular A-87”.

- Enter the amount of Internal Indirect Expenses on the appropriate line in Column 3.
- Enter the amounts from Column 3 for each line in Column 1.

NOTE: When calculating indirect expenses for Title XIX funding, apply the nonenhanced (50/50) rate to all qualified expenses in Column 3, regardless of whether personnel expenses are enhanced or nonenhanced.

Total Indirect Expenses

Enter the total for Columns 1 and 3 on the “Total Indirect Expenses” line item.

VI. Other Expenses

“Other Expenses” **cannot** be included on this budget.

Budget Grand Total

- Enter the sum of the “Total Personnel Expenses,” “Total Operating Expenses,” and “Total Indirect Expenses” lines in each Column (1,2, and 3), and
- Enter the grand total for each column on the “Budget Grand Total” line item.

HPCFC Administrative Budget Worksheet for FY 2007-08

County/City Name: _____

Column	1A	1B	1	2A	2	3A	3
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	% or FTE	Enhanced State/Federal (25/75)	% or FTE	Nonenhanced State/Federal (50/50)
I. Personnel Expenses							
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Total Salaries and Wages							
Less Salary Savings							
Net Salaries and Wages							
Staff Benefits (Specify %)	%						
I. Total Personnel Expenses							
II. Operating Expenses							
1. Travel							
2. Training							
II. Total Operating Expenses							
III. Capital Expenses							
1.							
2.							
III. Total Capital Expenses							
IV. Indirect Expenses (10% Cap)							
1. Internal (Specify %)	%						
2.							
IV. Total Indirect Expenses							
V. Other Expenses							
1.							
2.							
V. Total Other Expenses							
Budget Grand Total							

Prepared By _____

Date _____

Phone Number _____

CHDP Director or Deputy Director (Signature) _____

Date _____

Phone Number _____

HPCFC Administrative Budget Worksheet for FY 2007-08

SAMPLE

County/City Name: Golden

Column	1A	1B	1	2A	2	3A	3
Category/Line Item	% or FTE	Annual Salary	Total Budget (1A x 1B or 2 + 3)	% or FTE	Enhanced State/Federal (25/75)	% or FTE	Nonenhanced State/Federal (50/50)
I. Personnel Expenses							
1. SPHN – B. Jones	10%	\$61,000	\$6,100	60%	\$3,660	40%	\$2,440
2. PHN – C. Adams	75%	\$55,420	\$41,565	85%	\$35,330	15%	\$6,235
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
Total Salaries and Wages			\$47,665		\$38,990		\$8,675
Less Salary Savings							
Net Salaries and Wages			\$47,665		\$38,990		\$8,675
Staff Benefits (Specify %) 15%			\$7,150		\$5,849		\$1,301
I. Total Personnel Expenses			\$54,815		\$44,839		\$9,976
II. Operating Expenses							
1. Travel			\$700		\$500		\$200
2. Training			\$300		\$250		\$50
II. Total Operating Expenses			\$1,000		\$750		\$250
III. Capital Expenses							
1.							
2.							
III. Total Capital Expenses							
IV. Indirect Expenses (10% Cap)							
1. Internal (Specify %) %			\$5,481				\$5,481
2.							
IV. Total Indirect Expenses			\$5,481				\$5,481
V. Other Expenses							
1.							
2.							
V. Total Other Expenses							
Budget Grand Total			\$61,296		\$45,589		\$15,707

John Smith
Prepared By

May 1, 2007
Date

916-555-1122
Phone Number

Dr. Jane Doe
CHDP Director or Deputy Director (Signature)

May 1, 2007
Date

916-555-1122
Phone Number

HCPCFC Administrative Budget Summary Instructions

I. HCPCFC Administrative Budget Summary

Transfer the dollar amount from the total amount of each line item and column of the HCPCFC Administrative Budget Worksheet to the HCPCFC Administrative Budget Summary form. Compute the amounts in the "Source of Funds" section of the budget as described below (see sample, page 80).

II. Source of Funds

A. Enhanced Funds

- Multiply the Enhanced "Budget Grand Total" amount in Column 2 by 25 percent. Enter the amount on the "State Funds" line, Enhanced column, in the "Source of Funds" section.
- Multiply the Enhanced Column 2 "Budget Grand Total" amount by 75 percent, and enter the amount in the "Source of Funds" section, Enhanced column, on the Federal Funds line.

B. Nonenhanced Funds

- Multiply the Nonenhanced "Budget Grand Total" amount (Column 3) by 50%. Enter this amount on the "State Funds" line, Nonenhanced column, in "Source of Funds" section.
- Multiply the Nonenhanced, Column 3, "Budget Grand Total" amount by 50 percent, and enter the amount in the "Source of Funds" section, Nonenhanced column, on the Federal Funds line.

C. Total Funds and Grand Total

- Add the amount of State Funds in Column 1 in the Source of Funds section to the Federal Funds (Title XIX) in Column 1 in the Source of Funds section to arrive at a Grand Total.

NOTE: The Total Funds will equal the Enhanced plus the Nonenhanced State Funds for the State Funds line and the Enhanced plus the Nonenhanced Funds for the Federal Funds line.

The total of funding amounts entered under each column in the Source of Funds section must agree with the totals for the same column entered on the Budget Grand Total line.

State of California – Health and Human Services Agency

California Department of Health Care Services – Children's Medical Services Branch

HCPCFC Administrative Budget Summary for FY 2007-08

County/City Name: _____

Column	1	2	3
Category/Line Item	Total Budget (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses			
II. Total Operating Expenses			
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
Budget Grand Total			

Column	1	2	3
Source of Funds	Total Funds	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
State Funds			
Federal Funds (Title XIX)			
Budget Grand Total			

Prepared By _____ Date _____ Phone Number _____ Email Address _____

CHDP Director or Deputy Director (Signature) _____ Date _____ Phone Number _____ Email Address _____

State of California – Health and Human Services Agency

California Department of Health Care Services – Children's Medical Services Branch

SAMPLE

HCPCFC Administrative Budget Summary for FY 2007-08

County/City Name: Golden

Column	1	2	3
Category/Line Item	Total Budget (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses	\$54,815	\$44,839	\$9,976
II. Total Operating Expenses	\$1,000	\$750	\$250
III. Total Capital Expenses			
IV. Total Indirect Expenses	\$5,481		\$5,481
V. Total Other Expenses			
Budget Grand Total	\$61,296	\$45,589	\$15,707

Column	1	2	3
Source of Funds	Total Funds	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
State Funds	\$19,251	\$11,397	\$7,854
Federal Funds (Title XIX)	\$42,045	\$34,192	\$7,853
Budget Grand Total	\$61,296		

John Smith

May 1, 2007

916-555-1212

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Prepared By

Date

Phone Number

Email Address

Dr. Jane Doe

May 1, 2007

916-555-1122

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CHDP Director or Deputy Director (Signature)

Date

Phone Number

Email Address

CCS Administrative Budget Information, Staffing Standards, and Caseload Instructions

I. Funding for the Administrative Budget

The State and counties share in the administrative cost of the CCS program at the local level (Health and Safety Code Section 123955 [a]). Effective Fiscal Year (FY) 2003-04, Healthy Families (HF) funding was approved to share in the cost of case management and administration of the CCS Program.

A. The county CCS program shall:

1. Appropriate one-half of the required match of Healthy Families funds and one-half of the straight CCS non Medi-Cal funds and the State is responsible to match the costs to the extent funds are available in the State budget (Health and Safety Code Section 123955 [e] [1]).
2. Receive reimbursement from the State for case management and administrative costs for the county's Healthy Families caseload and Medi-Cal beneficiary caseload and comply with the Federal Financial Participation (FFP) requirements (see Section 9).
3. Submit by September 15 of each year for the subsequent fiscal year, the Administrative Budget Request (also known as an "application" per Health and Safety Code Section 123955 [e][2]) for the county cost of administration of the CCS program.

B. The State shall:

1. Determine the amount of State funds available for each county from the funds appropriated in the State CCS budget for CCS county case management and administration of the Healthy Families and non-Medi-Cal portion of the CCS caseload.
2. Review the county budget request to ensure that the county CCS program meets the minimum State administrative staffing standards. (Health and Safety Code, Section 123955 [b]).
3. Notify the county of the amount of funds to be:
 - a. Appropriated by the State for case management and administrative costs for one-half of the non-federal Healthy Families and one-half of the Straight CCS non Medi-Cal caseload, and
 - b. Provided by the State for administrative costs for case management of Medi-Cal beneficiaries.
4. Reimburse the county quarterly based upon submission of the invoice for actual administrative expenditures.

II. CCS Staffing Standards

A. Overview of Staffing Standards

In order to meet the Health and Safety Code, Section 123955 requirement regarding administrative costs for county CCS programs, staffing for the CCS Administrative Program must be based on staffing standards. CCS staffing standards pertain to all personnel included in the CCS Administrative Budget who are 1) directly employed by CCS, and 2) responsible for CCS program administration, operation, and implementation of State mandates in counties. Staff composition in county CCS programs will vary based on county size, CCS caseload, and county needs.

The Staffing Standards Profile (Page 93) was developed to allow for flexibility based on county need, to reflect the diversity of personnel requirements needed for CCS program administration/operation, and to create manageable caseloads to allow for the provision of proactive medical case management. The Staffing Standards Profile stipulates the minimum staff required in each category to manage the caseload.

The following five administrative functions/categories are included on the Staffing Standards Profile: Program Administration, Medical Case Management, Other Health Care Professionals, Ancillary Support, and Clerical and Claims Support.

NOTE: It is recognized that in a small county, one individual may function in several of the above categories. This will require staff time to be distributed and time studied appropriately.

B. Using the County Staffing Profile

1. CCS Independent Counties

- a. Determine the county caseload as described in III, A (see page 88).
- b. Use the calculated caseload to determine the number of staff needed in each of the five categories on the CCS County Staffing Standards Profile.
- c. Chief Therapist or Supervising Therapist position is allocated at .20 for all counties except those with caseloads below 1,000.
- d. A county program with more than one physician shall designate a Medical Director with responsibility of coordinating medical care among the other medical consultants.
- e. The staffing standard for nurse positions is one nurse to 400 cases. The 1:400 ratio includes the following nurse functions: Medical Case Management, Concurrent Hospital Review, and Early Childhood Coordinator (see pages 86 and 87).
- f. Medi-Cal Managed Care and Healthy Families Liaison positions (see page 87) are calculated outside the 1:400 nurse to case ratio. The Medi-Cal Managed Care and Healthy Families Liaison shall be

based on the number of Managed Care plans and Healthy Families plans in a county. This may be part of or equal to a full-time position. There must be a separate designated liaison for Medi-Cal Managed Care plans and Healthy Families plans.

- g. Positions for other health care professionals (see page 87) are allocated according to caseload using the Staffing Standards Profile (see page 93).
- h. Supervisory positions are calculated at a ratio of one supervisor to 10 FTE.
- i. Counties requesting a waiver of staffing below the staffing standards minimum must submit a justification for their request along with the CCS Administrative Budget.
- j. A request for staffing in the Other Health Care Professional category for medical case management services will be considered when the number of PHN FTEs exceeds six. Additional positions in the Other Health Care Professional category may be added when determined necessary and will be based on caseload using the Staffing Standards Profile.

NOTE: Other Health Care Professional staff requested to perform medical case management must meet the federal definition of an SPMP (See Section 9 – Federal Financial Participation).

- k. To determine the number of staff required to implement the CCS county program responsibilities in an Independent County CCS program with a caseload below the Staffing Standards Profile, the county shall determine the percentage to be applied for CCS staffing requirements based on the lowest caseload figure of 500. To obtain the percentage to apply to the staffing standards, divide the total number of cases by 500.

Example for a county with a caseload of 300:

Divide the county caseload of 300 by the 500 caseload on the CCS Staffing Standards Profile ($300 \div 500 = .60$ or 60 percent). The 60 percent is applied to the total number of staff in appropriate sections of the CCS Staffing Standard Profile. For example, applying 60 percent to the CCS Staffing Standards Profile for Program Administration for a caseload of 300 would provide for .3 FTE Administrative time ($.60 \times .50 = .30$).

2. CCS Dependent Counties

- a. Determine the county caseload as described in III A (see page 89).
- b. The staffing requirements for a Dependent County CCS program vary from that of an Independent County because the medical case

management and claims processing for authorized services are the responsibility of the State CMS Branch.

- c. The staff required to carry out the Dependent County CCS program responsibilities are:
- 1) Program Administration
 - 2) Medical Case Management: limited to Public Health Nurse staff required to perform the services identified as intensive case management activities (see page 85).
 - 3) Ancillary Support (see page 87): limited to Program Eligibility Technician staff responsible for determination of CCS program eligibility.
 - 4) Clerical and Claims Support (see page 88): limited to clerical staff except for CCS Dependent Counties who elect to review and correct the Paid Claims Data Reports (MR-9-40, MR-9-10). These counties may add the claims support staff.
- d. To determine the number of staff required to implement the CCS county program responsibilities in a Dependent County CCS program, the following instructions apply to Program Administration, Case Management Support, and Program Support Staff.
- 1) If the Dependent County caseload is equal to or above 500, then the staffing requirements on the CCS Staffing Standard shall be applied to the areas in 2, c, above.
 - 2) If the Dependent county caseload is below 500, then it is necessary to determine the percentage of the caseload that will be applied to the required Dependent County positions. To obtain the percentage, divide the total number of cases by 500.

Example for a county with a caseload of 300:

Divide the county caseload of 300 by the 500 caseload on the CCS Staffing Standards Profile ($300 \div 500 = .60$ or 60 percent). The 60 percent is applied to the total number of staff in appropriate sections of the CCS Staffing Standard Profile. For example, applying 60 percent to the CCS Staffing Profile for Program Administration, the CCS county with a caseload of 300 would have, at a minimum, .3 FTE Administrator ($.60 \times .50 = .30$).
- e. Determination of the percentage of time required for intensive case management functions within the CCS Dependent County by a PHN is based on the ratio of one FTE PHN per 80 cases for 15 percent of the county's CCS caseload. To calculate the percentage of FTE PHN time:

Example for a county with a caseload of 300: Determine 15 percent of the CCS caseload: $300 \times 15 \text{ percent} = 45$.

Divide 45 by 80, which equals .56 or 56 percent FTE PHN staff ($45 \div 80 = .56$ or 56 percent).

C. Staffing Profile Personnel

1. Program Administration

These are staff responsible for overall program direction and/or supervision of program-wide activities. Professional staff may be budgeted in this section for performance of administrative duties when these responsibilities are reflected in the professional's position description. Examples of positions that may be charged to the administration section are as follows:

- a. Program Administrator
- b. Fiscal/Budget Management staff
- c. Administrative Assistants/Secretary
- d. Administrative staff whose time is split between program administrative responsibilities and medical (Administrative) case management
- e. Information Technology Support staff
- f. Chief/Supervising Therapist for CCS and MTP Program Administration
- g. Parent Liaison – This position is highly recommended but not required. Only one position (or portion of an FTE) is allocated per county.

2. Medical Case Management

- a. Staff in this section are physicians, registered nurses, physical therapists, and occupational therapists who are responsible for day-to-day CCS medical case management (MCM) activities.
- b. Staff in this section shall meet the federal definition of a "skilled medical professional" required for claiming FFP at the enhanced level for Administrative Case Management services (known in CCS as MCM). Please refer to Section 9 for the federal definition of a "skilled medical professional."
- c. MCM includes coordination of care, identification and processing of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental services requests evaluating the needs of a child/family, and identifying other resources for eligible children and their families.

- d. The MCM role includes the proactive medical case management (PCM) function of concurrent review of documents to provide authorizations for services anticipated over the next 3 – 6 months. This is a function that shall be performed by all case management personnel.
- e. The nurse staffing roles may also include the following functions:
 - **Concurrent Hospital Review** of the medical necessity of inpatient hospital stays completed by Registered Nurses (RN) located on-site at facilities where the CCS caseload supports this activity such as Children's Hospitals, University of California medical centers, and county hospital facilities. (Concurrent hospital review medical case management services may be provided at the CCS program office for those hospitals with smaller CCS caseloads. RNs must be identified as dedicated to the task of performing inpatient hospital utilization reviews based on information received via fax and/or phone.)

Responsibilities of RNs assigned to perform concurrent review of inpatient hospital stays include, but are not limited to, active participation in discharge planning, PCM, and coordination of care in the community with the CCS nursing staff designated at the local CCS program.

The number of nursing staff requested for concurrent hospital review shall be based on the number of CCS-approved inpatient tertiary facilities, expected hours of on-site assignments, and the number of CCS cases discharged from the facility.

- **Intensive Medical Case Management (ICM)** of selected cases is required to ensure optimal coordination of medical services. Children in need of ICM are best identified through use of a risk assessment tool with a numerical scale. It is recommended that counties develop an assessment tool and implement a mechanism for documentation of ICM cases. ICM responsibilities require the knowledge and skill of a RN with a PHN certificate to ensure coordination of services for children with complex medical conditions requiring coordination between providers and agencies.
- **Early Childhood Nurse Liaison** provides care coordination and liaison services to programs that serve children aged 0-3. Examples of CCS programs requiring liaison activities are the Newborn Hearing Screening Program, Medically Vulnerable Infant Program, the High Risk Infant Follow-up Program and CHDP. Early Start and the Department of Education Individual Family Service Plan (IFSP) are examples of public programs requiring care collaboration to coordinate care.

The liaison responsibilities may include technical assistance to programs, problem resolution to families and providers involved with these agencies, and care coordination of a caseload.

- **Healthy Families/Medi-Cal Managed Care Liaison** is responsible for providing ongoing technical assistance and consultation to Plans and Plan providers to resolve issues/problems; coordinating and providing authorizations for services for Healthy Families and Medi-Cal-eligible beneficiaries with CCS-eligible conditions; and coordinating training and systems development activities with state CMS staff.

- f. Therapy staff responsible for administrative Medical Case Management (MCM) of CCS eligible clients shall be listed in this section. This includes review of eligibility for inpatient rehabilitation services, appropriate durable medical equipment, etc. Therapy staff time may be split between the CCS Administrative Budget and costs charged to the MTP.

NOTE: FTEs for CCS employed therapists who are in authorized MTP positions that provide direct therapy services to children are funded through the diagnosis, treatment, and therapy allocations and cannot be reflected on this budget. However, the percentage of therapy staff time devoted to NON-MTP-related administrative activities are reflected on this budget.

3. Other Health Care Professionals

- a. Staffing in this category includes the following professionals who must meet the SPMP requirement stipulated in Section 9 of this manual: audiologist, speech therapist, nutritionist, social worker and dental consultant.
- b. The number of FTEs for these positions for a county is based on caseload when the number of nurse FTEs exceed six. These positions are not mandatory, but are highly recommended for administrative MCM. The need for these types of health care professionals is determined by the county.

4. Ancillary Support

- a. This category includes personnel who may be called case managers, financial eligibility workers, CCS coordinators, etc. The Staffing Standards Profile refers to case managers as Case Management Technicians and financial eligibility workers as Program Eligibility Technicians.
- b. This category includes CCS county employees, under general supervision, who are responsible for making decisions and taking action on individual CCS applicant/client services. They conduct

interviews to determine financial and residential eligibility; review and take action on request for services; communicate with providers/vendors; code CCS medical records using appropriate ICD-9 (International Classification of Disease, Ninth Edition) classifications; etc.

5. Clerical and Claiming Support

- a. This category includes CCS County clerical staff working under direct supervision of Administrative or Medical Case Management staff.
- b. The program support staff duties include functions such as: processing mail; answering and directing phone calls; filing CCS records and other documents; typing assignments such as authorizations, notice of actions, appeal response, and other general program correspondence; photocopying; and performing other miscellaneous general office operation assignments.
- c. Clerical staff who provide support to the MTP shall not be charged to this portion of the budget. Transcription of the medical therapy conference reports is not accepted on the CCS administrative budget. These charges shall be reflected in quarterly CCS MTP invoices.
- d. Clerical staff charged to enhanced funding or who support staff performing intensive case management services shall have a job description and duty statement that reflects the areas of responsibility and percent of time spent in those functions that support the skilled medical professional. Staff charged as enhanced shall also appear on the organization chart as being directly supervised by a skilled medical professional. Clerical staff supporting intensive case management services must time study appropriately for that portion of time spent in those activities.
- e. Staff with special training in the processing of medical claims to ensure appropriate payment of CCS providers/vendors.

III. County CCS Caseload

Calculation of Eligible Months and Reporting as Caseload

Beginning in fiscal year (FY) 2006-07, the terminology for caseload changed to "eligible months". **However, the word caseload will be seen throughout the Plan and Fiscal Guidelines manual as this is the terminology that is most familiar to the previous users of this manual.**

Caseload in FY 2007-08 will be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS)/Medi-Cal client.

- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

There are two reports that can be accessed to calculate “eligible months” for caseload. There is one report in CMS Net Legacy titled “Monthly Caseload Count Report” (for Medi-Cal and Non-Medi-Cal counts), and the second report is in Business Objects (BO) titled “Healthy Families Caseload Count Report”. In the CMS Net Legacy report the non-Medi-Cal count is both HF and CCS together. Counties need to subtract HF from the total to get the CCS population.

The CMS Net Legacy report has a history so the report “Monthly Caseload Count Report” (Medi-Cal and non-Medi-Cal)” can be processed whenever a county needs the information. However, the HF count in the Business Objects report “Healthy Families Caseload County” only contains information as of the prior day so it is critical for counties to run the report every month to get the HF totals if they want to use BO to retrieve the caseload counts.

This Computes Information Bulletin #167 provides more details regarding these reports. This can be found at:

<http://www.dhs.ca.gov/PCFH/cms/ccs/cmsnet/pdf/thiscomputes/thiscomputes167.pdf>

The eligible month information should be retrieved for each type of case for which a child would be counted, e.g. CCS/Medi-Cal, CCS/HF, and CCS-only. At the end of the three month period the total number of “eligible months” from the three combined reports would need to be divided by three to achieve the “average caseload” number for the quarter.

An example would be:

- Month One = 150 eligible months
- Month Two = 148 eligible months
- Month Three = 167 eligible months

TOTAL 465 Eligible Months

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter.

A. Caseload Determination using quarterly invoices

Caseload is determined using the average quarterly active record as reported on CCS Administrative quarterly invoices from July 1 to June 30 of the previous fiscal year, plus a method for counting potential cases for the same period. In this section, “previous year” refers to the most recent fiscal year for which actual, end of year caseload data is available. For budget purposes, counties may submit actual caseload data from a more recent 12-month period (for example, April 1 to March 31). If using a different 12-month period than the fiscal year, the CCS Caseload Summary should still reflect fiscal year data.

Potential cases represent the work required on non-open cases referred to CCS. The potential caseload shall not include cases that have been opened because these cases are already included in the active caseload.

1. Add the average open (active) caseload number for all quarterly invoices from the previous fiscal year and divide by four.
2. Determine the number of potential cases by:
 - a. An actual count of potential cases assigned a temporary number if the county CCS Program is using CMS Net, or
 - b. An actual count of potential cases if the county CCS Program has a method for assigning a temporary number when the county is not on CMS Net, or
 - c. An estimate of potential cases may be used based on the county's experience.

3. Medi-Cal

Add the average total open (average) caseload (row 1, column A) to the potential cases (row 2, column A) to get the Total Medi-Cal caseload (row 3, column A).

4. Non Medi-Cal

- a. Add the average total open (active) caseload (row 4, column A) to the potential cases (row 5, column A) to get the Total Healthy Families caseload (row 6, column A). **NOTE:** If Healthy Families data are not available for one or more of the requested fiscal years, use zeros.
- b. Add the average total open (active) caseload (row 7, column A) to the potential cases (row 8, column A) to get the Total Straight CCS (row 9, column A).
- c. Add Total Healthy Families (row 6, column A) to the Straight CCS caseload (row 9, column A) to get the Total Non Medi-Cal caseload (row 10, column A).

5. Grand Total

Add Total Medi-Cal (row 3, column A), to Total Non Medi-Cal (row 10, column A), and place the result in row 11, column A.

6. Determine the total Medi-Cal and Non Medi-Cal percentage split:

(NOTE: Percentages are calculated as a percentage of the Grand Total.)

- a. Medi-Cal: Divide row 3, column A, by the Grand Total in row 11, column A. The resulting percentage is placed in row 3, column B.

- b. Non Medi-Cal: Divide row 10, column A by the Grand Total in row 11, column A. The resulting percentage is placed in row 10, column B.
- c. The percentages in row 3, column B added to row 10, column B, will equal 100 percent.

B. Application of Caseload to Budget Year (BY)

The CCS caseload number to be used to determine the staffing requirements for the budget year are based on the last fiscal year average total CCS caseload. The caseload numbers based on the instruction in A. above are to be used in applying the CCS Staffing Standards to the minimum staff required by a county CCS program to operate its program.

- C. The percentage to be applied to the Budget Worksheets for the Medi-Cal/Non Medi-Cal split are from Total Medi-Cal (row 3, column B) and Total Non Medi-Cal (row 10, column B).

Sample CCS Caseload Box

CCS Caseload 0 to 21 Years		A	B
		Caseload	% of Grand Total
MEDI-CAL			
1	Average of Total Open (Active) Medi-Cal Children	372	48%
2	Potential Case Medi-Cal	110	14%
3	TOTAL MEDI-CAL (Row 1 + Row 2)	482	62%
NON MEDI-CAL			
Healthy Families			
4	Average of Total Open (Active) Healthy Families	18	2%
5	Potential Cases Healthy Families	5	1%
6	Total Healthy Families (Row 4 + Row 5)	23	3%
Straight CCS			
7	Average of Total Open (Active) Straight CCS Children	211	27%
8	Potential Cases Straight CCS Children	64	8%
9	Total Straight CCS (Row 7 + Row 8)	275	35%
10	TOTAL NON MEDI-CAL (Row 6 + Row 9)	298	38%
11	GRAND TOTAL (Row 3 + Row 10)	780	100%

CCS County Staffing Standards Profile

Number of Staff by Personnel Class and Caseload

CCS Caseload	500-1000	1001-1500	1501-3000	3001-4500	4501-6000	6001-7500	7501-9000	9001-10500	10501-12000	12001-13500	13501-15000	15001-16500	16501-18000	18001-19500	19501-21000	21001-25500	80000-90000 ^(A)
Program Administration																	
Administrator	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Administrative Assistant Personnel	0	0	0	0.5	0.8	1.1	1.4	1.7	2.0	2.3	2.6	2.9	3.2	3.5	3.8	4.7	25-28
Information Technology Support	0.25	0.5	1.0	1.0	1.0	1.0	1.5	1.5	1.5	1.5	2.0	2.0	2.0	2.0	2.5	2.5	12-15
Parent Liaison ^(B)	0.5	0.5	0.75	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Medical Case Management																	
Physician ^(C)	0.5	0.5	0.5	1.0	1.0	1.0	2.0	2.25	3.0	3.0	3-3.5	4.0	4.0	4.5	5.0	6.0	10-15
Chief Therapist	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Therapist (OT/PT)	0.125	0.25	0.5	0.75	1.0	1.25	1.75	2.0	2.25	2.5	2.75	3.0	3.25	3.5	3.75	4.5	8-10
Nurse ^(D, E)	1-2.5	2.5-3.7	3.7-7.5	7.5-11.25	11.25-15	15-18.75	18.75-22.5	22.5-26.25	26.25-30	30-33.75	33.75-37.5	37.5-41.25	41.25-45	45-48.75	48.75-52.5	52.5-62.5	200-225
Other Health Care Professionals																	
Other Health Care Professionals ^(F)	0	0.3	0.7	1.0	1.2	1.7	2.0	2.3	2.7	3.0	3.3	3.7	4.0	4.3	4.7	5.0	10-12
Ancillary Support																	
Case Management Technician	1-3	3-4	4-8	8-11	11-15	15-19	19-23	23-26	26-30	30-34	34-38	38-41	41-45	45-49	49-53	53-64	*
Program Eligibility Technician	1	1	2.0	4.0	6.0	7.5	9.0	11.0	13.0	15.0	17.0	19.0	21.0	23.0	24.0	30.0	*
Clerical and Claims Support																	
Clerical Personnel	1	1.5	2.0	3.0	5.0	6.0	7.0	9.0	10.0	11.0	13.0	14.0	15.0	17.0	18.0	23.0	168-189
Claims Personnel	.25	0.5	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	9.0	10.0	11.0	12.0	13.0	17.0	68-75
Total FTEs	8.775	13.95	26.2	38.7	52.2	65.0	78.9	92.2	105.7	118.3	133.4	145.6	158.2	172.8	185.5	224.9	586.2

- A. Los Angeles County
- B. The Parent Liaison position is highly recommended but not required.
- C. Counties with more than one physician position shall designate a Medical Director.
- D. Nurse staff positions are calculated by using 1 nurse to 400 caseload. The nursing allocation includes Medical Case Management, Concurrent/Utilization Review, and Early Childhood Coordinator. The nurse positions for Medi-Cal Managed Care and Healthy Families Liaison are calculated according to the number of plans in each county as outlined in Section 5.
- E. Other Health Care Professional positions are added when the number of nurse FTEs exceeds 6. The positions for administrative MCM are highly recommended but not required. These include Audiologist, Speech Therapist, Nutritionist, Social Worker, and Dental Consultant.
- F. Supervision positions for nursing are not included in the staff ratio. Minimum supervisor to nursing staff, clerical and technician staff is calculated at a 1 to 10 FTE ratio.

CCS Administrative Budget Worksheet Instructions

Use the CCS Administrative Budget Worksheet on page 97 (see sample on pages 99 and 100). The Caseload box in the upper left corner of the worksheet must first be completed (see instructions on page 88)

I. Personnel Expenses

List each funded position as a separate line item under the appropriate subcategory (Administration, Medical Case Management, Other Health Care Professionals, Ancillary Support, and Clerical and Claims Support). In addition, follow steps A – K below for each position:

- A. Column 1: Enter the FTE %.
- B. Column 2: Enter the annual full-time salary.
- C. Column 3: Multiply Column 1 by Column 2 and enter the result in Column 3.
- D. Column 4A: Enter the "Non Medi-Cal %" from the caseload box in Column 4A.
- E. Column 4: Multiply the amount in Column 3 by Column 4A and enter the results in Column 4.
- F. Column 5A: Enter the "Medi-Cal %" from the caseload box in Column 5A.
- G. Column 5: Multiply the amount in Column 3 by Column 5A and enter the result in Column 5 (Column 5 + Column 4 = Column 3).
- H. Column 6A: Enter the percentage of the total Medi-Cal dollars from Column 5 that are **enhanced**. The amount in this column shall be supported by time study documentation for each staff position.
- I. Column 6: Multiply the amount in Column 5 by the percentage in Column 6A and enter the result in Column 6.
- J. Column 7A: Enter the percentage of the total Medi-Cal dollars from Column 5 that are **not enhanced** (% in Column 7A + % in Column 6A = 100%).
- K. Column 7: Multiply the amount in Column 5 by the percentage in Column 7A and enter the result in Column 7 (Column 6 + Column 7 = total in Column 5). The amount in Column 7 shall be supported by time study documentation for each staff position.

Staff Benefits – This line item under "Personnel Expenses" requires special instructions as follows:

- If your county uses an **actual** staff benefits amount, enter this amount in column 3 on the "Staff Benefits" line **or**

- If your county uses an **approved staff benefits percentage rate** to calculate these costs, multiply the amount in Column 3 on the "Net Salaries and Wages" line by your county's approved percentage rate and enter the product in Column 3 on the "Staff Benefits" line.
 1. From the "Net Salaries and Wages" line, divide the amount in Column 4 by the amount in Column 3 to calculate the overall percentage of Non-Medi-Cal "Personnel Expenses."
 2. From the "Net Salaries and Wages" line, divide the amount in Column 6 by the amount in Column 3 to arrive at the percentage of enhanced salary costs. Multiply this percentage by the amount in Column 3 on the "Staff Benefits" line. Enter this amount in Column 6 on the "Staff Benefits" line.
 3. From the "Net Salaries and Wages" line, divide the amount in Column 7 by the amount in Column 3 to arrive at the percentage of nonenhanced salary costs. Multiply this percentage by the amount in Column 3 on the "Staff Benefits" line. Enter this amount in Column 7 on the "Staff Benefits" line.
 4. Add Columns 6 and 7 to get Column 5. Divide the amount in Column 5 by the amount in Column 3 to calculate the overall percentage of Medi-Cal personnel expense costs. This percentage will usually be the same as the Medi-Cal % in the Caseload Box.

II. Operating Expenses

- A. For "Travel" and "Training" line items under "Operating Expenses," repeat steps under "Personnel Expenses," above.
- B. Multiply the amount in Column 3 by the "Non-Medi-Cal Percent" from the "Caseload" box. Enter this amount in Column 4.
- C. Subtract Column 4 from Column 3 and enter the result in Column 5 and 7 (except for training and travel which can be enhanced).

III. Capital Expenses

- A. Multiply the amount in Column 3 by the "Non-Medi-Cal Percent" from the "Caseload" box. Enter this amount in Column 4.
- B. Subtract Column 4 from Column 3 and enter the result in Column 5 and 7 (except for training and travel which can be enhanced).

IV. Indirect Expenses

- A. Multiply the amount in Column 3 by the "Non-Medi-Cal Percent" from the "Caseload" box. Enter this amount in Column 4.

- B. Subtract Column 4 from Column 3 and enter the result in Column 5 and 7 (except for training and travel which can be enhanced).

V. Other Expenses

- A. For the "Maintenance and Transportation" line item under "Other Expenses":
 - 1. Average the amount of funds spent on Maintenance and Transportation over the last 3 budget years and add 10 percent to determine the budget total in Column 3, or
 - 2. Use actual expenditures from the previous year.
 - 3. Follow the steps identified in B below
- B. For all other line items under Other Expenses:
 - 1. Multiply the amount in Column 3 by the Non-Medi-Cal Percent from the Caseload Box. Enter this amount in Column 4.
 - 2. Subtract Column 4 from Column 3 and enter the result in Column 5 and 7.

VI. Budget Grand Total

Add the amounts shown for "Total Personnel Expenses," "Total Operating Expenses," "Total Capital Expenses," "Total Indirect Expenses," and "Total Other Expenses" in each column. Enter the total for each column on the "Budget Grand Total" line.

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children		
Potential Cases Medi-Cal		
TOTAL MEDI-CAL		
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children		
Potential Cases HF		
Total Healthy Families		
Straight CCS		
Average of Total Open (Active) Straight CCS Children		
Potential Cases Straight CCS		
Total Straight CCS		
TOTAL NON MEDI-CAL		
GRAND TOTAL		

CCS Administrative Budget Worksheet for FY 2007-08

County Name: _____

Column	1	2	3	4A	4	5A	5	6A	6	7A	7
Category/Line Item	% FTE	Annual Salary	Total Budget (1 x 2 or 4 + 5)	% FTE	Non-Medi-Cal County/State (50/50)	% FTE	Medi-Cal (6 + 7)	% FTE	Medi-Cal Enhanced	% FTE	Medi-Cal Nonenhanced State/Federal (50/50)
I. Personnel Expense											
Program Administration											
Subtotal											
Medical Case Management											
Subtotal											
Other Health Care Professionals											
Subtotal											
Ancillary Support											
Subtotal											
Clerical and Claims Support											
Subtotal											

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children		
Potential Cases Medi-Cal		
TOTAL MEDI-CAL		
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children		
Potential Cases HF		
Total Healthy Families		
Straight CCS		
Average of Total Open (Active) Straight CCS Children		
Potential Cases Straight CCS		
Total Straight CCS		
TOTAL NON MEDI-CAL		
GRAND TOTAL		

CCS Administrative Budget Worksheet for FY 2007-08

County Name: _____

Total Salary and Wages											
Less Salary Savings											
Net Salary and Wages											
Staff Benefits (Specify %)											
I. Total Personnel Expense											
II. Operating Expense											
1. Travel											
2. Training											
II. Total Operating Expense											
III. Capital Expense											
III. Total Capital Expense											
IV. Indirect Expense											
1. Internal (specify %)											
2. External (specify %)											
IV. Total Indirect Expense											
V. Other Expense											
1. Maintenance and Transportation											
V. Total Other Expense											
Budget Grand Total											

Prepared By _____

Date Prepared _____

Phone Number _____

CCS Administrator (Signature) _____

Date Signed _____

Phone Number _____

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children	542	58%
Potential Cases Medi-Cal	108	12%
TOTAL MEDI-CAL	650	70%
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children	18	2%
Potential Cases HF	5	1%
Total Healthy Families	23	3%
Straight CCS		
Average of Total Open (Active) Straight CCS Children	214	23%
Potential Cases Straight CCS	41	4%
Total Straight CCS	255	27%
TOTAL NON MEDI-CAL	278	30%
GRAND TOTAL	928	100%

CCS Administrative Budget Worksheet FY 2007-08

County Name: Golden

SAMPLE

Column	1	2	3	4A	4	5A	5	6A	6	7A	7
Category/Line Item	% FTE	Annual Salary	Total Budget (1 x 2 or 4 + 5)	% FTE	Non-Medi-Cal County/State (50/50)	% FTE	Medi-Cal (6 + 7)	% FTE	Medi-Cal Enhanced	% FTE	Medi-Cal Nonenhanced State/Federal (50/50)
I. Personnel Expense											
Program Administration											
1. CCS Administrator – J. Brown	100%	\$38,028	\$38,028	30%	\$11,408	70%	\$26,620			100%	\$26,620
2. Program Coordinator – S. Hill	50%	\$28,334	\$14,167	30%	\$4,250	70%	\$9,917			100%	\$9,917
3. Analyst – B. Huang	20%	\$39,397	\$7,879	30%	\$2,364	70%	\$5,515			100%	\$5,515
Subtotal		\$105,759	\$60,074		\$18,020		\$42,052				\$42,052
Medical Case Management											
1. Medical Consultant – T. Smith	17%	\$89,507	\$15,216	30%	\$4,565	70%	\$10,651	90%	\$9,586	10%	\$1,065
2. PHN – Y. Jones	100%	\$49,754	\$49,754	30%	\$14,926	70%	\$34,828	85%	\$29,604	15%	\$5,224
3. PHN – P. Ford	75%	\$47,780	\$35,835	30%	\$10,750	70%	\$25,085	85%	\$21,322	15%	\$3,763
Subtotal		\$187,041	\$100,805		\$30,241		\$70,564		\$60,512		\$10,052
Other Health Care Professionals											
Subtotal											
Ancillary Support											
1. Eligibility Worker I – R. Williams	100%	\$25,887	\$25,887	30%	\$7,766	70%	\$18,121			100%	\$18,121
2. Eligibility Worker I – T. Young	100%	\$25,887	\$25,887	30%	\$7,766	70%	\$18,121			100%	\$18,121
3. Eligibility Worker I – A. White	100%	\$25,887	\$25,887	30%	\$7,766	70%	\$18,121			100%	\$18,121
Subtotal		\$77,661	\$77,661		\$23,298		\$54,383				\$54,363
Clerical and Claims Support											
1. Senior Office Assistant – P. Hill	10%	\$28,206	\$2,821	30%	\$846	70%	\$1,975	85%	\$1,679	15%	\$296
2. Office Assistant – H. Davidson	100%	\$22,562	\$22,562	30%	\$6,769	70%	\$15,793			100%	\$15,793
3. Fiscal Assistant – F. Brown	70%	\$27,375	\$19,162	30%	\$5,749	70%	\$13,413			100%	\$13,413
Subtotal		\$78,143	\$44,545		\$13,364		\$31,181		\$1,679		\$29,502

Column	1	2	3	4A	4	5A	5	6A	6	7A	7
Category/Line Item	% FTE	Annual Salary	Total Budget (1 x 2 or 4 + 5)	% FTE	Non-Medi-Cal County/State (50/50)	% FTE	Medi-Cal (6 + 7)	% FTE	Medi-Cal Enhanced	% FTE	Medi-Cal Nonenhanced State/Federal (50/50)
Total Salary and Wages			\$283,085		\$84,924	70%	\$198,161		\$62,191		\$135,970
Less Salary Savings			\$0		\$0		\$0		\$0		\$0
Net Salary and Wages			\$283,085		\$84,924		\$198,161		\$62,191		\$135,970
Staff Benefits (Specify %)	32.00%		\$90,587		\$27,176		\$63,411		\$19,898		\$43,513
I. Total Personnel Expense			\$373,672		\$112,100		\$261,572		\$82,089		\$179,483
II. Operating Expense											
1. Travel			\$10,000	30%	3,000	70%	\$7,000	85%	\$5,950	15%	\$1,050
2. Training			\$2,500	30%	750	70%	\$1,750	85%	\$1,487	15%	\$263
3. Communication			\$4,500	30%	1350	70%	\$3,150			100%	\$3,150
4. Office Supplies			\$9,150	30%	2745	70%	\$6,405			100%	\$6,405
5. Reproduction Services			\$2,300	30%	690	70%	\$1,610			100%	\$1,610
6. Janitorial			\$5,600	30%	1680	70%	\$3,920			100%	\$3,920
7. Office Furniture/Modular			\$28,934	30%	8680	70%	\$20,254			100%	\$20,254
8. Rents/Lease			\$6,000	30%	1800	70%	\$4,200			100%	\$4,200
II. Total Operating Expense			\$68,984		20695		\$48,289		\$7,437		\$40,852
III. Capital Expense											
II. Total Capital Expense											
IV. Indirect Expense											
1. Internal (specify %)	2.7%		\$7,860	30%	2358	70%	\$5,502				\$5,502
2. External (specify %)	1.6%		\$4,509	30%	1353	70%	\$3,156				\$3,156
IV. Total Indirect Expense			\$12,369		3711		\$8,658				\$8,658
V. Other Expense											
1. Maintenance and Transportation			\$10,000	30%	3000	70%	\$7,000				\$7,000
2. Information Technology Consultant			\$5,000	30%	1500	70%	\$3,500				\$3,500
3. Translation Services			\$5,000	30%	1500	70%	\$3,500				\$3,500
V. Total Other Expense			\$20,000		6000		\$14,000				\$14,000
Budget Grand Total			\$475,025		142506		\$332,519		\$89,526		\$242,993

John Smith
Prepared By

May 1, 2007
Date Prepared

916-555-2222
Phone Number

Dr. Jane Doe
CCS Administrator (Signature)

May 2, 2007
Date Signed

916-555-1111
Phone Number

CCS Administrative Budget Summary Instructions

I. CCS Administrative Budget Summary

A. Category/Line Item

Transfer total amounts from the budget worksheets for Personnel Expenses, Operating Expenses, Capital Expenses, and Other Expenses, and transfer the "Budget Grand Total" lines for each column to the CCS Administrative Budget Summary Form. See page 105 for the CCS Administrative Budget Summary Form and page 107 for a completed sample.

B. Source of Funds

Complete the worksheet on Page 104, and transfer the totals from the worksheet as indicated below (see sample on page 106).

II. Source of Funds Instructions

This section displays the funding sources for the CCS Administrative Budget and serves as a control for the expenditure of funds for the local program.

A. Non-Medi-Cal Funds

- Complete the "Worksheet to Determine Funding Sources for Administrative Costs related to Healthy Families".
- The Worksheet (see page 104) assists counties in completing Column 2 in the "Source of Funds" Section on the CCS Administrative Budget Summary.

Caseload Percentages

1. Line 1(a): enter the Total Non Medi-Cal Caseload from the Caseload Box on the Budget Summary.
2. Line 2(a): enter the Total Healthy Families Caseload from the Caseload Box on the Budget Summary. Divide line 2(a) by the total Non Medi-Cal Caseload on Line 1(a) and enter the percentage on line 2(b) **(calculated automatically by formula on the worksheet)**.
3. Line 3(a): enter the Total Straight CCS Caseload (from the Caseload Box on the Budget Summary. Divide line 3(a) by the total Non Medi-Cal Caseload on Line 1(a) and enter the percentage on line 3(b) **(calculated automatically by formula on the worksheet)**.

Source of Funds – Straight CCS

4. Line 4(a): enter the Budget Grand Total for Non Medi-Cal (from the Budget Summary, Column 2).
5. Line 5(a): determine the Total Straight CCS dollars by multiplying the Total Non Medi-Cal dollars (line 4(a) by the CCS Percentage (line 3(b) **(calculated automatically by formula on the worksheet)**).
6. Line 6(b): multiply the total Straight CCS Dollars (column 5(a) by 50 percent and enter on line 6(b) to get the State share of straight CCS (shared 50/50 by State/County) **(calculated automatically by formula on the worksheet)**.
7. Line 7(b): subtract line 6(b) from line 5(a) to get County Match Dollars **(calculated automatically by formula on the worksheet)**.

Source of Funds – CCS Healthy Families

8. Line 8(b): determine the Total Healthy Families Dollars by multiplying the HF percentage (line 2(b) by the Total Straight CCS Dollars (line 5(a)) **(calculated automatically by formula on the worksheet)**.
9. Line 9(a): Determine the Total State/County Share (35%) by multiplying the total Healthy Families Dollars (Line 8(a) by 35 percent **(calculated automatically by formula on the worksheet)**.
10. Line 10(b): determine state share of the total State/County Healthy Families Dollars by multiplying Line 9(a) by 50 percent **(calculated automatically by formula on the worksheet)**.
11. Line 11(b): determine county share of the Total State/County Healthy Families dollars by subtracting Line 10(b) from Line 9(a) **(calculated automatically by formula on the worksheet)**.
12. Line 12(b): determine Federal Title XX1 (65%) dollars by multiplying Total Healthy Families dollars (line 8(a) by 65 percent **(calculated automatically by formula on the worksheet)**.

Transfer Lines 6(b), 7(b), 10(b), 11(b), and 12(b) to the Budget Summary, Source of Funds, Column 2.

B. Medi-Cal Enhanced Funds

- Multiply the amount in Column 4 on the “Budget Grand Total” line by 25 percent and enter this amount in Column 4 on the “Source of Funds” line titled “Medi-Cal State.”
- Multiply the Enhanced, Column 4 “Budget Grand Total” amount by 75 percent, and enter the amount in the “Source of Funds” section, Enhanced column, on the Federal Funds line.

C. Medi-Cal Non-Enhanced Funds

- Multiply the amount in Column 5 on the "Budget Grand Total" line by 50 percent and enter this amount in Column 5 on the "Source of Funds" line titled "Medi-Cal State."
- Multiply the Nonenhanced, Column 5, "Budget Grand Total" amount by 50 percent, and enter the amount in the "Source of Funds" section, Nonenhanced column, on the Federal Funds line.

D. Total Medi-Cal Funds

- Add amounts from Columns 4 and 5 for each category and source of funds and enter totals in Column 3 "Total Medi-Cal".

E. Total Budget

- Add amounts across in Columns 2 and 3 for each of the four lines under "Source of Funds" and enter these totals in Column 1. The sum of these amounts equals "Budget Grand Total" in Column 1.

**WORKSHEET
TO DETERMINE FUNDING SOURCES FOR ADMINISTRATIVE ACTIVITIES
RELATED TO HEALTHY FAMILIES For FY 2007-08**

County _____

****This worksheet is formula driven. Fill in shaded areas and the calculations will be entered automatically**

Caseload Percentages

Enter the total Non Medi-Cal Caseload (from the Caseload Box on the Budget Summary)
Enter The total Healthy Families Caseload (from Caseload Box on the Budget Summary) and divide by the total Non Medi-Cal Caseload (line 2a divided by line 1(a))
Enter the Total Straight CCS Caseload (from the caseload box on the Budget Summary) and divide by the total Non Medi-Cal Caseload (line 3(a) divided by line 1(a))

(a)	(b)
0	
0	#DIV/0!
0	#DIV/0!

SOURCE OF FUNDS

Straight CCS

Enter Budget Grand Total for Non Medi-Cal (from Budget Summary, Column 2)
Total Straight CCS Dollars (multiply CCS percentage, line 3(b) x line 4(a))
State (Line 5(a) x 50%)
County (subtract Line 6(b) from Line 5(a))

\$0	
#DIV/0!	
(Transfer to Budget Summary, Column 2) →	#DIV/0!
(Transfer to Budget Summary, Column 2) →	#DIV/0!

CCS Healthy Families

Determine Total Healthy Families Dollars (HF percentage from line 2, column b above x total Straight CCS dollars, Line 4, column a)
State/County (35%) (multiply Total Healthy Families Dollars, line 8, column (a) by 35%)
State (multiply line 9, column (a) by 50%)
County (subtract line 10(b) from line 9(a))
Federal Title XXI (65%) (multiply Total Healthy Families Dollars, line 8, column (a) by 65%)

#DIV/0!	
#DIV/0!	
(Transfer to Budget Summary, Column 2) →	#DIV/0!
(Transfer to Budget Summary, Column 2) →	#DIV/0!
(Transfer to Budget Summary, Column 2) →	#DIV/0!

Budget Grand Total (equals Budget Grand total for Non Medi-Cal from Budget Summary)

#DIV/0!

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children		
Potential Cases Medi-Cal		
TOTAL MEDI-CAL		
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children		
Potential Cases HF		
Total Healthy Families		
Straight CCS		
Average of Total Open (Active) Straight CCS Children		
Potential Cases Straight CCS		
Total Straight CCS		
TOTAL NON MEDI-CAL		
GRAND TOTAL		

CCS Administrative Budget Summary for FY 2007-08

County Name: _____

Column	1	2	3	4	5
Category/Line Item	Total Budget	Non-Medi-Cal County/State/HF Co/St/Federal	Total Medi-Cal State/Federal	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expense					
II. Total Operating Expense					
III. Total Capital Expense					
IV. Total Indirect Expense					
V. Total Other Expense					
Budget Grand Total					

Column	1	2	3	4	5
Source of Funds	Total Budget	Non-Medi-Cal County/State/HF Co/State/Federal	Total Medi-Cal State/Federal	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
Straight CCS					
State					
County					
CCS Healthy Families					
State					
County					
Federal (Title XXI)					
Medi-Cal Funds:					
State					
Federal (Title XIX)					

Prepared By _____

Date Prepared _____

Phone Number _____ Email Address _____

CCS Administrator (Signature) _____

Date _____

Phone Number _____ Email Address _____

SAMPLE

Children's Medical Services Branch

**WORKSHEET
TO DETERMINE FUNDING SOURCES FOR ADMINISTRATIVE ACTIVITIES
RELATED TO HEALTHY FAMILIES For FY 2007-08**

County Golden

****This worksheet is formula driven. Fill in shaded areas and the calculations will be entered automatically**

Caseload Percentages	(a)	(b)
Enter the total Non Medi-Cal Caseload (from the Caseload Box on the Budget Summary)	278	
Enter The total Healthy Families Caseload (from Caseload Box on the Budget Summary) and divide by the total Non Medi-Cal Caseload (line 2a divided by line 1(a))	23	8.27%
Enter the Total Straight CCS Caseload (from the caseload box on the Budget Summary) and divide by the total Non Medi-Cal Caseload (line 3(a) divided by line 1(a))	255	91.73%

SOURCE OF FUNDS

Straight CCS		
Enter Budget Grand Total for Non Medi-Cal (from Budget Summary, Column 2)	\$142,506	
Total Straight CCS Dollars (multiply CCS percentage, line 3(b) x line 4(a))	\$130,716	
State (Line 5(a) x 50%)	(Transfer to Budget Summary, Column 2)	→ \$65,358
County (subtract Line 6(b) from Line 5(a))	(Transfer to Budget Summary, Column 2)	→ \$65,358

CCS Healthy Families		
Determine Total Healthy Families Dollars (HF percentage from line 2, column b above x total Straight CCS dollars, Line 4, column a)	\$11,790	
State/County (35%) (multiply Total Healthy Families Dollars, line 8, column (a) by 35%)	\$4,127	
State (multiply line 9, column (a) by 50%)	(Transfer to Budget Summary, Column 2)	→ \$2,063
County (subtract line 10(b) from line 9(a))	(Transfer to Budget Summary, Column 2)	→ \$2,063
Federal Title XXI (65%) (multiply Total Healthy Families Dollars, line 8, column (a) by 65%)	(Transfer to Budget Summary, Column 2)	→ \$7,664

Budget Grand Total (equals Budget Grand total for Non Medi-Cal from Budget Summary) \$142,506

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children	542	58%
Potential Cases Medi-Cal	108	12%
TOTAL MEDI-CAL	650	70%
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children	18	2%
Potential Cases HF	5	1%
Total Healthy Families	23	3%
Straight CCS		
Average of Total Open (Active) Straight CCS Children	214	23%
Potential Cases Straight CCS	41	4%
Total Straight CCS	255	27%
TOTAL NON MEDI-CAL	278	30%
GRAND TOTAL	928	100%

CCS Administrative Budget Summary for FY 2007-08

County Name: Golden

****SAMPLE****

Column	1	2	3	4	5
Category/Line Item	Total Budget	Non-Medi-Cal County/State/HF Co/St/Federal	Total Medi-Cal State/Federal	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expense	\$373,672	\$112,100	\$261,572	\$82,089	\$179,483
II. Total Operating Expense	\$68,984	\$20,695	\$48,289	\$7,437	\$40,852
III. Total Capital Expense	\$0	\$0	\$0		\$0
IV. Total Indirect Expense	\$12,369	\$3,711	\$8,658		\$8,658
V. Total Other Expense	\$20,000	\$6,000	\$14,000		\$14,000
Budget Grand Total	\$475,025	\$142,506	\$332,519	\$89,526	\$242,993

Column	1	2	3	4	5
Source of Funds	Total Budget	Non-Medi-Cal County/State/HF Co/State/Federal	Total Medi-Cal State/Federal	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
Straight CCS					
State	\$65,358	\$65,358			
County	\$65,358	\$65,358			
CCS Healthy Families					
State	\$2,063	\$2,063			
County	\$2,063	\$2,063			
Federal (Title XXI)	\$7,664	\$7,664			
Medi-Cal Funds:					
State	\$143,879		\$143,879	\$22,382	\$121,497
Federal (Title XIX)	\$188,640		\$188,640	\$67,144	\$121,496

John Smith
Prepared By

May 1, 2007
Date Prepared

916-555-2222
Phone Number

Jsmith@golden.ca.us
Email Address

Dr. Jane Doe
CCS Administrator (Signature)

May 1, 2007
Date

916-555-1111
Phone Number

Jdoe@golden.ca.us
Email Address

CMS Budget Revision General Information

I. Policies for CMS Budget Revisions

All requests for budget revisions must be submitted to the Regional Office Administrative Consultant/Analyst no later than six months (December 31) after the end of the fiscal year. Budget revision requests received after December 31 for the previous fiscal year will not be accepted. A budget revision worksheet, summary, **and** a budget revision justification narrative are required whenever the county/city anticipates:

- A. The original approved funding total will be exceeded (e.g., over expenditure due to an increase in caseload, need for special equipment, etc.)
- B. The original approved funding total will be decreased by at least 10 percent (e.g., under expended due to unexpected decreases in caseload, inability to fill position, inability to purchase equipment, etc.)
- C. Any permanent change in overall FTE during the fiscal year period.
- D. Any change in staff composition (e.g., a vacant RN position that will be refilled as a clerk position)
- E. A transfer of funds between enhanced and nonenhanced funding sources, even when there is no adjustment of the line item dollar amount
- F. A transfer of more than \$10,000 among any of the five budget line items (e.g., Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses). *Transfers of less than \$10,000 per budget and fiscal year may be made without prior State approval. A Budget Revision Worksheet, Summary and a Budget Justification Narrative are still required for all changes.*
- G. Transfer of funds into the Capital Expenses line item.
- H. A shift in caseload proportion of Medi-Cal and non-Medi-Cal claims of greater than 5 percent.
- I. If the county match increases for the CCS Program Administrative Budget, a new Certificate of County Appropriation is required.
- J. Purchases of equipment (Capital Expenses) require written justification and State approval prior to authorization of State funds for equipment purchases. Submit County/City Capital Expenses Justification Form.

The Budget Revision Justification Narrative (see page 134) must include :

- The total dollar amount for each budget line item by category and reason for change.
- The dollar amount for each line item changed within the budget category.

- A *Detailed* Explanation of need for revision.

NOTE: If the revision includes expenditures not indicated in the approved budget, explanation of the new expenditure and the need is required.

CHDP Administrative Budget Revision Instructions (No County/City Match)

CHDP Administrative Budget Revision Summary

I. CHDP Administrative Budget Revision (No County/City Match)(see sample page 117)

A. Complete the heading, entering the number of the budget revision; e.g., the first revision of the approved budget for the fiscal year would be number 1.

B. In Column 1, **Approved Budget:**

Copy the amounts from Column 1 of the last approved budget or budget revision:

1. All the amounts in each budget line item (Total Personnel Expenses, Total Operating Expenses, etc.) even though there is no adjustment in the line items.

2. The total amounts for all line item (Budget Grand Total).

C. In Column 2, **Revision Amount:**

1. Enter the amount of adjustment (positive or [negative]) for each line item. Use parentheses around a number to indicate a negative number.

2. Enter "0" in the line items with no adjustment.

D. In Column 3, **Revised Budget:**

Enter the proposed total budget amounts (Column 1 plus or minus Column 2).

E. In Column 4, **Revised CHDP Budget:**

Enter the proposed total CHDP amount for each line item.

F. In Column 5, **Revised Medi-Cal Budget:**

Enter the proposed total Medi-Cal amount for each line item.

G. In Column 6, **Enhanced State/Federal (25/75):**

Enter the amount of Personnel and Operating Expenses (travel and training) only to be allocated to program activities eligible for **enhanced** Medi-Cal funding.

H. In Column 7, **Nonenhanced State/Federal (50/50)**

Enter the amount to be allocated to program activities eligible for **nonenhanced** Medi-Cal funding.

NOTE: The totals of Column 6 and 7 must equal Column 5. The totals of Column 5 and 4 must equal Column 3.

- I. **Budget Grand Total:** Add the totals for each Column and enter the amounts on the Budget Grand Total line.

The total amount of state funds and the amounts of Title XIX Federal Funds authorized in the initial approved CHDP budget cannot be exceeded without specific written authorization.

Note: CHDP Administrative Budget Revision requests must include the worksheet, revision summary page and a Budget Justification Narrative.

CHDP Administrative Budget Revision Summary Number: ____
No County/City Match
CHDP State Funds and Medi-Cal State/Federal Funds
County/City Name: _____
Fiscal Year _____

Column	1	2	3	4	5	6	7
Category/Line Item	Approved Budget	Revision Amount	Revised Budget (1 + 2)	Revised CHDP Budget	Revised Medi-Cal Budget (6 + 7)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses							
II. Total Operating Expenses							
III. Total Capital Expenses							
IV. Total Indirect Expenses							
V. Total Other Expenses							
Budget Grand Total							

Column	3	4	5	6	7
Source of Funds	Total Revision Funds	Total CHDP *	Total Medi-Cal **	Enhanced State/Federal	Nonenhanced State/Federal
State General Funds					
Medi-Cal Funds:					
State					
Federal (Title XIX)					

* Total must not exceed State non-Medi-Cal (100% State Funds) allocation.

** Total State and Federal Funds must not exceed Medi-Cal allocation.

Prepared By _____

Date Prepared _____

Phone Number _____

Email Address _____

CHDP Director or Deputy Director (Signature) _____

Date _____

Phone Number _____

Email Address _____

SAMPLE

**CHDP Administrative Budget Revision Summary Number: 1
No County/City Match
CHDP State Funds and Medi-Cal State/Federal Funds
County/City Name: Golden
Fiscal Year: 2006-07**

Column	1	2	3	4	5	6	7
Category/Line Item	Approved Budget	Revision Amount	Revised Budget (1 + 2)	Revised CHDP Budget	Revised Medi-Cal Budget (6 + 7)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses	\$49,713	\$2,459	\$52,172	\$8,990	\$43,182	\$8,869	\$34,313
II. Total Operating Expenses	\$13,494	(\$2,459)	\$11,035	\$2,412	\$8,623	\$1,106	\$7,517
III. Total Capital Expenses	\$0	\$0	\$0	\$0	\$0		\$0
IV. Total Indirect Expenses	\$3,275	\$0	\$3,275	\$482	\$2,793		\$2,793
V. Total Other Expenses	\$0	\$0	\$0	\$0	\$0		\$0
Budget Grand Total	\$66,482	\$0	\$66,482	\$11,884	\$54,598	\$9,975	\$44,623

Column	3	4	5	6	7
Source of Funds	Total Revision Funds	Total CHDP *	Total Medi-Cal **	Enhanced State/Federal	Nonenhanced State/Federal
State General Funds	\$11,884	\$11,884			
Medi-Cal Funds:			\$54,598		
State	\$24,805		\$24,805	\$2,494	\$22,311
Federal (Title XIX)	\$29,793		\$29,793	\$7,481	\$22,312

* Total must not exceed State non-Medi-Cal (100% State Funds) allocation.

** Total State and Federal Funds must not exceed Medi-Cal allocation.

John Smith
Prepared By

May 1, 2007
Date Prepared

916-555-1212
Phone Number

jsmith@golden.ca.us
Email Address

Dr. Jane Doe
CHDP Director or Deputy Director (Signature)

May 1, 2007
Date

916-555-1122
Phone Number

jdoe@golden.ca.us
Email Address

CHDP Administrative Budget Revision Instructions (County/City Match)

CHDP Administrative Budget County/City Match Revision Summary

- I. Complete the heading, entering the number of the budget revision, e.g., the first revision of the approved budget for the fiscal year would be number 1 (see sample page 117).
- II. In Column 1, **Approved Budget**:
Copy from Column 1 of the last approved budget or budget revision:
 1. All the line item amounts in each budget category (Total Personnel Expenses, Total Operating Expenses, etc.) even though there is no adjustment in the line items.
 2. The total amount for all line items (Budget Grand Total).
- III. In Column 2, **Revision Amount**:
 3. Enter the amount of adjustment (positive or [negative]) for each line item to be revised. Use parentheses around a number to indicate a negative number.
 4. Enter "0" in the line items with no adjustments.
- IV. In Column 3, **Revised Budget**:
Enter the proposed total budget amounts (Column 1 plus or minus Column 2).
- V. In Column 4, **Enhanced County/Federal (25/75)**
Enter only the amount of Personnel and Operating Expenses (travel and training) to be allocated to program activities eligible for **enhanced** Medi-Cal funding (Title XIX Federal).
- VI. In Column 5, **Nonenhanced County/Federal (50/50)**
Enter the amounts to be allocated to program activities eligible for **nonenhanced** Medi-Cal funding (Title XIX Federal).
NOTE: That totals of Columns 4 and 5 must equal Column 3.
- VII. Add the totals for each Column, and enter the amounts of the Budget GrandTotal lines.
The total amount of county/city funds and the amounts of Title XIX Federal Funds authorized in the initial approved CHDP budget cannot be exceeded without specific written authorization.

CHDP Administrative Budget requests must include the worksheet, revision summary, and a budget justification narrative.

CHDP Administrative Budget Revision Summary Number: ____
County/City Match
County/City Funds and Title XIX Federal Funds
County/City Name: _____
Fiscal Year _____

Column	1	2	3	4	5
Category/Line Item	Approved Budget	Revision Amount	Revised Budget (1 + 2 or 4 + 5)	Enhanced County/Federal (25/75)	Nonenhanced County/Federal (50/50)
I. Total Personnel Expense					
II. Total Operating Expense					
III. Total Capital Expense					
IV. Total Indirect Expense					
V. Total Other Expense					
Budget Grand Total					

Source of Funds	Total Revision Funds	Enhanced County/Federal (25/75)	Nonenhanced County/Federal (50/50)
County Funds			
Federal Funds (Title XIX)			

Prepared By _____ Date Prepared _____ Phone Number _____ Email Address _____

CHDP Director or Deputy Director (Signature) _____ Date _____ Phone Number _____ Email Address _____

CHDP Administrative Budget Revision Summary Number: 1_
County/City Match
County/City Funds and Title XIX Federal Funds
County/City Name: Golden
Fiscal Year: 2007-08

Column	1	2	3	4	5
Category/Line Item	Approved Budget	Revision Amount	Revised Budget (1 + 2 or 4 + 5)	Enhanced County/Federal (25/75)	Nonenhanced County/Federal (50/50)
I. Total Personnel Expenses	\$46,948	(\$3,541)	\$43,407	\$34,750	\$8,657
II. Total Operating Expenses	\$4,000	\$4,000	\$8,000	\$900	\$7,100
III. Total Capital Expenses	\$0	\$0	\$0		\$0
IV. Total Indirect Expenses	\$6,139	(\$459)	\$5,680		\$5,680
V. Total Other Expenses	\$0	\$0	\$0		\$0
Budget Grand Total	\$57,087	\$0	\$57,087	\$35,650	\$21,437

Source of Funds	Total Revision Funds	Enhanced County/Federal (25/75)	Nonenhanced County/Federal (50/50)
County Funds	\$19,631	\$8,913	\$10,718
Federal Funds (Title XIX)	\$37,456	\$26,737	\$10,719

John Smith	May 1, 2007	916-555-1212	jsmith@golden.ca.us
Prepared By	Date Prepared	Phone Number	Email Address

<i>Dr. John Doe</i>	May 1, 2007	916-555-1122	jdoe@golden.ca.us
CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address

REVISED 8/7/06

Foster Care Administrative County/City Match Budget Revision Instructions

Foster Care Budget Revision Summary Page

I. Complete the heading, entering the number of the budget revision, e.g., the first revision of the approved budget for the fiscal year would be number 1 (see sample, page 121).

II. In Column 1, **Approved Budget:**

Copy from Column 1 of the last approved budget or budget revision:

1. All the line item amounts in each budget category (Total Personnel Expenses, Total Operating Expenses, etc.) even though there is no adjustment in the line items.
2. The total amount for all line items (Budget Grand Total).

III. In Column 2, **Revision Amount:**

1. Enter the amount of adjustment (positive or [negative]) for each line item to be revised. Use parentheses around a number to indicate a negative number.
2. Enter "0" in the line items with no adjustments.

IV. In Column 3, **Revised Budget:**

Enter the proposed total budget amounts (Column 1 plus or minus Column 2).

V. In Column 4, **Enhanced County-City/Federal (25/75)**

Enter only the amount of Personnel and Operating Expenses (travel and training) to be allocated to program activities eligible for **enhanced** Medi-Cal funding (Title XIX Federal).

VI. In Column 5, **Nonenhanced County-City/Federal (50/50)**

Enter the amounts to be allocated to program activities eligible for **nonenhanced** Medi-Cal funding (Title XIX Federal).

NOTE: That totals of Columns 4 and 5 must equal Column 3.

VII. Add the totals for each Column, and enter the amounts of the Budget Grand Total lines.

The total amount of county/city funds and the amounts of Title XIX Federal Funds authorized in the initial approved CHDP budget cannot be exceeded without specific written authorization.

Note: Foster Care Budget Revision requests must include the worksheet, revision summary and a Budget Justification Narrative.

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**Foster Care Administrative Budget Revision Summary Number 1
County/City Match
County/City Funds and Title XIX Federal Funds
County/City Name: Golden
Fiscal Year: _____**

Column	1	2	3	4	5
Category/Line Item	Approved Budget	Revision Amount	Revised Budget (1 + 2 or 4 + 5)	Enhanced County- City/Federal (25/75)	Nonenhanced County- City/Federal (50/50)
I. Total Personnel Expense					
II. Total Operating Expense					
III. Total Capital Expense					
IV. Total Indirect Expense					
V. Total Other Expense					
Budget Grand Total					

Source of Funds	Total Revision Funds	Enhanced County- City/Federal (25/75)	Nonenhanced County- City/Federal (50/50)
County-City Funds			
Federal Funds (Title XIX)			
Budget Grand Total			

Prepared By _____ Date Prepared _____ Phone Number _____ Email Address _____

CHDP Director or Deputy Director (Signature) _____ Date _____ Phone Number _____ Email Address _____

**Foster Care Administrative Budget Revision Summary Number 1
County/City Match
County/City Funds and Title XIX Federal Funds
County/City Name: Golden
Fiscal Year: 2006-07**

Column	1	2	3	4	5
Category/Line Item	Approved Budget	Revision Amount	Revised Budget (1 + 2 or 4 + 5)	Enhanced County- City/Federal (25/75)	Nonenhanced County- City/Federal (50/50)
I. Total Personnel Expense	\$35,000	(\$5,000)	\$30,000	\$24,250	\$5,750
II. Total Operating Expense	\$6,000	\$5,000	\$11,000	\$4,500	\$6,500
III. Total Capital Expense					
IV. Total Indirect Expense	\$1,200	\$0	\$1,200		\$1,200
V. Total Other Expense					
Budget Grand Total	\$42,200	\$0	\$42,200	\$28,750	\$13,450

Source of Funds	Total Revision Funds	Enhanced County- City/Federal (25/75)	Nonenhanced County- City/Federal (50/50)
County-City Funds	\$13,913	\$7,188	\$6,725
Federal Funds (Title XIX)	\$28,287	\$21,562	\$6,725
Budget Grand Total	\$42,200		

John Smith	May 1, 2007	916-555-4741	jsmith@golden.ca.us
Prepared By	Date Prepared	Phone Number	Email Address
<i>Dr. Jane Doe</i>	May 1, 2007	916-555-4742	jdoe@golden.ca.us
CHDP Director or Deputy Director (Signature)	Date	Phone Number	Email Address

HCPCFC Budget Revision Instructions

HCPCFC Budget Revision Summary Page

I. Complete the heading, entering the number of the budget revision; e.g., the first revision of the approved budget for the fiscal year would be number 1 (see sample, page 124).

II. In Column 1, **Approved Budget**:

Copy amounts from Column 1 of the last approved budget or budget revision:

A. All the line item amounts in each budget category (Total Personnel Expenses, Total Operating Expenses, etc.) even though there is no adjustment in the line items.

B. The total amounts for all line items. (Budget Grand Total)

III. In Column 2, **Revision Amount**:

A. Enter the amount of adjustment (positive or [negative]) for each line item to be revised.

B. Enter "0" in the line items with no adjustments.

IV. In Column 3, **Revised Budget**:

Enter the proposed total budget amounts (Column 1 plus or minus Column 2).

V. In Column 4, **Enhanced State/Federal (25/75)**:

Enter the amount of Personnel and Operating Expenses (travel and training) only to be allocated to program activities eligible for enhanced Medi-Cal funding.

VI. In Column 5, **Nonenhanced State/Federal (50/50)**:

Enter the amount to be allocated to program activities eligible for nonenhanced federal funding (Title XIX).

NOTE: The totals of Columns 4 and 5 must equal Column 3.

VII. **Budget Grand Total:** Add the totals for each Column, and enter the amounts on the Budget Grand Total lines.

The total amount of state funds and the amounts of Title XIX Federal Funds authorized in the initial approved CHDP budget cannot be exceeded without specific written authorization.

Note: HCPCFC Budget Revision requests must include the worksheet, revision summary and a Budget Justification Narrative.

State of California – Health and Human Services Agency

California Department of Health Care
 Services – Children's Medical Services
 Branch

HPCFC Administrative Budget Revision Summary Number ___
State/Federal Match
State Funds and Title XIX Federal Funds
County/City Name: _____
Fiscal Year _____

Column	1	2	3	4	5
Category/Line Item	Approved Budget	Revision Amount	Revised Budget (1 + 2 or 4 + 5)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses					
II. Total Operating Expenses					
III. Total Capital Expenses					
IV. Total Indirect Expenses					
V. Total Other Expenses					
Budget Grand Total					

Source of Funds	Total Funds	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
State Funds			
Federal Funds (Title XIX)			

Prepared By _____

Date prepared _____

Phone Number _____

Email Address _____

CHDP Director or Deputy Director (Signature) _____

Date _____

Phone Number _____

Email Address _____

State of California – Health and Human Services
Agency

California Department of Health Care Services – Children's Medical
Services Branch

**HCPCFC Administrative Budget Revision Summary Number _1_
State/Federal Match
State Funds and Title XIX Federal Funds
County/City Name: Golden
Fiscal Year: 2006-07**

Column	1	2	3	4	5
Category/Line Item	Approved Budget	Revision Amount	Revised Budget (1 + 2 or 4 + 5)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses	\$30,000	\$5,000	\$35,000	\$26,250	\$8,750
II. Total Operating Expenses	\$8,000	(\$5,000)	\$3,000	\$2,250	\$750
III. Total Capital Expenses					
IV. Total Indirect Expenses	\$3,000	\$0	\$3,000		\$3,000
V. Total Other Expenses					
Budget Grand Total	\$41,000	\$0	\$41,000	\$28,500	\$12,500

Source of Funds	Total Funds	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
State Funds	\$13,375	\$7,125	\$6,250
Federal Funds (Title XIX)	\$27,625	\$21,375	\$6,250

John Smith
Prepared By

May 1, 2007 916-555-1212 jsmith@golden.ca.us
Date Prepared Phone Number Email Address

Dr. Jane Doe
CHDP Director or Deputy Director (Signature)

May 1, 2007 916-555-1122 jdoe@golden.ca.us
Date Phone Number Email Address

CCS Administrative Budget Revision Instructions

Budget Revision Worksheet

- I. Complete the heading, entering the number of the Budget Revision; e.g. the first revision of the approved budget for the fiscal year would be Revision #1 (see sample, page 132).
- II. In Column 1, Approved Budget:

Copy from Column 1 of the last approved budget (or Column 3 of a Budget Revision).
 - A. All the line item amounts in each budget category even if there is no adjustment for a specific line item.
 - B. The Total amounts for all categories.
- III. In Column 2, Revisions:
 - A. Enter amount of adjustment (positive or negative) for each line item to be revised.
 - B. Enter "0" in the line item with no adjustments.
- IV. In Column 3, Revised Budget:

Enter the proposed Revised Budget amounts (column 1 plus or minus Column 2).
- V. Column 4 through Column 7:

Complete Columns 4-7 according to the CCS Administrative Budget Worksheet Instructions beginning on page 94.

Budget Revision Summary Page

Category/Line Item

- I. Complete the heading, entering the number of the budget revision; e.g., the first revision of the approved budget for the fiscal year would be revision Number 1 (see sample on page 129).
- II. In Column 1 **Approved Budget:**

Copy from Column 1 of the last approved budget (or Column 3 of budget revision):
 - A. All the line amounts in each budget category (Total Personnel Expenses, Total Operating Expenses, etc.) even if there is no adjustment for a specific line item.
 - B. The total amounts for all categories (Budget Grand Total).
 - C. The total amounts in the source of funds, Column 1.
- III. In Column 2, **Revisions:**
 - A. Enter the amount of adjustment (positive or [negative]) for each line item to be revised. Use parentheses around a number to indicate a negative number.
 - B. Enter "0" in the line items with no adjustments.
- IV. In Column 3, **Revised Budget:**

Enter the proposed total budget amounts (Column 1 plus or minus Column 2.)
- V. In Column 4, **Non-Medi-Cal, County/State/HF, Co/St/Federal:**

Multiply the total Non-Medi-Cal percentage by each amount in Column 3, and enter the amount for each line in Column 4.
- VI. Calculate the total amount available for Medi-Cal reimbursement by subtracting the amount entered in Column 4 for each line from the amount entered in Column 3 and enter in Column 5.
- VII. In Column 6, **Medi-Cal, Enhanced, State/Federal:**

Enter the amount allocated to program activities eligible for **enhanced** Medi-Cal funding.
- VIII. In Column 7, **Nonenhanced Funding:**

Enter the amount allocated to program activities eligible for nonenhanced Medi-Cal funding.
- IX. The totals of Column 6 and 7 must equal Column 5.

NOTE: The totals of Columns 4, 5, and must equal Column 3.

X. Budget Grand Total:

Add the totals for each Column, and enter the amounts on the Budget Grand Total lines.

Source of Funds

- I. Multiply the Budget Grand Total in Column 7, non-enhanced State/Federal (50/50) by 50% and enter result in Source of Funds Column 7, Medi-Cal Funds-State.
- II. Subtract Medi-Cal Funds –State from Budget Grand Total for Column 7, and enter result in Source of Funds Column 7, Medi-Cal Funds Federal (Title XIX).
- III. Multiply the Budget Grand Total in Column 6, Enhanced State/Federal (25/75) by 25% and enter result in Source of Funds Column 6, Medi-Cal Funds – State.
- IV. Subtract Medi-Cal Funds-State from Budget Grand Total in Column 6, and enter result in Source of Funds Column 6, Medi-Cal Funds Federal.
- V. Add Columns 6 and 7 and enter result in Column 5 & 3.
- VI. Complete the “Worksheet to Determine Healthy Families Administrative Costs (see page 104).
- VII. From this Worksheet, transfer lines 6(b), 10(b), 11(b), and 12(b) to Source of Funds, Columns 4 and 3 for Straight CCS/State and County and CCS Healthy Families (State/County/Federal (title XXI)).
- VIII. In Column 2, enter the difference between the approved Budget Amount in Column 1 and the Revised Budget Amount in Column 3.

Note: CCS Budget Revision requests must include the Budget Revision Worksheet, Budget Revision Summary, Budget Revision Justification Narrative and Healthy Families Worksheet.

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children		
Potential Cases Medi-Cal		
TOTAL MEDI-CAL		
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children		
Potential Cases HF		
Total Healthy Families		
Straight CCS		
Average of Total Open (Active) Straight CCS Children		
Potential Cases Straight CCS		
Total Straight CCS		
TOTAL NON MEDI-CAL		
GRAND TOTAL		

CCS Administrative Budget Revision Summary

County Name: _____

Fiscal Year: _____

Revision Number: ____

Column	1	2	3	4	5	6	7
Category/Line Item	Approved Budget	Revisions	Revised Budget	Non-Medi-Cal County/State/HF Co/St/Federal	Total Medi-Cal State/Federal	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expense							
II. Total Operating Expense							
III. Total Capital Expense							
IV. Total Indirect Expense							
V. Total Other Expense							
Budget Grand Total							

Column	1	2	3	4	5	6	7
Source of Funds	Approved Budget	Revisions	Revised Budget	Non-Medi-Cal County/State/HF Co/St/Federal	Total Medi-Cal State/Federal	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
Straight CCS:							
State							
County:							
CCS Healthy Families:							
State							
County							
Federal (Title XXI)							
Medi-Cal Funds:							
State							
Federal (Title XIX)							

Prepared By _____

Date Prepared _____

Phone Number _____

Email Address _____

CCS Administrator (Signature) _____

Date _____

Phone Number _____

Email Address _____

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children	542	58%
Potential Cases Medi-Cal	108	12%
TOTAL MEDI-CAL	650	70%
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children	18	2%
Potential Cases HF	5	1%
Total Healthy Families	23	3%
Straight CCS		
Average of Total Open (Active) Straight CCS Children	214	23%
Potential Cases Straight CCS	41	4%
Total Straight CCS	255	27%
TOTAL NON MEDI-CAL	278	30%
GRAND TOTAL	928	100%

SAMPLE
CCS Administrative Budget Revision Summary

County Name: Golden

Fiscal Year: 2006-07

Revision Number: 1

Column	1	2	3	4	5	6	7
Category/Line Item	Approved Budget	Revisions	Revised Budget	Non-Medi-Cal County/State/HF Co/St/Federal	Total Medi-Cal State/Federal	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expense	\$373,672		\$373,672	\$112,100	\$261,572	\$82,089	\$179,483
II. Total Operating Expense	\$68,984		68,984	\$20,695	\$48,289	\$7,437	\$40,852
III. Total Capital Expense	\$0		0	\$0	\$0		\$0
IV. Total Indirect Expense	\$12,369		\$12,369	\$3,711	\$8,658		\$8,658
V. Total Other Expense	\$20,000		\$20,000	\$6,000	\$14,000		\$14,000
Budget Grand Total	\$475,025		\$475,025	\$142,506	\$332,519	\$89,526	\$242,993

Column	1	2	3	4	5	6	7
Source of Funds	Approved Budget	Revisions	Revised Budget	Non-Medi-Cal County/State/HF Co/St/Federal	Total Medi-Cal State/Federal	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
Straight CCS:							
State	\$71,253	-\$5,895	\$65,358	\$65,358			
County	\$71,253	-\$5,895	\$65,358	\$65,358			
CCS Healthy Families:							
State	\$0	\$2,063	\$2,063	\$2,063			
County	\$0	\$2,063	\$2,063	\$2,063			
Federal (Title XXI)	\$0	\$7,664	\$7,664	\$7,664			
Medi-Cal Funds:							
State	\$143,879	\$0	\$143,879		\$143,879	\$22,382	\$121,497
Federal (Title XIX)	\$188,640	\$0	\$188,640		\$188,640	\$67,144	\$121,496

John Smith
Prepared By
Dr. Jane Doe
CCS Administrator (Signature)
Section 6

May 1, 2007
Date Prepared
May 1, 2007
Date

916-555-1212
Phone Number
916-555-2121
Phone Number

jsmith@golden.ca.us
Email Address
jdoe@golden.ca.us
Email Address

State of California – Health and Human Services Agency

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children		
Potential Cases Medi-Cal		
TOTAL MEDI-CAL		
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children		
Potential Cases HF		
Total Healthy Families		
Straight CCS		
Average of Total Open (Active) Straight CCS Children		
Potential Cases Straight CCS		
Total Straight CCS		
TOTAL NON MEDI-CAL		
GRAND TOTAL		

CCS Administrative Budget Revision Worksheet

County Name: _____

Fiscal Year: _____

Revision Number: _____

Column	1	2	3	4	5	6	7
Category/Line Item	Approved Budget	Revisions	Revised Budget	Non-Medi-Cal County/State/HF Co/St/Federal	Total Medi-Cal State/Federal	Medi-Cal Enhanced State/Federal (25/75)	Medi-Cal Nonenhanced State/Federal (50/50)
I. Personnel Expense							
Program Administration							
CCS Administrator – B. Williams							
Program Coordinator – J. Young							
Analyst – T. Smith							
Subtotal							
Medical Case Management							
PHN – T. Jones							
PHN – Y. Huang							
Subtotal							
Other Health Care Professionals							
Subtotal							
Ancillary Support							
Eligibility Worker – F. Rodriguez							
Subtotal							
Clerical and Claims Support							
Sr. Office Asst – T. Sung							
Office Assistant – R. Jones							
Subtotal							

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children		
Potential Cases Medi-Cal		
TOTAL MEDI-CAL		
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children		
Potential Cases HF		
Total Healthy Families		
Straight CCS		
Average of Total Open (Active) Straight CCS Children		
Potential Cases Straight CCS		
Total Straight CCS		
TOTAL NON MEDI-CAL		
GRAND TOTAL		

CCS Administrative Budget Revision Worksheet

County Name: _____

Fiscal Year: _____

Revision Number: _____

Total Salary and Wages							
Less Salary Savings							
Net Salary and Wages							
Staff Benefits (Specify %)							
I. Total Personnel Expense							
II. Operating Expense							
1. Travel							
2. Training							
3.							
4.							
5.							
6.							
II. Total Operating Expense							
III. Capital Expense							
III. Total Capital Expense							
IV. Indirect Expense							
1. Internal							
2. External							
IV. Total Indirect Expense							
V. Other Expense							
1. Maintenance and Transportation							
V. Total Other Expense							
Budget Grand Total							

Prepared By _____
 CCS Administrator (Signature)

Date Prepared _____
 Date

Phone Number _____
 Phone Number

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children	542	58%
Potential Cases Medi-Cal	108	12%
TOTAL MEDI-CAL	650	70%
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children	18	2%
Potential Cases HF	5	1%
Total Healthy Families	23	3%
Straight CCS		
Average of Total Open (Active) Straight CCS Children	214	23%
Potential Cases Straight CCS	41	4%
Total Straight CCS	255	27%
TOTAL NON MEDI-CAL	278	30%
GRAND TOTAL	928	100%

CCS Administrative Budget Revision Worksheet

County Name: Golden

Fiscal Year: 2006-07

Revision Number: 2

Column	1	2	3	4	5	6	7
Category/Line Item	Approved Budget	Revisions	Revised Budget	Non-Medi-Cal County/State/HF Co/St/Federal	Total Medi-Cal State/Federal	Medi-Cal Enhanced State/Federal (25/75)	Medi-Cal Nonenhanced State/Federal (50/50)
I. Personnel Expense							
Program Administration							
CCS Administrator – B. Williams	\$1,495	(\$300)	\$3,894	\$1,130	\$2,765		\$2,765
Program Coordinator – J. Young	\$4,521	(\$500)	\$4,021	\$1,166	\$2,855		\$2,855
Analyst – T. Smith	\$5,780	(\$3,000)	\$2,780	\$806	\$1,974		\$1,974
	\$5,048	(\$1,200)	\$3,848	\$1,116	\$2,732		\$2,732
Subtotal	\$19,544	(%5,000)	\$14,544	\$4,218	\$10,326		\$10,326
Medical Case Management							
PHN – T. Jones	\$33,806	\$0	\$33,806	\$9,804	\$24,002	\$20,402	\$3,600
PHN – Y. Huang	\$11,268	\$0	\$11,268	\$3,268	\$8,000	\$6,800	\$1,200
Subtotal	\$45,074	\$0	\$45,074	\$13,072	\$32,002	\$27,202	\$4,800
Other Health Care Professionals							
Subtotal							
Ancillary Support							
Eligibility Worker – F. Rodriguez	\$18,346	\$900	\$19,246	\$5,581	\$13,665		\$13,665
Subtotal	\$18,346	\$900	\$19,246	\$5,581	\$13,665		\$13,665
Clerical and Claims Support							
Sr. Office Asst – T. Sung	\$3,707	\$0	\$3,707	\$1,075	\$2,632		\$2,632
Office Assistant – R. Jones	\$7,862	\$300	\$8,162	\$2,367	\$5,795		\$5,795
Subtotal	\$11,569	\$300	\$11,869	\$3,442	\$8,427		\$8,427

CCS CASELOAD	Actual Caseload	Percent of Grand Total
MEDI-CAL		
Average of Total Open (Active) Medi-Cal Children	542	58%
Potential Cases Medi-Cal	108	12%
TOTAL MEDI-CAL	650	70%
NON MEDI-CAL		
Healthy Families		
Average of Total Open (Active) HF Children	18	2%
Potential Cases HF	5	1%
Total Healthy Families	23	3%
Straight CCS		
Average of Total Open (Active) Straight CCS Children	214	23%
Potential Cases Straight CCS	41	4%
Total Straight CCS	255	27%
TOTAL NON MEDI-CAL	278	30%
GRAND TOTAL	928	100%

CCS Administrative Budget Revision Worksheet

County Name: Golden

Fiscal Year: 2006-2007

Revision Number: 2

Total Salary and Wages	\$94,533	(\$3,800)	\$90,733	\$26,313	\$64,420	\$27,202	\$37,218
Less Salary Savings	\$0						
Net Salary and Wages	\$94,533	(\$3,800)	\$90,733	\$26,313	\$64,420	\$27,202	\$37,218
Staff Benefits (Specify %)	32%	\$30,251	(\$1,216)	\$29,035	\$9,091	\$19,944	\$8,705
I. Total Personnel Expense	\$124,784	(\$5,016)	\$119,766	\$35,404	\$84,364	\$35,907	\$48,457
II. Operating Expense							
1. Travel	\$2,200	\$700	\$2,900	\$841	\$2,059	\$1,750	\$309
2. Training	\$700	\$500	\$1,200	\$348	\$852	\$724	\$128
3. Office Space	\$1,500	\$2,750	\$4,250	\$1,233	\$3,017		\$3,017
4. Communications	\$1,200	(\$231)	\$969	\$281	\$688		\$688
5. Equipment Lease	\$1,500	\$1,200	\$2,700	\$783	\$1,917		\$1,917
6. Space Rental	\$1,500	\$1,000	\$2,500	\$725	\$1,775		\$1,775
II. Total Operating Expense	\$8,600	\$5,919	\$14,519	\$4,211	\$10,308	\$2,474	\$7,834
III. Capital Expense							
III. Total Capital Expense							
IV. Indirect Expense							
1. Internal	\$9,983	(\$401)	\$9,582	\$2,779	\$6,803		\$6,803
2. External	\$12,478	(\$502)	\$11,976	\$3,473	\$8,503		\$8,503
IV. Total Indirect Expense	\$22,461	(\$903)	\$21,558	\$6,252	\$15,306		\$15,306
V. Other Expense							
1. Maintenance and Transportation	\$1,500	\$0	\$15,00	\$435	\$1,065		\$1,065
V. Total Other Expense	\$1,500	\$0	\$15,00	\$435	\$1,065		\$1,065
Budget Grand Total	\$157,345	\$0	\$157,345	\$46,302	\$111,043	\$38,381	\$72,662

John Smith
Prepared By

May 1, 2007
Date Prepared

916-555-1212
Phone Number

Dr. Jane Doe
CCS Administrator (Signature)

May 1, 2007
Date

916-555-2121
Phone Number

Sample Budget Revision Justification Narrative

(A budget justification narrative must be included with all budget revision requests along with the Budget Revision Worksheet and Budget Revision Summary.)

1. Personnel expenses total \$119,768. Personnel expenses were decreased by \$5,016 from the originally approved \$124,784 because of PHN vacancies in the program.
2. Operating Expenses total \$14,519. In addition to the explanation contained in the original budget narrative, Operating Expenses were increased by \$5,919 as follows:
 - a. Travel Expenses – includes an increase of \$700 to \$2,900 to account for the actual mileage driven to attend meetings and perform program activities.
 - b. Training – includes an increase of \$500 to \$1,200 to account for more than expected tuition and registration costs for program training.
 - c. Office Supplies – includes an increase of \$2,750 to \$4,250 to account for actual costs for production of pamphlets and letters for providers, clients, schools, and community agencies.
 - d. Communications – includes a decrease of \$231 for unused costs.
 - e. Equipment lease – includes an increase of \$1,200 to \$2,700 for actual costs incurred for leasing/maintenance of copier/fax.
 - f. Space Rental – includes an increase of \$1,000 to \$2,500 for costs for additional space acquired.
3. Indirect Expenses total \$21,558. Indirect Expenses were decreased by \$903. These funds will be unused and redirected to Operating Expenses category as noted in 2. Above.

SECTION 7 – CHDP SPECIAL PROJECTS

Submitting a Special Project Request	2
CHDP Special Project Request Form	3
CHDP Special Project Scope of Work.....	4
Letters of Support.....	5
CHDP Special Project Budgets	5
Special Project Budget Instructions	5
Special Project Invoice Instructions	5
CHDP Special Project Budget.....	6
CHDP Quarterly Special Project Expenditure Invoice	7
Tips on Writing Measurable Objectives	8
Definition of Objectives	8
Guidelines for Stating Objectives.....	8
Examples of Objectives	9

Local CHDP programs have the opportunity to request funds during the program year for multidisciplinary and collaborative projects with regional and statewide applications that extend the purposes of the CHDP program. The availability of funds for these projects varies from year to year.

Special project requests are developed and implemented with collaboration of designated CMS Branch consultant staff. Concepts for special projects should first be shared with Regional Operations Section (ROS) regional program consultants or statewide specialty consultants, who will seek support from section management prior to further project development. Any product developed as a result of a special project is the property of the State of California.

Funds for special projects are approved separately from the local CHDP annual allocation plan and budget. Existing or new program staff and related expenses, and equipment are not funded by the special project funds. Continuation of a special project from one fiscal year to the next is based on available funds.

Submitting a Special Project Request

After the concept is approved by the CMS Branch, a formal request can be made by completing and submitting the following items:

- Request Form (page 3)
- Scope of Work (page 4)
- Letters of Support (page 5)
- Budget Worksheet (page 6)

The original and two copies of the request package should be submitted to the Regional Operations Section Chief with copies sent to collaborating CMS Branch consultant staff.

CHDP Special Project Request Form

1. Name of County/City CHDP Program _____
2. Name of Special Project Coordinator _____
3. Job Title of Special Project Coordinator _____
4. Title of Special Project _____
5. Time Period for Special Project _____
6. Amount of Funds Requested _____
7. Collaborating CHDP Programs _____
8. Using a separate sheet(s) of paper, describe the following:
 - The overall project, including what is unique about this project and not met in the CMS Scope of Work,
 - The problems/needs that this project will address, including targeted population(s), such as clients or providers,
 - The collaborative efforts with other local CHDP programs,
 - The expected outcomes for regional or statewide populations, and
 - The mechanisms for evaluating this project.
9. Signatures and Certification: We understand that this special project will be the property of the State of California.

CHDP Director

Date Signed

CHDP Deputy Director

Date Signed

Special Project Coordinator

Date Signed

CHDP Special Project Scope of Work

Fiscal Year _____

Write measurable objectives to accomplish the Special Project. Under the "Activities to Achieve Objective" column identify staff who have lead responsibilities as well as staff from other program(s) collaborating on the project.

Measurable Objective	Relates to which CMS Goal(s) (I-IV)	Activities to Achieve Objective	Start Date	End Date	Extent to which Objective/Activities Achieved

Letters of Support

Provide letters of support from other local CHDP programs that demonstrate their willingness to participate in the special project and/or describe the need for the special project in their local health jurisdiction. Letters of support should identify the name of the contact person for the local program and describe his or her role in the development and implementation of the project. Include letters of support from other agencies or managed care plans that will be impacted by the special project.

Letters should be addressed to the local CHDP program Deputy Director or special project coordinator who will submit the letters as part of the Special Project Request package.

CHDP Special Project Budgets

Special Project Budget Instructions

Prepare a separate budget sheet for each special project request using the budget format on page 6. Include a justification for each line item on a budget justification worksheet. General budget policies can be found in Section 6 – Budget Instructions.

The types of items under Operating Expense may include, but are not limited to, printing or copying costs, graphics, media, language translation services, distribution costs, shipping and handling, computer software, field testing and revisions. New or existing program staff, benefits, travel, and training are not funded through special projects. Indirect expenses are only to be included if the county/city applies its cost ratio to all direct costs.

Special Project Invoice Instructions

In general, follow the guidelines found in Section 8 – Expenditure Claims and Property Management. Enter in the appropriate Total Expenditures column the total of all expenses for that line and complete the Expenditure Grand Total. Complete the Sources of Funds Section using the percentage of state/federal funds provided by the CMS Branch when the project was approved.

Provide the contact name and telephone number of the county/city staff member who is responsible for processing the expenditure invoice. The fiscal officer or a county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the invoice. An original signature is required. Type or print the name and title of the official who signed the invoice.

State of California – Health and Human Services Agency

Department of Health Services – Children's Medical Services

County/City: _____

Fiscal Year: _____

CHDP Special Project Budget

Name of Special Project: _____

Column	1A	1B	1
Category/Line Item	% or FTE	Annual Salary	Total Budget
I. Personnel Expenses			
Total Salary and Wages			
Less Salary Savings			
Net Salaries and Wages			
Staff Benefits (%)			
Total Personnel Expenses			
II. Operating Expenses			
Total Operating Expenses			
III. Capital Expenses			
Total Capital Expenses			
IV. Indirect Expenses			
Internal			
External			
Total Indirect Expenses			
V. Other Expenses			
Total Other Expenses			
BUDGET GRAND TOTAL			

Prepared By _____ Date Prepared _____ Phone Number _____

CHDP Director or Deputy Director _____ Date Signed _____ Phone Number _____

State of California – Health and Human Services Agency

Department of Health Services – Children's Medical Services

County/City: _____

Fiscal Year: _____

Quarter Ending: _____

CHDP Quarterly Special Project Expenditure Invoice

Name of Special Project: _____

Category/Line Item	Total Expenditures
I. Total Personnel Expenses	
II. Total Operating Expenses	
III. Total Capital Expenses	
IV. Total Indirect Expenses	
V. Total Other Expenses	
EXPENDITURE GRAND TOTAL	

Source of Funds			
State Funds			
Federal (Title XIX)			

Prepared By _____ Date Prepared _____ Phone Number _____

CERTIFICATION: I hereby certify under penalty of perjury that these are actual expenditures (based on county/city records) incurred during the time period specified above, and that they comply with all laws and regulations governing this program.

CHDP Director _____ Date Signed _____ Phone Number _____

CHDP Deputy Director _____ Date Signed _____ Phone Number _____

Tips on Writing Measurable Objectives

The following description is taken from material developed by Stanford Center for Research in Disease Prevention and is provided as a resource only.

Definition of Objectives

Objectives are specific indicators of program goals. They define the necessary steps for reaching the goal. Objectives state a specific result within an identifiable time frame.

Objectives are outcomes of program activities (actions), and should not be confused with the activities themselves. Moreover, objectives should not be confused with goal statements, which are long-range anticipated results or consequences. For example, a goal to make domestic violence socially unacceptable.

It is important to break project goals into specific objectives so that everyone clearly understands what needs to be done, and when. The assumption is that if each objective is achieved, it contributes to the accomplishment of the overarching goal.

Developing measurable objectives requires time, systematic thinking, and a thorough understanding of your goals. The process may seem time-consuming, but will allow for smooth implementation and evaluation. In addition, developing specific, measurable objectives allow staff and volunteers to maintain a sharp focus on their commitments, and show how activities relate to desired outcomes.

Guidelines for Stating Objectives

The following are some simple questions that each objective statement should answer:

- What (measurable) change or benefit is expected?
- Who is expected to change or benefit?
- How much change or benefit is expected?
- When is the change or benefit expected to happen?

A helpful rule for writing objectives is that they should be "SMART"

Specific

Measurable

Achievable

Reachable

Time-bound

Use these verbs to help decide whether a statement is an objective or not:

Objectives	Not Objectives (Activities or Actions)
<ul style="list-style-type: none">• To increase	<ul style="list-style-type: none">• To provide
<ul style="list-style-type: none">• To decrease	<ul style="list-style-type: none">• To establish
<ul style="list-style-type: none">• To reduce	<ul style="list-style-type: none">• To create
<ul style="list-style-type: none">• To change	<ul style="list-style-type: none">• To assess

Examples of Objectives

Here is an example of a poorly defined objective: "To raise community awareness of domestic violence."

Measurement concerns with this objective include:

- What is awareness - how will you know it when you see it?
- How is community defined - adults, youth, geographic boundaries, etc.?
- What does "raise" mean - what is the baseline, and how much improvement is anticipated?
- How will this objective be met - via a media campaign, a school program, etc.?
- When is the anticipated change supposed to occur?

Here is an example of a **well-defined objective**:

At the conclusion of the two-day relationship skills class, at least 80 percent of the junior high school participants will be able to demonstrate non-violent interpersonal skills in role-play scenarios.

This objective tells us that there is a commitment to communicating certain information in a specific way to a group of learners, and that the learners will have demonstrated acquisition of new information during a certain time period.

SECTION 8 – EXPENDITURE CLAIMS AND PROPERTY MANAGEMENT

SECTION 8 – EXPENDITURE CLAIMS AND PROPERTY MANAGEMENT 1

General Information and Requirements for Children's Medical Services (CMS) Quarterly
Administrative Expenditure Invoices2

CHDP Quarterly Administrative Expenditure Invoice Instructions5

HCPCFC Quarterly Administrative Expenditure Invoice Instructions..... 14

Instructions for Preparation of Child Health and Disability Prevention (CHDP) Program Foster
Care Quarterly Administrative Expenditure Invoice 18

CCS QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS22

CCS ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS (SUPPLEMENTAL A) ...37

CCS ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS (SUPPLEMENTAL B) ...52

CCS DIAGNOSTIC, TREATMENT, AND THERAPY EXPENDITURE REPORTING.....67

 PART I. SUMMARY REPORT OF DIAGNOSTIC AND TREATMENT EXPENDITURES ..67

 PART II. SUMMARY REPORT OF THERAPY EXPENDITURES 70

CCS INSTRUCTIONS FOR CCS CLAIM FOR REIMBURSEMENT85

CCS INSTRUCTIONS FOR CCS HEALTHY FAMILIES (HF)87

Quarterly Report of Expenditures87

Management of Equipment Purchased with State Funds.....90

Equipment Identification Tag Transmittal Letter95

General Information and Requirements for Children's Medical Services (CMS) Quarterly Administrative Expenditure Invoices

- I. The quarterly administrative expenditure invoice forms contain the same five line items used in the budgets.
- II. Counties/cities are **not** required to submit expenditure justification worksheets with quarterly administrative invoices. However, justification worksheets and/or documentation of how expenditure amounts were derived must be maintained at the county/city level for audit purposes.
- III. Quarterly expenditure invoices for salaries and wages must be supported by time studies or attendance documentation maintained at the county/city level for audit purposes. Documentation for staff who qualify for enhanced federal funding and/or who work on more than one program must include quarterly time studies at a minimum, prepared for each budgeted position using the same representative month each quarter. (See Section 9).
- IV. Tools for using time study information to allocate personnel services and benefits expenses are included in References, Section 9.
- V. Overhead costs submitted on the quarterly invoices must be consistent with the county/city cost allocation plans for the approved invoicing period. Internal overhead costs must be prepared in accordance with the Office of the Assistant Secretary, Comptroller (OASC) 10 federal guidelines. External overhead costs invoiced for reimbursement must be based on the plan approved by the State Controller's Office (A-87 approval letter). Documentation must be maintained by the county/city for audit purposes.
- VI. Invoices must list **actual** expenditures made during the quarter for items approved in the budget justification worksheet, with the following exceptions:
 - A. Indirect costs are approved estimates for invoicing purposes based on federal OASC-10 cost allocation methods.
 - B. Staff benefits may be invoiced at an estimated rate for three quarters but must be adjusted to actual costs on the fourth quarter invoice.
 - C. Counties may not invoice for goods (e.g., equipment, printing, videos, etc.) until after they have actually been received. Budgeted goods that are supported by a purchase order, issued in the budget and for which funds are encumbered may not be received until the following fiscal year. These costs may be included on the fourth quarter invoice or submitted on a supplemental invoice for the fiscal year in which they were encumbered.
- VII. For questions concerning the appropriate line item usage for an expense, refer to Section 6 for the definitions of the five line item categories listed on the quarterly invoice or contact the regional administrative consultant/analyst.
- VIII. Round all figures to the nearest whole dollar; 50 cents or more is rounded up, and 49 cents and less is rounded down.

- IX. Quarterly invoices for expenditures authorized in CMS budgets shall be submitted no later than 60 days after the end of each quarter.
- A. First quarter invoice (time period of July 1 through September 30) is due by November 30.
 - B. Second quarter invoice (time period of October 1 through December 31) is due by February 28.
 - C. Third quarter invoice (time period of January 1 through March 31) is due by May 31.
 - D. Fourth quarter invoice (time period of April 1 through June 30) is due by August 31.
 - E. Supplemental invoices will only be accepted up to six months after the close of the fiscal year for which they apply. The fiscal year ends June 30; therefore December 31 would be the last day to submit supplemental invoices for any given fiscal year.
- X. Headings on invoices must contain the identification items identified below. Additional information as identified in the specific and separate California Children's Services (CCS) or Child Health and Disability Prevention (CHDP) instructions must also be provided:
- A. Program name (i.e., CCS, CHDP)
 - B. Name of county or city
 - C. Fiscal year of invoicing period
 - D. Quarter ending date
 - Quarter 1 ends September 30;
 - Quarter 2 ends December 31;
 - Quarter 3 ends March 31; and
 - Quarter 4 ends June 30.
- XI. **Signature/Certification blocks** must contain at a minimum the following, with additional information as identified in the specific and separate CCS or CHDP instructions:
- A. Contact person name and telephone number.
 - B. Signatures of authorized officials certifying the accuracy of the expenditures reported.
 - C. Date signed.

NOTE: Invoices submitted without signatures will be returned for authorized signatures before being processed for payment. Original signatures are required. Signature stamps are not acceptable.

- XII. Invoices that exceed budgeted funding sources, or do not compute, will be returned to the appropriate county for corrections.
- XIII. Agencies are responsible for federal audit exceptions and must notify the State in the event any exceptions are found.
- XIV. Numbered Letter 01-0106, California Children's Services (CCS) Expenditure Reporting to the California Department of Finance (DOF) for the purpose of Calculation of Realignment Caseload Growth, provided information on the development of the annual realignment caseload growth schedule by the California Department of Finance for programs covered by the State Local Program Realignment Initiative of 1993 which participates in caseload growth funding from the Caseload Sub-Account of the Sales Tax Growth Account of the Local Revenue Fund.

Starting with the 2006 reporting cycle, for the purpose of reporting county CCS program expenditures to DOF for calculation of Realignment Caseload Growth, a cut-off date has been established for receipt of quarterly county CCS program diagnosis, treatment, and therapy expenditure reports that will be included in the calculation of CCS services costs included in the caseload growth expenditures that will be reported to DOF for the reporting period.

For fiscal year (FY) 2006-07 expenditures which will be reported to DOF for the FY 2007-08 Realignment Caseload Growth calculations, the cut-off for receiving the diagnosis, treatment, and therapy expenditure reports will be December 31, 2007. The FY 2006-07 county expenditures reported after that date will not be reported to DOF. The CMS Branch will continue to receive and reconcile CCS overdue expenditure reports for purposes of State/County share of cost determination after the cut-off, but this late data will not be reported to DOF and will not be included in DOF's caseload growth calculation for the reporting period.

- XV. All invoices and supporting documentation should be submitted to:

California Department of Health Care Services
Children's Medical Services Branch
Program Support Section – Administration Unit
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

CHDP Quarterly Administrative Expenditure Invoice Instructions

The CHDP Quarterly Administrative Expenditure Invoice (No County/City Match) form is in Section 8, page 12. The CHDP Quarterly Administrative Expenditure invoice (County/City Match) form is in Section 8, page 13. All invoices must be prepared in accordance with these instructions in order to receive reimbursement for county/city administrative expenditures.

I. Instructions for Preparation of CHDP Quarterly Administrative Expenditure Invoices (No County/City Match)

CHPD administrative expenditures are reimbursed according to the individual county/city percentages of the Medi-Cal and non-Medi-Cal portions of the approved program's budget.

An exception to the application of the non-Medi-Cal percentage is for an expense qualifying as 100 percent Medi-Cal funded, i.e., costs of services exclusively for Medi-Cal eligibles. A county/city program having a category or line item that includes expenses designated as 100 percent Medi-Cal must asterisk (*) the category, footnote the specific amount and have supporting documentation on file. All other expenses must have the non-Medi-Cal percentage rate of the individual county/city approved budget applied to distribute the Medi-Cal and non-Medi-Cal share of the expenses.

Column 1 will always be the sum of Column 2 and Column 3 for each category/line item. Column 3 will always be the sum of Column 4 and Column 5 for each applicable category/line item.

A. Category/Line Item

1. (I.) Total Personnel Expenses

Enter the total amount for "Personnel Expenses" for the quarter being claimed on this line in Column 1. This amount is the total amount for all employees performing activities for the program as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the total of non-Medi-Cal personnel services claimed in Column 2. This number is derived by multiplying the total expenditures for personnel services in Column 1 by the percentage of the non-Medi-Cal share on the approved budget.

Enter the total amount of personnel services expenditures claimed for reimbursement from Medi-Cal in Column 3. This number is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for personnel expenses.

Enter the total amount of Medi-Cal personnel services claimed for enhanced funds in Column 4 and the total amount claimed for non-enhanced funds in Column 5. These amounts are calculated using time study percentages and other applicable documentation.

2. (II) Total Operating Expenses

Enter in Column 1 on this line, the total of all operating expenses.

Enter the non-Medi-Cal amount claimed of operating expenses in Column 2. This amount is derived by multiplying the Total Operating Expenses in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for operating expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for operating expenses.

Enter the total amount of enhanced operating expenses claimed in Column 4 and enter the non-enhanced operating expenses claimed in Column 5.

NOTE: Only travel and training expenses may qualify as operating expenses in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. (III) Total Capital Expenses

Enter in Column 1, the total of all capital expenses. The definitions of equipment and prerequisites for reimbursement are found in Section 8, page 90.

Enter in Column 2, the amount of non-Medi-Cal capital expenses. This amount is derived by multiplying the Total Capital Expenses amount in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for capital expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for Capital Expenses.

Enter the Capital Expenses amount from Column 3 into Column 5, non-enhanced.

4. (IV) Total Indirect Expenses

Enter in Column 1, the total of all Indirect Expenses.

Enter the amount of non-Medi-Cal indirect expenses in Column 2. This amount is derived by multiplying the total indirect expenses amount in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

Enter the Medi-Cal amount for indirect expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount entered in Column 1 for the indirect expenses.

Enter the indirect expenses amount from Column 3 in Column 5, non-enhanced.

5. (V) Total Other Expenses

Enter the total of all other expenses on this line in Column 1.

Enter in Column 2, the non-Medi-Cal other expenses. This amount is derived by multiplying the total Other Expenses amount in Column 1 by the percentage of the non-Medi-Cal share of the approved budget.

Enter the Medi-Cal amount claimed for other expenses in Column 3. This amount is derived by subtracting the amount in Column 2 from the amount in Column 1 for Other Expenses.

Enter the amount claimed for Other Expenses from Column 3 into Column 5, non-enhanced.

6. Expenditure Grand Total

Add the totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses for each column, and enter the amounts on this line.

B. Source of Funds

1. State

Enter the amount for State in Column 2. This amount is the same as the Expenditure Grand Total amount for TOTAL CHDP Non Medi-Cal.

2. Medi-Cal Funds

The Medi-Cal Funds under the Source of Funds are calculated beginning with Column 4, Enhanced State/Federal and Column 5, State/Federal.

a. Enhanced State/Federal

Multiply the Expenditure Grand Total line of Column 4, Enhanced by 25 percent and enter this amount on the State Funds line in Column 4.

Subtract the amount of State Funds for Column 4, Enhanced from the Expenditure Grand Total line of Column 4 and enter this amount on the Federal Funds line in Column 4.

b. Non-Enhanced State/Federal

Multiply the Expenditure Grand Total line of Column 5, Non-Enhanced by 50 percent and enter this amount on the State Funds line for Column 5.

Subtract the amount of State Funds for Column 5, Non-Enhanced from the Expenditure Grand Total line of Column 5 and enter this amount on the Federal Funds line in Column 5.

c. Total Medi-Cal Funds

Enter in Column 3 on the State Funds line the total of Column 4 and Column 5, State Funds.

Enter in Column 3 on the Federal (Title XIX) Funds line the total of Column 4 and Column 5, Federal (Title XIX) Funds.

3. Total Funds

Enter in Column 1, Total Funds for the State Funds (non-Medi-Cal) line, the same amount as entered in Column 2, Total CHDP Funds.

Add Columns 4 and 5 together for the State Funds line under Medi-Cal Funds and enter the total in Column 3, total Medi-Cal and Column 1, Total Funds.

Add Columns 4 and 5 together for the Federal (Title XIX) Funds line and enter the total in Column 3, Total Medi-Cal Funds, and Column 1, Total Funds.

NOTE: The totals of funding amounts entered under each column in the "Source of Funds" section must agree with the totals for the same column entered on the "Expenditure Grand Total" line.

C. Certification and Signatures

Provide the contact name and telephone number of the county/city staff who is responsible for processing the invoice form.

The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice.

Print or type the name and title of the official who signed the invoice.

Submit all invoices with original signatures. Signature stamps are not acceptable. Additional copies are not necessary.

All invoices and supporting documentation that justifies the expenditures should be submitted to:

California Department of Health Care Services
Children's Medical Services Branch
Program Support Section – Administration Unit
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

II. Instructions for Preparation of the CHDP Quarterly Administrative Expenditure Invoice Form (County/City Match)

The county/city match invoice for expanded services for Medi-Cal recipients is 100 percent county/city funds with federal fund match. No State funds are included on this invoice.

A. Category/Line Item

1. (I) Total Personnel Expenses

Enter the total amount of "Personnel Expenses" for the quarter being claimed on this line in Column 1. This amount is the total amount for all employees performing activities for the program as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, overtime, and temporary help.

Enter the total amount of personnel expenses invoiced in Column 2 for enhanced funding and the total amount invoiced in Column 3 for non-enhanced funding. These amounts are calculated using time study percentages and other applicable documentation.

2. (II) Total Operating Expenses

Enter in Column 1, the total of all operating expenses.

Enter the total amount of enhanced operating expenses claimed in Column 2 and enter the non-enhanced operating expenses claimed in Column 3.

NOTE: Only travel and training expenses may qualify as operating expenses for enhanced funding, and only when claimed by an SPMP following specific FFP guidelines (See Section 9).

3. (III) Total Capital Expenses

Enter the total Capital Expenses on this line in Column 1 and Column 3. The definitions of equipment and prerequisites for reimbursement are found in Section 8, page 90.

4. (IV) Total Indirect Expenses

Enter the total Indirect Expenses on this line in Column 1 and Column 3.

5. (V) Total Other Expenses

Enter the total other expenses on this line in Column 1 and Column 3.

6. Expenditure Grand Total

Add the totals for Personnel Expenses, Operating Expenses, Capital Expenses, Indirect Expenses, and Other Expenses for each column, and enter the amounts on this line.

B. Source of Funds.

1. County/City Funds

County/city expenditures must meet the Federal Title XIX funding match requirements to obtain this reimbursement but county/city matching funds are not reimbursed. Therefore, a county/city fund line is not completed on the invoice form.

2. Federal (Title XIX) Funds

a. Enhanced Funds

Multiply the Enhanced "Expenditure Grand Total" amount (Column 2) by 75 percent. Enter the amount on the "Federal (Title XIX) Funds" line, Enhanced, in the "Source of Funds" section.

b. Non-Enhanced Funds

Multiply the non-enhanced "Expenditure Grand Total" amount (Column 3) by 50 percent. Enter this amount on the "Federal (Title XIX) Funds" line, non-enhanced, in "Source of Funds" section.

c. Total Funds

Add Columns 2 and 3 together for the Federal (Title XIX) Funds line and enter the total in Column 1, Total Funds.

C. Certification and Signatures

Provide the contact name and telephone number of the county/city staff who is responsible for processing the CHDP Quarterly Administrative Expenditure Invoice form.

The fiscal officer or a county official with the authority to certify the invoice on behalf of the county does so by signing and dating the invoice.

Print or type the name and title of the official who signed the invoice.

Submit all invoices with original signatures. Signature stamps are not acceptable. Additional copies are not necessary.

All invoices and supporting documentation that justifies the expenditures should be submitted to:

California Department of Health Care Services
Children's Medical Services Branch
Program Support Section – Administration Unit
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health & Human Services Agency
 _____ COUNTY/CITY

Department of Health Care Services - Children's Medical Services
 QUARTER ENDING: _____

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
 (No County / City Match)
 FISCAL YEAR _____

MONTH/DATE/YEAR

CATEGORY/LINE ITEM	TOTAL EXPENDITURES (COLUMNS 2 + 3)	TOTAL CHDP <i>Non -Medi-Cal</i>	TOTAL MEDI-CAL (COLUMNS 4 + 5)	ENHANCED STATE/FEDERAL 25/75	NONENHANCED STATE/FEDERAL 50/50
COLUMN	1	2	3	4	5
I. TOTAL PERSONNEL EXPENSES					
II. TOTAL OPERATING EXPENSES					
III. TOTAL CAPITAL EXPENSES					
IV. TOTAL INDIRECT EXPENSES					
V. TOTAL OTHER EXPENSES					
EXPENDITURE GRAND TOTAL					

SOURCE OF FUNDS	TOTAL FUNDS	TOTAL CHDP	TOTAL MEDI-CAL	ENHANCED STATE/FEDERAL	NONENHANCED STATE/FEDERAL
COLUMN	1	2	3	4	5
STATE GENERAL FUNDS					
MEDI-CAL FUNDS:					
STATE					
FEDERAL (TITLE XIX)					

Prepared By _____ Date _____ Telephone Number _____

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

CHDP Director/Deputy Director _____ Date _____

 Type or Print Name and Title of Signer

Revision Date: February 2007

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health & Human Services Agency
 _____ COUNTY/CITY

Department of Health Care Services - Children's Medical Services
 QUARTER ENDING: _____

CHDP QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE
 (County / City Match)
 FISCAL YEAR _____

MONTH/DATE/YEAR

CATEGORY/LINE ITEM COLUMN	TOTAL EXPENDITURES (COLUMNS 2 + 3) 1	ENHANCED STATE/FEDERAL 25/75 2	NONENHANCED STATE/FEDERAL 50/50 3
I. TOTAL PERSONNEL EXPENSES			
II. TOTAL OPERATING EXPENSES			
III. TOTAL CAPITAL EXPENSES			
IV. TOTAL INDIRECT EXPENSES			
V. TOTAL OTHER EXPENSES			
EXPENDITURE GRAND TOTAL			

SOURCE OF FUNDS COLUMN	TOTAL FUNDS 1	ENHANCED COUNTY/FEDERAL 2	NONENHANCED COUNTY/FEDERAL 3
FEDERAL (TITLE XIX)			

Prepared By _____

Date _____

Telephone Number _____

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

CHDP Director/Deputy Director _____

Date _____

Print or Type Name and Title of Signer _____

Revision Date: February 2007

HPCFC Quarterly Administrative Expenditure Invoice Instructions

In order to receive reimbursement for Health Care Program for Children in Foster Care (HPCFC) expenditures, the Quarterly HPCFC Administrative Expenditure Invoice must be prepared in accordance with the following instructions. The HPCFC Quarterly Administrative Expenditure Invoice form is found in Section 8, page 17.

The HPCFC Quarterly Administrative Expenditure Invoice (No County/City Match) instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Signature sections of the invoice form. Local county and city Child Health and Disability Prevention (CHDP) programs administering the HPCFC are reimbursed for the actual administrative costs according to the amount of State General Funds and Federal Funds (Title XIX) on the invoice form. General information about Children's Medical Services Quarterly Administrative invoices is in Section 8, page 2.

A. Category/Line Item

1. Total Personnel Expenses (see I. Total Personnel Expenses on the invoice form).

Enter the total amount of Personnel Expenses for the quarter in Column 1. This is the total expenditure for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

Enter the total amount of state and federal funds at the enhanced percentage in Column 2.

Enter the total amount of state and federal funds at the non-enhanced percentage in Column 3.

The amount of enhanced and non-enhanced percentages are calculated using completed time study documents and other applicable documentation.

The Total Invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

2. Total Operating Expenses (see II. Total Operating Expenses on the Invoice form)

Enter the total amount of state and federal funds for the quarter in Column 1.

Enter the total amount of enhanced travel and training expenses in Column 2.

Enter the non-enhanced travel and training expenses in Column 3.

The Total Invoiced amount in Column 1 is the sum of the amounts in Columns 2 and 3.

NOTE: Only travel and training expenses may qualify in the enhanced funding category, and only when claimed for Skilled Professional Medical Personnel

(SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. Total Capital Expenses (see the shaded area III. Total Capital Expenses on the invoice form.)

Total Capital Expenses are not allowed on the HCPCFC Administrative Budget.

4. Total Indirect Expenses (see IV. Total Indirect Expenses on the Invoice form).

Indirect expenses are non-enhanced; they may not be claimed at the enhanced rate.

Enter the total of internal indirect expenses for the quarter in Columns 1 and 3.

The Total Invoiced amount in Column 1 is the same as the amount in Column 3.

5. Total Other Expenses (see the shaded area V. Total Other Expenses on the invoice form).

Total Other Expenses are not allowed on the HCPCFC Administrative Budget.

6. Expenditure Grand Total (see Expenditure Grand Total on the Invoice form).

Enter the sum of the Total Personnel Expenses, Operating Expenses, and Indirect Expenses in Column 1 in the Expenditure Grand Total at the bottom of Column 1 on the invoice form.

B. Source of Funds

1. State

Enter the amount of state general funds expended for this quarter in Column 1.

The Total State General Funds in Column 1 is the sum of the amounts in Columns 2 and 3.

2. Federal

Enter the amount of federal funds (Title XIX) expended for this quarter in Column 1.

The Total Federal Funds (Title XIX) is the sum of the amounts in Columns 2 and 3.

- a. Enhanced State/Federal (Column 2, Source of Funds)

Multiply the Expenditure Grand Total line of Column 2, by 25 percent. Enter this amount in the State Funds line of Column 2.

Subtract the amount of State Funds in Column 2, from the Expenditure Grand Total line of Column 2. Enter this amount in the Federal Funds (Title XIX) line in Column 2.

b. Non-Enhanced State/Federal (Column 3, Source of Funds)

Multiply the Expenditure Grand Total line of Column 3 by 50 percent. Enter this amount in the State Funds line of Column 3.

Subtract the amount of State Funds in Column 3, from the Expenditure Grand Total line of Column 3. Enter this amount in the Federal Funds (Title XIX) line in Column 3.

c. Expenditure Grand Total (Column 1, Source of Funds)

Enter in Column 1 the total of Column 2 and Column 3, in the County/City Funds line.

Enter in Column 1 the total of Column 2 and Column 3, in the Federal Funds (Title XIX) line.

NOTE: The totals of funding amount entered under each column in the "Source of Funds" section must agree with the totals for the same column entered on the Expenditure Grand Total line.

C. Certification and Signatures

Enter the name and telephone number of the staff person responsible for preparing the HCPCFC Quarterly Administrative Expenditure Invoice form.

The county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the completed invoice.

Submit all invoices with original signatures. Signature stamps are not acceptable. Additional copies are not necessary.

All invoices and supporting documentation that justifies the expenditures should be submitted to:

California Department of Health Care Services
Children's Medical Services Branch
Program Support Section – Administration Unit
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

State of California – Health and Human Services Agency

Department of Health Care Services – Children's Medical Services Branch

Quarter ending: _____

month/date/year

HCPCFC Quarterly Administrative Expenditure Invoice

Fiscal Year _____

County/City Name: _____

Column	1	2	3
Category/Line Item	Total Invoiced (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses			
II. Total Operating Expenses			
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
Expenditure Grand Total			

Column	1	2	3
Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
State Funds			
Federal Funds (Title XIX)			
Expenditure Grand Total			

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By _____ Date _____ Telephone Number _____

CHDP Director or Deputy Director _____ Date _____ Telephone Number _____
(Signature)

Revised February 2007

Instructions for Preparation of Child Health and Disability Prevention (CHDP) Program Foster Care Quarterly Administrative Expenditure Invoice

In order to receive reimbursement for the CHDP Program Foster Care expenditure, the Quarterly Foster Care Administrative Expenditure Invoice must be prepared in accordance with the following instructions. The Foster Care Quarterly Administrative Expenditure Invoice form is in Section 8, page 21.

The CHDP Foster Care Quarterly Administrative Expenditure Invoice (County/City Match) Instructions provide information and directions for the completion of the Category/Line Item, Source of Funds, and Certification and Signature sections of the Invoice form. Local county and city CHDP Programs administering the CHDP Foster Care Administrative Budget (County/City Match) are reimbursed for the actual administrative costs according to the amount of County/City Funds and Federal Funds (Title XIX) on the Invoice form. General information about Children's Medical Services Quarterly Administrative Invoices is in Section 8, page 2, Plan and Fiscal Guidelines Manual.

The CHDP Foster Care Administrative Budget (County/City Match) is an optional budget to fund PHN and SPHN staff working in support of children and youth in out-of-home placement or foster care. Local county/city funds may be matched with federal funds (Title XIX) for this budget. No state general funds are used in this budget or included on the CHDP Foster Care Administrative Expenditure Invoice form.

A. Category/Line Item

1. Total Personnel Expenses (see I. Total Personnel Expenses on the Invoice form).

Enter the total amount of Personnel Expenses for the quarter in Column 1. This amount is the total amount for all employees performing program activities as supported by time study, attendance, and payroll records. The total should include all related salaries and wages, staff benefits, and overtime.

Enter the total amount of county/city and federal funds at the enhanced percentage in Column 2.

Enter the total amount of county/city and federal funds at the non-enhanced percentage in Column 3.

The amount of enhanced and non-enhanced percentages is calculated using completed time study documents and other application documentation.

2. Total Operating Expenses (see II. Total Operating Expenses on the Invoice form).

Enter the total amount of operating expenses for the quarter in Column 1.

Enter the total amount of enhanced operating expenses in Column 2.

Enter the non-enhanced operating expenses in Column 3.

NOTE: Only travel and training expenses may qualify as operating expense for enhanced funding, and only when claimed by a Skilled Professional Medical Personnel (SPMP) following specific Federal Financial Participation (FFP) guidelines (see Section 9).

3. Total Capital Expenses (see the shaded area III. Total Capital Expenses on the Invoice form).

Total Capital Expenses are not allowed on this budget.

4. Total Indirect Expenses (see IV. Total Indirect Expenses on the Invoice form).

Indirect expenses are limited to a maximum of 10 percent of the Total Personnel Expenses.

External – External Indirect Expenses are not allowed on this budget.

Enter the total amount of indirect expenses for the quarter on this line in Column 1 and Column 3.

5. Total Other Expenses (see the shaded area V. Total Other Expenses on the Invoice form).

Total Other Expenses are not allowed on this budget.

6. Expenditure Grand Total

Enter the sum of the Total Personnel Expenses, Operating Expenses, and Indirect Expenses in Column 1 in the Expenditure Grand Total at the bottom of Column 1 on the Invoice form.

B. Source of Funds

1. County/City Funds

County/city expenditures must meet the federal funds (Title XIX) funding match requirements to obtain this reimbursement. The county/city matching funds are not reimbursed but must be shown on the invoice.

2. Federal Funds (Title XIX)

- a. Enhanced Funds

Multiply the Enhanced Expenditure Grand Total amount (Column 2) by 75 percent. Enter the amount on the federal funds (Title XIX) line, Enhanced, in the Source of Funds section.

- b. Non-Enhanced Funds

Multiply the non-enhanced Expenditure Grand Total amount, Column 3, by 50 percent. Enter this amount on the Federal Funds (Title XIX) line, non-enhanced in Source of Funds section.

c. Total Funds

Add Columns 2 and 3 together for the Federal Funds (Title XIX) line and enter the total in Column 1, Total Funds.

C. Certification and Signatures

Enter the name and telephone number of the staff person responsible for preparing the Foster Care Administrative Expenditure Invoice form.

The county/city official with the authority to certify the invoice on behalf of the county/city does so by signing and dating the completed invoice.

Submit all invoices with original signatures. Signature stamps are not acceptable. Additional copies are not necessary.

All invoices and supporting documentation that justifies the expenditures should be submitted to:

California Department of Health Care Services
Children's Medical Services Branch
Program Support Section – Administration Unit
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

State of California – Health and Human Services Agency

Department of Health Care Services – Children's Medical Services Branch

Quarter ending: _____

month/date/year

CHDP Foster Care Quarterly Administrative Expenditure Invoice

Fiscal Year _____

County/City Name: _____

Column	1	2	3
Category/Line Item	Total Invoiced (2 + 3)	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
I. Total Personnel Expenses			
II. Total Operating Expenses			
III. Total Capital Expenses			
IV. Total Indirect Expenses			
V. Total Other Expenses			
Expenditure Grand Total			

Column	1	2	3
Source of Funds	Total Funds Invoiced	Enhanced State/Federal (25/75)	Nonenhanced State/Federal (50/50)
County-City Funds			
Federal Funds (Title XIX)			
Expenditure Grand Total			

Source City-County Funds:

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By _____ Date _____ Telephone Number _____

CHDP Director or Deputy Director _____ Date _____ Telephone Number _____
(Signature)

Revised February 2007

CCS QUARTERLY ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS

INITIAL INVOICE INSTRUCTIONS

Beginning in fiscal year (FY) 2006-07, the terminology for caseload changed to “eligible months”. **However, the word caseload will be seen throughout the Plan and Fiscal Guidelines manual as this is the terminology that is most familiar to the previous users of this manual.**

Caseload in FY 2007-08 will be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS)/Medi-Cal client.
- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

There are two reports that can be accessed to calculate “eligible months” for caseload. There is one report in CMS Net Legacy titled “Monthly Caseload Count Report” (for Medi-Cal and Non-Medi-Cal counts), and the second report is in Business Objects (BO) titled “Healthy Families Caseload Count Report”. In the CMS Net Legacy report the non-Medi-Cal count is both HF and CCS together. Counties need to subtract HF from the total to get the CCS population.

The CMS Net Legacy report has a history so the report “Monthly Caseload Count Report” (Medi-Cal and non-Medi-Cal) can be processed whenever a county needs the information.

However, the HF count in the BO report “Healthy Families Caseload County” only contains information as of the prior day so it is critical for counties to run the report every month to get the HF totals if they want to use BO to retrieve the caseload counts.

This Computes Information Bulletin #167 provides more details regarding these reports. This can be found at:

<http://www.dhs.ca.gov/PCFH/cms/ccs/cmsnet/pdf/thiscomputes/thiscomputes167.pdf>

The eligible month information should be retrieved for each type of case for which a child would be counted, e.g. CCS/Medi-Cal, CCS/HF, and CCS-only. At the end of the three month period the total number of “eligible months” from the three combined reports would need to be divided by three to achieve the “average caseload” number for the quarter.

An example would be:

- Month One = 150 eligible months
- Month Two = 148 eligible months
- Month Three = 167 eligible months
- TOTAL 465 Eligible Months**

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter.

The Initial Invoice is the first invoice prepared for a quarter that is submitted to the Children's Medical Services (CMS) Branch for reimbursement. This means that no other invoice had been previously submitted to the CMS Branch for this particular quarter.

The following are instructions for the completion of the California Children's Services (CCS) Program Administrative Expenditure Invoice – Initial, which are prepared on a quarterly basis.

Fiscal Year

- 1) Enter the state fiscal year (FY) for which this invoice applies.

County

- 2) Enter the name of the county for which this invoice applies.

Quarter

- 3) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x
Quarter 2: October 1, 200x – December 31, 200x
Quarter 3: January 1, 200x+1 – March 31, 200x+1
Quarter 4: April 1, 200x+1 – June 30, 200x+1

CCS CASELOAD

Column B – Actual Caseload

Medi-Cal Cases

- 4) Enter the Average Total Cases of Open (Active) Medi-Cal Children.

Calculate the average total cases by adding the total cases of open (active) Medi-Cal Children for each month in the quarter and dividing by 3.

- 5) Enter the number of Potential Cases of Medi-Cal Children.
- 6) Enter Total Medi-Cal Cases by adding the Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Non-Medi-Cal Cases: Healthy Families

- 7) Enter the Average Total Cases of Open (Active) Healthy Families (HF) Children.

Calculate the average total cases by adding the total cases of open (active) HF Children for each month in the quarter and dividing by 3.
- 8) Enter the number of Potential Cases of HF Children.
- 9) Enter Total Healthy Families Cases by adding the Average Total Cases of Open (Active) HF Children and the Potential Cases of HF Children.

Non-Medi-Cal Cases: Straight CCS

- 10) Enter the Average Total Cases of Open (Active) Straight CCS Children.

Calculate the average total cases by adding the total cases of open (active) Straight CCS Children for each month in the quarter and dividing by 3.
- 11) Enter the number of Potential Cases of Straight CCS Children.
- 12) Enter Total Straight CCS Cases by adding the Average Total Cases of Open (Active) Straight CCS Children and the Potential Cases of Straight CCS Children.

Total Non-Medi-Cal Cases

- 13) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

- 14) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

Column C – Percent of Grand Total

Medi-Cal Percentages

- 15) Enter the percentage for Average Total Cases of Open (Active) Medi-Cal Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 16) Enter the percentage for Potential Cases of Medi-Cal Children by dividing the number of potential cases entered in Column B by the Total Caseload entered in Column B.
- 17) Enter the Total Percentage for Total Medi-Cal Cases by dividing the Total Medi-Cal Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Healthy Families

- 18) Enter the percentage for Average Total Cases of Open (Active) HF Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 19) Enter the percentage for Potential Cases of HF Children by dividing the number of potential cases entered in Column B by the Total Caseload entered in Column B.
- 20) Enter the Total Percentage for Total HF Cases by dividing the Total HF Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Straight CCS

- 21) Enter the percentage for Average Total Cases of Open (Active) Straight CCS Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 22) Enter the percentage for Potential Cases of Straight CCS Children by dividing the number of potential cases entered in Column B by the Total Caseload entered in Column B.
- 23) Enter the Total Percentage for Total Straight CCS Cases by dividing the Total Straight CCS Cases in Column B by the Total Caseload in Column B.

Total Non-Medi-Cal Cases Percentage

- 24) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

Total Caseload Percentage

- 25) Enter the Total Percentage by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases in Column C.

The Total Caseload Percentage must equal 100 percent.

ADMINISTRATIVE EXPENDITURES

County

- 26) Enter the name of the county for which this invoice applies.

Quarter

- 27) Enter the dates of the quarter for which the invoice applies.

Column C – Total Expenditures

- 28) Enter the total of all expenditures charged during the quarter to each category/line item listed in Column B.
- 29) Enter the Total Expenditures by adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the total of respective amounts in Columns D and G.

Column D – Total Non-Medi-Cal

- 30) Enter the amount of Total Non-Medi-Cal expenditures charged during the quarter to each category/line item listed in Column B.

The amount of Total Non-Medi-Cal expenditures is determined by multiplying the Total Expenditures for each category/line, except Total Other Expenses, in Column B by the percentage for Total Non-Medi-Cal Cases as calculated in step 24 for CCS Caseload.

The percentage for Total Non-Medi-Cal Cases cannot be applied to Total Other Expenses because any expenses for maintenance and transportation (M&T) cannot be distributed by caseload ratios. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the amount of Total Non-Medi-Cal expenditures for Total Other Expenses, use the following formula.

- Subtract all M&T expenditures from Total Other Expenses.
- Multiply the remaining balance by the percentage for Total Non-Medi-Cal Cases.
- To this end result, add the M&T expenditures directly related to non-Medi-Cal clients.
- The subsequent total is the amount of Total Other Expenses for Total Non-Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{r}
 + \quad \text{Total Other Expenses} \\
 - \quad \underline{\text{All M\&T Expenditures}} \\
 = \quad \text{Remaining Balance} \\
 \times \quad \underline{\text{Total Non-Medi-Cal Cases \%}} \\
 = \quad \text{Share of Total Other Expenses for Total Non-Medi-Cal Cases} \\
 + \quad \underline{\text{M\&T Expenditures for Non-Medi-Cal Clients}} \\
 = \quad \text{Amount of Total Other Expenses for Total Non-Medi-Cal Cases}
 \end{array}$$

- 31) Enter the Total Expenditures for Total Non-Medi-Cal expenditures by adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the total of respective amounts in Columns E and F.

Column E – Straight CCS

- 32) Enter the amount of Straight CCS expenditures charged during the quarter to each category/line item listed in Column B.

The amount of Straight CCS expenditures is determined by multiplying the Total Expenditures for each category/line in Column B by the percentage for Total Straight CCS Cases as calculated in step 23 for CCS Caseload.

- 33) Enter the Total Expenditures for Straight CCS by adding all entries in Column E.

Column F – Healthy Families (HF)

- 34) Enter the amount of HF expenditures charged during the quarter to each category/line item listed in Column B.

The amount of HF expenditures is determined by multiplying the Total Expenditures for each category/line in Column B by the percentage for Total HF Cases as calculated in step 20 for CCS Caseload.

- 35) Enter the Total Expenditures for HF by adding all entries in Column F.

Column G – Total Medi-Cal

- 36) Enter the amount of Total Medi-Cal expenditures charged during the quarter to each category/line item listed in Column G.

The amount of Total Medi-Cal expenditures is determined by multiplying the Total Expenditures for each category/line, except Total Other Expenses, in Column B by the percentage for Total Medi-Cal Cases as calculated in Step17 for CCS Caseload.

The percentage for Total Medi-Cal Cases cannot be applied to Total Other Expenses because any expenses for maintenance and transportation (M&T) cannot be distributed by caseload ratios. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the amount of Total Medi-Cal expenditures for Total Other Expenses, use the following formula.

- Subtract all M&T expenditures from Total Other Expenses.
- Multiply the remaining balance by the percentage for Total Medi-Cal Cases.
- To this end result, add the M&T expenditures directly related to Medi-Cal clients.
- The subsequent total is the amount of Total Other Expenses for Total Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{r}
 + \quad \text{Total Other Expenses} \\
 - \quad \text{All M\&T Expenditures} \\
 \hline
 = \quad \text{Remaining Balance} \\
 \times \quad \text{Total Medi-Cal Cases \%} \\
 \hline
 = \quad \text{Share of Total Other Expenses for Total Medi-Cal Cases} \\
 + \quad \text{M\&T Expenditures for Medi-Cal Clients} \\
 \hline
 = \quad \text{Amount of Total Other Expenses for Total Medi-Cal Cases}
 \end{array}$$

- 37) Enter the Total Expenditures for Total Medi-Cal expenditures by adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the total of respective amounts in Columns H and I.

Column H – Medi-Cal Enhanced

- 38) Enter the amount of Medi-Cal Enhanced expenditures charged during the quarter to Total Personnel Expenses and Total Operating Expenses listed in Column B.

The amount of expenditures charged to Personnel Expenses is based on time studies for:

- a. Skilled Professional Medical Personnel (SPMP) who meet the federal education and training requirements and perform activities requiring specialized medical knowledge and skill, and
- b. Clerical staff who directly support and are supervised by the SPMP.

Only training and travel costs for SPMP are allowed as expenditures for Operating Expenses.

Medi-Cal Enhanced **does not** allow expenditures for Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses.

Column I – Medi-Cal Non-Enhanced

- 39) Enter the amount of Medi-Cal non-enhanced expenditures charged during the quarter to each category/line item listed in Column B.

The amount of expenditures charged to each category/line item includes salaries, benefits, travel, training, and other administrative expenses for non-SPMP including, but not limited to, administrators; ancillary staff; clerical staff not providing direct support to, or supervised by, SPMP; and claims processing staff.

Also expenditures for staff hired under contract, including SPMP staff, are to be charged at the non-enhanced rate.

The amount of Medi-Cal Non-Enhanced expenditures for each category/line item listed in Column B is determined by subtracting the entries in Column H from the corresponding entries in Column G.

Maintenance & Transportation (M&T)

- 40) Enter the specific amounts of Total Expenditures, Total Non-Medi-Cal, Straight CCS, HF, and Total Medi-Cal for M&T.

Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and HF.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

SOURCE OF FUNDS

Complete the Non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

Column M – Straight CCS

- 41) Enter the amount of state and county funds that were used to pay straight CCS expenditures.

The funding distribution for straight CCS expenditures is 50 percent state funds and 50 percent county funds.

The amount of state funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

- 42) Enter Total Source of Funds by adding all entries in Column M.

Column N – Healthy Families

- 43) Enter the amount of federal, state, and county funds that were used to pay HF expenditures.

The funding distribution for HF expenditures is 65 percent federal funds (Title XXI), 17.5 percent state funds, and 17.5 percent county funds.

The amount of federal funds (Title XXI) is determined by multiplying the Total Expenditures in Column F by 65 percent.

The amount of state funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

- 44) Enter Total source of Funds by adding all entries in Column N.

Column L – Total Non-Medi-Cal

- 45) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

- 46) Enter Total Source of Funds by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the total of respective amounts in Columns M and N.

Column P – Medi-Cal Enhanced

- 47) Enter the amount of State and Federal funds that were used to pay Medi-Cal enhanced expenditures.

The funding distribution for Medi-Cal enhanced expenditures is 25 percent state funds and 75 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column H by 25 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column H by 75 percent.

- 48) Enter Total Source of Funds by adding all entries in Column P.

Column Q – Medi-Cal Non-Enhanced

- 49) Enter the amount of state and federal funds that were used to pay Medi-Cal non-enhanced expenditures.

The funding distribution for Medi-Cal non-enhanced expenditures is 50 percent state funds and 50 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column I by 50 percent.

- 50) Enter Total Source of Funds by adding all entries in Column Q.

Column O – Total Medi-Cal

- 51) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.
- 52) Enter Total Source of Funds by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the total of respective amounts in Columns P and Q.

Column K – Total Expenditures

- 53) Enter the amounts for Medi-Cal state and federal funds (Title XIX) from Column O to Column K.
- 54) Enter the amounts for HF state, county, and federal funds (Title XXI) from Column N to Column K.
- 55) Enter the amounts for straight CCS state and county funds from Column M to Column K.

Total Source of Funds

- 56) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the total of Columns M and N.

The entry in Column O must equal the total of Columns P and Q.

The entry in Column K must equal the total of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

CERTIFICATION

- 57) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices. Original signature is required. Signature stamps are not acceptable.
- 58) Type or print the name of the authorized official.
- 59) Enter the date that the signature was affixed.
- 60) Type or print the name of the contact person for the expenditure invoice.
- 61) Enter the telephone number for the contact person.

SUBMISSION

- 62) Submit the invoice with original signature. Signature stamps are not acceptable.

No additional copies are required.

- 63) Submit the quarterly invoice and any supporting documentation to justify expenditures to the following:

California Department of Health Care Services
Children's Medical Services Branch
Program Support Section – Administration Unit
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

Quarterly invoices shall be submitted **no later than 60 days** after the end of each quarter.

The following schedule shows the exact due dates for each quarterly invoice.

<u>Quarter</u>	<u>Due Date</u>
1 st	November 30, 200x
2 nd	February 28, 200x+1
3 rd	May 31, 200x+1
4 th	August 31, 200x+1

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services Branch

**CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM
FISCAL YEAR _____
CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL**

COUNTY _____

QUARTER _____

CCS CASELOAD	ACTUAL CASELOAD	PERCENT OF GRAND TOTAL
<i>A</i>	<i>B</i>	<i>C</i>
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
Potential Cases of Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
Potential Cases of HF Children		
TOTAL HEALTHY FAMILIES CASES		
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
Potential Cases of Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		
TOTAL CASELOAD		

Revised February 2007

Page 1 of 2

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services Branch

CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL

COUNTY: _____

QUARTER: _____

A	B CATEGORY/LINE ITEM	C=D+G TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			D=E+F TOTAL NON-MEDI-CAL	E STRAIGHT CCS 50/50 State/County	F HEALTHY FAMILIES 65/17.5/17.5 Fed/State/Co	G=H+I TOTAL MEDI-CAL	H ENHANCED 25/75 State/Federal	I NON-ENHANCED 50/50 State/Federal
I.	Total Personnel Expenses							
II.	Total Operating Expenses							
III.	Total Capital Expenses							
IV.	Total Indirect Expenses							
V.	Total Other Expenses							
	TOTAL EXPENDITURES							

Maintenance & Transportation \$ \$ \$ \$ \$

SOURCE OF FUNDS		K=L+O	L	M	N	O=P+Q	P	Q
J								
MEDI-CAL								
	State Funds							
	Federal Funds (Title XIX)							
HEALTHY FAMILIES								
	State Funds							
	County Funds							
	Federal Funds (Title XXI)							
STRAIGHT CCS								
	State Funds							
	County Funds							
TOTAL SOURCE OF FUNDS								

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official _____

Type or Print Name of Contact Person _____

Type or Print Name of Authorized Official _____ Date _____

() _____

Revised February 2007

Contact Person's Telephone Number _____

**CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM
FISCAL YEAR: 2007/2008
CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL**

COUNTY: ANY COUNTY, USA

QUARTER: JULY 1, 2007 THRU SEPTEMBER 30, 2007

CCS CASELOAD	CORRECT CASELOAD	PERCENT OF GRAND TOTAL
A	B	C
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children	1,736	61.89%
Potential Cases of Medi-Cal Children	218	7.77%
TOTAL MEDI-CAL CASES	1,954	69.66%
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children	25	0.89%
Potential Cases of HF Children	9	0.32%
TOTAL HEALTHY FAMILIES CASES	34	1.21%
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children	631	22.50%
Potential Cases of Straight CCS Children	186	6.63%
TOTAL STRAIGHT CCS CASES	817	29.13%
TOTAL NON-MEDI-CAL CASES	851	30.34%
TOTAL CASELOAD	2,805	100.00%

February 2007

Page 1 of 2

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services Branch

CCS ADMINISTRATIVE EXPENDITURE INVOICE - INITIAL

COUNTY: Any County USA

QUARTER: July 1, 2007 through September 30, 2007

A	B	C=D+G	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS 50/50 State/County	HEALTHY FAMILIES 65/17.5/17.5 Fed/State/Co	TOTAL MEDI-CAL	ENHANCED 25/75 State/Federal	NON-ENHANCED 50/50 State/Federal
			D=E+F	E	F	G=H+I	H	I
I.	Total Personnel Expenses	197,512	59,925	57,535	2,390	137,587	98,436	39,151
II.	Total Operating Expenses	49,207	14,929	14,334	595	34,278	26,507	7,771
III.	Total Capital Expenses							
IV.	Total Indirect Expenses	23,611	7,164	6,878	286	16,447		16,447
V.	Total Other Expenses	8,053	1,828	1,535	293	6,225		6,225
	TOTAL EXPENDITURES	278,383	83,846	80,282	3,564	194,537	124,943	69,594

Maintenance & Transportation \$ 4,500 \$ 750 \$ 500 \$ 250 \$ 3,750 \$ 3,750

SOURCE OF FUNDS		J	K=L+O	L	M	N	O=P+Q	P	Q
MEDI-CAL									
	State Funds	66,033					66,033	31,236	34,797
	Federal Funds (Title XIX)	128,504					28,504	93,707	34,797
HEALTHY FAMILIES									
	State Funds	624	624			624			
	County Funds	624	624			624			
	Federal Funds (Title XXI)	2,317	2,317			2,317			
STRAIGHT CCS									
	State Funds	40,141	40,141		40,141				
	County Funds	40,141	40,141		40,141				
	TOTAL SOURCE OF FUNDS	278,383	83,846	80,282	3,564	194,537	124,943	69,594	

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official
 MARY SMITH
 Type or Print Name of Authorized Official

12/1/2007
 Date

JANE DOE
 Type or Print Name of Contact Person
 (123) 456-7890
 Telephone Number

February 2007
 Page 2 of 2

CCS ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS (SUPPLEMENTAL A)

INSTRUCTIONS FOR COMPLETION

A supplemental invoice identifies the differences between the caseload, expenditures, and funding amounts previously submitted on the initial invoice and the caseload, expenditures, and funding amounts that are now true, correct, and accurately reflect the actual spending pattern for a particular quarter. Supplemental invoices are prepared on an as-needed basis during the fiscal year.

A supplemental invoice is comprised of the following two parts:

- Supplemental (Part A) – represents the Initial Invoice that has been approved by the Children's Medical Services (CMS) Branch, and any changes that update the information previously reported on the Initial Invoice.

Example: The Initial Invoice showed an expenditure total of \$500 for General Expenses in the 1st Quarter. Several months after the Initial Invoice was submitted to the CMS Branch for reimbursement, the county found a supply order for \$1,000 that was paid in the 1st Quarter.

In order to be reimbursed for the \$1,000 supply order, the county must now complete Supplemental (Part A) Invoice for the 1st Quarter that shows an expenditure total of \$1,500 (\$500 + \$1,000) for General Expenses.

- Supplemental (Part B) – represents the differences between the Initial Invoice and the Supplemental (Part A) Invoice.

Example: When the Supplemental (Part A) Invoice has been completed, the county must then complete Supplemental (Part B) Invoice for the 1st Quarter. To do this, the county must subtract the \$500 General Expenses costs, which was reported on the Initial Invoice, from the total General Expenses costs of \$1,500 that was reported on the Supplemental (Part A) Invoice. The difference of \$1,000 (\$1,500 - \$500) must be reported for General Expenses on the Supplemental (Part B) Invoice.

Separate instructions are prepared for the Supplemental (Part A) Invoice and Supplemental (Part B) Invoice.

The following are instructions for the completion of the Supplemental (Part A) Invoice for the CCS Program Administrative Expenditure Invoice.

Fiscal Year

- 1) Enter the state fiscal year (FY) for which this invoice applies.

County

- 2) Enter the name of the county for which this invoice applies.

No.

- 3) Enter the number in the sequence of supplemental invoices submitted to the CMS Branch.

Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

Quarter

- 4) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x

Quarter 2: October 1, 200x – December 31, 200x

Quarter 3: January 1, 200x+1 – March 31, 200x+1

Quarter 4: April 1, 200x+1 – June 30, 200x+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

CCS CASELOAD

Beginning in fiscal year (FY) 2006-07, the terminology for caseload changed to “eligible months”. **However, the word caseload will be seen throughout the Plan and Fiscal Guidelines manual as this is the terminology that is most familiar to the previous users of this manual.**

Caseload in FY 2007-08 will be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS)/Medi-Cal client.
- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

There are two reports that can be accessed to calculate “eligible months” for caseload. There is one report in CMS Net Legacy titled “Monthly Caseload Count Report” (for Medi-Cal and Non-Medi-Cal counts), and the second report is in Business Objects (BO) titled “Healthy Families

Caseload Count Report". In the CMS Net Legacy report the non-Medi-Cal count is both HF and CCS together. Counties need to subtract HF from the total to get the CCS population.

The CMS Net Legacy report has a history so the report "Monthly Caseload Count Report" (Medi-Cal and non-Medi-Cal) can be processed whenever a county needs the information. However, the HF count in the BO report "Healthy Families Caseload County" only contains information as of the prior day so it is critical for counties to run the report every month to get the HF totals if they want to use BO to retrieve the caseload counts.

This Computes Information Bulletin #167 provides more details regarding these reports. This can be found at:

<http://www.dhs.ca.gov/PCFH/cms/ccs/cmsnet/pdf/thiscomputes/thiscomputes167.pdf>

The eligible month information should be retrieved for each type of case for which a child would be counted, e.g. CCS/Medi-Cal, CCS/HF, and CCS-only. At the end of the three month period the total number of "eligible months" from the three combined reports would need to be divided by three to achieve the "average caseload" number for the quarter.

An example would be:

• Month One	=	150 eligible months
• Month Two	=	148 eligible months
• Month Three	=	167 eligible months
TOTAL		465 Eligible Months

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter.

Column B – Correct Caseload

Medi-Cal Cases

- 5) Enter the Average Total Cases of Open (Active) Medi-Cal Children that was previously reported on the Initial Invoice and any changes to this figure.
- 6) Enter the number of Potential Cases of Medi-Cal Children that was previously reported on the Initial Invoice and any changes to this figure.
- 7) Enter Total Medi-Cal Cases by adding the Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Non-Medi-Cal Cases: Healthy Families (HF)

- 8) Enter the Average Total Cases of Open (Active) HF Children that was previously reported on the Initial Invoice and any changes to this figure.
- 9) Enter the number of Potential Cases of HF Children that was previously reported on the Initial Invoice and any changes to this figure.

- 10) Enter Total Healthy Families Cases by adding the Average Total Cases of Open (Active) HF Children and the Potential Cases of HF Children.

Non-Medi-Cal Cases: Straight CCS

- 11) Enter the Average Total Cases of Open (Active) Straight CCS Children that was previously reported on the Initial Invoice and any changes to this figure.
- 12) Enter the number of Potential Cases of Straight CCS Children that was previously reported on the Initial Invoice and any changes to this figure.
- 13) Enter Total Straight CCS Cases by adding the Average Total Cases of Open (Active) Straight CCS Children and the Potential Cases of Straight CCS Children.

Total Non-Medi-Cal Cases

- 14) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

- 15) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

Column C – Percent of Grand Total

Medi-Cal Percentages

- 16) Enter the percentage for Average Total Cases of Open (Active) Medi-Cal Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 17) Enter the percentage for Potential Cases of Medi-Cal Children by dividing the potential cases entered in Column B by the Total Caseload entered in Column B.
- 18) Enter the Total Percentage for Total Medi-Cal Cases by dividing the Total Medi-Cal Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Healthy Families

- 19) Enter the percentage for Average Total Cases of Open (Active) HF Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 20) Enter the percentage for Potential Cases of HF Children by dividing the potential cases entered in Column B by the Total Caseload entered in Column B.
- 21) Enter the Total Percentage for Total HF Cases by dividing the Total HF Cases in Column B by the Total Caseload in Column B.

Non-Medi-Cal Percentages: Straight CCS

- 22) Enter the percentage for Average Total Cases of Open (Active) Straight CCS Children by dividing the average total cases entered in Column B by the Total Caseload entered in Column B.
- 23) Enter the percentage for Potential Cases of Straight CCS Children by dividing the potential cases entered in Column B by the Total Caseload entered in Column B.
- 24) Enter the Total Percentage for Total Straight CCS Cases by dividing the Total Straight CCS Cases in Column B by the Total Caseload in Column B.

Total Non-Medi-Cal Cases Percentage

- 25) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

Total Caseload Percentage

- 26) Enter the Total Percentage by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases in Column C.

The Total Caseload Percentage must equal 100 percent.

ADMINISTRATIVE EXPENDITURES

County

- 27) Enter the name of the county for which this invoice applies.

No.

- 28) Enter the number in the sequence of supplemental invoices submitted to the Children's Medical Services (CMS) Branch.

Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

Quarter

- 29) Enter the dates of the quarter for which the invoice applies.

These dates must be the same on pages 1 and 2 of the Supplemental (Part A) Invoice.

Column C – Total Expenditures

- 30) Enter the amounts of Total Expenditures that were previously reported on the Initial Invoice and any changes to these amounts.
- 31) Enter the Total Expenditures by adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the sum of respective amounts in Columns D and G.

Column D – Total Non-Medi-Cal

- 32) Enter the amounts of total non-Medi-Cal expenditures that were previously reported on the Initial Invoice for each category/line item, except Total Other Expenses, and any changes to these amounts.

Any changes to the category/line item entitled Total Other Expenses must consider how maintenance and transportation (M&T) costs are charged. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the correct amount of total non-Medi-Cal expenditures for Total Other Expenses, use the following formula.

- a. Subtract all M&T expenditures (which were previously reported on the Initial Invoice and any changes to these expenditures) from Total Other Expenses (which were the amounts previously reported on the Initial Invoice and any changes to these amounts).
- b. Multiply the remaining balance by the percentage for Total Non-Medi-Cal from the Supplemental (Part) Invoice.
- c. To this end result, add the correct M&T expenditures directly related to non-Medi-Cal clients.
- d. The subsequent total is the correct amount of Total Other Expenses for Total Non-Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{r}
 + \quad \text{Total Other Expenses (amounts previously reported and any changes)} \\
 - \quad \text{All M\&T Expenditures (amounts previously reported and any changes)} \\
 \hline
 = \quad \text{Remaining Balance (amounts previously reported and any changes)} \\
 \times \quad \text{Total Non-Medi-Cal Cases \% (from Supplemental (Part A) Invoice)} \\
 \hline
 = \quad \text{Correct Share of Total Other Expenses for Total Non-Medi-Cal Cases} \\
 + \quad \text{Correct M\&T Expenditures for Non-Medi-Cal Clients} \\
 \hline
 = \quad \text{Correct Amount of Total Other Expenses for Total Non-Medi-Cal Cases}
 \end{array}$$

- 33) Enter the total expenditures for total non-Medi-Cal expenditures by adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the sum of respective amounts in Columns E and F.

Column E – Straight CCS

- 34) Enter the amounts of straight CCS expenditures that were previously reported on the Initial Invoice and any changes to these amounts.
- 35) Enter the total expenditures for straight CCS by adding all entries in Column E.

Column F – Healthy Families (HF)

- 36) Enter the amounts of HF expenditures that were previously reported on the Initial Invoice and any changes to these amounts.
- 37) Enter the total expenditures for HF by adding all entries in Column F.

Column G – Total Medi-Cal

- 38) Enter the amounts of total Medi-Cal expenditures that were previously reported on the Initial Invoice for each category/line item, except Total Other Expenses, and any changes to these amounts.

Any changes to the category/line item entitled Total Other Expenses must consider how M&T costs are charged. Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

To determine the correct amount of total Medi-Cal expenditures for Total Other Expenses, use the following formula.

- a. Subtract all M&T expenditures (which were previously reported on the initial invoice and any changes to these expenditures) from Total Other Expenses (which were the amounts previously reported on the Initial Invoice and any changes to these amounts).
- b. Multiply the remaining balance by the percentage for Total Medi-Cal from the Supplemental (Correct) Invoice.
- c. To this end result, add the correct M&T expenditures directly related to Medi-Cal clients.
- d. The subsequent total is the correct amount of Total Other Expenses for Total Medi-Cal.

A visual calculation of the aforementioned formula is the following:

$$\begin{array}{r}
 + \quad \text{Total Other Expenses (amounts previously reported and any changes)} \\
 - \quad \text{All M\&T Expenditures (amounts previously reported and any changes)} \\
 \hline
 = \quad \text{Remaining Balance (amounts previously reported and any changes)} \\
 \times \quad \text{Total Medi-Cal Cases \% (from Supplemental (Part A) Invoice)} \\
 \hline
 = \quad \text{Correct Share of Total Other Expenses for Total Medi-Cal Cases} \\
 + \quad \text{Correct M\&T Expenditures for Medi-Cal Clients} \\
 \hline
 = \quad \text{Correct Amount of Total Other Expenses for Total Medi-Cal Cases}
 \end{array}$$

- 39) Enter the total expenditures for Total Medi-Cal expenditures by adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the sum of respective amounts in Columns H and I.

Column H – Medi-Cal Enhanced

- 40) Enter the amounts of Medi-Cal enhanced expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

Only personnel expenses and operating expenses (i.e., training and travel costs) for SPMP are allowed as expenditures for Medi-Cal Enhanced.

Medi-Cal enhanced **does not** allow expenditures for Total Capital Expenses, Total Indirect Expenses, and Total Other Expenses.

Column I – Medi-Cal Non-Enhanced

- 41) Enter the amounts of Medi-Cal non-enhanced expenditures that were previously reported on the Initial Invoice and any changes to these amounts.

The amount of expenditures charged to each category/line item includes salaries, benefits, travel, training, and other administrative expenses for non-SPMP including, but not limited to, administrators; associate staff; clerical staff not providing direct support to, or supervised by, SPMP; and claims processing staff.

Also expenditures for staff hired under contract, including SPMP staff, are to be charged at the non-enhanced rate.

Maintenance & Transportation (M&T)

- 42) Enter the specific amounts of Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal for M&T that were previously reported on the Initial Invoice and any changes to these amounts.

Expenditures for M&T **must be identified directly** to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and HF.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

SOURCE OF FUNDS

Complete the non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

Column M – Straight CCS

- 43) Enter the amounts of state and county funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for straight CCS expenditures is 50 percent State funds and 50 percent County funds.

The amount of State funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

The amount of County funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

Column N – Healthy Families

- 44) Enter the amounts of federal, state, and county funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for HF expenditures is 65 percent federal funds (Title XXI), 17.5 percent State funds, and 17.5 percent County funds.

The amount of federal funds is determined by multiplying the Total Expenditures in Column F by 65 percent.

The amount of state funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

Column L – Total Non-Medi-Cal

- 45) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

- 46) Enter Total Source of Funds by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the sum of respective amounts in Columns M and N.

Column P – Medi-Cal Enhanced

- 47) Enter the amounts of state and federal funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for Medi-Cal Enhanced expenditures is 25 percent State funds and 75 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column H by 25 percent.

The amount of federal funds is determined by multiplying the Total Expenditures in Column H by 75 percent.

Column Q – Medi-Cal Non-Enhanced

- 48) Enter the amounts of state and federal funds that were previously reported on the Initial Invoice and any changes to these amounts.

The funding distribution for Medi-Cal non-enhanced expenditures is 50 percent state funds and 50 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

The amount of federal funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

Column O – Total Medi-Cal

- 49) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

- 50) Enter Total Source of Funds by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the sum of respective amounts in Columns P and Q.

Column K – Total Expenditures

- 51) Enter the amounts for Medi-Cal state and federal funds (Title XIX) from Column O to Column K.

- 52) Enter the amounts for HF state, county, and federal funds (Title XXI) from Column N to Column K.

- 53) Enter the amounts for straight CCS state and county funds from Column M to Column K.

Total Source of Funds

- 54) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the total of Columns M and N.

The entry in Column O must equal the total of Columns P and Q.

The entry in Column K must equal the total of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

CERTIFICATION

- 55) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices and Supplemental Invoices (Parts A and B). An original signature is required. Signature stamps are not acceptable.
- 56) Type or print the name of the authorized official.
- 57) Enter the date that the signature was affixed.
- 58) Type or print the name of the contact person for the expenditure invoice.
- 59) Enter the telephone number for the contact person.

SUBMISSION

- 60) Submit the Supplemental (Part A) Invoice that has original signature with the Supplemental (Part B) Invoice that has original signature. Signature stamps are not acceptable.

No additional copies are required.

- 61) Submit the Supplemental Invoice (Parts A and B) and any supporting documentation to justify expenditures to the following:

Department of Health Care Services
Children's Medical Services Branch
Program Support Section – Administration Unit
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

Supplemental Invoices (Parts A and B) shall be submitted **no later than December 31st** after the end of the fiscal year.

Example: FY 2006-07 ends June 30, 2007. Supplemental Invoices (Parts A and B) for FY 2006-07 are due no later than December 31, 2007.

CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM
FISCAL YEAR _____
CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

COUNTY: _____ **No.:** _____

QUARTER: _____

CCS CASELOAD	CORRECT CASELOAD	PERCENT OF GRAND TOTAL
<i>A</i>	<i>B</i>	<i>C</i>
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
Potential Cases of Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
Potential Cases of HF Children		
TOTAL HEALTHY FAMILIES CASES		
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
Potential Cases of Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		
TOTAL CASELOAD		

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services Branch

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

COUNTY: _____

NO.: _____

QUARTER: _____

A	B	C=D+G	NON-MED-CAL			MEDI-CAL		
			TOTAL NON-MEDI-CAL	STRAIGHT CCS 50/50 State/County	HEALTHY FAMILIES 65/17.5/17.5 Fed/State/Co	TOTAL MEDI-CAL	ENHANCED 25/75 State/Federal	NON-ENHANCED 50/50 State/Federal
I.	Total Personnel Expenses							
II.	Total Operating Expenses							
III.	Total Capital Expenses							
IV.	Total Indirect Expenses							
V.	Total Other Expenses							
	TOTAL EXPENDITURES							

Maintenance & Transportation \$ \$ \$ \$ \$ \$

SOURCE OF FUNDS		J	K=L+O	L	M	N	O=P+Q	P	Q
MEDI-CAL									
	State Funds								
	Federal Funds (Title XIX)								
HEALTHY FAMILIES									
	State Funds								
	County Funds								
	Federal Funds (Title XXI)								
STRAIGHT CCS									
	State Funds								
	County Funds								
TOTAL SOURCE OF FUNDS									

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official

Type or Print Name of Authorized Official

Date

Type or Print Name of Contact Person

()

Telephone Number

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services Branch

CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM
FISCAL YEAR: 2007/2008
CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

COUNTY: ANY COUNTY, USA

NO.: 1

QUARTER: July 1, 2007 thru September 30, 2007

CCS CASELOAD	CORRECT CASELOAD	PERCENT OF GRAND TOTAL
<i>A</i>	<i>B</i>	<i>C</i>
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children	1,806	49.94%
Potential Cases of Medi-Cal Children	324	8.96%
TOTAL MEDI-CAL CASES	2,130	58.90%
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children	250	6.91%
Potential Cases of HF Children	73	2.03%
TOTAL HEALTHY FAMILIES CASES	323	8.94%
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children	895	24.75%
Potential Cases of Straight CCS Children	268	7.41%
TOTAL STRAIGHT CCS CASES	1,163	32.16%
TOTAL NON-MEDI-CAL CASES	1,486	41.10%
TOTAL CASELOAD	3,616	100.00%

February 2007

Page 1 of 2

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services Branch

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART A)

COUNTY: ANY COUNTY, USA

NO.: 1 QUARTER: July 1, 2007 thru September 30, 2007

A	B CATEGORY/LINE ITEM	C=D+G TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			D=E+F TOTAL NON-MEDI-CAL	E STRAIGHT CCS 50/50 State/County	F HEALTHY FAMILIES 65/17.5/17.5 Fed/State/Co	G=H+I TOTAL MEDI-CAL	H ENHANCED 25/75 State/Federal	I NON-ENHANCED 50/50 State/Federal
I.	Total Personnel Expenses	200,958	82,594	64,628	17,966	118,364	98,436	19,928
II.	Total Operating Expenses	63,752	26,202	20,503	5,699	37,550	26,507	11,043
III.	Total Capital Expenses	0	0	0	0	0		0
IV.	Total Indirect Expenses	32,611	13,403	10,488	2,915	19,208		19,208
V.	Total Other Expenses	9,053	2,574	1,823	751	6,479		6,479
	TOTAL EXPENDITURES	306,374	124,773	97,442	27,331	181,601	124,943	56,658

Maintenance & Transportation \$ 5,731 \$ 1,209 \$ 755 \$ 454 \$ 4,522 \$ 4,522

SOURCE OF FUNDS		J	K=L+O	L	M	N	O=P+Q	P	Q
MEDI-CAL									
	State Funds	59,565					59,565	31,236	28,329
	Federal Funds (Title XIX)	122,036					122,036	93,707	28,329
HEALTHY FAMILIES									
	State Funds	4,783	4,783			4,783			
	County Funds	4,783	4,783			4,783			
	Federal Funds (Title XXI)	17,765	17,765			17,765			
STRAIGHT CCS									
	State Funds	48,721	48,721		48,721				
	County Funds	48,721	48,721		48,721				
	TOTAL SOURCE OF FUNDS	306,374	124,773	97,442	27,331	181,601	124,943	56,658	

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official
 MARY SMITH 12/1/2007

Type or Print Name of Authorized Official
 February 2007 Date

JANE DOE
 Type or Print Name of Contact Person
 (123) 456-7890
 Telephone Number

CCS ADMINISTRATIVE EXPENDITURE INVOICE INSTRUCTIONS (SUPPLEMENTAL B)

INSTRUCTIONS FOR COMPLETION

Beginning in fiscal year (FY) 2006-07, the terminology for caseload changed to “eligible months”. **However, the word caseload will be seen throughout the Plan and Fiscal Guidelines manual as this is the terminology that is most familiar to the previous users of this manual.**

Caseload in FY 2007-08 will be calculated based upon the months the client was eligible for services. Below are examples of types of cases for which a child would be counted as an eligible month:

- If a child has Medi-Cal in a month, that child has an eligible month as a California Children's Services (CCS)/Medi-Cal client.
- If a child is a Healthy Families (HF) subscriber on any day in the month, the child has an eligible month as a CCS/HF client. However, HF will only pay for the dates of service in the month for which the child is actually a HF subscriber.
- If a child has CCS only eligibility on any day in the month, then the child has an eligible month as a CCS-only client. However, CCS-only will only pay for a date of service in the month for which the child has CCS-only eligibility.

There are two reports that can be accessed to calculate “eligible months” for caseload. There is one report in CMS Net Legacy titled “Monthly Caseload Count Report” (for Medi-Cal and Non-Medi-Cal counts), and the second report is in Business Objects (BO) titled “Healthy Families Caseload Count Report”. In the CMS Net Legacy report the non-Medi-Cal count is both HF and CCS together. Counties need to subtract HF from the total to get the CCS population.

The CMS Net Legacy report has a history so the report “Monthly Caseload Count Report” (Medi-Cal and non-Medi-Cal) can be processed whenever a county needs the information. However, the HF count in the BO report “Healthy Families Caseload County” only contains information as of the prior day so it is critical for counties to run the report every month to get the HF totals if they want to use BO to retrieve the caseload counts.

This Computes Information Bulletin #167 provides more details regarding these reports. This can be found at:

<http://www.dhs.ca.gov/PCFH/cms/ccs/cmsnet/pdf/thiscomputes/thiscomputes167.pdf>

The eligible month information should be retrieved for each type of case for which a child would be counted, e.g. CCS/Medi-Cal, CCS/HF, and CCS-only. At the end of the three month period the total number of “eligible months” from the three combined reports would need to be divided by three to achieve the “average caseload” number for the quarter.

An example would be:

- Month One = 150 eligible months
- Month Two = 148 eligible months
- Month Three = 167 eligible months
- TOTAL 465 Eligible Months**

465 eligible months ÷ 3 = 155 eligible months/caseload for the reporting quarter.

A supplemental invoice identifies the differences between the caseload, expenditures, and funding amounts previously submitted on the Initial Invoice and the caseload, expenditures, and funding amounts that are now true, correct, and accurately reflect the actual spending pattern for a particular quarter. Supplemental invoices are prepared on an as-needed basis during the fiscal year.

A supplemental invoice is comprised of the following two parts:

- Supplemental (Part A) – represents the Initial Invoice that has been approved by the CMS Branch, and any changes that update the information previously reported on the Initial Invoice.

Example: The Initial Invoice showed an expenditure total of \$500 for General Expenses in the 1st Quarter. Several months after the Initial Invoice was submitted to the CMS Branch for reimbursement, the county found a supply order for \$1,000 that was paid in the 1st Quarter.

In order to be reimbursed for the \$1,000 supply order, the county must now complete Supplemental (Part A) Invoice for the 1st Quarter that shows an expenditure total of \$1,500 (\$500 + \$1,000) for General Expenses.

- Supplemental (Part B) – represents the differences between the Initial Invoice and the Supplemental (Part A) Invoice.

Example: When the Supplemental (Part A) Invoice has been completed, the county must then complete Supplemental (Part B) Invoice for the 1st Quarter. To do this, the county must subtract the \$500 General Expenses costs, which was reported on the Initial Invoice, from the total General Expenses costs of \$1,500 that was reported on the Supplemental (Part A) Invoice. The difference of \$1,000 (\$1,500 - \$500) must be reported for General Expenses on the Supplemental (Part B) Invoice.

Separate instructions are prepared for the Supplemental (Part A) Invoice and Supplemental (Part B) Invoice.

The following are instructions for the completion of the Supplemental (Part B) Invoice for the CCS Program Administrative Expenditure Invoice.

Fiscal Year

- 1) Enter the state fiscal year (FY) for which this invoice applies.

County

- 2) Enter the name of the county for which this invoice applies.

No.

- 3) Enter the number in the sequence of supplemental invoices submitted to the Children's Medical Services (CMS) Branch.

Example: 01, 02, etc.

This number must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

Quarter

- 4) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x
Quarter 2: October 1, 200x – December 31, 200x
Quarter 3: January 1, 200x+1 – March 31, 200x+1
Quarter 4: April 1, 200x+1 – June 30, 200x+1

These dates must be the same on pages 1 and 2 of the Supplemental (Part B) Invoice.

CCS CASELOAD

Column B – Difference in Caseload

Medi-Cal Cases

- 5) Enter the difference for Average Total Cases of Open (Active) Medi-Cal Children by subtracting the Average Total Cases of Open (Active) Medi-Cal Children that were previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) Medi-Cal Children on the Supplemental (Part A) Invoice.
- 6) Enter the difference for Potential Cases of Medi-Cal Children by subtracting the number of Potential Cases of Medi-Cal Children that were previously reported on the Initial Invoice from the correct number of Potential Cases of Medi-Cal Children on the Supplemental (Part A) Invoice.
- 7) Enter Total Medi-Cal Cases by adding the Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Non-Medi-Cal Cases: HF

- 8) Enter the difference for Average Total Cases of Open (Active) Healthy Families (HF) Children by subtracting the Average Total Cases of Open (Active) HF Children that were

previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) HF Children on the Supplemental (Part A) Invoice.

- 9) Enter the difference for Potential Cases of HF Children by subtracting the number of Potential Cases of HF Children that were previously reported on the Initial Invoice from the correct number of Potential Cases of HF Children on the Supplemental (Part A) Invoice.
- 10) Enter Total Healthy Families Cases by adding the Average Total Cases of Open (Active) HF Children and the Potential Cases of HF Children.

Non-Medi-Cal Cases: Straight CCS

- 11) Enter the difference by subtracting the Average Total Cases of Open (Active) Straight CCS Children that were previously reported on the Initial Invoice from the correct Average Total Cases of Open (Active) Straight CCS Children on the Supplemental (Part A) Invoice.
- 12) Enter the difference by subtracting the number of Potential Cases of Straight CCS Children that were previously reported on the Initial Invoice from the correct number of Potential Cases of Straight CCS Children on the Supplemental (Part A) Invoice.
- 13) Enter Total Straight CCS Cases by adding the Average Total Cases of Open (Active) Straight CCS Children and the Potential Cases of Straight CCS Children.

Total Non-Medi-Cal Cases

- 14) Enter Total Non-Medi-Cal Cases by adding Total HF Cases and Total Straight CCS Cases.

Total Caseload

- 15) Enter Total Caseload by adding Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

Column E – Percent of Grant Total

Medi-Cal Cases Percentages

- 16) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) Medi-Cal Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) Medi-Cal Children on the Supplemental (Part A) Invoice.
- 17) Enter the difference by subtracting the percentage for Potential Cases of Medi-Cal Children that were previously reported on the Initial Invoice from the percentage for Potential Cases of Medi-Cal Children on the Supplemental (Part A) Invoice.
- 18) Enter the percentage for Total Medi-Cal Cases by adding the percentages for Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Non-Medi-Cal Percentages: HF

- 19) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) HF Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) HF Children Supplemental (Part A) Invoice.
- 20) Enter the difference by subtracting the percentage for Potential Cases of HF Children that were previously reported on the Initial Invoice from the percentage for Potential Cases of HF Children on the Supplemental (Part A) Invoice.
- 21) Enter the percentage for Total HF Cases by adding the percentages for Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Non-Medi-Cal Percentages: Straight CCS

- 22) Enter the difference by subtracting the percentage for Average Total Cases of Open (Active) HF Children that were previously reported on the Initial Invoice from the percentage for Average Total Cases of Open (Active) HF Children Supplemental (Part A) Invoice.
- 23) Enter the difference by subtracting the percentage for Potential Cases of HF Children that were previously reported on the Initial Invoice from the percentage for Potential Cases of HF Children on the Supplemental (Part A) Invoice.
- 24) Enter the percentage for Total Straight CCS Cases by adding the percentages for Average Total Cases of Open (Active) Medi-Cal Children and the Potential Cases of Medi-Cal Children.

Total Non-Medi-Cal Cases Percentage

- 25) Enter the percentage for Total Non-Medi-Cal Cases by adding the percentages for Total HF Cases and Total Straight CCS Cases.

Total Caseload Percentage

- 26) Enter the percentage for Total Caseload by adding the percentages for Total Medi-Cal Cases and Total Non-Medi-Cal Cases.

The Total Caseload Percentage must equal zero percent (0%).

ADMINISTRATIVE EXPENDITURES

County

- 27) Enter the name of the county for which this invoice applies.

No.

- 28) Enter the number in the sequence of supplemental invoices submitted to the CMS Branch.

Example: 01, 02, etc.

This number must be the same on Pages 1 and 2 of the Supplemental (Part B) Invoice.

Quarter

- 29) Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x

Quarter 2: October 1, 200x – December 31, 200x

Quarter 3: January 1, 200x+1 – March 31, 200x+1

Quarter 4: April 1, 200x+1 – June 30, 200x+1

These dates must be the same on Pages 1 and 2 of the Supplemental (Part B) Invoice.

Column C – Total Expenditures

- 30) Enter the difference for each category/line item listed in Column B by subtracting the Total Expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures reported on the Supplemental (Part A) Invoice.
- 31) Enter the difference for Total Expenditures by subtracting the Total Expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column C.

For each category/line item, the amounts entered in Column C must equal the sum of respective amounts in Columns D and G.

Column D – Total Non-Medi-Cal

- 32) Enter the difference for each category/line item listed in Column B by subtracting the Total Non-Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Non-Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.
- 33) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Total Non-Medi-Cal that were previously reported on the Initial Invoice from the correct Total Expenditures for Total Non-Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column D.

For each category/line item, the amounts entered in Column D must equal the sum of respective amounts in Columns E and F.

Column E – Straight CCS

- 34) Enter the difference for each category/line item listed in Column B by subtracting the Straight CCS expenditures that were previously reported on the Initial Invoice from the correct Straight CCS expenditures reported on the Supplemental (Part A) Invoice.
- 35) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Straight CCS that were previously reported on the Initial Invoice from the correct Total Expenditures for Straight CCS reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column E.

Column F – Healthy Families (HF)

- 36) Enter the difference for each category/line item listed in Column B by subtracting the HF expenditures that were previously reported on the Initial Invoice from the correct HF expenditures reported on the Supplemental (Part A) Invoice.
- 37) Enter the difference for Total Expenditures by subtracting the Total Expenditures for HF that were previously reported on the Initial Invoice from the correct Total Expenditures for HF reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column F.

Column G – Total Medi-Cal

- 38) Enter the difference for each category/line item listed in Column B by subtracting between the Total Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.
- 39) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Total Medi-Cal expenditures that were previously reported on the Initial Invoice from the correct Total Expenditures for Total Medi-Cal expenditures reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column G.

For each category/line item, the amounts entered in Column G must equal the sum of respective amounts in Columns H and I.

Column H – Medi-Cal Enhanced

- 40) Enter the difference for Total Personnel Expenses and Total Operating Expenses listed in Column B by subtracting the Medi-Cal Enhanced expenditures that were previously reported on the Initial Invoice from the correct Medi-Cal Enhanced expenditures reported on the Supplemental (Part A) Invoice.

- 41) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Medi-Cal Enhanced that were previously reported on the Initial Invoice from the correct Total Expenditures for Medi-Cal Enhanced reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column H.

Column I – Medi-Cal Non-Enhanced

- 42) Enter the difference for each category/line item listed in Column B by subtracting the Medi-Cal Non-Enhanced expenditures that were previously reported on the Initial Invoice from the correct Medi-Cal Non-Enhanced expenditures reported on the Supplemental (Part A) Invoice.
- 43) Enter the difference for Total Expenditures by subtracting the Total Expenditures for Medi-Cal Non-Enhanced that were previously reported on the Initial Invoice from the correct Total Expenditures for Medi-Cal Non-Enhanced reported on the Supplemental (Part A) Invoice.

The entry for Total Expenditures must equal the sum of adding all entries in Column I.

Maintenance & Transportation (M&T)

- 44) Enter the differences for Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal by subtracting the Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal amounts that were previously reported on the Initial Invoice from the correct Total Expenditures, Total Non-Medi-Cal, and Total Medi-Cal amounts reported on the Supplemental (Part A) Invoice.

Expenditures for M&T must be identified directly to either a Medi-Cal or non-Medi-Cal client.

The amount for Total Non-Medi-Cal must equal the sum of the amounts for Straight CCS and Healthy Families.

The amount for Total Expenditures must equal the sum of the amounts for Total Non-Medi-Cal and Total Medi-Cal.

SOURCE OF FUNDS

Complete the Non-Medi-Cal Columns M and N first; then complete Column L. Next complete Medi-Cal Columns P and Q before completing Column O. Last, complete Column K.

Column M – Straight CCS

- 45) Enter the difference for each source of funds listed in Column J by subtracting the state and county funds that were previously reported on the Initial Invoice from the correct state and county funds reported on the Supplemental (Part A) Invoice.

The funding distribution for straight CCS expenditures is 50 percent state funds and 50 percent county funds.

The amount of state funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column E by 50 percent.

- 46) Enter the Total Source of Funds by adding all entries in Column M.

Column N – Healthy Families (HF)

- 47) Enter the difference for each source of funds listed in Column J by subtracting the federal, state, and county funds that were previously reported on the Initial Invoice from the correct federal, state, and county funds reported on the Supplemental (Part A) Invoice.

The funding distribution for HF expenditures is 65 percent federal funds (Title XXI), 17.5 percent state funds, and 17.5 percent county funds.

The amount of federal funds (Title XXI) is determined by multiplying the Total Expenditures in Column F by 65 percent.

The amount of state funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

The amount of county funds is determined by multiplying the Total Expenditures in Column F by 17.5 percent.

- 48) Enter the Total Source of Funds by adding all entries in Column N.

Column L – Total Non-Medi-Cal

- 49) Enter Total Non-Medi-Cal amounts by adding the amounts in Columns M and N for each funding source listed in Column J.

- 50) Enter Total Source of Fund by adding all entries in Column L.

For each funding source, the amounts entered in Column L must equal the sum of respective amounts in Columns M and N.

Column P – Medi-Cal Enhanced

- 51) Enter the difference for each source of funds listed in Column J by subtracting the state and federal funds that were previously reported on the Initial Invoice from the correct state and federal funds reported on the Supplemental (Part A) Invoice.

The funding distribution for Medi-Cal enhanced expenditures is 25 percent state funds and 75 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column H by 25 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column H by 75 percent.

- 52) Enter the Total Source of Funds by adding all entries in Column P.

Column Q – Medi-Cal Non-Enhanced

- 53) Enter the difference for each source of funds listed in Column J by subtracting the state and federal funds that were previously reported on the Initial Invoice from the correct state and federal funds reported on the Supplemental (Part A) Invoice.

The funding distribution for Medi-Cal non-enhanced expenditures is 50 percent state funds and 50 percent federal funds (Title XIX).

The amount of state funds is determined by multiplying the Total Expenditures in Column I by 50 percent.

The amount of federal funds (Title XIX) is determined by multiplying the Total Expenditures in Column I by 50 percent.

- 54) Enter the Total Source of Funds by adding all entries in Column Q.

Column O – Total Medi-Cal

- 55) Enter Total Medi-Cal amounts by adding the amounts in Columns P and Q for each funding source listed in Column J.

- 56) Enter Total Source of Fund by adding all entries in Column O.

For each funding source, the amounts entered in Column O must equal the sum of respective amounts in Columns P and Q.

Column K – Total Expenditures

- 57) Enter the amounts for Medi-Cal state and federal funds (Title XIX) from Column O to Column K.

- 58) Enter the amounts for HF state, county, and federal funds (Title XXI) from Column N to Column K.

- 59) Enter the amounts for straight CCS state and county funds from Column M to Column K.

Total Source of Funds

- 60) Add all entries made in Columns K, L, M, N, O, P, and Q and enter the total for each respective column.

The entry in Column L must equal the sum of Columns M and N.

The entry in Column O must equal the sum of Columns P and Q.

The entry in Column K must equal the sum of Columns L and O.

The entries for Total Source of Funds in Columns K, L, M, N, O, P, and Q **must equal** the respective entries for Total Expenditures in Columns C, D, E, F, G, H, and I.

CERTIFICATION

- 61) Affix the signature of an official who is authorized to sign CCS Administrative Expenditure Invoices and Supplemental Invoices (Parts A and B). Original signatures are required. Signature stamps are not allowed.
- 62) Type or print the name of the authorized official.
- 63) Enter the date that the signature was affixed.
- 64) Type or print the name of the contact person for the expenditure invoice.
- 65) Enter the telephone number for the contact person.

SUBMISSION

- 66) Submit the Supplemental (Part A) Invoice that has original signature with the Supplemental (Part B) Invoice that has original signature. Signature stamps are not acceptable.

No additional copies are required.

- 67) Submit the Supplemental Invoice (Parts A and B) and any supporting documentation to justify expenditures to the following:

Department of Health Care Services
Children's Medical Services Branch
Program Support Section – Administration Unit
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

Supplemental Invoices (Parts A and B) shall be submitted **no later than December 31st** after the end of each fiscal year.

Example: FY 2006-07 ends June 30, 2007. Supplemental Invoices (Parts A and B) for FY 2006-07 are due no later than December 31, 2007.

**CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM
FISCAL YEAR _____
CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)**

COUNTY: _____ **NO.:** _____
QUARTER: _____

CCS CASELOAD	DIFFERENCE IN CASELOAD	PERCENT OF GRAND TOTAL
<i>A</i>	<i>B</i>	<i>C</i>

MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
Potential Cases of Medi-Cal Children		
TOTAL MEDI-CAL CASES		

NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children		
Potential Cases of HF Children		
TOTAL HEALTHY FAMILIES CASES		

STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children		
Potential Cases of Straight CCS Children		
TOTAL STRAIGHT CCS CASES		
TOTAL NON-MEDI-CAL CASES		

TOTAL CASELOAD		
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Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services Branch

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

COUNTY: _____

NO.: _____

QUARTER: _____

A	B CATEGORY/LINE ITEM	C=D+G TOTAL EXPENDITURES	NON-MED-CAL			MEDI-CAL		
			D=E+F TOTAL NON-MEDI-CAL	E STRAIGHT CCS 50/50 State/County	F HEALTHY FAMILIES 65/17.5/17.5 Fed/State/Co	G=H+I TOTAL MEDI-CAL	H ENHANCED 25/75 State/Federal	I NON-ENHANCED 50/50 State/Federal
I.	Total Personnel Expenses							
II.	Total Operating Expenses							
III.	Total Capital Expenses							
IV.	Total Indirect Expenses							
V.	Total Other Expenses							
	TOTAL EXPENDITURES							

Maintenance & Transportation \$ _____ \$ _____ \$ _____ \$ _____ \$ _____

SOURCE OF FUNDS		J	K=L+O	L	M	N	O=P+Q	P	Q
MEDI-CAL									
	State Funds								
	Federal Funds (Title XIX)								
HEALTHY FAMILIES									
	State Funds								
	County Funds								
	Federal Funds (Title XXI)								
STRAIGHT CCS									
	State Funds								
	County Funds								
TOTAL SOURCE OF FUNDS									

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official

Type or Print Name of Contact Person

Type or Print Name of Authorized Official

Date

()
Telephone Number

February 2007

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services Branch

**CALIFORNIA CHILDRENS SERVICES (CCS) PROGRAM
FISCAL YEAR: 2007-08
CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)**

COUNTY: ANY COUNTY, USA

NO.: 1

QUARTER: JULY 1, 1007 THRU SEPTEMBER 30, 2007

CCS CASELOAD	DIFFERENCE IN CASELOAD	PERCENT OF GRAND TOTAL
<i>A</i>	<i>B</i>	<i>C</i>
MEDI-CAL CASES		
Average Total Cases of Open (Active) Medi-Cal Children		
Potential Cases of Medi-Cal Children		
TOTAL MEDI-CAL CASES		
NON-MEDI-CAL CASES		
HEALTHY FAMILIES (HF)		
Average Total Cases of Open (Active) HF Children	895	24.75%
Potential Cases of HF Children	268	7.41%
TOTAL HEALTHY FAMILIES CASES	1,163	32.19%
STRAIGHT CCS		
Average Total Cases of Open (Active) Straight CCS Children	-895	-24.75%
Potential Cases of Straight CCS Children	-268	-7.41%
TOTAL STRAIGHT CCS CASES	-1,163	-32.16%
TOTAL NON-MEDI-CAL CASES	0	0.00%
TOTAL CASELOAD		

February 2007

Page 1 of 2

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services Branch

CCS ADMINISTRATIVE EXPENDITURE INVOICE - SUPPLEMENTAL (PART B)

COUNTY: ANY COUNTY, USA

NO.: 1 QUARTER: July 1, 2007 thru September 30, 2007

A	B CATEGORY/LINE ITEM	C=D+G TOTAL EXPENDITURES	NON-MEDI-CAL			MEDI-CAL		
			D=E+F TOTAL NON-MEDI-CAL	E STRAIGHT CCS 50/50 State/County	F HEALTHY FAMILIES 65/17.5/17.5 Fed/State/Co	G=H+I TOTAL MEDI-CAL	H ENHANCED 25/75 State/Federal	I NON-ENHANCED 50/50 State/Federal
I.	Total Personnel Expenses	0	0	-64,628	64,628	0		
II.	Total Operating Expenses	0	0	-20,503	20,503	0		
III.	Total Capital Expenses	0	0	0	0	0		
IV.	Total Indirect Expenses	0	0	-10,488	10,488	0		
V.	Total Other Expenses	0	0	-1,823	1,823	0		
	TOTAL EXPENDITURES	0	0	-97,442	97,442	0		

Maintenance & Transportation \$0 \$0 (\$755) \$755 \$0

SOURCE OF FUNDS		J	K=L+O	L	M	N	O=P+Q	P	Q
MEDI-CAL									
	State Funds								0
	Federal Funds (Title XIX)								0
HEALTHY FAMILIES									
	State Funds					17,052			
	County Funds					17,052			
	Federal Funds (Title XXI)					63,337			
STRAIGHT CCS									
	State Funds				-48,721				
	County Funds				-48,721				
TOTAL SOURCE OF FUNDS					-97,442	97,442			

CERTIFICATION: I hereby certify under penalty of perjury that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection, with the program; that I have not violated any of the provisions of Section 1030 to 1036 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claims; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Signature of Authorized Official
 MARY SMITH
 Type or Print Name of Authorized Official

12/1/2007
 Date

JANE DOE
 Type or Print Name of Contact Person
 (123) 456-7890
 Telephone Number

February 2007
 Page 2 of 2

CCS DIAGNOSTIC, TREATMENT, AND THERAPY EXPENDITURE REPORTING

INSTRUCTIONS FOR COMPLETION AND INVOICE FORMS

PART I. SUMMARY REPORT OF DIAGNOSTIC AND TREATMENT EXPENDITURES

Open the Excel file and go to the worksheet tab labeled 'Part I Dx Trtmnt' (yellow tab if you have Microsoft Excel 2003).

- Fill in the name of your county on the line at the top left corner.
- Fill in the 'from' and 'to' date on the 'Expenditures from:' line at the top right corner of the form.

1. DIAGNOSTIC Expenditures

- Enter on line **a** the total amount of Diagnostic expenditures for the quarter from the sum of the three **MR-0-940 Monthly Expenditure Reports**. (If the amount is negative, enter as a negative.)
- Enter on line **b** the total of **County paid diagnostic** expenditures for the quarter. (Please note, an entry on this line should only be made if the county has prior approval from the Children's Medical Services (CMS) Branch or the transition to the fiscal intermediary (FI) provider payment processing occurred within the last 18 months of the quarter being claimed.)
- Enter on line **c** the total amount of approved diagnostic expenditure **Adjustments** (the approved adjustment documentation must be attached). The amount entered must be entered as a **positive if it is increasing the expenditures or a negative if it is decreasing the expenditures**.
- Enter on line **d** the amount of **Miscellaneous Revenue** the county received during the quarter. (This includes deposits made within the county for returned warrants and provider refunds, enter amount as a positive.)
- Lines **e** and **f** are formula driven and will calculate based on the data entered in the lines a, b, c, and d.
- Enter on line **g** the amount of **Emergency Relief Funding (100% State)**. Per H&SC Section 123945, a board of supervisors signed request is required and must be on file with CMS. The amount entered must be entered as a **positive**. (Please note: an entry on this line should only be made provided the county has prior approval and has coordinated with state personnel the correct amount.)

2. TREATMENT Expenditures

- Enter on line **a** the total amount of treatment expenditures for the quarter from the sum of the three **MR-0-940 Monthly Expenditure Reports** that are applicable. (If the amount is negative, enter as a negative.)

- Enter on line **b** the sum of the three **MR-O-163(M) Monthly CCS Financial Reports**, CCS Funded totals, (Aid Code 9K), Net Paid Amount. **(If the amount is negative, enter as a negative.**
- Enter on line **c** the total of **County Paid Treatment** expenditures for the quarter (this includes county paid dental). *(Please note; an entry on this line should only be made if the county has prior approval or the transition to FI provider payment processing occurred within the last 18 months of the quarter being claimed.)*
- Enter on line **d** the total amount of approved treatment expenditure **Adjustments**, this amount also includes Delta Dental *(the approved adjustment documentation must be attached)*. The amount entered must be entered as a **positive if it is increasing the expenditures or a negative if it is decreasing the expenditures.**
- Enter on line **e** the amount of **Miscellaneous Revenue** the county received during the quarter. (This includes returned warrants and provider refunds, enter amount as a positive.)
- Lines **f** and **g** are formula driven and will calculate based on the data entered in the lines a, b, c, d, and e.
- Enter on line **h** the amount of **Emergency Relief Funding (100% State)**. Per H&SC Section 123945, a board of supervisors signed request required and must be on file with CMS. The amount entered must be entered as a **positive**. *(Please note: an entry on this line should only be made if the county has prior approval and has coordinated with state personnel the correct amount.)*

3. SUBTOTALS DIAGNOSTIC and TREATMENT EXPENDITURES

Lines **a** and **b** are formula driven and will calculate from the data entered in the lines above. Line **a** represents the total reportable expenditures, and line **b** represents a gross total which is used in determining the amount of reimbursement due to the state or due to the county.

4. TOTAL COUNTY SHARE 50% Net Diagnostic & Treatment Expenditures

This line calculates the **total county share** of the CCS diagnostic and treatment expenditures for the quarter. *This amount is the total reportable county cost of the non-Medi-Cal and non-Healthy Families CCS diagnostic and treatment expenditures for the quarter. This amount does not necessarily equal the amount of the Claim for Reimbursement which is determined by a number of different variables.*

5. ASSESSMENT FEES

Enter in field '**a**' the amount of the year to date outstanding assessment fees and enter in field '**b**' the amount collected for the quarter.

6. **ENROLLMENT FEES**

Enter in field 'a' the amount of the year to date outstanding enrollment fees and enter in field 'b' the amount collected for the quarter.

(The remaining lines on this worksheet are formula driven.)

7. **TOTAL FEES COLLECTED**

This line calculates from the entries in lines 5 and 6.

8. **GROSS Diagnostic and Treatment Expenditures, and FEES collected**

This line will calculate from the data in the fields '3.b.' and '7'.

9. **50% OF GROSS DIAGNOSTIC & TREATMENT, and FEES COLLECTED**

This field will calculate from the field on line 8.

10. **AMOUNT DUE STATE (positive) or DUE COUNTY (negative)**

This field will pull the same amount as line 9 , and is displayed only for summary purposes.

PART II. SUMMARY REPORT OF THERAPY EXPENDITURES

Open the Excel file and go to the worksheet tab labeled 'Part II Therapy' (orange tab if you have Microsoft Excel 2003).

Information pertaining to the expenditures claimed for the Medical Therapy Program (MTP) can be found in Numbered Letters 33-1293 and 35-0994. Additionally, County programs can find specific detail on the types of supplies and equipment that may be purchased and claimed through their California Children's Services (CCS) MTP in CCS Information Notice No.: 07-01, Revised Interagency Agreement (IA) between California Department of Health Services, Children's Medical Services (CMS) Branch and California Department of Education (CDE), Special Education Division.

HEADING

County

Enter the name of the county for which this invoice applies.

Quarter

Enter the number of the quarter for which the invoice applies.

Enter the dates of the quarter for which the invoice applies.

Quarter 1: July 1 200x – September 30, 200x

Quarter 2: October 1, 200x – December 31, 200x

Quarter 3: January 1, 200x+1 – March 31, 200x+1

Quarter 4: April 1, 200x+1 – June 30, 200x+1

MTP CASELOAD

Non-Medi-Cal

Enter the number of cases that qualify as Non-Medi-Cal.

Medi-Cal

Enter the number of cases that qualify as Medi-Cal.

Total

Enter the total number of cases by adding the number of cases for Non-Medi-Cal and Medi-Cal.

SECTION I. COUNTY EMPLOYED MEDICAL THERAPY UNIT (MTU) STAFF (excluding staff designated as MTP liaison and for Individualized Education Program (IEP) attendance)

1. Name

Enter the name of each county employed therapist and supporting staff (therapy aides, therapy assistants, etc.) allocated by the State who provided direct patient care in the MTU and/or directly supervised therapists during the reporting period.

2. Classification

Enter the appropriate civil service classification for each staff person.

3. Monthly Salary

Enter the monthly salary for each staff person listed.

4. Full Time Equivalent (FTE) Percent

Enter, in decimals, the percent of time that each staff person worked in the therapy program.

A staff person cannot claim time worked in both MTP and the administrative program. Also, a staff person's time cannot exceed 100 percent.

5. Expenditures Paid for Quarter

Enter the total expenditures paid for each staff person by:

- a. Multiplying the appropriate Monthly Salary in Column 3 by 3 (for the three months in the quarter), and
- b. Multiplying the result by the corresponding FTE Percent in Column 4.

6. Total, Personal Services

Enter the total for personal services by adding all entries in Column 5. Expenditures Paid for Quarter.

7. Staff Benefits

Enter the staff benefits percentage paid by the county for county employed therapy staff.

Enter the amount paid by the county for staff benefits by multiplying the amount in Line 6. Total, Personal Services by the staff benefits percentage.

Costs for staff benefits must be normal, reasonable, program related, and consistently applied to all employees, and must be in conformity with county policy for therapy positions.

8. Travel Costs

Enter the total amount of travel expenses incurred by therapy staff during the reporting quarter.

Allowable travel expenses are:

- a. Mileage defined as travel within the county to perform job related duties, and
- b. Expenses related to in-service training and State sponsored seminars. These expenses may include per diem, commercial auto rental, air travel, and private vehicle mileage costs.

All travel costs shall be supported by employee travel expense documents.

No travel outside the State of California shall be claimed without prior written State authorization.

9. Internal Indirect Costs

Enter the percentage paid by the county for internal indirect costs.

Enter the amount paid by the county for internal indirect costs by multiplying the total of the amounts in Line 6. Total, Personal Services and Line 7. Staff Benefits by the internal indirect costs percentage.

10. TOTAL, COUNTY EMPLOYED MTU STAFF

- a. Enter the total for county employed MTU staff by adding the amounts entered in Line 6. Total, Personal Services; Line 7. Staff Benefits; Line 8. Travel Costs; and Line 9. Internal Indirect Costs.
- b. Enter the State share due county by multiplying the total from Line 10a by 50 percent.

SECTION II. CONTRACT THERAPISTS

1. Name

Enter the name of each therapist contracted by the county to provide direct patient care in the MTU during the reporting period.

2. Job Title

Enter the job title of each therapist contracted by the county for the reporting quarter.

3. Hourly Rate

Enter the hourly rate paid by the county for each contract therapist.

4. Number of Hours Worked

Enter the number of hours, or fractions thereof, that each contract therapist worked during the reporting quarter.

5. Expenditures Paid for Quarter

Enter the total expenditures paid for each contract therapist by multiplying the appropriate Hourly Rate in Column 3 by the corresponding number of hours worked in Column 4.

6. TOTAL, CONTRACT THERAPISTS

- a. Enter the total for contract therapists by adding all entries in Column 5. Expenditures Paid for Quarter.
- b. Enter the State share due county by multiplying the total from Line 6a by 50 percent.

SECTION III. MTP COORDINATION with SPECIAL EDUCATION LOCAL PLANNING AREA/LOCAL EDUCATION AGENCY (SELPA/LEA) LIAISON ACTIVITIES and IEP ATTENDANCE by MTP STAFF

This section is specific to the MTP requirements that are outlined in interagency regulations. The State allocates the staffing levels and reimburses the county for the expenditures incurred by these staff with 100 percent State funding.

1. Name

Enter the name of each county employed therapist allocated by the State who performs SELPA/LEA/IEP functions during the reporting period.

2. Classification

Enter the appropriate civil service classification for each staff person.

3. Monthly Salary

Enter the monthly salary for each staff person listed.

4. FTE Percent

Enter, in decimals, the percent of time that each staff person worked in the therapy program.

A staff person cannot claim time worked in both MTP and the administrative program. Also, a staff person's time cannot exceed 100 percent.

5. Expenditures Paid for Quarter

Enter the total expenditures paid for each staff person by:

- a. Multiplying the appropriate Monthly Salary in Column 3 by 3 (for the three months in the quarter), and
- b. Multiplying the result by the corresponding FTE Percent in Column 4.

6. Total, Personal Services

Enter the total for personal services by adding all entries in Column 5. Expenditures Paid for Quarter.

7. Staff Benefits

Enter the staff benefits percentage paid by the county for county employed therapy staff performing SELPA/LEA/IEP functions.

Enter the amount paid by the county for staff benefits by multiplying the amount in Line 6. Total, Personal Services by the staff benefits percentage.

Costs for staff benefits must be normal, reasonable, program related, and consistently applied to all employees, and must be in conformity with county policy for therapy positions.

8. Travel Costs

Enter the total amount of travel expenses incurred by therapy staff during the reporting quarter.

Allowable travel expenses are:

- a. Mileage defined as travel within the county to perform job related duties, and
- b. Expenses related to in-service training and State sponsored seminars. These expenses may include per diem, commercial auto rental, air travel, and private vehicle mileage costs.

All travel costs shall be supported by employee travel expense documents.

No travel outside the State of California shall be claimed without prior written State authorization.

9. Internal Indirect Costs

Enter the percentage paid by the county for internal indirect costs.

Enter the amount paid by the county for internal indirect costs by multiplying the total of the amounts in Line 6. Total, Personal Services and Line 7. Staff Benefits by the internal indirect costs percentage.

10. TOTAL, COUNTY STAFF for SELPA/LEA/IEP FUNCTIONS

- a. Enter the total for county staff for SELPA/LEA/IEP functions by adding the amounts entered in Line 6. Total, Personal Services; Line 7. Staff Benefits; Line 8. Travel Costs; and Line 9. Internal Indirect Costs.
- b. Enter the State share due county by entering the total from Line 10a.

The State share of expenditures for county staff performing SELPA/LEA/IEP functions is 100%.

SECTION IV. MTU EXPENDITURES (Detail Document Required)

1. MTU Supply and Equipment Costs

Enter the total of MTU Supply and Equipment Costs from the MTU Expenditures – Detail Document.

2. MTU Conference Costs

Enter the total of MTU Conference Costs from the MTU Expenditures – Detail Document.

3. Training/Education

Enter the total of Training/Education from the MTU Expenditures – Detail Document.

4. Miscellaneous MTU Costs

Enter the total of Miscellaneous MTU Costs from the MTU Expenditures – Detail Document.

5. TOTAL, MTU EXPENDITURES

Enter the total for MTU expenditures by adding the amounts entered in Line 1. MTU Supply and Equipment Costs; Line 2. MTU Conference Costs; Line 3. Training/Education; and Line 4. Miscellaneous MTU Costs.

SECTION V. SUBTOTAL, THERAPY EXPENDITURES

- a. Enter the subtotal for therapy expenditures by adding the totals of Section I. County Employed MTU Staff; Section II. Contract Therapists; and Section IV. MTU Expenditures.
- b. Enter the total State share due county by multiplying the total from Line a. by 50 percent.

SECTION VI. ELECTRONIC DATA SYSTEMS (EDS) PAID CLAIMS

- a. Enter the amount of therapy expenditures from the MR-0-940 Report for the reporting quarter.

This amount represents the total of MR-0-940 expenditures for each of the three months within the reporting quarter.

- b. Enter the amount of offset to State share due county by multiplying the amount from Line a. by 50 percent.

SECTION VII. TOTAL STATE SHARE at 50% DUE COUNTY

Enter the amount of State share due county by subtracting the amount in Section VI.b. from Section V.b. only if section V.b. is greater than Section VI.b.

SECTION VIII. TOTAL COUNTY SHARE DUE STATE

Enter the amount of county share due State by subtracting the amount in Section V.b. from Section VI.b. only if Section VI.b. is greater than Section V.b.

SECTION IX. TOTAL, STATE SHARE at 100% DUE COUNTY

Enter the amount from Section III., Line 10.b. State Share Due County (100%).

SECTION X. TOTAL, THERAPY EXPENDITURES

Enter the total for therapy expenditures by adding the totals of Section I. County Employed MTU Staff; Section II. Contract Therapists; Section IV. MTU Expenditures; and Section VI. EDS Paid Claims.

The total of Section III. County Staff for SELPA/LEA/IEP Functions is excluded in this calculation.

SECTION XI. MTU MEDI-CAL/ COUNTY ORGANIZED HEALTH SYSTEM (COHS) PAID THERAPY

The CMS Branch releases a letter on a quarterly basis that indicates the amount of MTU claims billed to Medi-Cal for each county that does not use a COHS to process such claims. The letter also indicates the amount of reimbursement that each county owes the State for the MTU claims paid by Medi-Cal.

- a. Enter the amount of MTU claims billed to Medi-Cal or COHS for the reporting quarter.
- b. Enter the amount for county share due State by multiplying the amount in Line a. by 75 percent.

For counties that bill Medi-Cal for MTU claims, the county share due State is equal to the amount of reimbursement identified in the letter from the CMS Branch.

SECTION IV. MTU EXPENDITURES – Detail Document (purple tab)

1. MTU Supply and Equipment Costs

Item – List each individual supply or equipment item that is purchased.

Description – Provide a brief, concise description or explanation of the each item. Be specific.

Quantity – Enter the number of each item that is purchased.

Unit Cost – Enter the unit cost of each individual item. Unit cost must correlate to the unit of issue.

Cost Extension – Enter the total cost of each item by multiplying the quantity by the unit cost.

Unit of Issue – Enter how each individual item is produced for sale (box, roll, kit, package, each, etc.). Unit of issue must correlate to the unit cost.

Purpose – Explain the purpose, provide the reason(s), and/or justify the need for each item.

Authority – Identify the document (interagency agreement, information notice, numbered letter, etc.) and citation (page number, section, line, category, etc.) that authorizes the payment of each item by the CCS program. Be specific.

Total, MTU Supply and Equipment Costs – Enter the total for MTU supply and equipment costs by adding all entries in the Cost Extension column.

2. MTU Conference Costs

Item – List each individual conference cost that is incurred.

Description – Provide a brief, concise description or explanation of the each cost. Be specific.

Cost – Enter the cost of each item.

Purpose – Explain the purpose, provide the reason(s), and justify the need for each item.

Authority – Identify the document (interagency agreement, information notice, numbered letter, etc.) and citation (page number, section, line, category, etc.) that authorizes the payment of each item by the CCS program. Be specific.

Total, MTU Conference Costs – Enter the total for MTU conference costs by adding all entries in the Cost column.

3. Training/Education

Name – Enter the name of the county employed staff person registered for training/education.

Course Name and Description – Enter the name of the training/education course and provide a brief, concise description of the class, seminar, etc.

Cost – Enter the cost or registration fees for the training/education course.

Do not include any travel costs here. Any expenses incurred for travel related to the training/education course should be included in Line 8. Travel Costs under Section I or III.

No. of Days – Enter the number of days that the staff person will be attending the training/education.

Course Date(s) – Provide the dates of the scheduled training/education course.

Authority – Identify the document (interagency agreement, information notice, numbered letter, etc.) and citation (page number, section, line, category, etc.) that authorizes the payment of each item by the CCS program. Be specific.

Total, Training/Education – Enter the total for all training/education by adding all the entries in the Cost column.

4. Miscellaneous MTU Costs

Item – List each miscellaneous item that is purchased.

Description – Provide a brief, concise description or explanation of the each item. Be specific.

Quantity – Enter the number of each item that is purchased.

Unit Cost – Enter the unit cost of each miscellaneous item. Unit cost must correlate to the unit of issue.

Cost Extension – Enter the total cost of each item by multiplying the quantity by the unit cost.

Unit of Issue – Enter how each item is produced for sale (box, roll, kit, package, each, etc.). Unit of issue must correlate to the unit cost.

Purpose – Explain the purpose, provide the reason(s), and justify the need for each item.

Authority – Identify the document (interagency agreement, information notice, numbered letter, etc.) and citation (page number, section, line, category, etc.) that authorizes the payment of each item by the CCS program. Be specific.

Total, Miscellaneous MTU Costs – Enter the total for miscellaneous MTU costs by adding all entries in the Cost Extension column.

5. TOTAL, MTU EXPENDITURES

Enter the total for all MTU expenditures by adding the totals for MTU Supply and Equipment Costs, MTU Conference Costs, Training/Education, and Miscellaneous MTU Costs.

CCS QUARTERLY REPORT OF EXPENDITURES

DIAGNOSTIC AND TREATMENT

_____ COUNTY Expenditures from: _____ to: _____
(Per H&S Code, Sections 123800-123996 and related legislation)

PART I SUMMARY REPORT OF DIAGNOSTIC AND TREATMENT EXPENDITURES

1. DIAGNOSTIC Expenditures

- a. MR-0-940 \$ _____
- * b. County paid diagnostic (*requires approval*) _____
- c. Adjustments (approval documentation must be attached) _____
State approved adjustments not reported above may be entered by the State during processing. Net and Gross totals may change.
- d. Misc. Revenue & Refunds _____
- e. Net Diagnostic Expenditures = a + b + c - d **\$0**
the "Net" amount represents total reportable expenditures less revenues & refunds
- f. Gross Diagnostic = a - b + c + d **\$0**
the gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).
- g. Emergency Relief Funding (100% State) \$ _____
H&S Code Section 123945, Bd of Supvs signed request required & on file
- * *transition to EDS was within the last 18 months or approval on file to invoice for county paid claims.*

2. TREATMENT Expenditures

- a. MR-0-940 \$ _____
- b. MR-0-163 (M) Delta Dental _____
- * c. County paid treatment (*requires approval*) _____
- d. Adjustments (approval documentation must be attached) _____
State approved adjustments not reported above may be entered by the State during processing. Net and Gross totals may change.
- e. Misc. Revenue & Refunds \$ _____
- f. Net Treatment Expenditures = a + b + c + d - e **\$0**
the "Net" amount represents total reportable expenditures less revenues & refunds
- g. Gross Treatment = a + b - c + d + e **\$0**
the gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).
- h. Emergency Relief Funding (100% State) \$ _____
H&S Code Section 123945, Bd of Supvs signed request required & on file.
- * *transition to EDS was within the last 18 months or approval on file to invoice for county paid claims.*

3. SUBTOTALS DIAGNOSTIC and TREATMENT EXPENDITURES

- a. Net Diagnostic and Treatment (1.e. + 2.e.) **\$0**
- b. Gross Diagnostic and Treatment (1.f. + 2.f.) **\$0**

4. TOTAL COUNTY SHARE 50% Net Diagnostic & Treatment Expenditures
(amount reportable as actual County share of expenditures) **\$0**

5. ASSESSMENT FEES a. receivables _____ b. collected _____

6. ENROLLMENT FEES a. receivables _____ b. collected _____

7. TOTAL FEES COLLECTED **\$0**

8. GROSS Diagnostic and Treatment Expenditures, and Fees collected **\$0**
the gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).

9. 50% OF GROSS DIAGNOSTIC & TREATMENT, and FEES COLLECTED **\$0**

10. AMOUNT DUE STATE (positive) or DUE COUNTY (-) **\$0**
AMOUNT DUE may change if any State approved adjustments were entered by the State during processing.

County: _____

**CCS QUARTERLY REPORT OF EXPENDITURES
MEDICAL THERAPY PROGRAM (MTP)
PART II. SUMMARY REPORT OF THERAPY EXPENDITURES**

Quarter: _____
Expenditures from _____ to _____
per Health and Safety Code Sections 123800-123995

MTP Caseload	
Non-Medi-Cal	_____
Medi-Cal	_____
Total	0

SECTION I. COUNTY EMPLOYED MTU STAFF (excluding staff designated as MTP liaison and for IEP attendance)

1. Name	2. Classification	3. Monthly Salary	4. FTE Percent	5. Expenditures Paid for Quarter

- 6. Total, Personal Services _____
- 7. Staff Benefits @ _____% _____
- 8. Travel Costs _____
- 9. Internal Indirect Costs @ _____% _____
- 10. TOTAL, COUNTY EMPLOYED MTU STAFF a. _____ - b. State Share Due County (50%) _____ -

SECTION II. CONTRACT THERAPISTS

1. Name	2. Job Title	3. Hourly Rate	4. Number of Hours Worked	5. Expenditures Paid for Quarter

The county certifies that it invoices the State for reimbursement of contract physical therapists (PT) and occupational therapists (OT) at the same rate it pays county employed PTs and OTs, including benefits. The difference in the higher rate of pay for contract positions will be paid 100% from county funds, unless specifically pre-approved and authorized as an area of critical need by the State Children's Medical Services Branch. On a separate attachment, please notate any costs that are not reimbursed by the State.

- 6. TOTAL, CONTRACT THERAPISTS a. _____ - b. State Share Due County (50%) _____ -

Revised April 9, 2007

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

County: _____

CCS QUARTERLY REPORT OF EXPENDITURES
MEDICAL THERAPY PROGRAM (MTP)

Quarter: _____

Expenditures from _____ to _____

PART II. SUMMARY REPORT OF THERAPY EXPENDITURES

per Health and Safety Code Sections 123800-123995

SECTION III. MTP COORDINATION with SELPA/LEA LIAISON ACTIVITIES and IEP ATTENDANCE by MTP STAFF

1. Name	2. Classification	3. Monthly Salary	4. FTE Percent	5. Expenditures Paid for Quarter

6. Total, Personal Services _____
 7. Staff Benefits @ _____% _____
 8. Travel Costs _____
 9. Internal Indirect Costs @ _____% _____
 10. TOTAL, COUNTY STAFF for SELPA/LEA/IEP FUNCTIONS a. _____ - b. State Share Due County (100%) _____ -

SECTION IV. MTU EXPENDITURES (Detail Document Required)

1. MTU Supply and Equipment Costs _____
 2. MTU Conference Costs _____
 3. Training/Education _____
 4. Miscellaneous MTU Costs _____
 5. TOTAL, MTU EXPENDITURES a. _____ - b. State Share Due County (50%) _____ -

SECTION V. SUBTOTAL, THERAPY EXPENDITURES

Total of Sections I, II, and IV a. _____ - b. Total State Share Due County (50%) _____ -

SECTION VI. EDS PAID CLAIMS

MR-0-940 Expenditures including Adjustments a. _____ - b. Offset to State Share Due County (50%) _____ -

SECTION VII. TOTAL STATE SHARE at 50% DUE COUNTY

If Section V is greater than Section VI, subtract Section VI from Section V. State Share Due County (50%) _____ -

SECTION VIII. TOTAL COUNTY SHARE DUE STATE

If Section VI is greater than Section V, subtract Section V from Section VI. County Share Due State _____ -

SECTION IX. TOTAL, STATE SHARE at 100% DUE COUNTY

Section III, State Share Due County (100%) State Share Due County (100%) _____ -

SECTION X. TOTAL THERAPY EXPENDITURES

Total of Sections I, II, IV, and VI _____ -

SECTION XI. MTU MEDI-CAL/COHS PAID THERAPY

MTU Claims Paid by Medi-Cal or COHS Paid Therapy a. _____ - b. County Share Due State (75%) _____ -

Revised April 9, 2007

County: _____

**CCS QUARTERLY REPORT OF EXPENDITURES
MEDICAL THERAPY PROGRAM
PART II. SUMMARY REPORT OF THERAPY EXPENDITURES**

Quarter: _____
From: _____ to _____

SECTION IV. MTU EXPENDITURES - DETAIL DOCUMENT

1. MTU Supply and Equipment Costs

Item	Description	Quantity	Unit Cost	Cost Extension	Unit of Issue	Purpose	Authority

Total, MTU Supply and Equipment Costs \$ _____

2. MTU Conference Costs

Item	Description	Cost	Purpose	Authority

Total, MTU Conference Costs \$ _____

3. Training/Education

Name	Course Name and Description	Cost	No. of Days	Course Date(s)	Authority

Total, Training/Education \$ _____

4. Miscellaneous MTU Costs

Item	Description	Quantity	Unit Cost	Cost Extension	Unit of Issue	Purpose	Authority

Total, Miscellaneous MTU Costs \$ _____

5. TOTAL, MTU EXPENDITURES \$ _____

April 9, 2007

CCS INSTRUCTIONS FOR CCS CLAIM FOR REIMBURSEMENT

Open the Excel file and go to the worksheet tab labeled: "Claim for Reimb" (green tab if you have Microsoft Excel 2003).

This worksheet was developed to calculate the amount of reimbursement due to the state or due to the county from the two separate worksheets, 'Part I DX Trtmnt' (yellow tab) and 'Part II Therapy' (blue tab). The only entries the county will make are as follows:

Heading

The county will enter the county 'name', the 'fiscal year', and the 'from' and 'to' dates for the quarter being claimed.

No other data, or field entries are required before printing, however, the date fields and telephone number fields may be entered before printing the form.

Print out the worksheets, review for completeness, and have them signed by the appropriate staff. Signature stamps are not acceptable.

Send the original signed copy of the 'Claim for Reimbursement' and Parts I and II, including the required attachments, to:

Department of Health Care Services
Children's Medical Services Branch
Program Support Section – Administration Unit
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services Branch

**CCS CLAIM FOR REIMBURSEMENT
DIAGNOSTIC/TREATMENT/THERAPY**

To: STATE OF CALIFORNIA, DEPARTMENT OF HEALTH CARE SERVICES

CLAIM OF: _____ COUNTY _____ FISCAL YEAR: _____
FOR EXPENDITURES INCURRED FROM: _____ TO: _____

(PURSUANT TO SECTIONS 123800-123995 OF THE HEALTH AND SAFETY CODE, AND RELATED LEGISLATION)

PART I **DIAGNOSTIC AND TREATMENT** ('amount from Lines' are from the 'CCS QUARTERLY REPORT OF EXPENDITURES, PART I') **Positive amount = due State; negative (-) amount = due County. Except line 11&12 display as a positive, the amount due County (line 11) or due State (line 12).**

- | | | | |
|----|--|----------------------|----------------------|
| 1. | DIAGNOSTIC - (<i>amount from Line 1. f.</i>) | <input type="text"/> | <input type="text"/> |
| | 1.a. County Share (50% of line 1. above or adjusted for relief) | | <input type="text"/> |
| 2. | TREATMENT - (<i>amount from Line 2. f.</i>) | <input type="text"/> | <input type="text"/> |
| | 2.a. County Share (50% of line 2. above or adjusted for relief) | | <input type="text"/> |
| 3. | Subtotal COUNTY SHARE Diagnostic & Treatment (line 1.a.+ line 2.a.) | | <input type="text"/> |
| | <i>positive amount = amount due State, negative (-) amount = amount due County</i> | | |
| 4. | TOTAL Fees Collected | <input type="text"/> | <input type="text"/> |
| | 4.a. County Share (50% of line 4. above) | | <input type="text"/> |
| 5. | TOTAL PART I (line 3. + line 4.a.) | | <input type="text"/> |
| | <i>positive amount = amount due State, negative (-) amount = amount due County</i> | | |

- PART II** **MEDICAL THERAPY PROGRAM** (amounts are from CCS QUARTERLY REPORT OF EXPENDITURES, PART II)
- | | | | |
|----|---|----------------------|----------------------|
| 6. | Total County Share (<i>amount from Section VII or Section VIII</i>) | <input type="text"/> | <input type="text"/> |
| 7. | Total 100% Reimbursable to County (<i>from Section IX, as applicable</i>) | | <input type="text"/> |
| 8. | Total Medi-Cal /COHS due State (<i>amount from Section XI</i>) | | <input type="text"/> |
| 9. | TOTAL PART II (sum of lines 6, 7, & 8) | | <input type="text"/> |

- PART III** **TOTAL CLAIM FOR REIMBURSEMENT**
- | | | | |
|-----|---|----------------------|----------------------|
| 10. | TOTAL OF PART I and PART II (Line 5 + Line 9) | <input type="text"/> | <input type="text"/> |
| 11. | AMOUNT DUE COUNTY | | <input type="text"/> |
| | <i>or</i> | | |
| 12. | AMOUNT DUE STATE | | <input type="text"/> |

CERTIFICATION: I hereby certify under penalty of perjury, that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By: _____ Date: _____ Telephone Number : _____

Authorized Signature: _____ Title: _____ Date: _____

CCS INSTRUCTIONS FOR CCS HEALTHY FAMILIES (HF)

Quarterly Report of Expenditures

Open the Excel file **CCS HF Invoice**. Fill in the 'fiscal year', county 'name', and the 'Expenditures from' and 'to' dates for the quarter being reported.

1. HF TREATMENT

- Enter on line **a** the total amount of HF Treatment expenditures for the quarter from the sum of the three **MR-0-940 Monthly Expenditure Reports** applicable. **(If the amount is negative, enter as a negative.)**
- Enter on line **b** the sum of the three **MR-O-163(M) Monthly CCS Financial Reports, CCS HF (9H) FUNDED TOTALS, (Aid Code 9K), Net Paid Amount.** **(If the amount is negative, enter as a negative.)**
- Enter on line **c** the total amount of approved HF Treatment expenditure **Adjustments** **(only adjustments of FI paid claims, MR-0-940 corrections can be entered; approval documentation must be attached).** The amount entered must be entered as a positive if it is increasing the expenditures or a negative if it is decreasing the expenditures.
- Enter the amount of county paid HF treatment expenditures on line **d** (this includes county paid dental, also). **(Pre-approval by CMS must be attached or on file in the CMS Administration Unit).**
- Line **e** will calculate the total HF Treatment expenditures.

2. HF THERAPY

'HF Therapy' expenditures are payments to vendors, and are provided in lieu of the County MTP for HF. HF therapy expenditures should only be coded and paid from this fund source when services have been provided to HF clients.

- Enter on line **a** the total amount of HF therapy expenditures for the quarter from the sum of the three **MR-0-940** reports applicable. **(If the amount is negative, enter as a negative.)**
- Enter on line **b** the total amount of approved HF therapy expenditure **adjustments** **(only adjustments of FI paid claims, MR-0-940 corrections can be entered; approval documentation must be attached).** The amount entered must be entered as a positive if it is increasing the expenditures or a negative if it is decreasing the expenditures.
- Enter on line **c** the amount of County Paid HF Therapy expenditures **(pre-approval by CMS must be attached or on file in the CMS Administration Unit).**
- Line **d** calculates the total HF Therapy expenditures.

3. TOTAL HEALTHY FAMILIES EXPENDITURES

Formula will calculate from the entries made in HF Treatment and HF Therapy. This amount is rounded to the nearest dollar.

4. FUNDING SOURCES

The funding sources for **a** Total HF expenditures and adjustments; **b** Total County Paid; and **c** Total HF Expenditure Funding Sources are formula driven.

5. AMOUNT DUE

Amount due is formula driven and calculates the **Amount due State or Amount due County**

No other data or field entries are required before printing, however, the date fields and phone number field may be entered before printing the form.

Print out the worksheet, review for completeness, and have it signed by the appropriate staff. Signature stamps are not acceptable.

Send the original signed copy of the 'CCS HEALTHY FAMILIES QUARTERLY REPORT OF EXPENDITURES' including required attachments, to:

Department of Health Care Services
Children's Medical Services Branch
Program Support Section – Administration Unit
MS 8104
P.O. Box 997413
Sacramento, CA 95899-7413

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

State of California - Health and Human Resources Agency

Department of Health Care Services - Children's Medical Services Branch

CCS HEALTHY FAMILIES (HF) QUARTERLY REPORT OF EXPENDITURES

FISCAL YEAR: _____

COUNTY _____

Expenditures from: _____

to _____

(Per H&S Code, Sections 123800-123995 and related legislation)

1. HF TREATMENT

a. MR-0-940 \$ _____

b. MR-0-163 (M) Delta Dental _____

* c. Treatment Adjustments *(fiscal intermediary related, MR-0-940 only)* _____

d. County Paid HF Treatment _____

e. Total HF Treatment (a. + b. + c. + d.) [Green Box]

* *Approval documentation must be attached, or on file with CMS Administration Unit. Approved adjustments, not reported above, may be entered by the State during processing which may change the totals.*

2. HF THERAPY

a. MR-0-940 \$ _____

* b. Therapy Adjustments *(fiscal intermediary related, MR-0-940 only)* _____

c. County Paid HF Therapy _____

d. Total HF Therapy (a.+ b.+c.) [Green Box]

e. Total Gross HF Therapy (a.+ b.-c.) [Green Box]

* *Adjustments of FI paid claims only, documentation must be attached, or on file with CMS Administration Unit. Approved adjustments, not reported above, may be entered by the State during processing which may change the totals.*

3. TOTAL HEALTHY FAMILIES EXPENDITURES *(Total is rounded to nearest dollar)* [Green Box]

4. FUNDING SOURCES

Federal Title XXI

State

County

a. Total MR-0-940 and Adjustments

[Green Box]
[Green Box]
[Green Box]

[Green Box]
[Green Box]
[Green Box]

[Green Box]
[Green Box]
[Green Box]

b. Total County Paid

c. Total HF Expenditure Funding Sources

5. AMOUNT DUE (formula will calculate) :

Amount due STATE

[Orange Box]

or

Amount due COUNTY

[Yellow Box] **\$0**

CERTIFICATION: I hereby certify under penalty of perjury, that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or services claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previously been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By: _____ Date: _____ Telephone Number : _____

Authorized Signature: _____ Title: _____ Date: _____

Management of Equipment Purchased with State Funds

I. County/City Guidelines for Equipment

All equipment purchased with funds furnished in whole or in part by the State under the terms of this agreement shall be the property of the State and shall be subject to the following provisions.

- A. The county/city shall use its own procurement process when purchasing equipment. The cost of equipment includes the purchase price plus all costs to acquire, install, and prepare equipment for its intended use. Examples of items may include computers, printers, photocopiers, etc.
- B. All equipment purchased under this agreement shall be used only to conduct business related to programs funded by Children's Medical Services (CMS) Branch.
- C. The county/city shall maintain and administer, in accordance with sound business practice, a program for the utilization, maintenance, repair, protection, and preservation of state property to assure its full availability and usefulness.
- D. The county/city shall forward to the CMS Branch regional office a list of all new equipment purchased on the "Contractor Equipment Purchased with DHCS Funds" form (HAS 1203). This form can be found at:

<http://www.dhcs.ca.gov/publications/forms/pdf/has1203.pdf> (see page 84).

The regional office will forward the HAS 1203 to the Branch's Administration Unit, Program Support Section. The Administration Unit will contact the Department's Asset Management for identification tags. Asset Management is responsible for inventory and control of equipment. Asset Management staff will determine which type of tag should be applied to the pieces of equipment. Each piece of equipment will retain the same tag number for its duration. All equipment must have State identification tags affixed to the front left-hand corner. Identification tags will be forwarded to the contact person on the HAS 1203.

- E. Invoices for budgeted equipment purchases are to be submitted with their quarterly invoice only after the equipment is received.
- F. The county/city shall submit an annual inventory of state-purchased equipment on the form entitled "Inventory/Disposition of DHCS-Funded Equipment" (HAS 1204) <http://www.DHCS.ca.gov/publications/forms/pdf/has1204.pdf> (see page 93). This form has a dual purpose; it serves to provide an inventory to Asset Management of the Department's assets and to notify Asset Management when disposal of those assets is needed.
- G. Final disposition of all equipment shall be in accordance with instructions from the State and reported on the Property Survey Report.

- H. Management of all county/city equipment purchased with State funds shall be coordinated through the CMS Administrative Consultant in accordance with the procedures described in Section II below.

II. Tagging and Disposal of State Purchased Equipment

- A. Equipment subject to these procedures is defined in the State Administrative Manual (SAM), Section 8602, as all equipment with a unit cost of \$5,000 or more and a life expectancy of more than four years that is used to conduct state business.
- B. In response to the HAS 1203 received from the county/city, the CMS Branch Administrative Consultant forwards state tag(s) to the county/city with an equipment identification tag transmittal letter.
- C. State-purchased equipment used by counties/cities in performance of CMS program obligations must be disposed of according to DHCS procedures. Disposition occurs when funding is terminated; the useful life of the equipment is expended; the equipment is determined by the State to be obsolete for purpose for which it was intended; or any other reason deemed by the State to be in its own best interest.
 - 1. The county/city representative submits a written request to the CMS Branch Regional Administrative Consultant to dispose of equipment, or the CMS Branch Administrative Consultant notifies the county/city in writing that certain equipment is scheduled for disposition.
 - 2. The CMS Branch Regional Administrative Consultant notifies the DHCS Business Services Section, Property Unit, of the need for equipment disposition by submitting a completed Property Survey Report (STD 152) <http://www.osp.dgs.ca.gov/StandardForms/fill+and+Print+Standard+efor+ms.htm> (see page 94).

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

Print
Clear

STATE OF CALIFORNIA
PROPERTY SURVEY REPORT
 STD. 152 (REV. 9-2003)

Record as of disposition data (lost, stolen or destroyed property—record as of the date such determination was made).

Authority is requested to dispose of the following State property:

FUND OWNED BY:	CONTACT PERSON:	TELEPHONE NUMBER:
----------------	-----------------	-------------------

RETURN TO: REPORTING DEPARTMENT/AGENCY	ATTENTION:	DOCUMENT NUMBER:
RETURN ADDRESS:	INS. CODE:	DATE:
CITY:	ZIP CODE:	REPLACEMENTS: SEE PURCHASE ESTIMATE NUMBER:

ITEM--DESCRIPTION, MODEL NUMBER, SERIAL NUMBER, ETC.	STATE IDENT. NO. (1)	DATE PURCHASED	ORIGINAL COST	LOCATION (CITY)	PRESENT CONDITION	DISP. CODE*	PRICE OFFERED (2)	PRICE RECEIVED (3)	RECEIPT NUMBER
1.									
2.									
3.									
4.									
5.									
6.									
7.									

(1) PROPERTY TAG NUMBER OR NUMBER FOR VEHICLE (2) DO NOT OBTAIN BIDS ON TRADE-INS. ESTIMATE PRICE OFFERED (3) AMOUNT ALLOWED IF TRADED IN OR SOLD

<p>*DISPOSITION CODE</p> <p>1. TRADE-IN 2. SALE (INCLUDING JUNK SALE) 3. JUNK-VALUELESS 4. LOST** 5. STOLEN** 6. DESTROYED (AS BY FIRE, ETC.)** } DEPARTMENT OF GENERAL SERVICES REVIEW NOT REQUIRED 7. TO BE SALVAGED 8. PROPERTY REUTILIZATION—GENERAL SERVICES, SURPLUS PROPERTY</p> <p><small>**IF LOST, STOLEN OR DESTROYED, REFER TO SAM SECTION 9840 FOR INSTRUCTIONS</small></p>	<p>EXPLANATION—REASONS FOR PROPOSED DISPOSITION OF EACH ITEM</p>
--	--

<p>APPROVED BY PROPERTY SURVEY BOARD</p> <p><small>(A minimum of two signatures is required)</small></p> <p><i>The above statements regarding state property are true and correct; culpable negligence (check appropriate box)</i></p> <p><input type="checkbox"/> was <input type="checkbox"/> was not</p> <p><i>involved in loss, theft, or damage; the disposition proposed is best for the public interest.</i></p>	<p>CERTIFICATION OF DISPOSITION</p> <p><i>The above described property was disposed of as follows: (specify if no consideration was received)</i></p> <p>MANNER OF DISPOSAL:</p>	<p>REVIEWED BY DEPT. OF GENERAL SERVICES</p> <p>FOR DGS REVIEW, SEND TO: Department of General Services State Agency for Surplus Property</p> <p>NORTH 1700 National Drive Sacramento, CA 95834</p> <p>SOUTH 701 Burning Tree Road Fulleton, CA 92833</p> <p>FOR DISPOSITION OF VEHICLES AND MOBILE EQUIPMENT, SEND TO: Department of General Services Office of Fleet Administration 802 J Street Sacramento, CA 95814</p>
SIGNATURE	DATE SIGNED	DISPOSAL DATE
1.		SIGNATURE (Officer Suspending Disposal of the Property)
2.		TITLE
3.		SIGNATURE
		DATE SIGNED

(DO NOT USE HALF SHEETS OR STAPLES)

1228RT.PRP

Equipment Identification Tag Transmittal Letter

Date

County/City Program

Address

City, State Zip Code

Dear _____:

EQUIPMENT IDENTIFICATION TAG TRANSMITTAL

In accordance with State requirements for equipment management, this equipment identification tag transmittal is being issued in response to your request dated _____ and detailed on the "Contractor Equipment Purchased with DHCS Funds" form (HAS 1203). The enclosed Department of Health Care Services Equipment identification tag(s) is/are to be affixed by County/City staff to the equipment as follows:

ITEM DESCRIPTION

STATE ID NUMBER

- 1.
- 2.
- 3.
- 4.

All tags must be placed on the front left-hand corner of the item. Manufacturer's marks must be left intact.

If you have any questions regarding the instructions in this letter or the appropriate procedures for affixing the enclosed tag(s), please contact me at (____) _____-_____.

Sincerely,

(State CMS Branch Staff Name)
Administrative Consultant
Children's Medical Services Branch

SECTION 9 – FEDERAL FINANCIAL PARTICIPATION

Time Study Instructions for Enhanced/Nonenhanced Title XIX Medicaid Funding	4
Skilled Professional Medical Personnel Quiz	13
Time Study Function Code Descriptions and General Activities	15
Function 1 – Outreach.....	15
Function 2 – SPMP Administrative Medical Case Management	15
Function 3 – SPMP Intra/Interagency Coordination, Collaboration, and Administration	16
Function 4 – Non-SPMP Intra/Interagency Coordination, Collaboration, and Administration.....	16
Function 5 – Program Specific Administration	17
Function 6 – SPMP Training	17
Function 7 – Non-SPMP Training.....	18
Function 8 – SPMP Program Planning and Policy Development.....	18
Function 9 – Quality Management by Skilled Professional Medical Personnel.....	19
Function 10 – Non-Program Specific General Administration	19
Function 11 – Other Activities	20
Function 12 – Paid Time Off.....	21
Federal Financial Participation Examples of Activities for CMS Programs	22
Function 1 – Outreach.....	22
California Children's Services	22
Child Health and Disability Prevention Program.....	22
Health Care Program for Children in Foster Care	23
Function 2 – SPMP Administrative Medical Case Management	23
California Children's Services	23
Child Health and Disability Prevention Program.....	24
Health Care Program for Children in Foster Care	25
Function 3 – SPMP Intra/Interagency Coordination, Collaboration, and Administration	26

California Children's Services	26
Child Health and Disability Prevention Program.....	26
Health Care Program for Children in Foster Care	27
Function 4 – Non-SPMP Intra/Interagency Coordination, Collaboration, and Administration	28
California Children's Services	28
Child Health and Disability Prevention Program.....	28
Function 5 – Program Specific Administration	28
California Children's Services	28
Child Health and Disability Prevention Program.....	29
Health Care Program for Children in Foster Care	30
Function 6 – SPMP Training	31
California Children's Services	31
Child Health and Disability Prevention Program.....	31
Health Care Program for Children in Foster Care	31
Function 7 – Non-SPMP Training.....	32
California Children's Services	32
Child Health and Disability Prevention Program.....	32
Health Care Program for Children in Foster Care	33
Function 8 – SPMP Program Planning and Policy Development.....	33
California Children's Services	33
Child Health and Disability Prevention Program.....	33
Health Care Program for Children in Foster Care	34
Function 9 – Quality Management by Skilled Professional Medical Personnel.....	34
California Children's Services	34
Child Health and Disability Prevention Program.....	35
Health Care Program for Children in Foster Care	36

Function 10 – Non-Program Specific General Administration 36

 California Children's Services, Child Health and Disability Prevention Program, and Health
 Care Program for Children in Foster Care 36

Function 11 – Other Activities 37

 California Children's Services, Child Health and Disability Prevention Program, and Health
 Care Program for Children in Foster Care 37

Function 12 – Paid Time Off..... 37

Federal Financial Participation Form and Excel File Instructions..... 38

 Time Study Forms 38

 Monthly Form..... 38

 Weekly Form..... 39

 FFP Calculations 39

Time Study Instructions for Enhanced/Nonenhanced Title XIX Medicaid Funding

I. Introduction

The Social Security Act provides for variable federal matching rates for the administrative functions of the Medicaid (Title XIX) program, including a Federal Financial Participation (FFP) rate of 50 percent (nonenhanced) for the majority of expenses necessary to the proper and efficient operation of the program and an FFP rate of 75 percent (enhanced) for expenses of skilled professional medical personnel (SPMP) and their direct clerical support staff necessary for development and administration of a medically sound program. The Medicaid program in California is known as Medi-Cal.

Federal funds may be claimed at:

- A. An enhanced rate which is 75 percent of the salaries, benefits, training, and travel expenses for SPMP who meet the federal education and training requirements and perform activities requiring specialized medical knowledge and skill, and for the clerical staff who directly support and are supervised by the SPMP. Contract employees are exempted from claiming the enhanced rate.
- B. A nonenhanced rate which is 50 percent of the salaries, benefits, travel, training and other administrative expenses for non-SPMP including, but not limited to, administrators, associate staff, clerical staff not providing direct support to, or supervised by, SPMP, and claims processing staff. Staff hired under contract, including SPMP staff, are to be charged at the nonenhanced rate.

42 Code of Federal Regulations (CFR) Part 432.2, 432.45, 432.50 and 433.15
http://www.access.gpo.gov/nara/cfr/waisidx_00/42cfrv3_00.html

II. Time Study Policy and Instructions for Completion

- A. Time Study Requirements Overview
 - 1. The basic documentation required by the federal Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration (HCFA), to support FFP claiming for costs of administrative support activities must be collected based on an approved time study method.
 - 2. The Primary Care and Family Health (PCFH) Division's time study is designed to support FFP claiming in a uniform system that allows for the time study to be used by staff working in various Maternal and Child Health (MCH) and CMS programs.
 - 3. Tools for FFP timekeeping including a sample time study form are located in Section 10 – References.

Stipulations for Enhanced FFP and Classifications Eligible to Time Study as SPMP

1. SPMP Stipulations

Staff who meet SPMP qualifications for professional education and training (see page 4) may record time to SPMP (enhanced) functions in performing those duties that require professional medical knowledge and skills, as evidenced by position descriptions, job announcements, or job classifications and when qualified functions per Title 42, Code of Federal Regulations (CFR), Chapter IV, are performed such as, but not limited to:

- a. Liaison on medical aspects of the program with providers of services and other agencies that provide medical care,
- b. Furnishing expert medical opinions,
- c. Reviewing complex physicians' billings,
- d. Participating in medical review, or independent professional review team activities,
- e. Assessing, through case management activities, the necessity for, and adequacy, of medical care and services.

PCFH and local programs have the responsibility to determine whether their staff meet the qualifications and must substantiate the qualifications of SPMP status. The State and local program job specifications must stipulate that the job requires staff from one of the classifications listed below, and the program duty statement for the SPMP must (1) reflect SPMP and non-SPMP activities and (2) specify that the incumbent be from one of the following classifications per Title 42, CFR, Chapter IV:

- 1) Physicians;
- 2) Registered Nurses;
- 3) Dentists; and
- 4) Other specialized personnel who have professional education and training in the field of medical care.

Examples of other specialized personnel classifications that PCFH recognizes as meeting the professional education and training criteria detailed above include but, are not limited to the following:

- a) Licensed Clinical Psychologists with a Ph.D. in psychology;

- b) Licensed Audiologists certified by the American Speech and Hearing Association;
- c) Licensed Physical Therapists;
- d) Occupational Therapists Registered registered by the National Registry of American Occupational Therapy Association;
- e) Licensed Speech Pathologists;
- f) Licensed Clinical Social Workers;
- g) Dental Hygienists;
- h) Nutritionists with a Bachelor of Science (BS) or Arts (BA) degree in Nutrition or Dietetics and registered with the Commission of Dietetics Registration (RD);
- i) Medical Social Workers with a Master's degree in Social Work (MSW) with a specialty in a medical setting;
- j) Health Educators with a Master's degree in Public or Community Health Education and graduation from an institution accredited by the American Public Health Association or the Council on Education for Public Health; and
- k) Licensed Vocational Nurses with graduation from a **two-year** program.

2. Direct Support Staff Stipulations

Directly supporting clerical staff time may be recorded when performing those clerical job responsibilities that directly support SPMP (Part 432.2, 42 CFR). To qualify, the clerical staff must be directly supervised by a SPMP and must meet the following criteria for directly supporting clerical staff.

"Directly supporting staff," means clerical staff who:

- a. Are secretarial, stenographic, copy, file, or record clerks providing direct support to the SPMP, and
- b. Provide clerical services directly necessary for carrying out the professional medical responsibilities and functions of the SPMP.

Directly supporting staff are eligible to record SPMP time when, as clerical staff, their position documentation meets the following stipulations:

- 1) Job requirements are in the direct support of, and under the direct supervision of, SPMP:
 - a). the SPMP must be immediately responsible for the work performed by the clerical staff, and must directly supervise (immediate first-level supervision) the supporting staff and the performance of the supporting staff's work, and
 - b). the SPMP is responsible for preparing, conducting, and signing the directly supporting staff's performance appraisal as the immediate first-level supervisor, and
 - c). the SPMP and directly supporting staff relationship is reflected on the organization chart.
- 2) Civil service job specifications require clerical skills such as typing, filing, or photocopying.
- 3) Program duty statements reflect clerical functions in direct support of SPMP.

Note: "Directly Supporting Staff" does not include the costs of other subprofessional staff, for example, administrative assistants, statistical clerks, office managers, technicians, accounting clerks, and management assistants not performing clerical functions.

B. Professional Education and Training For SPMP

SPMP are required to have education and training at a professional level in the field of medical care or appropriate medical practice before time can be recorded by those individuals to SPMP functions. "Education and training at professional level" means the completion of a two-year or longer program leading to an academic degree or certificate in a medically related profession. Completion may be demonstrated by possession of a medical license, certificate, or other document issued by a recognized national or state medical licenser or certifying organization, or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care.

SPMP includes only professionals in the field of medical care that meet the above criteria. SPMP does not include non-medical health professionals such as public administrators, medical budget directors or analysts, lobbyists, or senior managers of public assistance or Medicaid programs.

C. Documentation of Staff and Time

Personnel who prepare time studies for FFP must be in an employee-employer relationship with the State, county/city, or may be contract personnel, and must be involved in activities that are necessary for proper and efficient Medi-Cal program administration. An organization chart, civil service classification/specification, and job duty statement for each position must be on file with the county/city program. If the employee is in a position that requires staffing at the level that meets Medicaid criteria for SPMP and the employee is planning to record time to enhanced functions, a SPMP questionnaire (see page 13) should be used and maintained on file to document the professional education and training.

The organization chart documents the chain of command which can either qualify or eliminate the enhanced reimbursement rate for direct clerical support staff. Employee job specifications for SPMP must reflect health-related duties and, if possible, health-related qualification requirements as well. The job duty statement should be program specific and reflect the appropriate activities with an estimated percentage of time allocated to each activity. Activities described in a catchall category such as "and other duties as required," are considered nonenhanced or General Administrative functions.

It is very important that staff documentation materials be revised when changes occur. All claiming documentation, including the original time study forms, must be kept through the documentation retention period. The documentation retention period is no less than three years after the reimbursement or until the completion of any federal financial audit in progress, whichever time is longer.

Completion of a time study is not required in limited situations. In general, a detailed time study is not required when a person: 1) performs only non-SPMP functions (100 percent of their time); and 2) works for only one program; and 3) is claimed against a single budget. However, all employees must have documentation of time worked on a time certification or employee attendance record. The time certification must identify the hours worked and the paid time away from work, such as sick leave and vacation, and must be signed by the employee and supervisor.

Detailed time studies must be completed, regardless of Medicaid FFP personnel category (SPMP, clerical staff directly supervised by and directly supporting SPMP, or non-SPMP), by those persons who: 1) perform any combination of SPMP, non-SPMP, and/or non-claimable functions; or 2) work for more than one program; or 3) are funded through more than one budget.

The time study must:

1. Utilize the code numbers and function titles as specified and defined by the PCFH Division (see sample form in Section 10 - References).
2. Be completed at the same time either during the first, middle, or last month of each calendar quarter for the fiscal year unless given written

permission by the State to do otherwise, or the following conditions are met.

- a. Staff who vacate before or are newly hired after the time study month may time study the month they are available during the quarter.
 - b. Staff not performing their regular duties/activities for more than two (2) weeks of the time study month due to extended absence, may use the average of previous time studies for that position (more than two) or time study in the next quarter and apply those to the previous quarter with a supplemental invoice.
 - c. For additional questions, technical assistance from the State should be requested.
3. Reflect actual time spent on the functions for each program and account for all time each workday in the period being studied.
 4. Be signed and dated by the employee and the immediate supervisor of the employee under declarations of accuracy. These original time study forms must be retained.

Time study supportive claiming materials, such as day logs, appointment books, meeting agendas or minutes, and SPMP medical training documentation, must be kept through the retention period.

D. Time Study Function Codes

There are twelve time study functions grouped in four categories: (1) Non-SPMP, (2) SPMP, (3) Non-claimable, and (4) Allocated.

1. **Non-SPMP (nonenhanced) functions** include those activities generally performed by clerical, paraprofessional, supervisory, administrative, and contract personnel. However, these functions may be performed by staff classified as SPMP in which case their time must also be recorded to one of these codes. The non-SPMP code numbers and functions are:

- Code 1: Outreach
- Code 4: Non-SPMP Intra/Interagency Coordination, Collaboration, and Administration
- Code 5: Program Specific Administration
- Code 7: Non-SPMP Training

2. **SPMP (enhanced) functions** include those medically related activities performed only by SPMP and the associated typing, filing, and photocopying activities of medically related materials that are performed by clerical personnel directly supervised (immediate first level) by the SPMP. The SPMP code numbers and functions are:

- Code 2: SPMP Administrative Medical Case Management
- Code 3: SPMP Intra/Interagency Coordination, Collaboration, and Administration
- Code 6: SPMP Training
- Code 8: SPMP Program Planning and Policy Development
- Code 9: Quality Management by Skilled Professional Medical Personnel

Personnel from a variety of disciplines may qualify as SPMP as determined through the use of the SPMP Questionnaire. Multidisciplinary personnel implementing program responsibilities in a position that requires their professional medical education and training should refer to the general description of the functions and apply the principles articulated in that description to their program specific responsibilities. Some examples of activities related to administrative functions in CMS programs (CCS, CHDP, and HCPCFC) follow on page 22.

3. The **Non-Claimable function** includes those activities and services the federal government does not reimburse or finance under administrative claiming. Examples of these activities include, but are not limited to:
 - a. Direct client services that are reimbursed via the Medi-Cal fee-for-service system or managed care contracts;
 - b. Services that benefit a specific client such as child care;
 - c. Client services funded as targeted case management services; and,

- d. Health department programs or services that are not part of supporting the administration of the Medi-Cal program, including but not limited to grant-funded training programs for bioterrorism preparation and mass immunization programs.

The non-claimable code number and function are:

Code 11: Other Activities

- 4. **Allocated functions** are activities that relate to multiple functions, or are not specific to any identified function due to their general nature such as general staff meetings, computer training, budget development, overtime, compensatory time off, etc. Allocated code numbers and functions are coded to:

Code 10: Non-Program Specific General Administration

Code 12: Paid Time Off

E. Instructions to General Staff Must Specify:

- 1. **Only** SPMP and clerical staff who qualify as supervised by and supporting the SPMP may record their time under all of the function codes including the **SPMP** function codes.
- 2. Staff qualifying as non-SPMP only are not to record any time under the SPMP function codes but can utilize all other function codes.
- 3. Time study participants must:
 - a. Include on each time study form, their name, time study period (month/year), position/employee number, personnel classification, agency name, etc.
 - b. Complete the time study form on a daily basis during the time study period.
 - c. Specify the program for which any SPMP or non-SPMP activities are performed.
 - d. Record all time worked each day under the appropriate function. "Extra" time that qualifies as overtime and earned compensating/certified time must be recorded under the General Administration function regardless of any other function under which it would have been recorded.
 - e. Round time recorded under a function to the nearest half-hour unless the employer elects to have time rounded to a smaller increment.
 - f. Record time for performing necessary paperwork and travel under the function to which it pertains. If that time pertains to multiple

- functions or no specific, identifiable function, record the time under General Administration.
- g. Clerical staff recording SPMP function time in support of an SPMP should use the same function codes as directed by the SPMP which reflect the SPMP's activities.
 - h. Record time spent going to, attending, and returning from meetings to the function to which it pertains. The content of a meeting dictates use of the appropriate function code(s). If that time pertains to multiple functions or no specific, identifiable function, record the time under General Administration.
 - i. Record, under the function Paid Time Off, time spent on vacation, holiday, sick leave, and any other paid time. The exception is the time spent using compensating/certified time earned. Lunch, use of compensating/certified time earned, normal time off, and leave without pay are **not recorded** under any function on a time study.
 - j. Sign and date the original time study form under a declaration of accuracy and give it to the immediate supervisor as soon as possible following the close of the time study period.
 - k. All signatures must be original, not photocopies.

Skilled Professional Medical Personnel Quiz

Date: _____
To: _____
From: _____
Re: **Skilled Professional Medical Personnel Questionnaire For Claiming Status**

To determine whether you qualify as Skilled Professional Medical Personnel for recording time worked to enhanced functions of Medi-Cal administration, please complete the following form and return it to the person indicated above no later than _____ as this is very important for our funding. Thank you.

Name: _____
Department: _____
Position Classification: _____

1. Are you a physician licensed to practice medicine in the State of California?

YES **NO**

If **YES**, provide license number (_____), sign this form, and turn it in.

If **NO**, proceed to Question 2.

2. Have you completed an educational program in a health or health-related field?

YES **NO**

If **YES**, list the highest academic degree you received in a health or health-related field, the subject in which it was received, and the name of the college/university where it was earned, and proceed to Question 3.

Academic Degree: _____
Field: _____
College/University: _____

If **NO**, stop, sign this form, and turn it in.

3. Did your educational program last at least two years?

YES **NO**

If **YES**, proceed to Question 4.

If **NO**, stop, sign this form, and turn it in.

4. Did your educational program lead to a California licensure in a medically related profession?

YES

NO

If **YES**, provide the license type (_____) and number (_____), sign this form, and turn it in.

If **NO**, proceed to Question 5.

5. Did your educational program lead to certification or registration by a health or health-related national or California certifying organization?

YES

NO

If **YES**, please provide the certification/registration type and number (if appropriate), the name of the certifying organization, sign this form, and turn it in.

Certificate/Registration Type: _____

Certificate/Registration Number: _____

Certifying/Registry Organization: _____

If **NO**, proceed to Question 6.

6. Did part of your educational program involve medical or health-related training including fieldwork (i.e., in the area of health, mental health, or substance abuse)?

YES

NO

If **YES**, describe the training/fieldwork and sign the form and turn it in.

If **NO**, proceed to Question 7.

7. As a part of your educational program, did you take any courses, which had a medical or health-related focus (e.g., in the area of health, mental health, or substance abuse)?

YES

NO

If **YES**, list these courses below, sign this form, and turn it in.

If **NO**, sign this form and turn it in.

Signature: _____

Date: _____

Time Study Function Code Descriptions and General Activities

Function 1 – Outreach

This function is to be used by all staff when performing activities that inform Medi-Cal eligible or potentially eligible individuals, as well as other clients, about health services covered by Medi-Cal and how to access the health programs. Activities include a combination of oral and written informing methods that describe the range of services available through the Medi-Cal program and the benefits of preventive or remedial health care offered by the Medi-Cal program.

Examples of administrative activities which are included in the outreach function are:

1. Inform individuals, agencies, and community groups about health programs using oral and written methods.
2. Develop and provide program materials to individuals and their families, community agencies, and health care providers.
3. Inform and assist clients and their families to access program services.
4. Design and carry out strategies that inform high-risk children and their families of health programs that will benefit them.
5. Develop and implement a system for ensuring that clients obtain needed preventive and health services by providing information on accessing transportation and assistance with scheduling of appointments.

Function 2 – SPMP Administrative Medical Case Management

This function is to be used only by SPMP when participating in medical reviews; assessing the necessity for, and types of, medical care associated with medical case management and case coordination activities required by individual Medi-Cal beneficiaries. Examples of activities which are included in this function are:

1. Review the results of health assessments and medical and dental examinations and evaluations needed to coordinate and facilitate the client's care. This activity is not conducted as part of a standard medical examination or consultation and is not a direct service.
2. Assess and review for determining medical eligibility, medical necessity and sources for services required to correct or ameliorate health conditions identified by a medical or dental provider.
3. Provide consultation to professional staff in other agencies about specific medical conditions identified within their client population.
4. Identify eligible, covered medically necessary services required to achieve the goals of the treatment plan and ensure that linkages are made with other providers of care.
5. Provide follow-up contact to assess the client's progress in meeting treatment goals.

6. Participate in case conferences or multi-disciplinary teams to review client needs and treatment plans.
7. Interpret medical guidelines, health assessment results, and medical and dental evaluations, to an individual, a provider, or professional staff of another agency.
8. Provide consultation, separate from a standard medical examination, to clients to assist them in understanding and identifying health problems or conditions and in recognizing the value of preventative and remedial health care as it relates to their medical conditions.
9. Provide technical assistance on clinical protocols, health assessments, and medical and dental benefits.
10. Consult on client-specific appeals relating to medical care issues including expert witness services.
11. Paperwork directly associated with any of the above activities.
12. Travel time directly associated with performance of any of the above activities.

Function 3 – SPMP Intra/Interagency Coordination, Collaboration, and Administration

This function is to be used only by SPMP when performing collaborative activities that involve planning and resource development with other agencies which will improve the cost effectiveness of the health care delivery system and improve availability of medical services. Examples of activities which are included in this function are:

1. Provide technical assistance to other agencies/programs that interface with the medical care needs of clients.
2. Participate in provider meetings and workshops on issues of client health assessment, preventive health services, and medical care and treatment.
3. Develop medical and dental referral resources such as referral directories, round tables, and advisory groups.
4. Assist in health care planning and resource development with other agencies which will improve the access, quality and cost-effectiveness of the health care delivery system, and availability of Medi-Cal medical and dental referral sources.
5. Assess the effectiveness of inter-agency coordination in assisting clients to access health care services in a seamless delivery system.

Function 4 – Non-SPMP Intra/Interagency Coordination, Collaboration, and Administration

This function is to be used by non-SPMP staff when performing activities that are related to program planning functions, including collaborative and intra/interagency coordination activities. Examples of activities which are included in this function are:

1. Provide technical assistance and program monitoring to other agencies/programs that interface with Medi-Cal program requirements.
2. Assist in health care planning and resource development with other agencies which will improve the access, quality, and cost effectiveness of the health care delivery system and availability of Medi-Cal medical and dental referral sources.
3. Assess the effectiveness of inter-agency coordination in assisting clients to access health care services in a seamless delivery system.

Function 5 – Program Specific Administration

This function is to be used by all staff when performing activities that are related to program specific administration, which are identifiable and directly charged to the program. Examples of activities which are included in this function are:

1. Develop and implement program administrative policies and fiscal procedures in compliance with Medi-Cal program requirements.
2. Participate in the development, maintenance, and analysis of program management information servicing the Medi-Cal population.
3. Participate in the distribution of Medi-Cal program specific information including procedural manuals and brochures.
4. Prepare responses to appeals on non-medical program issues.
5. Provide general supervision of staff, including supervision of interns and students.
6. Develop budgets and monitor program expenditures.
7. Review of technical literature and research articles.
8. Draft, analyze, and/or review reports, documents, correspondence, and legislation.
9. Direct recruitment, selection and hiring process, perform employee evaluations.

Function 6 – SPMP Training

This function is to be used only when training is provided for or by SPMP and only when the training activities directly relate to the SPMP's performance of specifically allowable SPMP administrative activities. Examples of activities which are included in this function are:

1. Training related to the SPMP's performance of allowable administrative activities to include utilization review of medical services, program planning and policy development, SPMP administrative medical case management, intra/interagency and provider coordination, and quality management.
2. Completing paperwork directly associated with the above activities.
3. Travel time directly associated with the performance of the above activities.

Function 7 – Non-SPMP Training

This function is to be used by all staff when training relates to non-SPMP allowable administrative activities and to the medical care of clients. Examples of activities which are included in this function are:

1. Training related to the performance of administrative activities to include Medi-Cal outreach; non-emergency, non-medical transportation; and Medi-Cal eligibility.
2. Joint orientation and on-going in-service training.
3. Professional training and technical assistance which improves the quality of health assessment, preventive health services, and care.
4. Training which improves the medical knowledge and skill level of skilled professional medical staff providing Medi-Cal services.
5. Completing paperwork directly associated with the above activities.
6. Travel time directly associated with the performance of the above activities.

Function 8 – SPMP Program Planning and Policy Development

This function is to be used only by SPMP and only when performing program planning and policy development activities. The SPMP's tasks must officially involve program planning and policy development, and those tasks must be identified in the employee's position description/duty statement. Examples of activities which are included in this function are:

1. Participate in the development of program direction and annual scope of work, program budget, set goals, objectives, activities, and evaluation tools to measure Medi-Cal program outcomes.
2. Participate in the development of Medi-Cal program standards and procedures for coordinating health-related programs and services.
3. Provide consultation and technical assistance in the design, development, and review of health related professional educational material.
4. Provide technical assistance on practitioner protocols, including the development of uniform policy and procedures on the care and treatment of Medi-Cal clients.
5. Assess and review the capacity of the agency and its providers to deliver medically appropriate health assessment, treatment, and care.
6. Provide ongoing liaison with Medi-Cal providers around issues of treatment, health assessment, preventive health services, medical care, program policy, and regulations.
7. Identify, recruit, and provide technical assistance and support to new Medi-Cal providers.

8. Develop round tables, advisory or work groups of other SPMP to provide Medi-Cal program consultation.
9. Participate in the planning, implementation, and evaluation of services that relate to the Medi-Cal programs.
10. Participate in program workshops and meetings relating to the scope of Medi-Cal program benefits and changes in program management.
11. Participate in the development and review of Medi-Cal health-related regulations, policies, and procedures such as scopes of work, MOUs and other related Medi-Cal health care services, and other health care service standards for total quality management.

Function 9 – Quality Management by Skilled Professional Medical Personnel

This function is to be used only by SPMP and only when performing quality management activities such as monitoring the authorization for medical services (utilization review) process, ongoing program assessment and evaluation, and the development of standards and protocols. Examples of activities which are included in this function are:

1. Conduct periodic review of protocols.
2. Perform peer reviews, medication management and monitoring, and monitoring of the service authorization and re-authorization process.
3. Schedule, coordinate, and conduct medical chart or case reviews for adequacy of assessment, documentation, and appropriate intervention.
4. Schedule, coordinate, and conduct quality assurance activities; evaluate compliance with program standards; and monitor the clinical effectiveness of programs, including Medi-Cal client satisfaction surveys.
5. Evaluate the need for new modalities of medical treatment and care.
6. Assess and review the capacity of the agency and its providers to deliver medically appropriate health assessments, preventive health services and medical care, and respond to appeals on medical quality of care issues.
7. Complete paperwork directly associated with the above activities.
8. Travel time directly associated with the performance of the above activities.

Function 10 – Non-Program Specific General Administration

This function is to be used by all staff when performing non-program specific administrative activities that relate to multiple functions or to no specific, identifiable functions due to the general nature of the activities. It is also to be used to record any break time as well as time that may become overtime or earned compensatory or certified time off. Examples of activities which are included in this function are:

1. Review departmental or unit procedures and rules.
2. Develop and implement program administrative policies and fiscal procedures.
3. Participate in the design, development and review of health related professional educational material.
4. Attend non-program related staff meetings.
5. Provide general supervision of staff, including supervision of interns and students.
6. Develop and provide health promotion activities for agency employees.
7. Provide and attend non-program specific in-service orientations and other staff development activities.
8. Develop budgets and monitor program expenditures.
9. Review of technical literature and research articles.
10. Provide general clerical support.
11. Draft, analyze, and/or review reports, documents, correspondence, and legislation.
12. Direct recruitment, selection and hiring process, perform employee evaluations.

Function 11 – Other Activities

This function is to be used by all staff to record time performing activities that are not specific to the administration of the Medi-Cal program. Examples of activities which are included in this function are:

1. Outreach activities that inform individuals about non-Medi-Cal health programs financed by other federal and State programs.
2. Program planning and policy development activities of non-Medi-Cal programs financed by other federal and State programs.
3. Develop funding proposals that do not benefit the Medi-Cal population.
4. Coordinate or participate in research activities that do not benefit the Medi-Cal population.
5. Write grants for federal funding for services/activities which do not benefit the Medi-Cal population.
6. Participation in health promotion activities for agency employees.
7. Provide client-specific, health related services which can be billed as fee-for-service to Medi-Cal, including Targeted Case Management; another State program; private insurance; the client; or the county health department.

8. Activities otherwise funded through the Medi-Cal Program.

Function 12 – Paid Time Off

This function is to be used by all staff to record usage of paid leave, holiday, vacation, sick leave, etc. Do not record on the time study lunchtime, dock time, absence without pay, or compensatory/certified time off (CTO). CTO shall be recorded under Function 10, Non-Program Specific General Administration, when it is earned.

Federal Financial Participation Examples of Activities for CMS Programs

Function 1 – Outreach

This function is to be used by all staff when performing activities that inform Medi-Cal eligible or potentially eligible individuals, as well as other clients, about health services covered by Medi-Cal and how to access the health programs. Activities include a combination of oral and written informing methods that describe the range of services available through the Medi-Cal program and the benefits of preventive or remedial health care offered by the Medi-Cal program. Examples of administrative activities included in the outreach function are identified below.

California Children's Services

1. Inform individuals, agencies, potential providers, and community groups about the CCS program using written and oral methods.
2. Coordinate and participate in screening programs to facilitate identification of at-risk patient populations that are eligible for program services.
3. Order, maintain, and distribute CCS/CMS program materials to families, community agencies, and health care providers.
4. Determine financial and residential eligibility for CCS, conduct interviews of applicant/client families, including screening potential eligibility for Medi-Cal.
5. Inform and assist applicant/client and family in accessing other Medicaid program services, as related to the client's medical condition, such as Medi-Cal and EPSDT Supplemental Services.
6. Identify barriers and assist the applicant/client, whose primary language is other than English, to secure medical services related to the client's medical condition.
7. Provide translation to assist the applicant/client, whose primary language is other than English.

Child Health and Disability Prevention Program

1. Inform individuals, agencies, potential providers, and community groups about the CHDP program using written and oral methods.
2. Follow up with clients referred from local social service departments including telephone calls, letters, and home visits with respective documentation required on social service referral forms (PM 357).
3. Order, maintain, and distribute program material for outreach purposes.
4. Check with local social service departments for Medi-Cal status and up-to-date client phone numbers and addresses.

5. Inform and assist applicant/client and family with need for support services such as finding assistance to complete an application for health care coverage, scheduling appointments, and obtaining other services.
6. Identify barriers and assist applicants/clients, whose primary language is not English, to secure medical services.
7. Provide translation to assist the applicant/client, whose primary language is other than English.
8. Contact medical and dental providers to schedule appointments for clients and families.
9. Work with other agencies such as churches, homeless shelters, housing authorities, day care providers, hospital discharge planners/emergency rooms, and youth-serving organizations to increase community awareness of preventive health services.

Health Care Program for Children in Foster Care

1. Inform and assist child/youth in foster care and foster care providers with the need to obtain preventive health services within 30 days of placement.
2. Inform and assist child/youth and foster care providers with the need for support services such as finding appropriate resources and scheduling appointments for medical, dental, mental health and developmental services.
3. Promote an understanding of the need to maintain a link to health care services provided through the Child Health and Disability Prevention, Medi-Cal, and Denti-Cal programs.

Function 2 – SPMP Administrative Medical Case Management

This function is to be used only by SPMP when participating in medical reviews; assessing the necessity for, and types of, medical care associated with medical case management and case coordination activities required by individual Medi-Cal beneficiaries. Examples of activities included in this function are identified below.

California Children's Services

Use skilled professional medical expertise to:

1. Determine the medical rationale to ensure timely and appropriate medical follow-up.
2. Collect and interpret information regarding the applicant/client's medical status and his/her needs for medical services; conduct hospital-based utilization review activities to determine number of days for approval; identify resources and referrals needed to support a patient's care in the home for his/her medical condition.
3. Initiate a proactive medical case management plan, including a review of the adequacy and availability of medical services for the applicant/client and participation in medical case management conferences to coordinate medical service needs and program benefits.

4. Assist medical, dental and other health care providers including those not previously enrolled as Medi-Cal/Denti-Cal/CCS providers, to obtain EPSDT Supplemental Services for their clients when needed.
5. Review literature and research articles to determine eligibility and/or benefits relating to a client's specific medical condition.
6. Review complex physician billing and making fee determinations.
7. Provide information on specialized medical program services available to medically high-risk children and their families.
8. Furnish medical opinions on decisions relating to adjudication of administrative appeals based on program medical eligibility and benefit laws, regulations, and policies.
9. Determine estimated cost of medical care for exceptional cases.
10. Determine the authorizations to be issued for medical services and benefits to paneled medical/allied health providers and vendors based on knowledge and application of program standards and county requirements.

Child Health and Disability Prevention Program

Use skilled professional medical expertise to:

1. Determine the medical rationale to ensure timely referral for medical and/or dental health assessments services.
2. Collect and interpret information regarding the applicant/client's health status and his/her needs for preventive health services; explain the significance of actual and suspected medical conditions to clients and their families; identify resources and encourage clients to follow up on medical, dental, nutritional, and mental health conditions found during health assessment screens.
3. Participate in medical case conferencing with other agencies regarding client's medical condition to coordinate medical services needs and program benefits including a review of the adequacy and availability of medical services for the applicant/client.
4. Assist medical, dental, and other health care providers including those not previously enrolled as Medi-Cal/Denti-Cal providers, to obtain EPSDT Supplemental Services for their clients when needed.
5. Review professional literature and research articles to determine eligibility and/or benefits relating to a client's health care services needs and specific medical/health conditions.
6. Review complex physician billing and making fee determinations.
7. Provide information on specialized medical program services available to medically high-risk children and their families.

8. Furnish medical opinions on program standards, based on laws, regulations, and policies.

Health Care Program for Children in Foster Care

Use skilled professional medical expertise to:

1. Inform caseworkers, foster care providers, judicial court officers, health care providers, etc. about the preventive health services and special medical needs of the client and services available through CHDP, CCS, and other agencies to address those needs.
2. Collect and interpret information regarding the client's health status and his/her needs for services to caseworkers, foster care providers, judicial court officers, health care providers; explain the significance of actual and suspected medical conditions to clients, caseworkers, foster care providers and others; identify resources and assist clients, their caseworkers and foster care providers in obtaining comprehensive assessments and treatment services.
3. Evaluate and prioritize the client's medical and health care needs based on information obtained from court interviews of biological parents, medical and school record reviews, and other medical documentation, etc.
4. Consult with the caseworker, foster care provider, and health care provider to develop and update a health plan in the client's case plan.
5. Provide follow-up consultation on changes in health status, service needs, and effectiveness of services provided to promote continuity of care.
6. Collaborate with the caseworker, biological parent and foster care provider to ensure that all necessary medical/health care information is available to those responsible for providing health care for the client, including the Health and Education Passport or its equivalent.
7. Review the client's health plan with the caseworker as needed and at least every six months.
8. Participate in multi-disciplinary team conferences (MTD) with other members of the foster care team regarding the medical and health care services needs of the clients.
9. Assist medical, dental, mental health, and other health care providers including those not previously enrolled as Medi-Cal/Denti-Cal/CCS providers, to obtain EPSDT Supplemental Services for their clients when needed.
10. Review professional literature and research articles to determine eligibility and/or benefits relating to a client's health care services needs and specific medical/health conditions.
11. Interpret medical information on specialized health services for medically high-risk clients and assist the caseworkers and foster care providers to obtain referrals for necessary services.

12. Interpret the medical, dental, mental health, and developmental needs of the client leaving foster care, consult with the client and caseworker regarding the availability of health care coverage and community resources to meet the client's needs upon emancipation.
13. Consult PHN to PHN regarding the medical and health needs of clients placed outside of their county of jurisdiction or transferred to a new county of jurisdiction.

Function 3 – SPMP Intra/Interagency Coordination, Collaboration, and Administration

This function is to be used only by SPMP when performing collaborative activities that involve planning and resource development with other agencies which will improve the cost effectiveness of the health care delivery system and improve availability of medical services. Examples of activities included in this function are identified below.

California Children's Services

Use skilled professional medical expertise and program knowledge to:

1. Collaborate with groups of physicians, health department staff (e.g., public health nurses), CHDP, WIC, school nurses, hospital, and managed care professional staff to improve the availability and use of medical services.
2. In counties with managed care plans, assist plans/providers in developing strategies to increase appropriate utilization of medical services for their enrollees.
3. Provide CCS program consultation and technical assistance to the medical provider network, and other health care service providers.

Child Health and Disability Prevention Program

Use skilled professional medical expertise and program knowledge to:

1. Collaborate with groups of physicians, health department staff (e.g., public health nurses), CHDP, WIC, school nurses, hospital, and managed care professional staff to improve the availability and use of medical services.
2. In counties with managed care plans, assist plans/providers in developing strategies to increase appropriate utilization of medical services for their enrollees.
3. Provide CHDP program and CHDP Gateway consultation and technical assistance to the medical provider network, and other health care service providers.
4. Interpret the medical aspects of CHDP, including the CHDP Health Assessment Guidelines, to recruit and maintain medically qualified providers.
5. Recruit Denti-Cal providers as providers of dental services for the CHDP target population.

6. Participate on child health boards and commissions to appropriately interpret the medical components of the CHDP program.
7. Assure medical input into the development of the health component of Head Start and social services interagency agreement and assure qualified practitioners appropriately provide medically related services.
8. Provide a liaison with public and private schools to assure the delivery of health assessment services to school age children.

Health Care Program for Children in Foster Care

Use skilled professional medical expertise and program knowledge to:

1. Collaborate with caseworkers, medical, dental, mental and developmental health providers, Independent Living Skills Program coordinators, foster care providers, Foster Family Agencies, Group Homes, health department staff (e.g., public health nurses), CHDP, WIC, school nurses, hospital, and managed care professional staff to improve the availability and use of medical services.
2. In counties with managed care plans, assist plans/providers in developing strategies to increase appropriate utilization of medical services for their enrollees who are in foster care.
3. Interpret the health care needs of clients in foster care to the medical provider network, other health care service providers, caseworkers, juvenile court officers, and foster care providers.
4. Evaluate the adequacy, accessibility and availability of the referral network for health care services. Collaborate with CHDP, CCS, and other health services programs to recruit qualified providers.
5. Participate on advisory boards and commissions to interpret the health care services needs of clients in foster care.
6. Assure medical input into the negotiation, implementation, and monitoring of the PHN role and activities as outlined in the HCPCFC Memorandum of Understanding with the local departments of social services and probation.
7. Coordinate and network with other programs/services such as WIC, immunization, oral health, mental health, lead poisoning and injury prevention, Independent Living Skills Program, Transitional Housing program, etc. on behalf of the medical needs of clients in foster care.
8. Participate in coordination activities to develop the medical and health care services role of the public health nursing program in foster care in relation to other agencies such as Regional Centers, Medi-Cal field offices, local education agencies (LEAs), public health agencies (including maternal, child, and adolescent health services), Medi-Cal Managed Care Plans, hospitals, and CCS Special Care Centers.

Function 4 – Non-SPMP Intra/Interagency Coordination, Collaboration, and Administration

This function is to be used by non-SPMP staff when performing activities that are related to program planning functions, including collaborative and intra/interagency coordination activities. Examples of activities included in this function are identified below.

California Children's Services

1. Participate in coordination activities to develop the program in relation to other agencies such as Regional Centers, Medi-Cal field offices, local education agencies, public health agencies (including maternal, child, and adolescent health services), Medi-Cal Managed Care Programs, hospitals, and special care centers.

Child Health and Disability Prevention Program

1. Participate in coordination activities to develop the program in relation to other agencies such as Regional Centers, Medi-Cal field offices, local education agencies, public health agencies (including maternal, child and adolescent health services), Medi-Cal Managed Health Care Programs.
2. Negotiate, implement, and monitor the Interagency Agreement with the local social services department.
3. Coordinate/network with other programs/services such as WIC immunization, oral health, child abuse, and injury prevention.
4. Provide lists of CHDP providers to Head Start/State Preschool programs.

Function 5 – Program Specific Administration

This function is to be used by all staff when performing activities that are related to program specific administration, which are identifiable and directly charged to the program. Examples of activities included in this function are identified below.

California Children's Services

1. Participate in multi-year planning to develop goals, objectives, activities, and evaluation tools in order to measure outcomes.
2. Review CCS data, and analyze and utilize in program-related needs assessments, program planning, and evaluation.
3. Develop, monitor, and revise yearly budgets to implement program plan within program appropriations in accordance with CMS Plan and Fiscal Guidelines.
4. Recruit, orient, supervise, and evaluate personnel responsible for implementing the CCS program according to the Staffing Standards.

5. Assure that CCS funded personnel perform only allowable functions, audit trail is maintained for all expenditures, and staff complete time studies a minimum of one month a quarter and retain on file.
6. Develop and review program standards, regulations, policies, procedures, and health-related educational materials.
7. Develop, maintain, and analyze management information system.
8. Review literature and research articles to apply up-to-date knowledge in delivery of health care services.
9. Analyze and/or review program-related legislation.
10. Formulate and apply program administrative policies.
11. Evaluate fiscal procedures related to the program.
12. Prepare program-related reports, documents, and correspondence.
13. Develop and distribute program specific information including procedure manuals and brochures.

Child Health and Disability Prevention Program

1. Participate in multi-year planning to develop goals, objectives, activities, and evaluation tools in order to measure outcomes.
2. Review CHDP and CHDP Gateway data, and analyze and utilize in program-related needs assessments, program planning, and evaluation.
3. Develop, monitor, and revise yearly budgets to implement program plan within program allocations in accordance with CMS Plan and Fiscal Guidelines.
4. Recruit, orient, supervise, and evaluate personnel responsible for implementing the CHDP program.
5. Assure that CHDP/EPSTDT funded personnel perform only allowable functions, audit trail is maintained for all expenditures, and staff complete time studies a minimum of one month a quarter and retain on file.
6. Develop and review program standards, regulations, policies, procedures, health-related educational materials.
7. Develop, maintain, and analyze management information system.
8. Review literature and research articles to apply up-to-date knowledge in delivery of health care services.
9. Analyze and/or review program-related legislation.
10. Formulate and apply program administrative policies.

11. Evaluate fiscal procedures related to the program.
12. Prepare program-related reports, documents, and correspondence.
13. Maintain current list of CHDP medical and dental providers.
14. Develop and distribute program specific information including manuals and brochures.

Health Care Program for Children in Foster Care

1. Participate in multi-year planning to develop goals, objectives, activities, and evaluation tools in order to measure outcomes.
2. Review and use HCPCFC data in program planning and evaluation.
3. Develop, monitor, and revise annual budgets within program appropriations, in accordance with CMS Plan and Fiscal Guidelines.
4. Recruit and evaluate PHN personnel responsible for implementing the HCPCFC program in accordance with the Welfare and Institutions Code, Sec.16501.3 and the HCPCFC Model Scope of Work activities.
5. Assure that HCPCFC funded PHN personnel perform only allowable functions and complete time studies a minimum of one month a quarter. Assure that an audit trail is maintained and all appropriate documentation is retained on file.
6. Develop and review program standards, regulations, policies and procedures.
7. Assure that the Health and Education Passport or its equivalent is present and updated as necessary.
8. Develop and use management information systems for local program planning and evaluation.
9. Evaluate the impact of the PHN on the foster care team and the health status of clients in foster care.
10. Use data systems such as the CWS/CMS to assist with program planning and evaluation.
11. Review literature and research articles relating to foster care systems, services, and special health care needs but not specifically requiring skilled professional medical expertise.
12. Analyze and/or review program-related legislation.
13. Formulate and apply program administrative policies.
14. Evaluate fiscal procedures related to the program.
15. Prepare program-related reports, documents, and correspondence.

16. Maintain a current list of CHDP providers, dental, mental health and specialty providers who will care for clients in foster care
17. Develop and distribute program specific information including brochures and general health services information.

Function 6 – SPMP Training

This function is to be used only when training is provided for or by SPMP and only when the training activities directly relate to the SPMP's performance of specifically allowable SPMP administrative activities. Examples of activities included in this function are identified below.

California Children's Services

Use skilled professional medical expertise and program knowledge to:

1. Develop, conduct, and/or participate in training health care professionals on the program medical eligibility requirements and medical services, including but not limited to, physicians, registered nurses, medical social workers, physical therapists, occupational therapists, and dietitians, including Medi-Cal managed care plan providers.
2. Develop, conduct, and/or participate in county, regional, and state-conducted medical training sessions/meetings and include those Managed Care providers under contract with Medi-Cal.
3. Attend professional education programs relevant to the role of the medical professional and/or to medical administration of the program(s).

Child Health and Disability Prevention Program

Use skilled professional medical expertise and program knowledge to:

1. Develop, conduct, and/or participate in provider in-services and/or workshops and state-conducted medical training sessions/meetings.
2. Attend professional education programs relevant to the role of the medical professional and/or medical administration of the program(s).

Health Care Program for Children in Foster Care

Use skilled professional medical expertise and program knowledge to:

1. Develop, conduct, and/or participate in training health care professionals on the medical/health aspects of the HCPCFC including special health care services needs of the clients in foster care, standards of care, guidelines for best practices, etc.
2. Develop, conduct, and/or participate in county, regional, and state-conducted medical/health training sessions/meetings for caseworkers, juvenile court officers, and foster care providers on issues related to the health care needs of clients in foster care.

3. Attend professional education programs relevant to the role of the medical professional and/or the medical administration of the program.
4. Attend training on reviewing and interpreting health information that can be entered in the CWS/CMS as documentation of medical and health information in the Health and Education Passport or its equivalent.
5. Provide health training and technical assistance to other agencies/programs that interface with the medical, dental, mental and developmental health care needs of the client in foster care.
6. Participate in training/education programs designed to improve the skill level of the individual staff member in meeting and serving the medical and health needs of the client in foster care.

Function 7 – Non-SPMP Training

This function is to be used by all staff when training relates to non-SPMP allowable administrative activities and to the medical care of clients. Examples of activities included in this function are identified below.

California Children's Services

1. Participate in program-required and/or county, regional, and statewide workshops, meetings, and educational sessions relating to the scope of program benefits and changes in program management.
2. Provide training and technical assistance to other agencies/programs that interface with the medical care needs of the applicant/client.
3. Participate in training/education programs to improve the skill level of the individual staff member in meeting and serving the medical needs of the applicant/client.

Child Health and Disability Prevention Program

1. Conduct in-service training for school staff on CHDP documentation requirements in such areas as first grade entry and current eligibility for CHDP services.
2. Orient all appropriate health, welfare, and probation workers on CHDP requirements and services.
3. Provide training to ensure children who may be eligible are informed of CHDP in appropriate language, provided brochures, and asked if medical, dental, and/or support services are wanted, and that their responses are documented.
4. Periodically observe eligibility workers (EWs) during the CHDP informing process, and based on observations, provide annual updated training and informing materials consistent with federal informing requirements.
5. Conduct and attend educational programs relevant to the scope of services administered by the program.

6. Participate in training/education programs to improve the skill level of the individual staff member in meeting and serving the medical needs of the applicant/client.
7. Conduct training sessions for providers on claiming for CHDP services, CHDP program policy and regulations.

Health Care Program for Children in Foster Care

1. Participate in program-required and/or county, regional, and statewide workshops, meetings, and educational sessions relating to the scope of program benefits and changes in program management.
2. Provide program information to caseworkers, juvenile court officers, foster care providers, foster family agencies, group homes, and other service agencies on the public health nursing services available through the HCPCFC.

Function 8 – SPMP Program Planning and Policy Development

This function is to be used only for SPMP and only when performing program planning and policy development activities. The SPMP's tasks must officially involve program planning and policy development, and those tasks must be identified in the employee's position description/duty statement. Examples of activities included in this function are identified below.

California Children's Services

Use skilled professional medical expertise and program knowledge to:

1. Develop medical procedures and protocols for the delivery and coordination of CCS services.
2. Recruit and maintain medical provider resources required to meet the medical needs for the program's population.
3. Inform individual providers and special care center medical staff of medical responsibilities necessary to achieve and maintain CCS panel status.
4. Develop educational resources regarding CCS services and benefits for use by patients/families, providers, and community agencies.
5. Develop and review medically related regulations, policies and procedures, and other health care service standards.
6. Interpret CCS program standards and policy letters to physicians and other health care professionals.

Child Health and Disability Prevention Program

Use skilled professional medical expertise and program knowledge to:

1. Develop and test health education materials related to preventive health services.

2. Develop standards for resolving clinical practice issues.
3. Write medical procedures, and protocols for the delivery and coordination of CHDP services.
4. Draft, analyze, and review medical implications of legislation.
5. Review medical literature and research articles to apply up-to-date knowledge in the delivery of health care services.
6. Develop medical strategies needed to incorporate CHDP preventive services into on-going medical and dental care.

Health Care Program for Children in Foster Care

Use skilled professional medical expertise and program knowledge to:

1. Review medical and social services literature and research articles, requiring medical expertise, with a focus on clinical issues, health care service delivery, and ongoing evaluation of the health care needs of clients in foster care.
2. Develop medical/ health related procedures, protocols, and guidelines for the delivery and coordination of HCPCFC services.
3. Participate in the development and review of medically related policies, procedures, and other health care service standards.
4. Recruit and maintain health care provider resources to meet the medical/health care needs for the program's population.
5. Develop medical/health-related strategies needed to incorporate CHDP, AAP preventive health services into on-going medical, dental, mental health and developmental services.
6. Develop standards and statements of guidance for resolving clinical practice issues.
7. Provide supervision and evaluation of the PHN(s) in the performance of their professional program activities.
8. Review, analyze and develop legislation impacting the medical and health care services for clients in foster care.

Function 9 – Quality Management by Skilled Professional Medical Personnel

This function is to be used only by SPMP and only when performing quality management activities such as monitoring the authorization for medical services (utilization review) process, ongoing program assessment and evaluation, and the development of standards and protocols. Examples of activities included in this function are identified below.

California Children's Services

Use skilled professional medical expertise and program knowledge to:

1. Conduct site reviews and perform other activities necessary to complete the CCS approval process for hospitals, special care centers, and satellite centers.
2. Develop the CCS utilization review teams necessary to carry out the utilization review activities.
3. Identify and implement quality management procedures relating to the medical services aspect of the program that would cover such areas as: authorization of health care services, appropriateness of health care delivery, etc.
4. In those counties with Medi-Cal Managed Care Plans, develop and monitor MOUs with managed care contractors according to the guidelines distributed by the CCS program. Assure that providers caring for children have implemented the tracking and case management processes expressed in the MOU.
5. Conduct medical data analysis to determine adequacy and effectiveness of current standards/practices, identify gaps in services, problems with utilization of resources, need for services/benefits not currently available, etc.
6. Perform concurrent utilization review at acute hospital facilities; ensure the appropriateness/level of care and quality of care provided.
7. Perform county, regional, and state program reviews; evaluate performance, attainment of goals/ objectives, measure outcomes, etc.
8. Develop and utilize medical criteria to review claims, reporting forms, and client charts for the purpose of evaluating the appropriateness and adequacy of medical and allied professional health care.
9. Assess provider qualifications to achieve/ maintain CCS panel status.
10. Develop and utilize criteria to assess services of providers, including medical professional, special care centers, hospitals, and other clinical settings (e.g., MTU, surgicenters).

Child Health and Disability Prevention Program

Use skilled professional medical expertise and program knowledge to:

1. Develop and utilize medical criteria to assess provider qualifications and evidence of quality care.
2. Develop and utilize medical criteria to review claims, reporting forms, and individual medical charts for the purpose of determining appropriateness of medical care.
3. Identify and implement quality management procedures relating to the medical service aspects of the program.
4. Conduct site reviews and chart audits to assure quality exams according to periodicity, calibrated equipment, and appropriately-stored vaccines.

5. Assure that providers caring for children have implemented the follow up to diagnosis and treatment or case management processes expressed in their provider agreement.
6. Review data reports on provider specific assessments of children. Address issues with provider.
7. In those counties with Medi-Cal Managed Care, monitor MOUs with managed care contractors according to the guidelines distributed by the CHDP program.

Health Care Program for Children in Foster Care

Use skilled professional medical expertise and program knowledge to:

1. Conduct joint reviews of case records for documentation of medical, dental and health care services with child welfare services agencies and probation departments.
2. Develop and implement a plan for the evaluation of the impact of the PHN component of the foster care team.
3. Develop and utilize medical criteria to determine evidence of quality care for clients in foster care.
4. Establish baseline data for evaluating the medical, dental and health care services provided to clients in foster care.

Function 10 – Non-Program Specific General Administration

California Children's Services, Child Health and Disability Prevention Program, and Health Care Program for Children in Foster Care

1. Review departmental and unit procedures not related to program administration.
2. Formulate and apply administrative policies.
3. Evaluate fiscal procedures.
4. Develop budgets and monitor use of program funds
5. Prepare reports, documents, and correspondence.
6. Draft, analyze, and/or review legislation.
7. Review literature and research articles.
8. Attend non-program related staff meetings.
9. Direct recruitment, selection, and hiring process - not program specific.
10. Provide and attend non-program specific in-service orientation and other staff development activities.

11. Provide general supervision of staff, including supervision of intern students.
12. Provide general clerical support.

Function 11 – Other Activities

California Children's Services, Child Health and Disability Prevention Program, and Health Care Program for Children in Foster Care

1. Develop funding proposals which do not benefit the Medi-Cal population.
2. Coordinate or participate in research activities which do not benefit the Medi-Cal population.
3. Write grants for federal funding which do not benefit the Medi-Cal population.
4. Participate in health promotion activities for agency employees.
5. Provide related services which can be billed as fee-for-service to Medi-Cal, other State programs, private insurance, the patient, or the county health department, including but not limited to:
 - a. Health status monitoring
 - b. Direct clinical/treatment services
 - c. Individual or group therapy
 - d. Developmental assessments
 - e. Mental status assessments and examinations
 - f. Medical screening services
 - g. Counseling services
 - h. Targeted case management
 - i. Services provided in a Medical Therapy Unit (MTU) such as physical and occupational therapy

Function 12 – Paid Time Off

This function is to be used by all staff to record usage of paid leave, holiday, vacation, sick leave, etc. Do not record on the time study lunchtime, dock time, absence without pay, and use of compensated/certified time off (CTO).

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							

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

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 Col. V x New Gen Admin hrs	VII. ALLOCATE GEN ADMIN HRS Col. VI x New 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														
Program A	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.0		#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-CLAIMABLE														
Program A	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.0		#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!
GENERAL ADMIN	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL FOR DISTRIBUTION PAID TIME OFF	0.0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/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

SECTION 10 – REFERENCES

Staffing Standards for California Children's Services (Historical Document)	3
Figure 2: County Estimates of FTEs Required (Type and Number of Staff).....	10
Figure 3: County Staffing Profiles (Number of Staff by Personnel Class and Active Cases)	11
The Staffing Matrix and Funding of the Child Health and Disability Prevention Program (Historical Document)	12
Legislation, Regulations, and Guidelines for CCS.....	15
Selected State Laws Relating to CCS	16
Health and Safety Code Section.....	16
Government Code Sections (Re: School Therapy Services).....	29
Insurance Code (Re: Healthy Families)	33
Welfare and Institutions Code (Re: Medi-Cal Managed Care Contract Laws).....	34
Legislation, Regulations, and Guidelines for the CHDP Program	39
Selected State Laws Relating to the CHDP Program.....	41
Health and Safety Code Section.....	41
Insurance Code (Re: CHDP Gateway)	52
Welfare and Institutions Code (Re: CHDP Gateway)	53
Legislation, Regulations, and Guidelines for the HCPCFC	57
Selected State Laws Relating to the HCPCFC.....	59
Welfare and Institutions Code Section.....	59
Annual Review for Cash Aid and Food Stamps (TEMP CA 600)	65
CHDP Pre-Enrollment Application (DHS 4073).....	66
CHDP Referral (PM 357).....	67
CHDP Referral for SAWS Automated Template	70
CHDP Referral for Welfare Case Data System Counties.....	71
Confidential Referral/Follow Up Report (PM 161)	72
Confidential Screening/Billing Report - Standard (PM 160)	73
Confidential Screening/Billing Report – Information Only (PM 160 INFO ONLY)	75

Medical and Dental Exams for Children and Youth and Family Planning Services (TEMP 602 B) 77

Important Information for Persons Requesting Medi-Cal (MC 219) 78

Medi-Cal/Healthy Families Mail-In Application (MC 321 HFP) 79

Statement of Citizenship, Alienage, and Immigration Status (MC 13)..... 80

Statement of Facts for Cash Aid, Food Stamps, and Medi-Cal/State-Run County Medical Services Program (SAWS 2) 81

Medi-Cal New Mail-In Application and Instructions (MC 210) 82

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 10-10).

- 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 of 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
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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 10-11). 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 10-11). 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)

Active Cases	Personnel ^A									Total
	MD	Nurse	Other Health Prof ^B	Adm	Asst Admin	Admin Sec	Account Clerks	Tech Staff	Clerks ^C	
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			9	117.4		172.4
				1.0	3.0	2.0				

- 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

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

²Government 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. Notwithstanding 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 or 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 managed 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 from 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.
- (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 as required by Section 124085.

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 601 and 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 and 1203.4a 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. Notwithstanding 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)

To access the most current version of the TEMP CA 600 form, please click on the link listed below.

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

CHDP Pre-Enrollment Application (DHS 4073)

To access the most current version of the DHS 4073 form, please click on the link listed below.

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

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 _____
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5. Requested additional information, but no services.

Requested Medical Services (Health Assessment)			Requested Dental Services		
6. Services <input type="checkbox"/> Yes <input type="checkbox"/> No	7. Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Scheduling <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Services <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Scheduling <input type="checkbox"/> Yes <input type="checkbox"/> No
12. <input type="checkbox"/> New application	13. <input type="checkbox"/> Redetermination	14. <input type="checkbox"/> Self-referral	15. <input type="checkbox"/> CALWORKs		
16. <input type="checkbox"/> Foster care	17. <input type="checkbox"/> Medi-Cal only	18. <input type="checkbox"/> Share-of-cost			
19. Primary language, if other than English _____			20. Other circumstances _____		

Person Number	Client(s) Name (Last, First, Middle)	Birth Date			Age	If health care plan member, give plan name
		Month	Day	Year		
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 CA	ZIP code _____	32. Home phone () _____
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

Children's Medical Services Plan and Fiscal Guidelines for Fiscal Year 2007-08

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: <input type="checkbox"/> Contact made <input type="checkbox"/> No contact made
<input type="checkbox"/> Face-to-face							
<input type="checkbox"/> Telephone							
<input type="checkbox"/> Mail							

Comments:

Client Name	Type		Assistance Given	Date	Provider Name and Telephone	Appt. Date	Appt. Kept		Further Dx/ Rx Needed		Source of Info.	Date PM 160 Received
	T	S					Yes	No	Yes	No		
	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: <input type="checkbox"/> Contact made <input type="checkbox"/> No contact made
<input type="checkbox"/> Face-to-face							
<input type="checkbox"/> Telephone							
<input type="checkbox"/> Mail							

Comments:

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

Comments:

CHDP Health Professional Signature _____ Date _____

PM 357 (8/99) 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

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

BD50120--5Z COUNTY OF ALAMEDA WELFARE CASE DATA SYSTEM CHDP REFERRAL FORM
 CDS286
 CASE NAME LAST FIRST AID-T CASE NUMBER ELIG. DET. DATE
 MS-X
 PAYEE - PHONE NUMBER-
 OAKLAND CA 94603-1602 LANGUAGE-
 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

PM 357 DEL 4/87
 CODE 4 SW EW HH6H
 4-14-00

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
<input type="checkbox"/> FACE - TO - FACE						
<input type="checkbox"/> TELEPHONE						
<input type="checkbox"/> MAIL						

COMMENTS:

FINAL RESULT:
 CONTACT MADE
 NO CONTACT MADE

PART B CONTINUED ON REVERSE SIDE

Confidential Referral/Follow Up Report (PM 161)

To access the most current version of the PM 161 form, please click on the link listed below.

Online Version: <http://www.dhs.ca.gov/publications/forms/pdf/pm161.pdf>

Confidential Screening/Billing Report - Standard (PM 160)

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

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

7

P L E A S E		PATIENT NAME (LAST) (FIRST) (INITIAL)		MEDICAL RECORD NUMBER		LA. CODE	
BIRTH DATE		AGE		SEX MF		PATIENT'S COUNTY OF RESIDENCE	
Month Day Year		Year		()		TELEPHONE NUMBER	
RESPONSIBLE PERSON (NAME)		(STREET)		(APT/SPACE NUMBER)		(CITY) (ZIP CODE)	

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		DATE OF SERVICE Month Day Year	FEE	FOLLOW-UP CODES	
			NEW C	KNOWN D			1. NO DX/RX INDICATED OR NOW UNDER CARE.	4. DX PENDING/RETURN VISIT SCHEDULED.
01 HISTORY AND PHYSICAL EXAM	A							REFERRED TO: _____ TELEPHONE NUMBER _____
02 DENTAL ASSESSMENT/REFERRAL								REFERRED TO: _____ TELEPHONE NUMBER _____
03 NUTRITIONAL ASSESSMENT								COMMENTS/PROBLEMS IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA.
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION								
05 DEVELOPMENTAL ASSESSMENT								
06 SNELLEN OR EQUIVALENT								
07 AUDIOMETRIC			M					
08 HEMOGLOBIN OR HEMATOCRIT								
09 URINE DIPSTICK								
10 COMPLETE URINALYSIS								
12 TB MAN TOUX								
CODE	OTHER TESTS—PLEASE REFER TO THE CHDP LIST OF TEST CODES				CODE	OTHER TESTS		

HEIGHT IN INCHES	WEIGHT Pounds Ounces	BLOOD PRESSURE
0 4		
HEMOGLOBIN	HEMATOCRIT 0%	BIRTH WEIGHT Pounds Ounces

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

PATIENT VISIT (✓)		TYPE OF SCREEN (✓)		TOTAL FEES
<input type="checkbox"/> New Patient or Extended Visit	<input type="checkbox"/> Routine Visit	<input type="checkbox"/> Initial	<input type="checkbox"/> Periodic	

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

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 _____

<input type="checkbox"/> Enrolled in WIC	<input type="checkbox"/> Referred to WIC
NOTE: WIC requires Ht., Wt., and Hemoglobin/Hematocrit	
<input type="checkbox"/> PARTIAL SCREEN	<input type="checkbox"/> SCREENING PROCEDURE RECHECK
ACCOMPANIES PRIOR PM 160 DATED _____	
PATIENT ELIGIBILITY	
COUNTY	AD
IDENTIFICATION NUMBER	
<input type="checkbox"/> If covered by Medi-Cal or pre-enrolled in CHDP Gateway, enter BIC number above.	
<input type="checkbox"/> Patient eligible for CHDP benefits only.	

STATE OF CALIFORNIA—CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

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

COPY 1—MAIL TO MEDI-CAL CHDP

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

7

CLAIM CONTROL NUMBER * FOR STATE USE ONLY

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

BIRTH DATE (Month Day Year) AGE SEX MT PATIENT'S COUNTY OF RESIDENCE CO. CODE TELEPHONE NUMBER (Month Day Year) NEXT CHDP EXAM (Month Day Year) Ethnic Code

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

1—American Indian
2—Asian
3—Black
4—Filipino
5—Mexican American Hispanic
6—White
7—Other
8—Pacific Islander

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		DATE OF SERVICE Month Day Year	FEE	FOLLOW-UP CODES	
			NEW C	KNOWN D			1. NO DX/RX INDICATED OR NOW UNDER CARE	4. DX PENDING/RETURN VISIT SCHEDULED
01 HISTORY AND PHYSICAL EXAM		A						2. QUESTIONABLE RESULT, RECHECK SCHEDULED
02 DENTAL ASSESSMENT/REFERRAL								3. DX MADE AND RX STARTED
03 NUTRITIONAL ASSESSMENT								5. REFERRED TO ANOTHER EXAMINER FOR DX/RX
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION								6. REFERRAL REFUSED
05 DEVELOPMENTAL ASSESSMENT								
06 SNELLEN OR EQUIVALENT								
07 AUDIOMETRIC								
08 HEMOGLOBIN OR HEMATOCRIT								
09 URINE DIPSTICK				M				
10 COMPLETE URINALYSIS								
12 TB MANTOUX								
CODE	OTHER TESTS—PLEASE REFER TO THE CHDP LIST OF TEST CODES				CODE	OTHER TESTS		

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

INFORMATION ONLY REPORTING

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

ICD 9 CODES: 1 | 2 | 3

THE QUESTIONS BELOW MUST BE ANSWERED.

1. Is patient exposed to passive (second-hand) tobacco smoke? Yes No

2. Is tobacco used by patient? Yes No

3. Is patient counseled about/referred for tobacco use prevention/cessation? Yes No

PATIENT VISIT (✓) New Patient or Extended Visit Routine Visit

TYPE OF SCREEN (✓) Initial 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

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)

RELEASE OF INFORMATION NOTICE TO THE RESPONSIBLE PERSON:

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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)

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: _____

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

To access the most current version of the MC 219, please click on the link listed below.

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

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

To access the most current version of the MC 321 HFP, please click on the link listed below.

Online Version: www.healthyfamilies.ca.gov/english/publications/full_app_english.pdf

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

To access the most current version of the MC 13 form, please click on the link listed below.

Online Version: www.dhs.ca.gov/publications/forms/pdf/mc013.pdf

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

For the most current version of SAWS 2, please click on the link listed below.

Online Version: www.dss.cahwnet.gov/pdf/SAWS2.pdf

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

To access the most current version of the MC 210, please click on the link listed below.

Online Version: www.dhs.ca.gov/mcs/medi-calhome/MC210.htm

SECTION 11 – APPENDIX

The Essential Services of Public Health and Ten Essential Public Health Services to Promote Child Health in America	2
Data and Research Resource Guide	4
Child Care	4
Demographics	4
Education	4
Health	5
Social Services.....	7
Abbreviations and Acronyms	8
REPORT OF HEALTH EXAMINATIONS -- ANNUAL SCHOOL REPORT (Optional	12

The Essential Services of Public Health and Ten Essential Public Health Services to Promote Child Health in America¹

1. Monitor health status to identify community health problems.
Assess the status of child health at the local, state, and national levels so problems can be identified and addressed.
2. Diagnose and investigate health problems and health hazards in the community.
Diagnose and investigate the occurrence of health problems and health hazards that impact children.
3. Inform, educate, and empower people about health issues.
Inform, educate, and empower the public and families regarding child health in order to promote positive health beliefs, attitudes and behaviors.
4. Mobilize community partnerships to identify and solve health problems.
Mobilize community partnerships between policy makers, health care providers, the public, and others to identify and implement solutions to child health problems.
5. Develop policies and plans that support individual and community health efforts.
Work with the community to assess the relative importance of children's needs based on scientific, economic and political factors, and provide leadership for planning and policy development to address priority needs.
6. Enforce laws and regulations that protect health and ensure safety.
Promote and enforce laws, regulations, standards, and contracts that protect the health and safety of children and that assure public accountability for their well being.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
Link children to needed population-based, personal health and other community and family support services, and assure availability, access, and acceptability by enhancing system capacity, including directly supporting services when necessary.

¹ See United States Public Health Service. "A Time for Partnership. Report of State Consultations on the Role of Public Health." Prevention Report, December 1994/January 1995: 1-12; and United States Public Health Service, Maternal Child Health Bureau. "Ten Essential Public Health Services to Promote Maternal and Child Health in America." In Public Maternal and Child Health Program Functions: Essential Public Health Services to Promote Maternal and Child Health in America, Preliminary Edition, March 1995.

8. Assure a competent public health and personal health care workforce.

Assure the capacity and competency of the public health and personal health work force to effectively address children's needs.

9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

Evaluate effectiveness, accessibility, and quality of personal health and population-based child health services.

10. Research for new insights and innovative solutions to health problems.

Conduct research and support demonstrations to gain new insights and innovative solutions to child health-related problems.

Data and Research Resource Guide

This guide has been prepared to assist local health departments in accessing data for community health assessments and program planning. These websites provide health, demographic, and socioeconomic data relative to children and youth.

Those data tables marked with an asterisk (*) have been included in previous editions of the CMS Plan and Fiscal Guidelines. Local CMS programs should now obtain these data tables on the web.

Child Care

California Child Care Resource and Referral Network

Homepage and Path: www.rnetwork.org > Enter > Our Research > Select Data

Notes: This link provides information on the California Child Care Portfolio, zip code level maps for childcare supply, and other research and data on working parents and childcare.

Demographics

California Department of Finance *

Homepage and Path: www.dof.ca.gov > Demographic Information > Reports and Research Papers > Select document.

Notes: This link provides information on county-level populations by race/ethnicity, age, and gender, city and county population estimates, school enrollment projections, immigration estimates.

U.S. Bureau of Census

Homepage and Path: www.census.gov > Subjects A to Z > Select subject

Notes: This link provides information on current and historical demographic data from the U.S. Census; poverty estimates; data on child support and health insurance.

Education

California Department of Education *

Homepage: www.cde.ca.gov

Notes: For data on public school enrollment, student demographics, academic performance measures, school lunch programs, and more, go to <http://data1.cde.ca.gov/dataquest>. For private school listings and enrollment, go to <http://www.cde.ca.gov/ds/si/ps/>

California Department of Finance (see Demographics above)

Health

Business Objects Reporting System

Homepage: <http://dhsreports.dhs.ca.gov> (Note: You will need a user name and password to access this system).

Notes: Refer to CHDP Program Letter No. 03-08 for information on accessing the system.

California Department of Alcohol and Drug Programs

Homepage: www.adp.ca.gov/risk_indicators.shtml

Note: This link provides information on county-level statistics on substance use and treatment, health, crime, and other indicators.

California Health Interview Survey

Homepage and Path: www.chis.ucla.edu > Data and Findings

Notes: This website includes the online query system (AskCHIS) as well as downloadable data files; survey data on health behavior and status, service utilization, and demographics; statewide, regional, and county data.

Center for Health Statistics (CDHS)

Homepage and Path: www.dhs.ca.gov/hisp/chs > [click on](#) Vital Statistics Query System or Vital Statistics Data Tables

Notes: This link provides information on creating ad hoc reports or view standard reports for specific birth and death indicators; statewide, county, and zip code level data.

Department of Justice

Homepage and Path: <http://caag.state.ca.us/> > Programs and Services > Criminal Justice Statistics Center > Publications or Statistics

Notes: This link provides data tables and reports on domestic violence, crime, and substance use.

Epidemiology and Prevention for Injury Control Branch (CDHS) *

Homepage: www.applications.dhs.ca.gov/epicdata

Notes: This website includes the California Injury Data Online system and provides information on creating ad hoc reports and viewing standard reports; data on fatal and nonfatal injuries, intentional and unintentional injuries; and statewide and county data.

Immunization Branch (CDHS) *

Homepage and Path: www.dhs.ca.gov/ps/dcdc/izgroup > Schools and Child Care Providers > Immunization Coverage > Select Desired Report

Reports: Child Care Centers Assessment Survey Result; Kindergarten Assessment Survey Result

Notes: This link also provides information on statewide and county-level data on immunization rates for young people.

Improved Perinatal Outcome Data Management

Homepage: <http://www.ipodr.org>

Notes: This link provides information on perinatal data by county of residence and zip code.

Managed Risk Medical Insurance Board

Homepage and Path: www.mrmib.ca.gov > click on Reports > Select Access for Infants and Mothers (AIM) or Healthy Families Monthly Enrollment Reports

Notes: This link provides information on statistical data on enrollment figures.

Medi-Cal Policy Institute

Homepage: www.chcf.org/topics/medi-cal > Click on County Data

Notes: This link provides information on Medi-Cal expenditures and enrollment trends.

Medical Care Statistics Section (CDHS) *

Homepage and Path: www.dhs.ca.gov/mcss > Publications > California's Medical Assistance Program - Annual Statistical Reports > Select Desired Year > Select Desired Format > Go to Table 17

Report: Persons Certified Eligible by County, Sex, and Age (Table 17)

Homepage and Path: www.dhs.ca.gov/mcss > Publications > Medi-Cal Funded Deliveries - Annual Statistical Reports > Select Desired Format > Go to Desired Tables

Reports: This link provides the following reports: Number of Medi-Cal Funded Deliveries by County of Beneficiary and Age of Mother; Number of Medi-Cal Funded Deliveries by County, Age, and Ethnicity of Mother

UCLA Center for Health Policy Research

Homepage: www.healthpolicy.ucla.edu

Notes: This link provides research studies on statewide, regional, and county health insurance coverage and medical service utilization.

Social Services

Child Welfare Research Center

Homepage and Path: <http://cssr.berkeley.edu/CWSCMSreports> > Select Foster Care Dynamics

Notes: These reports include entry and/or exit cohorts as well as other data beyond the first entry cohorts.

Employment Development Department

Homepage and Path: <http://www.edd.ca.gov/> > Labor Market Information

Notes: This link provides county level data on income, unemployment, and labor trends.

Research and Development Division (CDSS)

Homepage and Path: www.dss.cahwnet.gov/research > Children's Programs > Data Tables > Select CWS/CMS2

Data System: Child Welfare Services/Case Management System (CWS/CMS)

Notes: This monthly report provides information on children in out-of-home care statewide and for each county. It shows the characteristics of the children, including age, gender, ethnicity, type of placement home, funding source, agency responsible, number of cases that were terminated and reason for termination.

Homepage and Path: www.dss.cahwnet.gov/research > Program Area

Notes: This link provides utilization data on CalWorks, Food Stamps, Community Care Licensing, and other social services programs.

California State Controller's Office

Homepage and Path: www.sco.ca.gov > SCO Services > State & Local Govt > Local Government

Notes: This link provides references for external administrative overhead allocations for indirect expenses.

Federal Office of Management and Budget

Homepage and Path: <http://www.whitehouse.gov> > OMB > Circulars > State and Local Government > OMB Circular A-87

Notes: This link provides reference for internal administrative overhead costs for cost allocation plan (CAP) for indirect expenses.

Abbreviations and Acronyms

AAP	American Academy of Pediatrics
AB	Assembly Bill
ACIN	All County Information Notice
ACL	All County Letter
ACWDL	All County Welfare Directors Letter
AER	Annual Eligibility Review
AFLP	Adolescent Family Life Program
BIC	Benefits Identification Card
BY	Budget Year
CalWIN	CalWorks Information Network
CalWORKS	California Work Opportunity and Responsibility to Kids
CCR	California Code of Regulations
CCS	California Children's Services
CDC	Centers for Disease Control and Prevention
CDHS	California Department of Health Services
CDSS	California Department of Social Services
CFR	Code of Federal Regulations
CHDP	Child Health and Disability Prevention Program
CHEAC	County Health Executives Association of California
CIN	Client Index Number
CLPPP	Childhood Lead Poisoning Prevention Program
CMS Net	Children's Medical Services Network
CMS	Children's Medical Service; Centers for Medicare and Medicaid Services
CMSP	County Medical Services Program
COHS	County Organized Health Systems
CSHCN	Children with Special Health Care Needs
CTO	Compensatory/Certified Time Off
CWS	Child Welfare Services
CWS/CMS	Child Welfare System/Case Management System
CY	Calendar Year
DHS 4073	CHDP Pre-Enrollment Application
DHS 4505	CHDP Report of Distribution
E 47	Enhancement 47
EDC	Expected Date of Confinement
EDS	Electronic Data Systems (CDHS's Fiscal Intermediary)
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EPSDT-SS	Early and Periodic Screening, Diagnosis, and Treatment-Supplemental Services
EW	Eligibility Worker

FFP	Federal Financial Participation
FIG	Federal Income Guidelines
FTE	Full Time Equivalent
FY	Fiscal Year
GHPP	Genetically Handicapped Persons Program
GMC	Geographic Managed Care
HCC	Hearing Coordination Center
HCFA	Health Care Financing Administration (now known as CMS)
HCPCFC	Health Care Program for Children in Foster Care
HEP	Health Education Passport
HF	Healthy Families
HFP	Healthy Families Program
HIPAA	Health Insurance Portability and Accountability Act
HRIF	High Risk Infant Follow-up Program
HRSA	Health Resources and Services Administration
IAA	Interagency Agreement
ICD 10	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision
ICD 9	International Classification of Diseases, Ninth Revision
IEP	Individualized Educational Plan
IFSP	Individualized Family Services Plan
IHO	In-Home Operations
IN	Information Notice
LEA	Local Education Agency
M & T	Maintenance and Transportation
MC 13	Statement of Citizenship, Alienage, and Immigration Status
MC 210	Statement of Facts (Medi-Cal Only Mail in Application)
MC 219	Important Information for Persons Requesting Medi-Cal
MC 321 HFP	Medi-Cal/Healthy Families Mail-In Application
MC	Medi-Cal
MCAH	Maternal, Child, and Adolescent Health
MCMC	Medi-Cal Managed Care
MEBIL	Medi-Cal Eligibility Branch Information Letter
MEDS	Medi-Cal Eligibility Data System
MMCD	Medi-Cal Managed Care Division
MOE	Maintenance of Effort
MOU	Memorandum of Understanding
MPP	Manual of Policies and Procedures
MRMIB	Managed Risk Medical Insurance Board
MTC	Medical Therapy Conference
MTP	Medical Therapy Program

MTU	Medical Therapy Unit
NHSP	Newborn Hearing Screening Program
NICU	Neonatal Intensive Care Unit
NL	CCS Numbered Letter
Non SPMP	Non Skilled Professional Medical Personnel
NPP	Notice of Privacy Practices
OPRC	Outpatient Rehabilitation Centers
PCFH	Primary Care and Family Health Division
PCMS	Program Case Management Section
PFG	Plan and Fiscal Guidelines
PHD	Public Health Department
PHN	Public Health Nurse
PICU	Pediatric Intensive Care Unit
PIN	CHDP Provider Information Notice
PL	CHDP Program Letter
PM 160 INFO ONLY	Confidential Screening/Billing Report (Information Only)
PM 160	Confidential Screening/Billing Report (Standard)
PM 161	Confidential Referral/Follow Up Report
PM 171 A	Report of Health Examination For School Entry
PM 171 B	Waiver of Health Examination for School Entry
PM 272	CHDP Annual School Report
PM 357	CHDP Referral Form
PO	Probation Officer
POS	Point of Service Device
PSA	Program Service Agreement
PSD	Payment Systems Division
PSQA	Program Standards and Quality Assurance
PSS	Program Support Section
PSU	Provider Services Unit
RC	Regional Center
ROS	Regional Operations Section
SAWS 2	Statement of Facts for Cash Aid, Food Stamps, and Medi-Cal/State Run CMSP
SB	Senate Bill
SCC	Special Care Center
SCHIP	State Child Health Insurance Program
SCRO	CCS Southern California Regional Office
SELPA	Special Education Local Planning Area
SFRO	CCS San Francisco Regional Office
SOW	Scope of Work
SPC	Substitute Care Provider
SPHN	Supervising Public Health Nurse

SPMP Skilled Professional Medical Personnel
SRO CCS Sacramento Regional Office
SY School Year
TCM Targeted Case Management
TEMP 602 B ..Medical and Dental Exams for Children and Youth and Family Planning Services,
Annual Mail-In Redetermination Referral
TEMP CA 600.....Annual Review for Cash Aid and Food Stamps
WIC Women Infants and Children Supplemental Nutrition Program

REPORT OF HEALTH EXAMINATIONS -- ANNUAL SCHOOL REPORT (Optional)

See instructions on reverse side.

1. School code—public school district or private school _____ County School District School Code	2. Check one Public school district Private school	3. School year 20__ to 20__
4. Number of schools in district with first grade enrollment _____	5. Telephone number ()	

6. Please provide name of public school district or private school, mailing address (number, street), City, State, and ZIP code in the space provided below.

7. Physical address (if different from mailing address)			City	State	ZIP code	
Name of School (School Districts and Private Agencies Reporting More Than One School Must Complete Items 10–15 for Each School Reported)	Total Number of Children Enrolled in First Grade at Time Report Prepared (Columns 10, 11, 12, 13, and 14)	Number of Children With Report of Health Examination for School Entry (PM 171 A) On File	Number of Children with Waiver of Health Examination for School Entry (PM 171 B)			Number of Children with Neither Documentation Nor Waiver of Examination On File
			Parent Does Not Want the Examination	Parent Unable to Obtain the Examination	Reason Not Specified	
8.	9.	10.	11.	12.	13.	14.
15. Total number of schools reporting	16. Total enrolled first graders	17.	18.	19.	20.	21.

HAVE ALL ITEMS BEEN COMPLETED?

22. I certify that the numbers of children reported above are true numbers and that the parents and guardians of these children were informed of the requirement for health screening prior to first grade entry, pursuant to Section 124100, Health and Safety Code.

Print Name	Signature	Date
23. Name of contact person if different than above		24. Telephone number of contact person, if different from item 5

REPORT OF HEALTH EXAMINATIONS ANNUAL SCHOOL REPORT

INSTRUCTIONS

This form is used to report data described in Section 124100 of the Health and Safety Code. The data are a record at a point in time of the children entering first grade with a report of health examination or waiver. Using the form makes it possible to compare the results from year to year. The Report of Health Examinations Annual School Report can be obtained from the CHDP program in your local health department.

1. For public school districts and offices of education, enter the two-digit county code, the five-digit school district code, and seven zeros (0) for the school code. For private schools, enter the two-digit county code, the five-digit school district code, and the seven-digit school code. Codes for public school districts and offices of education are listed in the "California Public School Directory." Codes for private schools are listed in the "California Private School Directory." School codes can also be found at <http://www.cde.ca.gov/re/sd/>.
- 2-7. Self-explanatory.
8. Enter the name of each school reporting. If more than seven schools, attach a separate sheet with all required information.
9. Enter total first grade enrollment for each school. The SDE Annual Enrollment Data Report (R30) may be used as a source for this data.

NOTE: Ungraded Schools—Children age six on or before December 2 of any school year are defined as the equivalent of "children entering first grade."

Special Education Pupils—If school records indicate a complete examination was received within 18 months of first grade entry, report the child as having a documented examination. See "Ungraded Schools" above to determine equivalent of first grade entry.

10. Enter the number of children with a Report of Health Examination for School Entry (PM 171 A) on file. Children with only documentation signed by the parent or oral confirmation by the parent or examiner should be reported in item 14.
11. Enter the number of children with a Waiver of Health Examination for School Entry (PM 171 B) whose parent(s) indicate they are waiving because they do not want the examination.
12. Enter the number of children with a Waiver (PM 171 B) whose parent(s) indicate they are waiving because they cannot obtain the examination.
13. Enter the number of children with a Waiver (PM 171 B) with no reason or a reason that does not correspond to items 11 or 12.
14. Enter the number of children with neither documentation of a health examination, as defined in item 10, above, nor a signed waiver as indicated in items 11-13 above. Include children whose parents have not responded or refused to submit documentation/waiver, and the children who entered late and still have 90 days to complete the requirement, etc.
15. Enter the total number of schools reporting (include schools on any attached sheets).
- 16-21. Enter the total number of children from each column. (Include totals from multiple schools on any attached sheets, if necessary.) Item 16 should equal the total of items 17, 18, 19, 20, and 21.
22. Print or type name of individual authorized to submit report on the first line. Their original signature and date signed must be entered in ink on the signature and date lines.
23. Print or type the name of contact person, if different from item 22.
24. Print or type the telephone number of the contact person (from items 22 or 23) if it is different from the telephone number in item 5.

Provide a copy of the Annual School Report to the CHDP program in the local health department and other agencies, organizations, or entities according to your local school district policies. If you have any difficulty completing the form, please contact the local CHDP program.

Online version: www.dhs.ca.gov/pcfh/cms/chdp/publications.htm

SECTION 12 – INDEX

A

Abbreviations and Acronyms.....	11-7
Agency Description	2-3
Agency Information Sheet	2-2, 2-8
Allocations	
CHDP	1-11, 6-17
HCPCFC	1-17, 6-70

B

Budget Instructions.....	6-3
Budget Justification Narrative Sample.....	6-12
Budget Revision Information	6-108
Budget Revision Justification Narrative Sample	6-134
Budget Tips	6-6

C

Capital Expense Justification Form	6-15
Capital Expense	6-9
Cash Aid Annual Review (TempCA 600)	10-65
CCS Administrative Budget Worksheet.....	6-97
CCS Administrative Budget Worksheet Instruction	6-94
CCS Caseload	
CCS Caseload Box	6-90, 6-92
CCS Caseload Summary – Instructions	4-4
CCS Caseload Summary – Form	4-7
CCS/Healthy Families Worksheet	6-104

CCS Diagnostic, Treatment and Therapy Reporting Invoice.....

CCS Legislation, Regulations and Guidelines..... 10-15

CCS Program Overview 1-6

CCS Staffing Standards6-93, 6-81, 10-3

Certification Statement – CCS 2-10

Certification Statement – CHDP 2-9

CHDP Baseline Allocation Table 6-34

CHDP Budget Worksheet 6-42

CHDP Budget Worksheet Instructions 6-37

CHDP Legislation, Regulations, and Guidelines 10-41

CHDP Pre-Enrollment Application (DHS 4073)..... 10-66

CHDP Program Case Management Data Form 4-1, 4-11

CHDP Program Overview 1-11

CHDP Referral (PM 357)..... 10-67

CHDP Special Projects 7-2

CHDP Staffing Factor Worksheet..... 6-28

CHDP Staffing Guidelines 6-17

CHDP Staffing Matrix Profile Guidelines 6-35

Checklist (required documents in plan submission) 2-2, 2-6

Children's Medical Services Branch Overview 1-3

Confidential Referral/Follow-up Report (PM 161)..... 10-72

Confidential Screening/Billing Report (PM 160) 10-73

Cost Allocation Plan

D

Data and Research Resource Guide..... 11-3

Data Forms 4-1

DHS 4073 CHDP Pre-Enrollment Application 10-66

Diagnostic, Treatment, and Therapy Reporting Invoice

E

Equipment Identification Tag Transmittal Letter 8-95

Essential Services of Public Health and Ten Essential
Public Health Services to Promote Child Health In America 11-1

Expenditure Claims and Property Management..... 8-1, 8-70

 CHDP 8-5

 HCPCFC 8-14

 CCS..... 8-22, 8-40

F

Federal Financial Participation (FFP) 9-1

FFP Forms and Excel File Instructions..... 9-38

Forms – see

 Capital Expense Justification Form 6-15

 CHDP Program Case Management Date Form 4-11

 CCS Caseload Summary 4-7

 Data Forms 4-1

 Other Expenses Justification Form..... 6-16

Foster Care Administrative (county/city match) Budget Instructions 6-61

Foster Care Administrative (county/city match) Budget Worksheets..... 6-65

Furniture (see Operating Expenses) 6-8

G

Genetically Handicapped Persons Program Overview 1-14

H

HCPCFC Average Annual Caseload..... 4-19
HCPCFC Administrative Budget Worksheet 6-76
HCPCFC Administrative Budget Worksheet Instructions 6-73
HCPCFC Legislation, Regulations, and Guidelines 10-59
HCPCFC Overview 1-17
HCPCFC Staffing Guidelines 6-71

I

Important Information for Persons Requesting

Medi-Cal (MC 219) 10-79

Incumbent Lists

CCS..... 2-11
CHDP 2-12
HCPCFC 2-13

Indirect Expenses, Internal and External..... 6-10

Interagency Agreement (IAA) CHDP, Social Services Probation 5-3, 5-10

Inventory of State Furnished Equipment 8-93

Invoices (See Quarterly Administrative Expenditure Invoices or Diagnostic, Treatment and Therapy Reporting)

J

Justification Forms (see Other Expenses Justification Form or Capital

Expense Justification Form

K

L

Legislation

CCS..... 10-15
CHDP 10-39
HCPCFC 10-57

M

MC 13 Statement of Citizenship, Alienage, and Immigration Status 10-80
MC 210 Medi-Cal New Mail-in Application and Instructions 10-82
MC 219 Important Information for Persons Requesting Medi-Cal 10-79
MC 321 HFP Medi-Cal/Healthy Families Mail-in Application..... 10-91
Medi-Cal/Healthy Families Mail-in Application (MC 321 HFP) 10-91
MOU/IAA Model Agreements
 CCS/HF 5-4
 CCS/Regional Offices and CCS Dependent Counties 5-7
 CHDP/DSS..... 5-10
 HCPCFC 5-25
MOU/IAA Agreement List 2-14

N

Newborn Hearing Screening Program Overview..... 1-19

O

Office Supplies (see Operating Expenses)..... 6-8

Operating Expenses..... 6-7
Other Expenses 6-10
Other Expenses Justification Form 6-16

P

Performance Measures..... 3-9
 Directions for Completing Performance Measures 3-10
Personnel Expenses 6-7
PM 160 Confidential Screening/Billing Report..... 10-73
PM 272 CHDP School Annual Report..... 11-11
PM 357 CHDP Referral 10-67
Property Survey Report..... 8-94

Q

Quarterly Administrative Expenditure Invoices..... 8-1
 CCS..... 8-33
 CHDP 8-12
 CHDP Foster Care 8-18
 HCPCFC 8-17
Quarterly Diagnostic, Treatment and Therapy Reporting..... 8-67
 CCS Diagnostic, Treatment, and Therapy..... 8-67
 CCS Healthy Families 8-87

R

References..... 10-1

S

Salary Savings

CHDP Administrative Budget No County/City Match..... 6-38
CHDP Administrative Budget County/City Match 6-51
CHDP Foster Care Administrative Budget County/City Match 6-68
SAWS 2 Statement of Facts for Cash Aid, Food Stamps and Medi-Cal..... 10-81
School Annual Report (PM 272)..... 11-11
Scope of Work..... 3-1
Skilled Professional Medical Personnel (SPMP) 9-13
Space Rental..... 6-8
Statement of Citizenship, Alienage, and Immigration Status (MC 13)..... 10-80
Statement of Facts for Cash Aid, Food Stamps and Medi-Cal SAWS 2..... 10-81

T

Target Population, CHDP

FY 2005-06 4-13
FY 2006-07 4-15
FY 2007-08 4-17
Time Study Forms 9-7
Time Study Function Codes 9-15
Time Study Examples by Program 9-22
Time Study Instructions 9-4
Training Expenses..... 6-7
Travel Expenses 6-7

U

V

W

Web References, Resources 11-3